Mock-up Copy

SOCIAL SECURITY ADMINISTRATION **TOE 250**

Form Approved
OMB No. 0960-0014

REQUEST TO BE SELECTED AS PAYEE

PRINT IN INK:

FOR SSA USE ONLY							
Name or Bene. Sym.	Program	Date of Birth	Type	Gdn.	Cus.	Inst.	Nam.

FOR SSA USE ONLY

DISTRICT OFFICE CODE

STATE AND COUNTY CODE:

The name of the NUMBER HOLDER

SOCIAL SECURITY NUMBER

The name of the PERSON(S) (if different from above) for whom you are filing (the "claimant(s)")

SOCIAL SECURITY NUMBER(S)

Answer item 1 ONLY if you are the claimant and want your benefits paid directly to you.

1. I request that I be paid directly.

   CHECK HERE ☐ and answer only items 3, 5, 6, and 8 before signing the form on page 4.

I REQUEST THAT THE SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, OR SPECIAL VETERANS BENEFITS FOR THE CLAIMANT(S) NAMED ABOVE BE PAID TO ME AS REPRESENTATIVE PAYEE.

2. Explain why you think the claimant is not able to handle his/her own benefits.
   (In your answer, describe how he/she manages any money he/she receives now.)

   ☐ Claimant is a minor child.

3. Explain why you would be the best representative payee. (Use Remarks if you need more space.)

4. If you are appointed payee, how will you know about the claimant's needs?

   ☐ Live with me or in the institution I represent.
   ☐ Daily visits.
   ☐ Visits at least once a week.
   ☐ By other means. Explain:

5. Does the claimant have a court-appointed legal guardian/conservator? ☐ YES ☐ NO

   IF YES, enter the legal guardian/conservator's:

   NAME _____

   ADDRESS _____

   PHONE NUMBER _____

   TITLE _____

   DATE OF APPOINTMENT _____

   Explain the circumstances of the appointment. (Use remarks if you need more space.)

6. (a) Where does the claimant live?

- ☐ Alone
- ☐ In my home (Go to (b).)
- ☐ With a relative (Go to (b).)
- ☐ With someone else (Go to (b).)
- ☐ In a board and care facility (Go to (b).)
- ☐ In a public institution (Go to (c).)
- ☐ In a private institution (Go to (c).)
- ☐ In a nursing home (Go to (c).)
- ☐ In the institution I represent (Go to (c).)

(b) Enter the names and relationships of any other people who live with the claimant.

NAME	RELATIONSHIP

(c) Enter the claimant's residence and mailing addresses (if different from yours).

Residence: Mailing: Telephone Number:

(d) Do you expect the claimant's living arrangements to change in the next year?

☐ YES ☐ NO If YES, explain what changes are expected and when they will occur. (Use Remarks if you need more space.)

7. If you are applying on behalf of minor child(ren) and you are not the parent,

Does the child(ren) have a living natural or adoptive parent? ☐ YES ☐ NO

If YES, enter: (a) Name of parent _____

(b) Address of parent _____

(c) Telephone number _____

(d) Does the parent show interest in the child? ☐ YES ☐ NO

Please explain. _____

8. List the names and relationship of any (other) relatives or close friends who have provided support and/or show active interest with the claimant. Describe the type and amount of support and/or how interest is displayed.

NAME	ADDRESS/PHONE NO.	RELATIONSHIP	DESCRIBE

9. Check the block that describes your relationship to the claimant.

(a) ☐ Official of bank, agency or institution with responsibility for the person. Enter below which you represent:

- ☐ Bank
- ☐ Social Agency
- ☐ Public Official
- ☐ Institution:
  - ☐ Federal
  - ☐ State/Local
  - ☐ Private non-profit
  - ☐ Private proprietary institution. Is the institution licensed under State law? ☐ YES ☐ NO

IF (a) ABOVE CHECKED, COMPLETE ONLY QUESTIONS 10 AND 11 AND SIGN THE FORM ON PAGE 4.

