**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**

## 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?