

# PLAN FOR ACHIEVING SELF-SUPPORT

Date Received

*In order to minimize recontacts or processing delays, please complete all questions and provide thorough explanations where requested. If you need additional space to answer any questions, use the Remarks section or a separate sheet of paper*

Name \_\_\_\_\_ SSN \_\_\_\_\_

## PART 1 – YOUR WORK GOAL

- A. What is your work goal? *(Show the specific job you expect to have at the end of the plan. If you do not yet have a specific work goal and will be working with a vocational professional to find a suitable job match, show "VR Evaluation." If you show "VR Evaluation," be sure to complete Part II, question F on page 4.*

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If your goal involves supported employment, show the number of hours of job coaching you will receive when you begin working \_\_\_\_\_ **per week/month** *(circle one)*.

Show the number of hours of job coaching you expect to receive after the plan is completed.  
\_\_\_\_\_ **per week/month** *(circle one)*.

- B. Describe the duties you expect to perform in this job. Be as specific as possible *(standing, walking, sitting, lifting stooping, bending, contact with the public, writing reports/documents, etc.)*

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- C. How did you decide on this work goal and what makes this job attractive to you?

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- D. If your work goal does not involve self-employment, how much do you expect to earn each month (gross) after your plan is completed? \$\_\_\_\_\_/month

E. If your work goal involves self-employment, explain why working for yourself will make you more self-supporting than working for someone else.

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**NOTE:** If you plan to start your own business, attach a detailed business plan. At a minimum, the business plan must include the type of business; products or services to be offered by your business; a description of the market for the business; the advertising plan; technical assistance needed; tools, supplies, and equipment needed; and a profit-and-loss projection for the duration of the PASS and at least one year beyond its completion. Also include a description of how you intend to make this business succeed.

F. Did someone help you prepare this plan?  YES  NO If "No," skip to G.  
If "YES," show the name, address and telephone number of that individual or organization.

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May we contact them if we need additional information about your plan?  YES  NO

Do you want us to send them a copy of our decision on your plan?  YES  NO

Are they charging you a fee for this service?  YES  NO

If "YES," how much are they charging? \_\_\_\_\_

G. Have you ever submitted a Plan for Achieving Self Support (PASS) to Social Security?  YES  NO

If "NO," skip to Part II.

If "YES," complete the following:

Was a PASS ever approved for you?  YES  NO If "NO," skip to Part II.

If "YES," complete the following:

When was your most recent plan approved (month/year)? \_\_\_\_\_

What was your work goal in that plan? \_\_\_\_\_

Did you complete that PASS?  YES  NO

If "NO," why weren't you able to complete it? \_\_\_\_\_

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If "YES," why weren't you able to become self-supporting? \_\_\_\_\_

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Why do you believe that this new plan you are requesting will help you go to work? \_\_\_\_\_

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## PART II – MEDICAL/VOCATIONAL BACKGROUND

A. What are your disabling illnesses, injuries, or conditions? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Describe any limitations you have because of your disability (e.g., limited amount of standing or lifting, stooping, bending, or walking; difficulty concentrating; unable to work with other people, difficulty handling stress, etc.) Be specific. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In light of the limitations you described, how will you carry out the duties of your work goal?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. List the jobs you have had **most often** in the past few years. Also list any jobs, including volunteer work, which are similar to your work goal or which provided you with skills that may help you perform the work goal. List the dates you worked in these jobs. Identify periods of self-employment. If you were in the Army, list your Military Occupational Specialty (MOS) code; for the Air Force, list your Air Force Specialty (AFSC) code; and for the Navy, Marine Corps, and Coast Guard, list your RATE.

Job Title	Type of Business	Dates Worked	
		From	To

D. Circle the highest grade of school completed.

0 1 2 3 4 5 6 7 8 9 10 11 12 GED or High School Equivalency

College: 1 2 3 4 or more

1. Were you awarded a college or postgraduate degree?  YES  NO If "NO," skip to 2.

When did you graduate? \_\_\_\_\_

What type of degree did you receive? (B.A., B.S., M.B.A., etc.) \_\_\_\_\_

In what field of study? \_\_\_\_\_

2. Did you attend special education classes?  YES  NO If "NO," skip to E.

If "YES," complete the following:

Name of school \_\_\_\_\_

Address: \_\_\_\_\_

Dates attended: From \_\_\_\_\_ To \_\_\_\_\_

Type of program \_\_\_\_\_

E. Have you completed any type of special job training, trade or vocational school?  YES  NO

If "NO," skip to F.

