SOCIAL SECURITY ADMINISTRATION

Form Approved
TOE 420 OMB No. 0960-0001

CERTIFICATE OF SUPPORT

See Revised Privacy Act Statement

(Do not write in this space)

(There is a time limitation for the filing of this certificate. It should be filed promptly.)

PRIVACY ACT PAPERWORK REDUCTION NOTICE: This form is authorized by sections 202(c), (f) and (h) of the Social Security Act, as amended (42 U.S.C. 402 (c), (f), and (h) and section 334 of Public Law 95-216. While it is not mandatory for you to complete this form, failure to provide the information requested may result in the denial of your claim for Social Security benefits or to a reduction in your benefit amount due to insufficient information. The information provided will be used to determine whether you meet the support requirements necessary for entitlement to the benefits for which you are applying or the application of the exception to government pension offset. The information may be disclosed to another person or to another governmental agency as follows: 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 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)*.

PAPERWORK REDUCTION ACT: 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 Paperwork Reduction Statment

ENTER NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(Herein referred to as the "worker")*	ENTER HIS (HER) SOCIAL SECURITY NUMBER
	___ ___ ___ ___ ___

PART I - IDENTITY

I intend that this certificate shall be considered as part of my application for insurance benefits which may be payable to me under the provisions of Title II of the Social Security Act, as amended. I hereby certify that I was receiving at least one-half my support from the worker at the time specified in Item 8 of this Certificate and submit the following information as proof of the facts.

1. Enter your full name *(Print or write clearly)*

2. Enter your date of birth *(Month, Day and Year)*

3. Enter your Social Security number *(If none, write "None")* ___ ___ ___ ___ ___

4. (a) Show your relationship to the worker. *(Husband, wife, widower, widow, mother, father, stepmother, adopting father, etc.) (If you indicate that you are the husband, wife, widower, or widow, Skip to item 9.)*

5. If the worker has another living parent *(other than yourself)* enter the following information regarding the other parent:

FULL NAME	AGE

ADDRESS	RELATIONSHIP TO WORKER *(Father, mother, stepfather, etc.)*

6. If you are a stepparent:

WHEN DID YOU MARRY THE WORKER'S FATHER OR MOTHER?	WHERE DID THIS MARRIAGE TAKE PLACE?

7. If you are an adopting parent:

WHEN DID YOU ADOPT THE WORKER?	WHERE DID THIS ADOPTION TAKE PLACE?

PART II - SUPPORT

8. QUESTIONS 9 THROUGH 19 APPLY TO YOUR INCOME AND SUPPORT FOR THE 12-MONTH PERIOD ENDING: MONTH DAY YEAR

This form must be filed not later than . . . . . DATE

9. Enter the total amount of the worker's income during the 12-month period shown in item 8. AMOUNT

10. (a) Did you own the dwelling in which you lived during the 12-month period shown in item 8? ☐ Yes ☐ No

(If "Yes," go on to item 11. If "No," enter below the name and relationship of the person who owned the dwelling in which you lived and complete (b) and if appropriate, (c) and (d).)

NAME OF OWNER	RELATIONSHIP TO YOU *(If none, write "None.")*

(b) Did you pay either rent or all the costs of maintaining the property (such as repairs, mortgage, taxes, etc.)? ☐ Yes ☐ No

(If "Yes," skip (c) and (d) and go to item 11) *(If "No," answer (c) and (d).)*

(c) List below each person who paid the rent or the costs of maintaining the property, what each paid for, and how much:

PERSON WHO PAID	ITEM PAID FOR	AMOUNT
		$
		$
		$
		$

(d) What was the monthly rental value of the house? $

11. Enter the following about the worker and any other person who lived with you or who contributed to the support of your household during the 12-month period shown in item 8. Include contributions for support, payments for room and board, household expenses, clothing, insurance and medical expenses, gifts, etc.

