**Massachusetts State Supplement Program**

**Request for Access to SSP Client Record and Information**

This form is to be completed by an SSP client who wishes to authorize another individual to have access to his or her SSP record and information.

**Section 1. SSP Client Information:**

* Client Name:
* Client Date of Birth:
* Client Address:

(number and street) (apartment, P.O. Box or Rural Route)

(city) (state) (zip code)

* Last Four (4) Digits of Client’s SSN:

**Section 2. Authorization for Access to My SSP Record:**

I hereby authorize the individual named below to have access to my SSP record and information. I understand that if I wish to stop this access, I must call the SSP Assistance Line at 1-877-863-1128.

* + Name:
  + Address:

(number and street) (apartment, P.O. Box or Rural Route)

(city) (state) (zip code)

* + Telephone Number:

**Section 3. REQUIRED: SSP Client Signature:**

Date:

Please call the Massachusetts SSP Assistance Line at 1-877-863-1128 if you have any questions about this form. Return completed form to:

**MASSACHUSETTS SSP**

**PO BOX 4018**

**TAUNTON MA 02780-0315**

or fax to: **857-323-8310**