Human Resources Administration
Department of Social Services
Customized Assistance Services

Robert Doar
Administrator/Commissioner

Frank R. Lipton, M.D.
Executive Deputy Commissioner/Medical Director

WeCARE Procedure

Functional Capacity Outcome of Unable to Work

Clients determined by HRA's Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) program to be *Unable to Work* for twelve or more months due to a medical and/or mental health condition are potentially eligible for federal disability benefits and are required to apply for those benefits as a condition of continuing eligibility for Cash Assistance (CA). These clients are assigned to the Federal Disability Benefits pathway in which they receive assistance with filing initial applications or supplementing existing applications for federal disability benefits with the Social Security Administration (SSA).

Preparation for the Functional Capacity Outcome Service Initiation Appointment

Following the completion of the Biopsychosocial (BPS) evaluation, Clinical Review Team (CRT) assessment or the completion of a Wellness Plan, the WeCARE vendor schedules a Functional Capacity Outcome (FCO) Service Initiation appointment.

Prior to the FCO Service Initiation appointment the WeCARE vendor contacts SSA to ascertain whether the client has a current Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) application pending as well as to obtain the individual's work history. The vendor faxes to the local SSA field office two separate ***SSA Consent for Release of Information*** (***SSA-3288***) forms signed during the BPS assessment appointment. One consent is required to determine if there is a pending application on file and another consent is required to secure the work history[1]. The worker then contacts the SSA liaison directly to obtain the requested information.

Vendors must ensure that each client receives services promptly with minimal wait time. Calculated from his/her arrival time, including the initiation of services through completion of the SSI/SSDI application and creation of the Comprehensive Service Plan (CSP), the total time for the FCO Service Initiation appointment must not exceed three hours.

[1] Templates of these consents, completed to SSA's specifications, have been provided to the vendors and are available through CAS WeCARE Operations upon request.

Functional Capacity Outcome Service Initiation Appointment

During the FCO Service Initiation appointment the client meets with a Federal Disability Benefits case manager to discuss the results of the BPS, CRT or completed Wellness Plan including the diagnostic findings and the conditions which resulted in the client's FCO determination of *Unable to Work*. The vendor also informs the client that assignment to the Federal Disability Benefits pathway exempts the client from participating in work-related activities. The vendor explains the SSI/SSDI application process, advises the client that filing for federal disability benefits is required for continued CA eligibility, and informs him/her that s/he is responsible for attending SSA appointments and obtaining medical documentation from treating physicians. The vendor presents the ***Authorization for the Release of Health Information Pursuant to HIPAA*** (***OCA 960***), which can be accessed at the following web address: www.nycourts.gov/forms/hipaa_fillable.pdf, to the client for his/her signature to allow the vendor to assist in the collection of that medical documentation[2].

Prior to the FCO Service Initiation appointment the vendor faxed the signed *SSA Consent for Release of Information* (*SSA-3288*) forms to SSA for information regarding the client's current status and work history. If the signed consents were not found in the record at that time, the vendor addresses the need for the authorization with the client and asks him/her to sign the forms. The vendor faxes the signed consents to the SSA field office and contacts the SSA liaison directly. If the client does not sign the consents, the vendor proceeds with the application.

The vendor is required to review and assist the client in acquiring the travel accommodations which were identified as necessary during the BPS evaluation. When posting the FCO code in the New York City Work, Accountability and You (NYCWAY) system, the vendor is prompted to view the T*ravel Accommodations* screen. The need for travel-related accommodations may be reported by the client or determined as necessary at any time throughout the client's engagement in WeCARE activities. If a client requests a travel-related accommodation after the BPS or CRT process the client is required to provide medical documentation from his/her treating physician to support the need for the requested travel accommodation(s). A WeCARE physician then makes a determination based on review of the requested documentation. All relevant documentation must be scanned into the WeCARE Viewer. Once approved, the vendor assists the client in accessing these required accommodations and enters the appropriate NYCWAY codes for travel-related accommodations via the *Travel Accommodations* screen. In a case note in the vendor system, the vendor describes the clinical reasons that make the accommodation necessary along with the estimated duration for a time-limited travel-related accommodation. The vendor also updates the CSP with the new travel-related accommodation information and enters the ***WeCARE CSP Updated*** action code (***169U/969U***) in NYCWAY. For more details regarding travel-related accommodations, refer to the *Travel-Related Accommodations* procedure.

[2] This fillable form can be completed online and then printed for client signature.

The vendor enters the ***WeCARE Unable to Work*** action code (***968S/168S***) in NYCWAY and prints the ***Notification of Temporary Assistance Work Requirements (NOWR) Determination (exempt)*** (***LDSS-4005 NYC***) which must be reviewed with the client. Prior to reviewing the document, the vendor must manually complete the *NOWR* by:

- checking the appropriate box: **Part 1 (Medical)**
- entering the **client's name** in the available space
- entering **effective date**, which is the date of the FCO determination

The completed NOWR letter must be scanned into the WeCARE Viewer and given to the client. When the *NOWR* is printed, NYCWAY auto-posts the ***WeCARE NOWR Forms Printed*** action code (***16NP***).

Filing an Initial Application

The vendor works with a client assigned to the Federal Disability Benefits pathway to complete and submit an SSI/SSDI application with SSA. The application must be initiated during the FCO Service Initiation appointment and must be completed as soon as possible but no later than seven calendar days from the date of the FCO Service Initiation appointment. If a client previously submitted an application to SSA, the vendor assists the client in supplementing the existing application as detailed on page five.

To begin the application process, the vendor accesses the SSA website, www.ssa.gov, to complete and submit the ***Adult Disability Report, Authorization to Disclose Information to SSA*** and the ***Benefit Application*** together on the same day.[3] Copies of these completed forms **must be printed *prior*** to pressing the transmit button, which electronically submits the documents to SSA. The vendor is responsible for recording and updating federal disability benefits related information in the vendor system.

The application must identify the vendor and include the case manager's name and telephone number. The vendor agency name should be listed as the primary medical source and as the report completer. The type of organization should be listed as not-for-profit social service agency. Relevant treating sources also must be listed on the application.

A client may meet SSA's criteria for expedited application processing if his/her clinical condition is included in the *Compassionate Allowance List of Conditions* (*CAL*), which the vendor can access via the following hyperlinked[4] address: http://www.socialsecurity.gov/compassionateallowances. The vendor ensures that correct terminology is used when describing the client's condition.

[3] Submissions of these documents separately on different days may cause files to be lost and medical decisions to be delayed.
[4] To access the website, the user may click on the hyperlink or copy and paste the address into the URL.

In addition to the electronic *Adult Disability Report, Authorization to Disclose Information to SSA* and the *Benefit Application*, the SSI/SSDI application includes the following forms which must be mailed to the local SSA Field Office according to the client's zip code.

- ***Authorization to Disclose Information to SSA*** (***SSA 827***)
- ***Application for Supplemental Security Income*** (***SSA 8000-BK***)
- ***Function Report – Adult –Third Party*** (***SSA 3380-BK***)
- ***Appointment of Representative*** (***SSA 1696-U4***)

Note: All of these forms may be accessed electronically. All must be printed, completed, signed and scanned into the case record.

All supporting documentation, such as medical reports, lab results and proof of citizenship or residency, (for example: *Birth Certificate*, *Alien Registration Card* (*I-551*), *U.S. Passport* or *Certificate of Naturalization)* must be included in these packets. Available documents may be viewed by vendors in the *HRA Documents* section of the WeCARE Viewer.

The original ***Authorization to Disclose Information to SSA*** (***SSA 827***) and ***Appointment of Representative*** (***SSA 1696-U4***) forms signed by the client must be sent to SSA in this packet, as SSA requires "wet" signatures on these forms.

If a client refuses to sign the authorization the vendor must work to address the client's concerns regarding giving consent. The vendor explains that as a recipient of CA benefits, the client is responsible for pursuing income maximization, which makes filing for federal disability benefits a requirement. SSA rules allow SSA to review documents without consent and make a determination solely based on those documents. If SSA determines that there is adequate medical documentation to make a disability determination, the application will be processed. If additional medical documentation (such as a Consultative Examination (CE) or report from a community-based treating source) is needed to make a determination, SSA cannot pursue the claim without the client's consent which could lead to CA case rejection or closure. The vendor forwards an unsigned consent, annotated with a statement that the client refused to sign, to SSA.

Authorized Representative

The vendor explains that the client may choose to assign an authorized representative for assistance with SSA matters. The Authorized Representative (AR) obtains the same notifications as the client including notices of all SSA appointments and requests for information as well the SSA decision on the initial application. The client benefits from the WeCARE AR's assistance in complying with these appointments and following up on SSA decisions.

If the client agrees to have the vendor serve as his/her AR, the vendor submits the *Appointment of Representative* (*SSA 1696-U4*) form completed and signed by the

client. The AR should receive the ***Notice to Representative of Claimant before the Social Security Administration*** (***Form SSA-L1697-U3***) as verification of SSA's receipt of the authorization. If the client declines to have the vendor serve as his/her AR, the vendor indicates this refusal on the *Appointment of Representative* (*SSA 1696-U4*) form. These documents must be imaged into the WeCARE Viewer.

The initial federal disability (SSI/SSDI) application is considered complete when all required forms, listed in the following chart, have been submitted to SSA. The vendor indicates the application has been completed by entering the ***Disability Benefit Referral Completed*** action code (***969S/169S***) in NYCWAY within seven calendar days from the date of the FCO Service Initiation appointment. All application and supporting documents must be imaged into the WeCARE Viewer within seven calendar days of the posting of the above action code.

Document/Form Name	Form Number
Application for Disability Insurance Benefits / Benefit Application (electronic submission)	SSA-16-F6 (Form number assigned to paper version only)
Adult Disability and Work History Report /Adult Disability Report (electronic submission)	SSA-3368-BK (Form number assigned to paper version only)
Application for Supplemental Security Income	SSA-8000-BK
Authorization to Disclose Information to SSA	SSA-827
Function Report –Adult – Third Party	SSA-3380-BK
Appointment of Representative	SSA-1696-U4

Supplementing an Existing Application

Individuals may have applied for federal disability benefits prior to their involvement with WeCARE or prior to receiving CA. Through client disclosure and/or direct contact with SSA, the vendor may learn that a client with an FCO of *Unable to Work* has a **pending application** with SSA. The vendor is required to supplement that application with supporting documentation relevant to his/her WeCARE history including the latest BPS assessments (Phase 1 and/or Phase 2 evaluations), the Wellness Plan Treating Physician's Report, any clinical documentation submitted at the conclusion of the Wellness Plan, CRT outcome reports and any additional medical and/or mental health documentation provided by the client or treating physicians. Additionally, the vendor must complete the *Function Report –Adult – Third Party* (*SSA 3380-BK*) and submit it to SSA along with the other supporting documentation.

The vendor determines whether the client would like the vendor to represent him/her as an Authorized Representative, as described on the previous page.

The vendor is responsible for sending to SSA the case manager's name and contact information and a completed and signed *Authorization to Disclose Information to*

SSA (*SSA 827*). If a client refuses to sign the authorization the vendor must work to reduce the client's concerns about giving consent.

The process to supplement the pending federal disability benefits application is considered complete when the vendor delivers documents to SSA for a pending application within seven calendar days of the client's FCO Service Initiation appointment. Once these supplemental documents are submitted, the vendor enters the ***WeCARE Assisted Disability Benefit Application Completed*** action code (***969N/169N***).

