Help Line Work Incentives Planning and Assistance (WIPA) Referral and WIPA Intake (SSA-4565)

Instructions: Use Acrobat to open and save this form to retain accessibility features. Help Line representatives should complete items 1-20, and Work Incentives Planning and Assistance (WIPA) Community Work Incentives Coordinators (CWICs) should complete items 21-66. If the referral does not come from the Help Line, CWICs should complete the entire form. CWICs must complete this form. Beneficiaries should not complete it themselves.

1. Date of contact:	2. Servicing WIPA:

3. a. Previously referred? ☐ Yes ☐ No b. If yes, date:

4. Name (first, middle, last):

5. a. Address (include city, state and ZIP):

b. County:

6. a. Cell phone:	b. Work phone:
c. Home phone:	d. Teletype (TTY/TDD)/Videophone number/Internet Protocol (IP) address:

7. Email address:

8. Best time and number to call:

9. a. Beneficiary's preferred language: ☐ English ☐ Other

b. If "Other", specify

10. a. Representative Payee? ☐ Yes ☐ No If yes, complete 10b - e:

b. Representative Payee name (first, middle, last):

c. Representative Payee address (include city, state and ZIP):

d. Representative Payee phone:

e. Representative Payee email:

11. Social Security Number (SSN) :

12. Claim number (if different from beneficiary SSN):

13. Date of birth:

14. Is the beneficiary between the ages of 14 and 25 at the time of referral? ☐ Yes ☐ No

15. Is the beneficiary a Veteran of the United States Military? ☐ Yes ☐ No

16. Type of benefits received by the beneficiary (verified by iTOPSS):

- ☐ Supplemental Security Income (SSI)
- ☐ Title II (Social Security Disability Insurance (SSDI) (Includes: Childhood Disability Benefits (CDB) and Disabled Widow(er)s Benefits (DWB))
- ☐ Concurrent entitlement (SSI and SSDI)

17. a. Ticket status (if over 18):	b. If assigned/in-use with Vocational Rehabilitation agency, agency name:

18. a. Employment status:

- ☐ Full-time employment or self-employment
- ☐ Part-time employment or self-employment
- ☐ Job offer pending
- ☐ Not employed

b. If employed, job details (job title, # hours/week, pay rate):

c. Employer health benefits? ☐ Yes ☐ No ☐ Not Applicable(N/A)

d. Reported work to Social Security Administration (SSA)? ☐ Yes ☐ No ☐ N/A

19 a. Other benefits received? ☐ Yes ☐ No ☐ N/A

b. If "Yes", specify

20. Beneficiary concerns/questions:

WIPA Intake Information

21. Date of referral:

22. Source of referral:

- ☐ Ticket to Work Help Line
- ☐ Beneficiary or Representative Payee self-referral
- ☐ Vocational Rehabilitation agency
- ☐ Employment Network
- ☐ Other community agency

23. Beneficiary Unique Identifier:	24. CWIC:

25. Local SSA Field Office:

Additional Demographics

26. a. Primary contact:

☐ Beneficiary ☐ Representative Payee ☐ Guardian ☐ Other

b. If "Other", specify

27. a. Is the Representative Payee the legal guardian? ☐ Yes ☐ No

If there is a legal guardian who is not the representative payee, complete lines 27 b-e.

b. Legal guardian name (first, middle, last):

c. Legal guardian address:

d. Legal guardian phone:

e. Legal guardian email:

28. a. Preferred method of contact for primary contact:

☐ Telephone ☐ Email ☐ In-person
☐ Skype or other video conferencing ☐ Via an interpreter ☐ Other

b. If "Other", specify

29. a. Alternate contact: ☐ Representative Payee ☐ Guardian ☐ Other

b. If "Other", specify relationship and complete lines 29 c-f

c. Alternate contact name:

d. Alternate contact address:

e. Alternate contact phone:

f. Alternate contact email:

30. a. Preferred method of contact for alternate contact:

