IMPAIRMENT RELATED WORK EXPENSE REQUEST

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

Note: Please do not use this form if you are a blind individual who only receives SSI benefits.

Date:
Period Worked:
Beneficiary Name:
Rep Payee (if applicable):
Social Security Number:
SSN on which payment is made (if different):
Type of Benefits Received: ☐ SSI ☐ Title II Disability benefit (SSDI, CDB, DWB)

This is a request that the items described below be deducted as Impairment Related 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; and
- They relate to an impairment being treated by a health-care provider
- For each expense, I will attach a receipt. 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: You can include monthly expenses 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.

Date of Payment	Amount of Expense	Impairment to Which Cost is Related	Healthcare Provider Name and Type (Example: Dr. Smith, Chiropractor)

Thank you for your consideration of this request.

Beneficiary or payee signature: