

**Appendix F —  
BENEFITS SCREENING PROFILE  
A MODEL QUESTIONNAIRE**

*This Questionnaire is adapted from one developed by Neighborhood Legal Services, Inc. of Buffalo, New York and is intended as an aid to analyze the effect of work on benefits. It should be used as a guide in conducting both telephone and in-person interviews of persons with disabilities and/or the persons who seek assistance on their behalf. In some cases the interviewer will need to gather no more than a fraction of the information sought by the form. In other cases the interviewer will want to cover all or most of the questions. If in doubt, obtain all the suggested information during the interview and gather any documents (e.g., Social Security Administration notices) that might be relevant.*

**Name of Interviewer:**

**Date of Interview(s):**

**Was the Client/Consumer Interviewed? \_\_ yes \_\_ no**

**Other Person Interviewed**

**(i.e., not the client/consumer):**

**Initial Questions Presented:**

## I. Personal Demographics

**Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **County of residence:** \_\_\_\_\_  
**State of residence:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_  
**Type of residence, check one:**  
 Home, apartment  
 Group home  
 Intermediate Care Facility (ICF)  
 Hospital  
 Other, please describe: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Residential placement funding (specify): \_\_\_\_\_

Married / single / divorced (circle one)

Name of spouse: \_\_\_\_\_

Names, ages of children: \_\_\_\_\_

Living arrangements

Live alone?  yes  no

Live with spouse?  yes  no

Live with children?  yes  no

Live with roommate?  yes  no

Share expenses?  yes  no

## II. Personal Direction and Future Outlook

Reason for referral:

Expectations for services being requested:

Preferred location to receive services:

Individual's long-range dreams and aspirations:

Employment:

Postsecondary and/or continuing education:

Community living:

What the person expresses they need to achieve their desired outcomes (frame as supports):

Individual's current family and social connections:

### III. Disability Description

Primary diagnosis:

Secondary diagnosis:

Tertiary diagnosis:

Age of onset of disability:

Specific date if available:

Currently seeing a doctor or therapist?       yes  no

Name(s), address(es) of doctor(s) or therapist(s):

Medication, please list:

Any side effects:  yes  no

Describe side effects:

How does disability limit activities?

How does disability limit ability to work?

**IV. Involvement With Other Agencies / Support Systems**

Is the individual still enrolled in secondary school?     yes  no

If yes, name of school:

Name, phone number of teacher:

Describe education program:

Is the individual enrolled in continuing education or a postsecondary education institution?     yes  no

If yes, name of school:

Name, phone number of counselor:

Describe education program:

Is the individual involved with the state VR agency?     yes  no

If yes, name of agency:

Name, phone number of VR counselor:

Describe program, services getting from agency:

Is the individual involved with a private VR agency?     yes  no

If yes, name of agency:

Name, phone number of VR counselor:

Describe program, services getting from agency:

Is the individual involved with the State MR/DD system?  yes  no

If yes, name of agency:

Name, phone number of case manager/rep:

Describe program, services getting from agency:

Is the individual involved with the State MH system?  yes  no

If yes, name of agency:

Name, phone number of case manager/rep:

Describe program, services getting from agency:

Is the individual involved with any other agencies?  yes  no

If yes, name of agency:

Name, phone number of case manager/rep:

Describe program, services getting from agency:

If yes, name of agency:

Name, phone number of case manager/rep:

Describe program, services getting from agency:

If yes, name of agency:

Name, phone number of case manager/rep:

Describe program, services getting from agency:

Briefly describe other informal or unpaid supports in the individual's life (family, friends, etc.):

## V. Monthly Income

Unearned Income:

SSDI amount:

Type of benefit (check appropriate benefit):

- Against own record  
 Disabled Adult Child  
 Widows/Widowers  
 Other:  
 Unknown

Unemployment amount:

Veteran's benefit amount:

Railroad Retirement Pension amount:

Alimony / Palimony amount:

Child Support amount:

Private disability insurance amount:

Worker's Compensation amount:

Other amount (specify types):

Financial Needs-Based Assistance (means tested):

SSI amount:

Pell grant amount:

TANF amount:

Food stamps amount:

State subsidized housing:     yes  no amount:

HUD:     yes  no amount:

Other amount (specify types):

Anyone in household receive welfare benefits?     yes  no

Describe form and amount:



If individual receives SSDI or SSI:

Name, address of Social Security office serving them:

If known, name, address, phone, fax and email address of Claims Representative serving them:

Earned Income / Wages:

\_\_\_ employed by others \_\_\_ self-employed

Monthly gross amount:

Weekly gross amount:

Bi-weekly gross amount:

If wages vary, please explain:

Other income in household:

Spouse, describe form and amount:

Children, describe form and amount:

**VI. Resources***(Relevant to SSI, Medicaid eligibility.)*

The individual

Own home  yes  no

If jointly owned, please indicate other owner(s):

