Social Security Administration
Retirement, Survivors, and Disability Insurance

Important Information

Date: _____ BNC#: _____

One of Social Security's highest priorities is to support the efforts of beneficiaries with disabilities who want to work. The Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs include several employment support provisions commonly referred to as work incentives, or special rules that help you to receive, or continue to receive benefits even if you are working. We need more information to see if any of these incentives apply to you. If you are just now applying for disability benefits, the information you give us helps us decide if you can receive benefits. If you are currently receiving disability benefits, the information you give us helps us decide if your benefits can continue.

The information we ask for includes:

- Employment History – This includes your dates of employment, wages or salary earned, and any special pay you received (e.g., sick and vacation pay, disability pay from your employer, and workers' compensation, etc.).
- Special Employment Conditions – If you receive more supervision than other workers doing the same job, have fewer or simpler tasks to complete, are given additional or longer breaks, or have a job coach/mentor who performs some of your work tasks, you may be working under special conditions. We may need to contact your employer to verify your special work conditions.
- Work Expenses related to your disability – If you work and have a disability, you may need certain items or services to assist you (e.g., co-pays for prescription drugs, medical device expenses, special transportation, counseling fees, expenses related to a service animal, etc.)

We may ask for proof of any of the information you provide.

What You Need To Do

Please complete and return this form **within 15 days**. It is important to fill out the form carefully and completely even if you receive additional forms requesting authorization to obtain wage and employment information from payroll data providers. If you do not return this form, we may contact your employer or make our decision based on the information we have in our records.

For More Information

Please read the pamphlet, “Working While Disabled: How We Can Help.” It will tell you more about why we need to know about your work and will explain our rules about working. This pamphlet is available online at www.ssa.gov/pubs/EN-05-10095.pdf. You may also visit www.choosework.ssa.gov or contact the Ticket to Work Help Line at **1-866-968-7842** (**TTY 1-866-833-2967**) to learn more about work incentives and find service providers who can explain how work can affect your benefits.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit https://oig.ssa.gov/report or call the Inspector General's Fraud Hotline at **1-800-269-0271 (TTY 1-866-501-2101)**.

Need More Help?

If you have any questions, or need help completing the form:

- Visit our website at www.ssa.gov for fast, simple, and secure online service.
- Call us at **1-800-772-1213**, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call **TTY 1-800-325-0778**. Please mention this letter when you call.
- You may also call the office working on your case at _____

How are we doing? Go to www.ssa.gov/feedback to tell us.

Social Security Administration

Work Activity Report - Employee Identification

Name of Claimant or Beneficiary	BNC# or SSN	☐ Blind ☐ Not Blind

We have information that you have worked since your disability began, since your date of entitlement to benefits, or since your last work review. Please answer the questions below. This will help us decide if you can receive or continue to receive benefits, and if work incentives apply to you. Please provide information since the date shown below.

Please describe your work activity since: (***If a date is not shown, please provide information for the last two years.)***	Date (to be completed by SSA)

Income Information

1. Have you had any employment income or wages since your disability began, since the date shown in the identification section, or since we last reviewed your work activity? (check one)

☐ NO. If you **did not work**, but income was reported for you, go to question 2.

☐ YES. If you have worked, go to the **EMPLOYMENT INFORMATION** section, question 3A.

2. We may receive reports of other types of income for you even if you are not working. Other types of income include back pay, vacation pay, sick pay, disability pay/insurance, and workers' compensation. We may ask for more information about the income that has been reported.

Did you receive other types of income since your disability began or since we last reviewed your work activity?

☐ NO. If you did not receive any other type of income and have not worked since the date shown in the **IDENTIFICATION** section or within the last two years, please specify any possible source of reported income below, then go to the **SIGNATURE** section, complete, sign and return the form.

☐ YES. Mark below any that apply and then go to the **SIGNATURE** section, complete, sign and return the form.

☐ Back Pay ☐ Vacation Pay ☐ Sick Pay ☐ Disability Pay/Insurance

☐ Workers' Compensation ☐ Other (please explain below)

Please use this space to tell us more about the income you checked above (employer name, amount, date(s) paid, and if other, type of income.)

BNC#: _____

3A. Beginning with your most recent employer, please tell us about your work activity since the date shown in the **IDENTIFICATION** section, the date your disability began, since your last work review or within the last two years. **If we have not already received proof of income from your employer(s), we may ask you to submit it.**

Employer's Name	Direct Supervisor's Name		
Telephone Number *(include area code)*	Fax Number (*include area code*)		
Mailing Address	City	State	ZIP Code
Job Title	Rate of Pay $ _____ per _____	Average Hours Worked _____ per _____	
Date Work Started (MM/DD/YYYY) ☐ Still working	Date Work Ended (if ended) (MM/DD/YYYY)	Reason Work Ended (if applicable) ☐ Because of my disability ☐ Other reason(s)	

☐ I am enclosing or have already provided pay stub information (online, by mail, or in the office), or it has already been submitted for me.

