

# Proposed IAR Authorization Screen

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## Interim Assistance Reimbursement Authorization

\* indicates a mandatory field.

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\* FIRST NAME:  MIDDLE NAME:  \* LAST NAME:  SUFFIX:

\* SSN:  (XXXXXXXX) \* DOB:  (MM/DD/CCYY) \* SEX:  (M/F)

\* ADDRESS LINE 1:  LINE 2:

ADDRESS LINE 3:  LINE 4:

\* CITY:  \* STATE:  ZIP:

\* TELEPHONE #:  (XXXXXXXXXX) \* GR CODE:  \* DATE AUTH SIGNED BY STATE:  (MM/DD/CCYY)



### Agreement

I understand that the Social Security Administration will validate the information I provide against the information in Social Security Administration's systems. I certify that: I understand that I may be subject to penalties if I submit fraudulent information. I agree that I am responsible for all actions taken with my User ID. I am aware that any person who knowingly and willfully makes any representation to falsely obtain information from Social Security records and/or intends to deceive the Social Security Administration as to the true identity of an individual could be punished by a fine or imprisonment, or both. I am authorized to do business under this User ID.



I, NAME OF PERSON, have read and agree with the above statement.

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