Form Approved
OMB No. 0960-0698

Request for Waiver of Special Veterans Benefits (SVB) Overpayment Recovery or Change in Repayment Rate

We will use your answers on this form to decide if we can waive collection of the overpayment or change the amount you must pay us back each month. If we can't waive collection, we may use this form to decide how you should repay the money.

Please answer the questions on this form as completely as you can. We will help you fill out the form if you want. If you are filling out this form for someone else, answer the questions as they apply to that person.

If you need more room for responses, use "REMARKS" on page 13.

FOR SSA USE ONLY

Input Date _____

Waiver Approval ☐

Denial ☐

Amt of O/P (Show in U.S. $)

_____

Period (Dates) of O/P

_____

MM/YYYY to MM/YYYY

1. Name of Beneficiary

_____

Social Security Number

☐☐☐-☐☐-☐☐☐☐

Name of Representative Payee (if applicable)

_____

Social Security Number

☐☐☐-☐☐-☐☐☐☐

If representative payee is requesting waiver or change in repayment rate, answer 1.A. and 1.B. and continue:

A. Were all or some of the overpaid SVB payments received used for the beneficiary?

Yes ☐ If yes, answer B. below.
No ☐ If no, skip to Question 2.

Address of the beneficiary

_____

_____

B. How were the overpaid benefits used?

_____

_____

2. If you are requesting waiver of the overpayment, please check block A. if it applies to you:

A. ☐ The SVB overpayment was not my fault and I cannot afford to pay the money back and/or it is unfair to make me pay the money back for some other reason. (Explain in "REMARKS" on page 13.)

If you are currently receiving SVB, please check block B. if it applies to you:

B. ☐ I am receiving SVB, but cannot afford to have the amount of my monthly benefit (or an amount equal to 10% of the maximum SVB monthly payment amount, whichever is less) withheld from my SVB to pay back the overpaid benefits I received. Instead, I want $_____ (cannot be less than $1) withheld each month from my SVB to pay back the overpayment.

If you are no longer receiving SVB, check block C. if it applies to you:

C. ☐ I want to pay back $_____ (cannot be less than $10) each month instead of repaying the SVB overpayment at once.

SECTION I - INFORMATION ABOUT RECEIVING THE OVERPAYMENT

3. Why did you think you were due the overpaid money and why do you think you were not at fault in causing the overpayment or accepting the money?

_____
_____
_____

4. A. Did you tell us about the change or event that made you overpaid?
Yes ☐ If yes, complete 4.B. and, if applicable, 4.C. below.
No ☐ If no, why didn't you tell us?

_____
_____

B. If yes, how, when and where did you tell us? If you told us by phone or in person, with whom did you talk, and what was said?

_____
_____
_____

C. If you did not hear from us after your report, and/or the amount or payment of your SVB did not change, did you contact us again?

Yes ☐ If yes, what were you told would happen?
No ☐

_____

_____

5. A. Have we ever overpaid you before?

Yes ☐ If yes, complete B. and C. below
No ☐ If no, skip to Question 6.

B. If yes, on what Social Security number were you overpaid?

_____

C. Why were you overpaid before? If the reason is similar to why you are overpaid now, explain what you did to try to prevent the present overpayment.

_____

_____

SECTION II - YOUR FINANCIAL STATEMENT

You must complete this section if you are asking us either to waive the collection of the overpayment or to change the rate at which we asked you to repay it. Please answer all questions as fully and as carefully as possible. We may ask to see some documents to support your statements, so you should have them with you when you visit our office, or we may ask you to send them to us.

Examples of documents are:

- Current rent or mortgage books
- Savings passbooks
- Pay stubs
- Your most recent tax return
- 2 or 3 recent utility, medical, charge card and insurance bills
- Cancelled checks
- Similar documents for your spouse or dependent family members

You can express amounts in local currency. If U.S. currency is shown, show whole dollar amounts only – round any cents to the nearest dollar.

