Applies to:
ADRC
DBS
EBS
SHIP
Tribal ADRS

P-02009-22-08
(07/2025)

Guidelines for Communicating with and Escalating Cases with the Social Security Administration

Table of contents

Introduction

Partner agency staff are to reference this document when seeking assistance with Social Security (SSA) field offices for customer-specific issues. This document provides instructions for requesting information and escalating unresolved concerns. Questions about this document should be directed to the regional quality specialist, benefit specialist's program attorney, or to the Wisconsin SHIP director.

Staff should continue to communicate with the Wisconsin local field office using these instructions when a customer's claim has been referred out of state.

Note: Contact information for individual field office and regional SSA staff is not available publicly. Private contact information is available in the Supplement to Guidelines for Escalating Cases with SSA. SHIP counselors who lack access to the SharePoint site should email the SHIP Director for contact information.

Communicating with the DDB

The Disability Determination Bureau (DDB) completes the medical disability determination for SSA programs and the Wisconsin Medicaid program. Refer to the Communicating with the DDB guidelines for instructions on how to share information with the DDB for SSA and Medicaid purposes. That document includes the inbox address to use to request a barcoded fax sheet to submit medical evidence or to request a medical file and who to contact for case-specific needs.

Establish consent to communicate with SSA

There are three primary methods for establishing a customer's consent to request information from SSA:

- Placing a three-way phone call with the customer and SSA.
- Using the Consent for Release of Information form (SSA-3288) to request information.
- Signing on as appointed representative (SSA-1696) when advocating for a customer's disability-related claim.

The appropriate method to use will differ based on the staff person's role and the context of the customer's need for assistance. For example, the SSA-1696 is most useful when a benefit specialist is assisting a customer to apply for or to appeal a disability benefit.

Placing a three-way phone call

Verbal communication with SSA is allowable when the customer provides consent during a three-way phone call with SSA. The customer does not need to be in the office with the agency staff during the call. It is best practice to have the customer on the phone before calling the SSA office. SSA representatives are not required to wait on the line in order to add the customer to the call.

Ask the representative for their name or unit code to document the outcome of the call. **Note:** for security reasons, SSA staff may choose not to share their names, but they should at least share their unit code.

Questions and concerns that are appropriate to address through a three-way phone call include but are not limited to:

- Requesting an appointment.
- Asking for a date last insured.
- Responding to an SSA field office's request for information.
- Confirming the status of a submitted document such as an appeal form or application.
- Asking for more information about an overpayment.
- Enrolling in Medicare Parts A or B.
- Requesting conditional enrollment to obtain the Qualified Medicare Beneficiary (QMB) benefit. (Contact the income maintenance agency for QMB financial eligibility issues.)

Using the Consent for Release of Information form

The 3288 allows Social Security to provide written information about a claimant to an individual or group. When using the SSA-3288 to obtain written information from SSA, agency staff must:

- Fax a valid 3288 form to the local field office to initiate an information request. Indicate on the cover sheet why you're submitting the SSA-3288.
- Attach the form to each follow-up communication with SSA.
- Limit each communication to one claimant.

Agency staff must be specific about the information they need and its purpose when requesting records from SSA. SSA staff must consider the best source to use when providing the requested information to meet the business need, without releasing information that was not requested and/or does not meet the specified business need.

Disclosure timeframe

The SSA-3288 is considered a one-time request for information unless the customer specifies otherwise in the "I want this information released because:" section. For example:

- This consent to disclose is valid for one year from the date of signature. (**Note:** One year is the longest period of time that an SSA-3288 can be used.)
- This consent to disclose is valid for 90 days from the date of signature. (**Note:** staff must use this wording when using the SSA-3288 to request medical records.)