☐ Telephone ☐ Email ☐ In-person

☐ Skype or other video conferencing ☐ Via an interpreter ☐ Other

b. If "Other", specify

31. Describe any language or accommodation needs:

32. If over age 18 and receiving SSI, has Social Security conducted the age 18 redetermination?

☐ Yes ☐ No

33. When did the disability begin?

☐ Prior to age 22 ☐ Between age 22 and prior to age 26 ☐ Age 26 or older

34. Does the beneficiary have a *my* Social Security account?

☐ Yes ☐ No ☐ Recommended

35. List the primary disability:

36. Statutorily Blind?

☐ Yes ☐ No

37. Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)

38. Race (choose all that apply):

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefers not to provide

39. Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefers not to provide

40. Sex:

☐ Male ☐ Female ☐ Other

41. List other people in the household:

Name / Relationship	Age	Receiving Benefits?		Type of Benefit	Amount	Comments
		☐ Yes	☐ No			
		☐ Yes	☐ No			
		☐ Yes	☐ No			
		☐ Yes	☐ No			

42. If any household member (spouse or children) receives any type of means-tested benefits describe:

43. For SSI and Medicaid recipients only, describe all income or in-kind support:

Type of Income/ In-Kind Support	Source	Amount

Benefits at Intake

44. a. Health insurance:

☐ Medicare (list parts in 44b.) ☐ Medicaid (list type in 44b.) ☐ Private
☐ Employer-sponsored ☐ Veteran's Affairs ☐ Other (describe in 44b.) ☐ None

b. Health insurance notes:

45. SSA benefits:

Benefit	Receiving	Amount	Comments
SSI	☐		
SSDI	☐		
CDB	☐		
DWB	☐		
Other	☐		

46. a. Medicaid number (if applicable):

b. Medicaid benefits:

Benefit	Receiving	Recommended	Comments
SSI-based	☐	☐	
1619 (b)	☐	☐	
Medicaid Home and Community-based Waiver (specify in comments)	☐	☐	
Medicaid Spend-down	☐	☐	
Medicaid Buy-in	☐	☐	
Other Medicaid Program (specify in comments)	☐	☐	

47. a. Medicare number (if different than SSN):

b. Medicare benefits:

Benefit	Receiving	Recommended	Comments
Part A	☐	☐	
Part B	☐	☐	
Medicare Savings Program (Qualified Medicare Beneficiary (QMB)/Special Low-Income Medicare Beneficiary (SLMB)/ Qualified Individual (QI) or other Medicare Buy-in group	☐	☐	
Medicare Advantage Plan – Part C (specify in comments)	☐	☐	
Part D	☐	☐	
Part D Low Income Subsidy (full / partial)	☐	☐	
Premium Health Insurance (HI) for the Working Disabled	☐	☐	

48 . Other Benefits:

Benefit	Receiving	Amount (if applicable)	Recommended
Employer or other private health insurance (specify type) _____	☐		☐
Food stamps (Supplemental Nutrition Assistance Program (SNAP))	☐		☐
Housing subsidy (specify type) _____	☐		☐
Veteran’s compensation	☐		☐
Veteran’s pension	☐		☐
Temporary Aid to Needy Families (TANF)	☐		☐
Unemployment insurance	☐		☐
Worker’s compensation	☐		☐
Public disability benefit	☐		☐
Alimony or child support (specify) _____	☐		☐
Energy assistance	☐		☐
SSI State Supplementation	☐		☐
Other (specify) _____	☐		☐

49. Excluded savings:

Benefit	Receiving	Recommended
Individual Development Account (IDA)	☐	☐
Achieving a Better Life Experience (ABLE) Account	☐	☐
Trust	☐	☐
Property Essential for Self Support (PESS)	☐	☐

50. Additional benefits or assets (for example, benefits specific to your state):

Benefit/Asset	Amount (if applicable)	Comments

51. Eligible for WIPA services? ☐ Yes ☐ No

Educational History and Goals

52. Highest grade completed:

☐ Primary or secondary school ☐ Certificate ☐ Graduate equivalent (GED)
☐ High school diploma ☐ Vocational/technical ☐ Some college
☐ Undergraduate degree ☐ Graduate degree

