WORK INCENTIVES PLANNING AND ASSISTANCE (WIPA)
REFERRAL FORM

CLIENT INFORMATION (Your personal information is kept confidential)

Referral Date:______________________

Local WIPA Office:____

WIPA Contact Person: First Name: ______________________ Last Name:_____________________

E-mail Address:______________________________________ Title:____CWIC_______________________

Mailing Address:____

City: ______________________ State ________________ Zip _________________________

Office Phone: (_______)___________________ Fax: (______)__________________________________

Beneficiary Name:____

Home Phone: ___________________________________ DOB:____________________________

SSN:______________________________ Disability:____

REFERRING INFORMATION

Referring Office Location:

☐ Houston, Texas ☐ Atlanta, Georgia

www.healthwaysservices.org

Referring Health and Rehabilitation Consultant:__Dr. Christopher A. Lowery, DHSc, CLCP______________

Mailing Address: P.O. Box 41217____

City: _Houston__________ State __Texas_______ Zip ___77241_____________

Office Phone: (713)_996-9200__ Fax: (832) 504-9500___

Toll Free Office: (888) 340-1116 Toll Free Fax: (877) 700-5058

E-mail Address: clowery@healthwaysservices.org______________________________________

WORK INCENTIVE BENEFITS COUNSELING SERVICES:

Benefits: ☐ SSI or ☐ SSDI **Type of Appointment:** ☐ Face-to-Face or ☐ By Phone

Comprehensive Educational Service (Educate and Counsel):

☐ **Work Incentives Evaluation** ☐ **Benefits Analysis** ☐ **Benefits Planning** ☐ **Benefits Assistance/Counseling**

☐ **Other**__Education on Work Incentives____

Healthways Services Beneficiary Use:

*** Attached is a copy of the beneficiary Benefits Planning Query (BPQY)**

Beneficiary Appointment Date:________________________ **Time:**_________________**: AM/PM**

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