6. A. Do you now have any of the overpaid benefits in your possession (or in a savings or other type of account)?

Yes ☐ Amount: _____ Please contact ~~VARO or~~ SSA personnel as shown in "IMPORTANT" below to return these funds to SSA.

No ☐

B. Did you have any of the overpaid benefits in your possession (or in a savings or other type of account) when you received the overpayment notice?

Yes ☐ Amount _____ Please complete Question 7 below.

No ☐

7. Explain why you believe you should not have to return this amount.

_____

_____

_____

8. A. Are you now receiving U.S. Federal, state or local cash public assistance such as Supplemental Security Income (SSI) payments?

Yes ☐ If yes, answer B. and C. See "IMPORTANT" below.

No ☐

B. Name or kind of public assistance

_____

_____

C. Claim number

_____

IMPORTANT: If you answered "Yes" to Question 8, **DO NOT** answer any more questions on this form. Go to the spaces provided on page 13 at the end of the form for signature and date. Sign and date the form, and provide your address and a telephone number. Bring or mail this form (and any papers that show you receive U.S. Federal, state or local public assistance, if this is the case) to your local Social Security office or to the ~~U.S. Department of Veterans Affairs Regional Office, 1130 Roxas Blvd., 0930 Manila (Ermita)~~ as soon as possible.

U.S. Embassy, SSA, 1201 Roxas Blvd. Ermita 0930 Manila

MEMBERS OF HOUSEHOLD – *DO NOT* Complete if Answer to 8.A. was "Yes"

9. List any person (child, parent, friend, etc.) who depends on you for support ***and*** who lives with you.

NAME	AGE	RELATIONSHIP (If none, say why the person is your dependent)

ASSETS - THINGS YOU HAVE AND OWN – *DO NOT* Complete if Answer to 8.A. was "Yes"

10. A. How much money do you and any person(s) listed in Question 9 above have as cash on hand, in a checking account, or otherwise readily available?

Amount:

B. If there is an amount of cash on hand or in checking accounts shown in Question 10.A., is it being held for a special purpose?

- ☐ No amount on hand
- ☐ No (Money available for any use.)
- ☐ Yes (Explain on line below.)

C. Does your name, or that of any other member of your household, appear either alone or with any other person, on any of the following?

TYPE OF ASSET	OWNER	BALANCE OR VALUE	SHOW THE INCOME (interest, dividends) EARNED EACH MONTH. (If none, explain in spaces below.) If paid quarterly, divide by 3.
SAVINGS (Bank, Savings and Loan, Credit Union)			
CERTIFICATES OF DEPOSIT (CD)			
INDIVIDUAL RETIREMENT ACCOUNT (IRA)			
MONEY OR MUTUAL FUNDS			
BONDS, STOCKS			
TRUST FUND			
CHECKING ACCOUNT			
OTHER (Explain)			
TOTALS			

D. Is there any reason you CANNOT convert to cash the "Balance or Value" of any financial asset shown in Question 10.C.?

Yes ☐ If yes, explain on line below.
No ☐

_____

_____

_____

11. A. If you or a member of your household owns a car, van, truck, camper, motorcycle or any other vehicle or a boat, (other than a vehicle used for family or work transportation) list below.

OWNER	YEAR, MAKE/MODEL	PRESENT VALUE	LOAN BALANCE (if any)	MAIN PURPOSE FOR USE

B. If you or a member of your household owns any real estate (buildings or land), OTHER than where you live; or owns or has an interest in any business, property or valuables, describe below.

OWNER	DESCRIPTION	MARKET VALUE	LOAN BALANCE (if any)	USAGE-INCOME (rent, etc.)

C. Is there any reason you CANNOT SELL or otherwise convert to cash any of the assets shown in Question 11.A. and 11.B.?

Yes ☐ If yes, explain on line below.
No ☐

_____

_____

MONTHLY HOUSEHOLD INCOME

BE SURE TO SHOW MONTHLY AMOUNTS BELOW. If paid weekly, multiply by 4.33 (4 1/3) to figure monthly pay. If paid every 2 weeks, multiply by 2.166 (2 1/6). If self-employed, enter 1/12 of net earnings. Also, enter monthly TAKE HOME amounts on line A of Question 14.

