

## Work Incentive Plan

**Customer Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
**Benefits Summary & Analysis review date:** \_\_\_\_\_ **Customer Initials:** \_\_\_\_\_  
**Employment Goal:** \_\_\_\_\_

### ACCESSING EMPLOYMENT SERVICES AND SUPPORTS

Action Step	Person Responsible	Target Date	Completed Date

### RESOLVING EXISTING BENEFIT ISSUES

Action Step	Person Responsible	Target Date	Completed Date

### MANAGING SSA BENEFITS AND WORK INCENTIVES

Action Step	Person Responsible	Target Date	Completed Date

### MANAGING FEDERAL, STATE OR LOCAL BENEFIT PROGRAMS

Action Step	Person Responsible	Target Date	Completed Date

### PLANNING FOR FUTURE HEALTHCARE NEEDS

Action Step	Person Responsible	Target Date	Completed Date

### FOLLOW-UP CONTACT PLAN

Action Step	Person Responsible	Target Date	Completed Date

Beneficiary Signature: \_\_\_\_\_  
 CWIC Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
 Date: \_\_\_\_\_