

BLIND WORK EXPENSE REQUEST

This request should accompany wage reports made to the Social Security Administration if you are a blind person receiving an SSI benefit, or Medicaid under the 1619(b) provisions. **You should include receipts, and proof of wages or your self-employment tax returns.**

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| Date: |
| Period Worked: |
| Beneficiary Name: |
| Rep Payee (if applicable): |
| Social Security Number: |
| Contact Phone Number: |

This is a request that the items outlined on this document be deducted as Blind Work Expenses when you consider the work activity I am reporting. The items listed below meet the following requirements:

- They are necessary for my work activity or self-employment
- They were paid by me, and not reimbursed by another source
- They were not deducted as a business expense;
- I will be happy to provide additional documentation, if requested.

List of expenses for this report period that appear on my attached pay stubs:

Note to beneficiary: You can include the cost of services or perishable goods for months when you worked, or you can include the cost of durable goods, either the down-payment, the monthly payment, or the total cost, depending on how you paid for the item. Durable expenses may be pro-rated over a 12-month period.

| Pay Date | Federal Taxes | State Taxes | Local Taxes | Social Security Taxes | Mandatory Dues or Pension Costs | Other |
|---------------|---------------|-------------|-------------|-----------------------|---------------------------------|-------|
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| Totals | | | | | | |

List of other work expenses, such as: transportation, child care, disability-related expenses, meals consumed at work, uniforms, etc. I have attached receipts, where possible, as verification.

| Date of Payment | Type of Expense | Amount of Expense |
|-----------------|-----------------|-------------------|
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Thank you for your consideration of this request.

Beneficiary or payee signature: