IMPAIRMENT RELATED WORK EXPENSE REQUEST

Please accept this information as a formal request for consideration of Impairment Related Work Expenses (IRWEs).

Beneficiary/Recipient Name:
SSN:
Type of Social Security benefits received:
Address:
City/State/Zip Code:
Phone Number:
Representative Payee (if applicable):

Part 1: Brief description of current employment status (name and address of employing company, date of hire, job title, rate of pay, and hours worked per week)

Part 2: Itemized list and brief description of proposed Impairment Related Work Expenses (IRWEs). For each item/service, provide the estimated monthly cost, the month/year in which the expense was/will be incurred, and a brief explanation of how it meets the Social Security Administration's criteria for an Impairment Related Work Expense summarized below:

Impairment Related Work Expense (IRWE) Criteria:

1. Expenses are directly related to enabling the individual to work;
2. The individual, because of a severe physical or mental impairment, needs the items or services in order to work;
3. Costs are paid by the individual and not be reimbursable from other sources;
4. Expenses are be paid in a month in which the individual is or was working; and
5. Expenses are reasonable.

(See POMS DI 24001.035 Impairment Related Work Expenses (IRWE) for specific information on how IRWE provisions are applied to both DI and Title XVI cases.)

Itemized List of Proposed Impairment Related Work Expenses

(Attach additional pages as needed)

Item/service 1:
Estimated monthly cost:
Month(s) expense incurred:
Explanation of how this item/service meets IRWE criteria:

Item/service 2:
Estimated monthly cost:
Month(s) expense incurred:
Explanation of how this item/service meets the IRWE criteria:

Item/service 3:
Estimated monthly cost:
Month(s) expense incurred:
Explanation of how this item/service meets the IRWE criteria:

Item/service 4:
Estimated monthly cost:
Month(s) expense incurred:
Explanation of how this item/service meets the IRWE criteria:

Other information about this request:

I understand that I am responsible for reporting any changes in any approved IRWE to SSA in a timely fashion and for keeping receipts to document these expenses.

Thank you for considering this request. I look forward to receiving written notice of the determination within 30 days. Please contact me if you have any questions or require more information to make a determination.

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Signature **Date**

Send completed form to your Work Incentive Liaison or Area Work Incentive Coordinator