Healthways Services

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Intake

Date: _____

_____

Last Name First Name Middle Initial

Address**:**_____

City/State: _____ Zip: _____ Marital Status:_____

Phone #: _____Cell: _____ Work: _____

Spouse's/Partner's Phone#: _____

Date of Birth: _____ SS#: _____-_____-_____ Cause#:_____

Referral Name: _____

How did you hear of this program?

- ☐ Spouse/Partner
- ☐ Insurance Company
- ☐ Counselor
- ☐ Judge
- ☐ Ticket-to-Work
- ☐ Attorney
- ☐ Other:_____
- ☐ Probation
- ☐ Parole
- ☐ D.A.s Office
- ☐ Orthopedic Medical Doctor
- ☐ State Vocational Rehabilitation Agency

What is your ***eMail*** address:_____

Emergency Contact:

Emergency Contact Name: _____ Relationship: _____

Emergency Contact's Phone Number: _____ Alternate #: _____

Employment:

Are you currently employed? (circle) Yes No

If yes, who is your current employer:_____

Wage per year:_____

Type of work:_____

Check all that Apply:

- ☐ I am currently working
- ☐ I had no earning in the last 18 months
- ☐ I had some earnings in the last 18 months
  - ☐ None of my earnings were in the last 6 months
  - ☐ Some of my earnings were in the last 6 months.

If you had earnings in the last 6 to 18 months, please describe those earnings in the following chart. List your lastest Employer first.

Employer	Start Date	End Date	Wage Per Hour	Hours Worked Per Week

If you're not employed, do you receive any of the following: (circle)

SSI SSDI Unemployment Worker's Compensation

Both SSI/SSDI SSA Retirement Veterans Benefits

None of the Above

If you receive one of the above payment sources, how much do you receive:_____

What ***State*** do you reside in? _____

Beneficiary Expected Monthly Earnings:

- Are you willing to use the guidelines of Ticket to Work and earn over $850.00 per month? (see below)*

  - ☐ Yes, I am willing to earn over $850 per month, with the help of Ticket to Work
  - ☐ No, I am not willing to earn over $850 a month

SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

Are you a SSDI recipient? ☐ Yes ☐ No

- During a Trial work period (TWP), a beneficiary receiving Social Security disability benefits (SSDI) may 'test' their ability to work for at least 9 months and still be considered disabled. During a Trial work period, a person will still receive full Social Security benefits and health insurance, regardless of how much is earned, as long as, they report work activity. A trial work month is any month in which total monthly earnings are over $850. To read more about Ticket to Work & SSDI benefits, visit: www.socialsecurity.gov/pubs/10095.pdf
- **You answered SSDI. If you have worked while on benefits, have you used up 'All' of your 9 month Trial Work Period months?**

  - ☐ Yes, I have used up all 9 trial period months
  - ☐ No, I have not used up all 9 trial period months
  - ☐ I have not worked at all while receiving SSDI. (Not Applicable)

Additional Information

Upon completing TWP, and your earnings are over $1180. SSA will put you in a work incentive called "Extended Period of Eligibility", and SSA can still pay you your cash benefits as long as your work is not substantial. If your monthly payments are stopped, you can keep your Medicare for at least 93 months after your trial work period date ends. Your hospital insurance will be free, but you will still pay for your medical insurance. Beginning in July 1990, you can keep your Medicare after your free hospital insurance coverage ends. But, you must pay a premium for both parts.

SUPPLEMENTAL SECURITY INCOME (SSI)

Are you a SSI recipient? □ Yes □ No

Does SSA count all your earned income when SSA figures your Supplemental Security Income (SSI) payment?

- SSA does not count the first $65 of the earnings you receive in a month, plus one-half of the remaining earnings. This means that SSA count less than one-half of your earnings when SSA figure your SSI payment amount.
- SSA applies this exclusion in addition to the $20 general income exclusion. SSA applies the $20 general income exclusion first to any unearned income that you may receive.

Red Book Info:

You're encouraged to read the **2018 RED BOOK** to learn about beneficiary benefits and how to use it as a self-help guide. The Red Book contains a general description of SSA disability-related policies. For information specific to your situation regarding eligibility or benefits, you may need to talk to your Employment Network Provider

Background Information:

*If you have worked while on Social security benefits and unsure of how many trial work period months you have used up, you can call **Social Security at 1-800-772-1213** and ask for a **BPQY (Benefits Planning Query)**

What is your vocational goal/desired position? _____

- **How many hours do you want to work? _____**

□ **Full-time**

□ **Part-time**

Past Employer's:

Name: _____ City/State: _____

Title:_____ Duties:_____

_____

Past Employer's:

Name: _____ City/State: _____

Title:_____ Duties:_____

_____

Past Employer's:

Name: _____ City/State: _____

Title:_____ Duties:_____

_____

Past Employer's:

Name: _____ City/State: _____

Title:_____ Duties:_____

_____

Past Employer's:

Name: _____ City/State: _____

Title:_____ Duties:_____

_____

- What is your short-term expected monthly earnings (in the next 3-12 months)?

  _____

- What is your long-term expected monthly earnings (in the next 3-5 years)?

  _____

- Have you ever assigned your Ticket to Work?

  - ☐ Yes
  - ☐ No

- Do you currently receive job placement services from another employment network or State Department of Vocational Rehabilitation (VR)?

  - ☐ Yes
  - ☐ No

- If you have worked with a State Department of Vocational Rehabilitation (VR) Agency - was closure successful or unsuccessful? (Did you find employment while with VR)?

  - ☐ Yes, I found employment with VR
  - ☐ No, I did not find employment with VR
  - ☐ I have never worked with a State Department of Vocational Rehab Office

- Do you owe Social Security Administration any overpayments?

