Social Security Administration
Retirement, Survivors, and Disability Insurance
Important Information

FO Address

Date:
Claim Number:

Beneficiary name
Address
City St ZIP

We are writing to you because we need to know more about your work. Please tell us about your work since ____ /_____/_____. We will use this information to decide if you can receive or continue to receive disability benefits.

What You Need To Do

Please complete and return the completed form **within 15 days** to the address shown above. It is important to fill out the form carefully and completely. Remember to sign and date the form. If you do not return this form, we may make our determination based on the evidence we have in our records.

Some Information To Help You Complete This Form

Our records show these employers and yearly earnings for you. This list may not be complete. It may not show your work for this year or last year. You should add any additional work information as you complete the form.

Employer Name	Year	Earnings

If You Have Questions

If you have any questions, or need help completing the form:

- Visit us online at www.socialsecurity.gov. We can answer many of your general questions online.
- Call us toll-free at 1-800-772-1213, or call your local field office at *xxx-xxx-xxxx*. If you are deaf or hearing impaired, our TTY toll-free number is 1-800-325-0778. We can answer most of your questions over the phone.
- Write or visit any Social Security office. The office that serves your area is located at:

Insert local FO address

If you live outside the United States, please contact any Social Security office or the nearest United States Embassy, or consulate. If you live in the Philippines, you may contact the Veterans Administration Regional Office, Social Security Division, 1131 Roxas Boulevard, Manila. You may also write the Social Security Administration, P.O. Box 17775, Baltimore, Maryland, 21235-7775, USA.

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, please call ahead to make an appointment. This will help us serve you more quickly.

Please read the enclosed pamphlet, "Working While Disabled ... How We Can Help." It will tell you more about why we need to know about your work, and will explain our rules about working. This pamphlet is also available online at www.ssa.gov/pubs/10095.html.

District Manager

Enclosures:
~~Form(s): SSA-820-F4 or SSA-821-BK~~
SSA Pub No. 05-10095
Pre-addressed Envelope

Social Security Administration

Claim # Form Approved
OMB No. 0960-0598

Work Activity Report - Self Employment

Identification - To Be Completed by SSA

Name of Claimant or Beneficiary	Claimant or Beneficiary's Own SSN	☐ Blind ☐ Not Blind
Claim Number(s) & BIC		

Please use this form to tell us about your work activity since **(Insert alleged onset date, date of onset, date of entitlement, or last determination date, as appropriate).**

DATE

Information - To Be Completed By Person Applying For Or Receiving Benefits

Please answer each of the questions on this form with as many details as you can. This information will help us decide if you should get or keep getting disability benefits.

If you need more room for your answers, go to the Remarks section at the end of the form.

1. Have you had any self-employment income **since the DATE shown above in the Identification section?** (check one)

☐ **NO.** If you did not work but income was reported for you, **go to Question 2.**

☐ **YES. Go to Question 3.**

2. If you did not work but income was reported for you, complete the information below. When you are finished, **go to Question 9.**

Payment For	Name and Address of Payer	Amount or Estimate of Value	Date Worked (MM/YYYY - MM/YYYY)
Example: *Income after business stopped*	*ABC Company 123 Any Street, Your Town, MD 54321*	*$100* per *day, week, month,* or *year*	*01/2000 - 02/2000*
		$ _____per_____	
		$ _____per_____	

3. Please tell us about your work **since the DATE in the Identification section.**

Type of Self-Employment or Name of Business		Area Code and Telephone Number		Area Code and Fax Number	
Mailing Address		City		State	ZIP
What is the primary product or service?					
Date Work Started (MM/YYYY)	Date Work Ended (If ended) (MM/YYYY) ☐ Still working			Average Number of Hours Worked	

Type of ownership arrangement? (Check One)

☐ Sole Owner ☐ Limited Liability Company (LLC) ☐ Other (Please explain)

☐ Corporation ☐ Partnership _____

☐ Farm Landlord ☐ Farm Tenant _____

4. In the space below, show each month you worked in your business, the net earnings, and if you worked 45 hours or more.