If "YES," complete the following:

Type of training \_\_\_\_\_

Date completed \_\_\_\_\_

Did you receive a certificate or license?  YES  NO If "NO," skip to F.

If "YES," what kind of certificate or license did you receive?

\_\_\_\_\_

\_\_\_\_\_

F. Have you ever had or expect to have a vocational evaluation or an Individualized Written Rehabilitation Plan (IWRP) or an Individualized Employment Plan (IEP)?  YES  NO

If "NO," skip to Part III (page 5).

If "YES," attach a copy of the evaluation and skip to Part II (page 5). If you cannot attach a copy, complete the following:

When were you evaluated or when do you expect to be evaluated or when was the IWRP or IEP done or when do you expect it to be done? \_\_\_\_\_

Show the name, address, and phone number of the person or organization who evaluated you or will evaluate you or who prepared the IWRP or IEP or will prepare the IWRP or IEP.

\_\_\_\_\_

\_\_\_\_\_



PART IV - EXPENSES

A. If you propose to purchase, lease, or rent a vehicle, please provide the following additional information:

1. Explain why less expensive forms of transportation (*e.g., public transportation, cabs*) will not allow you to reach your work goal.

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2. Do you currently have a valid driver's license?  YES  NO

If "YES," skip to 3.

If "NO," complete the following:

Does Part III include the steps you will follow to get a driver's license?

YES  NO

If "YES," skip to 3.

If "NO," complete the following:

Who will drive the vehicle? \_\_\_\_\_

How will it be used to help you with your work goal? \_\_\_\_\_

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3. If you are proposing to **purchase** a vehicle, explain why renting or leasing are not sufficient.

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4. Explain why you chose the particular vehicle. (**Note:** the purchase of the vehicle should be listed as one of the steps in Part III.)

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B. If you propose to purchase computer equipment or other expensive equipment, please explain why a less expensive alternative (e.g., rental of a computer or purchase of a less expensive model) will not allow you to reach your goal. Explain why you need the capabilities of the particular computer/equipment you identified. Also, if you attend (or will attend) a school with a computer lab for student use, explain why use of that facility is not sufficient to meet your needs.

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C. Other than the items identified in A or B above, list the items or services you are buying or renting or will need to buy or rent in order to reach your work goal. Be as specific as possible. If schooling is an item, list tuition, fees, books, etc. as separate items. List the cost for the entire length of time you will be in school. Where applicable, include brand and model number of the item. **(Do not include expenses you were paying prior to the beginning of your plan; only additional expenses incurred because of your plan can be approved.)**

**NOTE:** Be sure that Part III shows when you will purchase these items or services or training.

1. Item/service training: \_\_\_\_\_ Cost: \$ \_\_\_\_\_

Vendor provider: \_\_\_\_\_

How will this help you reach your work goal? \_\_\_\_\_

\_\_\_\_\_

How did you determine the cost? \_\_\_\_\_

\_\_\_\_\_

Why wouldn't something less expensive meet your needs? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Item/service training: \_\_\_\_\_ Cost: \$ \_\_\_\_\_

Vendor provider: \_\_\_\_\_

How will this help you reach your work goal? \_\_\_\_\_

\_\_\_\_\_

How did you determine the cost? \_\_\_\_\_

\_\_\_\_\_

Why wouldn't something less expensive meet your needs? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Item/service training: \_\_\_\_\_ Cost: \$ \_\_\_\_\_

Vendor provider: \_\_\_\_\_

How will this help you reach your work goal? \_\_\_\_\_

How did you determine the cost? \_\_\_\_\_

Why wouldn't something less expensive meet your needs? \_\_\_\_\_

4. Item/service training: \_\_\_\_\_ Cost: \$ \_\_\_\_\_

Vendor provider: \_\_\_\_\_

How will this help you reach your work goal? \_\_\_\_\_

How did you determine the cost? \_\_\_\_\_

Why wouldn't something less expensive meet your needs? \_\_\_\_\_

5. Item/service training: \_\_\_\_\_ Cost: \$ \_\_\_\_\_

Vendor provider: \_\_\_\_\_

How will this help you reach your work goal? \_\_\_\_\_

How did you determine the cost? \_\_\_\_\_

Why wouldn't something less expensive meet your needs? \_\_\_\_\_





**PART V FUNDING FOR WORK GOAL**

A. Do you plan to use any items you already own (e.g., equipment or property) to reach your work goal?

YES  NO

If "NO," skip to B.