Bank accounts

Savings, list amount:

Checking, list amount:

Other, describe and list amount:

Individual retirement account (IRA), tax deferred annuity or similar retirement account - describe and list amounts:

Vehicle owned by individual

Model and year:

Check one:  car  van  truck  other, describe:

Current fair market value:

If market value is more than \$4,500, is it:

Modified for use by a person w/ disability?  yes  noUsed as transportation to get to work?  yes  noUsed for necessary medical appointments?  yes  no

Responsible relative with whom person resides

Check one:  spouse  parent(s)  other, describe:

Own home \_\_ yes \_\_ no

Bank accounts

Savings, list amount:

Checking, list amount:

Other, describe and list amount:

Individual retirement account (IRA), tax deferred annuity or similar retirement account - describe and list amounts:

## VII. Property Essential for Self Support

Describe any property owned (and its value) that is used in job as an employee (such as mechanic's tools, carpenter's tools):

Describe any property owned (and its value) that is used in "self employment" (such as office equipment, company vehicle, stock, business bank account):

### VIII. Employment Information

*(If Employed, About to Start Working or Considering a Job)*

Name, address of employer or potential employer:

Describe job (or potential job)

Title:

Duties:

Hours:

Salary/hourly wage:

Benefits:

Date you started working (as employee):

How job was found?

Found on own:  yes  no

Agency helped find job, describe:

If self employed (or potentially self employed)

Describe business:

Date started:

Was job selected because of limits of disability?  yes  no

If yes, please explain:

Any extra or special supervision on job?  yes  no

If yes, describe:

Is this a "supported employment" position?  yes  no

Agency sponsoring job:

Is there a job coach?  yes  no

Name:

Hours per month:

Services performed:

How long will job coach remain in picture?

Does government agency (i.e., other than employer) pay all or part of wage?  yes  no

Please describe:

Please record work history (past 10 years) or attach resume/vita.

Place of Employment

Title

Duties

Wage/Hours

Dates

Briefly describe any past attempts at self-employment:

Business Type

Location

Dates

Income

Reason for Cessation

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## IX. Trial Work Period (TWP) Analysis

*This section applies to SSDI recipients only. To complete this section, it may be necessary to develop a comprehensive, month-by-month, history of work and wages since the consumer first started collecting SSDI benefits. This can be done on the attached "Notes" pages or on a separate document. Also, if the person is self-employed you may need to discuss what constitutes a trial work month. NOTE: The minimum gross wages for a TWP "services month" was \$200 from 1/90 to 12/00; \$530 during calendar year 2001; \$560 during calendar year 2002; \$570 during calendar year 2003; and will be \$580 during calendar year 2004.*

Date when first received SSDI?

Has person worked and earned more than TWP amount in any month(s) since first receipt of SSDI?  yes  no

*If no, full nine-month TWP available.*

*If yes, continue through questions.*

Did person use up nine TWP months before 1/1/92?

*If yes, no TWP available unless SSDI terminated, eligibility re-established after new application and new five-month waiting period.*

If person did not exhaust TWP before 1/1/92

Work nine TWP months during 60-month period which ended after 1/1/92?  yes  no

*If yes, TWP exhausted.*

If less than nine TWP months during 60-month period, list each TWP month during past 60 months. For each, list month, year and gross wages earned. [Note: In many cases, will have to obtain information from SSA. This information is now available through the Benefits Planning Query or BPQY, which can be requested from SSA.]

<u>Month</u>	<u>Year</u>	<u>Gross Wages Earned</u>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Based on information, how many TWP months left?



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## **X. Extended Period of Eligibility (EPE) Analysis** *(SSDI recipients only)*

Ninth TWP month (month/year):

Beginning of EPE (month/year):

Last month of 36-month EPE (month/year):

### **Remember, during EPE:**

*The first time that the individual is determined to be performing substantial gainful activity by earning more than the applicable SGA amount, they will get SSDI checks for that month and two more (i.e., during the “grace period”)*

*Following the grace period:*

- *No SSDI check during months countable gross wages exceed the SGA amount.*
- *Will get SSDI check when countable gross wages less than the SGA amount.*

*Impairment related work expenses (IRWEs) and subsidies are deducted from gross wages.*

### **Listing of EPE payment, nonpayment months:**

*This should be done on a separate worksheet.*

**XI. EXPEDITED REINSTATEMENT (EXR)**

A. Has individual received SSDI benefits in the past?

yes  no

*If no, stop and go on to B.*

*If yes, continue.*

Did individual lose SSDI due to performance of SGA?

yes  no

*If no, stop and go to B.*

*If yes, continue.*

Has individual completed their TWP and EPE?

yes  no

*If no, stop and go to B.*

*If yes, continue.*

Has individual either stopped working or ceased performing SGA?

yes  no

*If no, stop and go to B*

*If yes, continue.*

Interviewer should do a full screening for potential EXR eligibility on the SSDI claim.

