SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0719

APPLICATION TO COLLECT A FEE FOR PAYEE SERVICES

I/We, as representative of the organization named below, request authorization from the Social Security Administration to collect a fee for providing payee services in accordance with section 205(j)(4)(A) of the Social Security Act. (42 USC 405(j)(4)(A))

I understand that I must provide the following documents along with this application:

- Proof of tax exempt status under Sec. 501(c) of the Internal Revenue Code (if applicable).
- Our organization's mission statement.
- A list of current beneficiaries being served (if applicable) including name, address and SSN.

1.) Name of Organization

2.) EIN

3.) Type of Organization

☐ Community based, non-profit social service agency

☐ State/Local Government Agency

4.) Address

5.) City, State, Zip Code

Phone Number ( ) -

6.) Licensed Yes No (Circle One)

If YES, Licensor name and type of license _____

Exp. Date _____

Licensor Address _____ Phone Number ( ) -

_____

_____

7.) Bonded/Insured Yes No (Circle One)

If YES, Bond/Insurance Co. name _____

Address _____ Phone Number ( ) -

_____

_____

Bond/Policy Type _____ Exp. Date _____

Amount _____ Serial/Policy # _____

8.) Maximum number of beneficiaries that you are able to serve

9.) Is your organization currently charging a fee for providing payee services? Yes No **(Circle One)**

10.) Number of employees that handle affairs for the SSA beneficiaries

11.) Indicate your service area by counties served or zip codes

_____

_____

12.) Do you serve any beneficiaries who owe you money now, or will owe you in the future?

Yes No **(Circle One)**

If YES, please describe the amount and reason for the debt:

_____

_____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I understand the information furnished in this form is subject to verification by the Social Security Administration (SSA) at the time of initial application and during subsequent recertifications as a fee-for-service organizational payee.

I understand I may not collect a fee for payee services unless and until I have received written authorization to do so by SSA. If granted authorization, I agree not to collect a fee higher than the amount authorized by SSA.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and that the information is true and correct to the best of my knowledge. I understand that if I knowingly and willfully make a false, fictitious, or fraudulent statement or representation on this form, or cause someone else to do so, I may be fined and/or imprisoned (18 U.S.C. §1001).

Signature: _____ Date: _____

Print Your Name & Title: _____ Phone: _____

Signature of Director/CEO (if different than above): _____

Print Your Name and Title: _____ Phone: _____

Signature of SSA Official: _____ Title: _____

DO Code: _____ Date: _____

Privacy Act: The Social Security Administration is authorized to request the information on this form under sections 205(j)(4) and 1631(a)(2) of the Social Security Act and 20 CFR 404.2040a and 416.640a. The information requested on this form will be used to consider your eligibility as a Fee for Service Representative Payee. You do not have to give us this information. However, without the information, we may not be able to authorize you to collect a fee for providing payee services.

See Revised Privacy Act Statement

The information you provide may be disclosed to the Office of the President or to a congressional office requesting information on your behalf, to the General Services Administration and the National Archives and Records Administration for conducting records management studies, and to contractors and other Federal agencies, as necessary, to assist in the administration of Social Security Administration programs.

We may also use this information 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 may be used or given out are available in Social Security offices. If you want to k ffice.

See Revised Paperwork Reduction Act Statement

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 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**. 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.*