

## REFERRAL INSTRUCTIONS – Benefits Counseling

**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](mailto: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](mailto: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](http://www.workwithoutlimits.org/benefits-counseling)**

For general information, contact the Ticket to Work Help Line at **866-968-7842**.

## REFERRAL FORM – Benefits Counseling (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 – Benefits Counseling (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 an item.
  - Race/Ethnicity: Choose an item.
- 

### Additional Remarks or Comments

---

---

---

---

---

---

**Phone: 877-937-9675 | Fax: 508-856-6607 | [www.workwithoutlimits.org/benefits-counseling](http://www.workwithoutlimits.org/benefits-counseling)**

For general information, contact the Ticket to Work Help Line at **866-968-7842**.

## 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](http://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](http://www.workwithoutlimits.org/benefits-counseling)**

For general information, contact the Ticket to Work Help Line at **866-968-7842**.

## 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](mailto: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.
  - 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](mailto:mail@dlc-ma.org).

Initials: \_\_\_\_\_

Date: \_\_\_\_\_

**Phone: 877-937-9675 | Fax: 508-856-6607 | [www.workwithoutlimits.org/benefits-counseling](http://www.workwithoutlimits.org/benefits-counseling)**

For general information, contact the Ticket to Work Help Line at **866-968-7842**.

**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. \*\*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:		
<b>*NAME OF PERSON OR ORGANIZATION:</b>	<b>*ADDRESS OF PERSON OR ORGANIZATION:</b>	
Work Without Limits Benefits Counseling	333 South Street	
UMass Medical School	Shrewsbury, MA 01545	

**\*I want this information released because:**  
 We may charge a fee to release information for non-program purposes.  
 I am planning on going to work and need this information for benefits planning. Please fax a BPQY to Work Without Limits Benefits Counseling at (508) 856-6607

**\*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.)  
 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 § 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 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.