B. Has the individual received SSI benefits in the past?

yes  no

*If no, stop. If yes, continue.*

Did the individual lose SSI due to budgeting of wages or a combination of wages and other income?

yes  no

*If no, stop. If yes, continue.*

Is individual currently receiving Medicaid through the 1619(b) program?

yes  no

*If yes, stop. The EXR provisions are not needed to reinstate SSI cash benefits. If no, continue.*

Has individual received either SSI cash benefits or 1619(b) Medicaid within the past 12 months?

yes  no

*If yes, stop. The EXR provisions are not needed to reinstate cash benefits. If no, continue.*

Would individual be eligible for SSI based on current income because he/she either stopped working or is now earning less money?

yes  no

*If no, stop. If yes, continue.*

Interviewer should do a full screening for potential EXR eligibility on the SSI claim.

**XII. Health Insurance Needs**

Health insurance coverage, check each that is available:

Medicaid

Amount of spend down, if any:

If enrolled in a Buy-In program, amount of premium, if any:

*(Note: Not every state will have a Medicaid spend down program.)*

Medicare

Part A (hospitalization)

Part B (outpatient)

Does individual pay Part B premium?  yes  no

*Discuss availability of Medicaid payment of Part B premium*

Private insurance

Monthly/quarterly/yearly premium paid by individual:

Other, please describe:

Total out-of-pocket expenses for spend downs, premiums:

Monthly:

Yearly:

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### Special Medicaid categories

If not eligible for Medicaid, or receive Medicaid with a spend down:

Did you receive SSI in the past?                    \_\_\_ yes \_\_\_ no

Section 1619(b) eligibility:

Did you lose SSI due to wages?                    \_\_\_ yes \_\_\_ no

If yes, go through 1619(b) eligibility work up.

Medicaid eligibility under SSDI/DAC, SSDI for widows/widowers, Pickle Amendment provisions:

Did you lose SSI due to receipt of some form of Social Security benefits?                    \_\_\_ yes \_\_\_ no

If yes, please describe:

*Go through work up for special eligibility categories.*

*If your state has a Medicaid Buy-In and individual is not otherwise eligible for Medicaid or eligible for Medicaid with a spend down, screen for buy-in eligibility.*

### Doctor visits

Estimate monthly or annual costs:

What purpose?

How covered?

Total out-of-pocket expenses

Monthly:

Yearly:

Psychiatrist visits

Estimate monthly or annual costs:

What purpose?

How covered?

Total out-of-pocket expenses

Monthly:

Yearly:

Mental health counseling

Estimate monthly or annual costs:

What purpose?

How covered?

Total out-of-pocket expenses

Monthly:

Yearly:

Other therapies (occupational, physical, speech, etc.)

Please describe

Estimate monthly or annual costs:

What purpose?

How covered?

Total out-of-pocket expenses

Monthly:

Yearly:

Home health care

Estimate monthly or annual costs:

What purpose?

How covered?

Total out-of-pocket expenses

Monthly:

Yearly:

Medication

Estimate monthly or annual costs:

Describe each medication and purpose?

How covered?

Total out-of-pocket expenses

Monthly:

Yearly:

Other health-related costs

For each, list item(s), monthly or annual costs, purpose and how covered:

Item

Monthly/Annual Cost

Purpose

How Covered

### XIII. Analysis of Impairment Related Work Expenses

*Remember three-part criteria for IRWE: Individual must pay expense in question; Item/expense must be related to disability; and, Individual could not work if he or she did not receive item or service.*

#### Transportation IRWE

Nature of item/service:

How related to disability and work:

Monthly cost:

#### Medication IRWE

Nature of item/service:

How related to disability and work:

Monthly cost:

#### Health insurance IRWE (premiums, co-payments, deductibles)

*(Note: Current SSA policy allows IRWE deductions for co-payments and deductible, but not for premiums.)*

Nature of item/service:

How related to disability and work:

Monthly cost:

#### Other IRWEs (check each that applies and describe below):

- |  |   |
|--|---|
| <input type="checkbox"/> attendant care at home                          | <input type="checkbox"/> attendant care at work |
| <input type="checkbox"/> medical devices                                 | <input type="checkbox"/> prosthetic devices     |
| <input type="checkbox"/> work related equipment                          |   |
| <input type="checkbox"/> residential modification to work away from home |   |
| <input type="checkbox"/> residential modifications to work at home       |   |



Other # 1

Nature of item/service:

How related to disability and work:

Monthly cost:

Other # 2

Nature of item/service:

How related to disability and work:

Monthly cost:

**XIV. Blind Work Expenses (BWEs)**

Is the individual legally blind?  yes  no

If legally blind and individual is working:

Is the individual an SSI recipient?  yes  no

*If yes, do BWE work up.*

If the person is not an SSI recipient, do work up for potential SSI eligibility using BWEs.