3B. *If you did not work for any more employers*, *go to Question 4***.**

Employer's Name	Direct Supervisor's Name		
Telephone Number *(include area code)*	Fax Number (*include area code*)		
Mailing Address	City	State	ZIP Code
Job Title	Rate of Pay $ _____ per _____	Average Hours Worked _____ per _____	
Date Work Started (MM/DD/YYYY) ☐ Still working	Date Work Ended (if ended) (MM/DD/YYYY)	Reason Work Ended (if applicable) ☐ Because of my disability ☐ Other reason(s)	

☐ I am enclosing or have already provided pay stub information (online, by mail, or in the office), or it has already been submitted for me.

BNC#: _____

3C. *If you did not work for any more employers, go to question 4.*

Employer's Name	Direct Supervisor's Name
Telephone Number *(include area code)*	Fax Number (*include area code*)

Mailing Address	City	State	ZIP Code

Job Title	Rate of Pay	Average Hours Worked
	$ _____ per _____	_____ per _____

Date Work Started (MM/DD/YYYY) ☐ Still working	Date Work Ended (if ended) (MM/DD/YYYY)	Reason Work Ended (if applicable) ☐ Because of my disability ☐ Other reason(s)

☐ I am enclosing or have already provided pay stub information (online, by mail, or in the office), or it has already been submitted for me.

If you need to tell us about more employers, use the "ADDITIONAL EMPLOYMENT INFORMATION" pages at the end of this form.

4. We only count income directly related to your work. For example, if you are working, but also received income for time off, like sick or vacation pay, we will deduct that income from your total (gross) earnings before we decide if you are eligible for benefits. Or, when you work and receive other types of income, like tips or bonuses, we may add that pay to your total (gross) income before we decide if you are eligible for benefits.

If you worked, did you also get any other income from any employer(s) that you told us about in the **EMPLOYMENT INFORMATION** section (including the **ADDITIONAL EMPLOYMENT INFORMATION** pages)?

☐ NO. If you did not receive any other payments in addition to earnings from work, go to the **WORK INCENTIVES** section.

☐ YES. Mark below any that apply, then go to the **WORK INCENTIVES** section.

☐ Sick Pay ☐ Disability Pay ☐ Vacation Pay ☐ Bonus ☐ Tips ☐ Workers' Comp

☐ Other (please explain below)

Please use this space to tell us more about the income you checked above (employer name, amount, date(s) paid, and if other, type of income.)

BNC#: _____

Work Incentives

We have work incentives that may allow you to work and receive Social Security Disability benefits. When we review your earnings to decide if you have done substantial work, we may be able to deduct income not directly related to your work or that you use to pay for items or services related to your disability and necessary for you to work.

5A. Having extra support on the job may result in SSA not counting part of your earnings when we decide if you are eligible for or can continue to receive benefits.

For any job(s) that you told us about in the **EMPLOYMENT INFORMATION** section (including the **ADDITIONAL EMPLOYMENT INFORMATION** pages), do you get extra support, easier work, or more time to do your work because of your disability?

☐ NO. Go to question 6A.

☐ YES. Go to question 5B.

5B. Please mark any below that apply, then go to question 5C.

☐ I need help to complete my job duties. (job coach, extra help, or extra supervision, etc.)

Employer(s)	Contact Name(s)

☐ I have fewer or easier duties than most people doing the same job.

Employer(s)	Contact Name(s)

☐ My employer allows me to take additional or longer breaks, to work fewer hours, extra time to complete work tasks, or they let me be absent more often because of my disability.

Employer(s)	Contact Name(s)

☐ My employer gives me other support, not checked above.

Employer(s)	Contact Name(s)
Support(s)	

BNC#: _____

5C. Does someone other than your employer have firsthand knowledge about the extra help, easier work, or extra time you get to do your work, because of your disability?

- ☐ NO. Go to question 6A.
- ☐ YES. Please tell us about them below, then go to question 6A.
  - ☐ Job Coach ☐ Vocational Rehab Counselor ☐ Employment Network
  - ☐ Community Work Incentive Coordinator ☐ Other

Contact Name	Title	Phone Number (include area code)
Address		Fax Number (include area code)

Use this space to tell us more about support not listed above or to provide more information on the extra help, easier work, or extra time you get to do your work, because of your disability.

