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

WORK WITHOUT LIMITS & MASS CULTURAL COUNCIL

*** REFERRAL PACKET INSTRUCTIONS ***

STEP 1 – REFERRAL FORM (REQUIRED)

To get benefits counseling, fill out the *Referral Form* found on page 2 of this document.

- By completing this form, your benefits counselor will be better prepared for your meeting by understanding your public benefits situation in advance.

STEP 2 – BENEFITS VERIFICATION (OPTIONAL)

If you receive Social Security Administration (SSA) disability benefits, such as Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), we recommend verifying your benefits, which will help your benefits counselor provide you with the most accurate information possible about your public benefit situation.

- To verify SSI or SSDI benefits, fill out the *Social Security Consent for Release of Information Form* found on page 3 of this document as follows:
  - At the top, include your full name, date of birth, and Social Security Number.
  - At the bottom, include the date, your address and daytime phone number.
  - Print and sign this form with ink because e-signatures are not accepted.
  - Please do not fill out or change any other fields or boxes on this form.
- If you receive SSI, to verify your state SSI payment, please fill out sections 1 and 3 of the *MA SSI State Supplement Program Form* found on page 4 of this document.
  - Print and sign this form with ink because e-signatures are not accepted.

STEP 3 – REFERRAL PACKET SUBMISSION OPTIONS (REQUIRED)

- Email as an attachment to: workwithoutlimits_benefitscounseling@umassmed.edu.
  - Type “SECURE: Referral Form” as the email subject.
  - If applicable, attach scanned copies or pictures of the forms from Step 2.
    - Use Evernote app for Apple or Simple Scan or CamScanner for Android.
- Fax to 508-856-4017.
- Mail to the following address: *Attn: Stephanie Major, Work Without Limits Benefits Counseling, UMass Chan Medical School, 333 South St., Shrewsbury, MA 01545.*

NEED HELP? CONTACT US!

Phone: 877-937-9675 Option 1| Email: workwithoutlimits_benefitscounseling@umassmed.edu

CLICK HERE FOR MORE INFORMATION.

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REFERRAL FORM

Contact Information

Full Name:

City/Town:

Preferred Phone #:

Alternative Phone #:

Preferred Email:

Alternative Email:

Meeting Format Preference:

Meeting Time Preference:

Reasonable Accommodations:

Other:

Demographic Information

Age:

Race/Ethnicity:

Marital Status:

Number of Dependents:

Disability:

Other:

Type of Artist:

Other:

Employment Information

Total Gross Monthly Earnings:

Type of Work (Job 1):

Hourly Pay:

Weekly Hours:

Type of Work (Job 2):

Hourly Pay:

Weekly Hours:

Household/Housing Information

Housing Situation:

Household Size:

Type of Housing:

Monthly Rent/Mortgage:

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

- ☐ SSA Retirement:
- ☐ SSI:
- ☐ SSDI:
- ☐ Underemployment:
- ☐ Veterans Benefits:
- ☐ Other Public Benefits:
- ☐ EAEDC:
- ☐ TANF:
- ☐ Food Stamps:
- ☐ WIC:
- ☐ Child Support:

Health Insurance Information (*check all that apply; enter amount you pay for, if applicable)*

- ☐ MassHealth:
- ☐ Medicare:
- ☐ Private Health Insurance:
- ☐ Other:

Phone: 877-937-9675 Option 1| Fax: 508-856-4017

Email: workwithoutlimits_benefitscounseling@umassmed.edu | Click here for more information.

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	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.

I am planning to go to work and need this information for benefits planning. This form is valid for one year from the date of my signature. My BPQY can be faxed to 1-508-856-4017.

'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)

My Cash benefits,entitlements,health insurance,medical review dates,representation,SSDI&SSI work activity & earnings,and a detailed explanation of the overpayment(s). All employment supports and work incentives on my 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
    - 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: _____

[X] 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.