If legally blind and not currently working, explain potential for BWEs.

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## XV. Analysis of Subsidies

*Remember why we look for a subsidy: to ensure that only earnings that represent the true value of the work a person is performing are considered in making the determination of SGA.*

### Subsidy checklist

- Is government agency paying part of wage?       yes  no
- Does individual get special assistance on  
the job?       yes  no
- Does individual perform fewer duties than  
others?       yes  no
- Does employer accept less productivity than  
from others?       yes  no
- Does individual receive extra rest periods/  
breaks?       yes  no
- Is individual frequently absent or working  
hours because of disability?       yes  no
- Does individual receive job coach assistance?       yes  no

If you checked yes to any of the above, describe the special circumstances:

Calculate value of monthly subsidy, indicating countable wages after subsidy:

## XVI. SSI Plan for Achieving Self Support (PASS)

Does individual have an approved PASS? \_\_\_ yes \_\_\_ no

If yes, describe briefly and obtain a copy for file.

If no, explain PASS and then complete remaining questions.

Does individual have income other than SSI? \_\_\_ yes \_\_\_ no

If yes, please describe (see section V, above):

Does individual have resources in the form of bank accounts or items that could quickly be converted to cash?

If yes, please describe (see section VI, above):

Are there goods and/or services, that would help individual reach a vocational goal, that he or she would purchase if extra money were available? \_\_\_ yes \_\_\_ no

If yes, list items, their expected purpose and their approximate cost, if known:

Items

Expected Purpose

Approximate Cost

**XVII. Ticket to Work**

Has SSA started to implement the Ticket program in your state?  yes  no

*If no, stop. If yes, continue.*

Is individual receiving services under a Ticket?  yes  no

*If no, stop. If yes, continue.*

Name of Employment Network: \_\_\_\_\_

Contact at EN: \_\_\_\_\_

Describe services received from EN: \_\_\_\_\_

\_\_\_\_\_

*NOTE: If individual is receiving services from the state's vocational rehabilitation agency, they may be receiving those services under the Ticket.*

Explain that individual will not be subject to a continuing disability review while using a Ticket and making timely progress.

**NOTES**

**NOTES**

# BENEFITS SCREENING PROFILE

## A SAMPLE COMPLETED QUESTIONNAIRE

**Name of Interviewer:** *Connie Michaels*

**Date of Interview(s):** *9/24/06*

**Was the Client/Consumer**

**Interviewed?**  **yes**  **no**

**Other Person(s) Interviewed:**

*Mark Sanders, Rehabilitation  
Counselor, ABC Rehab, Inc.*



**Interview  
Completed in  
the Future**

**Initial Questions Presented:**

*Has been working for nearly 2 years. Is she still entitled to SSDI?  
Was she entitled to checks she got during past 2 years?*

### I. Personal Demographics

**Name:** *Anne Perreault*

**Social Security #:** *000-00-0000*

**Address:** *Anywhere*

**County of residence:** *Local*

**State of residence:** *USA*

**Date of birth:** *7/2/65*

**Type of residence, check one:**

**Home, apartment**

**Group home**

**Intermediate Care Facility (ICF)**

**Hospital**

**Other, please describe:**



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**Home phone:** 888-8888

**Work phone:** 999-9999 (*emergency calls only*)

**Fax:** *N/A*

**E-mail:** *N/A*

**Residential placement funding (specify):**

**Married / *single* / divorced**

**Name of spouse:** *N/A*

**Names, ages of children:** *Jill Perreault, age 20 (also lives in Buffalo)*

**Living arrangements:**

**Live alone?**  yes  no

**Live with spouse?**  yes  no

**Live with children?**  yes  no

**Live with roommate?**  yes  no

**Share expenses?**  yes  no

## II. Personal Direction and Future Outlook

### **Reason for referral:**

*Wants to know if still eligible for SSDI despite her working for nearly 2 years.*

### **Expectations for services being requested:**

*Wants to know if she was entitled to the SSDI checks received to date. Is she entitled to any SSDI checks in the future?*

### **Preferred location to receive services:**

### **Individual's long-range dreams and aspirations:**

#### **Employment:**

*Maintain her current employment. In future, work in supervisory capacity, or run her own business doing this work.*

#### **Postsecondary and/or continuing education:**

*None at this time.*

#### **Community living:**

*Continue in her own apartment.*

**What the person expresses they need to achieve their desired outcomes:**

*Timely information regarding benefits – i.e., benefits advisement. Rehabilitation counseling support.*

**Individual's current family and social connections:**

*66 year old mother, Madeline Perrault; 20 year old daughter, Jill Perrault; one close friend, Mary Jamison, who also is in treatment for mental illness. Mother – Does things socially with Anne. They go to church, to dinner, to movies together. They support each other. Daughter – Calls on the phone; visits on weekends. Has car and often takes Anne shopping. Friend, Mary – A person with similar problems. She is the one person, other than Anne's therapist, that Anne can really confide in about her disability. Anne talks to her by phone 3 to 4 times per week.*