Transmittal Document

All documents the vendor sends to SSA, including initial applications and/or additional documentation supplementing pending applications, should be listed on an accompanying transmittal sheet that contains the following information:

TO:	SSA Field Office, address and liaison
FROM:	WeCARE Agency name, address, site location and SSI unit liaison contact information
LISTING	Name of each client for whom there are forms/documentation along with: • Application filed date • Social Security Number • DOB (optional) • AR status (i.e., Y or N)

Transmittal cover sheets should list documents in the following order:

1. Initial applications
2. Supplemented applications
3. Additional documentation provided by the client and/or vendor to update a previously submitted SSI/SSDI application

Comprehensive Service Plan

Once the vendor has filed an initial SSI/SSDI application or supplemented a pending application, the vendor begins the CSP process. The CSP is a client-centered document maintained in the vendor system that delineates the specific steps necessary for the client to obtain his/her highest possible level of health, functioning and/or self-sufficiency. The CSP is ideally completed on the same day as the federal disability benefits application but must be completed or updated no later than seven calendar days after the FCO Service Initiation appointment date. The CSP:

- Describes the client's medical, mental health, vocational, social, familial and community barriers to employment identified through the BPS or CRT assessment

- Identifies and addresses the client's treatment and service needs to overcome these barriers and provides the appropriate referrals for treatment and other needed services
- Specifies the client's responsibility in applying for or supplementing the application for federal disability benefits and providing the vendor with updated clinical documentation from treatment providers
- Outlines the client's responsibility to respond to all correspondence from SSA and comply with SSA appointments and other requirements in an effort to secure federal disability benefits

After the vendor and client review and discuss the CSP, the client is asked to sign the agreement. If the client chooses not to sign the CSP, the vendor notes this on the document. The vendor enters a note into the vendor system and into NYCWAY as a ***Case Entry Note*** action code (***100A***) in NYCWAY. The note must indicate that the CSP was reviewed, discussed and signed or not signed. The CSP is scanned and indexed into the WeCARE Viewer, and a copy is given to the client regardless of whether s/he signed it.

The vendor indicates completion of the CSP by entering the ***WeCARE CSP Completed*** action code (***169C***) or the ***WeCARE CSP Updated*** action code (***169U***) in NYCWAY. The code must be posted within seven calendar days of the CSP completion date. The CSP must be updated as necessary. The completion of the CSP marks the completion of the FCO Service Initiation appointment for a client on the Federal Disability Benefits pathway.

Ongoing Federal Disability Benefit Case Management

WeCARE provides ongoing case management services to the client after the application is initially submitted or supplemented, to ensure compliance with treatment and at all levels of the application/appeal process. The vendor has an ongoing responsibility to link the client with treatment providers, monitor compliance with treatment, scheduled Consultative Exams, and/or other SSA appointments. The vendor also assists the client in obtaining medical documentation from hospitals and community-based treatment sources as well as submitting new and/or updated documentation to SSA. The vendor advises the client that non-compliance with the process of filing for federal disability benefits and with WeCARE appointments may result in the rejection or closing of his/her CA case, and/or denial of federal disability benefits. The client is instructed to respond to all SSA mail and attend all appointments even after receiving notification of an award outcome. The vendor also advises the client to inform WeCARE about all correspondence with SSA.

Outreach

If an individual fails to report (FTR) to or fails to comply (FTC) with a WeCARE federal disability benefits appointment, the vendor enters the ***Outreach FTR FCO Appointment*** action code (***173G***) or ***Outreach FTC FCO Appointment*** action code

(***173J***) respectively in NYCWAY and conducts escalating outreach activities to engage the client in services.

Escalating outreach services include phone calls, emails, and letters or when indicated, home visits. Vendors are required to monitor the ***WeCARE Outreach*** (***WCOUT***) worklist which they receive daily through NYCWAY and complete outreach services within eleven calendar days for each participant who appears on the list. The vendor is required to document the outreach efforts on the outreach form in the vendor system as well as in a NYCWAY ***Case Note*** action code (***100A***) that details the nature of non-compliance, the date(s) and type(s) of their outreach efforts (phone calls, email, letters and/or home visits) and the outreach results.

The vendor scans a copy of the outreach documents, such as letters sent to the client and any documentation presented by the client to support his/her reason for non-compliance, into the WeCARE Viewer.

When the client responds to the vendor's outreach efforts, the vendor posts the ***WeCARE Outreach Successful*** action code (***168G***) and re-schedules the appointment.

Collaboration with the Disability Services Program to Process Appeals on Denied Applications

A WeCARE client with an FCO of *Unable to Work* whose SSI/SSDI application is denied for a medical reason is required to file an appeal to maintain eligibility for CA. This client receives a call-in letter for a mandatory appointment with the Disability Services Program (DSP) to initiate the appeal process. A client has **sixty days** from the initial application denial date to file an appeal. DSP ensures that an appeal is filed within the timeframe and assists individuals to obtain and complete the required documentation for an appeal. Appeal requests submitted by DSP are reflected in NYCWAY by the ***Denial Medical Reason: ALJ Filed*** action code (***376A***). The ***ALJ Appeal Filed by Client/Other Than Social Security Income Case Control (SSICC)*** action code (***376S***) is displayed when an appeal is filed by the client, or someone other than DSP, filing on his/her behalf. A client who reports having filed his/her own appeal is required to bring verification of that filing to DSP.

Since DSP assumes responsibility for assisting the client with the appeal process, the DSP worker explains the AR role and the client's option to select DSP to function as the AR. If the client chooses DSP, s/he signs the *Appointment of Representative* form (*SSA-1696-U4)*. If the client declines the offer, s/he is provided with a list of legal services and DSP continues to assist the client with the appeal. Once the client designates DSP or an attorney as his/her AR, the ***Authorized Representative Form Signed and Sent to SSA*** action code (***320A***) is posted in NYCWAY. The WeCARE vendor is then responsible for submitting AR deauthorization notifications to both the client and SSA.

After filing the appeal, DSP schedules regular appointments with the client until the appeal hearing is scheduled, which may take as long as twenty-four months. Subsequent mandatory DSP Documentation Review Appointments are scheduled every six months by posting the ***Return Appointment Scheduled - SSICC Evaluation*** action code (***364B***) in NYCWAY. DSP meets with the client to update information on his/her medical status. DSP submits all new and updated information to SSA and enters the ***Pending Appeal Documentation Review*** action code (***364N***) in NYCWAY.

During the appeal process, the vendor monitors the client's compliance with DSP appointments and provides outreach services as needed. Vendors requiring assistance with DSP may contact the appropriate DSP WeCARE liaisons directly at the following numbers:

- Region I DSP WeCARE liaison at 212-835-7760
- Region II DSP WeCARE liaison at 212-835-7178
- DSP WeCARE backup liaison 212-835-7934

Special Circumstances

A client who filed an SSI/SSDI application that was denied *prior to participating in WeCARE* may apply for CA benefits and be referred to the WeCARE program. If the client's FCO is determined to be *Unable to Work*, s/he is assigned to the Federal Disability Benefits pathway. If the sixty-day timeframe for requesting an appeal of SSA's denial has not elapsed, the vendor schedules an expedited appointment for the client with DSP. DSP assists the client with filing an appeal. The expedited appointment is scheduled by posting the ***WeCARE Reschedule DSP Appointment*** action code (***168A***) in NYCWAY.

If the timeframe for filing an appeal has passed, the vendor schedules an expedited appointment for the client who may be able to establish good cause for the late appeal request, thus preserving the protective file date. In this situation, DSP assists the client in sending a letter to the SSA field office to explain the reason s/he missed the request deadline. This letter must accompany the Appeal Request. In determining whether the client has good cause for failure to file a timely appeal request, SSA considers whether:

1. The client's physical, mental, educational or linguistic limitations, including limited English proficiency (LEP), prevented him/her from filing a timely request or from understanding the need to file a timely request for appeal
2. Special circumstances impeded the client's efforts to pursue his/her claim

If good cause is not granted, the vendor is responsible for assisting the client in filing a new application for federal disability benefits.

If the client filed an appeal before participating in WeCARE, the vendor supplements the FDB application with the BPS and any other relevant documentation brought in by the client. The vendor then enters the ***WeCARE Assisted Disability Benefit***

Application Completed action code (***969N/169N***) followed by the ***WeCARE Reschedule DSP Appointment*** action code (***168A***) in NYCWAY. This appointment should be scheduled expeditiously to provide adequate time for DSP to assist the client who self-appealed to prepare for the ALJ hearing.

Outreach for Non-Compliance with a Scheduled DSP Appointment

When a client fails to report to or comply with his/her DSP appointment, NYCWAY autoposts the ***FTR/FTC Outreach-WC Client at DSP*** action code (***173Y***) two days after the missed appointment. The WeCARE vendor conducts escalating outreach activities to engage the client in DSP services. When the client responds to the vendor's outreach efforts, the vendor posts the ***WeCARE Outreach Successful*** action code (***168G***) and re-schedules the appointment ensuring that DSP appeal appointments fall within the sixty-day timeframe for filing the ALJ appeal hearing. The vendor is required to document the outreach efforts on the outreach form in the vendor system as well as in a NYCWAY ***Case Note*** action code (***100A***) that details the nature of non-compliance, the date(s) and type(s) of their outreach efforts (phone calls, email, letters and/or home visits) and the outreach results.

Two action codes are available when rescheduling a DSP appointment. Depending on the type of DSP appointment the client did not attend or comply with, NYCWAY displays the appropriate rescheduled appointment action code:

- ***WeCARE Reschedule DSP Appointment*** action code (***168A***) may be entered after successful outreach to the original DSP Appeal Assessment appointment
- ***Pending Appeal Documentation Review*** action code (***16DA***) may be posted after successful outreach to the DSP Documentation Review appointment (six month call-in appointment)

Posting the reschedule code generates the ***DSP Mandatory Assessment Interview*** letter (***W-331A***). The vendor scans the appointment letter into the WeCARE Viewer and provides a copy to the client, either in person or via mail. If the client does not report to this rescheduled appointment, NYCWAY indicates that outreach is required again. The client is provided with a total of three opportunities to attend the DSP appointment, two of which result from vendor outreach efforts.

Notice of Intent Conference

A client's failure to respond to outreach efforts within eleven calendar days from the initiation of outreach or failure to report to the third appointment results in an automatic posting of one of the following codes in NYCWAY initiating the Notice of Intent (NOI) Conference process.

Action Code Description	Action Code
WeCARE FTR/FTC Appeal of Disability Benefits Denial	491D
WeCARE FTR to Disability Benefits Appointment	468D
WeCARE FTC with Disability Assessment/Appeals Process	468E

WeCARE FTR to Disability Benefits Appointment (applicants)	469D
WeCARE FTC with Disability Assessment/Appeals Process (applicants)	469E

Failure to cooperate on the Federal Disability Benefits pathway is an instance of eligibility-related non-compliance. The NOI letter informs the client of a pending sanction (reduction or discontinuation of CA benefits) and the date the sanction would become effective (fourteen calendar days from the date of issue). To prevent the sanction the client must report to the Job Center before the effective date for an NOI Conference with Fair Hearing and Conference (FH&C) staff.

During the NOI Conference the client is required to submit evidence of good cause to address the reason for non-compliance. In accordance with state regulations, only when the client presents acceptable documentation and expresses a willingness to comply with agency requirements will the Family Independence Administration (FIA) grant good cause via the *Good Cause Granted* action code *(820H)* in NYCWAY.
Failure to respond to the NOI within fourteen calendar days or failure to establish good cause during the NOI Conference will result in a reduction or discontinuation of cash assistance benefits.

Re-Engagement

A client who returns to WeCARE following an NOI Conference, CA case closure or other event is reinstated in the Federal Disability Pathway with the system reposting of the ***WeCARE Assisted Disability Benefit Application Completed*** action code (***969N/169N***) or the ***Disability Benefit Referral Completed*** action code (***969S/169S***). The Job Center informs the client that s/he is reengaged in the WeCARE Federal Disability Benefits pathway with claim status pending and that no further action is required.

