WorkWithoutLimits™
PUTTING ABILITIES TO WORK

UMASS MEDICAL SCHOOL Commonwealth Medicine

REFERRAL INSTRUCTIONS

Dear Referring Counselor or Beneficiary,

In order to ensure you're sending Work Without Limits Benefits Counseling an *appropriate* and *complete* referral (**preferably typed**), please follow the steps below:

- A beneficiary must be actively seeking employment or currently working in order to receive benefits counseling. The exceptions are veterans and transition-aged youth (ages 14 through 25). If you or your client are only thinking about work, call Social Security's Ticket to Work Help Line at 1-866-968-7842 or 1-866-833-2967 (TTY) for general information.
- Complete the *Work Without Limits Benefits Counseling Referral Form* on page 2.
- Read and initial the *WIPA Privacy Statement, Cancellation Policy, and Dispute Resolution Policy* on page 3.
- Complete and sign the *Social Security Consent for Release of Information* form by filling the fields containing asterisks (*) found on the top and bottom sections of the form. **Important:** Do not check any boxes on release forms.
- Complete sections 1 and 3 of the *Massachusetts SSI State Supplement Program (SSP) Request for Access to SSP Recipient Record and Information* form on page 6.
- Upon completion, fax pages 2 through 5 to **(508) 856-6607** or mail them to the following address:

  Attn: Stephanie Major
  Work Without Limits Benefits Counseling
  UMass Medical School 333 South Street
  Shrewsbury, MA 01545

If you have any questions, contact Stephanie Major, Work Without Limits Benefits Counseling Intake Specialist, at (508) 856-3815 or at Stephanie.Major@umassmed.edu.

Your cooperation is greatly appreciated, and we look forward to working with you.

Thank you, The Work Without Limits Benefits Counseling Team

Work Without Limits is an initiative of Commonwealth Medicine, the consulting and operations division of UMass Medical School.
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REFERRAL FORM

Referring Counselor Information:

Full Name:_________________________________ Agency: ______________________________

Email:______________________________________Phone:_________________________Ext: _______

Address:___________________________________City:___________________________Zip:

Beneficiary Information:

First Name:____________________________ Last Name:______________________ Age: _______

Address:____________________________Apt:_______City:________________________Zip: _______

Home Phone:_____________________________ Cell Phone: _________________________________

Email:___________________________ Best Contact Time: ☐ AM ☐ PM | Specific Time: _________

☐ Veteran ☐ Transition Age Youth (ages 14 – 25)

Other Main Contact Information (*If Applicable*):

First Name:_______________________________Last Name: _________________________________

Home Phone:______________________________Cell Phone: __________________________________

Email:____________________________Best Contact Time: ☐ AM ☐ PM | Specific Time: ___________

Employment Situation (*Required*):

☐ Currently Employed/Self-Employed

Gross Monthly Earnings: $_____________

☐ Pending job offer, promotion, interview(s)

☐ Actively seeking employment

☐ Considering employment

Meeting Preferences & Needs (*Check All That Apply*):

☐ Coordinate meeting with referring counselor

☐ Coordinate meeting with other main contact

☐ Limited English Proficiency (LEP)

☐ Needs ASL and/or CDI interpreter

☐ Reasonable Accommodations: ______________

____

Reason for Referral (*Check All That Apply*):

☐ Quitting due to impact on benefits

☐ Notice of an overpayment

☐ Change in pay or weekly hours

☐ Health insurance issues

☐ Other: _______________________________

Services & Benefit Information (*Check All That Apply*):

☐ DDS ☐ DMH ☐ MCB ☐ MCDHH ☐ MRC

☐ SSI ☐ SSDI ☐ MassHealth ☐ Medicare

☐ Public Housing ☐ Food Stamps

☐ TAFDC ☐ EAEDC

☐ Other: _______________________________

Goals:

☐ Short Term job goal (3-12 months) ____

☐ Long Term job goal (3-5 years) ____

Additional Remarks: ____

Phone: 1-877-937-9675 • Fax: 508-856-6607

This facsimile is intended only for the use of the named addressee and may contain information that is confidential or privileged. If you are not the intended recipient, or you are not the employee responsible for delivering the facsimile for the intended recipient, you are hereby notified that any dissemination, distribution or copying of this facsimile is strictly prohibited. If you received this facsimile in error, please notify the sender immediately for retrieval or destruction of this information.

