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

REFERRAL INSTRUCTIONS – Employment Network (EN)

Dear Referring Counselor or Beneficiary,

To ensure a **complete** referral package is submitted, please follow the steps below:

STEP 1: Work Without Limits Employment Network Referral Form (2 pages) (required)

- Complete pages 2-3 of this package (preferably typed)
- Use dropdown menus where indicated

STEP 2: Social Security Consent for Release of Information Form

- At the top, include the beneficiary's full name, date of birth, and Social Security Number
- At the bottom, include the date signed and the beneficiary's address and daytime phone number; you must print and **sign this form with ink (e-signatures are not allowed)**
- Please do not fill out or change any other fields or check any boxes on this form

STEP 3: (MA residents only) Request for Access to State Supplement Program (SSP) Recipient Record and Information

- Complete and sign **(must be signed in ink)** sections 1 and 3 only if you receive SSI.

STEP 4: Referral Package Submission (required)

- **Option 1: Email**
  - Complete, print, sign, and scan the package
  - Use the Scannable app for Apple or Simple Scan or CamScanner apps for Android
  - Email the scanned package to stephanie.major@umassmed.edu with the following subject line, "*SECURE: EN Referral Package*"
- **Option 2: Fax**
  - Complete, print, sign, and fax the package to Stephanie Major at (508) 856-4017
- **Option 3: Postal Mail**
  - Complete, print, sign, and mail the package to:
    Stephanie Major, Work Without Limits
    UMass Chan Medical School
    333 South Street, Shrewsbury, MA 01545

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

If you have any questions, contact: Kathy Muhr (she/her), Director of Community Engagement at kathy.muhr@umassmed.edu or (508) 856-3533

We look forward to working with you!

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.**

REFERRAL FORM – Employment Network

Date Completed: _____

Referring Counselor Information: (If Applicable)

☐ Coordinate meeting with Referring Counselor

First Name: _____ Last Name: _____

Pronouns: _____ Other: _____

Agency: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Ext: _____ Other Phone: _____

Email: _____

Beneficiary Information:

Legal First Name: _____ Legal Last Name: _____

Chosen or Preferred Name (if applicable): _____

Pronouns: _____ Other: _____

May we use Chosen or Preferred Name for sending Postal mail? _____

Address: _____ Apt: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Age: ____

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: _____

☐ Race: _____ ☑ Ethnicity: _____

☐ Gender Identity: _____ Other: _____

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Employment Goals:

Short Term (3 to 12 Months): _____

_____

_____

Long Term (3 to 5 years): _____

_____

_____

Employment Situation: (Required)

☐ Full-time employed or self-employed ☐ Part-time employed or self-employed

Gross Monthly Earnings: $_____

☐ Pending job offer, promotion or interview ☐ Actively seeking employment

☐ Attending School or Vocational Program

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 Benefits: _____

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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:	'ADDRESS OF PERSON OR ORGANIZATION: " PHONE NUMBER OF PERSON OR ORGANIZATION:
Work Without Limits at the University of	333 South Street, Shrewsbury, MA 01545
Massachusetts Chan Medical School	1-877-937-9675

***1 want this information released because:**

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

My cash benefits, health insurance, benefits review dates, representation, SSI & SSDI work activity and earnings, Benefits Planning Query, all employment supports data on SSA record.

'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)

   At this time, we are only requesting a Benefits Planning Query (BPQY) to assist with benefits and work incentives planning services.

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.