### III. Disability Description

**Primary diagnosis:** *Longstanding depression*

**Secondary diagnosis:** *Anxiety disorder*

**Tertiary diagnosis:** *None*

**Age of onset of disability:** *28*

**Specific date if available:** *summer 1993*

**Currently seeing a doctor or therapist?**  yes  no

**Name(s), address(es) of doctor(s) or therapist(s):**

*Dr. Renee Paul, Psychiatrist  
Psychiatrist  
Southside Counseling Center  
22 Elm Street  
Buffalo, N.Y. 14203*

*John Johnson, MSW,  
Counselor  
Same address*

**Medication, please list:**

*Prozac, xx mg., xx times per day*

**Any side effects:**

yes  no

**Describe side effects:**

*None at this time*

**How does disability limit activities?**

*“On bad days, I have very limited energy. Generally, I do not want to interact with lots of different people. On a bad day, I prefer to keep to myself.”*

**How does disability limit ability to work?**

*It is difficult to work a full-time schedule; and difficult to constantly interact with others on the job. Needs a job where she can take off if having a bad day. An understanding and tolerant employer is a key.*

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#### IV. Involvement With Other Agencies / Support Systems

Is the individual still enrolled in secondary school?  yes  no

If yes, name of school:

Name, phone number of teacher:

Describe education program:

Is the individual enrolled in continuing  yes  no  
education or a postsecondary education institution?

If yes, name of school:

Name, phone number of counselor:

Describe education program:

Is the individual involved with the state VR agency?

yes  no

If yes, name of agency:

*NYS Office of Vocational and Educational Services to  
Individuals with Disabilities (VESID)*

Name, phone number of VR counselor:

*Teddy Thomas, 847-0000*

Describe program, services getting from agency:

*Paid for past job coaching supports. Still paying for  
limited case management  
supports from ABC Rehab.*

Is the individual involved with a private VR agency?

yes  no

If yes, name of agency: *ABC Rehab*

Name, phone number of VR counselor:

*Donna Romero, Case Manager*

**Describe program, services getting from agency:**

*Meets with Anne 2 to 4 times per month to discuss problems on job, develop strategies to deal with them.*

**Is the individual involved with the State MR/DD system?**

yes  no

**Is the individual involved with the State MH system?**

yes  no

**Is the individual involved with any other agencies?**  yes  no

Briefly describe other informal or unpaid supports in the individual's life (family, friends, etc.):

## V. Monthly Income

### Unearned Income:

**SSDI amount:** \$486

**Type of benefit (check appropriate benefit):**

- Against own record  
 Disabled Adult Child  
 Widows/Widowers  
 Other:  
 Unknown

**Unemployment amount:** *No other unearned income*

**Veteran's benefit amount:**

**Railroad Retirement Pension amount:**

**Alimony / Palimony amount:**

**Child Support amount:**

**Private disability insurance amount:**

**Worker's Compensation amount:**

**Other amount (specify types):**

### Financial Needs-Based Assistance (means tested):

**SSI amount:** *None currently, received in past*

**Pell grant amount:** *None*

**TANF amount:** *None*

**Food stamps amount:** *None*

**State subsidized housing:**  yes  no amount:

**HUD:**  yes  no amount:

**Other amount (specify types):** *None*

**Anyone in household receive welfare benefits?**  yes  no

**Describe form and amount:**



**If individual receives SSDI or SSI:****Name, address of Social Security office serving them:**

*Buffalo District Office, 111 West Huron Street, Buffalo,  
N.Y. 14202*

**If known, name, address, phone, fax and email address of  
Claims Representative serving them:**

*Gary Janes, same address, 845-1234, 845-1238 (fax),  
gjaner@ssa.gov*

**Earned Income / Wages:**

X employed by others \_\_\_ self-employed

**Monthly gross amount:** *\$850, expected to temporarily  
increase to \$1,400*

**Weekly gross amount:**

**Bi-weekly gross amount:**

**If wages vary, please explain:**

*October, November and December 2006 will be busy  
season.*

**Other income in household:** *N/A*

**Spouse, describe form and amount:**

**Children, describe form and amount:**

## VI. Resources (Relevant to SSI, Medicaid eligibility.)

### The individual

**Own home**  yes  no

**If jointly owned, please indicate other owner(s):**

### Bank accounts

**Savings, list amount:** \$350

**Checking, list amount:** \$229

**Other, describe and list amount:** none

**Individual retirement account (IRA), tax deferred annuity or similar retirement account - describe and list amounts:**

*N/A*

### Vehicle owned by individual

**Model and year:** *N/A*

### Responsible relative with whom person resides

**Check one:**  spouse  parent(s)  other, describe: *N/A*

## VII. Property Essential for Self Support

**Describe any property owned (and its value) that is used in job as an employee (such as mechanic's tools, carpenter's tools):** *N/A*

