WIPA REFERRAL PACKAGE INSTRUCTIONS – MA

Who We Serve: With funding from a Social Security Work Incentives Planning and Assistance (WIPA) cooperative agreement, Work Without Limits provides benefits and work incentives counseling services to beneficiaries of Social Security disability benefits. To prioritize services for beneficiaries who are most vulnerable to overpayment, and most in need of immediate attention, we serve beneficiaries meeting the following priority order:

- Individuals who are engaged in full-time employment, self-employment or gig employment.
- Individuals who are engaged in part-time employment, self-employment or gig employment.
- Individuals who have a job offer pending or are about to start a business or gig employment.
- Individuals who are interested in work or self-employment, and have worked since receiving benefits, possibly using work incentives, or otherwise affecting their benefits.

Please Note: For individuals who do not meet the above criteria, contact Social Security's national toll-free Ticket to Work Help Line at 1-866-968-7842 or 1-866-833-2967 for TTY users. The Help Line is available Monday through Friday from 8 a.m. - 8 p.m. EST and representatives can answer questions or provide guidance tailored to your situation.

Please follow the steps below to apply for Work Without Limits WIPA services:

STEP 1: Work Without Limits Benefits Counseling Referral Form (2 pages) (required)

- Download the referral form from our website and complete it electronically
- Use the dropdown menus within the form where indicated
- Complete pages 3-4 of this package (preferable typed)

STEP 2: Read the WIPA Privacy Statement, Cancellation Policy, and Dispute Resolution Policy on pages 5-6 of this package and type your initials where indicated. (required)

STEP 3: Social Security Consent for Release of Information Form

- At the top, include your full name, date of birth, and Social Security Number
- At the bottom, type the date and your 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 4: Request for Access to State Supplement Program (SSP) Recipient Record and Information

- Complete and sign **(must be signed in ink)** sections 1 and 3

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Work Without Limits is an initiative of ForHealth Consulting, the consulting and operations division of UMass Chan Medical School.

STEP 5: Referral Package Submission (required)

- **Option 1: Email**
  - Complete electronically, print, sign, and scan the package
  - Use the Scannable app for Apple or CamScanner app for Android
  - Email the scanned package to WIPAreferral@umassmed.edu with the following subject line, "*SECURE: WIPA Referral Package*"
- **Option 2: Fax**
  - Complete, print, sign, and fax the package to (508) 856-6607

Questions or need assistance? Email, WIPAreferral@umassmed.edu.

We look forward to working with you!

Toll-Free: 877-937-9675 (YES-WORK) | Fax: 508-856-6607
https://workwithoutlimits.org/benefits-counseling/wipa-home
For general information, contact the Ticket to Work Help Line at **866-968-7842.**

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

REFERRAL FORM – WIPA (page 1 of 2)

Date Completed: _____

Referring Counselor Information:

First and Last Name: _____

Agency: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

Beneficiary Information:

Legal First Name:_____Legal Last Name:_____

Chosen or Preferred Name (if applicable): _____

May we use Chosen or Preferred Name for sending postal mail? Select One

May we use Chosen or Preferred Name for leaving voice mail messages? Select One

Age: _____ Email: _____

Address:_____Apt:_____ City:_____Zip: _____

Home Phone:_____ Cell Phone: _____

May we leave a voicemail message? (Choose all that apply) ☐Yes on home phone ☐ Yes on cell phone

☐ No on home phone ☐ No on cell phone

Other Main Contact Information: (If Applicable)

First Name:_____Last Name:_____

Home Phone:_____Cell Phone: _____

Email:_____

Relationship: ☐ Legal Guardian ☐ Rep Payee ☐ Other: _____

Employment Status: (Required)

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

☐ Pending job offer ☐ Recent or upcoming/scheduled job interview(s) ☐ Serious intent to work

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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: _____

REFERRAL FORM – WIPA (page 2 of 2)

Meeting Preferences: (Check all that apply)

☐ Coordinate meeting with Referring Counselor ☐ Coordinate meeting with Other Main Contact

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 ☐ EN ☐ 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: Select One:

Additional Remarks or Comments

_____

_____

_____

_____

_____

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 or at your local Social Security office.

Initials: _____

Date: _____

Toll-Free:877-937-9675 (YES-WORK) | Fax: 508-856-6607

https://workwithoutlimits.org/benefits-counseling/wipa-home

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

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Cancellation Policy

If you need to cancel your appointment, please provide your benefits counselor with a minimum of 24- hour notice. If cancelled a second time, your benefits counselor will contact the person who referred you to Work Without Limits WIPA and if applicable, 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 WIPA 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 Muhr (she/her), Director of Workforce Inclusion and Advancement at kathy.muhr@umassmed.edu or call her directly at 508-856-3533.
2) If still dissatisfied, contact the Protection and Advocacy for Beneficiaries of Social Security (PABSS) Program in your state.
   - In Massachusetts 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.
   - In New York contact Disability Rights New York located at 725 Broadway, Suite 450 Albany, NY 12207-500 or by calling toll-free 1-800-993-8982 or by email at mail@drny.org.

Initials: _____

Date: _____

Toll-Free: 877-937-9675 (YES-WORK) | Fax: 508-856-6607
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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	PO Box 947 Worcester, MA 01603
Massachusetts Chan Medical School	Phone: 1-877-937-9675
	Fax: 1-508-856-6607

***1 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. This form is valid for one year from the date of my signature. My BPQY can be faxed to 1-508-856-6607

'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)

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 Benefits Counseling
    - Address: UMass Medical School PO Box 947
      (Number and street) (Suite, PO Box or Rural Route)

      Worcester MA 01603
      (City or town) (State) (Zip code)
    - Telephone Number: (508) 856-3815 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.