NAME	RELATIONSHIP TO YOU	DATES EACH LIVED WITH YOU	DATES EACH CONTRIBUTED	TOTAL AMOUNT CONTRIBUTED BY EACH	DATE AND AMOUNT OF LAST CONTRIBUTION	
					DATE	AMOUNT
				$		$
				$		$
				$		$
				$		$

12. If any of the contributions to you stopped before the end of the period, explain why:

13. (a) Did you furnish room and board to anyone who lived with you during the 12 month period shown in item 8?

☐ Yes *(If "Yes," complete (b).)* ☐ No *(If "No," go on to item 14)*

(b) PERSON TO WHOM YOU FURNISHED ROOM AND BOARD	DATES FURNISHED	COST OR ESTIMATED COST OF ROOM AND BOARD (MONTHLY)

14. (a) Did you receive any income during the 12-month period shown in item 8 from any of the sources shown below?

☐ Yes *(If "Yes," complete (b) below.)* ☐ No *(If "No," go on to item 15.)*

(b) SOURCE	INCOME	DATE YOU LAST RECEIVED INCOME AND AMOUNT	
		DATE	AMOUNT
Wages, salary, commissions, etc. *(Show gross amounts before deductions for taxes, FICA contributions, insurance, etc.)*	$		$
Pensions, annuities, insurance *(including Social Security benefits)*	$		$
Stocks, bonds, securities, etc.	$		$

15. Did you or any member of the household receive any kind of public or private aid during the 12-month period shown in item 8?

☐ Yes *(If "Yes," give the following information.)* (Include payments for room and board, for household expenses, for clothing, for medical expenses, etc.) ☐ No *(If "No," go on to item 16.)*

NAME OF PERSON FOR WHOM AID WAS GIVEN	NAME AND ADDRESS OF AGENCY	TOTAL AMOUNT CONTRIBUTED BY EACH	DATE AND AMOUNT OF LAST CONTRIBUTION	
			DATE	AMOUNT
		$		$
		$		$
		$		$

16. Complete this item if you deposited or withdrew funds from a bank account during the 12-month period shown in item 8.

OWNER(S) OF ACCOUNT	TOTAL DEPOSITS MADE DURING PERIOD	TOTAL WITHDRAWALS DURING PERIOD
	$	$
	$	$
	$	$

17. Give the nature and amount of any other funds which were used for support (or saved) during the 12-month period shown in item 8.

18. State the nature and amount of your debts, if any, at the end of the period shown in item 8. *(If none, write "None.")*

DESCRIPTION	DATE INCURRED	AMOUNT
		$
		$
		$

19. State any additional facts which you believe tend to show that you were receiving at least one-half of your support from the worker during the period shown in item 8.

REMARKS: *(This space is for more detailed answers to the above questions, if necessary. If you need more space, attach a separate sheet.)*

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 by fine, imprisonment or both. I affirm that all information I have given in this document is true.

SIGNATURE OF APPLICANT

SIGNATURE *(First name, middle initial, last name)* *(Write in ink)*	DATE *(Month, day, year)*
SIGN HERE ▶	TELEPHONE NUMBER *(Area Code)*

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

CITY AND STATE	ZIP CODE	ENTER NAME OF COUNTY (if any) IN WHICH YOU NOW LIVE

Witnesses are only required if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant making the request 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)*

*U.S. Government Printing Office: 2001 — 472-692/20692

SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting:

Privacy Act Statement

Collection and Use of Personal Information

Sections 202(c), 202(f), and 202(h) of the Social Security Act, as amended, and section 334 of Public Law 95-216, authorize us to collect this information. We will use the information you provide to determine whether you meet the support requirements necessary for entitlement to the benefits for which you are applying or the application of the exception to government pension offset.

The information you furnish on this form is voluntary. However, failure to provide all or part of the information requested may result in the denial of your claim for Social Security benefits or to a reduction in your benefit amount.

We rarely use the information you supply for any purpose other than for determining entitlement. 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 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 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.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at your local Social Security office.

SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

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