**Describe any property owned (and its value) that is used in "self employment"(such as office equipment, company vehicle, stock, business bank account):** *N/A*

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**VIII. Employment Information****Name, address of employer or potential employer:**

*Quality Mailers, Inc., 239 Swan Street, Buffalo, New York  
14203*

**Describe job (or potential job)**

**Title:** *Bulk Mail Specialist*

**Duties:** *Ensure that mail is properly sorted, coded, and bagged for delivery to Post Office.*

**Hours:** *Monday, Tuesday, Thursday, Friday – 9:30 to 3:30*

**Salary/hourly wage:** *\$8.50/hour*

**Benefits:** *Only benefits required by law, plus one week's vacation. No health insurance, no sick days.*

**Date you started working (as employee):** *January 2006*

**How job was found?** *Placed by ABC Rehab*

**Found on own:**  yes  no

**Agency helped find job, describe:**

*Placement following success at similar position within ABC Rehab.*

**If self employed (or potentially self employed)**

**Describe business:** *N/A*

**Date started:**

**Was job selected because of limits of disability?**

yes  no

**If yes, please explain:**

*Employer has hired other persons with disabilities, was expected to make allowances for Anne's disability.*

**Any extra or special supervision on job?**      \_\_\_ yes X no

**If yes, describe:**

**Is this a "supported employment" position?**      X yes \_\_\_ no

**Agency sponsoring job:**

**Is there a job coach?**      X yes \_\_\_ no

**Name:**      *Jerry Greene*

**Hours per month:**

*13 hours per month, January – March 2006*

**Services performed:**

*Acclimate to job; develop strategies to work around limitations associated with disability.*

**How long will job coach remain in picture?**

*Stopped after 3 months.*

**Does government agency (i.e., other than employer) pay all or part of wage?**      \_\_\_ yes X no

**Please describe:**

**Place of Employment:** *Quality Mailers, Inc. [Current job]*

**Title:** *Bulk Mail Specialist*

**Duties:** *Ensure that mail is properly sorted, coded, and bagged for delivery to Post Office*

**Wage/Hours:** *\$8.50/hour 100 hours per month*

**Dates:** *1/06-9/06*

**Place of Employment:** *ABC Rehab, Inc., Bulk Mail Service*

**Title:** *Bulk Mail Specialist*

**Duties:** *Nearly identical to above, in a more supported environment*

**Wage/Hours:** *\$6.60/hour 100 hours per month*

**Dates:** *1/05-12/05*

**Place of Employment:** *J.C. Penny Cheektowaga, N.Y.*

**Title:** *Sales Clerk*

**Duties:** *Wait on customers run cash register*

**Wage/Hours:** *\$5/hour*

**Dates:** *Fall 1997*

**Place of Employment:** *Kelly Services, Buffalo, N.Y.*

**Title:** *Temporary secretary jobs*

**Duties:** *General office*

**Wage/Hours:** *\$5 to \$7/hr.*

**Dates:** *Sporadic 1995-97*

**Place of Employment:** *General Accounting, Inc.*

**Title:** *Secretary*

**Duties:** *Typing, filing, telephoning, make appointments*

**Wage/Hours:** *\$14,000/yr.*

**Dates:** *1990-94*

Briefly describe any past attempts at self-employment: *N/A*

Business Type

Location

Dates

Income

Reason for Cessation

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## IX. Trial Work Period (TWP) Analysis

**Date when first received SSDI?** *January 1998*

**Has person worked and earned more than \$200 in any month(s) since first receipt of SSDI?** X yes \_\_\_ no

*If no, full nine-month TWP available.*

*If yes, continue through questions.*

**Did person use up nine TWP months before 1/1/92?**

*No*

*If yes, no TWP available unless SSDI terminated, eligibility re-established after new application and new five-month waiting period.*

**If person did not exhaust TWP before 1/1/92**

**Work nine TWP months during 60-month period which ended after 1/1/92?** X yes \_\_\_ no

*If yes, TWP exhausted.*

**If less than nine TWP months during 60-month period, list each TWP month during past 60 months. For each, list month, year and gross wages earned. [Note: In many cases, will have to obtain information from SSA.]**

<u>Month</u>	<u>Year</u>	<u>Gross Wages Earned</u>
--------------	-------------	---------------------------

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

**Based on information, how many TWP months left?**



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**X. Extended Period of Eligibility (EPE) Analysis**  
*(SSDI recipients only)*

<b>Ninth TWP month (month/year):</b>	<i>September 2004</i>
<b>Beginning of EPE (month/year):</b>	<i>October 2004</i>
<b>Last month of 36-month EPE (month/year):</b>	<i>September 2007</i>

**Remember, during EPE:**

*The first time that the individual is determined to be performing substantial gainful activity by earning more than the applicable SGA amount, they will get SSDI checks for that month and two more (i.e., during the “grace period”)*