Following a Fair Hearing, a client whose FCO was determined **within the last twelve months**, is referred back to WeCARE when the Job Center posts the ***Referral to WeCARE Review Board – Fair Hearing Result*** action code (***16HR***) in NYCWAY. The Job Center provides the client with the *Referral to WeCARE for a Clinical Review* letter (*CAS-322*). During the CRT appointment the team discusses the Fair Hearing decision with the client. If the client brings documentation of the decision, the team reviews the documentation, explaining how the information factored into the FCO determination, whether CRT re-affirms the existing FCO, or determines a more appropriate FCO. The vendor must detail the CRT discussion in the client record and scan all documentation into the WeCARE Viewer. At the conclusion of the CRT assessment, the client is assigned to the appropriate WeCARE activity.

A client returning to WeCARE from Fair Hearing whose FCO was determined **more than twelve months ago** is referred for a new BPS assessment with the ***Initial Referral to WeCARE*** action code (***168W***). This client receives the ***Medical Provider Appointment*** letter (***W-538C***).

Attachments

CAS-310	Mandatory WeCARE Appointment
CAS-322	Referral to WeCARE for a Clinical Review
SSA 827	Authorization to Disclose Information to SSA
SSA 1696-U4	Appointment of Representative
SSA 3288	SSA Consent for Release of Information
SSA 3288 template	SSA Consent for Release of Information – mock up of request for application status
SSA 3288 template	SSA Consent for Release of Information – mock up of request for work history
SSA-3368-BK	Adult Disability and Work History Report /Adult Disability Report
SSA-3380-BK	Function Report–Adult–Third Party
SSA-8000-BK	Application for Supplemental Security Income
W-331A	DSP Mandatory Assessment Interview

CAS-310 (E) 05/01/2012

Human Resources Administration
Department of Social Services
Customized Assistance Services

Date:
Case Number:
Case Name:
Action Code:

Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE)
Mandatory Appointment

You must report to the WeCARE appointment indicated below:

Appointment Date:		**Time:**	**Telephone:**
Location Name:			
Address:			
City:		**State:**	**Zip Code:**
Travel Directions:			

Please bring this letter and a photo ID/Medicaid Card to the appointment

If you cannot keep this appointment or you require a reasonable accommodation to keep this appointment, please contact WeCARE at the number listed above prior to your appointment. You must contact us prior to your reporting time to arrange for a new appointment.

This is a mandatory appointment. Failure to keep this appointment or cooperate may result in the reduction or closing of your cash assistance case. Please note that failure to comply with this cash assistance resource requirement has no effect on your Medicaid eligibility.

You may have someone accompany you to this appointment if you require assistance. All WeCARE facilities are wheelchair accessible.

Human Resources Administration
Department of Social Services
Customized Assistance Services

Notice Date:
Case #:
Case Name:
Action Code:

Referral to
Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE)
for a Clinical Review

You must report to WeCARE for an appointment with a Clinical Review Team (CRT). The goal of the clinical review is to determine if your most recent Functional Capacity Outcome (FCO) is still appropriate.

Your appointment is at the WeCARE Vendor Site indicated below:

Appointment Date: **Time:** **Telephone:**
Location Name:
Address:
City: **State:** **Zip Code:**

Travel Directions:

Please bring copies of any medical documentation to the CRT appointment. In addition, if you recently had a Fair Hearing, please bring any documents submitted at the Fair Hearing and your Fair Hearing decision notice to this meeting.

If you cannot keep this appointment or you require a reasonable accommodation to keep this appointment, please contact WeCARE at the number listed on page 1 prior to your appointment. You must contact us prior to your reporting time to arrange for a new appointment.

This is a mandatory appointment. Failure to keep this appointment or cooperate may result in the reduction or closing of your cash assistance case. Please note that failure to comply with this cash assistance resource requirement has no effect on your Medicaid eligibility.

You may have someone accompany you to this appointment if you require assistance. All WeCARE facilities are wheelchair accessible.

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*	
SSN – –	Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange)**:**
OF WHAT *All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including* , and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP –

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

Phone Number (or Address)

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ▶

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any 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 10 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 Social Security at 1-800-772-1213 (TTY 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.***

COMPLETING THIS FORM TO APPOINT A REPRESENTATIVE

Choosing to be Represented

You can choose to have a representative help you when you do business with Social Security. We will work with your representative, just as we would with you. It is important that you select a qualified person because, once appointed, your representative may act for you in most Social Security matters. We give more information, and examples of what a representative may do, in the section titled "Information for Claimants."

Privacy Act Statement

Collection and Use of Personal Information
Sections 206(a) and 1631(d) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on this form to verify your appointment of an individual as your representative and his or her acceptance of the appointment.

Completion of this form is voluntary; however, if you want to use this form to appoint someone to act on your behalf in matters before the Social Security Administration (SSA), then you and that individual must complete the appropriate sections of this form.

We rarely use the information you supply for any purpose other than to verify your appointment of an individual as your representative and his or her acceptance of the appointment. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing right to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office or the Department of Veterans Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state, or local government agencies.

Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs. A complete list of routine uses for this information is available in our System of Records Notice entitled "Appointed Representative File" (60-0325). The notice, additional information regarding this form, routine uses of information, and our programs and systems are available on-line at www.socialsecurity.gov or at your local Social Security office.

With your permission, your representative may designate an associate or other party to request and receive information from your claim file on your representative's behalf.

For more information about this privacy statement and how information you provide to us may be used or disclosed to others please contact any Social Security office.

How to Complete this Form

Please print or type your answers on this form. At the top of the form, provide your full name and your Social Security number. If your claim is based on another person's work and earnings, also provide the "wage earner's" name and Social Security number. If you appoint more than one individual as your representative, you may want to complete a form for each of them.

Part I Appointment of Representative

Give the name and address of the individual(s) you are appointing. You may appoint an attorney or any other qualified individual to represent you. You also may appoint more than one individual, but please refer to the "Information for Claimants" section "What your Representative(s) May Charge" for more information about payment of fees. You can appoint one or more individuals in a firm, corporation, or other organization as your representative(s), but you may not appoint a law firm, legal aid group, corporation or organization itself.

Check the block(s) showing the program(s) under which you have a claim. You may check more than one block. Check:

- Title II (RSDI), if your claim concerns retirement, survivors, or disability insurance benefits.
- Title XVI (SSI), if your claim concerns Supplemental Security Income.
- Title XVIII (Medicare Coverage), if your claim concerns entitlement to Medicare or enrollment in the Supplementary Medical Insurance (SMI) plan.
- Title XVIII (SVB), if your claim concerns entitlement to Special Veterans Benefits.

When you give your permission your representative may designate an associate (e.g. a clerk), or other party or entity (e.g. a copying service) to receive information from your claim file on your representative's behalf for the duration of your claim. If you want to give your representative permission to do that, check the block to authorize this release.

If you will have more than one representative, check the appropriate block and give the name of the individual you want to be your main representative.

You must sign and date the form. Print or type your address, area code and telephone number.

If you are appointing a representative to replace a representative that you discharged or who withdrew his or her representation, you must notify us in writing that the prior appointment has ended.

Part II Acceptance of Appointment

Each individual you appoint in Part I should also complete Part II. If the individual is not an attorney, he or she must give his or her name, state that he or she accepts the appointment, and sign the form.

Part III Fee Arrangement

To help in processing benefits and fee payments timely you and your representative should complete this section. Your representative should check a box, sign and date the form. Your representative may choose to receive payment, waive direct payment, or waive payment of the fee altogether. If you and your representative change your arrangement before we decide your claim, you can provide a new or amended form so that we can update our records. If you appoint a second representative or co-counsel who also will not charge a fee, he or she should also complete this part or provide a new form, or if not using the form, give us a separate, written waiver statement. If your representative is not eligible for direct payment, or is an attorney or an eligible non-attorney who waives direct payment, you will be responsible for paying any fee we authorize.

Under certain circumstances, we do not have to authorize the fee. These circumstances include where a Court has awarded a fee based on your representative's actions as a legal guardian or court-appointed representative, or where a business (such as an insurance company), other organization or government agency will pay your representative's fee and you and your beneficiaries have no liability to pay any fees or expenses.

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 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 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.***

References

- 18 U.S.C. §§ 203, 205, and 207; and 42 U.S.C. §§ 406 (a), 1320a-6, and 1383(d)(2)
- 20 CFR §§ 404.1700 et. seq. and 416.1500 et. seq.
- Social Security Rulings 83-27 and 82-39
- 26 U.S.C. §§ 6041 and 6045(f)

INFORMATION FOR REPRESENTATIVES

Fees for Representation

An attorney or other individual who wants to charge or collect a fee for providing services in connection with a claim before the Social Security Administration (SSA) must generally obtain our prior authorization of the fee for representation. The only exceptions are if:

- certain requirements are met and a third-party entity, such as a business, an insurance carrier, a for profit, or nonprofit organization or a government agency will pay the fee and any expenses from its own funds and the claimant and auxiliary beneficiaries incur no liability, directly or indirectly, for the cost(s); or
- a Federal court awarded a fee based on the representative's activities as the claimant's legal guardian or court-appointed representative;
- a Federal court awarded a fee for representational services provided before the court. In those cases, neither the Federal court nor SSA can authorize a fee for the other.

Obtaining Authorization of a Fee

To charge a fee for services, you must use one of two mutually exclusive fee authorization processes. You must file either a fee petition or a fee agreement with us. In either case, you cannot charge more than the fee amount we authorize.

Fee Petition Process

You may file a fee petition after you complete your services to the claimant. This written request must describe in detail the amount of time you spent on each service provided and the amount of the fee you are requesting. In order to directly pay you under a fee petition, you must either file a fee petition or notify us within 60 days after we decide the claim of your intent to file a fee petition.

You must give the claimant a copy of the fee petition and each attachment. The claimant may disagree with the information shown by contacting a Social Security office within 20 days of receiving his or her copy of the fee petition. We will consider the reasonable value of the services provided, and send you notice of the amount of the fee you can charge.

Fee Agreement Process

If you and the claimant have a written fee agreement, one of you must give it to us before we decide the claim(s). We usually will approve the agreement if:

- you both signed it;
- the fee you agreed on is no more than 25 percent of past-due benefits, or $6,000 (or a higher amount we set and announce in the Federal Register), whichever is less;
- we approve the claim(s); and
- the claim results in past-due benefits.

We will send you a copy of the notice we send the claimant telling him or her the amount of the fee you can charge based on the agreement.

If we do not approve the fee agreement, we will tell you in writing. We also will tell you and the claimant that you must file a fee petition if you wish to charge and collect a fee.

After we tell you the amount of the fee you can charge, you or the claimant may ask us in writing to review the authorized fee. If we approved a fee agreement, the person who decided the claim(s) also may ask us to lower the amount. Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee

Collecting a Fee

You may accept money for your fee in advance, as long as you hold it in a trust or escrow account. The claimant never owes you more than the fee we authorize, except for:

- any fee a Federal court allows for your services before it; and
- out-of-pocket expenses you incur or expect to incur, for example, the cost of getting evidence. Our authorization is not needed for such expenses.

If you are not an attorney and you are ineligible to receive direct payment, you must collect the authorized fee from the claimant. If you are interested in becoming eligible to receive direct payment, you can find more information about this on our "Attorneys and Appointed Representatives" website: http://www.ssa.gov/representation/.

If you are an attorney or a non-attorney whom SSA has found eligible to receive direct payment and you register with SSA, as described below, we usually withhold 25 percent of any past-due benefits that result from a favorably decided retirement, survivors, disability insurance, or supplemental security income claim. Once we authorize a fee, we pay you all or part of the fee from the funds withheld. We will also charge you the assessment required by section 206(d) and 1631(d)(2)(C) of the Social Security Act. You cannot charge or collect this expense from the claimant. You will need to collect from the claimant:

- **the rest of the fee he or she owes,** if the amount of the authorized fee is more than the amount of money we withheld and paid you for the claimant, plus any amount you held for the claimant in a trust or escrow account.

