SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-XXXX

WAIVER OF SUPPLEMENTAL SECURITY INCOME PAYMENT CONTINUATION

NAME OF CLAIMANT

SOCIAL SECURITY NUMBER

- This refers to the advance notice of planned action I received on _____, 20____.
- I have been advised of the proposed action (reduction, suspension, or termination) concerning my Supplemental security income (SSI) payments. I fully understand the results will have on my monthly payment amounts.
- I understand I have the right to continuation of unreduced payments until a decision is made on my initial appeal request.
- I understand I may request my unreduced payments be reinstated at any time up to the date I receive a decision on my initial appeal. I understand this includes any retroactive payments back to the month they were reduced, suspended or terminated.
- I understand my rights. I request the Social Security Administration (SSA) take immediate action to make the change in my payments.
- My rights have been explained to me. I voluntarily sign this form.

Your Signature (If you sign with an X, two people must witness below)

Date (Month / Day / Year)

SIGN HERE ►

Mailing Address (Number and Street, City, State, Zip Code)

Telephone Number (include area code)

Your statement does not have to be witnessed. If, however, you have signed by marking an (X), two witnesses must sign below and provide their complete address.

1. Signature of Witness

2. Signature of Witness

Address of Witness #1
(Number and Street, City, State, Zip Code)

Address of Witness #2
(Number and Street, City, State, Zip Code)

SSA will insert the following revised Privacy Act and PRA Statements into the form upon receipt of OMB approval:

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a) and 1631(e)(A) and (B), and Title 20 CFR 404.1589 and 416.989 of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to further document your claim and permit a determination about your continuing disability.

The information you furnish on this form is voluntary. However, failure to provide the requested information could result in a decision based on information already in your file that your period of disability has ceased.

We rarely use the information you supply for any purpose other than for making a determination about your continuing disability. 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 and improvement of 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 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 Systems of Records Notices entitled, Supplemental Security Income Record, 60-0103 and Supplemental Security Income Quality Initial Claims Review Process System, 60-0212. These notices, additional information regarding this form, and information regarding our programs and

systems, are available on-line 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 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. 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.***