53. a. If under age 22, is the beneficiary regularly attending school? ☐ Yes ☐ No ☐ Not Applicable

b. If “Yes”, is the Student Earned Income Exclusion applicable? ☐ Yes ☐ No

54. Describe any educational goal(s):

Employment history and financial goals:

55. a. Does the beneficiary want to (choose one):

- ☐ Increase income without losing SSDI or SSI benefits
- ☐ Reduce SSDI or SSI benefits
- ☐ Eliminate SSDI or SSI benefits

b. Comments on work goals

Employment goal(s):

56. Earning goal 1:

a. Type of position or field of work:

b. Number of hours anticipated per week:

c. Hourly wage or salary:

d. Estimated monthly earning goal:

57. Earning goal 2:

a. Type of position or field of work:

b. Number of hours anticipated per week:

c. Hourly wage or salary:

d. Estimated monthly earning goal:

58. Employment services the beneficiary receives:

Agency	Contact	Service(s)
Employment Network (specify name) _____		
Vocational Rehabilitation		
Other Employment Services (specify name) _____		
American Job Center		
Vocational Training (specify name) _____		
Youth Transition Program (specify name) _____		
Other (specify below): _____		

59. List the services the beneficiary needs to reach his or her employment goal:

60. Does the beneficiary want you to share the Benefits Summary and Analysis (BS&A) or other information about benefits counseling with any employment support agency or other person? If yes, obtain release. ☐ Yes ☐ No

61. BS&A delivery:

a. Beneficiary:

☐ Telephone ☐ Email ☐ US mail ☐ In-person
☐ Skype or other video conferencing ☐ Via an interpreter ☐ Other

b. If "Other", specify

c. Alternate Contact:

☐ Telephone ☐ Email ☐ US mail ☐ In-person
☐ Skype or other video conferencing ☐ Via an interpreter ☐ Other

d. If "Other", specify

Employment Since Entitlement

62. a. Employment status at the time the CWIC begins providing individualized services

☐ Full-time employment or self-employment ☐ Part-time employment or self-employment
☐ Job offer pending ☐ Not employed

If job offer pending or not employed skip to #63

b. Start date of current employment or self-employment:

c. If employed, name of employer:

d. If employed, weekday or dates employer issue paychecks

e. If employed, the amount of gross wages per ☐ hour ☐ week ☐ month ☐ year is _____ (enter amount)

f. If self-employed, nature of the business

g. If self-employed, estimated net profit

h. Has the beneficiary reported these earnings to Social Security? ☐ Yes ☐ No

i. If “Yes”, give the date(s) of the report, and the manner he or she used to report the earnings:

63. Prior Work History:

Employer/Job title	Hours/week	Rate of pay	Dates of Employment	Comments

64. List out of pocket expenses that could be Impairment Related Work Expenses (IRWE) or Blind Work Expenses (BWE):

65. Describe special employment supports the beneficiary received in the past, currently uses, or expects to need in the near future. Also describe any other indication that the beneficiary has a possible subsidy, such as working with a job coach.

66. Notes, additional information and next steps:

Privacy Act Statement
Collection and Use of Personal Information

Sections 1148 and 1149 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may limit your ability to participate in the Work Incentive Planning and Assistance (WIPA) program.

We will use the information you provide to determine if you qualify for the WIPA program. We may also share your information for the following purposes, called routine uses:

- To State or Employment Networks having an approved business arrangement with Social Security Administration (SSA) to perform vocational rehabilitation services for SSA disability beneficiaries and recipients; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent
debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0295, entitled Ticket-to-Work and Self-Sufficiency Program Payment Database, as published in the Federal Register (FR) on April 4, 2001, at 66 FR 17985, and 60-0300, entitled Ticket-to-Work Program Manager Management Information System, as published in the FR on June 15, 2001, at 66 FR 32656. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*