- **all of the fee he or she owes,** if we did not withhold past-due benefits, (for example, because there are no past-due benefits; you waived direct payment or did not register for direct payment; the claimant discharged you or you withdrew from representing before we issued a favorable decision); or we withheld past-due benefits, but you did not ask us to authorize a fee or tell us that you planned to ask for a fee within 60 days after the date of the notice of award and we released the withheld amount to the claimant.

Registering for Direct Fee Payment

If you are eligible and want to receive direct payment, you must register with us before we effectuate a favorable decision on the claim. To register, you must submit a Form SSA-1699 (Registration of Individuals and Staff for Appointed Representative Services) once and a Form SSA-1695 (Identifying Information for Possible Direct Payment of Authorized Fees) with each appointment. We will use the information you provide on these forms to issue you a Form 1099-MISC if we pay you aggregate fees of $600 or more in a calendar year. The Internal Revenue Code requires that we do this. For information on the registration process, see our "Attorneys and Appointed Representatives" website http://www.ssa.gov/representation/.

Conflict of Interest and Penalties

If you commit improper acts, you can be suspended or disqualified from representing anyone before SSA. You also can face criminal prosecution. Improper acts include:

- If you are or were an officer or employee of the United States, providing services as a representative in certain
- claims against and other matters affecting the Federal government.
- Knowingly and willingly furnishing false information.
- Charging or collecting an unauthorized fee, or charging or collecting too much for services provided in any claim, including services before a court that made a favorable decision.

References

- 18 U.S.C. §§ 203, 205, and 207; and 42 U.S.C. §§ 406 (a), 1320a-6, and 1383(d)(2)
- 20 CFR §§ 404.1700 et. seq. and 416.1500 et. seq.
- Social Security Rulings 83-27 and 82-39
- 26 U.S.C. §§ 6041 and 6045(f)

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number - -
Wage Earner (If Different)	Social Security Number - -

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, _____
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is _____
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part II ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.

☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☐ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part III FEE ARRANGEMENT

☐ **Charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)* *(Select an option, sign and date this section.)*

☐ **Charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **Waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number - -
Wage Earner (If Different)	Social Security Number - -

Part I

APPOINTMENT OF REPRESENTATIVE

I appoint this person, _____
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is _____
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part II

ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.

☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency ☐ YES ☐ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part III

FEE ARRANGEMENT

(Select an option, sign and date this section.)

☐ **Charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Charging a fee but waiving direct payment** of the fee from withheld past-due benefits —I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** —By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **Waiving fees from any source** —I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

INFORMATION FOR CLAIMANTS

What Your Representative(s) May Do

We will work directly with your appointed representative unless he or she asks us to work directly with you. Your representative may:

- get information from your claim(s) file;
- with your permission, designate associates who perform administrative duties (e.g. clerks), partners and/or parties under contractual arrangements (e.g., copying services) to receive information from us on his or her behalf (by checking the appropriate block and signing this form, you are providing your permission for your representative to designate such associates, partners, and/or contractual parties);
- give us evidence or information to support your claim;
- come with you, or for you, to any interview, conference, or hearing you have with us;
- request a reconsideration, a hearing, or Appeals Council review; and
- help you and your witnesses prepare for a hearing and question any witnesses.

Also, your representative will receive a copy of the decision(s) we make on your claim(s). We will rely on your representative to tell you about the status of your claim(s), but you still may call or visit us for information.

You and your representative(s) are responsible for giving Social Security accurate information. It is wrong to knowingly and willingly furnish false information. Doing so may result in criminal prosecution.

We usually continue to work with your representative until (1) you notify us in writing that he or she no longer represents you; or (2) your representative tells us that he or she is withdrawing or indicates that his or her services have ended (for example, by filing a fee petition or not pursuing an appeal). We do not continue to work with someone who is suspended or disqualified from representing claimants. We will inform you if we suspend your representative.

What Your Representative(s) May Charge

Each representative you appoint can ask for a fee. To charge you a fee for services, your representative must get our authorization if you or another individual will pay the fee. However, as described in "Completing this form to appoint a representative, Part III Fee Arrangement" section of this form, under certain circumstances, we do not have to authorize the representative's fee. To request a fee, your representative must file a fee agreement or a fee petition. In either case, your representative cannot charge you more than the fee amount we authorize. If he or she does, promptly report this to your Social Security office.

Filing A Fee Petition

Your representative may file a fee petition when his or her work on your claim(s) is complete. This written request describes in detail the amount of time your representative spent on each service he or she provided you. The request also gives the amount of the fee the representative wants to charge for these services. Your representative must give you a copy of the fee petition and each attachment. If you disagree with the information shown in the fee petition, contact your Social Security office. Please do this within 20 days of receiving your copy of the petition.

We will review the petition and consider the reasonable value of the services provided. Then we will tell you in writing the amount of the fee we authorize.

Filing A Fee Agreement

If you and your representative have a written fee agreement, one of you must give it to us before we decide your claim(s). We usually will approve the agreement if:

- you both signed it;
- the fee you agreed on is no more than 25 percent of past-due benefits, or $6,000 (or a higher amount we set and announced in the Federal Register), whichever is less;
- we approve your claim(s); and
- your claim results in past-due benefits.

We will tell you in writing the amount of the fee your representative can charge based on the agreement.

If we do not approve the fee agreement, we will tell you and your representative in writing. If your representative wishes to charge and collect a fee, he or she must file a fee petition.

After we tell you the amount of the fee your representative can charge, you or your representative can ask us to look at it again if either or both of you disagree with the amount. If we approved a fee agreement, the person who decided your claim(s) also may ask us to lower the amount. Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee

How Much You Pay

You never owe more than the fee we authorize, except for:

- any fee a Federal court allows for your representative's services before it; and
- out-of-pocket expenses your representative incurs or expects to incur, for example, the cost of getting your doctor's or hospital's records. Our authorization is not needed for such expenses.

Your representative may accept money in advance as long as he or she holds it in a trust or escrow account. We usually withhold 25 percent of your past-due benefits to pay toward the fee for you if:

- your retirement, survivors, disability insurance, and/or supplemental security income claim(s) results in past-due benefits;
- your representative is an attorney or a non-attorney whom we have determined to be eligible to receive direct payment of fees; and
- your representative registers with us for direct payment before we effectuate a favorable decision on your claim.

You must pay your representative directly:

- **the rest of the fee you owe,** if the amount of the authorized fee is more than the money we withheld and paid to your representative for you plus any amount your representative held for you in a trust or escrow account.
- **all of the fee you owe,** if we did not withhold past-due benefits, (for example, because there are no past-due benefits; your representative waived direct payment, did not register for direct payment, you discharged the representative, or he or she withdrew from representing you, before we issued a favorable decision); or we withheld an amount from your past-due benefits, but your representative did not ask us to authorize a fee or tell us that he or she planned to ask for a fee within 60 days after the date of your notice of award and we released the withheld amount to you

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number - -
Wage Earner (If Different)	Social Security Number - -

Part I

APPOINTMENT OF REPRESENTATIVE

I appoint this person, _____
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is _____
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part II

ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.

☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☐ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part III

FEE ARRANGEMENT

(Select an option, sign and date this section.)

☐ **Charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Charging a fee but waiving direct payment** of the fee from withheld past-due benefits —I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** —By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **Waiving fees from any source** —I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number - -
Wage Earner (If Different)	Social Security Number - -

Part I

APPOINTMENT OF REPRESENTATIVE

I appoint this person, _____
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is _____
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part II

ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.

☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☐ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part III

FEE ARRANGEMENT

(Select an option, sign and date this section.)

☐ **Charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Charging a fee but waiving direct payment** of the fee from withheld past-due benefits —I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** —By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **Waiving fees from any source** —I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

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, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any 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 "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- 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 information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, 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. The information you provide will be used to respond to your request for SSA records information or process your request when we 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, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided 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. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at 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 (TTY 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

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name _____ *Date of Birth _____ *Social Security Number _____

I authorize the Social Security Administration to release information or records about me to:

*NAME _____ *ADDRESS _____

_____ _____

_____ _____

*I want this information released because: _____
There may be a charge for releasing information.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) _____

I am the individual to whom the requested information/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 in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on 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 seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

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, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any 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 "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- 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 information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, 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. The information you provide will be used to respond to your request for SSA records information or process your request when we 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, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided 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. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at 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 (TTY 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

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name _____ *Date of Birth _____ *Social Security Number _____

I authorize the Social Security Administration to release information or records about me to:

*NAME
FEGS/FEDCAP individual worker

*ADDRESS
Contact information including address, phone number and fax number

*I want this information released because:
There may be a charge for releasing information.
I am pursuing entitlement to Social Security disability programs

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☒ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) The status of my most current SSI applications or appeals if any and the date and status of my most current T2 applications and appeals if any.

I am the individual to whom the requested information/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 in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on 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 seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

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, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any 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 "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- 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 information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, 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. The information you provide will be used to respond to your request for SSA records information or process your request when we 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, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided 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. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at 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 (TTY 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

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name | *Date of Birth | *Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME | *ADDRESS

FEGS/FEDCAP individual worker | Contact information including address, phone number and fax number

*I want this information released because:
There may be a charge for releasing information.

It is needed to complete an application for federal disability benefits

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☒ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) Work history to include the names and addresses of former employers for the last 15 years (1998 to 2013)

I am the individual to whom the requested information/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 in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on 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 seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

FUNCTION REPORT - ADULT - THIRD PARTY Form SSA-3380-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to make a decision on the disabled person's claim. You can help by completing as much of the form as you can. When a question refers to the "disabled person," it refers to the person who is applying for or receiving disability benefits.

It is important that you tell us what you know about the disabled person's activities and abilities.

DO NOT ASK THE DISABLED PERSON TO GIVE YOU ANSWERS

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If you need more space to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM ON PAGE 8

Privacy Act and Paperwork Reduction Act Statements

Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. We generally use the information you supply for the purpose of making decisions regarding claims. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs. We may also use the information you provide in computer matching programs. Matching programs compare our records with those kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or any 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 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not have that address, you may call Social Security at 1-800-772-1213 (TTY 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.***

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Form Approved OMB
No . 0960 - 0635

FUNCTION REPORT- ADULT - THIRD PARTY

How the disabled person's illnesses, injuries, or conditions limit his/her activities

SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle, Last)*

2. **YOUR NAME** *(Person completing the form)*	3. **RELATIONSHIP** *(To disabled person)*	4 . **DATE** *(Month, Day, Year)*

5. **YOUR DAYTIME TELEPHONE NUMBER** *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

( ) - ☐ Your Number ☐ Message Number ☐ None

Area Code *Phone Number*

6. a. How long have you known the disabled person? _____

b. How much time do you spend with the disabled person and what do you do together?

_____

7. a. Where does the disabled person live? *(Check one.)*

☐ House ☐ Apartment ☐ Boarding House ☐ Nursing Home

☐ Shelter ☐ Group Home ☐ Other *(What?)* _____

b. With whom does he/she live? *(Check one.)*

☐ Alone ☐ With Family ☐ With Friends

☐ Other *(Describe relationship.)* _____

SECTION B - INFORMATION ABOUT ILLNESSES, INJURIES, OR CONDITIONS

8. How do this person's illnesses, injuries, or conditions limit his/her ability to work?

_____

_____

_____

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

9. Describe what the disabled person does from the time he/she wakes up until going to bed.

10. Does this person take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? ☐ Yes ☐ No

If "YES," for whom does he/she care, and what does he/she do for them?

11. Does he/she take care of pets or other animals? ☐ Yes ☐ No

If "YES," what does he/she do for them?

12. Does anyone help this person care for other people or animals? ☐ Yes ☐ No

If "YES," who helps, and what do they do to help?

13. What was the disabled person able to do before his/her illnesses, injuries, or conditions that he/she can't do now?

14. Do the illnesses, injuries, or conditions affect his/her sleep? ☐ Yes ☐ No

If "YES," how?