Date Worked (MM/YYYY)	Net Earnings	Worked more than 45 hours per month?	Date Worked (MM/YYYY)	Net Earnings	Worked more than 45 hours per month?
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No

If you need more room for your answers, **go to the Remarks section**.

5. Please attach all of your self-employment tax returns (including Schedule C & SE) **since the DATE shown in the Identification section.**

☐ I have **ENCLOSED my Tax Returns. Go to Question 6.**

☐ **I DO NOT have Tax Returns.** For any years that you DO NOT have tax returns, use the chart below to tell us about your total annual gross and net self-employment income.

Year (YYYY)	Gross	Net	Year (YYYY)	Gross	Net
	$	$		$	$
	$	$		$	$

6. Has anyone besides yourself had **management responsibilities** for this business (i.e., a partner, employee, relative, or helper) **since the DATE shown in the Identification section**?

☐ **NO. Go to Question 7.**

☐ **YES.** Complete the questions below.

- How many hours per month (on average) does or did the other person(s) spend on management duties? ____________ Hours per month.
- How many hours per month (on average) do or did you spend on management duties? ____________ Hours per month.
- Please tell us what duties you and the other person performed below.

7. Since the DATE shown in the Identification section, did you make any changes in your work activity due to your physical and/or mental condition(s)?

- ☐ **NO. Go to Question 8.**
- ☐ **YES.** Please, describe your changes below. (Check all that apply below.)

Type of Change	Date (MM/YYYY)	Please Explain.
☐ Stopped Working		
☐ Reduced my work hours		My hours reduced from _____ per _____ to _____ per _____ because
☐ Changed to lighter or easier work.		
☐ Other changes		

8. Has any person or organization **contributed to or paid for** any business expenses or provided any **free help, items, or services** related to your business **since the DATE shown in the Identification section?** (For example: rent, supplies, inventory, purchase, repair of equipment, or an employee or helper that works for you for free.)

- ☐ **NO. Go to Question 9.**
- ☐ **YES.** Describe the expenses paid or items or services provided, the value of the contribution, and who provided them below.

9. Do or did you spend any of your own money for items or services **related to your physical and/or mental condition(s)** that you needed in order to work and for which you did not get reimbursed? (For example: medicines or co-pays, medical devices or procedures, Braille equipment, special telephone or equipment, service animal, attendant care, modifications to a car used for work, or other special transportation.) We may ask you for proof of payment.

☐ **NO. Go to the next section.**

☐ **YES.** Tell us what you paid below. Do not show any expenses that have been or will be paid by an insurance company, other organization, or other person.

Describe Item or Service	Cost	Date Paid (MM/YYYY - MM/YYYY)
Example: *Money spent for medicines*	*$100* per *day, week, month,* or *year*	*01/2009 - 02/2009*
	$_____ per _____	
	$_____ per _____	
	$_____ per _____	
	$_____ per _____	

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition(s) or my work.

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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

Signature of Claimant, Beneficiary, or Representative	Date	Area Code and Telephone Number	
Mailing Address	City	State	ZIP

If this statement is signed with a mark (e.g. X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	Date	Area Code and Telephone Number	
Mailing Address	City	State	ZIP
2. Signature of Witness	Date	Area Code and Telephone Number	
Mailing Address	City	State	ZIP

Privacy Act Statement
Collection and Use of Personal Information

Sections 223 and 1632 of the Social Security Act as amended [42 U.S.C. 423 and 1383a], authorize us to collect this information. The information you provide will allow us to determine your eligibility for benefits. Your response is voluntary. However, your failure to provide all or part of the requested information could prevent us from making an accurate and timely decision on your claim and could result in the loss of benefits. 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 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, 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 System of Records Notice entitled, Earnings Recording and Self-Employment Income System, 60-0059. The notice, 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

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 30 minutes to read the instructions, gather the necessary facts, and answer the questions. **SEND 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**. *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.***