*Following the grace period:*

- *No SSDI check during months countable gross wages exceed the SGA amount.*
- *Will get SSDI check when countable gross wages less than the SGA amount.*

*Impairment related work expenses (IRWEs) and subsidies are deducted from gross wages.*

**Listing of EPE payment, nonpayment months:**

*This should be done on a separate worksheet.*

**See “Notes” section for analysis of SSDI payments due and not due during the EPE.**

**XI. EXPEDITED REINSTATEMENT (EXR)**

A. Has individual received SSDI benefits in the past?

yes  no

*If no, stop and go on to B.*

*If yes, continue.*

Did individual lose SSDI due to performance of SGA?

yes  no

*If no, stop and go to B.*

*If yes, continue.*

Has individual completed their TWP and EPE?

yes  no

*If no, stop and go to B.*

*If yes, continue.*

Has individual either stopped working or ceased performing SGA?

*If no, stop and go to B*

yes  no

*If yes, continue.*

Interviewer should do a full screening for potential EXR eligibility on the SSDI claim.

B. Has the individual received SSI benefits in the past?

yes  no

*If no, stop. If yes, continue.*

---

Did the individual lose SSI due to budgeting of wages or a combination of wages and other income?

yes  no

*If no, stop. If yes, continue.*

Is individual currently receiving Medicaid through the 1619(b) program?

yes  no

*If yes, stop. The EXR provisions are not needed to reinstate SSI cash benefits.*

*If no, continue.*

Has individual received either SSI cash benefits or 1619(b) Medicaid within the past 12 months?

yes  no

*If yes, stop. The EXR provisions are not needed to reinstate cash benefits.*

*If no, continue.*

Would individual be eligible for SSI based on current income because he/she either stopped working or is now earning less money?

yes  no

*If no, stop. If yes, continue.*

Interviewer should do a full screening for potential EXR eligibility on the SSI claim.

## XII. Health Insurance Needs

**Health insurance coverage, check each that is available:**

**Medicaid**

**Amount of spend down, if any:**

*none (appears to be 1619(b) recipient)*

*If eligible through a Buy-In, the amount of premium, if any:*

**Medicare**

**Part A (hospitalization)**

**Part B (outpatient)**

**Does individual pay Part B premium?**      yes     no

*Discuss availability of Medicaid payment of Part B premium*

**Private insurance**

**Monthly/quarterly/yearly premium paid by individual:**

**Other, please describe:**

**Total out-of-pocket expenses for spend downs, premiums:**

**Monthly:**

**Yearly:**

## Special Medicaid categories

**If not eligible for Medicaid, or receive Medicaid with a spend down:**

**Did you receive SSI in the past?**      X yes \_\_\_ no

**Section 1619(b) eligibility:**

**Did you lose SSI due to wages?**    X yes \_\_\_ no

*If yes, go through 1619(b) eligibility work up.*

*(Interviewer's note: Appears to be getting Medicaid through 1619(b))*

**Medicaid eligibility under SSDI/DAC, SSDI for widows/widowers, Pickle**

**Amendment provisions:**

**Did you lose SSI due to receipt of some form of Social Security benefits?**      \_\_\_ yes X no

**If yes, please describe:**

*Go through work up for special eligibility categories.*

*If your state has a Medicaid Buy-In and individual is not otherwise eligible for Medicaid, screen for buy-in eligibility.*

**Doctor visits**

**Estimate monthly or annual costs:**    \$200/year

**What purpose?**

*Periodic check ups, as needed when sick*

**How covered?**

*Medicaid and Medicare*

**Total out-of-pocket expenses**

**Monthly:**      \$0

**Yearly:** \$0

**Psychiatrist visits****Estimate monthly or annual costs:** \$600**What purpose?***Monitor counseling progress and medication***How covered?***Medicaid and Medicare***Total out-of-pocket expenses****Monthly:** \$0**Yearly:** \$0**Mental health counseling****Estimate monthly or annual costs:** \$1,200/year**What purpose?***Ongoing treatment***How covered?***Medicaid***Total out-of-pocket expenses****Monthly:** \$0**Yearly:** \$0**Other therapies (occupational, physical, speech, etc.):** N/A**Home health care:** N/A**Medication:****Estimate monthly or annual costs:** \$120 mos/\$1,440 yr**Describe each medication and purpose?***Prozac, to treat depression***How covered?***Medicaid***Total out-of-pocket expenses****Monthly:** \$0**Yearly:** \$0**Other health-related costs****For each, list item(s), monthly or annual costs, purpose and how covered:**

