



**Intake
Form**

*Please fill out as completely
as possible and send to:*

Plan to Work
Community-Minded Enterprises
25 W Main Ave #310
Spokane, WA 99201

*Or Fax to (509) 444-3077
Attn: Plan to Work*

Questions:
1-866-497-9443 (toll free)
1-877-846-0775 (toll free TTY)

Top section for Plan to Work use only—do not fill out information in this area.

Beneficiary Name: _____ Date of Intake: _____

Benefits Specialist Name: _____ Date of Plan: _____

VCU Number: _____ SSDI SSI Concurrent

SSA Information Release Form Date Sent: _____ Date Received: _____

Contact Information *Please fill out the first two pages as completely as possible. PLEASE PRINT.*

Name: _____

Address: _____ / _____
(Street Address) (Mailing Address, if different)

(City) (State) (Zip) (County)

Phone: _____ Alternate Phone: _____

Email: _____ Date of Birth: _____

SSN: _____ -- _____ -- _____ Gender: M / F (circle one)

Primary Disability: _____

Language or Accommodations Needs: _____

Other Contact, if desired (relative, guardian, representative payee, advocate, vocational provider, etc)

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Provide this person a copy of your Plan to Work information, as needed?

Y / N (circle one) Initials: _____

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Provide this person a copy of your Plan to Work information, as needed?

Y / N (circle one) Initials: _____

Note: If you have a payee, conservator, or guardian, they will need to be included in your employment decisions, and they are encouraged to participate in benefits planning services.

General Information

This section gives us the information we need to make sure that our benefits planning information is tailored for you. This information is kept confidential unless you sign a release for us to share it with another person or agency.

Income:

SSI (\$_____) SSDI (\$_____) *is this off your own record ___ or a parent's ___?*
 Gross Wages (\$_____) Widow/Widower's benefits (\$_____)
 Spouse Survivor's Benefits (\$_____) Children's Survivor's Benefits (\$_____)

Other Household Income: (list all amounts and sources, including child support, veterans benefits, etc.)

Marital Status: single married divorced engaged deceased spouse

Household Composition: _____ # of people in house

Describe: _____

Are you head of household? Y / N (circle one)

Housing: rent own other (_____) Amt. per month: (\$_____)

Current Employment: part time not employed, seeking employment
 full time not employed, not seeking employment

Have you worked since beginning to receive disability payments? Y / N (circle one)

Describe: _____

Other Services/Programs:

- | | | |
|--|--|---|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Subsidized Housing | <input type="checkbox"/> Veterans' Benefits |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Sect. 8 Tenant Based | <input type="checkbox"/> Civil Service Ret/Dis. |
| <input type="checkbox"/> Spend Down | <input type="checkbox"/> Sect. 8 Project Based | <input type="checkbox"/> LTC Insurance Benefits |
| <input type="checkbox"/> HWD (Medicaid Buy-In) | _____ | <input type="checkbox"/> Worker's Comp. |
| <input type="checkbox"/> Private Health Ins. | <input type="checkbox"/> Supportive Housing | <input type="checkbox"/> Unemployment Insurance |
| <input type="checkbox"/> TANF | <input type="checkbox"/> Group Home | <input type="checkbox"/> Railroad Retirement |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Adult Family Home | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> HOPWA | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> HOME Investment Partnership | |

Transportation: *Check all that apply*

Car Bus Other (_____)

Do you have a driver's license? Y / N (circle one)

Other Related Information

Filling out this page will help us have a better picture of your situation and other parts of your life that may be involved in your employment decisions. Please include anything you think we should know—concerns, goals, needs, etc.

Employment:

Financial:

Housing:

Transportation:

Education/Training:

Medical:

Other Concerns:



SOCIAL SECURITY

BENEFITS PLANNING, ASSISTANCE, AND OUTREACH PROGRAM

Data Collection Use

The Benefits Planning, Assistance, and Outreach (BPAO) program is established by the Social Security Administration (SSA) under a law called the Ticket to Work and Work Incentives Improvement Act of 1999. Under the BPAO program, SSA awards money to organizations so they can provide SSA beneficiaries with accurate information about work incentives and benefits planning. SSA collects information from these organizations, including the names and Social Security numbers of the beneficiaries that the organizations serve, so SSA can evaluate the BPAO program.

