PLAN TO ACHIEVE SELF-SUPPORT (PASS)

Name	SSN

Date Received

PART A – YOUR WORK GOAL

A.1. What is your work goal? (Show the job you expect to have at the end of the plan. Be specific)

A.2. Will you be self-employed? If yes, attach a copy of your business plan or contact your PASS Cadre.	☐ Yes	☐ No
A.3. Do you have a job coach you pay with your own money?	☐ Yes	☐ No
A.4. If yes, will this plan reduce the number of hours you pay the job coach?	☐ Yes	☐ No

A.5. Describe the duties you expect to perform in this job (Be specific about the tasks you will perform):

A.6. Does your work require a special certificate or license (for example a drivers, realtor, or cosmetologist license)?	☐ Yes	☐ No

A.7. How did you decide on this work goal and what makes this type of work attractive to you?

A.8. How much money do you expect to earn before any deductions? (Monthly) $

A.9. Have you previously been approved for a PASS?	☐ Yes	☐ No Skip to B1

A.10. If Yes:

- When was your plan approved?
- What was your work goal?
- Why weren't you able to become self-supporting?

PART B – MEDICAL/VOCATIONAL/EDUCATIONAL BACKGROUND

B.1. List all your disabling illnesses, injuries, or conditions.

B.2. Do you have any limitations that could affect your ability to achieve your work goal (e.g., limited amount of standing or lifting, stooping, bending, or walking; difficulty concentrating; unable to work with other people; difficulty handling stress, etc.)?

B.3. How will you address the listed limitation(s) so that you reach your work goal?

B.4. List the types of jobs you have had in the past; including volunteer work, self-employment, and military service. List the dates you have worked in these jobs.

Job Title	Type of Business	Dates Worked	
		From	To

B.5. Check the highest grade of school completed.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

☐ GED or ☐ High School Equivalency

College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ more than 4

If a college degree(s) was earned:

Type of Degree:	Date of Graduation:
Field of Study:	
Type of Degree:	Date of Graduation:
Field of Study:	

B.6. Have you completed any type of special job training, trade or vocational school?	☐ Yes ☐ No
If Yes: Type of Certificate or License:	Date Obtained:
B.7. If you have a college degree or specialized training, does your plan include additional education?	☐ Yes ☐ No

If Yes, explain why the additional education is needed to achieve your goal:

B.8. Have you assigned your **Ticket to Work** or applied for services with a vocational rehabilitation organization?	☐ Yes ☐ No **If Yes**, please show below.

If you have developed a work plan with this organization, please include a copy with your PASS application.

Name of Organization:	Contact:
Address:	Phone:
Name of Organization:	Contact:
Address:	Phone:

PART C – YOUR PLAN

List the steps that you will take or have to take to reach your work/self-employment goal. Be as specific as possible.

- For education -- list the credits for each term and the expected date of graduation.
- Show your job search start date and expected date of employment.
- For job coaching -- show the timeline for reducing job coaching hours or increasing your hours of employment.
- For self-employment -- list each step from startup to successful business operation.

Steps	Beginning Date	Completion Date
Example: Spring semester 2012 12 credits	*mm/yy*	*mm/yy*
Example: Start job search, send out resumes	*mm/yy*	*mm/yy*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

PART D – EXPENSES

D.1. List the items or services that are necessary to achieve your work goal. Be as specific as possible. **(Do not include expenses you were paying prior to the beginning of your plan.)**

a. Item/service/training:

Vendor/Provider:

Frequency of Payment (monthly, quarterly, one-time, etc.):

Total Cost: $

When will you pay for these items or services?

How will these items or services help you reach your work goal?

b. Item/service/training:

Vendor/Provider:

Frequency of Payment (monthly, quarterly, one-time, etc.):

Total Cost: $

When will you pay for these items or services?

How will these items or services help you reach your work goal?

c. Item/service/training:

Vendor/Provider:

Frequency of Payment (monthly, quarterly, one-time, etc.):

Total Cost: $

When will you pay for these items or services?