(b) ☐ Parent

(c) ☐ Spouse

(d) ☐ Other Relative - Specify _____

(e) ☐ Legal Representative

(f) ☐ Board and Care Home Operator

(g) ☐ Other Individual - Specify _____

IF (b), (c), (d), or (e) ABOVE CHECKED, GO ON TO QUESTION 12

10. Does the claimant owe you/your organization any money now or will he/she owe you money in the future? ☐ YES ☐ NO

If YES, enter the amount he/she owes you/your organization, the date(s) was/will be incurred and describe why the debt was/will be incurred.

INFORMATION ABOUT INSTITUTIONS, AGENCIES AND BANKS APPLYING TO BE REPRESENTATIVE PAYEE

11. (a) Enter the name of the institution _____

(b) Enter the EIN of the institution _____

INFORMATION ABOUT INDIVIDUALS APPLYING TO BE REPRESENTATIVE PAYEE

12. Enter: YOUR NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

ANY OTHER NAME YOU HAVE USED _____

OTHER SSN'S YOU HAVE USED _____

13. How long have you known the claimant? _____

14. If the claimant lives with you, who takes care of the claimant when work or other activity takes you away from home?

What is his/her relationship to the claimant?

15. (a) Main source of your income

☐ Employed (answer (b) below)
☐ Self-employed (Type of Business _____)
☐ Social Security benefits (Claim Number _____)
☐ Pension (describe _____)
☐ Supplemental Security Income payments (Claim Number _____)
☐ AFDC (County & State _____)
☐ Other Welfare (describe _____)
☐ Other (describe _____)

(b) Enter your employer's name and address:

How long have you been employed by this employer? _____

(If less than 1 year, enter name and address of previous employer in Remarks.)

16. (a) Have you ever been convicted of a felony? ☐ YES ☐ NO

If YES: What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

(b) Have you ever been convicted of any offense under federal or state law which resulted in imprisonment for more than one year? ☐ YES ☐ NO

If YES: What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

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17. (a) Do you have any unsatisfied FELONY warrants (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) for your arrest? YES NO

If YES: Date of Warrant _____

State where warrant was issued _____

(b)

Are you violating a condition of probation or parole imposed by Federal or State law?

/ /YES / /NO

18. How long have you lived at your current address? (Give Date MM/YY)

REMARKS: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I/my organization:

- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuse the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:

- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheets(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE *(Month, day, year)*
Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE** ▶	Telephone number(s) at which you may be contacted during the day

Print Your Name & Title *(if a representative or employee of an institution/organization)*

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

City and State	Zip Code	Name of County

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

City and State	Zip Code	Name of County

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)*

MOCK-UP

SOCIAL SECURITY
Information for Representative Payees Who Recieve Social Security Benefits

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant DIES (Social Security entitlement ends the month before the month the claimant dies);
- the claimant MARRIES, if the claimant is entitled to child's, widow's, mother's, father's, widower's or parent's benefits, or to wife's or husband's benefits as divorced wife/husband, or to special age 72 payments;
- the claimant's marriage ends in DIVORCE or ANNULMENT, if the claimant is entitled to wife's, husband's or special age 72 payments;
- the claimant's SCHOOL ATTENDANCE CHANGES if the claimant is age 18 or over and entitled to child's benefits as a full time student
- the claimant is entitled as a stepchild and the parents DIVORCE (benefits terminate the month after the month the divorce becomes final);
- the claimant is under FULL RETIREMENT AGE (FRA) and WORKS for more than the annual limit (as determined each year) or more than the allowable time (for work outside the United States);
- the claimant receives a GOVERNMENT PENSION or ANNUITY or the amount of the annuity changes, if the claimant is entitled to husband's, widower's, or divorced spouse's benefit's;
- the claimant leaves your custody or care or otherwise CHANGES ADDRESS;
- the claimant NO LONGER HAS A CHILD IN CARE, if he/she is entitled to benefits because of caring for a child under age 16 or who is disabled;
- the claimant is confined to jail, prison, penal institution or correctional facility;
- the claimant is confined to a public institution by court order in connection WITH A CRIME.
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issue for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

IF THE CLAIMANT IS RECEIVING DISABILITY BENEFITS, YOU MUST ALSO REPORT IF:

- the claimant's MEDICAL CONDITION IMPROVES;
- the claimant STARTS WORKING;
- the claimant applies for or receives WORKER'S COMPENSATION BENEFITS, Black Lung Benefits from the Department of Labor, or a public disability benefit;
- the claimant is DISCHARGED FROM THE HOSPITAL (if now hospitalized).

