

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
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
		<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/>		
SSDI	<input type="checkbox"/>		
CDB	<input type="checkbox"/>		
DWB	<input type="checkbox"/>		
Other	<input type="checkbox"/>		

46. a. Medicaid number (if applicable):

b. Medicaid benefits:

Benefit	Receiving	Recommended	Comments
SSI-based	<input type="checkbox"/>	<input type="checkbox"/>	
1619 (b)	<input type="checkbox"/>	<input type="checkbox"/>	
Medicaid Home and Community-based Waiver (specify in comments)	<input type="checkbox"/>	<input type="checkbox"/>	
Medicaid Spend-down	<input type="checkbox"/>	<input type="checkbox"/>	
Medicaid Buy-in	<input type="checkbox"/>	<input type="checkbox"/>	
Other Medicaid Program (specify in comments)	<input type="checkbox"/>	<input type="checkbox"/>	

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

b. Medicare benefits:

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

48 . Other Benefits:

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

49. Excluded savings:

Benefit	Receiving	Recommended
Individual Development Account (IDA)	<input type="checkbox"/>	<input type="checkbox"/>
Achieving a Better Life Experience (ABLE) Account	<input type="checkbox"/>	<input type="checkbox"/>
Trust	<input type="checkbox"/>	<input type="checkbox"/>
Property Essential for Self Support (PESS)	<input type="checkbox"/>	<input type="checkbox"/>

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Primary or secondary school | <input type="checkbox"/> Certificate | <input type="checkbox"/> Graduate equivalent (GED) |
| <input type="checkbox"/> High school diploma | <input type="checkbox"/> Vocational/technical | <input type="checkbox"/> Some college |
| <input type="checkbox"/> Undergraduate degree | <input type="checkbox"/> 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.**