WIPA PRIVACY ACT STATEMENT
(*Abbreviated Version*)

Section 1148 of the Social Security Act, as amended, authorizes UMass Medical School's Work Without Limits Benefits Counseling program to collect this information to support the Work Incentives Planning and Assistance (WIPA) program. Furnishing us this information is voluntary. However, failing to provide us with all or part of the requested information may limit your ability to participate in the WIPA program. We will use the information to determine if you qualify for the WIPA program. We may also share your information in accordance with approved routine uses.

If you would like more information detailing how we collect and use your information, your Benefits Counselor can read you the full Privacy Act Statement.

CANCELLATION POLICY

If you need to cancel your appointment, please provide your benefits counselor with 24-hour notice. If cancelled a second time, your benefits counselor will contact the person who referred you to Work Without Limits Benefits Counseling, if applicable and a letter will also be sent to both you and that person. Thank you for your cooperation.

Please Note: At least 48 hours prior to the appointment, the benefits counselor will provide a reminder of the appointment, by either phone, text or email.

DISPUTE RESOLUTION POLICY

The WWL Benefits Counseling Team is committed to providing prompt and professional services. We take all concerns and complaints seriously. In the event an individual or a referral source is dissatisfied with our services, they should follow the 3-Step Dispute Resolution Process listed below, until the matter is resolved.

1. Submit a written complaint or concern to the Director of Work Without Limits.
2. If still dissatisfied, contact the Protection and Advocacy for Beneficiaries of Social Security (PABSS) Program at the Massachusetts Disability Law Center.

Initials: ___________

Date: ___________

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**	***ADDRESS OF PERSON OR ORGANIZATION:**
Work Without Limits Benefits Counseling	333 South Street
UMass Medical School	Shrewsbury, MA 01545

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

I am planning on going to work and need this information for benefits planning. Please fax a BPQY to Work Without Limits Benefits Counseling at (508) 856-6607

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date ___________ to date ___________
5. ☐ My Medicare entitlement from date ___________ to date ___________
6. ☐ Medical records from my claims folder(s) from date___________ to date___________
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)
   My cash benefits, Health Insurance, Medical review dates. Representation, SSI&SSDI Work Activity and earnings. Benefits Planning Query: All Employment Supports data on SSA record

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** ______________________ ***Date:** ______________

****Address:** ______________________ ****Daytime Phone:** ______________

Relationship (if not the subject of the record): ______________ ****Daytime Phone:** ______________

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

RID # (for SSP use only)

Massachusetts SSI State Supplement Program (SSP)
Request for Access to SSP Recipient Record and Information

This form is to be completed by an SSP recipient who wishes to authorize another individual to have access to his or her SSP record and information.

Section 1. Recipient Information:

- Recipient Name: ______________________________
- Recipient Date of Birth: ______________________________
  - Recipient Address: ______________________________
    (Number and street) (Apartment, PO Box or Rural Route)

    ____
    (City or town) (State) (Zip code)
- Last Four (4) Digits of Recipient's SSN: ______________________________

Section 2. Authorization for Access to My SSP Record:

- I hereby authorize the individual named below to have access to my SSP record and information. I understand that if I wish to stop this access, I must call SSP Customer Service at 1-877-863-1128.
  - Name: Work Without Limits Benefits Counseling
  - Address: UMass Medical School 333 South Street
    (Number and street) (Suite, PO Box or Rural Route)

    Shrewsbury MA 01545
    (City or town) (State) (Zip code)
  - Telephone Number: (508) 856-2513 FAX: (508) 856-6607

Section 3. REQUIRED: SSP Recipient Signature:

______________________________ Date: ______________________

Check to request an SSP Income Verification letter.

The SSP recipient should complete the form and return it to:

Massachusetts SSP
P. O. Box 15661
Worcester, MA 01615-0661
Fax: **877-533-4383**

Please call SSP Customer Service at **1-877-863-1128** with any questions about the form.