IF THE CLAIMAINT IS RECEIVING SPECIAL AGE 72 PAYMENTS, YOU MUST ALSO REPORT IF:

- the claimant or spouse becomes ELIGIBLE FOR PERIODIC GOVERNMENTAL PAYMENTS, whether from the U.S. Federal government or from any State or local govenment;
- the claimant or spouse receives SUPPLEMENTAL SECURITY INCOME or PUBLIC ASSISTANCE CASH BENEFITS;
- the claimant or spouse MOVES outside the United States (the 50 States, the District of Columbia and the Northern Marian Islands).

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have a UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

*→ • You are Violating a condition of Probation or Parole under State or Federal law.

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail, or in person.

REMEMBER:

- **payments must be used for the claimant's current needs or saved if not currently needed;**
- **you may be held liable for repayment of any payments not used for the claimant's needs or of any over payment that occured due to your fault;**
- **you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with correct accounting;**
- **to tell us as soon as you know you will no longer be able to act as representative payee or the claimant no longer needs a payee.**

Keep in mind that benefits may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

A REMINDER TO PAYEE APPLICANTS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for Social Security benefits on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have give us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits payable, you — or someone for you — should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

see Revised Privacy Act Statement Attached

THE PRIVACY ACT

Sections 205(a) and 205(j) of the Social Security Act, as amended, authorize us to collect the information on this form. The information you provide will be used to determine if you are qualified to serve as a representative payee. Your response is voluntary. However, failure to provide the requested information will prevent us from making a determination to select you as representative payee.

We rarely use the information provided on this form for any purpose other than for making representative payee selections. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form (1) to enable a third party or an agency to assist Social Security in evaluating payee applicants' suitability to be named representative payees; (2) to claimants or other individuals when needed to pursue a claim for recovery of misapplied or misused benefits; (3) to comply with Federal laws requiring the disclosure of the information from our records; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of 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. The law allows us to do this even if you do not agree to it.

A complete list of routine uses for this information is contained in our System of Records Notice 60-0222 (Master Representative Payee File). Additional information regarding this form and our other systems of records notices and Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

see Revised PRA Statement Attached

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 10.5 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.**

Mock-up

SUPPLEMENTAL SECURITY INCOME

Information for Representative Payees Who Receive Social Security Benefits

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant or any member of the claimant's household DIES (SSI eligibility ends with the month in which the claimant dies);
- the claimant's HOUSEHOLD CHANGES (someone moves in/out of the place where the claimant lives);
- the claimant LEAVES THE U.S. (the 50 states, the District of Columbia, and the Northern Mariana Islands) for 30 consecutive days or more;
- the claimant MOVES or otherwise changes the place where he/she actually lives (including adoption, and whereabouts unknown);
- the claimant is ADMITTED TO A HOSPITAL, skilled nursing facility, nursing home, intermediate care facility, or other institution;
- the INCOME of the claimant or anyone in the claimant's household CHANGES (this includes income paid by an organization or employer, as well as monetary benefits from other sources);
- the RESOURCES of the claimant or anyone in the claimant's household CHANGES (this includes when conserved funds reach over $2,000);
- the claimant or anyone in the claimant's household MARRIES;
- the marriage of the claimant or anyone in the claimant's household ends in DIVORCE or ANNULMENT;
- the claimant SEPARATES from his/her spouse;
- the claimant is confined to jail, prison, penal institution or correctional facility;
- the claimant is confined to a public institution by court order in connection WITH A CRIME;
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

IF THE CLAIMANT IS RECEIVING PAYMENTS DUE TO DISABILITY OR BLINDNESS, YOU MUST ALSO REPORT IF:

- the claimant's MEDICAL CONDITION IMPROVES;
- the claimant GOES TO WORK;
- the claimant's VISION IMPROVES, if the claimant is entitled due to blindness;

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

* → • YOU are violating a Condition of Probation or Parole under State or Federal law.