15 . **PERSONAL CARE** (Check here ☐ if **NO PROBLEM** with personal care.)

a. Explain how the illnesses, injuries, or conditions affect this person's ability to:

Dress

Bathe

Care for hair

Shave

Feed self

Use the toilet

Other

b. Does he/she need any special reminders to take care of personal needs and grooming? ☐ Yes ☐ No

If "YES," what type of help or reminders are needed? _____

_____

c. Does he/she need help or reminders taking medicine? ☐ Yes ☐ No

If "YES," what kind of help does he/she need? _____

_____

16. **MEALS**

a. Does the disabled person prepare his/her own meals? ☐ Yes ☐ No

If "Yes," what kind of food is prepared? (For example, sandwiches, frozen dinners, or complete meals w ith several courses.) _____

_____

How often does he/she prepare food or meals? (For example, daily, weekly, monthly.)

_____

How long does it take him/her? _____

Any changes in cooking habits since the illness, injuries, or conditions began?

_____

b. If "No," explain why he/she cannot or does not prepare meals. _____

_____

17. **HOUSE AND YARD WORK**

a . List household chores , both indoors and outdoors , that the disabled person is able to do . *(For example, cleaning, laundry, household repairs, ironing, mowing, etc.)*

_____

b. How much time do chores take, and how often does he/she do each of these things?

_____

c. Does he/she need help or encouragement doing these things? ☐ Yes ☐ No

If "YES," what help is needed? _____

d. If the disabled person doesn't do house or yard work, explain why not. _____

_____

18. **GETTING AROUND**

a. How often does this person go outside? _____

If he/she doesn't go out at all, explain why not. _____

_____

b. When going out, how does he/she travel? *(Check all that apply.)*

☐ Walk ☐ Drive a car ☐ Ride in a car ☐ Ride a bicycle

☐ Use public transportation ☐ Other *(Explain)* _____

c. When going out, can he/she go out alone? ☐ Yes ☐ No

If "NO," explain why he/she can't go out alone. _____

_____

d. Does the disabled person drive? ☐ Yes ☐ No

If he/she doesn't drive, explain why not. _____

_____

19. **SHOPPING**

a. If the disabled person does any shopping, does he/she shop: *(Check all that apply.)*

☐ In stores ☐ By phone ☐ By mail ☐ By computer

b. Describe what he/she shops for. _____

_____

c. How often does he/she shop and how long does it take? _____

_____

20. **MONEY**

a. Is he/she able to:

Pay bills	☐ Yes	☐ No	Handle a savings account	☐ Yes	☐ No
Count change	☐ Yes	☐ No	Use a checkbook/money orders	☐ Yes	☐ No

Explain all "NO" answers. _____

_____

b. Has the disabled person's ability to handle money changed since the illnesses, injuries, or conditions began? ☐ Yes ☐ No

If "YES," explain how the ability to handle money has changed. _____

_____

21. **HOBBIES AND INTERESTS**

a. What are his/her hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.) _____

_____

b. How often and how well does he/she do these things? _____

_____

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

_____

_____

22. **SOCIAL ACTIVITIES**

a. Does the disabled person spend time with others? *(In person, on the phone, on the computer, etc.)* ☐ Yes ☐ No

If "YES," describe the kinds of things he/she does with others. _____

_____

How often does he/she do these things? _____

b. List the places he/she goes on a regular basis. (For example, church, community center, sports events, social groups, etc.) _____

_____

Does he/she need to be reminded to go places? ☐ Yes ☐ No

How often does he/she go and how much does he/she take part? _____

_____

Does he/she need someone to accompany him/her? ☐ Yes ☐ No

c. Does this person have any problems getting along with family, friends, neighbors, or others? ☐ Yes ☐ No

If "YES," explain. _____

_____

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

_____

_____

SECTION D - INFORMATION ABOUT ABILITIES

23. a. Check any of the following items the disabled person's illnesses, injuries, or conditions affect:

☐ Lifting	☐ Walking	☐ Stair Climbing	☐ Understanding
☐ Squatting	☐ Sitting	☐ Seeing	☐ Following Instructions
☐ Bending	☐ Kneeling	☐ Memory	☐ Using Hands
☐ Standing	☐ Talking	☐ Completing Tasks	☐ Getting Along With Others
☐ Reaching	☐ Hearing	☐ Concentration	

Please explain how his/her illnesses, injuries, or conditions affect each of the items you checked. (For example, he/she can only lift [how many pounds], or he/she can only walk [how far])

_____

_____

_____

b. Is the disabled person: ☐ Right Handed? ☐ Left Handed?

c. How far can he/she walk before needing to stop and rest? _____

If he/she has to rest, how long before he/she can resume walking? _____

_____

d. For how long can the disabled person pay attention? _____

e. Does the disabled person finish what he/she starts? (For example, a conversation, chores, reading, watching a movie.) ☐ Yes ☐ No

f. How well does the disabled person follow written instructions? (For example, a recipe.)

_____

g. How well does the disabled person follow spoken instructions? _____

_____

h. How well does the disabled person get along with authority figures? (For example, police, bosses, landlords or teachers.)

i. Has he/she ever been fired or laid off from a job because of problems getting along with other people? ☐ Yes ☐ No

If "YES," please explain.

If "YES," please give name of employer.

j . How well does the disabled person handle stress?

k. How well does he/she handle changes in routine?

l. Have you noticed any unusual behavior or fears in the disabled person? ☐ Yes ☐ No

If "YES," please explain.

24. Does the disabled person use any of the following? *(Check all that apply.)*

☐ Crutches	☐ Cane	☐ Hearing Aid
☐ Walker	☐ Brace/Splint	☐ Glasses/Contact Lenses
☐ Wheelchair	☐ Artificial Limb	☐ Artificial Voice Box

☐ Other *(Explain)*

Which of these were prescribed by a doctor?

When was it prescribed?

When does this person need to use these aids?

25. Does the disabled person currently take any medicines for his/her illnesses, injuries, or conditions? ☐ Yes ☐ No

If " YES," do any of the medicines cause side effects? ☐ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that the disabled person takes. List only the medicines that cause side effects for the disabled person.)

NAME OF MEDICINE	SIDE EFFECTS PERSON HAS

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

Name of person completing this form (Please print) | Date *(month, day, year)*

Address (Number and Street) | Email address (optional)

City | State | Zip Code

SOCIAL SECURITY ADMINISTRATION ☐ TEL

Form Approved
OMB No. 0960-0229

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)

Note: Social Security Administration staff or others who help people apply for SSI will fill out this form for you.

Do Not Write in This Space
DATE STAMP

I am/We are applying for Supplemental Security Income and any federally administered state supplementation under Title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under Title XIX of the Social Security Act.

Filing Date (month, day, year)

☐ **Receipt** ☐ **Protective**

☐ **FS-SSA/APP** ☐ **FS-REFERRED**

Preferred Language
Written: **Spoken:**

TYPE OF CLAIM ☐ Individual ☐ Individual with Ineligible Spouse ☐ Couple ☐ Child ☐ Child with Parents

PART I--BASIC ELIGIBILITY-- Answer the questions below beginning with the first moment of the filing date month.

1. (a) First Name, Middle Initial, Last Name | Sex ☐ Male ☐ Female | Birthdate (month, day, year) | Social Security Number

(b) Did you ever use any other names (including maiden name) or any other Social Security Numbers? ☐ YES Go to (c) ☐ NO Go to (d)

(c) Other Name(s) | Other Social Security Number(s) used

(d) If you are also filing for Social Security Benefits, go to #2; otherwise complete the following:

Mother's Maiden Name: Father's Name: Go to #2

2. Applicant's Mailing Address (Number & Street, Apt. No. P.O. Box, Rural Route)

City and State | ZIP Code | County

3. Claimant's Residence Address (If different from applicant's mailing address)

City and State | ZIP Code | County

4. **DIRECT DEPOSIT PAYMENT ADDRESS (FINANCIAL INSTITUTION)**

Routing Transit Number | Account Number | ☐ Checking ☐ Savings | ☐ Enroll in Direct Express ☐ Direct Deposit Refused

5. (a) Are you married? ☐ YES Go to (b) ☐ NO Go to #6

(b) Date of marriage: (month, day, year)

(c) Spouse's Name (First, middle initial, last)	Birthdate (month, day, year)	Social Security Number

(d) Did your spouse ever use any other names (including maiden name) or Social Security Numbers? ☐ YES Go to (e) ☐ NO Go to (f)

(e) Other Name(s)	Other Social Security Number(s) Used

(f) Are you and your spouse living together? ☐ YES Go to #6 ☐ NO Go to (g)

(g) Date you began living apart : (month, day, year)

(h) Address of spouse or name of someone who knows where spouse is. (Complete only if spouse is age 65, blind or disabled.)

6. (a) Have you had any other marriages?
If never married, check this box ☐

	You	**Your Spouse, if filing**
	☐ YES Go to (b) ☐ NO Go to #7	☐ YES Go to (b) ☐ NO Go to #7

(b) Give the following information about your former spouse. If there was more than one former marriage, show the remaining information in Remarks and go to #4.

	YOU	**YOUR SPOUSE**
FORMER SPOUSE'S NAME (including maiden name)		
BIRTHDATE (month, day, year)		
SOCIAL SECURITY NUMBER		
DATE OF MARRIAGE (month, day, year)		
DATE MARRIAGE ENDED (month, day, year)		
HOW MARRIAGE ENDED		

7. If you are filing for yourself, go to (a); if you are filing for a child, go to (e).

	You	**Your Spouse**
(a) Are you unable to work because of illnesses, injuries or conditions?	☐ YES Go to (b) ☐ NO Go to #8	☐ YES Go to (b) ☐ NO Go to #7
(b) Enter the date you became unable to work.	(month, day, year)	(month, day, year)

(c) What are your illnesses, injuries or conditions?

You	**Your Spouse**
Go to (d)	Go to (d)

7. (d) If you were unable to work because of illnesses, injuries, or conditions before you were age 22, do you have a parent who is age 62 or older, unable to work because of illnesses, injuries or conditions, or deceased?

☐ YES Parent's Name: _____

Social Security Number: _____

Address: _____

_____

☐ NO Go to #8

(e) When did the child become disabled? (month, day, year)

Go to (f)

(f) What are the child's disabling illnesses, injuries or conditions?

Go to (g)

(g) Does the child have a parent(s) who is age 62 or older, unable to work because of illness, injuries, or conditions, or deceased?

☐ YES Parent's Name: _____

Social Security Number: _____

Address: _____

_____

☐ NO Go to #8

8.

Birthplace	City	State	Country (if other than the U.S.)
You			
Your Spouse, if filing			

Go to #9

		You		Your Spouse, if filing	
9.	Are you a United States citizen by birth?	☐ YES Go to #15	☐ NO Go to #10	☐ YES Go to #15	☐ NO Go to #10
10.	Are you a naturalized United States citizen?	☐ YES Go to #15	☐ NO Go to #11	☐ YES Go to #15	☐ NO Go to #11
11.	(a) Are you an American Indian born outside the United States?	☐ YES Go to (b)	☐ NO Go to (c)	☐ YES Go to (b)	☐ NO Go to (c)

(b) Check the block that shows your American Indian status.

You	Your Spouse, if filing
☐ American Indian born in Canada Go to #15	☐ American Indian born in Canada Go to #15
☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #15	☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #15
☐ Other American Indian Explain in Remarks, then Go to (c)	☐ Other American Indian Explain in Remarks, then Go to (c)

11. (c) Check the block below that shows your current immigration status

You	Your Spouse, if filing
☐ Amerasian Immigrant — Go to #12	☐ Amerasian Immigrant — Go to #12
☐ Lawful Permanent Resident — Go to #12	☐ Lawful Permanent Resident — Go to #12
☐ Refugee Date of entry: — Go to #14	☐ Refugee Date of entry: — Go to #14
☐ Asylee Date status granted: — Go to #14	☐ Asylee Date status granted: — Go to #14
☐ Conditional Entrant Date status granted: — Go to #14	☐ Conditional Entrant Date status granted: — Go to #14
☐ Parolee for One Year — Go to #14	☐ Parolee for One Year — Go to #14
☐ Cuban/Haitian Entrant — Go to #14	☐ Cuban/Haitian Entrant — Go to #14
☐ Deportation/Removal Withheld Date: — Go to #14	☐ Deportation/Removal Withheld Date: — Go to #14
☐ Other Explain in Remarks, then Go to (d)	☐ Other Explain in Remarks, then Go to (d)

(d) If you have status, or have applied for status as the spouse, child, or parent of a child of a US citizen, or lawfully admitted permanent resident alien, Go to #13; otherwise Go to #15.

