

## Income Improvement and Advancement Plan (IIAP)

Name \_\_\_\_\_

### Advancement Goals (check all that apply)

- Promotion to \_\_\_\_\_
- Earn raise from \_\_\_\_\_ to \_\_\_\_\_
- Increase in hours from \_\_\_\_\_ to \_\_\_\_\_
- Education & skills training: \_\_\_\_\_
- Move into \_\_\_\_\_ job in \_\_\_\_\_
- Be awarded employer benefits: \_\_\_\_\_

### Income Stabilization Goals (check all that apply)

- Child care and/or transportation assistance
- Assistance with food costs
- Health insurance for self and/or family
- EITC/ Child Tax Credit
- Child and Dependent Care Tax Credit
- Financial education

### Motivation for achieving goals:

\_\_\_\_\_

Current Employer: \_\_\_\_\_

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

Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Job Title \_\_\_\_\_ Work Hours \_\_\_\_\_

Current Wage \_\_\_\_\_ Start date: \_\_\_\_\_

Additional Contacts: \_\_\_\_\_

## Work Support Eligibility Screening Worksheet

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Company/Location \_\_\_\_\_

**Citizenship Status**       U.S. Citizen       Legal Alien       Non-Citizen Family Member

Please list all family members in your household

Family Member	Relation	Age	Sex		Pregnant		Widow		Employed		Wages	Citizenship	
			M	F	Yes	No	Yes	No	Yes	No		U.S. Citizen	Legal Resident
	self												

Income/Resources (Monthly)	Expenses (Monthly)
Wage Earner # 1 _____	Rent/ Mortgage Payment _____
Wage Earner # 2 _____	Home Insurance/Taxes _____
	<b>Utilities</b>
<b>Other Income/Resources</b>	Gas _____
Savings/Checking Accounts _____	Water _____
Grants/Loans/Scholarships _____	Electricity _____
Car Model & Year _____	Telephone _____
Child Support _____	Trash Removal _____
Alimony _____	Child/Dependent Care _____
VA Benefits _____	Transportation (to & from school) _____
Unemployment _____	Medical Costs _____
Pensions/Railroad Retirements _____	Other _____
Worker's Compensation _____	
TANF Cash Assistance _____	
Retirement Survivors/Disability _____	
SSI _____	
Stocks & Bonds _____	
<b>TOTAL INCOME:</b>	<b>TOTAL EXPENSES:</b>

### Benefit Information

Please check all the benefits you are receiving now or in the past

- |                                          |                                                   |                                                           |
|------------------------------------------|---------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Medicaid        | <input type="checkbox"/> Currently receiving SSI  | <input type="checkbox"/> Receiving Food Stamps Now        |
| <input type="checkbox"/> Medicare        | <input type="checkbox"/> Received SSI in the past | <input type="checkbox"/> Received food stamps in the past |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Veteran's benefits       |                                                           |









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Start Screening



### Complete Screening:

You have chosen to complete screening.

#### What Is Screening?

By completing the following self-screening questionnaire, you can find out what State benefits you may qualify to receive.

The screening questionnaire will ask you several questions about you and your family. The answers you provide will help us find ways to help you. To best assist you, please answer all the questions carefully. The screening process should take about 20 minutes to complete.

**Please note the results provided by the screening are not an official determination of your eligibility. To find out if your household is eligible to receive benefits, you must complete and submit a formal application for benefits. Each of the benefit programs has different eligibility requirements. After you fill out an application we may ask you for other information that may help us decide if you are eligible for the benefits.**

#### What Information Do I Need?

Before you begin, you may want to gather the following information to help you answer questions:

- **Household financial information, such as:**
  - Money spent on rent, house payments or utilities
  - Money in a cash or bank account
  - Income from a job or training
  - Payments for adult or child care
- **Information on benefits** you currently receive or have received in the past (for example, Medicaid, Medicare, Social Security, veteran's benefits, etc.)
- **Medical information** related to you and other members of your household.

***The information you provide on this website is secure and will be kept confidential.***

#### What Happens When I am Finished?

When you have completed the self-screening questionnaire, a results page will provide you a list of the benefits you/your household may be eligible to receive.

### What If I Want to Apply Now?

You do not have to fill out the screening questionnaire before applying. If you choose, you can go directly to the online application to apply for benefits.

To begin the screening, please click START SCREENING.



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Information

Tell Us About  
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## Please Tell Us Who You Are

- I am screening for my household and me.
- I am screening for someone else.

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Please Tell Us Who You Are

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## General Household

**\* = Required Fields**

\* How many people live in the household?

Is anyone in the home a migrant worker or a seasonal farm worker?  Yes  No

Does anyone need help with alcohol or drug abuse?  Yes  No

Does anyone need help with getting child support?  Yes  No

Does anyone need help finding a job?  Yes  No

Does the household have a telephone?  Yes  No

Does the household live in Texas?  Yes  No

How much is the household's monthly rent or house payment? \$

Did the household pay for utilities this month?

Yes  No

Was the household already certified to receive food stamps this month?

Yes  No

Can the applicant or authorized representative (AR) being interviewed provide proof of identity during or prior to an interview?

Yes  No

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## Tell us about the head of household

Name

## Tell Us About the Household

Name

Name

Name

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## Person 1's Information

**\* = Required Fields**

What is Person 1's Citizen Status?	(Select One)
* What is Person 1's sex?	<input checked="" type="radio"/> Male <input type="radio"/> Female
What is Person 1's age?	<input type="text" value="0"/>
Is Person 1 a widower/widow?	<input type="radio"/> Yes <input type="radio"/> No

## Financial Information

Tell us the information that applies to Person 1.

Cash on hand or money in bank accounts (include EBT cash account, certificates of deposit, stocks, bonds, etc.)	\$ <input type="text" value="0"/>
Income received this month from a current job ( <b>Note:</b> Do not include income from a new or past job).	\$ <input type="text" value="0"/> /month
Income from child support, TANF support or any other source not yet listed.	\$ <input type="text" value="0"/> /month
Amount paid for child care	\$ <input type="text" value="0"/> /month
Amount paid for adult care	\$ <input type="text" value="0"/> /month
Did Person 1 lose a job or other income source this month or the last month?	<input type="radio"/> Yes <input type="radio"/> No
Will Person 1 receive income from a <b>new</b> job or other source this month?	<input type="radio"/> Yes <input type="radio"/> No

### Benefit Information

Please check all the benefits below that Person 1 does receive or has received in the past.

- |                                          |                                                   |
|------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Medicaid        | <input type="checkbox"/> Currently Receiving SSI  |
| <input type="checkbox"/> Medicare        | <input type="checkbox"/> Received SSI in the Past |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Veteran's Benefits       |

### Medical Information

Please check all that apply to Person 1.

- |                                                 |                                                                                |
|-------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Physical Disability    | <input type="checkbox"/> Risk of developmental disability (child under age 3)  |
| <input type="checkbox"/> Hearing Loss           | <input type="checkbox"/> Developmental disability before age 22                |
| <input type="checkbox"/> Severe Visual Problems | <input type="checkbox"/> Need ongoing nursing care                             |
| <input type="checkbox"/> Mental Illness         | <input type="checkbox"/> Need help with personal care                          |
| <input type="checkbox"/> Mental Retardation     | <input type="checkbox"/> Need help finding a job (over age 15 with disability) |
| <input type="checkbox"/> High medical Bills     |                                                                                |

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