WIPA Intake Information

1. Date:	2. CWIC:

3. Referral Source:

☐ Help Line ☐ State VR Agency ☐ Other (specify) _____

Beneficiary Demographics

4. Name:	5. Social Security Number:
6. Medicare Claim Number (if different from SSN):	7. Medicaid Number (if applicable):
8. Date of Birth:	9. Age:

10. If under age 18 and receiving SSI, has Social Security conducted the Age 18 redetermination?

☐ Yes ☐ No

11a. 11. Was the beneficiary disabled prior to age 26? ☐ Yes ☐ No

11b. If "Yes," does the beneficiary have an Achieving a Better Life Experience (ABLE) account? ☐ Yes ☐ No

12. List the primary disability:

13. Statutorily blind? ☐ Yes ☐ No

14. When did the disability begin?

15. Is the beneficiary a U.S. Military Veteran? ☐ Yes ☐ No

16. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)

17. List other people in the household

Name	Age	Receiving Benefits?

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

19. For SSI and Medicaid recipients only, describe all income or in-kind support received including source and amount of income:

20. Does the beneficiary have a My Social Security account? ☐ Yes ☐ No ☐ Recommended

21. Primary contact information:

☐ Beneficiary ☐ Representative Payee ☐ Guardian ☐ Other (specify) _____

22. Address (include city, state, and ZIP):

23. Phone	a. Home:	
	b. Cell:	c. Work:
	d. TTY/Videophone Number/IP address:	

24. Email address:

25. Best time to reach:

26. Preferred manner of contact:

☐ Telephone ☐ Email ☐ In-Person ☐ Skype or Other Video Conferencing

☐ Via an Interpreter ☐ Other (specify) _____

27. Benefits Summary and Analysis (BS&A) delivery:

☐ Telephone ☐ Email ☐ In-Person ☐ Skype or Other Video Conferencing

☐ Via an Interpreter ☐ Other (specify) _____

28. Describe language or accommodation needs:

29. Alternate contact information:

☐ Beneficiary ☐ Representative Payee ☐ Guardian ☐ Other (specify) _____

30. Address (include city, state, and ZIP):

31. Phone	a. Home:	
	b. Cell:	c. Work:
	d. TTY/Videophone Number/IP address:	

32. Email address:

33. Best time to reach:

34. Preferred manner of contact:

☐ Telephone ☐ Email ☐ In-Person ☐ Skype or Other Video Conferencing

☐ Via an Interpreter ☐ Other (specify) _____

35. Please describe any language or accommodation needs:

Educational History and Goals

36. Highest grade completed:

☐ Primary or Secondary school ☐ Certificate ☐ Graduate Equivalent (GED) ☐ High School

☐ Vocational/Technical ☐ Some college ☐ Undergrad ☐ Graduate Degree

37. Describe any educational goal(s):

Employment history and financial goals:

38. Does the beneficiary want to eliminate benefits? ☐ Yes ☐ No

39. Does the beneficiary want to reduce dependence on benefits? ☐ Yes ☐ No

Employment goal(s):

40. 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: _____

41. 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: _____

42. Please list the employment services the beneficiary receives:

Agency	Service	Service	Service
Employment Network			
State VR			
Other Employment Services			
American Job Center			
Vocational Training			
Youth Transition Program			
Other (specify below):			

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

44. Does the beneficiary want you to share the BS&A or other information about benefits advisement with any employment support agency or other person? If yes, obtain release. ☐ Yes ☐ No

Employment Since Entitlement

45. Is the beneficiary currently employed or self-employed? ☐ Yes ☐ No

a. If "Yes," list the name of the beneficiary's Employer or beneficiary business

_____

b. The beneficiary is ☐ employed ☐ self-employed

c. The employment or self-employment is ☐ full-time ☐ part-time

d. If employed, the amount of gross wages every ☐ hour ☐ week ☐ month ☐ year is _____

e. If employed, what weekday or dates does the employer issue the paycheck? _____

f. If the beneficiary is self-employed, what is the nature of the business:

_____

g. What is the beneficiary's 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:

_____

Benefits at intake

46. SSA Benefits:

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

47. Medicaid:

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

48. Medicare:

Benefit	Receiving	Recommended
Part A	☐	☐
Part B	☐	☐
Medicare Savings Program (QMB/SLMB/ QI1) or other Medicare Buy-in group	☐	☐
Part D	☐	☐
Part D Low Income Subsidy	☐	☐
Premium HI for Working Disabled	☐	☐

49. Other Benefits:

Benefit	Receiving	Recommended
Employer or other Private Health Insurance	☐	☐
Food Stamps (SNAP)	☐	☐
Housing Subsidy (Specify type)	☐	☐
Veteran's Compensation	☐	☐

Benefit	Receiving	Recommended
Veteran's Pension	☐	☐
TANF	☐	☐
Unemployment Insurance	☐	☐
Worker's Compensation	☐	☐
Public Disability Benefit	☐	☐
Alimony or child support (specify)	☐	☐
Energy Assistance	☐	☐
SSI State Supplementation	☐	☐
Other (specify)	☐	☐
	☐	☐

50. Excluded Savings

Benefit	Receiving	Recommended
Individual Development Account (IDA)	☐	☐
ABLE account	☐	☐
Trust	☐	☐

51. Additional Benefits (For example, benefits specific to your state)

Benefit	Comments

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

53. 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.

54. Notes, additional information and next steps:

SSA will insert the following revised PRA Statement into the form as soon as possible:

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.*