

# CHILD-CARE DROPOUT QUESTIONNAIRE

**See Paperwork/Privacy Act Notice  
on Reverse**

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER

NAME OF PERSON MAKING STATEMENT *(If other than above wage earner or self-employed person)*

RELATIONSHIP TO WAGE EARNER OR SELF-EMPLOYED PERSON

1.

Was a child, either your own or your spouse's, living with you while the child was under age 3 in any year after 1950? →

YES

NO

If "Yes," give the following information:

Name of Each Child	Child's Date of Birth	Relationship to You or Your Spouse	Years the Child Was Under 3 and Lived With You	No. of Days in Each Year the Child Lived With You

2.

Did you work in any of the years listed in item 1? →

YES

NO

If "Yes," indicate each year in which you worked:


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

### SIGNATURE OF PERSON MAKING STATEMENT

SIGNATURE *(First name, middle initial, last name) (Write in ink)*

DATE *(Month, day, year)*

SIGN  
HERE 

TELEPHONE NUMBER *(Include Area Code)*

MAILING ADDRESS *(Number and street, Apt. No., P.O. Box, Rural Route)*

CITY AND STATE

ZIP CODE

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

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)*

## COLLECTION AND USE OF INFORMATION

### PAPERWORK/PRIVACY ACT NOTICE

The Social Security Administration is authorized to collect the information on this form under sections 202(b), 202(c), 205(a), and 1872 of the Social Security Act, as amended (42 U.S.C. 402(b), 402(c), 405(a), and 1395(ii)). While it is VOLUNTARY, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage. Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of the Social Security programs or for the administration of programs requiring coordination with the Social Security administration, information may be disclosed to another person or to another governmental agency as follows: 1. enable a third party or an 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 General Accounting Office and the Veterans Administration); and 3. to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

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.

These and other reasons why information about you may be used or given out are explained in the Federal Register. If you want to learn more about this, contact any Social Security office.

### PAPERWORK REDUCTION ACT STATEMENT

See Revised PRA, Attached

~~The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.~~

*The following revised PRA Statement will be inserted into the form at its next scheduled reprinting:*

**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 5 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.*