If "YES," complete the following:

Item \_\_\_\_\_

Value \_\_\_\_\_

How will this help you reach your work goal? \_\_\_\_\_

Item \_\_\_\_\_

Value \_\_\_\_\_

How will this help you reach your work goal? \_\_\_\_\_

B. Have you saved any money to pay for the expenses listed on pages 6-8 in Part IV? (Include cash on hand or money in a bank account.)  YES  NO If "NO," skip to C.

If "YES," how much have you saved? \_\_\_\_\_

C. Do you receive or expect to receive income other than SSI payments?  YES  NO

If "NO," skip to F.

If "YES," provide details as follows:

Type of Income	Amount	Frequency (Weekly, Monthly, Yearly)

D. How much of this income will you use each month to pay for the expenses listed in Part IV?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Keep records and receipts of all expenditures I make under the plan until asked to provide them to SSA:

Use the income or resources set aside under the plan **only** to buy the items or services shown in the plan as approved by SSA.

I realize that if I do not comply with the terms of the plan or if I use the income or resources set aside under my plan for any other purpose, SSA will count the income or resources that were excluded and I may have to repay the additional SSI I received.

I also realize that SSA may not approve any expenditures for which I do not submit receipts or other proof of payment.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law and/or State Law. I affirm that all the information I have given on this form is true.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone:  
Home \_\_\_\_\_

Work \_\_\_\_\_

## **PRIVACY ACT STATEMENT**

The Social Security Administration is allowed to collect the information on this form under section 1631 (e) of the Social Security Act. We need this information to determine if we can approve your plan for achieving self-support. Giving us this information is voluntary. However, without it, we may not be able to approve your plan. Social Security will not use the information for any other purpose.

We would give out the facts on this form without your consent only in certain situations. For example, we give out this information if a Federal law requires us to or if your congressional Representative or Senator needs the information to answer questions you ask them.

## **PAPERWORK REDUCTION ACT NOTICE AND TIME IT TAKES STATEMENT:**

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 120 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

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## OUR RESPONSIBILITIES TO YOU

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We received your plan for achieving self-support (PASS) on \_\_\_\_\_  
Your plan will be processed by Social Security employees who are trained to work with PASS.

The PASS expert handling your case will work directly with you. He or she will look over the plan as soon as possible to see if there is a good chance that you can meet your work goal. The PASS expert will also make sure that the things you want to pay for are needed to achieve your work goal and are reasonably priced. If changes are needed, the PASS expert will discuss them with you.

You may contact the PASS expert toll-free at 1- \_\_\_\_\_

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## YOUR REPORTING AND RECORD KEEPING RESPONSIBILITIES

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**If we approve your plan, you must tell Social Security about any changes to your plan. You must tell us if:**

- Your medical condition improves.
- You are unable to follow your plan.
- You decide not to pursue your goal or decide to pursue a different goal.
- You decide that you do not need to pay for any of the expenses you listed in your plan.
- Someone else pays for any of your plan expenses.
- You use the income or resources we exclude for a purpose other than the expenses specified in your plan.
- There are any other changes to your plan.

You must tell us about any of these things within 10 days following the month in which it happens. If you do not report any of these things, we may stop your plan.

You should also tell us if you decide that you need to pay for other expenses not listed in your plan in order to reach your goal. We may be able to change your plan or the amount of income we exclude so you can pay for the additional expenses.

**YOU MUST KEEP RECEIPTS OR CANCELLED CHECKS TO SHOW WHAT EXPENSES YOU PAID FOR AS PART OF THE PLAN.** You need to keep these receipts or cancelled checks until we contact you to find out if you are still following your plan. When we contact you, we will ask to see the receipts or cancelled checks. If you are not following the plan, you may have to pay back some or all of the SSI you received.