PAYMENT MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail or in person.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed. (Savings are considered resources and may affect the claimant's eligibility to payment.);
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee;
- you will be asked to help in periodically redetermining the claimant's continued eligibility or payment. You will need to keep evidence to help us with the redetermination (e.g., evidence of income and living arrangements).
- you may be required to obtain medical treatment for the claimant's disabling condition if he/she is eligible under the childhood disability provision.

Keep in mind that payments may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

A REMINDER TO PAYEE APPLICANTS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for SSI payments on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have give us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits payable, you — or someone for you — should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

THE PRIVACY ACT

see Revised Privacy Act Statement Attached

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We rarely use the information provided on this form for any purpose other than for making representative payee selections. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form (1) to enable a third party or an agency to assist Social Security in evaluating payee applicants' suitability to be named representative payees; (2) to claimants or other individuals when needed to pursue a claim for recovery of misapplied or misused benefits; (3) to comply with Federal laws requiring the disclosure of the information from our records; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of 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. The law allows us to do this even if you do not agree to it.

A complete list of routine uses for this information is contained in our System of Records Notice 60-0222 (Master Representative Payee File). Additional information regarding this form and our other systems of records notices and Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

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MOCK-UP

SPECIAL BENEFITS FOR WORLD WAR II VETERANS
Information for Representative Payees Who Receive Special Benefits for WW II Veterans

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant DIES (special veterans entitlement ends the month after the claimant dies);
- the claimant returns to the United States for a calendar month or longer;
- the claimant moves or changes the place where he/she actually lives;
- the claimant receives a pension, annuity or other recurring payment (includes workers' compensation, veterans benefits or disability benefits), or the amount of the annuity changes;
- the claimant is or has been deported or removed from U.S.;
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

* → • YOU are violating a condition of probation or parole under State or federal law.

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You can make your reports by telephone, mail or in person. You can contact any U.S. Embassy, Consulate, Veterans Affairs Regional Office in the Philippines or any U.S. Social Security Office.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed;
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know, as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee.

A REMINDER TO PAYEE APPLICANTS

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	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for Special benefits for WW II Veterans on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have give us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits payable, you — or someone for you — should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

THE PRIVACY ACT

see Revised Privacy Act Statement Attached

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We rarely use the information provided on this form for any purpose other than for making representative payee selections. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form (1) to enable a third party or an agency to assist Social Security in evaluating payee applicants' suitability to be named representative payees; (2) to claimants or other individuals when needed to pursue a claim for recovery of misapplied or misused benefits; (3) to comply with Federal laws requiring the disclosure of the information from our records; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of 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. The law allows us to do this even if you do not agree to it.

A complete list of routine uses for this information is contained in our System of Records Notice 60-0222 (Master Representative Payee File). Additional information regarding this form and our other systems of records notices and Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

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17. Do you have any unsatisfied FELONY warrants (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) for your arrest? YES NO

If YES: Date of Warrant _____

State where warrant was issued _____

18. How long have you lived at your current address? (Give Date MM/YY)

_____

REMARKS: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I/my organization:

- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuse the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:

- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheets(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE *(Month, day, year)*
Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE** ▶	Telephone number(s) at which you may be contacted during the day

Print Your Name & Title *(if a representative or employee of an institution/organization)*

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

City and State	Zip Code	Name of County

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

City and State	Zip Code	Name of County

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)*

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

Request to Be Selected as Payee, form SSA-11-BK
Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a) and (j) of the Social Security Act as amended, [42 U.S.C. 405(a) and (j)] authorize us to collect this information. We will use the information you provide to help us determine if you are qualified to serve as a representative payee. The information you provide on this form is voluntary. However, failure to provide the requested information may prevent us from making a determination to select you as a representative payee.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. 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 or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records to other agencies (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the 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 agencies 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, Claims Folder System, 60-0089 and Master Representative Payee File, 60-0222. The notices, additional information regarding this form, and information regarding our system and programs, are available on-line at www.socialsecurity.gov or at any 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 10.5 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.***