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

REFERRAL PACKAGE INSTRUCTIONS --- Mass Cultural Council

Please follow the steps below to apply for Work Without Limits Benefits Counseling services.

STEP 1: Work Without Limits Benefits Counseling Referral Form (required)

- As best you can, provide as much information as possible on page 2 (preferably typed)

STEP 2: Social Security Consent for Release of Information Form (if applicable)

- If you receive SSI and/or SSDI, complete the following on page 3:
  - At the top, include your full name, date of birth, and Social Security Number
  - At the bottom, include the date and your address and daytime phone number; you must also print and sign this form with ink (e-signatures are not allowed)
    - Please do not fill out or change any other fields or boxes on this form

STEP 3: Massachusetts SSI State Supplement Program Form (if applicable)

- If you receive SSI, complete sections 1 and 3 on page 4 (e-signatures are not allowed)

STEP 4: Referral Package Submission (required)

- Option 1: Email (Referral Form/Page 2 Only)
  - Email the form to workwithoutlimits_benefitscounseling@umassmed.edu with the following subject line, "*SECURE: Referral Form*"
- Option 2: Scan and Email (Referral Package)
  - Complete, print, and scan the pages you filled out and signed
    - Tip: Use the Scanable app for Apple or Simple Scan or CamScanner for Android
  - Email the scanned package to workwithoutlimits_benefitscounseling@umassmed.edu with the following subject line, "*SECURE: Referral Package*"
- Option 3: Print and Fax (Referral Package)
  - If unable to email, print and fax the package to (508) 856-4017
- Option 4: Print and Postal Mail (Referral Package)
  - If unable to email or fax, print and mail the package to the following address:
    Attn: Stephanie Major, Work Without Limits Benefits Counseling
    UMass Chan Medical School
    333 South Street, Shrewsbury, MA 01545
    - Please note there will be a delay in processing mailed referral packets.

IF YOU NEED HELP:

- Email workwithoutlimits_benefitscounseling@umassmed.edu or call 877-937-9675 option 1

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

Thank you, The Work Without Limits Benefits Counseling Team

Phone: 877-937-9675 | Fax: 508-856-4017 | Email: workwithoutlimits_benefitscounseling@umassmed.edu

Click here for more information.

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REFERRAL FORM --- Mass Cultural Council

Beneficiary Information

First/Last Name: | Pronouns: | Other:

Address: | City/Zip Code:

Preferred Phone #: | Alternative Phone #:

Preferred Email: | Alternative Email:

Meeting Format Preference: | Meeting Time Preference:

Reasonable Accommodations: | Other:

Demographic Information

DOB: | Age:

Marital Status: | Number of Dependents:

Disability: | Other:

Race/Ethnicity: | Veteran: ☐ Yes ☐ No

Type of Artist: | Other:

Household/Housing Information

Composition: | Household Size:

Type of Housing: | Monthly Rent/Mortgage:

Employment Information

Employed: ☐ Yes ☐ No | Type of Employment:

Weekly Hours: | Hourly Pay:

Gross Monthly Earnings:

Public Benefits Information (*check all that apply; enter amount, if possible*)

☐ Unemployment: | ☐ SSA Retirement:

☐ SSI: | ☐ TANF:

☐ SSDI: | ☐ Food Stamps:

☐ Child Support: | ☐ Other:

☐ Veterans Benefits:

Health Insurance Information (*check all that apply)*

☐ MassHealth | ☐ Private Health Insurance

☐ Medicare | ☐ Other:

Phone: 877-937-9675 | Fax: 508-856-4017 | Email: workwithoutlimits_benefitscounseling@umassmed.edu

Click here for more information.

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	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
    - 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.