REFERRAL INSTRUCTIONS – Employment Network

Dear Referring Counselor or Beneficiary,

To ensure you are sending Work Without Limits Employment Network (EN) a **complete** referral (**preferably typed**), please follow the steps below:

- Complete the *EN Referral Form* on page 2.
- Complete and sign the *Social Security Consent for Release of Information* form on page 2 by filling in your *name*, *date of birth* and *Social Security number* at the top then *sign and date* the bottom. **Do not check any boxes on release forms.**
- Complete the *Massachusetts SSI State Supplement Program (SSP) Request for Access to SSP Recipient Record & Information* on page 4 ***ONLY*** if you receive SSI.
- Upon completion send pages 2 through 4 to:

  Fax: **(508) 856-4017** or
  SECURE email to stephanie.major@umassmed.edu

If you are unable to fax or email, mail to the following address:

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

Please note there will be a delay in processing mailed referral packets.

If you have any questions, contact:

Marjorie Longo, EN Program Manager, CPWIC
(508) 340-3888
marjorie.longo@umassmed.edu

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

Thank you, The Work Without Limits EN Team

Phone: 877-937-9675 | Fax: 508-856-4017

https://workwithoutlimits.org/en

For general information, contact the Ticket to Work Help Line at **866-968-7842.**

This document was developed at U.S. taxpayer expense and is funded through a Social Security cooperative agreement. Although Social Security reviewed this document for accuracy, it does not constitute an official Social Security communication.

forHealth™ CONSULTING at UMass Chan Medical School | WorkWithoutLimits™ — PUTTING ABILITIES TO WORK —

REFERRAL FORM – Employment Network

Referring Counselor Information (If Applicable)

☐ Coordinate meeting with Referring Counselor

Full Name: _____ Agency: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Ext: _____ Other Phone: _____

Email: _____

Beneficiary Information

First Name:_____ Last Name:_____ Age: ____

Address:_____ Apt:_____ City:_____ Zip: _____

Home Phone:_____ Cell Phone: _____

Email:_____

Other Main Contact Information (If Applicable)

☐ Coordinate meeting with Other Main Contact

First Name:_____ Last Name:_____

Home Phone:_____ Cell Phone: _____

Email:_____

Demographic Information (Check all that apply)

☐ Veteran ☐ Transition Age Youth (14-25)

Disability: Choose One

Race/Ethnicity: Race/Ethnicity Not Listed Here

Employment Situation (Required)

☐ Currently Employed/Self Employed

Gross Monthly Earnings: $_____

Accommodations Needed for Meeting

_____

Currently Receiving Services From (Check all that apply)

☐ DDS ☐ DMH ☐ MCB ☐ MCDHH ☐ MRC

☐ Other: _____

Benefit Information (Check all that apply)

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare

☐ Public Housing ☐ SNAP (Food Stamps)

☐ Other:_____

Short Term Goals (3 to 12 months): _____

Long Term Goals (3 to 5 years): _____

Phone: 877-937-9675 | Fax: 508-856-6607 | www.workwithoutlimits.org/benefits-counseling

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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 Employment Network	333 South Street
UMass Chan Medical School	Shrewsbury, MA 01545

***I want this information released because:** I am planning to return to work. I authorize this requestor to receive information to provide me with program related return to work assistance.

We may charge a fee to release information for non-program purposes.

I authorize release of the records for 1 year beginning with the date I signed this form.

***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.)

   Beneficiary's cash benefits, health insurance, medical review dates, representation, SSDI and SSI work activity and earnings. All employment supports data on SSA's records.

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 Employment Network
    - 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.