Iowa Work Incentive Planning and Assistance
Initial Contact & Demographics

Date: ______________

Last Name: ______________________________
First Name: ______________________________
Middle Initial: __________
Street Address: ___________________________
City: ________________ Zip Code: _________
County of Residence: _____________________
Marital Status:

- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Common Law
- ☐ Divorced
- ☐ Never Married/ Single
- ☐ Domestic Partner

Date of Birth: _________________________
Best phone number to reach you: ____________
E-Mail Address: __________________________
Gender: ☐ Male
☐ Female

Does anyone else in the household receive income or benefits? ☐ Yes ☐ No

Relationship to the Beneficiary? __________________ Amount of other person's income? ________

Referred by: ______________________________________ Phone: _____________________

Benefits received at Intake: (Check all that apply)

- ☐ Supplemental Security Income (SSI) $__________
- ☐ Social Security Disability Insurance (SSDI) $________
- ☐ Childhood Disability Beneficiary CDB/DAC $_______
- ☐ Medicare- A☐ B☐ D☐
- ☐ Medicaid - Eligibility Group? _________________
- ☐ Private Disability $_______________
- ☐ Private Health Insurance
- ☐ Veterans Benefits $______________
- ☐ Worker's Compensation $______________
- ☐ Private Retirement $______________
- ☐ Low Income Energy Assistance $______________
- ☐ Blind Supplement Other: $_______________

Employment status at intake:

- ☐ Currently working
- ☐ Job offer pending
- ☐ Looking for employment
- ☐ Self-employed
- ☐ Employed Full-Time
- ☐ Employed Part-Time
- ☐ Considering Employment

Name of Job: __________________________ Start Date: __________ $_____/Hour or $________/Month

Total Hours worked per week: _________ Monthly gross wages/salary $________________

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Self-Reported Primary and Secondary Disability:

☐ Blind/Visual Impairment
☐ Cognitive/Developmental Disability
☐ Infectious Disease
☐ Mental/Emotional Disorders
☐ System Diseases (e.g. nerve, endocrine, cardiac, etc.)
☐ Cancer/Neoplasm
☐ Hearing, Speech, and other sensory impairment
☐ Injury
☐ Orthopedic/Amputations/Non-Spinal Cord Impairment
☐ Spinal Cord Injury
☐ Traumatic Brain Injury
☐ Unknown
☐ Other: ________________ If Other, please specify: _______________________________________
Secondary disability, please specify: ____

Representative Payee (if applicable):

Name and Agency: ____________________ Address: _________________ Phone Number: ____________

How would you describe your racial or ethnic background?

☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Hispanic/Latino/a
☐ Native American/American Indian ☐ Other (Please specify : ________________________)

English Proficiency:

☐ Understands neither written nor verbal communication
☐ Understand both verbal and written English communication
☐ Understands written English communication
☐ Understands verbal English communication

Level of Education that you have completed at Intake?

☐ Elementary (0-8 yrs.)
☐ Some High School (1-3 yrs.)
☐ High School diploma/GED
☐ Master's degree
☐ Other degree/certification
☐ Some College
☐ Associates Degree/2 year degree
☐ Bachelor's degree

Area of Study: ___________________________________

Health Status at Intake (self-identified): ☐ Very Good ☐ Good ☐ Fair ☐ Poor