FORM APPROVED
OMB No. 0960-0456

STATEMENT OF HOUSEHOLD EXPENSES AND CONTRIBUTIONS

CLAIMANT'S / RECIPIENT'S NAME	SOCIAL SECURITY NUMBER

NAME OF SPOUSE OR PARENT(S) OF INDIVIDUAL NAMED ABOVE

NAME OF PERSON MAKING THIS STATEMENT

The questions on this form are divided into four sections. Answer the questions where we have checked the block. Then sign the form and return to Social Security.

☐ PART I - HOUSEHOLD EXPENSES

Show the average monthly amount of money your household has spent on the expenses listed for the period ____________ through ____________.

But for expenses that are usually the same from month to month (like rent), show the amount your household paid as of ____________.

Write "0" under amount if your household has not spent any money for one of the expenses.

ITEM	MONTHLY AMOUNT SPENT
1. Food (Do not include food bought with food stamps.)	$
2. Rent or Mortgage Payment	$
3. Property Insurance (if not included in mortgage payment and if required by mortgage holder)	$
4. Real property taxes (if not included in mortgage payment). Subtract any rebate or credit.	$
5. Electricity	$
6. Gas	$
7. Heating fuel (wood, coal, oil, kerosene, etc.)	$
8. Water	$
9. Sewerage	$
10. Garbage Removal	$

☐ PART II-CONTRIBUTIONS TO HOUSEHOLD EXPENSES

In the spaces below, show the amount of money the person(s) names gave for the household expenses listed in Part I. Provide your answer for the blocks we have checked.

NAME	☐ AVERAGE MONTHLY AMOUNT GIVEN from ________ through ________	☐ AMOUNT GIVEN In ________
	$	$
	$	$
	$	$

☐ PART III - OTHER ARRANGEMENTS

1. ☐ Do(es) ______________________ eat every meal during the month some where else?	☐ YES ☐ NO
2. ☐ Do(es) ______________________ buy all his/her/their own food with his/her/their own money?	☐ YES ☐ NO
3. ☐ Do(es) ______________________ pay a certain amount just for household *food?*	☐ YES * ☐ NO
*If "Yes" how much each month?	AMOUNT
NAME	$
NAME	$
NAME	$
4. ☐ Do(es) ______________________ pay a certain amount for the household shelter expenses (The expenses other than food)?	☐ YES * ☐ NO
*If "Yes" how much each month?	AMOUNT
NAME	$
NAME	$
NAME	$

PART IV-REMARKS-Use this space for any additional explanations.

Total Household Expenses: $ __________

I know that anyone who makes or causes to be made a false statement or representation of material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal or State law or both, I affirm that all information I have given in this document is true.

SIGNATURE

Your Signature (First name, middle initial, last name) SIGN HERE ▶	Date (Month, Day, Year)	Day Time Telephone No. *(Include Area Code)*

WITNESSES

If you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (Number,and Street)	ADDRESS (Number and Street)
CITY,STATE, AND ZIP CODE	CITY,STATE, AND ZIP CODE

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 15 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.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001.* ***Send only comments relating to our time estimate to this address, not the completed form.***

PRIVACY ACT NOTICE

Section 1631(e)(1) of the Social Security Act authorizes us to collect the information requested on this form to decide if the individual(s) named can receive Supplemental Security Income (SSI) payments from us and, if so, how much. The individual or the individual's representative has given permission to us to obtain this information. You do not have to give us this informaiton but if you do not, it may adversely affect the individual's eligibility for or amount of SSI.

The information collected on this form may be disclosed without your consent (1) to comply with a Federal law requiring the release of information from our records, or (2) to an agency needing this information to decide if the individual(s) named is (are) eligible for a health or income-maintenance program such as SSI State supplementary payments, food stamps, Medicaid, energy assistance, or unemployment insurance. Information about other disclosures of this information is published in the Federal Register and is available in local Social Security offices.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

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