

Center for Independent Living Southwest Kansas
Ticket Contract

EIN Number: 48-1191961

Please print all questions must be answered to enable CILSWKS to accept your ticket.

1. Beneficiary Name (Last, First MI)

2. Name of Beneficiary's Legal Representative, (only if applicable, Last, First, MI)

3. Beneficiary's Ticket
Number _____

4. Beneficiary's Date of Birth _____/_____/_____ (mm/dd/yyyy)

- A) I understand that CILSWKS will not receive any payment from me for the cost of services.
- B) I understand that payment for CILSWKS services will come from the Social Security Administration.
- C) I understand that CILSWKS will only receive payment from the Social Security Administration for months in which I do not collect cash benefits from the Social Security Administration due to my work or earnings.
- D) I understand that as long as *I am NOT collecting a monthly cash benefit* from the Social Security Administration due to my work or earnings, then the Employment Network which holds my Ticket (in this case CILSWKS) will collect monthly payments from the Social Security Administration for an amount equal to 40% of the national average SSDI payment or SSI payment - for up to 60 months.
- E) I understand that any information I provide to CILSWKS will be kept confidential and private.
- F) I understand that if I request a copy of this ILP/IWP in an alternative format due to my disability, CILSWKS will provide me with an accessible copy.
- G) I understand that it is my responsibility to turn in my pay stubs to CILSWKS to determine my benefits throughout my ticket assignment with them. I further understand that I must do this by the fifth of every month along with any changes in my employment (this includes hiring, firing, promotions, etc.) This for purpose of benefits management and payment processing.
- H) I have been given and understand the grievance procedure available to me at CILSWKS. If at any time I am not satisfied with the service provided I can file a grievance or revoke ticket assignment.
- I) I understand that the assignment of my ticket to an EN (in this case CILSWKS) protects me from Continuing Disability Reviews or CDR's

Contact Information (Beneficiary or legal representative of Beneficiary)

5A. Telephone of Beneficiary or legal representative: () _____

5B. E-mail address (if you have one) _____

NAME: (Title, First, Last) _____

Apt. or street number, name: _____

City, State, Zip Code: _____

6. Beneficiary Gender Male Female

6a. Type of Income: SSI SSDI SSI/SSDI

7. A registered voter in the State of Kansas Yes No

7b. If No would you like to register _____

Work Background

8. Beneficiary education level (check highest level completed)

- No formal education level completed
 Elementary Education (Grades 1-8)
 Secondary Education, no high school diploma (grades 9-12)
 Special Education certificate of completion/attendance
 High School diploma equivalent (e.g., GED)
 Post-secondary education, no degree
 Associate Degree or Vocational Technical Certificate
 Bachelor's Degree
 Master's Degree or higher

9. Is beneficiary currently working? Yes No

10A. If beneficiary is working, insert the dollar amount earned in ONE of the following three blanks: \$ _____ per hour OR \$ _____ per week OR \$ _____ per month (leave blank if not working)

10B. If beneficiary is working, insert current average hours in ONE of the following two blanks _____ hours per week OR _____ hours per month. (leave blank if not working)

EMPLOYMENT GOALS (Answer to the best of your ability. These are goals. We understand that they might change and that dates given are approximations)

11. Date beneficiary expects to start work (leave blank if you are already working):

_____/_____/_____(mm/dd/yyyy)

12. Does the employment goal include employer offered benefits? Yes No

13. If yes, which benefits:

- vacation
 sick leave/short-term disability insurance
 health insurance
 long-term disability insurance
 retirement or pension plan
 child care

14. How far is beneficiary willing to travel to a new job (maximum miles from beneficiary's home): _____ miles.

15. Expected earnings amount (insert the dollar amount expected in ONE of the following three blanks) \$ _____ per hour OR \$ _____ per week OR \$ _____ per month.

16. Expected average hours of work (insert the average number of hours expected in ONE of the two following blanks _____ hours per week OR _____ hours per month.

17. Type of Employment expected: ___ wage employment ___ self-employment

18. Expected category of job sought (EEOC classification): Check one.

- | | |
|---|--|
| <input type="checkbox"/> Executive/Managerial | <input type="checkbox"/> Skilled Craft |
| <input type="checkbox"/> Professional | <input type="checkbox"/> Secretarial/Office/Clerical |
| <input type="checkbox"/> Sales | <input type="checkbox"/> Service Worker |
| <input type="checkbox"/> Technical/Paraprofessional | <input type="checkbox"/> Operative |
| <input type="checkbox"/> Skilled Craft | <input type="checkbox"/> Laborer |

18. Expected Occupation

(specify) _____

SERVICES TO BE PROVIDED BY CILSWKS

19. A peer specialist will be contacting you within 24-48 hours of confirmation with Maximums that your ticket is assignable. At this point they will discuss and develop a plan to achieve your goal of work. And what service(s) you want our assistance to complete and which ones you will do. Once this is agreed upon you will sign ILP/IWP and it will be submit to Maximums for approval. While we wait we will begin work on your goals.

20. Assignment begin the date that the beneficiary and CILSWKS signs the ILP/IWP NOT the day of confirmation from Maximums

J) CILSWKS reserves the right to terminate the ILP/IWP if the individual fails to make progress towards employment within a six month period of ticket assignment. By not following through with goals and objectives, or fails to turn in pay stubs for benefits and payment processing in a timely manner.

K) I understand that if for any reason I am dissatisfied with CILSWKS, I can retrieve my Ticket from CILSWKS and reassign my Ticket to a new Employment Network. I start that process by calling (866) 968-7842.

L) I understand that should I have a dispute with CILSWKS, advocacy services and assistance in resolving disputes is available to me by my State Protection and Advocacy (P&A) System. (Include as part of this packet)

M) I understand that this IWP/ILP may be amended if CILSWKS and I agree to do so.

N) I understand that if I am unable to actively prepare for, or pursue my employment goals, for a period of time in excess of 90 days, I am obligated to inform CILSWKS so that they can classify my Ticket as in-active.

By signing this I verify that I have read, understand and I am in agreement with Statements A through N

Signature of Beneficiary or Legal Representative of Beneficiary

Date

Signature of CILSWKS Representative

Date

Please review form to ensure that you have responded correctly to all questions.

If you have any further question please contact the Office Coordinator at 1-800 736-9443 or email at sritt@cilswks.org

Please mail form to:

**Center for Independent Living Southwest Kansas
1802 E. Spruce St.
P.O. Box 2090
Garden City, KS 67846
FAX: (620) 271-0200**

Once your application has been reviewed and approved, CILSWKS peer specialist will be in with in 24-48 of receiving application contact to set up an appointment to complete your own plan to achieve the goal of employment with our assistance a copy of your completed plan will be given to you at that time.