Valid 3288

A properly completed and signed SSA-3288 is valid when the customer:

1. **Completes all required fields** of the form as indicated by a single asterisk next to the field name.
2. **Provides the email address** of the person to whom SSA will release the information.
3. **Indicates a clear purpose** for the release of information in the field where it states, "*I want this information released because*." Examples of reasons to release information include:
   - I am receiving help with my disability claim and related benefits.
   - I am being screened for functional eligibility to enroll in a long-term care program.
   - I have requested help to contest my alleged overpayment (OP).
4. **Indicates the specific information being requested** in field 9 (Other Social Security record(s)) of the section where it states, "*Please release the following information selected from the list below*." Requests that are general or broad will not be honored. Examples of specific requests for information include:
   - Consultative exams, award and/or denial notices, disability determination explanations (DDEs), benefit applications, appeals, questionnaires, doctor reports, and determinations.
   - Diagnosis code(s), disability established onset date (EOD), diary date.
   - Due process notice(s) with details of trial work period (TWP) and impairment-related work expenses (IRWEs), OP period, payments made and recalculated values, earnings record, cause for OP, disability EOD.
5. **Signs the form in ink** on a printed copy of the form. This is referred to as a "wet signature." SSA does not accept an electronic or digital signature on the SSA-3288. See section GN 03305.003 Sections F and H in the SSA POMS (Program Operations Manual System) for more information.

Alternative language forms

The SSA-3288 is available in Spanish and other languages. However, staff must submit the English version of the form to the local field office. The alternate language versions are to be used as an interview tool to explain the form and obtain the customer's consent to release information.

Fees associated with requests for information

SSA policies allow field offices to charge for the release of information when it is requested for a "non-program purpose." When evaluating whether to charge a fee, the SSA considers both why the information is needed and what information has been requested.

Here is an example of an information request for a program purpose that would not incur a fee:

> **I want this information released because:** *I am receiving help with my disability claim and related benefits.*
>
> **Please release the following information: Other SSA record(s):** *Consultative exams, award and/or denial notices, DDE, benefit applications, appeals, questionnaires, doctor reports, and determinations*

Examples of information requests for non-program purposes that would incur a fee include:

- Requesting documentation of a customer's diary date to apply for student loan forgiveness.
- Requesting a customer's electronic disability claim folder to obtain the diagnosis code(s) to complete a long-term care screen for publicly funded Medicaid long-term care programs.
- Requesting a customer's prior electronic disability claim folder at the onset of a continuing disability review (CDR). **Note:** If the CDR determination results in a cessation of benefits due to medical improvement and the determination is appealed, a request for the medical file is a programmatic request at that time as the prior determination is part of the record due to the CDR disability determination.
- Requesting a BPQY (benefits planning query) to appeal an overpayment.

Signing on as appointed representative

Appointed representatives may communicate with SSA verbally or in writing without obtaining further consent from the customer. Appointed representatives have specific duties, and staff should consult with their supervisor before agreeing to be an appointed representative.

Signing on as an appointed representative is especially beneficial when assisting a client with a disability claim. The Guidelines for Agreeing to Become an Appointed Representative (P-02009-22-12) supplements the DBS Program section (P-03062-05a) of the ADRC Operations Manual.

Communicating with SSA

Establish a relationship with the local SSA field office.

Agency staff are encouraged to develop a relationship with their local field office manager. Each field office implements processes unique to their office based on the needs in their service area. The needs within the field office's service area directly impact how staff at that field office prioritize case work. Contact the assigned area work incentives coordinator for help contacting the field office manager, if needed.

Use the SSA secure email system

SSA requires partner agencies to use SSA's secure email system to communicate by email. Secure email is available to all users of the same email domain. Contact the SSA area systems coordinator to confirm your agency has implemented the secure email process and/or to communicate a change to your agency's domain. Be prepared to provide your agency's IT support contact information to SSA if secure email access needs to be established.

Note: Do not use encryption when using the SSA secure email system. Always include the customer's SSN when using the SSA secure email system.

