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The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Massachusetts Rehabilitation Commission
600 Washington Street
Boston, MA 02111-1704

Phone: (617) 204-3665
Email: MRC.Connect@mass.gov
Fax: (617) 727-1354

Dear Applicant,

Thank you for your interest with Massachusetts Rehabilitation Commission (MRC), where we are dedicated to helping individuals with disabilities live and work independently. To continue your journey with us in obtaining services we have outlined the following instructions to help you through the process!

Step 1: Apply for Services Online

Our application is now online at https://www.mass.gov/mrc-connect. Applicants can apply for Vocational Rehabilitation, Homecare Assistance, Statewide Head Injury and Supportive Living programs through one application. If you have questions on applying, please feel free to contact us at 617-204-3665.

Step 2: Schedule a Time with Us for Your Eligibility Interview Appointment

As part of the eligibility process, we'll be reaching out to you to schedule a Zoom interview appointment with one of our MRC Connect Eligibility Screeners. This will allow us to hear more about your specific needs and identify how our services could support you. If you have any questions prior to your interview appointment date, please feel free to contact us at 617-204-3665 or MRC.Connect@mass.gov.

If already scheduled; your appointment date is _____

Step 3: Submit your Documents Before Your Interview Appointment

Submit documents to MRC.Connect@mass.gov so we can review them during your interview and determine your eligibility sooner. Please contact our team if there are issues in meeting this deadline via our email at MRC.Connect@mass.gov or call 617-204-3665.

Which documents should I submit?

1. **Submit Medical Records –** these are records and information that document your medical disability and/or condition. There are two options applicants can use to collect and send their documents.

   Option 1 (Recommended Option): Collect and Send Records Yourself

   - **A. Fill Out Authorization for Release of Information -** This form provides consent for MRC to share your personal information across divisions within MRC, and across other office of Health and Human Services (HHS) agencies. This release of information form is also used to determine which services may be the best fit for you, and which services you may be eligible for.
     This document can be found on page 6 of this packet

   - **B. Use Your Online Medical/Provider Portal to Download Medical Records** - If you have a patient portal or online medical chart through your provider, access your portal online and download your records. If you don't have access to your portal, please call your primary care doctor or provider to obtain access. If there are restrictions on your access, please reach out to your doctor or provider to be granted access.

   - **Submit A and B to MRC.Connect@mass.gov or fax via (617) 727-1354 att: MRC Connect**

   Option 2: Have Your Medical Provider(s) Collect and Send Your Records

   - **A. Fill Out Authorization for Release of Information -** This form provides consent for MRC to share your personal information across divisions within MRC, and across other office of Health and Human Services (HHS) agencies. This release of information form is also used to determine which services may be the best fit for you, and which services you may be eligible for.
     This document can be found on page 6 of this packet

   - **C. Fill Out Authorization for Two-Way Release of Information (required only if MRC needs to collect medical information on your behalf).** This form is used to authorize MRC to receive and release information, including confidential communications, from or to a Person, Agency or Facility either verbally or in writing (e.g., hospital, service provider, professional, other.)
     This document can be found on page 8 of this packet

     THEN

   - **D. Contact Your Medical Providers and Have Them Send Your Medical Records Directly to MRC Connect -** Contact your medical provider(s) and request them to send your medical records to MRC via fax (617) 727-1354 att: MRC Connect or emailed to MRC.Connect@mass.gov.

     OR

- **E. Contact Your Medical Providers and Have Them Fill Out the MRC Medical Summary Form.** This document is mailed to or brought to your medical provider(s) for them to fill out and send to MRC via fax (617) 727-1354 att: MRC Connect or emailed to MRC.Connect@mass.gov.
  This document can be found on page 10 of this packet

  Examples of medical records that may need to be sent are;

  - **SSI or SSDI Award Letter**: Individuals receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits under Title II or Title XVI of the Social Security Act are presumed eligible for VR services.
  - **Physical Disability**: medical doctors, surgeons, chiropractors, physical and speech therapists, neuropsychologists, neurologists, occupational therapists, physical therapists, other trained health care professionals.
  - **Psychiatric Disability**: licensed psychologist, neuropsychologists, psychiatrists, clinical social workers, school psychologists, psychiatric nurse practitioners, other counselors, therapists, or relevant medical doctors.
  - **Cognitive Disability**: clinical, school, or educational psychologists, learning disability specialists, neuropsychologists, other trained medical doctors.
  - **Blindness, Low Vision**: ophthalmologist, optometrist, or other trained eye care specialist.
  - **Deaf, Hard of Hearing:** audiologist, otolaryngologist, or other trained hearing specialist.