The information collected is used for statistical purposes and to verify that the people being served are SSA beneficiaries. Information reported as part of the BPAO program will **not** become part of your Social Security record. The information will **not** be reported to the SSA office that makes eligibility determinations. You are responsible for reporting income or changes in status to the SSA office.

→ _____
Signature

_____ Date

→ _____
Print Name

NOTE: Plan to Work is one of the two BPAO projects in Washington state.
1-866-497-9443 (toll free)
1-877-846-0775 (toll free TTY)

Release 1

Form Approved
OMB NO. 0960-0566

Social Security Administration Consent for Release of Information

Please read these instructions carefully before completing this form.

When To Use This Form Complete this form only if you want the social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- o non-medical records, should use this form.
- o medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F3. You can get this form at any social Security office.

How To Complete This Form

This consent form must be completed and signed only by:

- o the person to whom the information or record applies, or
- o the parent or legal guardian of a minor to whom the non-medical information applies, or
- o the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- o Fill in the name, date of birth, and social security number of the person to whom the information applies.
- o Fill in the name and address of the individual or group to which we will send the information.
- o Fill in the reason you are requesting the information.
- o Check the type(s) of information you want us to release.
- o Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PAPERWORK REDUCTION ACT: Paperwork Reduction Act Statement: This information collection meets the clearance 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 control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. The office is listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 for the address. You may send comments on our estimate of the time needed to complete the forms to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form SSA-3288 (3-2005) EF (3/2005)

RELEASE 1

Form Approved
OMB NO. 0960-0566

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name Date of Birth Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME ADDRESS

Plan to Work
Community-Minded Enterprises
25 W Main Ave #310
Spokane, WA 99201

I want this information released because:

I need to have accurate and current information about my benefits and work record so I can make an informed choice about work.

(There may be a charge for releasing information.)

Please release the following information:

- ___ Social Security Number
- ___ Identifying information (includes date and place of birth, parents' names)
- ___ Monthly Social Security benefit amount
- ___ Monthly Supplemental Security Income payment amount
- ___ Information about benefits/payments I received from _____ to _____
- ___ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
- ___ Medical records
- ___ Record(s) from my file (specify) _____

Other (specify) **I request a Benefits Planning Query (BPQY) be sent to the person(s) named above that will include information about Trial Work Period status, Continuing Disability Review, SSI and/or SSDI amount, Medicare/Medicaid status, etc. if applicable. The information will be used solely for the development of an individual plan for employment to assist me in achieving employment and accessing the Social Security work incentive programs.**

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

Release 2

Form Approved
OMB NO. 0960-0566

Social Security Administration Consent for Release of Information

Please read these instructions carefully before completing this form.

When To Use This Form **Complete this form only if you want the social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).**

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- o non-medical records, should use this form.
- o medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F3. You can get this form at any social Security office.

How To Complete This Form

This consent form must be completed and signed only by:

- o the person to whom the information or record applies, or
- o the parent or legal guardian of a minor to whom the non-medical information applies, or
- o the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- o Fill in the name, date of birth, and social security number of the person to whom the information applies.
- o Fill in the name and address of the individual or group to which we will send the information.
- o Fill in the reason you are requesting the information.
- o Check the type(s) of information you want us to release.
- o Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

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RELEASE 2

Form Approved
OMB NO. 0960-0566

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number
_____	_____	_____

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
_____	_____
_____	_____
_____	_____

_____	Plan to Work	_____
_____	Community-Minded Enterprises	_____
_____	25 W Main Ave #310	_____
_____	Spokane, WA 99201	_____

I want this information released because:

I need to have accurate and current information about my benefits and work record so I can make an informed choice about work.

(There may be a charge for releasing information.)

Please release the following information:

- Social Security Number
- Identifying information (includes date and place of birth, parents' names)
- Monthly Social Security benefit amount
- Monthly Supplemental Security Income payment amount
- Information about benefits/payments I received from _____ to _____
- Information about my Medicare claim/coverage from _____ to _____
(specify) _____
- Medical records
- Record(s) from my file (specify) _____
- Other (specify) **I authorize release of the summary of my posted annual earnings as reported from employers and the IRS and recorded by SSA.**

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____