

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 (page 2)

- Download and save this Referral Form.
- Complete it electronically.
 - Please do not fill out by hand.

STEP 2: Social Security Consent for Release of Information Form (page 3)

- At the top, type your full name, date of birth and Social Security Number.
- At the bottom, type the date, your address and daytime phone number.
- Please do not fill out or change any other fields or check any boxes on this form.
- Print and sign with ink (e-signatures are not allowed).

STEP 3: Request for Access to State Supplement Program (SSP) Recipient Record and Information (page 4) *(Required for Massachusetts residents)*

- You only have to complete this step if you receive SSI.
- Complete sections 1 and 3 electronically.
- Print and sign with ink (e-signatures are not allowed).

STEP 4: Referral Package Submission

- Once printed and signed select an option to submit:
- Option 1: Email
 - Use the [Scannable app](#) for Apple or [CamScanner](#) app for Android (or search for other free scan apps).
 - Email the scanned package to ENreferral@umassmed.edu with the following subject line, “*SECURE: EN Referral Package*”.
- Option 2: Fax to (508) 856-4017.

If you have any questions, please contact us at ENreferral@umassmed.edu.

We look forward to working with you!

Toll Free: 877-937-9675 (YES-WORK) | Fax: 508-856-4017

[Work Without Limits Employment Network](#)

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

REFERRAL FORM – Employment Network

Date Completed: _____

Referring Counselor Information: (If Applicable)

Coordinate meeting with Referring Counselor

First Name: _____ Last Name: _____

Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Other 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? Yes No

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: _____

Accommodations Needed for Meeting: _____

Benefit Information: (Check all that apply)

SSI SSDI Medicaid Medicare Public Housing SNAP (Food Stamps)

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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 Massachusetts Chan Medical School	PO Box 947 Worcester, MA 01603	Phone: 1-877-937-9675 Fax: 1-508-856-4017

***I 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)

**Massachusetts State Supplement Program
Request for Access to SSP Client Record and Information**

This form is to be completed by an SSP client who wishes to authorize another individual to have access to his or her SSP record and information.

Section 1. SSP Client Information

SSP CLIENT NAME:	DATE OF BIRTH:	LAST 4 DIGITS OF SSN:
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SSP CLIENT ADDRESS:

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 the SSP Assistance Line at 1-877-863-1128.

Work Without Limits Benefits Counseling

(508) 856-2513

NAME OF AUTHORIZED INDIVIDUAL

PHONE#

ADDRESS OF AUTHORIZED INDIVIDUAL:
UMass Chan Medical School
PO Box 947
Worcester, MA 01603

Section 3. Signature (of SSP Client or Designated Payee: REQUIRED)

SIGNATURE

DATE

REQUIRED IF COMPLETING THIS FORM AS DESIGNATED PAYEE OR POWER OF ATTORNEY:

TITLE OR RELATIONSHIP TO CLIENT

PHONE#

SSP EMPLOYEE NAME

Please call the Massachusetts SSP Assistance Line at **1-877-863-1128** if you have any questions about this form. Return completed form to:

**MASSACHUSETTS SSP
PO BOX 4018
TAUNTON MA 02780-0315**

or fax to: **857-323-8310**