Rev. 7/2018

Maine Medical Center
MaineHealth

Department of Vocational Services

Request for Benefits Counseling Services

This is a free statewide service that helps Social Security disability beneficiaries understand how working impacts all of their public benefits. To qualify, you must be age 14 or older, employed or interested in working, and receiving Social Security disability and/or extended medical benefits.

Please complete this entire packet. ***On the release forms, complete the highlighted sections only.***
Once we receive your paperwork, we will contact you to schedule an appointment with one of our Community Work Incentives Coordinators (CWICs) at a time and place convenient for you.
If you need assistance completing this packet, please call us at 1-888-208-8700.

Your Name: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email address (if preferred contact): _____

Marital Status: ☐ Single ☐ Widowed ☐ Married Gender: _____ *(please fill in)*

If married, does spouse get disability benefits? ☐ No ☐ Yes

Please answer the following questions:

1. **Do you have a Representative Payee?**
   ☐ No ☐ Yes: Please list name and phone number: _____

2. **Do you have a Legal Guardian?**
   ☐ No ☐ Yes: Please list name and phone number: _____

   Please note: *Legal guardian must sign all release forms. If not attending the appointment in person or by phone, the legal guardian must include a signed note stating who can attend the meeting on his/her behalf.*

3. **Please verify your job situation:**
   ☐ I am thinking about going back to work, but haven't applied or interviewed for jobs yet.
   ☐ I have applied for and/or interviewed for jobs in the past month.
   ☐ I am currently self-employed. I earn _____ /month profit and work about ____ hours/month.
   ☐ I am working _____ hours/week at $ _____ /hour. I began working at this job on _____.
   ☐ I have a job offer for _____ hours/week at $ _____ /hour.

4. **Which best describes how you now feel about your job situation?**
   ☐ I am **very dissatisfied** with my job situation and feel an **URGENT NEED** to change it.
   ☐ I am **dissatisfied** with my job situation, and feel a **STRONG NEED** to change it.
   ☐ I am **not sure** how I feel about my job situation and **NOT SURE** if I want to change it.
   ☐ I am **satisfied** with my job situation and **DON'T WANT** to change it now, but maybe in the future.
   ☐ I am **very satisfied** with my job situation, and **DEFINITELY DON'T WANT** to change it.

5. What organization referred you to our program? _____

6. What benefits do you receive? Check all that apply.

- ☐ SSI (Supplemental Security Income)
- ☐ Title II (SSDI, DWB, DAC)
- ☐ MaineCare
- ☐ Medicare
- ☐ Food Stamps
- ☐ Housing (ex: Section 8, Group Home, BRAP)
- ☐ Veteran's Benefits
- ☐ Other: _____

7. Do you have children under 21 living with you who get MaineCare? ☐ No ☐ Yes

8. Are you looking for an answer to a specific question? If so, please list: _____

_____

9. Please check the most convenient location to meet if an in-person meeting is needed:

Northern Maine:	☐ Bangor	☐ Calais	☐ Caribou	☐ Ellsworth
	☐ Dover-Foxcroft	☐ Fort Kent	☐ Houlton	☐ Lincoln
	☐ Machias	☐ Millinocket	☐ Newport	☐ Presque Isle
Central Maine:	☐ Augusta	☐ Bath	☐ Belfast	☐ Brunswick
	☐ Lewiston	☐ Rockland	☐ Rumford	☐ Skowhegan
	☐ South Paris	☐ Wilton		
Southern Maine:	☐ Biddeford	☐ Portland	☐ Sanford	

10. If an in-person meeting is scheduled, will you need any accommodation to fully participate?

- ☐ Sign Language Interpreter
- ☐ Foreign Language Interpreter
- ☐ Large print documents
- ☐ Other (please identify): _____

11. Who should we contact to schedule your appointment? ☐ Me ☐ The person listed below.

Name: _____ Phone: _____ Relationship to you: _____

12. Do you have a State of Maine Vocational Rehabilitation Counselor?

☐ No ☐ Yes: ***Your VR counselor must complete the section below.***

VR Counselor Name: _____ **Phone Number:** _____

Current VR Status: ☐ In application ☐ Eligible ☐ Service ☐ Employed **VR Status Date:** _____

Estimated return to work: ☐ Next two months ☐ Next six months ☐ Next year or two ☐ Not sure

Does client have an IPE? ☐ No ☐ Yes: ***List IPE goal (or include copy of IPE with referral):*** _____

_____

_____

Estimated hours per week: _____ **IPE Date:** _____ **Expected End Date:** _____

Please either fax or mail all documents to:

- Fax (207) 662-6789
- Mail: MMC Vocational Services, 22 Bramhall Street, Portland ME 04102

Thank you, and we will be in contact with you soon!

