

## 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** (pages 3-4) (required)

- Download and save this Referral Form.
- Complete pages 3 and 4 electronically. Please do not fill out by hand.
- Use the dropdown menus within the form where indicated

**STEP 2: WIPA Privacy Statement, Cancellation Policy, and Dispute Resolution Policy** (pages 5-6) (required)

- Read and electronically type your initials and date where indicated.

**STEP 3: Social Security Consent for Release of Information Form** (page 7)

- At the top, type your full name, date of birth, and Social Security Number
- At the bottom, type the date and 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 4: Request for Access to State Supplement Program (SSP) Recipient Record and Information** (page 8)

- 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 5: 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 [WIPArefferral@umassmed.edu](mailto:WIPArefferral@umassmed.edu) with the following subject line, “*SECURE: WIPA Referral Package*”
  - Option 2: Fax to (508) 856-6607
  - **IMPORTANT:** Please include the Massachusetts State Supplement Program (SSP) Form in your submission. You **DO NOT** have to send it separately to the SSP Office in Taunton. We will forward your form to the SSP Office.

Questions or need assistance? Email [WIPArefferral@umassmed.edu](mailto:WIPArefferral@umassmed.edu).

**We look forward to working with you!**

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

**[Work Without Limits Benefits Counseling](#)**

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

## 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? Choose an item.

May we use Chosen or Preferred Name for leaving voice mail messages? Choose an item.

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

### 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)

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**Meeting Preferences:** (Check all that apply)

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

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**Accommodations Needed for Meeting:** (Check all that apply)

- Language Interpreter - Specify Language: \_\_\_\_\_
- ASL Interpreter     CDI Interpreter     CART Reporter
- Other Reasonable Accommodations - Specify: \_\_\_\_\_

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**Currently Receiving Services From:** (Check all that apply)

- DDS     DMH     MCB     MCDHH     MRC     EN     Other: \_\_\_\_\_

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**Benefit Information:** (Check all that apply)

- SSI     SSDI     MassHealth     Medicare     Public Housing     Food Stamps
- Other: \_\_\_\_\_

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**Demographic Information:** (Check all that apply)

- Veteran
- Transition Age Youth (ages 14 – 25)
- Disability: Choose an item.

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**Additional Remarks or Comments**

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## 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: \_\_\_\_\_

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

**[Work Without Limits 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 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](mailto: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](mailto: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](mailto:mail@drny.org).

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

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

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

**[Work Without Limits 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. \*\*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:		
<b>*NAME OF PERSON OR ORGANIZATION:</b>	<b>'ADDRESS OF PERSON OR ORGANIZATION:</b>	
	<b>"" PHONE NUMBER OF PERSON OR ORGANIZATION:</b>	
Work Without Limits at the University of Massachusetts Chan Medical School	PO Box 947 Worcester, MA 01603 Phone: 1-877-937-9675 Fax: 1-508-856-6607	

**\*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. 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)

**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**