WorkWithoutLimits

UMMS Administrative Employment Network

Dear Referring Counselor or Beneficiary,

In order to ensure that you are sending the UMMS Administrative Employment Network (AEN) a complete referral, please follow the steps below:

- Fill out all applicable information in the attached *UMMS AEN Referral Fax Cover Sheet* form
- Complete the top and bottom sections of the **two (2)** *Social Security Administration (SSA) Consent for Release of Information* forms by filling all fields containing an asterisk (*).

  PLEASE NOTE: Both forms look very similar, but they are requesting different information under the *'Other record(s) from my file'* section.
- Upon completion, return **all three (3) forms** by postal mail in the self-addressed envelope provided or send them to UMMS AEN secure and confidential fax machine at 508-856-4017.

  IMPORTANT: Please do not check off or edit any other items on either release forms.

I look forward to working with you.

Thank you,

Barbara J. Lee

Barbara Lee, CPWIC
Work Without Limits Administrative Employment Network
333 South Street
Shrewsbury, MA 01545
508.856.2659
Barbara.Lee@umassmed.edu

Referral FAX Cover Sheet

WorkWithoutLimits **Administrative Employment Network**

To: Barbara Lee UMMS/Administrative Employment Network Date Faxed: _____
Email: Barbara.Lee@umassmed.edu Office #: (508) 856-2659 Fax #: (508) 856-4017

Referring Staff (Full Name): _____ Referring Agency: _____

Email: _____ Office #: (___) ___ - _____ Ext: ____

Address: _____ City: _____ Zip: _____ County: _____

☐ Self-Referral (check if you are referring yourself)

I would like to refer the following individual to the UMMS AEN Ticket-to-Work Program. Attached are **three (3)** signed release forms.

First Name: _____ Middle: _____ Last: _____ Age: _____

Address: _____ Apt.: ____ City: _____ Zip: _____ County: _____

Phone #: (___) ___ - _____ 2nd Phone #: (___) ___ - _____ Email: _____

IMPORTANT: Please fill out if another person is main contact. Full Name: _____

Phone #: (___) ___ - _____ 2nd Phone #: (___) ___ - _____ Email: _____

Best Contact Time for Individual or Other Contact: ☐ AM ☐ PM | Specific Time: _____

Client Employment Situation (required):

☐ Employed or self-employed
Estimated monthly earnings: _____
☐ Pending job offer
Estimated monthly earnings: _____
☐ Actively seeking employment
Monthly earnings goal: _____
☐ Participating in OJT or internship (un/paid)

Additional Client Information (check all that apply):

☐ Aged 14 to 25
☐ DMH ☐ DDS ☐ MCB ☐ MCDHH ☐ MRC Client
☐ Prefers services in Spanish ☐ Limited English Proficiency
☐ Requires an ASL interpreter
☐ Requires reasonable accommodations
Please Specify: _____

Client Benefit Information (check all that apply):

☐ SSI
☐ MassHealth
☐ Food Stamps
☐ TANF
☐ Veterans Benefits
☐ SSDI
☐ Medicare
☐ Subsidized Housing
☐ EAEDC
☐ Other: _____

IMPORTANT: REFERRAL FORM MUST BE SIGNED BY CLIENT

I authorize the UMMS AEN to communicate with **referring agency** (named above) during the time that I am participating in the Ticket-to-Work Program. I understand that the attached releases allow the AEN to provide me with benefits/work incentives counseling services (**Please sign and date below**):

Signature _____ **Date** _____

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

*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:

NAME OF PERSON OR ORGANIZATION:

Barbara Lee

University of MA Medical School

Administrative Employment Network

ADDRESS OF PERSON OR ORGANIZATION:

Center for Health Policy and Research

333 South Street

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 send me a Benefits Planning Query.

Please release the following information selected from the list below:

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ 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 **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

   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 any accompanying statements or forms, 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. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** **Date:**

***Address:**

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)

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. ***(*signifies a required field).***

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:

NAME OF PERSON OR ORGANIZATION:

Barbara Lee

University of MA Medical School

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ADDRESS OF PERSON OR ORGANIZATION:

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8. ☒ Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

   Non-Certified yearly totals of earnings.

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 any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain 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.

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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)