# 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: (Massachusetts 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)

- **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 ENreferral@umassmed.edu with the following subject line, "*SECURE: EN Referral Package*"
- **Option 2: Fax**
  - Complete, print, sign, and fax the package to (508) 856-4017
- **Option 3: Postal Mail**
  - Complete, print, sign, and mail the package to:

    *EN Referral, 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, please contact us at ENreferral@umassmed.edu**

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.**

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

Date Completed: _____

**Referring Counselor Information: (If Applicable)**

☐ Coordinate meeting with Referring Counselor

First Name: _____ Last Name: _____

Pronouns: Choose an item 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: Choose an item Other: _____

May we use Chosen or Preferred Name for sending Postal mail? Choose an item

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: Choose an item

☐ Race: Choose an item ☐ Ethnicity: Choose an item

☐ Gender Identity: Choose an item 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)**

☐ State Vocational Rehabilitation (VR) Agency ☐ State VR Agency-Blind ☐ Developmental Services
☐ Mental Health Services ☐ Deaf and Hard of Hearing Services ☐ American Job Center

☐ Other: _____

**Benefit Information: (Check all that apply)**

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Public Housing ☐ SNAP (Food Stamps)

☐ Other Benefits: _____

**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.**

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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:<br>" PHONE NUMBER OF PERSON OR ORGANIZATION: |
|---|---|
| Work Without Limits at the University of | 333 South Street, Shrewsbury, MA 01545 |
| Massachusetts Chan Medical School | Phone: 1-877-937-9675 |
| | Fax: 1-508-856-4017 |

***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 record
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)

   We request a Benefits Planning Query (BPQY)that can be returned to the third party via fax. I authorize release of records for one year from the date I signed this form.

**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.