12. If you are lawfully admitted for permanent residence:

	You (month, day, year)	**Your Spouse** (month, day, year)
(a) Date of Admission		
(b) Was your entry into the United States sponsored by any person or promoted by an institution or group?	☐ YES Go to (c) ☐ NO Go to (d)	☐ YES Go to (c) ☐ NO Go to (d)

(c) Give the following information about the person, institution, or group, then Go to (d):

Name	Address	Telephone Number
		( ) -

(d) What was your immigration status, if any, before adjustment to lawful permanent resident?	**You**	**Your Spouse, if filing**
	Status:	Status:
	(month, day, year) From:	(month, day, year) From:
	To:	To: Go to (e)
(e) If filing as an adult, did your parents ever work in the United States before you were age 18?	☐ YES Go to (f) ☐ NO Go to #14	☐ YES Go to (f) ☐ NO Go to #14

(f) Name and Social Security Number of parent(s) who worked.

Name	Social Security Number
Name	Social Security Number

		You	Your Spouse, if filing
13.	(a) Have you, your child or your parent, been subjected to battery or extreme cruelty while in the United States?	☐ YES Go to (b) ☐ NO Go to #15	☐ YES Go to (b) ☐ NO Go to #15
	(b) Have you, your child, or your parent filed a petition with the Department of Homeland Security for a change in immigration status because of being subjected to battery or extreme cruelty?	☐ YES Go to #14 ☐ NO Go to #15	☐ YES Go to #14 ☐ NO Go to #15
14.	Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	☐ YES Explain in #60(b), then Go to #15 ☐ NO Go to #15	☐ YES Explain in #60(b), then Go to #15 ☐ NO Go to #15
15.	(a) When did you first make your home in the United States?	(month, day, year)	(month, day, year)
	(b) Have you lived outside of the United States since then?	☐ YES Go to (c) ☐ NO Go to #16	☐ YES Go to (c) ☐ NO Go to #16
	(c) Give the dates of residence outside the United States.	(month, day, year) From: To:	(month, day, year) From: To:
16.	(a) Have you been outside the United States (the 50 states, District of Columbia and Northern Mariana Islands) 30 consecutive days prior to the filing date?	☐ YES Go to (b) ☐ NO Go to #17	☐ YES Go to (b) ☐ NO Go to #17
	(b) Give the date (month, day, year) you left the United States and the date you returned to the United States.	Date Left: Date Returned:	Date Left: Date Returned:
	IF YOU ARE FILING ON BEHALF OF YOUR CHILD, GO TO #17. IF YOU ARE MARRIED AND YOUR SPOUSE IS NOT FILING FOR SUPPLEMENTAL SECURITY INCOME AND YOU LIVED TOGETHER AT ANY TIME SINCE THE FIRST MOMENT OF THE FILING DATE MONTH, GO TO #17; OTHERWISE GO TO #18.		
17.	(a) Is your spouse/parent the sponsor of an alien who is eligible for supplemental security income?	☐ YES Go to (b) ☐ No Go to #18	
	(b) Eligible Alien's Name	Eligible Alien's Social Security Number Go to #18	
18.	(a) Do you have any unsatisfied felony warrants for your arrest?	☐ YES Go to (b) ☐ NO Go to #19	☐ YES Go to (b) ☐ NO Go to #19
	(b) In which state or country was this warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
	(c) Was the warrant satisfied?	☐ YES Go to (d) ☐ NO Go to #19	☐ YES Go to (d) ☐ NO Go to #19
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)
19.	(a) Do you have any unsatisfied Federal or State warrants for violating the conditions of probation or parole?	☐ YES Go to (b) ☐ NO Go to #20	☐ YES Go to (b) ☐ NO Go to #20

19.			
	(b) In which state or country was the warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
	(c) Was the warrant satisfied?	☐ YES ☐ NO Go to (d) Go to #20	☐ YES ☐ NO Go to (d) Go to #20
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)

PART II - LIVING ARRANGEMENTS - The questions in this section refer to the signature date.

20. Check the block which best describes your present living situation:

☐ Household	Since (month, day, year) Go to #25
☐ Non-Institutional Care	Since (month, day, year) Go to #23
☐ Institution	Since (month, day, year) Go to #21
☐ Transient or homeless	Since (month, day, year) Go to #38

INSTITUTION

21. Check the block that identifies the type of institution where you currently reside, then Go to #22:

☐ School	☐ Rehabilitation Center
☐ Hospital	☐ Jail
☐ Rest or Retirement Home	☐ Other (Specify)
☐ Nursing Home	

22. Give the following information about the INSTITUTION:

(a) Name of institution:

(b) Date of admission:

(c) Date you expect to be released from this institution:

Go to #38

NON-INSTITUTIONAL CARE

23. Check the block that best describes your current residence, then Go to #24:

☐ Foster Home ☐ Group Home ☐ Other (Specify)

24. Give the following information about your Noninstitutional Care:

(a) Name of facility where you live:

24.	(b) Name of placing agency	Address	Telephone Number
			( ) -

(c) Does this agency pay for your room and board?

☐ YES Go to #38 ☐ NO If NO, who pays?

Go to #38

HOUSEHOLD ARRANGEMENTS

25. Check the block that describes your current residence, then Go to #26:

☐ House	☐ Mobile Home
☐ Apartment	☐ Houseboat
☐ Room (private home)	☐ Other (Specify)
☐ Room (commercial establishment)	

26. Do you live alone or only with your spouse? ☐ YES Go to #28 ☐ NO Go to #27

27. (a) Give the following information about everyone who lives with you:

Name	Relationship	Public Assistance		Sex		Birthdate mm/dd/yy	Blind or Disabled		If Under 22				Social Security Number
									Married		Student		
		YES	NO	M	F		YES	NO	YES	NO	YES	NO	

If anyone listed is under age 22 and not married, Go to (b); otherwise, Go to #28.

27. (b) Does anyone listed in 27(a) who is under age 18, OR between ages 18-22 and a student, receive income? ☐ YES Go to (c) ☐ NO Go to #28

(c) Child Receiving Income	Source and Type	Monthly Amount
		$
		$
		$
		$
		$
		$

28. (a) Do you (or does anyone who lives with you) own or rent the place where you live? ☐ YES Go to #29 ☐ No Go to (b)

(b) Name of person who owns or rents the place where you live	Address	Telephone Number
		( ) -

(c) If you live alone or only with your spouse, and do not own or rent, Go to #38; otherwise, Go to #32.

29. (a) Are you (or your living with spouse) buying or do you own the place where you live? ☐ YES Go to (c) ☐ No If you are a child living with your parent(s) Go to (b); otherwise Go to #30

(b) Are your parent(s) buying or do they own the place where you live? ☐ YES Go to (c) ☐ NO Go to #30

(c) What is the amount and frequency of the mortgage payment?

Amount: $ Frequency of Payment:

Go to (d)

(d) If you are a child living only with your parents, or only with your parents and their other children who are subject to deeming, or with others in a public assistance household, or living alone or with your spouse, Go to #38; otherwise Go to #32.

30. (a) Do you (or your living with spouse) have rental liability for the place where you live? ☐ YES Go to (d) ☐ NO If you are a child living with your parent(s) Go to (b); otherwise Go to (c)

(b) Does your parent(s) have rental liability? ☐ YES Go to (d) ☐ NO Go to (c)

30. (c) Does anyone who lives with you have rental liability for the place where you live?

☐ YES Give name of person with rental liability: _____ Go to #31

☐ NO Give name of person with home ownership: _____ Go to #32

(d) What is the amount and frequency of the rent payment?

Amount: $ Frequency of Payment:

Go to #31

31. (a) Are you (or anyone who lives with you) the parent or child of the landlord or the landlord's spouse? ☐ YES Go to (b) ☐ NO Go to (c)

(b) Name of person related to landlord or landlord's spouse	Relationship	Name and address of landlord (include telephone number and area code, if known):

(c) If you are a child living only with your parents, or only with your parents and their other children who are subject to deeming, or with others in a public assistance household, or living alone or with your spouse, Go to #38.

32. (a) Does anyone living with you contribute to the household expenses? (NOTE: See list of household expenses in #37) ☐ YES Go to (b) ☐ NO Go to #33

(b) Amount others contribute: $

Go to #33

33. (a) Do you eat all your meals out? ☐ YES Go to #34 ☐ NO Go to (b)

(b) Do you buy all your food separately from other household members: ☐ YES Go to #34 ☐ NO Go to #34

34. Do you contribute to household expenses?

☐ YES Average Monthly Amount: $ _____ Go to #35

☐ NO Go to #35

35. (a) Do you have a loan agreement with anyone to repay the value of your share of the household expenses? ☐ YES Go to (b) ☐ NO Go to #35(d)

(b) Give the name, address and telephone number of the person with whom you have a loan agreement :

(c) Will the amount of this loan cover your share of the household expenses? ☐ YES Go to #38 ☐ NO Go to (d)

(d) **If you contribute** toward household expenses and you answered "NO" to both 33(a) & (b), Go To #36. If you answered "YES" to either 33(a) or 33(b), Go to #37.

If you do not contribute toward household expenses, go to #38.

36. (a) Is part or all of the amount in #34 just for food?

☐ YES Give Amount: $ _____ Go to (b) ☐ NO Go to (b)

(b) Is part or all of the amount in #34 just for shelter?

☐ YES Give Amount: $ _____ Go to #37 ☐ NO Go to #37

37. What is the average monthly amount of the following household expenses:
(Show average over the past 12 months unless you have been residing at your present address less than 12 months. If so, show average for the months you have resided at your present address.)

CASH EXPENSES	AVERAGE MONTHLY AMOUNT
Food (complete only if #33(a) & (b) are answered NO)	$
Mortgage or Rent	$
Property Insurance (if required by mortgage lender)	$
Real Property Taxes	$
Electricity	$
Heating Fuel	$
Gas	$
Sewer	$
Garbage Removal	$
Water	$
TOTAL	$ Go to #38

38. (a) Does anyone who does NOT LIVE with you pay for, or provide you or your household (if applicable), any of your food or shelter items?

☐ YES Name of Provider (Person or Agency) _____

List of Items _____

Monthly Value: $ _____

☐ NO Go to (b)

(b) Does anyone who does NOT LIVE with you give you, or your household (if applicable), money to pay for any of your or your household's food or shelter items?

☐ YES Name of Provider (Person or Agency) _____

List of Items _____

Monthly Value: $ _____

☐ NO Go to #39

39. (a) Has the information given in #20-38 been the same since the first moment of the filing date month?	☐ YES Go to (b)	☐ NO Explain in Remarks, then Go to (b)
(b) Do you expect any of this information to change?	☐ YES Explain in Remarks, then Go to #40	☐ NO Go to #40

PART III - RESOURCES - The questions in this section pertain to the first moment of the filing date month.

		You		Your Spouse	
40.	(a) Do you own, or does your name appear (alone or with any other person's name) on the title of any vehicles (auto, truck, motorcycle, camper, boat, etc.)?	☐ YES Go to (b)	☐ NO Go to #41	☐ YES Go to (b)	☐ NO Go to #41

40.

(b) Owner's Name	Description (Year, Make & Model)	Used For	Current Market Value	Amount Owed
			$	$
			$	$
			$	$
			$	$

41. (a) Do you own or are you buying any life insurance policies?

