IRWE Expense Request Form

Impairment-Related Work Expense Request

Please accept this information for consideration of IRWE

Beneficiary Name:

Social Security Number:

Type of Social Security benefits received:

Address:

City/State/Zip Code:

Phone Number:

Part 1: Current Employment Status

Part 2: List and description of expense(s), and an explanation of how it meets SSA's criteria for an Impairment-Related Work Expense:

Impairment-Related Work Expense Criteria:

1. Expenses are directly related to enabling the individual to work;
2. The individual, because of a severe physical or mental impairment, needs the items or services in order to work;
3. Costs are paid by the individual and not reimbursable from other sources;
4. Expenses are to be paid in a month in which the individual is or was working; and
5. Expenses are reasonable.

(See POMS DI 24001.035, Impairment Related Work Expenses, for specific information on how IRWE provisions are applied to both DI and Title XVI cases.)

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Itemized List of Proposed Impairment-Related Work Expenses
Item 1: Estimated monthly cost: Month(s) expense incurred: Explanation of how this item/service meets IRWE criteria:
Item 2: Estimated monthly cost: Month(s) expense incurred: Explanation of how this item/service meets IRWE criteria:
Item 3: Estimated monthly cost: Month(s) expense incurred: Explanation of how this item/service meets IRWE criteria:

Other information about this request:	
I look forward to receiving written notice of the determination within 30 days. Please contact me if you have any questions or require more information to make a determination. Beneficiary Signature	Date

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