12. A. Are you employed?
    Yes ☐ If yes, provide information below.
    No ☐ If no, skip to 12.B.

    Employer Name _____
    Employer Address _____
    Employer Telephone Number _____
    If self-employed write "Self" _____
    Monthly pay before any deduction: (Gross) _____
    Monthly TAKE HOME pay (Net) _____

    B. Is your spouse employed?
    Yes ☐ If yes, provide information below.
    No ☐ If no, skip to 12.C.

    Employer Name _____
    Employer Address _____
    Employer Telephone Number _____
    If self-employed write "Self" _____
    Monthly pay before any deduction: (Gross) _____
    Monthly TAKE HOME pay (Net) _____

    C. Is any other person listed in Question 9 above employed?
    Yes ☐
    No ☐
    Name(s) of person listed in Question 9 _____

    Employer Name _____
    Employer Address _____
    Employer Telephone Number _____
    If self-employed write "Self" _____
    Monthly pay before any deduction: (Gross) _____
    Monthly TAKE HOME pay (Net) _____

13. A. Do you, your spouse or any dependent member of your household receive support or contributions from any person or organization?
Yes ☐ If yes, answer 13.B.
No ☐ If no, skip to Question 14.

. B. How much money is received each month?
Amount $ _____ (Show this amount on line K of Question 14.)
Source of support or contributions _____

MONTHLY INCOME

BE SURE TO SHOW MONTHLY AMOUNTS BELOW. If paid weekly, multiply by 4.33 (4 1/3) to figure monthly pay. If paid every 2 weeks, multiply by 2.166 (2 1/6).

14. INCOME FROM #12 & #13 ABOVE, AND OTHER INCOME TO YOUR HOUSEHOLD	YOURS	SPOUSE'S	OTHER HOUSEHOLD MEMBERS	**SSA USE ONLY**
A. TAKE HOME Pay (Net) (From #12 A, B and C above)				
B. SVB				
C. SOCIAL SECURITY RETIREMENT & SURVIVORS BENEFITS (e.g., spouse/widow[er] benefits)				
D. SUPPLEMENTAL SECURITY INCOME (SSI)				
E. PENSIONS (VA, PVAO,PSSS,Military, Civil Service, Railroad, etc.)	TYPE			

	YOURS		SPOUSE'S		OTHER HOUSEHOLD MEMBERS		**SSA USE ONLY**
F. PUBLIC ASSISTANCE (Other than SSI)	TYPE						
G. FOOD STAMPS (Show full face value of stamps received)							
H. INCOME FROM REAL ESTATE (rent, etc.) (From #11B above)							
I. ROOM AND/OR BOARD PAYMENTS (Explain in Remarks, below)							
J. CHILD SUPPORT AND/OR ALIMONY							
K. OTHER SUPPORT (From #13B above)							
L. INCOME FROM ASSETS (From #10 above)							
M. OTHER (From any source, explain below)							
TOTALS							

GRAND TOTAL; (Add total of 3 blocks from Question 14.) _____

REMARKS _____

_____

_____

_____

MONTHLY HOUSEHOLD EXPENSES

BE SURE TO SHOW MONTHLY EXPENSES BELOW. If paid weekly, multiply by 4.33 (4 1/3) to figure monthly pay. If paid every 2 weeks, multiply by 2.166 (2 1/6). DO NOT list an expense that is withheld from income (such as Medical Insurance under Medicare). Only take home pay is used to figure income.
Show "CC" as the expense amount if the expense (such as clothing) is part of CREDIT CARD EXPENSE shown on line 15.F.