You		Your Spouse	
☐ YES	☐ NO	☐ YES	☐ NO
Go to (b)	Go to #42	Go to (b)	Go to #42

(b) Owner's Name		Name of Insured	Name & Address of Insurance Company	Policy Number
Policy (#1)				
Policy (#2)				
Policy (#3)				

	Face Value	Cash Surrender Value	Date of Purchase	Dividends		Accumulations	
				YES	NO	YES	NO
Policy (#1)	$	$					
Policy (#2)	$	$					
Policy (#3)	$	$					

(c) Loans Against Policy? ☐ YES ☐ NO

Policy Number: _____

Amount: $_____ Go to #42

42.

(a) Do you (either alone or jointly with any other person) own any:	You		Your Spouse	
	YES	NO	YES	NO
Life estates or ownership interest in an unprobated estate?				
Items acquired or held for their value as an investment?	☐	☐	☐	☐

42. (b) Give the following information for any "Yes" answer in #42(a); otherwise, Go to #43.

Owner's Name	Name of Item	Value	Amount Owed	Give Name & Address of Bank or Other Organization
		$	$	
		$	$	
		$	$	
		$	$	

43. (a) Do you own, or does your name appear on (either alone or with any other person's name) any of the following items?

	You		**Your Spouse**	
	YES	NO	YES	NO
Cash at home, with you, or anywhere else				
Financial Institution Accounts				
Checking				
Savings				
Credit Union				
Christmas Club				
Time Deposits/Certificates of Deposit				
Individual Indian Money Account				
Other (Including IRAs and Keough Accounts)				

(b) If all the items in #43(a) are answered "NO", Go to #44. For any "YES" answer, give the following information:

Owner's/Trustee's Name	Name of Item	Value	Name & Address of Bank or Other Organization	Identifying Number
		$		
		$		
		$		

44.	(a) Do you give us permission to obtain any financial records from any financial institution?	You		Your Spouse, if filing	
		☐ YES Go to (b)	☐ NO Go to (b)	☐ YES Go to (b)	☐ NO Go to (b)

(b) Do you own or does your name appear on any of the following items:	You		Your Spouse	
	YES	NO	YES	NO
Stocks or Mutual Funds				
Bonds (Including U.S. Savings Bonds)				
Promissory Notes				
Trusts				
Other items that can be turned into cash				

(c) If all the items in #44(b) are answered "NO", Go to #45. For any "YES" answer, give the following information:

Owner's/Trustee's Name	Name of Item	Value	Name & Address of Bank or Other Organization	Identifying Number
		$		
		$		
		$		
		$		

45.	(a) Do you own, or does your name appear (alone or with any other person's name) on any land, houses, buildings, real property, property in foreign country, equipment, mineral rights, items in a safe deposit box, assets set aside for emergencies or heirs, or any other property of any kind that has not been shown anywhere else on the application	You		Your Spouse	
		☐ YES Go to (b)	☐ NO Go to #46	☐ YES Go to (b)	☐ NO Go to #46

(b) Describe the property (including size, location, and how it is used. If the property is not used now, when was it last used? Do you plan to use the property in the future?

Item #1

Item #2

45.

Owner's Name	Estimated Current Market Value	Tax Assessed Value	Mortgage	Owed on Item
	$	$	$	$
	$	$	$	$
	$	$	$	$

46. (a) Have you or your spouse acquired any assets since the first moment of the filing date month? ☐ YES Go to (b) ☐ NO Go to (c)

(b) Explain:

(c) Has there been any increase or decrease in the value of you or your spouse's resources since the first moment of the filing date month? ☐ YES Go to (d) ☐ NO Go to #47

(d) Explain:

47. (a) Have you or your spouse sold, transferred title, disposed of or given away, any money or other property, (including money or property in foreign countries), since the first moment of the filing date month or within the 36 months prior to the filing date month?

	You	**Your Spouse**
	☐ YES ☐ NO Go to (b)	☐ YES ☐ NO Go to (b)

(b) If you co-owned any money or property with another person(s), did you or any co-owner sell, transfer, or give away any co-owned money or property within the 36 months prior to the filing date month?

	☐ YES ☐ NO	☐ YES ☐ NO

IF YOU ANSWERED "YES" TO (a) OR (b), GO TO (c). IF "NO" TO BOTH, GO TO #48.

(c)	OWNER'S/CO-OWNERS NAME	DESCRIPTION OF PROPERTY	DATE OF DISPOSAL
ITEM #1			
ITEM #2			
ITEM #3			

	NAME AND ADDRESS OR PURCHASER OR RECIPIENT	RELATIONSHIP TO OWNER	VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT
ITEM #1			$

47.

ITEM #2			$
ITEM #3			$

	SALES PRICE OR OTHER CONSIDERATION	ARE OTHER CONSIDERATION OR PROCEEDS EXPECTED? EXPLAIN.	DO YOU STILL OWN PART OF THE PROPERTY?
ITEM #1			
ITEM #2			
ITEM #3			

	SOLD ON OPEN MARKET?	GIVEN AWAY?	TRADED FOR GOODS/SERVICES?
ITEM #1	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ITEM #2	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ITEM #3	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

48. (a) Do you have any assets set aside for burial expenses such as burial contracts, trusts, agreements, or anything else you intend for your burial expenses? Include any items mentioned in #41 and #43-47.

You	Your Spouse
☐ YES ☐ NO	☐ YES ☐ NO
Go to (b) Go to #49	Go to (b) Go to #49

(b) DESCRIPTION (Where appropriate, give name & address of organization and account/ policy number.)	VALUE	WHEN SET ASIDE (month, day, year)	OWNER'S NAME
Item 1	$		
Item 2	$		

FOR WHOSE BURIAL	IS ITEM IRREVOCABLE?	WILL INTEREST EARNED OR APPRECIATION IN VALUE REMAIN IN THE BURIAL FUND?
Item 1	☐ YES ☐ NO	☐ YES Go to #49 ☐ NO Explain in (c)
Item 1	☐ YES ☐ NO	☐ YES Go to #49 ☐ NO Explain in (c)

(c) EXPLANATION

49. (a) Do you own any cemetery lots, crypts, caskets, vaults, urns, mausoleums, or other repositories for burial or any headstones or markers?	You ☐ YES Go to (b) ☐ NO Go to #50	Your Spouse ☐ YES Go to (b) ☐ NO Go to #50

(b) Owner's Name	Description	For Whose Burial	Relationship to You or Your Spouse	Current Market Value
				$
				$
				$ Go to #50

PART IV -- INCOME

50. (a) Since the first moment of the filing date month, have you (or your spouse) received or do you (or your spouse) expect to receive income in the next 14 months from any of the following sources?	You		Your Spouse	
	YES	NO	YES	NO
State or Local Assistance Based on Need				
Refugee Cash Assistance				
Temporary Assistance for Needy Families				
General Assistance from the Bureau of Indian Affairs				
Disaster Relief				
Veteran Benefits Based on Need (Paid Directly or Indirectly as a Dependent)				
Veteran Payments Not Based on Need (Paid Directly or Indirectly as a Dependent)				
Other Income Based on Need				
Social Security				
Black Lung				
Railroad Retirement Board Benefits				
Office of Personnel Management (Civil Service)				
Pension (Foreign Military, State, Local, Private, Union, Retirement or Disability)				
Military Special Pay or Allowance				
Unemployment Compensation				

50.

Workers' Compensation				
State Disability				
Insurance or Annuity Payments				
Dividends/Royalties				
Rental/Lease Income Not from a Trade or Business				
Alimony				
Child Support				
Other Bureau of Indian Affairs Income				
Gambling/Lottery Winnings				
Other Income or Support				

(b) Give the following information for any block checked YES in #50(a); otherwise, Go to #51

Person Receiving Income	Type of Income	Amount Received	Frequency of Payment	Date Expected or Received	Source (Name, Address of Person, Bank, Organization, or Company)	Identifying Number
		$				
		$				
		$				

IF YOU EVER RECEIVED SSI BEFORE, GO TO #51; OTHERWISE GO TO #52

		You		Your Spouse	
51.	Are any overpayments being collected from benefits you receive from the Social Security Administration, Railroad Retirement Board, Office of Personnel Management, Veterans' Affairs, Military Pensions, Military Special Pay Allowances, Black Lung, Workers' Compensation, or State Disability or Unemployment Benefits?	☐ YES Explain in Remarks, then Go to #52	☐ NO Go to #52	☐ YES Explain in Remarks, then Go to #52	☐ NO Go to #52
52.	Since the first moment of the filing date month, have you received or do you expect to receive any meals or other gifts which are not cash?	☐ YES Explain in Remarks, then Go to #53	☐ NO Go to #53	☐ YES Explain in Remarks, then Go to #53	☐ NO Go to #53
53.	(a) Have you (or your spouse) received wages or sick pay since the first moment of the filing date month through the current month?	☐ YES Go to (b)	☐ NO Go to (e)	☐ YES Go to (b)	☐ NO Go to (e)

(b) Name and Address of Employer (include telephone number and area code, if known)

You	Your Spouse
Go to (c)	Go to (c)

53. (c)

	Date last worked (month, day, year)	Date last paid (month, day, year)	Date next paid (month, day, year)
You			
Your Spouse			

(d) Total monthly wages received (before any deductions)	Your Amount $	Your Spouse's Amount $
(e) Do you (or your spouse) expect to receive any wages in the next 14 months?	**You** ☐ YES Go to (f) ☐ NO Go to #54	**Your Spouse** ☐ YES Go to (f) ☐ NO Go to #54

(f) Name and address of employer if different from #53(b) (include telephone number, if known)

You	Your Spouse

(g) Give the following information:

	RATE OF PAY	AMOUNT WORKED PER PAY PERIOD	HOW OFTEN PAID	PAY DAY OR DATE PAID	DATE LAST PAID (month, day, year)
You	$				
Your Spouse	$				

(h) Do you expect any change in wage information provided in #53(g)	**You** ☐ YES Go to (i) ☐ NO Go to #54	**Your Spouse** ☐ YES Go to (i) ☐ NO Go to #54

(i) Explain Change:

You	**Your Spouse**

54. (a) Have you been self-employed at any time since the beginning of the taxable year in which the filing date month occurs or do you expect to be self-employed in the current taxable year?

You ☐ YES Go to (b) ☐ NO Go to #55

Your Spouse ☐ YES Go to (b) ☐ NO Go to #55

(b) Give the following information; then Go to #55

Date(s) Self-Employed	Type of Business	**Last Year's:** Gross Income $	**Last Year's:** Net Profit $	**Last Year's:** Net Loss $
Date(s) Self-Employed	Type of Business	**This Year's:** Gross Income $	**This Year's:** Net Profit $	**This Year's:** Net Loss $

55.	If you or your spouse are blind or disabled, do you have any special expenses that you paid which are necessary for you to work?	**You** ☐ YES Explain in Remarks; then Go to #56 ☐ NO Go to #56	**Your Spouse** ☐ YES Explain in Remarks; then Go to #56 ☐ NO Go to #56
56.	(a) Does your spouse/parent who lives with you have to pay court-ordered support?	☐ YES Go to (b)	☐ NO Go to NOTE
	(b) Give amount and frequency of court-ordered support payment.	Amount: $	Frequency: Go to (c)
	(c) Give the following information about the person who receives these payments:	Name:	Address:

NOTE: IF YOU ARE FILING AS A CHILD AND YOU ARE EMPLOYED OR AGE 18 - 22 (WHETHER EMPLOYED OR NOT), GO TO #57; OTHERWISE, GO TO #58.

