Plan for Work

serving Oregon and Southern Washington

A project of Disability Rights Oregon

INTAKE FORM

Please fill out as completely as possible

CONTACT and PERSONAL INFORMATION							
Last Name		First Name		MI			
Mailing Address							
City		State		Zip Code		County	
Phone		Email Address					
Social Security Number	- -	Date of Birth					
Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widow(er)	☐ Partner	
Gender:	☐ Male	☐ Female	☐ Other/Prefer Not Disclose	Veteran	☐ Yes	☐ No	
Primary Disability		Special Language Needs					
Representative Payee Name		Phone					
Address							

HOUSING INFORMATION

☐ Rent ☐ Own ☐ Other Total Amount per month ______ Your monthly share ______

Does this include utilities? ☐ Yes ☐ No Number of people in house ______

Household composition (parents, roommates, significant other, group home)

EDUCATION

Current student? ☐ Yes ☐ No Do you have education goals? (describe) ______

Level of Education: ☐ High School Graduate ☐ GED ☐ College (Degree?) ☐ Graduate Studies

EMPLOYMENT INFORMATION / WORK GOALS

Type of work desired: ______

Hours per week desired (part time/full time): ______ hrs/week Monthly Earning Goal: $ ______

Employment Status: ☐ considering work ☐ looking for work ☐ job offer pending ☐ considering self-employment ☐ currently working

Current Work— ☐ Full-time ☐ Part-time Benefits (sick/vacation, insurance, etc) ☐ Yes ☐ No

Employer: ______

Job Title: ______ Start Date: ______

Hours per week: ______ Rate of pay: ______

Are you working with any vocational providers (Vocational Rehabilitation/WorkSource/Employment Network); do you have a job coach? ☐ Yes ☐ No

Organization/Contact Person ______ Phone ______

Organization/Contact Person ______ Phone ______

BENEFITS RECEIVED

SSDI $ ______	SSI $ ______	Medicaid (OHP or AppleHealth)	☐ Yes ☐ No
Food Stamps $ ______	TANF $ ______	Medicaid Spend down $	______
Subsidized Housing $ ______		Medicaid Personal Care—hrs/month	______
Section 8 $ ______		Waiver—APD, DD brokerage/Comp	______
Alimony / Child Support $ ______		Waiver—DDA, COPES, mental health	______
Unemployment / Worker's Comp $ ______		EPD or HWD—monthly cost/fee $	______
Veterans Benefits $ ______		Other Health Care	______
Medicare #	☐ Yes ☐ No	Other Benefits	

How did you hear about us? ______

A project of
Disability Rights Oregon

PLAN FOR WORK

Please fill out as completely as possible and send to:

Plan for Work
c/o Disability Rights Oregon
610 SW Broadway, Suite 200
Portland, OR 97205

Or FAX to:
1(503) 482-6042
Attn: ***Plan for Work***

Questions: 1(800) 452-1694 x227 toll-free

This document is funded through a Social Security cooperative agreement. Although Social Security reviewed this document for accuracy, it does not constitute an official Social Security communication.

Plan for Work

serving Oregon and Southern Washington

Your Rights and Responsibilities

Plan for Work strives to provide accurate and thorough information regarding employment and the effects it will have on your benefits. We take this task seriously and in order to provide this information we engage your involvement by outlining your rights and responsibilities in this process.

DISCLAIMER: The accuracy of the information and advice is dependent upon:

- The accuracy and completeness of the information you provided about your current and past benefits status;
- The accuracy and completeness of information you provided about relevant factors such as current and past earnings, unearned income, resources, disability status/medical condition, marital status, and living arrangement;
- Current laws and regulations governing the effect of employment and other factors on Social Security disability benefits and other federal benefits; and
- Current Social Security Administration (SSA) policies and procedures regarding the use of applicable work incentives.

CONFIDENTIALITY POLICY:

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 or at your local Social Security office.

PROGRAM RESPONSIBILITIES: Our services are provided at no cost. As your Community Work Incentives Coordinator (CWIC) we will provide quality benefits counseling and support services, to include the following:

- Complete, accurate information on federal and state work incentive programs for which you may be eligible,
- Referral information to other entities/services,
- Long-term follow-up and support for ongoing work incentive services and information,
- Availability of protection and advocacy services for beneficiaries and how to access these services.

