REFERRAL INSTRUCTIONS – WIPA

Who We Serve: With funding from a Social Security Work Incentives Planning and Assistance (WIPA) grant, Work Without Limits provides Benefits Counseling services to individuals with disabilities who receive Social Security disability benefits who are:

- Working, self-employed or about to start work either full-time or part-time.
- Actively interviewing for employment.
- Currently receiving services from State Vocational Rehabilitation (VR), Ticket to Work Employment Network (EN) or other vocational program or indicate serious intent to work.
- Transition-age youth ages of 14-25 at any stage of employment.
- Veterans seeking to return to work.
- Members of racial, ethnic and disability communities or other underserved populations seeking resources to assist them to obtain training or education with a clear employment goal.

Please Note: For individuals who do not meet the above criteria, please contact Social Security's national toll-free Ticket to Work Help Line at **866-968-7842.**

Referral Process: Please complete the referral packet **(preferably typed)** by following the steps below:

1. Complete the Referral Form on pages 2-3 of this document.
2. Read and initial the WIPA Privacy Statement, Cancellation Policy and Dispute Resolution Policy on pages 4-5 of this document.
3. Complete and sign **(must be signed in ink)** the Social Security Consent for Release of Information form on page 6 of this document by filling in the fields containing asterisks (*) found on the top and bottom sections of the form. **Important:** Do not check any boxes on the release forms.
4. Complete and sign **(must be signed in ink)** sections 1 and 3 of the Massachusetts SSI State Supplement Program (SSP) Request for Access to SSP Recipient Record and Information form on page 7 of this document.
5. Submit completed referral packet by using one of the following methods:
   - **Fax:** (508) 856-6607
   - **Scan and email:** stephanie.major@umassmed.edu
   - **Mail originals:** (*please note there will be a delay in processing mailed referral packets)*:

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

If you have any questions, please contact Stephanie Major at stephanie.major@umassmed.edu or at (508) 856-3815. Your cooperation is greatly appreciated, and we look forward to working with you.

Phone: 877-937-9675 | Fax: 508-856-6607 | www.workwithoutlimits.org/benefits-counseling
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 – WIPA (page 1 of 2)

Referring Counselor Information

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)

First Name:_____ Last Name:_____

Home Phone:_____ Cell Phone: _____

Email:_____

Employment Situation (Required)

☐ Currently Employed ☐ Currently Self-Employed

☐ Full-time ☐ Part-time Gross Monthly Earnings: $_____

☐ Pending job offer, promotion or interview ☐ Actively seeking employment ☐ Thinking about work

Reason for Referral (Check all that apply)

☐ Quitting job due to impact on benefits ☐ Notice of an overpayment ☐ Health insurance issues

☐ Increase or decrease in pay or weekly hours ☐ Other: _____

Meeting Preferences (Check all that apply)

☐ Coordinate meeting with Referring Counselor

☐ Coordinate meeting with Other Main Contact

REFERRAL FORM – WIPA (page 2 of 2)

Accommodations Needed for Meeting (Check all that apply)

☐ Language Interpreter - Specify Language: _____

☐ ASL Interpreter ☐ CDI Interpreter ☐ CART Reporter

☐ Other Reasonable Accommodations - Specify: _____

Currently Receiving Services From (Check all that apply)

☐ DDS ☐ DMH ☐ MCB ☐ MCDHH ☐ MRC ☐ Other: _____

Benefit Information (Check all that apply)

☐ SSI ☐ SSDI ☐ MassHealth ☐ Medicare ☐ Public Housing ☐ Food Stamps

☐ Other: _____

Demographic Information (Check all that apply)

☐ Veteran

☐ Transition Age Youth (ages 14 – 25)

☐ Disability: Choose One

☐ Ethnicity: Choose One

Additional Remarks or Comments

_____

_____

_____

_____

_____

_____

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

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WIPA Privacy Act Statement

Section 1148 of the Social Security Act, as amended, authorizes us to collect this information to support the WIPA program. We will use the information you provide to determine if you qualify for the WIPA program. We will also share the information with a certified Community Work Incentive Coordinator, working for the WIPA program.

Furnishing us this information is voluntary. However, failing to provide us with all or part the requested information may limit your ability to participate in the WIPA program.

Social Security will be collecting information from the WIPA program including the names and Social Security Numbers of the beneficiaries they serve, so Social Security can evaluate the success of the WIPA program and can determine how to best meet beneficiaries' needs.

Any information reported as part of the WIPA program will not become part of your Social Security record. The information will not be reported to the Social Security office that makes eligibility determinations. You are responsible for reporting income or changes in your status to the Social Security office.

We rarely use the information for any other purpose other than the WIPA program. However, we may use it for the administration and integrity of our programs. We may disclose the information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

- To comply with Federal laws requiring the release of the information from our records (e.g., to the Government Accountability Office)
- To facilitate statistical research, audit, and investigatory activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us)

A complete list of routine uses for the information you provide us is available in our System of Records Notice entitled Disability Insurance and Supplemental Security Income Demonstration Projects and Experiments System, 60-0218. This notice, additional information about this form, and any other information regarding our systems and programs are available on-line at www.socialsecurity.gov or at your local Social Security office.

Initials: _____

Date: _____

Phone: 877-937-9675 | Fax: 508-856-6607 | www.workwithoutlimits.org/benefits-counseling
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Work Without Limits is an initiative of ForHealth Consulting, the consulting and operations division of UMass Chan Medical School.

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.

Initials: _____

Date: _____

Dispute Resolution Policy

The Work Without Limits 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 referring counselor is dissatisfied with our services, please follow the Dispute Resolution Process listed below.

1) Submit a written complaint or concern to Kathy Petkauskos, Director of Work Without Limits at kathy.petkauskos@umassmed.edu or to her attention at 333 South Street, Shrewsbury, MA 01545 or call 508-856-3897.
2) If still dissatisfied, contact the Protection and Advocacy for Beneficiaries of Social Security (PABSS) Program in your state.
    - In Massachusetts contact the Massachusetts Disability Law Center located at 11 Beacon Street, Suite 925, Boston, MA 02108 or by calling toll-free 1-800-872-9992 or by email at mail@dlc-ma.org.
    - In New York contact Disability Rights New York located at 725 Broadway, Suite 450 Albany, NY 12207-500 or by calling toll-free 1-800-993-8982 or by email at mail@drny.org.

Initials: _____

Date: _____

Consent for Release of Information

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

TO: Social Security Administration

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

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

***NAME OF PERSON OR ORGANIZATION:**

Work Without Limits Benefits Counseling
Umass Chan Medical School
333 South Street

***ADDRESS OF PERSON OR ORGANIZATION:**
**** PHONE NUMBER OF PERSON OR ORGANIZATION:**

Shrewsbury, MA 01545
FAX: (508)856-6607

***I want this information released because:**

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

I am planning to return to work and need this information for benefits planning services.
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. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific 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. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

   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 § 1746) 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 seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***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.