Dear Referring Staff Member,

In order to ensure you're sending PROJECT IMPACT Benefits Counseling an *appropriate* and *complete* referral (**preferably typed**), please follow the steps below:

1. Complete the *PROJECT IMPACT Referral Form*
2. Have your client complete and sign the *Social Security Consent for Release of Information* form by filling the fields containing asterisks (*) found on the top and bottom sections of the form. **Important:** Do not check any boxes on release forms.
3. Email both forms to Joseph Reale at:

   joseph.reale@mass.gov

Massachusetts Rehabilitation Commission Statewide Employment Services Department Individual Members Planning and Assessing Choices Together

Project IMPACT

1-800-734-7475
Fax (617) 204-3847

INTAKE REFERRAL FORM

Benefits Specialist: (for **Project Impact** to fill out) _____

Date of Referral: _____

Referral Portal Organization Name: _____
Referral Portal Individual Staff Person's Name: _____
Phone Number: _____
Email: _____
Description of Service: Benefits Counseling

CLIENT INFORMATION

Is this client still enrolled in high school? _____YES _____NO

Receiving: ( ) SSI $ _____ ( ) SSDI $ _____

( ) VA Pension $ _____ Compensation $ _____

( ) Section 8 _____ ( ) Other Housing _____( ) Public Benefits _____

Name: _____ D.O.B. _____

Address: _____

City: _____ZIP_____

Phone: _____ Email: _____

SSN#_____ Rep Payee _____

Is Client Working? _____YES _____NO Start Date: _____

Employer Information: _____

_____

Additional Information: _____

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. **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/DDIYYYY)	*My 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:
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 $5,000.1 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, street, City, State, and Zip Code)	Address (Number. street, City, State, and Zip Code)