610 SW Broadway, Suite 200 / Portland, OR 97205
Voice: 503-243-2081 or 1-800-452-1694 / Fax: 503-243-1738 / **www.droregon.org**

PARTICIPANT RESPONSIBILITIES: Program participants must:

- Be age 14 to Retirement Age, and be receiving a disability-based benefit (SSI or SSDI),
- Sign release(s) to allow a CWIC access to pertinent benefits information,
- Demonstrate your interest to obtain employment,
- Report all earned income, employment or personal changes to SSA,
- Provide information regarding employment status to ***Plan for Work***,
- Ask questions, share success stories, and stay in touch with your CWIC regarding concerns/issues of impact on earnings and the support services you receive,
- Treat the project representative with respect and expect the same in return,
- Take responsibility for the informed decisions that you make.

GRIEVANCE PROCEDURES: If you believe that you have received improper or inadequate service provided to you by a CWIC, you may contact Disability Rights Oregon by calling 1(800)452-1694 or email welcome@DROregon.org to request a grievance form and detailed instructions of our grievance policy. The form must be filed within 30 days after the date the decision or action became known to the aggrieved person.

I agree to be a participant in ***Plan for Work***. I understand that I may discontinue my participation in ***Plan for Work*** at any time.

________________________________ Date____________ **_______________________________ Date__________**
Beneficiary or Legal Guardian (signature) **Community Work Incentives Coordinator (CWIC)**

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Social Security Administration

Form Approved
OMB No. 0960-0566

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).*

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:**
Plan for Work -- Arlene Jones, Sirenia Gonzalez	Disability Rights Oregon -- Plan for Work
Barbara Dirks, Matthew Hall	610 SW Broadway, Suite 200
Lloyd DeMers	Portland, OR 97205

***I want this information released because:** I am planning to go to work and need the information for

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

Benefits and work incentives planning. Please send a Benefits Planning Query (BPQY).

***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)**

   My cash benefits, health insurance information, medical review dates, representation, SSDI and SSI work activity and earnings. All employment supports data on my 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 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)

Consent for Release of Information

Form Approved
OMB No. 0960-0566

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.***

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).*

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:**
Plan for Work -- Arlene Jones, Sirenia Gonzalez	Disability Rights Oregon -- Plan for Work
Barbara Dirks, Matthew Hall	610 SW Broadway, Suite 200
Lloyd DeMers	Portland, OR 97205

***I want this information released because:** I need this information for program purposes.
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 authorize release of the summary of my posted annual earnings as reported from employers and the IRS and recorded by SSA.

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

Form Approved
OMB No. 0960-0566

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.

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Authorization for Use & Disclosure of Information

This form is available in alternative formats including Braille, computer disk, and oral presentation.

Legal Last Name of Client/Applicant	First	MI	Date of Birth
Other Names Used by Client/Applicant			Case ID# xxx-xx-

By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

Section A

Release From ONE Record Holder – (Individual, School, Employer, Agency, Medical or Other Provider)	**Specific Information to be Disclosed**	**Mutual Exchange: Yes / No**
Department of Human Services, OVRS, CEP	Eligibility information for: Medicaid/OSIPM,	Yes
	QMB, HCBS Waivers, Unemployment, OHP	
	Standard, TANF, SNAP, LIS, Medicare, and	
	SSA benefits.	

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

HIV/AIDS: _________ **Mental Health:** _________

Alcohol/Drug diagnoses, treatment, referral: _________ **Genetic Testing:** _________

Section B

Release To (address required if mailed) If releasing to a team, list members.	**Purpose**	**Expiration Date or Event***
Disability Rights Oregon, 610 SW Broadway, Suite 200, Portland OR, 97205	Delivery of Work Incentive Planning Services	

*** This authorization is valid for one year from the date of signing unless otherwise specified.**

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, vocational rehabilitation records, or referral information, without specific authorization.