  Examples of SHIP specific medical records or acute records that may need to be sent are;

  - Documentation of externally caused traumatic brain injury, documentation of current and significant impairment of behavioral, cognitive, and/or physical functioning resulting primarily from an externally caused traumatic brain injury.

- **Submit A, C and D or E to MRC.Connect@mass.gov or fax via (617) 727-1354 att: MRC Connect**

2. **Financial Verification Information -** Please provide verification of your financial information, such as the last three (3) pay stubs from your employer, a W-2 or other income verification documentation.

   - **Submit to MRC.Connect@mass.gov or fax via (617) 727-1354 att: MRC Connect**

Ways to get support to complete the previous two steps: We are here to help and are committed to providing the best level of customer service to meet your needs. If you have any questions, or need additional assistance please contact us:

- **Call or email** us at 617-204-3665 or MRC.Connect@mass.gov. Let us know how we can help.
- **Have a provider?** Contact your provider to ask questions, and we can work with them to support you
- **Learn more about MRC programs and services** – Visit our website to learn more about the services we provide: https://www.mass.gov/mrc-connect
- **Need help with Translation Services / Accessibility Services?** Please reach out to staff at MRC Connect at MRC.Connect@mass.gov

Additional Information included in This Packet:

- **Mail-In Voter Registration and Information About Voter Registration -** The National Voter Registration Act of 1993 requires MRC to give you the opportunity to register to vote. Your decision to register to vote will NOT affect your eligibility for benefits. A mail-in voter registration form is enclosed in the middle of this welcome package. Or If you or any household member age 18 or over would like to register to vote, click on the link below (or copy/paste into your web browser) for a voter registration form via https://www.sec.state.ma.us/ele/elepdf/Voter-reg-mail-in.pdf

- **Your Informed Choice -** Informed choice is the process of choosing from options based on accurate information and knowledge. These options are developed by a partnership consisting of the consumer and the counselor that will empower the consumer to make decisions resulting in a successful vocational rehabilitation outcome. For more information, please visit https://www.mass.gov/mrc-connect.

- **Client Rights -** An informational brochure has been designed for you, the consumer of the Massachusetts Rehabilitation Commission, in order to inform you of your rights to appeal a decision regarding vocational rehabilitation services. For more information, please visit https://www.mass.gov/mrc-connect.

- **Client Assistance Program (CAP) -** CAP is a federally funded program that provides advocacy for and information to people who seek and receive services from the Massachusetts Rehabilitation Commission (MRC), the Massachusetts Commission for the Blind (MCB) and the Independent Living Centers (ILCs) in Massachusetts. CAP is independent of the vocational rehabilitation and independent living agencies. It is run by MOD, a state agency. MOD works to ensure the full and equal participation of all people with disabilities in all aspects of life in a manner that fosters dignity and self-determination. For more information, please visit https://www.mass.gov/mrc-connect.

- **If any applicant has any issues in accessing this information via MRC's website, paper documents can be provided.**

INCLUDE SHEET - REQUIRED

If Mailing or Faxing Documents to MRC Connect, This Sheet Needs to Be Included

Name:_____

Date of When You Applied:_____

Please mail documents to:

Att: MRC Connect
600 Washington Street, 2nd Floor
Boston, MA, 02111

Please fax documents to:

Att: MRC Connect
617-727-1354

Authorization for Release of Information

Overview: Massachusetts Rehabilitation Commission (MRC) is an agency under the Executive Office of Health and Human Services (EOHHS), that provides services to people with disabilities. These services sit under three main groups: The Vocational Rehabilitation Division, the Community Living Division, and Disability Determination Services.

This release form will provide access to the information we need to help determine if you are eligible for our services, and what services are the best fit for you.