Allow sufficient time for SSA's response

Allow **30 days** for the SSA field office to process and respond to the initial information request.

Allow up to **14 days** for the SSA field office to process and respond to the initial information request for a **TERI** (terminal illness) or urgent need. A shorter time allowance may be warranted for an **immediately urgent, dire need** case.

Use your professional discretion to determine when to follow-up on an urgent, dire need or TERI claim. Consider whether SSA has the potential to resolve the issue directly through their action. For example, if you contacted SSA related to a payment issue for a customer who was given a five-day eviction notice from their long-term residence, a swift response from SSA could resolve that customer's pending eviction. This type of need warrants follow-up with SSA sooner than 14 days. Conversely, resolving a payment issue for an individual who has been unhoused for a long time, while urgent, may not warrant an immediate response as SSA's action would not resolve the lack of housing.

Keep detailed notes to summarize resolution attempts

Staff are encouraged to use the Problem Tracking Template to document communication with Social Security field offices on each case. The template is in the Tools for Professionals section of the Medicare Outreach and Assistance Resources web page. Having detailed notes to reference is helpful if the case needs to be escalated to the field office management team or the area work incentives coordinators.

Escalating Social Security income benefit cases

Escalate information requests after the appropriate response time has passed without a response from SSA.

Step 1: Consult with program attorney (benefit specialists only)

Prior to escalating the case, the benefit specialist must consult with their program attorney if the matter requires consultation according to program policies and processes.

Step 2: Escalate to the SSA field office management team

Send a secure email or eFax to the SSA field office management team. This information must be included in each communication with the field office. *Copy and paste the following into your email and enter all applicable information for each bullet.*

Subject line: ADRC Follow-Up Request to Office Management
(*if applicable, add* "DIRE NEED" *and/or deadlines*)

- Client name and/or Social Security number (SSN):
- SSA field office location:
- Date of contact with the SSA field office:
- Detailed description of the issue, including attempts to resolve the issue and date(s) actions were taken:
- Representative spoken to (if known), or a description of what was tried and didn't work:
- Response from representative:
- Date of email or eFax to the SSA field office:
- Description of the field office's response to your email or eFax:
- Date of referral to the area work incentives coordinator:

Step 3: Escalate to an area work incentives coordinator

Escalate the matter to the area work incentives coordinator assigned to the local office if the issue is not able to be resolved by the office management team or the team does not respond within the appropriate time allowance.

Escalating Original Medicare benefit cases

Escalate information requests after the appropriate response time has passed without a response from SSA.

Step 1: Consult with program attorney (benefit specialists only)

Prior to escalating the case, the benefit specialist must consult with their program attorney if the matter requires consultation according to program policies and processes.

Step 2: Escalate to the SSA field office management team

Send a secure email to the SSA field office management team indicating the customer's intent to enroll into Medicare. *Copy and paste the information below into your email and enter the information for each bullet*:

- Customer's name:
- Social Security number (SSN):
- Phone number:
- Specifics regarding attempts made to reach the field office and the result of those attempts:

This email or eFax will document the attempt for purposes of asking for equitable relief at a future date if enrollment is not effectuated timely within the enrollment period.

Step 3: Escalate to an area work incentives coordinator

Escalate the concern by sending another secure email to the relevant SSA field office with the same information and copy the SSA Area 2 public affairs specialist or the Area 1 AWIC if the issue was not resolved within the appropriate time allowance.

Appendix

This appendix provides examples of how to complete the Consent for Release of Information (SSA-3288) to receive records from SSA for different purposes.

Example: Disability case

Here is an example of a request for information related to a disability claim. It is important to ask only for the information needed to advocate for the customer's situation. Not all of the information included in this example will be needed for every disability claim, and some cases may need information not included in this example.

