SUBSTANTIAL GAINFUL ACTIVITY WORKSHEET

Name of Disabled Person: _____ **Social Security Number:** _____

Disability: ☐ **Blindness** ☐ **Other**

1. **Gross** Earned Income (Please attach verification) $ _____ per month
2. **Employer Subsidy** (if any) included in your pay (e.g., some employers employ disabled persons and subsidize their wages by paying them the same wages as a nondisabled employee though they may be performing less strenuous work, or working less hours) $ _____ per month
3. **Impairment-Related Work Expenses** per month (see attached for description)
   a. Attendant Care Services $ _____
   b. Transportation Costs _____
   c. Medical Devices _____
   d. Work-Related Equipment _____
   e. Prosthesis _____
   f. Residential Modifications _____
   g. Routine Drugs and Routine Medical Services _____
   h. Diagnostic Procedures _____
   i. Nonmedical Applications and Devices _____
   j. Assistants (e.g., if visually impaired, cost to hire reader) _____
   k. Other Items and Services _____

++

~~**Office Use only** (Case Manager complete below)~~

4. **TOTAL Impairment-Related Work Expenses**
   Add together all that apply (total of 3a through 3k) $ _____ per month
5. **NET Countable Earnings** (from 1 subtract 2 and 4) $ _____ per month

- Are current countable earnings (line 5) greater than
  Blind SGA Amount $ _____ _____ Yes _____ No
  Non Blind SGA Amount $ _____ _____ Yes _____ No

- If the answer is No, the customer must apply for Social Security benefits.
- If the answer is Yes, the client is engaging in SGA. Deny the MA application.

_____ Case Manager Signature _____ Telephone Number _____ Date

Address: _____

_____