Specify the purpose for this authorization (check all that apply):

- ☐ Service Planning
- ☒ Determine eligibility for services
- ☐ Referral
- ☐ Coordinate care
- ☐ Obtain insurance, financial, or other benefits
- ☐ Other purpose, please specify: _____

Please provide the following information:

Legal Name: Preferred Name: _____
Previous Names: _____ Phone: _____
Address: Alternate Phone: _____

City, State, Zip: Date of Birth: _____
Email:
Social Security #: _____ MassHealth #: _____

Who will have access to my information? By signing this document, I agree to share my information with: (1) Massachusetts Rehabilitation Commission (2) Other agencies run by the Executive Office of Health and Human Services including the Department of Transitional Assistance, the Department of Mental Health, the Department of Children and Family Services, Department of Public Health, MassHealth, the Commissioner for the Deaf and Hard of Hearing, Department of Developmental Services, Commission for the Blind, Department of Veterans Services, and Soldiers' Home, and (3) the Massachusetts Executive Office of Elder Affairs, and (3) with workforce development partners.

The following state agencies do not have my permission to access or share my information (if none write N/A): _____

How will my information be used? My information will be used to determine if I'm eligible for services and what services fit my needs, and this information would be shared only if necessary for program administration and service delivery. The information shared may include written documents and conversations between MRC staff. Once my information is shared, it may no longer be protected by federal or state privacy laws or regulations.

Volunteering Information: Sharing my information is my choice. I do not have to sign this form to receive services. However, without this information, MRC may be unable to provide helpful and appropriate care for me.

How long does this approval last? This release will expire in 12 months from the date listed with my signature, unless I specify a different time or date here: _____

What if I want to revoke this approval? I have a right to revoke this approval at any time. If I want to revoke this approval, I must put it in writing and give a copy to the person, facility or agency that requested this release. The withdrawal would not apply to information that has already been shared.

When can MRC share my information without my permission?

- In order to protect you or the public, where this is a threat to either yourself or others;
- In response to investigations in connection with law enforcement, fraud, or abuse, unless expressly prohibited by Federal or State laws or regulations, and in response to a judicial order;
- Release for audit, evaluation, and research; or
- If required by Federal/State law or regulations, unless otherwise prohibited.

Specify information you agree to be shared:

My Entire Record ☐ **OR**

Check all that apply below:

Assessment & Tests	☐	Consultations	☐	Evaluations	☐
Functional Abilities Assessment	☐	Provider Records & Reports	☐	Summary of services	☐
Verbal exchange of information	☐	Vocational Rehab Records	☐	Service plans	☐
Neuropsychology / Neurology	☐	Psychological Evaluations	☐	Medical Record	☐
Statewide Head Injury Records	☐	Vocational Evaluations	☐	Home Care Records	☐
Shared Living Records	☐	Supported Living Records	☐	ABI/MFP Waiver Records	☐
Admission(s) Notes	☐	Treatment Plans	☐	Progress Notes	☐
Discharge Summaries	☐	OT / PT / Speech	☐	School Records	☐
Other – specify:	☐	_____			

Specially Authorized Releases of Information ***(please check all that apply)***

☐ **By checking this box**, I agree to share any alcohol or drug treatment information (protected under Federal law) included in my medical record.

☐ **By checking this box,** I agree to share any HIV antibody and antigen testing (protected by Massachusetts state law), or an HIV/AIDS diagnosis or treatment included in my medical record.

Your signature or Personal Representative's signature: _____

Date: _____

Print name of signer: _____

If signed by a personal representative, type of authority (e.g., court appointed guardian, custodial parent): _____

INSTRUCTIONS:

1. Print this form to be double sided.
2. This form must be completed in full to be considered valid.
3. Distribution of copies: send original copy to appropriate MRC record; copy to individual or Personal Representative.
4. This form can be mailed, faxed, or emailed as an attachment

A copy of this authorization shall be considered as valid as the original.

Authorization for Two-Way Release of Information

Please provide the following information:

Legal Name: _____ Preferred Name: _____

Previous Names: _____ Phone: _____

Address: _____ Alternate Phone: _____

City, State, Zip: _____ Date of Birth: _____

Email: _____

Social Security #: _____ MassHealth #: _____

Authorization to Release: I authorize the Massachusetts Rehabilitation Commission to receive and release information, including confidential communications, from or to the Person, Agency or Facility named below, either verbally or in writing.