Form **SSA-3288** (02-2023) UF Page 2 of 3

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. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

Sample Customer	MM/DD/YYYY	xxx-xx-xxxx
***Full Name**	***Date of Birth (MM/DD/YYYY)**	***Full 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:** **** PHONE NUMBER OF PERSON OR ORGANIZATION:**
Staff person's name	Agency name
Staff person's email address	Agency street address
	City, WI xxxxx

***I want this information released because:**

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

I am receiving help with my disability claim and related benefits.

This consent to disclose is valid for 90 days from the date of signature.

***Please release the following information selected from the list below:**

Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

   Consultative exams, award/denial notices, DDE, benefit applications, appeals,

   questionnaires, doctor reports, and determinations

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 § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** _____ ***Date:** MM/DD/YYYY

****Address:** Customer's address ****Daytime Phone:** xxx-xxx-xxxx

****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)

Example: Long-term care program

Here is an example of a request for information needed to complete a long-term functional screen so that a customer may enroll in a Medicaid long-term care program.

Form **SSA-3288** (02-2023) UF Page 2 of 3

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. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

Sample Customer	MM/DD/YYYY	xxx-xx-xxxx
***Full Name**	***Date of Birth (MM/DD/YYYY)**	***Full 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:** ** PHONE NUMBER OF PERSON OR ORGANIZATION:**
Staff person's name	Agency name
Staff person's email address	Agency street address
	City, WI xxxxx

***I want this information released because:**

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

I am being screened for functional eligibility to enroll in a Medicaid long-term care program.

This consent to disclose is valid for 90 days from the date of signature.

***Please release the following information selected from the list below:**

Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

   Diagnosis code(s), disability established onset date, diary date

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 § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** _____ ***Date:** MM/DD/YYYY

****Address:** Customer's address ****Daytime Phone:** xxx-xxx-xxxx

****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)

Example: Overpayment

Here is an example of a request for information related to an overpayment. It is important to ask only for the information needed to advocate for the customer's situation. Not all of the information included in this example will be needed for every overpayment, and some cases may need information not included in this example.

Form **SSA-3288** (02-2023) UF — Page 2 of 3

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. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

Sample Customer	MM/DD/YYYY	xxx-xx-xxxx
***Full Name**	***Date of Birth (MM/DD/YYYY)**	***Full 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:** ** PHONE NUMBER OF PERSON OR ORGANIZATION:*
Staff person's name	Agency name
Staff person's email address	Agency street address
	City, WI xxxxx

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

I have requested help to contest my alleged overpayment.

This consent to disclose is valid for one year from the date of signature

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

   Due process notice(S) with details of TWP and IRWEs, OP period, payments made and recalculated values, earnings record, cause for overpayment, disability EOD.

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 § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** _____ ***Date:** MM/DD/YYYY

****Address:** Customer's address ****Daytime Phone:** xxx-xxx-xxxx

****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)

Example: Medicare Part A Conditional Enrollment

Here is an example of a request for information related to Medicare Part A conditional enrollment. It is important to ask only for the information needed to advocate for the customer's situation. Not all of the information included in this example will be needed for every enrollment, and some cases may need information not included in this example.

Form **SSA-3288** (02-2023) UF — Page 2 of 3

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. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

Sample Customer	MM/DD/YYYY	xxx-xx-xxxx
***Full Name**	***Date of Birth (MM/DD/YYYY)**	***Full 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:** ** PHONE NUMBER OF PERSON OR ORGANIZATION:**
Staff person's name	Agency name
Staff person's email address	Agency street address
	City, WI xxxxx

***I want this information released because:**

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

I have requested help with enrolling in Medicare Part A and applying for QMB.

This consent to disclose is valid for one year from the date of signature

***Please release the following information selected from the list below:**

Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☐ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

Current status of Medicare Part A enrollment application, Medicare Part A entitlement and/or eligibility date, a copy of the conditional enrollment letter for QMB application

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 § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:**	***Date:** MM/DD/YYYY
****Address:** Customer's address	****Daytime Phone:** xxx-xxx-xxxx
****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)