15. MONTHLY HOUSEHOLD EXPENSES	Amount per month	**SSA USE ONLY**
A. Rent or Mortgage (If mortgage payment includes property or other local taxes, insurance, etc. **DO NOT** list again below.)		
B. Food (groceries—include the value of food stamps) and food at restaurants, work, etc.		
C. Utilities (gas, electricity, telephone)		
D. Other heating/cooking fuel (oil, propane, coal, wood, etc.)		
E. Clothing		
F. Credit card payments (Show minimum monthly payment allowed.)		
G. Property tax		
H. Other taxes or fees related to your home (trash collection, water-sewer fees)		
I. Insurance (life, health, fire, homeowner, renter, car, and any other casualty or liability policies)		
J. Medical-Dental (after amount, if any, paid by insurance)		
K. Car operation and maintenance (Show any car loan payment in N below.)		
L. Other transportation		
M. Church-charity cash donations		
N. Loan, credit, lay-away payments (If payment amount is optional, show minimum.)		
O. Support to someone NOT in household (Show name, age, relationship (if any) and address.)		
P. Any expense not shown above (Specify)		
Total		

EXPENSE REMARKS: (Also explain any unusual or very large expenses, such as medical, college, etc.)

INCOME AND EXPENSES COMPARISON

		Amount
16. A.	Monthly Income (Write the amount from the Grand Total of Question #14.)	
B.	Monthly Expenses (Add $10 to the amount from the Total of Question #15.)	

17. If your expenses shown in 16.B. are more than your income shown in 16.A., explain how you are paying your bills in the space below.

FOR SSA USE ONLY	
☐ INCOME EXCEEDS MONTHLY EXPENSES	Income= +
☐ INCOME LESS THAN MONTHLY EXPENSES	Income= –

FINANCIAL EXPECTATION AND FUNDS AVAILABILITY

18. Do you, your spouse or any dependent member of your household expect your or their financial situation to change (for the better or worse) in the next 6 months? (For example: Expect tax refund, pay raise or full repayment of a current bill for the better; or major house repairs expected for the worse.)

Yes ☐ If yes, explain on line below.
No ☐

REMARKS SPACE: If you are continuing an answer to a question, please show the number and letter (if any) of the question you are responding to.

IMPORTANT: 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 OVERPAID PERSON OR REPRESENTATIVE PAYEE

PRINT (First name, middle initial, last name in ink)	DATE (MM/DD/YY)
SIGNATURE (Sign Here)	HOME TELEPHONE NUMBER (Include area code) WORK TELEPHONE NUMBER IF WE MAY CALL YOU AT WORK (Include area code)

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

CITY AND STATE/ COUNTRY	ZIP CODE	ENTER NAME OF COUNTY (IF ANY) IN WHICH YOU NOW LIVE

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

SIGNATURE OF WITNESS	SIGNATURE OF WITNESS
ADDRESS (Number and street, City, State and Zip Code, Country)	ADDRESS (Number and street, City, State and Zip Code, Country)

THE PRIVACY AND PAPERWORK REDUCTION ACTS

The information requested on this form is sought pursuant to the authority granted in 42 U.S.C. 404, 1008, 1383(b), 1395gg, the Social Security Protection Act of 2004 (P.L. 108-203) and the Federal Coal Mine Health and Safety Act of 1969. Your response to the questions on this form is required for you to continue to receive benefits. Failure to report those events which can cause suspension of benefits may cause the loss of additional benefits.

See Revised Privacy Act Statement Attached

The information provided will be used to confirm past and continuing entitlement to benefits and may be disclosed by SSA to another person or to another governmental agency for the following purposes: (1) to assist SSA in establishing the right of an individual to Social Security coverage and/or benefits; (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs; (3) to comply with Federal laws requiring the exchange of information between SSA and another agency; and (4) to comply with the Freedom of Information Act (5 U.S.C. 552).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any 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 120 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments on our time estimate above to*** SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

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 204, 808, 1631(b), and 1870 of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to decide if we can waive collection of the overpayment or change the amount you must pay us back each month.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from waiving collection of the overpayment or change the amount you must repay us each month. Failure to report all events, which can cause suspension of benefits, may also cause the loss of additional benefits.

We rarely use the information you supply for any purpose other than determining continuing eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices entitled, Master Beneficiary Record (60-0090) and the Recovery of Overpayments, Accounting and Reporting/Debt Management System (60-0094). Additional information about this and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.