**Item:** *Bus fare – travel*

**Monthly/Annual Cost:** *\$7.50/month, \$90/year*

**Purpose:** *Psychiatrist, mental health, counselor visits*

**How Covered:** *Out-of-pocket*

**Item:** *Over-the-counter medications*

**Monthly/Annual Cost:** *\$5.00/month, \$60/year*

**Purpose:** *As needed*

**How Covered:** *Out-of-pocket*

### XIII. Analysis of Impairment Related Work Expenses

#### Transportation IRWE

**Nature of item/service:**

*Bus fare to psychiatrist, mental health counselor*

**How related to disability and work:**

*Cannot work without ongoing treatment*

**Monthly cost:**

*\$7.50*

#### Medication IRWE

**Nature of item/service:**

*None*

#### Health insurance IRWE (premiums, co-payments, deductibles)

**Nature of item/service:**

*Medicare Part B premium*

**How related to disability and work:**

*Medicare pays 80% of cost for psychiatrist*

**Monthly cost:**

*\$66.60*

*[Interviewer's note: Medicaid may pay for premium under either QMB or SLMB programs.]*

**Other IRWEs (check each that applies and describe below):** *N/A*



**XIV. Blind Work Expenses (BWEs)**

**Is the individual legally blind?**     yes  no

**If the answer is yes, do work up for BWEs.**

**XV. Analysis of Subsidies****Subsidy checklist**

**Is government agency paying part of wage?**

yes  no

**Does individual get special assistance on the job?**

yes  no *yes, in past*

**Does individual perform fewer duties than others?**

yes  no

**Does employer accept less productivity than from others?**

yes  no

**Does individual receive extra rest periods/breaks?**

yes  no

**Is individual frequently absent or working irregular hours because of disability?**

yes  no

**Does individual receive job coach assistance?**

yes  no *yes, in past*

**If you checked yes to any of the above, describe the special circumstances:**

*Currently, off site support is from ABC Rehab case manager approximately 3 hours per month. Employer has set up work schedule based on disability-related limitations. Employer tolerates disability-related absences of one or two days per month. Between January and March 2006, ABC also provided job coach support of 3 hours per week.*

**Calculate value of monthly subsidy, indicating countable wages after subsidy:**

*Value of job-coaching subsidy, January – March 2006, using SSA-approved method:  
- 13 hours job coaching x \$8.50 per hour (Anne's hourly wage) = \$110.50 per month*

**XVI. SSI Plan for Achieving Self Support (PASS)**

**Does individual have an approved PASS?    \_\_ yes X no**

**If yes, describe briefly and obtain a copy for file.**

**If no, explain PASS and then complete remaining questions.**

**Does individual have income other than SSI?   X yes \_\_ no**

**If yes, please describe**

*See section V, above*

**Does individual have resources in the form of bank accounts or items that could quickly be converted to cash?**

**If yes, please describe:**

*See section VI, above. Only a small reserve, \$350, in savings account.*

**Are there goods and/or services that would help individual reach a vocational goal that he or she would purchase if extra money were available?   X yes \_\_ no**

**If yes, list items, their expected purpose and their approximate cost, if known:**

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<u>Items</u>	<u>Expected Purpose</u>	<u>Approximate Cost</u>
<i>Automobile</i>	<i>Allow her to travel to places of employment in suburbs, or allow her needed vehicle to establish her own bulk mail business</i>	<i>\$8,000 for good used car</i>

**XVII. Ticket to Work**

Has SSA started to implement the Ticket program in your state?

yes  no

*If no, stop. If yes, continue.*

Is individual receiving services under a Ticket?

yes  no

*If no, stop. If yes, continue.*

**Name of Employment Network:** VESID (i.e., New York's VR agency)

**Contact at EN:** Teddy Thomas

**Describe services received from EN:** Paid for job coaching in part. Counseling provided as needed.

*NOTE: If individual is receiving services from the state's vocational rehabilitation agency, they may be receiving those services under the Ticket.*

Explain that individual will not be subject to a continuing disability review while using a Ticket and making timely progress.

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## NOTES

*SSDI payment and nonpayment months during EPE:*

*10/05-12/05:*

*Non-SGA months, only \$660 in monthly earnings ... SSDI checks due*

*1 /06-3/06:*

*Non-SGA months, less than \$810 in countable earnings ... SSDI checks due [After subsidy deductions for job coaching assistance (see section XIV.), job coaching subsidy is at least \$110.50 per month for January, February, and March 2006, reducing wages below \$810 SGA amount.]*

*4/06:*

*Benefit cessation month (i.e., first month of SGA within EPE)*

*4/06-6/06:*

*Grace period (cessation month and next two months) ... SSDI checks due*

*7/06:*

*SGA month ... no SSDI check due [Gross wages \$850 with no subsidy, meaning that countable earnings are \$850 (i.e., more than SGA amount of \$810).]*

*8/06, 9/06:*

*Same analysis as July*

*10/06, 11/06, SGA months ... no SSDI checks due 12/06:*

*[With expected wages of \$1,400 per month, there are not enough projected IRWEs and subsidies, no matter how calculated, to reduce wages below \$810.]*