Social Security Administration

Consent for Release of Information

A 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:**

Maine Medical Center

Benefits Counseling Services

Department of Vocational Services

***ADDRESS OF PERSON OR ORGANIZATION:**

Maine Medical Center

22 Bramhall Street, Portland, ME 04102

Fax: 207-662-6789

***I want this information released because:** I am planning to return to work. I authorize this requestor to receive information to provide me with program related return to work assistance.

We may charge a fee to release information for non-program purposes.

I authorize release of the records for 1 year beginning with the date I signed this form.

***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)**

   Beneficiary's cash benefits, health insurance, medical review dates, representation, SSDI and SSI work activity and earnings. All employment supports data on SSA's records.

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.

***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

B

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:**	***ADDRESS OF PERSON OR ORGANIZATION:**
Maine Medical Center	Maine Medical Center
Benefits Counseling Services	22 Bramhall Street, Portland, ME 04102
Department of Vocational Services	Fax: 207-662-6789

***I want this information released because:** I am planning to return to work. I authorize this requestor to receive information to provide me with program related return to work assistance. I authorize release of the records for 1 year beginning with the date I signed this form.

We may charge a fee to release information for non-program purposes.

***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)**

   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.

***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)

MAINE DEPARTMENT OF LABOR
BUREAU OF REHABILITATION SERVICES

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

This information will be used to assist Bureau of Rehabilitation Services (BRS) Staff in determining eligibility and/or in planning for Vocational Rehabilitation services for:

NAME: _____ DOB: _____/_____/_____
(Client Name)

I authorize The Division of Vocational Rehabilitation ☒ **or** The Division For The Blind and Visually Impaired ☒
(Vocational Rehabilitation Counselor's Name) _____
Address: _____

☒ to receive my information from: CWIC
(Hospital/Doctor/Therapist/Counselor/Other's Name)

(Agency)	(Street)	(City)	(State)	(Zip)	(Telephone)
MMC VOC SERVICES	22 Bramhall Street	Portland	ME	04102	

Or

☒ to give my information to: SAME AS ABOVE
(Hospital/Doctor/Therapist/Counselor/Other's Name)

(Agency)	(Street)	(City)	(State)	(Zip)	(Telephone)
SAME AS ABOVE					

I authorize the following information to be released to the above entity: **(Please check appropriate information)**

☐ General Health Information ☐ Medical/Psychiatric Hospital Records ☐ Psychiatric/ Psychological Evaluations (Diagnosis/Axis Codes)
☐ Medical Specialist Reports ☐ Occupational /Physical Therapy Eval ☐ Psychiatric/Psychological Comprehensive Assessments
☐ Substance Abuse Evaluations ☐ Vocational Assessments and Plans ☐ Psychiatric Progress Notes
☐ Educational / School Records ☒ On Going Written & Verbal Information Exchange
☒ Other (Specify) COORDINATE VOCATIONAL SERVICES & PROVIDE COPY OF BENEFITS ANALYSIS

****** PLEASE SPECIFY APPLICABLE DATES AND OTHER INFORMATION******

This release is for the period from: _____ to _____

I understand that:

- I can refuse to give some or all of the information in my treatment records, and also understand this could delay or cause denial of services.
- At any time, I can cancel all or part of this authorization, by notifying my counselor named above, except to the extent that BRS has already acted on it, and also understand this could delay or cause denial of services.
- I am entitled to a copy of this release.
- BRS will not release any information about my disability to any other agency or person without the specific written consent of the individual.
- BRS may release information without my specific consent if I pose a direct threat to others or myself. BRS may release information without my specific consent, if required by State or Federal law; in response to an investigation in connection with law enforcement; and in response to a court order.
- BRS may release information without my specific consent, for program audit, evaluation, or research purposes. The final product will not reveal any personal identifying information.
- This release is effective for no more than one year from date of signing.