  - ☐ Yes, I owe overpayments in the amount of _____
  - ☐ No, I do not owe any money for overpayments

- Are you a Veteran and receive benefits?
  - □ Yes
  - □ No
- Are you a Worker's Compensation recipient?
  - □ Yes
  - □ No
- Are you comfortable using the internet?
  - □ Yes
  - □ No
- Do you have a Resume?
  - □ Yes
  - □ No
- Are you able to hear without the assistance of a TTY relay service or other assistive methods?
  - □ Yes, I can hear fine and on my own without assistance
  - □ No, I cannot hear well and often/sometimes need assistance to hear
- Are you able to speak clearly or is it difficult for you to verbally communicate?
  - □ Yes, I can speak clearly and without assistance
  - □ No, I have a difficult time speaking clearly

- Are you able to read without assistive technology program?

    - ☐ Yes, I am able to read and use the computer without needing assistive technology programs

    - ☐ No, I require the use of technology programs such as Zoomtech or Jaws to read

- Are you also interested in jobs Outside the Home in your local community?

    - ☐ Yes, I am interested in both work-from-home & jobs in my community

    - ☐ Yes, I am ONLY interested in jobs in my community

    - ☐ No, I am ONLY interested in work from home opportunities

Education:

What is the highest level of education you received? (circle)

Grade School High School Junior College

GED Trade School University

High School:

Name: _____ City/State: _____

Number of Years Attended: _____ Graduate: _____ G.E.D._____

College:

Name: _____ City/State: _____

Number of Years Attended: _____ Course/ Major: _____ Diploma/ Degree:_____

College:

Name: _____ City/State: _____

Number of Years Attended: _____ Course/ Major: _____ Diploma/ Degree:_____

Trade, Professional School, or Other:

Name: _____ City/State: _____

Number of Years Attended:_____ Course/Major: _____ Diploma/Degree: _____

- Have you ever received help for any of the following?

☐	Individual Counseling	☐	Couples Counseling
☐	Pastoral Counseling	☐	Psychiatrist
☐	Drug Program	☐	AA
☐	Vocational Counseling		
☐	Other: _____		

If you have or are currently in counseling, will you sign a release of information so that we may speak with your counselor if necessary? (circle) Yes No

Did you check counseling/Therapy above? (circle) Yes No

If yes, please explain what was it for:_____

_____

Medical History:

Are you under physician's care and need a release-to-return? (circle) Yes No

Are you currently under a physician's care? (circle) Yes No

Are you currently receiving Medical Insurance? (circle) Yes No

If yes, what type of medical coverage do you have?

Medicaid Medicare Both Medicaid/Medicare

Other

Name of Insurance Coverage:

_____ Phone Number:_____

_____ Phone Number:_____

_____ Phone Number:_____

_____ Phone Number:_____

Primary Physician/Therapist:

_____ Phone Number:_____

_____ Phone Number:_____

_____ Phone Number:_____

- Are you taking any prescribed medication? (circle) Yes No

If you are taking medication(s), list them: _____

_____

_____

_____

_____

_____

_____

_____

Do you have any medication allergies?_____

Family of Origin:

How many brothers and sisters do you have? _____ sisters_____ brothers

You are number: _____ (1 being the oldest)

Immediate Family:

How long have you been with your spouse/partner, if applicable?_____

Are you married? Yes No

If you are married, how long have you been married?_____

Do you live together with your spouse/partner? Yes No

Do you have children? Yes No

If you have children, please complete the following: (from youngest to the oldest)

Name	Age	School Attending
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Do you live with your children now? Yes No

Have the children in your household ever seen or heard you being without a job? Yes No

How has you lack self-sufficiency affected the children in the household?

- □ Unemployment
- □ Medical Illnesses
- □ Lack of Food TANF/SNAP
- □ Other:_____
- □ Criminal History
- □ Family Violence
- □ Alcohol/Drugs

- Have you ever been investigated by CPS? Yes No

Status with Criminal Justice:

Have you ever been arrested? Yes No

If you have been arrested, what were the charges? _____

_____

_____

Were you convicted of the charges? Yes No
If you were convicted of the charges, were they a? (circle one)

Misdemeanor Felony Both

Is attending this program a diversion from jail? Yes No

Are you currently on Probation or Parole? Yes No

Name of Probation/Parole Officer: _____

Probation/Parole Officer Phone Number: _____

Current Probation/Parole Stipulations:_____

_____

Present Situation:

Are there circumstances that led to this referral?_____

Is this the first interest involving vocational opportunities to become self-sufficient?

Yes No

What do you believe is the problem?_____

_____

What kind of solutions do you have?_____

_____

History of Mental Health:

Have you ever had a history of depression? Yes No

If yes, please explain when and if you received medical attention:

_____

_____

Do you have a history of threats/ideation, creation of homicide or suicide?

Yes No

If yes, please explain:

_____

_____

Have you ever seek services/treatment from MHMR within your community? Yes No

If yes, what was it for?

_____

_____

Have you ever been hospitalized for mental illness? Yes No

If yes, when, where and for how long? _____

_____

What are your health limitations?: _____

_____

_____

Disability Diagnosis:

What is your disability, please indicate below: Note: if you run out of space below, please feel free to use office space on page 15.

_____

_____

Family and Friends References:

Alternate Contact's Name: _____

Telephone: _____

Relationship_____

Email: _____

Alternate Contact's Name: _____

Telephone: _____

Relationship:_____

Email: _____

Alternate Contact's Name: _____

Telephone: _____

Relationship:_____

Email: _____

_____ _____

Client Signature Date

For Office Use ONLY

Recommendations: _____

_____

_____

_____