Social Security Administration

Form Approved
OMB No. 0960-0460

MARITAL RELATIONSHIP QUESTIONNAIRE

CLAIMANT'S NAME	SOCIAL SECURITY NUMBER

Privacy Act Notice - Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to determine eligibility for Supplemental Security Income. Furnishing us this information is voluntary. However, failure to provide all or part of the information could prevent us from making an accurate and timely decision on Supplemental Security Income benefits. We rarely use the information you supply for any purpose other than for making a determination relating to Supplemental Security Income benefits. 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 are available in Systems of Records Notices entitled, Master Beneficiary Record, 60-0090, and Supplemental Security Income Record, 60-0103. 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 (OMB) control number. The OMB control number for this collection is 0960-0460. We estimate that it will take between 5 minutes to read the instructions, gather the facts, and answer the questions. Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

NAME OF PERSON MAKING STATEMENT (*If not Claimant)*

Please answer the following questions as they relate to yourself and to ▶

1. By what name or names are you known?

2. How do you introduce the other person to friends, relatives, or others?

3. How is mail addressed to you and the other person?

4. Are there any bills, installment contracts, tax returns, or other papers showing the two of you as husband and wife? ☐ YES ☐

(If yes, explain.)

replace with "a married couple"?

5. Is the place where you live owned or rented by both of you or only by one? ☐ Both ☐ Only by one

If both, please furnish the names on the deed or lease.

Further Explanation of Relationship:

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law and/or State law. I affirm that all information I have given in this document is true.

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
SIGN HERE ▶	Telephone Number *(Include Area Code)*

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

City and State	ZIP Code

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant 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)*