How will these items or services help you reach your work goal?

d. Item/service/training:

Vendor/Provider:

Frequency of Payment (monthly, quarterly, one-time, etc.):

Total Cost: $

When will you pay for these items or services?

How will these items or services help you reach your work goal?

e. Item/service/training:

Vendor/Provider:

Frequency of Payment (monthly, quarterly, one-time, etc.):

Total Cost: $

When will you pay for these items or services?

How will these items or services help you reach your work goal?

f. Item/service/training:

Vendor/Provider:

Frequency of Payment (monthly, quarterly, one-time, etc.):

Total Cost: $

When will you pay for these items or services?

How will these items or services help you reach your work goal?

If you have additional expenses, please use the remarks section in **Part H on page 7**.

D.2. Will any other person or organization (e.g., grants, assistance, or Vocational Rehabilitation agency) pay for or reimburse you for any part of the expenses listed in your plan? If Yes, give details ☐ Yes ☐ No

Who Will Pay	Item/Service	Amount	When will the item/ service be purchased?
		$	
		$	
		$	
		$	
		$	

PART E – FUNDING YOUR PASS PLAN

E.1. Do you plan to use any items you already own (equipment, property or savings) to reach your work goal? If yes, list the items and the value. ☐ Yes ☐ No

Item | Value

How will this help you reach your work goal?

Item | Value

How will this help you reach your work goal?

E.2. How do you plan to keep the money set aside for your PASS separate from your other funds? (Examples: checking or savings account, Direct Express or other debit card)

E.3. List the income you currently receive ***or*** expect to receive.

Type of Income	Amount Received	
Social Security Disability (SSDI)	$	Monthly
Supplemental Security Income (SSI)	$	Monthly
Earned Income (Wages)	$	Monthly
Self-Employment Income	$	
Other (please list):	$	
Other (please list):	$	

E.4. How much of this income, other than SSI, will you set aside to pay for the items or services requested? $

PART F – CURRENT LIVING EXPENSES

Average Current Living Expenses

HOUSEHOLD EXPENSES	AMOUNT PER MONTH
Food (Do not include food stamps.)	$
Rent/Mortgage	$
Property Insurance/ Taxes not included in mortgage	$
Gas	$
Electric	$
Heating Fuel	$
Water/Sewer	$
Garbage Removal	$
Telephone (Home and Cell)	$
Cable/Satellite TV	$
Internet	$
Other (Please list)	$

PERSONAL EXPENSES	AMOUNT PER MONTH
Recreation, Movies, Restaurants	$
Clothing	$
Haircuts, Manicures	$
Dental/Medical After Insurance	$
Vehicle Expenses (Gas and Maintenance)	$
Transportation Costs (Bus Pass, Etc.)	$
Membership (Gym, Dating/Social, Etc.)	$
Service Animal	$
Pet Expenses	$
Other (Please list)	$

INSTALLMENTS	AMOUNT PER MONTH
Auto Loans/Leases	$
Insurance Premiums	$
Credit card Accounts	$
Child Support/Alimony	$
Other (Please list)	$

TOTAL MONTHLY EXPENSES:	$

PART G – OTHER CONTACTS

G.1 If someone helped you prepare this plan, please give us the name, address and telephone number of that person or organization.

Name			
Address			
City		State	ZIP Code
Telephone	E-mail address		

G.2. If they are charging you a fee for this service, how much is the total cost? $

PART H – REMARKS

Use this section or a separate sheet of paper if you need additional space to answer any questions:

Name	SSN

PART I – AGREEMENT

I authorize the Social Security Administration (SSA) to contact the person(s) or organization(s) listed in Part G of this plan for additional information about my PASS. I authorize this contact for the duration of my plan.

Signature

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number, Street, City, State, ZIP Code)	Address (Number, Street, City, State, ZIP Code)

(Please note that if you do not sign the above, SSA may need to recontact you.)

Name	SSN

I authorize SSA to release information regarding my PASS to _____ to assist SSA in processing my plan. This information may include a copy of SSA's decision on my plan or other information about my benefits that are related to my plan, but excludes medical records and tax return information. I authorize this disclosure for the duration of my plan.

