Subject: Impairment Related Work Expenses deduction request

Date:

Beneficiary Name:

Social Security Number:

Representative Payee Name *(if applicable):*

Type of Benefits Received *(check which one applies):*

☐ **SSI**

☐ **SSDI, CDB, DWB**

☐ **Both**

This is a request that the items described in the attached chart be deducted as Impairment Related Work Expenses when you consider the work activity I am reporting. The items meet the following requirements:

- They are necessary for my work activity or self-employment;
- They were paid by me and not reimbursed by another source;
- They were not deducted as a business expense; and
- They relate to an impairment being treated by a health care provider.

Thank you for your consideration of this request.

Sincerely,

Signature

Receipts are attached for the following IRWEs for this report period:

Date of Payment	Cost Out-of-Pocket	Item or Service Purchased	Related to What Medical Condition?	Healthcare Provider or Vendor

IRWE #1 Remarks:

Date of Payment	Cost Out-of-Pocket	Item or Service Purchased	Related to What Medical Condition?	Healthcare Provider or Vendor

IRWE #2 Remarks:

Date of Payment	Cost Out-of-Pocket	Item or Service Purchased	Related to What Medical Condition?	Healthcare Provider or Vendor

IRWE #3 Remarks:

Date of Payment	Cost Out-of-Pocket	Item or Service Purchased	Related to What Medical Condition?	Healthcare Provider or Vendor

IRWE #4 Remarks:

Date of Payment	Cost Out-of-Pocket	Item or Service Purchased	Related to What Medical Condition?	Healthcare Provider or Vendor

IRWE #5 Remarks:

Date of Payment	Cost Out-of-Pocket	Item or Service Purchased	Related to What Medical Condition?	Healthcare Provider or Vendor

IRWE #6 Remarks:

IRWEsTotal Out-of-Pocket Cost
$ 0.00

Paystubs attached for period worked: