



Benefits Orientation Checklist

02/2018

Beneficiary Name:		SSN:	Date of BPQY:
Guardian (if applicable): Phone Number:		Signed SSA Consent form(s) on file: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Consent signatures are valid for a period of 6 months</i>	
Payee (if applicable): Phone Number:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Does the spouse also receive SSA benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of Dependents:	

CURRENT BENEFITS AND PROGRAM SUPPORTS

<input type="checkbox"/> Social Security Disability Insurance (SSDI) <input type="checkbox"/> Childhood Disability Benefit (CDB) <input type="checkbox"/> Disabled Widow(er) Benefit (DWB) <input type="checkbox"/> Auxiliary Benefits (<i>applicable to children</i>) <input type="checkbox"/> Medicare: Part(s) A ___ B ___ D ___ <i>Check all that apply</i> <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Social Security Retirement <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid Waiver	<input type="checkbox"/> AABD Cash Payment <input type="checkbox"/> TANF/ADC <input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> Subsidized Housing <input type="checkbox"/> Energy Assistance <input type="checkbox"/> Telephone Assistance Program <input type="checkbox"/> MHCP <input type="checkbox"/> Welfare to Work/EF <input type="checkbox"/> HHSS <input type="checkbox"/> Disabled Persons & Family Support <input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Unemployment Insurance <input type="checkbox"/> Private Insurance COBRA, Employer or Spousal Employer coverage, etc.. List here: <input type="checkbox"/> General Assistance <input type="checkbox"/> Other
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EMPLOYMENT

<input type="checkbox"/> Earned Income (check if employed) ↳ Amount: _____ week _____ month _____ year <input type="checkbox"/> Self-Employment ↳ Amount: _____ week _____ month _____ year	If employed, does the individual require: <input type="checkbox"/> Workplace Personal Assistance Services <input type="checkbox"/> Specialized or Modified Transportation Needs <input type="checkbox"/> Employment Supports (job coach, extra supervision, etc.)
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SSA WORK INCENTIVES Review this information or use the Work Incentive Guide(s) as applicable

<p align="center">TITLE II (SSDI/CDB/DWB)</p> <p><i>Most commonly used:</i> Trial Work Period (TWP) ↳ Months Used: _____ Extended Period of Eligibility (EPE) ↳ Start Date: _____ ↳ End Date: _____ Impairment Related Work Expense (IRWE) <i>Also includes:</i> Subsidy & Special Conditions, Unsuccessful Work Attempt, Plan to Achieve Self-Support (PASS)*, Extended Medicare (ExM), Expedited Reinstatement of Benefits (ExR), Section 301, Ticket to Work * A SSI incentive that can also be available to a Title II beneficiary.</p>	<p align="center">TITLE XVI (SSI)</p> <p><i>Most commonly used:</i> Earned Income Exclusion (- \$20 GIE & - \$65 EIE) Continuation of Medicaid through 1619(b) Student Earned Income Exclusion (SEIE) Impairment Related Work Expense (IRWE) <i>Also includes:</i> Plan to Achieve Self-Support (PASS), Blind Work Expenses (BWE), Property Essential for Self-Support (PESS), Expedited Reinstatement of Benefits (ExR), Section 301, Ticket to Work</p>
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_____ VR Benefits Specialist	_____ Date
Pre-Employment Plan Action: <input type="checkbox"/> Orientation Completed Referred to (if applicable):	

NOTES/COMMENTS: