**Work Incentives Planning and Assistance Program Referral**

Please send all referrals for services to the following only:

**E-mail for all WIPA referrals:**[**WIPATXImagine@imagineenterprises.org**](mailto:WIPATXImagine@imagineenterprises.org)

## Name:       SS#:       DOB:

## Address (Mailing):       City:       County:       Zip:

Phone Number:       Email:      Primary disability:

**Additional Helpful Information:** ***Indicate all that apply.*** Medicare  Medicaid

**Waiver:** Medically Dependent Children Program,Community Living Assistance and Support Services, Deaf Blind & Multiple Disabilities, Home & Community Based Services, Texas Home Living Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:**  SNAP  HUD section 8 housing  HUD income based housing  Group housing  Other:

**Social Security cash benefits they receive/amount:**  ***Indicate all that apply.***

SSI: $      SSDI/CDB/DWB: $      RSDI $

**Employment/education information: Student:**  Yes No

Unemployed Works PT Works FT Self-employed Sheltered Workshop (subminimum wage worker)

If employed/student, where?

**Anticipated or current hours per week**:       **Anticipated or current earnings per hour:**

**If not employed, what is the employment goal?**

**Open with TWC-VR?**  Yes  No **Assigned Ticket to Work:**  Yes  No  In use with VR

VR or EN Counselor’s Name:       Phone:

**Two SSA 3288 and one general consent forms signed?**  Yes  No **Has a BPQY from SSA?**  Yes  No

Does this person have a rep payee (If yes, list name and contact information)? Are they receiving other benefits CWIC should know about? Do you have any other information or special instructions for making contact?