KWIN Work Incentive Planning & Assistance

Beneficiary/Recipient Contact Form & Profile

ETO CASE#: ______________

SPOE#: ______________

Date: __________________ **Referral source: ________________**

Beneficiary Name: ____

Gender: Male / Female **Date of Birth __________________________**

Social Security Number: ___________________________________

Address: ___________________________________Zip: ______________Cnty: ________________

Phone: __________________________2nd Phone: ___________________________

Email: _______________________________

Primary Disability: ____

Date of Entitlement / Second DI: ____

Current Benefits: ***Please fill in your benefit amount for each box that you receive a benefit***

SSI	SSDI	SSCDB	DWB	Dependent Benefit	Any reductions?
Medicaid	Medicare	Part A	Part B	Part D	Veteran Benefit
Private Health Ins	Food Stamps	HUD/Section 8	LIEAP	Workers Comp	UnEmp Comp
Private Disability	TANF	Other	Working Healthy	WORK	

Notes:

Office Use Only Date Sent:

INTAKE PACKET_____________________________
RELEASES ONLY_____________________________
GENERIC ANALYSIS__________________________

SSA821 WK ACTIVITY REPORT ________________
WORKING HEALTHY INFO______________________

PERSONAL DEMOGRAPHICS – for grant data collection only

Education Level: ____________________________ Under 22? Are you a full-time student?: ___________

Race/Ethnicity: ____

Representative Payee (if applicable)

Name and Agency: ____

Address: ____

Phone Number: ____________________________________

CURRENT EMPLOYMENT STATUS

☐ **Employed Full-Time** ☐ **Employed Part-Time** ☐ **Not Employed, Seeking Employment**

☐ **Under Age 22 and full time student**

Name of Job/Potential Job: __________________________Start Date: __________________________

Hourly wage/Salary: $_____________________________

TOTAL HOURS WORKED PER WEEK: ___________________

Anticipated Employment Status Change:

☐ Do not intend to change current employment status

☐ Intend to seek new job or supplemental job

☐ Intend to increase work hours in current job

☐ Intend to decrease work hours in current job

☐ Have not decided yet

And, I do… (Check each, if Yes)

☐ Intend to use CPRF Employment Network

☐ Intend to pursue education or training

HAVE YOU WORKED PART-TIME SINCE YOUR DISABILITY DETERMINATION?

☐ **YES** ☐ **NO**

Have you worked full-time since their disability determination? ☐ **Yes** ☐ **No**

Have you worked as self-employed person since their disability determination? ☐ **Yes** ☐ **No**

RESIDENTIAL AND FAMILY INFORMATION

Type of Residence:

☐ House ☐ Apartment ☐ Group home ☐ Other, please describe: ______________________

Does the beneficiary own the beneficiary's home?
☐ Yes ☐ No

Living Situation:

☐ **Independently** ☐ **With spouse** ☐ **With Child(ren)** ☐ **With parent(s)**

☐ **With another responsible adult (describe)** ______________________________

Are parents or spouse contributing to the beneficiary's household income? ☐ **Yes** ☐ **No**
Is there any additional income to your household? ☐ **Yes** ☐ **No**
What is the source? ______________________
Do you personally pay a rent or room and board? ☐ **Yes** ☐ **No**

Individual's marital status: ☐ **Married** ☐ **Separated** ☐ **Widowed** ☐ **Divorced** ☐ **Single/Never Married**

Number and Ages of individual's dependent children:

Do children receive any Social Security benefits based upon beneficiary's record?

Amount received per child: $________________

WAIVERS / SERVICE PROGRAMS

Does the individual participate in any of the following waiver or service programs? Please indicate waiver used and service provided.

	Service Provided
☐ **Mental Retardation/Developmental Disability Waiver**	______________________
☐ **TBI Waiver**	______________________
☐ **Physical Disability Waiver**	______________________
☐ **Technology Assisted Children's Waiver**	______________________
☐ **Vocational Rehabilitation Services**	______________________
☐ **Protection and Advocacy Services**	______________________
☐ **Para transit Services**	______________________
☐ **Work-Related Training**	______________________

ASSETS

Please indicate the total dollar value of cash equivalent items: **$**____________________
(Savings, Checking, Stocks, Promissory Notes, Retirement Accounts, etc.)

Does the individual own a car? ☐ **Yes** ☐ **No**

Modified for use by a person with a disability? ☐ Yes ☐ No

Used as transportation to get to work? ☐ Yes ☐ No

Used for necessary medical treatment? ☐ Yes ☐ No

IMPAIRMENT RELATED-WORK EXPENSES

List monthly expenses used to control or assist with the disabling condition that the individual has to have in order to work. (The individual must pay the expense; it must be related to the impairment; and it must enable the individual to work.)

	Monthly Cost
☐ **Transportation**	**$______________________**
☐ **Medication Expense (co-payments or cost)**	**$______________________**
☐ **Medical Expenses (co-payments/insurance) Not premiums**	**$______________________**
☐ **Attendant care at home**	**$______________________**
☐ **Medical devices**	**$______________________**
☐ **Work related equipment**	**$______________________**
☐ **Residential modification to work away from home**	**$______________________**
☐ **Residential modifications to work at home**	**$______________________**
☐ **Attendant care at work**	**$______________________**
☐ **Prosthetic devices**	**$______________________**
☐ **Blind Work Expense**	**$ ______________________**

Examples are:
Helper animal expenses, transportation to and from work, Federal, State and local income taxes, Social Security taxes, attendant care services, visual and sensory aids, Braille translation cost, association fees and union dues.

You may attach a resume.

You need to attach an example of your current budget especially if you are interested in using the Plan to Achieve Self-Sufficiency commonly known as a PASS – SSA form 545.