Person, Agency, or Facility (e.g., hospital, service provider, professional, other)	**MRC Contact Information:**
Name: _____	Name: _____
Organization: _____	Street: _____
Street: _____	City/Town: _____
City/Town: _____	State/Zip Code: _____
State/Zip Code: _____	Phone: _____
Phone: _____	Fax: _____
Fax: _____	Email: _____
Email: _____	

Specify the purpose for this authorization (check all that apply):

☐ Service Planning ☐ Determine eligibility for services ☐ Referral
☐ Coordinate care ☐ Obtain insurance, financial, or other benefits
☐ Other purpose, please specify: _____

Specify information you agree to be shared:

My Entire Record ☐ **OR**

Check all that apply below:

Assessment & Tests	☐	Consultations	☐	Evaluations	☐
Functional Abilities Assessment	☐	Provider Records & Reports	☐	Summary of services	☐
Verbal exchange of information	☐	Vocational Rehab Records	☐	Service plans	☐
Neuropsychology / Neurology	☐	Psychological Evaluations	☐	Medical Record	☐
Statewide Head Injury Records	☐	Vocational Evaluations	☐	Home Care Records	☐
Shared Living Records	☐	Supported Living Records	☐	ABI/MFP Waiver Records	☐
Admission(s) Notes	☐	Treatment Plans	☐	Progress Notes	☐
Discharge Summaries	☐	OT / PT / Speech	☐	School Records	☐
Other – specify:	☐	_____			

This consent, unless revoked by me in writing (please check one):

☐ Is valid for 45 days from the date of signature; or

☐ Expires on (date): _____.

Signature / Authorization: **Sign and provide information as required below**.

X _____ _____

Your signature or Personal Representative's signature Date

_____

Print name of signer

The following information is needed if signed by a personal representative:

Type of authority (e.g., court appointed, custodial parent): _____

NOTICE REGARDING FURTHER DISCLOSURE OF INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by federal and state law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of information is NOT enough for this purpose.

Medical, psychological or other information which may be harmful to the individual may not be disclosed directly to the individual but must be provided to a third party chosen by the individual unless a representative has been appointed by a court to represent the individual, in which case the information must be released to the court-appointed representative. Information about individuals who are minors, i.e., under 18 years of age, which relates to or reveals substance abuse diagnosis or treatment may not be released to the individual's representative, including a parent or guardian, without the explicit written consent of the individual, in accordance with federal alcohol and drug abuse confidentiality regulations, 42 CFR §2.

The information should be managed in a manner to protect confidentiality and to protect against unauthorized disclosure. Anyone who willfully and knowingly discloses or uses confidential information in violation of the law may be liable to the individual for actual and punitive damages, attorneys' fees, and litigation costs, and may also be subject to criminal penalties.

MRC Connect
MASSACHUSETTS REHABILITATION COMMISSION
Medical Summary Form

REV: 9/2021

Patient's Name: _____

Today's Date: _____

When reviewing the questions below, please evaluate each activity within the context of the individual's capacity to sustain that activity over a normal workday/week.

1. What is the medical diagnosis or psychiatric/clinical diagnosis?

2. What is the medical prognosis or current mental status?

3. Current medications the patient taking (including dosages and purpose)?
Please include attachment if additional space is needed.

Medication:	Dosage:	Purpose:

4. What are the medical or treatment goals and what is the patient's level of commitment to these goals?

Section 1: Functional Limitations

Section 1a: History

1. Check all that apply

- ☐ Alcohol/Substance Abuse
- ☐ Domestic Abuse/History of Assault
- ☐ Suicidal/Homicidal Ideation
- ☐ History of Legal Involvement

Additional Comments:

Section 1b: Exertional Limits

1. **Occasionally** lift and/or carry (including upward pulling). Please identify maximum weight. When less than one-third of the time or less than 10 pounds, explain in 'Additional Comments' section below:

☐ 10 pounds ☐ 20 pounds ☐ 50 pounds ☐ 100 Pounds or more

Additional Comments:

2. **Frequently** lift and/or carry (including upward pulling). Please identify maximum weight. When less than one-third of the time or less than 10 pounds, explain in 'Additional Comments' section below:

☐ 10 pounds ☐ 20 pounds ☐ 50 pounds ☐ 100 Pounds or more

Additional Comments:

3. Stand and/or walk (with normal breaks):

☐ Less than 2 hours in an 8-hour workday
☐ At least 2 hours in an 8-hour workday
☐ Approximately 6 hours in an 8-hour workday
☐ Medically required handheld assistive device is necessary for ambulation

Additional Comments:

4. Sit (with normal breaks):

☐ Less than 2 hours in an 8-hour workday
☐ At least 2 hours in an 8-hour workday
☐ Approximately 6 hours in an 8-hour workday
☐ Must periodically alternate sitting and standing to relieve pain or discomfort

Additional Comments:

5. Push and/or pull (including operation of hand and/or foot controls)

	Unlimited, other than as shown for lift and/or carry
	Limited in upper extremities (describe nature and degree)
	Limited in lower extremities (describe nature and degree)
	Frequent breaks
	Maintain acceptable attendance (ex: no more than 2 days off per month for a full time employee)

Additional Comments:

Section 1c: Postural Limits

	Significant	Not Significant	Not able to Evaluate
1. Climbing: ramp, stairs, ladder, rope, scaffolds			
2. Balancing			
3. Kneeling			
4. Bending/Crouching			
5. Twisting			

Additional Comments:

Section 1d: Manipulative Limitations

	Significant	Not Significant	Not able to Evaluate
1. Reaching in all directions (inc. overhead)			
2. Handling (gross manipulation)			
3. Fingering (fine manipulation)			
4. Feeling (skin receptors)			

Additional Comments:

Section 1e: Visual Limitations

	Significant	Not Significant	Not able to Evaluate
1. Near acuity			
2. Far acuity			
3. Depth perception			
4. Accommodation			
5. Color vision			
6. Field of vision			

	Yes	No
7. Does patient use a sight cane?		
8. Does patient use a guide dog?		
9. Does patient use assistive technology?		

Additional Comments:

Section 1f: Communication Limitations

	Significant	Not Significant	Not able to Evaluate
1. Hearing			
2. Speaking			
3. Difficulty communicating with co-workers or supervisors.			

5. Primary form of communication in the workplace?	
6. Utilizes accommodations and/or assistive technology for communication	☐ Yes ☐ No

Additional Comments:

Section 1g: Environmental limitations

		Significant	Not Significant	Not able to Evaluate
1.	Extreme cold			
2.	Extreme heat			
3.	Light			
4.	Noise			
5.	Vibration			
6.	Fumes, odors, dust, gases, poor ventilation			
7.	Hazards (machinery, height, etc.)			
8.	Sensory Integration			

		Yes	No
9.	Ability to drive due to disability		
10.	Ability to use public transportation		

Additional Comments:

Section 1h: Interpersonal Limitations

		Yes	No
1.	Difficulty with co-workers, supervisors due to disability		
2.	Disruptive and/or inappropriate behavior due to disability		
3.	Behavior resulting in sudden shifts in mood and attitude		
4.	Low frustration tolerance, avoidance and unpredictability		
5.	Requires extra time to learn tasks		
6.	Exhibits social isolation or withdrawal to a degree that diminishes vocational opportunities		

Additional Comments:

Section 1i: Self Care

	Significant	Not Significant	Not able to Evaluate
1. PCA			
2. Medication compliance			
3. Live independently			
4. ADLs			
5. Hygiene			
6. Decision Making/Judgement			

Additional Comments:

Section 1j: Cognitive

	Significant	Not Significant	Not able to Evaluate
1. Extra time to learn work tasks			
2. Learning style			
3. Safety in the home or workplace			
4. Focus/Concentration			
5. Memory			
6. Stress tolerance level			

Additional Comments:

Section 2: Patient's Readiness for Services

1. Please explain any other recommendations that will assist MRC with finding employment, needs in the home or other services that would benefit the patient?

2. Has the patient expressed interest in employment or a work program? If so, please describe.

3. Does the patient have any issues or fears about returning to work, supports in home or accessing community needs? If so, please describe.

4. In your opinion is this individual medically clear to work? If not, why?

Subject 3: Medical Consultant Authorization

By signing below, I confirm to the best of my knowledge that the information provided is complete and accurate.

Medical Consultant Signature	Medical Consultant Printed Name	License Number	Date