6A. We may not count short periods of substantial work (6 months or less) when we decide if you are eligible for benefits.

For any job(s) that you told us about in the **EMPLOYMENT INFORMATION** section (including the **ADDITIONAL EMPLOYMENT INFORMATION** pages), did you make any changes to your work due to your disability, or due to the removal of special conditions that allowed you to work?

Examples of special conditions include, on-the-job coaching and similar services, close or continuous supervision or when the job coach or another employee performs part or all your job duties, because of your disabling condition.

- ☐ NO. Go to question 7A.
- ☐ YES. Go to question 6B.

BNC#: _____

6B. Mark any that apply, provide requested information, then go to question 7A.

- ☐ I stopped working within 6 months or less due to my disability, or due to the removal of special conditions that allowed me to work.
- ☐ I changed to fewer hours of work or less earnings after 6 months or less due to my disability or due to the removal of special conditions that allowed me to work.
- ☐ I changed to a lighter or easier type of work due to my disability, or due to the removal of special conditions that allowed me to work.

For any items checked above, please provide:

Employer Name(s)	Contact Name(s)
Date(s) of any Change	

Use this space to tell us more about changes in your work activity due to your disability, or due to the removal of special conditions that allowed you to work. Include information about the special conditions that were removed.

7A. We may be able to deduct certain expenses from your total (gross) wages before we decide if you are eligible to receive or continue to receive benefits. The expenses must be for items or services that ***you pay for***, that are ***needed because of your disability***, and that are ***needed for you to work***. The expenses must be paid for out of pocket. We cannot count expenses that Medicare, Medicaid, an insurance company, or another person paid or will pay back to you.

Examples of allowable expenses include medicines or co-pays, medical devices or procedures, special transportation, special telephone or other equipment, service animal, attendant care, or special equipment if you are blind, etc.

Did you spend any of your own money for items or services related to your disability that you needed for you to work?

- ☐ NO. Go to **SIGNATURE** section, complete, sign and return the form.
- ☐ YES. Go to question 7B.

For each expense, we may ask you for proof of payment, that you needed the item or service because of an impairment(s) being treated by a healthcare provider, and how it helps you do your job.

BNC#:

7B. Please, use this section to tell us about the item(s) or service(s), the date(s) you purchased them and what they cost. You should also tell us about recurring expenses.

Describe Item or Service	Cost per (day, week, month, or year)	Date Paid MM/YYYY - MM/YYYY	Continuing Y/N
Example: Medication	*$25 per month*	*01/2024 - 02/2024*	*Y*

Please use this space to tell us more about the income you checked above (employer name, amount, date(s) paid, and if other, type of income.)

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition or my work.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of Claimant, Beneficiary or Representative Payee		Date	Area Code and Telephone Number	
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)	City		State	ZIP Code

If this statement is signed with a mark (e.g., X), two individuals who know the person making the statement must witness the signature and sign below, giving their full addresses and telephone numbers.

1. Signature of Witness		Date	Area Code and Telephone Number	
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)	City		State	ZIP Code
2. Signature of Witness		Date	Area Code and Telephone Number	
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)	City		State	ZIP Code

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(d) and 1633 of the Social Security Act, as amended, allow us to collect this information, which we will use to determine benefits eligibility. Providing this information is voluntary, but not providing all or part of the information may prevent us from making an accurate and timely decision on your claim and benefit payments. As law permits, we may use and share the information you submit, including with other Federal agencies, contractors, employers, and others, as outlined in the routine uses within System of Records Notices 60-0059 and 60-0320, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs for Federal benefits eligibility and to recoup debts under these programs.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 40 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

BNC#: _____

ADDITIONAL EMPLOYMENT INFORMATION

Employer's Name	Direct Supervisor's Name
Telephone Number *(include area code)*	Fax Number (*include area code*)

Mailing Address	City	State	ZIP Code

Job Title	Rate of Pay	Average Hours Worked
	$ _____ per _____	_____ per _____

Date Work Started (MM/DD/YYYY) ☐ Still working	Date Work Ended (if ended) (MM/DD/YYYY)	Reason Work Ended (if applicable)
		☐ Because of my disability ☐ Other reason(s)

☐ I am enclosing or have already provided pay stub information (online, by mail, or in the office), or it has already been submitted for me.

Employer's Name	Direct Supervisor's Name
Telephone Number *(include area code)*	Fax Number (*include area code*)

Mailing Address	City	State	ZIP Code

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