

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Disability: \_\_\_\_\_

Gender:  Female  Male Ethnicity:  White  Black  Native American  Asian  Hispanic  Other

**Special Language Considerations:**

Sign Language  English as a Second Language Primary Language: \_\_\_\_\_

**Current Benefits:** (Check all that apply and indicate monthly amounts)

SSI \$ \_\_\_\_\_  SSDI \$ \_\_\_\_\_  Both SSI/SSDI \$ \_\_\_\_\_ /\$ \_\_\_\_\_

Spouses Benefits \$ \_\_\_\_\_  Children's Benefits \$ \_\_\_\_\_

Medicare  MassHealth  Private Health Insurance

Subsidized Housing  Food Stamps \$ \_\_\_\_\_  TANF/EAEDC \$ \_\_\_\_\_

Unemployment Insurance \$ \_\_\_\_\_  Workers Compensation \$ \_\_\_\_\_

Veterans Benefits \$ \_\_\_\_\_  Other: \_\_\_\_\_

**Current Employment Status:**

Not Employed, Seeking Employment  Not Employed, Not Seeking Employment

Employed Full-Time  Employed Part-Time

# hours/wk \_\_\_\_\_ Salary per hour \_\_\_\_\_

**Reason for Referral:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referred by:**

Counselors Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Please Note:** In order to expedite services please ask your client to call Social Security at 1-800-772-1213 and request a Benefit Planning Query (BPQY SSA-2459) be mailed to their home. Instruct them to bring the BPQY to our meeting.



## Release of Information

Referring Counselor: \_\_\_\_\_

Client Name: \_\_\_\_\_

Client SSN: \_\_\_\_\_

I give my permission for the release of any and all documentation concerning my employment records/reports to be released and forwarded to the Resource Partnership's BenePLAN Program.

I also authorize the Resource Partnership's BenePLAN Program to share any and all information gathered or generated as a result of Benefits Counseling to be shared with the referring entity.

Without my express revocation this release will expire in one year.

Client \_\_\_\_\_ Date \_\_\_\_\_

Parent, Legal Guardian or Representative Payee \_\_\_\_\_