FORM APPROVED
OMB NO. 0960-0324

SOCIAL SECURITY ADMINISTRATION
Supplemental Security Income
Claim Information

Office Address:

Telephone Number:

Contact Person:

Date:

Social Security Number:

We are writing to let you know that you may be able to receive a benefit from the organization shown at the bottom of this page. We need to know if you can receive benefits from this organization so that we can make a decision about your Supplemental Security Income (SSI) payments.

You must apply for and take any action needed to receive benefits from this organization by _____.

If you do not take action by this date:

- You will not be eligible for SSI.
- You will have to pay back any SSI you may have received beginning _____.
- We will send you another letter that explains our decision and what you can do if you think we are wrong before we take any further action on your claim.

If you want to receive SSI payments, you must apply for any benefits you can get now. In some cases, you can get a lower benefit if you apply now but a higher benefit if you apply later. You have to take whatever benefit the organization will give you now to receive SSI.

Please take or mail the enclosed form to the organization shown below right away. When the organization returns the form to us, we will make a decision about your SSI payments.

If you have any questions, please get in touch with the Social Security office shown above.

Manager

Organization Name and Address

PART 1 - TO BE COMPLETED BY THE INDIVIDUAL

Please let me know how to file a claim for a pension, annuity, or benefit from your organization.

I hereby authorize the Social Security Administration to release the information shown below. I also authorize your organization to release any information to the Social Security Administration about any claim I have filed or intend to file with your organization.

SIGNATURE	DATE

PART 2 - TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION

This information refers to ☐ Claimant ☐ Other

NAME		RELATIONSHIP	
SSN	DATE OF BIRTH	SERIAL OR OTHER IDENTIFYING NUMBER	
DATES OF MILITARY SERVICE		FROM	TO

BRANCH OF SERVICE

DATES OF EMPLOYMENT	FROM	TO

PLACE OF EMPLOYMENT

PART 3 - TO BE COMPLETED BY THE ORGANIZATION

☐ Ineligible ☐ Refused to Apply ☐ Will Contact Individual

☐ Expect Decision by _____ (Date) ☐ Claim Approved

SIGNATURE	DATE
TITLE	PHONE NO. *(Include Area* Code)

Privacy Act and Paperwork Reduction Act Statements

The Social Security Act, sections 1611 (e)(2) and 1612 (a)(2)(B), allows us to collect the facts we ask for on this form. You do not have to answer this request. However, if you do not give us the facts we have requested, we may not be able to make Supplemental Security Income payments to this person.

Sometimes we share the information on this form with another government agency, or person to administer the Social Security program or programs requiring coordination with the Social Security Administration (SSA).

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 governmen do this even if you do not agree to it.

Explanations about these and other reas provide us may be used or given ou Security offices. If you want to learn any Social Security office.

This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 10 minutes to read the instructions, gather the necessary facts, and answer the questions.

See revised Privacy Act and Paperwork Reduction Act Statements below.

Privacy Act Notice:

Sections 1611(e)(2) and 1612(a)(2)(B) of the Social Security Act, as amended, authorize us to collect this information. This information is needed to determine if you qualify for benefits from the listed organization and a possible adjustment to your Supplemental Security Income (SSI). The information you provide on this form is voluntary, however, failure to provide the requested information may adversely impact your SSI benefits.

We rarely use the information you supply for any purpose other than for establishing benefit eligibility. 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 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 Department of Veteran Affairs);

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

(5) To State agencies providing services to disabled children; and

(6) 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 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 and 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 System of Records Notices 60-0103. The notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.ssa.gov or at your local Social Security office.

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 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. 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.***