Signature

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number, Street, City, State, ZIP Code)	Address (Number, Street, City, State, ZIP Code)

I authorize any public or private custodian of records to disclose to SSA any non-medical records or information about me. In the case of a minor or incapable person, I, as the guardian or representative authorize the same disclosure of records about the person I represent.

Signature

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number, Street, City, State, ZIP Code)	Address (Number, Street, City, State, ZIP Code)

Name	SSN

If my plan is approved, I agree to follow all of the terms and conditions of the plan as approved by SSA;

- report any changes in my plan **to SSA** immediately
- keep records of all deposits and receipts of all expenditures I make under the plan
- use approved income or resources **only** to buy the items or services approved in the plan, and
- report any changes that may affect my SSI payment immediately, such as a change in income, resources, living arrangements, or marital status.

Signature	Date:
Address	
City	State / ZIP Code
Home Telephone	Work Telephone
Other Telephone	E-mail address

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number, Street, City, State, ZIP Code)	Address (Number, Street, City, State, ZIP Code)

If you have a representative payee, the representative payee must sign below:

I, _____ as the Representative Payee for _____ agree to the submission of this PASS.

Representative Payee Signature	Date:

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number, Street, City, State, ZIP Code)	Address (Number, Street, City, State, ZIP Code)

Privacy Act Statement
Collection and Use of Personal Information

Sections 1612(b), 1613(a) and 1631(e) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may limit your ability to participate in the Plan to Achieve Self-Support (PASS) Supplemental Security Income (SSI) program.

We will use the information to evaluate your PASS and determine eligibility under the provisions of the SSI program. We may also share your information for the following purposes, called routine uses:

- To third-party contacts when the party to be contacted has, or is expected to have, information relating the individual's PASS, when:

  (a) the individual is unable to provide the information being sought; or

  (b) the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual in connection with his or her PASS; or the Social Security Administration is reviewing the information as a result of suspected abuse or fraud, concern for program integrity, quality appraisal, or evaluation and measurement activities; and

- To a contractor or another Federal agency, as necessary for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person' eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0255, entitled PASS Management Information System, as published in the Federal Register (FR) on January 1, 2006, at 71 FR 1867. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

Paperwork Reduction Act Statement - This information collection meets the 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 120 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to*: *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

PART J – RECEIPT

We received your plan to achieve self-support (PASS) on (MM/DD/YY)

A PASS Cadre member will contact you to discuss your plan and advise you if any changes are needed.

You may contact your PASS expert _____ toll-free at 1- _____

You can also locate your local PASS Cadre at http://www.socialsecurity.gov/disabilityresearch/wi/passcadre.htm.

YOUR REPORTING RESPONSIBILITIES

You must tell Social Security about any changes to your plan and any changes that may affect the amount of your SSI payment. You must tell us if:

- ☐ Your medical condition improves.
- ☐ You are unable to follow your plan.
- ☐ You decide not to pursue your goal or decide to pursue a different goal.
- ☐ You decide that you do not need to pay for any of the expenses you listed in your plan.
- ☐ Someone else pays for any of your plan expenses.
- ☐ You use the income or resources we exclude for a purpose other than the expenses specified in your plan.
- ☐ There are any other changes to your plan.
- ☐ There are any changes in your income, help you get from others, or things of value that you own.
- ☐ There are any changes in where you live, how you live, or to your marital status.

You must tell us about any of these things within 10 days following the month in which it happens. If you do not report any of these things, we may stop your plan.

You should also tell us if you decide that you need to pay for other expenses not listed in your plan in order to reach your goal. We may be able to change your plan or the amount of income we exclude so you can pay for the additional expenses.

YOU MUST KEEP RECEIPTS OR CANCELLED CHECKS TO SHOW WHAT EXPENSES YOU PAID FOR AS PART OF THE PLAN. When we review your plan, we will ask about your progress towards your work goal and for proof of payment for PASS plan expenses. If you are not following the plan, you may have to pay back some or all of the SSI you received.