(Consumer Initials) _____ **Date** _____

State and Federal Laws requires my specific consent to disclose any of the following information:
Check one response for each of the statements below:

☐ I DO ☐ I DO NOT	Authorize disclosure of information, which refers to treatment, or diagnosis of drugs or alcohol abuse. If I authorize the release of such information, I understand it cannot be re -disclosed by BRS without specific consent.
☐ I DO ☐ I DO NOT	Authorize disclosure of information, which refers to treatment or diagnosis of mental illness.
☐ I DO ☐ I DO NOT	Wish to review this information before it is released. I understand any such review must be supervised
☐ I DO ☐ I DO NOT	Authorize disclosure of information, which refers to treatment, or diagnosis of HIV infection, ARCS, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.

Signature: _____ Date: _____

Parent/Guardian: _____ _____ Date _____
Relationship

THIS RELEASE MUST BE FILLED OUT COMPLETELY,
PLEASE READ CAREFULLY, IF YOU HAVE QUESTIONSPLEASE ASK YOUR COUNSELOR.

Rev.7/09

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Ricker Hamilton, Commissioner

Authorization to Release Information

We are committed to the privacy of your information. Please read this form carefully.

Which DHHS office(s) should help you? Please check.

☒Office of MaineCare Services	☒ Substance Abuse and Mental Health Services
☒Office for Family Independence and Medical Review Team	❒ Office of Child and Family Services
❒ Maine Center for Disease Control and Prevention	☒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	☒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:

Whose information is being released? Please print clearly.

Individual's Name		Date of Birth	Social Security #
Home Address	Town/City	State	Zip Code
Telephone ( ) -	Email address @		

What information should DHHS release? Please check all that apply.

General permission:

❒**All** health information from the DHHS office(s) checked above
❒Claims or encounter data (information about visits to health care providers)
❒Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits
❒Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2017" or "Claims from 2015-2017")

_____

☒Other: Vocational and work incentives planning

Special permission: D**rug/Alcohol Referral or Services**

❒Include **all** drug/alcohol information in the release
❒Include only the **specific** drug/alcohol records checked:

❒Diagnosis and treatment
❒Clinical notes and discharge summaries
❒ Drug/Alcohol history or summary
❒Payment or claims information
❒Living situation and social supports
❒Medication, dosages or supplies
❒Lab results
❒Other: _____

Special permission: Mental/Behavioral Health Services

❒Include this information in the release

❒I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.

Please note: Maine law allows us to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.

Special permission: HIV/AIDS Status/Test Results

❒Include this information in the release

Please note: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if your data is misused. **DHHS** will protect your HIV data, and all your information, as the law requires.

Are you asking DHHS to send your information by EMAIL? ❒ Yes.

Although DHHS has privacy and security protections for my information, I understand that email and the internet have risks that DHHS cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask DHHS to send my information by email**. INITIAL HERE** ____

Where should DHHS send your information by email? Please print the email address clearly:

What is the purpose of the release? Please check or write a response.

❒**To coordinate or manage my care** ❒ **For a legal matter, including to provide testimony**
❒ **A personal request** ❒**To see if I qualify for benefits or insurance** ☒ **Other** Vocational and work incentives planning

Please check and print clearly below: ☒Send my information to ☒Get my information from:

Name MMC Dept. of Vocational Services - Benefits Counseling Services	Name MMC Dept. of Vocational Services - Benefits Counseling Services
Address 22 Bramhall Street	Address 22 Bramhall Street
City, State, Zip Code Portland, ME 04102	City, State, Zip Code Portland, ME 04102
Phone 207-662-4757 Fax No. 207-662-6789	Phone 207-662-4757 Fax No. 207-662-6789

I understand and agree that:

- "Information" may be in written, spoken and/or electronic format.
- This form will expire **one year** from the date below unless I revoke (take back) my permission sooner.
- To take back my permission, I will fill out the Revocation Form found at http://www.maine.gov/dhhs/privacy/index.shtml and send it to the office where I receive services. It will not apply to the information that DHHS already released with my permission.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance coverage.
- I permit the people and/or offices listed on this form to speak to each other for the purpose(s) on this form.
- Health information from other providers (such as doctors, hospitals, and counselors) in my DHHS file is included in this release.
- Unless I am applying for benefits, DHHS will not base my treatment, payment for services, or benefits on whether I sign this form.
- DHHS offices will keep my information confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, DHHS will include a notice saying that such information may not be re-released or shared without my written permission.

I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.

Date:_____ **Signature**_____

Personal Representative's authority to sign: _____

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- You, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***