Section C

Full Legal Signature of Individual OR Authorized Personal Representative	**Relationship to Client**	**Date**
Name Of Staff Person (print) Arlene Jones	**Initiating Agency Name/Location** Disability Rights Oregon--Portland 97205	**Date**
Full Legal Signature of Agency Staff Person Making Copies	**This is a True Copy of the Original Authorization Document.**	
Print Staff Person Name Arlene Jones		

See Required Information on Page 2 of This Form.
(Not Valid Without Page 2)

Required Information for the Client

To provide or pay for health services: If the Department of Human Services (DHS) is acting as a **provider** of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. (Examples of this would be assessments, tests or evaluations.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may also be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS program or service not acting as a health care provider

This is a Voluntary Form. DHS cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Using This Form

1. **Terms Used: Mutual exchange:** A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a DHS staff person should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
3. **Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact your DHS staff person. You can remove a team member from the form. You will be asked to put the cancellation request in writing.
   Exception: Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. DHS can continue to use information obtained prior to cancellation.
5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. **Special Attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed and the purpose.

Re-disclosure: Federal regulations (42 CFR Part 2) prohibit making any further disclosure of Alcohol and Drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.

A project of
Disability Rights Oregon

MY AUTHORIZATION TO RELEASE INFORMATION

I, ______________________________ authorize,

Name: ______________________________

Agency/Organization: ______________________________

Address: ______________________________

Phone: ______________________________

to share all documents and other information about me in his/hers/its possession or knowledge according to the following instructions:

The above-named individual or entity may speak with and/or release information about me to WIPA Community Work Incentives Coordinators ("CWICs") of **Disability Rights Oregon ("DRO")**, and DRO CWICs may exchange information to the above-named individual or entity as pertains to benefits counseling, Social Security, Medicaid/Medicare and other public benefits, and Ticket to Work. Information may be released to DRO CWICs by allowing file inspection, by photocopying records, by telephone or in person conversation, by fax transmission, by computer or by any other regular means. The information that is gathered by and for CWICs at DRO may be used ***only*** for the purpose of assisting them to help me in

UNDERSTANDING BENEFITS PLANNING, Title II benefits (SSDI, CDB, DWB) and SSI, other public benefits, Medicaid/Medicare, and TICKET TO WORK

I understand that I may cancel this authorization at *any time* by notifying the above-named individual or entity *in writing* of my decision. However, my cancellation *will not* apply to information that the individual or entity and DRO already shared *before* they received my written cancellation. This authorization will remain in effect until (1) I give *written notice* to the above-named individual or entity that I am canceling my authorization, or (2) my file with DRO is *closed*, or (3) *one year* from date of signing. A photocopy of this authorization has the same power as the original.

Signature: ______________________________ Date: ______________

Print Name: ______________________________

610 SW Broadway, Suite 200 / Portland, OR 97205
Voice: 503-243-2081 or 1-800-452-1694 / Fax: 503-243-1738 / **www.droregon.org**
Disability Rights Oregon is the Protection and Advocacy System for Oregon

A project of
Disability Rights Oregon

MY AUTHORIZATION TO RELEASE INFORMATION

I, ____ authorize,

Name: ____

Agency/Organization: ____

Address: ____

Phone: ____

to share all documents and other information about me in his/hers/its possession or knowledge according to the following instructions:

The above-named individual or entity may speak with and/or release information about me to WIPA Community Work Incentives Coordinators ("CWICs") of **Disability Rights Oregon ("DRO")**, and DRO CWICs may exchange information to the above-named individual or entity as pertains to benefits counseling, Social Security, Medicaid/Medicare and other public benefits, and Ticket to Work. Information may be released to DRO CWICs by allowing file inspection, by photocopying records, by telephone or in person conversation, by fax transmission, by computer or by any other regular means. The information that is gathered by and for CWICs at DRO may be used ***only*** for the purpose of assisting them to help me in

UNDERSTANDING BENEFITS PLANNING, Title II benefits (SSDI, CDB, DWB) and SSI, other public benefits, Medicaid/Medicare, and TICKET TO WORK

I understand that I may cancel this authorization at *any time* by notifying the above-named individual or entity *in writing* of my decision. However, my cancellation *will not* apply to information that the individual or entity and DRO already shared *before* they received my written cancellation. This authorization will remain in effect until (1) I give *written notice* to the above-named individual or entity that I am canceling my authorization, or (2) my file with DRO is *closed*, or (3) *one year* from date of signing. A photocopy of this authorization has the same power as the original.

Signature: ______________________________ Date: ______________

Print Name: ____

610 SW Broadway, Suite 200 / Portland, OR 97205
Voice: 503-243-2081 or 1-800-452-1694 / Fax: 503-243-1738 / **www.droregon.org**
Disability Rights Oregon is the Protection and Advocacy System for Oregon