57.	(a) Have you attended school regularly since the filing date month?	☐ YES Go to (d)	☐ NO Go to (b)	
	(b) Have you been out of school for more than 4 calendar months?	☐ YES Go to (c)	☐ NO Go to (c)	
	(c) Do you plan to attend school regularly during the next 4 months?	☐ YES Explain absence in Remarks and Go to (d)	☐ NO Go to #58	
	(d) Name of School	Name of School Contact Phone Number	Dates of Attendance From / To Hours Attending or Planning to Attend	Course of Study

PART V - POTENTIAL ELIGIBILITY FOR FOOD STAMPS/MEDICAL ASSISTANCE/OTHER BENEFITS - If a California resident, Skip to #59

58.	(a) Are you currently receiving food stamps?	**You** ☐ YES Go to (b)	☐ NO Go to (c)	**Your Spouse, if filing** ☐ YES Go to (b)	☐ NO Go to (c)
	(b) Have you received a recertification notice within the past 30 days?	☐ YES Go to (e)	☐ NO Go to #59	☐ YES Go to (e)	☐ NO Go to #59
	(c) Have you filed for food stamps in the last 60 days?	☐ YES Go to (d)	☐ NO Go to (e)	☐ YES Go to (d)	☐ NO Go to (e)
	(d) Have you received an unfavorable decision?	☐ YES Go to (e)	☐ NO Go to #59	☐ YES Go to (e)	☐ NO Go to #59
	(e) If everyone in the household receives or is applying for SSI, Go to (f); otherwise Go to #59.				
	(f) May I take your food stamp application today?	☐ YES Go to #59	☐ NO Explain in (g)	☐ YES Go to #59	☐ NO Explain in (g)
	(g) Explanation:				

59. You may be eligible for Medicaid. However, you must help your State identify other sources that pay for medical care. Also, you must give information to help the State get medical support for any child(ren) who is your legal responsibility. This includes information to help the State determine who a child's father is. If you want Medicaid, you must agree to allow your State to seek payments from sources, such as insurance companies, that are available to pay for your medical care. This includes payments for medical care for you or any person who receives Medicaid and is your legal responsibility. The State cannot provide you Medicaid if you do not agree to this Medicaid requirement. If you need further information, you may contact your Medicaid Agency.

IN STATES WITH AUTOMATIC ASSIGNMENT OF RIGHTS LAWS, Go to (b).

	You		Your Spouse, if filing	
(a) Do you agree to assign your rights (or the rights of anyone for whom you can legally assign rights) to payments for medical support and other medical care to the State Medicaid agency?	☐ YES Go to (b)	☐ NO Go to #60	☐ YES Go to (b)	☐ NO Go to #60
(b) Do you, your spouse, parent or stepparent have any private, group, or governmental health insurance that pays the cost of your medical care? (Do not include Medicare or Medicaid.)	☐ YES Go to (c)	☐ NO Go to (c)	☐ YES Go to (c)	☐ NO Go to (c)
(c) Do you have any unpaid medical expenses for the 3 months prior to the filing date month?	☐ YES Go to #60	☐ NO Go to #60	☐ YES Go to #60	☐ NO Go to #60

60. (a) Have you ever worked under the U.S. Social Security System? ☐ YES Go to (b) ☐ NO Go to (b)

(b) Have you, your spouse, or a former spouse (or parent if you are filing as a child) ever:

	You		Your Spouse/Parent		Filed for Benefits	
	Yes	No	Yes	No	Yes	No
Worked for a railroad						
Been in military service						
Worked for the Federal Government						
Worked for a State or Local Government						
Worked for an employer with a pension plan						
Belonged to union with a pension plan						
Worked under a Social Security system or pension plan of a country other than the United States?						

(c) Explain and include dates for any "Yes" answer given in #14 or #60(a); otherwise Go to #61.

You:	Your Spouse, if filing/Your Parent, if filing as a child:

PART VI -- MISCELLANEOUS -- (Answer #61 ONLY IF YOU ARE APPLYING ON BEHALF OF SOMEONE ELSE: OTHERWISE GO TO #62.

61.	(a) Name of Person/Agency Requesting Benefits.	Relationship to Claimant	Your Social Security Number (or EIN)

(b) If SSA determines that the claimant needs help managing benefits, do you wish to be selected representative payee?	☐ YES	☐ NO (Explain in Remarks)

PART VII -- REMARKS--(You may use this space for any explanations. Enter the item number before each explanation. If you need more space, use a signed form SSA-795.)

PART VIII -- IMPORTANT INFORMATION AND SIGNATURES

62. **IMPORTANT INFORMATION--PLEASE READ CAREFULLY**

- ▶ Failure to report any change within 10 days after the end of the month in which the change occurs could result in a penalty deduction.
- ▶ The Social Security Administration will check your statements and compare its records with records from other State and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount.
- ▶ We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you or your spouse notify us in writing that you are canceling your permission, (2) your application for SSI is denied in a final decision, (3) your eligibility for SSI terminates, or (4) we no longer consider your spouse's income and resources to be available to you. If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

63. **I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

Your Signature (First name, middle initial, last name) (Sign in ink.)	Date (month, day, year)
SIGN HERE ▶	Telephone Number(s) where we can contact you during the day: ( ) -

Spouse's Signature **(Sign only if applying for payments.)** (First name, middle initial, last name) (Sign in ink.)

SIGN HERE ▶

64. If you are blind or visually impaired, check the type of mail you want to receive from us.

☐ Standard notice First Class ☐ Standard notice First-Class with a follow-up phone call ☐ Standard notice & data CD by First-Class
☐ Standard notice Certified ☐ Standard & Braille notices by First-Class ☐ Standard & large print notices ☐ Standard notice & audio CD

65. WITNESS

Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing who know you, must sign below giving their full address.

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)

RECEIPT FOR YOUR CLAIM FOR SUPPLEMENTAL SECURITY INCOME

Name	Social Security Number	Date
Name	Social Security Number	Date

If you have a question or something to report call:	Social Security Office you may visit or mail your request to:
( ) -	

For general information about Social Security, visit our website at www.socialsecurity.gov on the Internet.

We will process your application for Supplemental Security Income as quickly as possible. If you have trouble getting any information or records we have asked for, please contact us and we will help you.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed. If you do not get a check or notice of determination within that time, please get in touch with us.

Privacy Act Statement/ Paperwork Reduction Act Statement
Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. We will use this information to help us determine your entitlement to benefits. Furnishing us this information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim, which may result in the loss of payments. We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Medicare benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State and local level; and,
4. To facilitate statistical research and audit activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete use of routine uses for this information is available in System of Records Notices 60-0089, Claims Folder System and 60-0050, Completed Determination-Continuing Disability Determinations. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or any 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 40 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 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.**

REPORTING RESPONSIBILITIES

The amount of a Supplemental Security Income (SSI) check is based on the information told to us. You must tell Social Security every time there is a change-while we process your application AND if you start receiving SSI.

Remember, a change may make the SSI monthly payment bigger or smaller. Report changes in income of your ineligible husband/wife or child who lives with you or your sponsor or sponsor's spouse, if you are an alien. You must also report changes in the things of value that these people own. You must also report changes in income, school attendance and marital status of ineligible children who live with you.

You must tell us about any change within 10 days after the month it happens. If you do not report changes, we may have to take as much as $25, $50, or $100 out of future checks.

HOW TO REPORT

You may make your reports:

- **By telephone at the telephone number shown above or call us toll free at 1-800-772-1213 (TTY 1-800-325-0778) or**
- **In person or**
- **By mail at the address shown above.**

CHANGES TO REPORT

☐ **WHERE YOU LIVE --You must report to Social Security if:**

- You move.
- You (or your spouse) leave your household for a calendar month or longer. (For example, you enter a hospital or visit a relative.)
- You are admitted to (for a calendar month or longer), or released from, a hospital or nursing home, jail, prison, or other correctional facility or other institution.
- You leave the United States for 30 consecutive days.
- You are no longer a legal resident of the United States

☐ **HOW YOU LIVE -You must report to Social Security:**

- If anyone moves into or out of your household.
- If the amount of money you pay toward household expenses changes.
- Births and deaths of any people with whom you live.
- Your spouse or former spouse dies.
- Your marital status changes:
  --You get married, separated, divorced, or your marriage is annulled.
  --You begin living with someone as husband and wife.

☐ **INCOME-You must report to Social Security if you, your spouse/your parent(s):**

- Start to receive money (or checks or any other type of payment) from someone or someplace.
- Have a change in the amount of money you receive.
- Begin to receive child support payments or those payments go up or down.
- Win money from gambling or a lottery.
- Start work or stop work.
- Earn more or less money. (**Keep all paystubs** and provide them to SSA when requested.)
- Become eligible for benefits other than SSI.

☐ **HELP YOU GET FROM OTHERS -You must report to Social Security if:**

- The amount of help (money or food, or payment of household expenses) you receive goes up or down.
- Someone stops helping you.
- Someone starts helping you.

☐ **THINGS OF VALUE THAT YOU OWN -You must report to Social Security if:**

- The value of things that you own goes over $2000 when you add them all together ($3000 if you are married and live with your spouse).
- You sell or give any thing of value away.
- You buy or are given anything of value.

☐ **YOU ARE BLIND OR DISABLED-You must report to Social Security if:**

- Your condition improves or your doctor says you can return to work.
- You go to work.

☐ **IF YOU ARE THE PARENT, STEP PARENT, OR REPRESENTATIVE PAYEE FOR A CHILD UNDER 18 - A report to Social Security must be made if:**

- There is a change in any income the child, his or her parent(s), step parent, or brother(s) or sister(s) receive.
- There is a change in the student status of the child's brother(s) or sister(s).
- There is a change in his or her parents' or step parents' marriage, a change in the value of anything they own, or a change in their residence.

☐ **YOU ARE UNMARRIED AND UNDER AGE 22 - A report to Social Security must be made if:**

- You start or stop school
- You get married or divorced
- You start or stop working

☐ **YOUR IMMIGRATION STATUS CHANGES-**

- You must report any changes to Social Security.

☐ **YOU ARE SELECTED AS A REPRESENTATIVE PAYEE -You must report to Social Security if:**

- The person for whom you receive SSI checks has any changes listed above. (You may be held liable if you do not report changes that could affect the SSI recipient's payment amount, and he/she is overpaid.)
- You will no longer be able or no longer wish to act as that person's representative payee.

☐ **IF A WARRANT HAS BEEN ISSUED FOR YOUR ARREST -You must report to Social Security if:**

- Your warrant is for a crime or an attempted crime that is a felony (or, in jurisdictions that do not define crimes as felonies, a crime that is punishable by death or imprisonment for a term exceeding 1 year); or
- Your warrant is for a violation of probation or parole under Federal or State law.

Human Resources Administration
Department of Social Services
Customized Assistance Services

Notice Date:
Case #:
Case Name:
Action Code:

Disability Services Program Mandatory Assessment Interview

Your application for Supplemental Security Income (SSI) / Social Security Disability Insurance (SSDI) was denied by the Social Security Administration (SSA). In order to remain eligible for Cash Assistance (CA), you are required to appeal that denial. You are being referred to the Disability Services Program for assistance in filing the appeal. If you have filed a request for an appeal already, please bring documentation with you to this appointment.

Your appointment is at the WeCARE Vendor Site indicated below:

Appointment Date: **Time:** **Telephone:**
Location Name:
Address:
City: **State:** **Zip Code:**

Travel Directions:

<u>Please bring this letter and the following documents to the appointment (if available)</u>:

- **copies of current medical information / documentation**
- **A list of current medical prescriptions**
- **A copy of the filed SSI application**
- **All correspondence (letters) and receipts from the Social Security Administration**
- **Proof of citizenship / alien status**

If you cannot keep this appointment or you require a reasonable accommodation to keep this appointment, please contact DSP at the number listed above **prior** to your appointment. You must contact us prior to your reporting time to arrange for a new appointment.

This is a mandatory appointment. Failure to keep this appointment or cooperate may result in the reduction or closing of your cash assistance case. Please note that failure to comply with this cash assistance resource requirement has no effect on your Medicaid eligibility.

You may have someone accompany you to this appointment if you require assistance. All facilities are wheelchair accessible.