STATEMENT OF CARE AND RESPONSIBILITY FOR BENEFICIARY

NAME AND ADDRESS OF CUSTODIAN	In replying, use this address: SOCIAL SECURITY ADMINISTRATION
	TELEPHONE NUMBER
	DATE
IDENTIFYING INFORMATION (If different from patient)	SSA CONTACT
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	SOCIAL SECURITY NUMBER
APPLICANT'S NAME AND ADDRESS	BENEFICIARY NAME
	BENEFICIARY SOCIAL SECURITY NUMBER
	APPLICANT'S RELATIONSHIP TO BENEFICIARY

YOUR HELP IS NEEDED

The applicant shown above has applied to be appointed representative payee for the above beneficiary. We need you to complete this form and return it to us in the enclosed envelope. The information you provide will help us decide if we should pay this person directly or if he or she needs a representative payee to handle funds. If a representative payee is needed, you will help us to determine the responsibility assumed by the applicant for the beneficiary's well-being. Thank you for your help.

1. DATE BENEFICIARY BEGAN LIVING WITH YOU (month/day/year)	HOW LONG WILL BENEFICIARY LIVE WITH YOU?	REASON BENEFICIARY DOES NOT LIVE WITH THE APPLICANT

2. If the beneficiary is not living with you, where and with whom is the beneficiary living and when did he or she leave your care?

3. Do you believe the beneficiary is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean the beneficiary:

- Is able to understand and act on the ordinary affairs of life, such as providing food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them. ☐ Yes ☐ No ☐ Unsure

If "No" or "Unsure," please provide a brief explanation.

4. Please show the approximate amount you charge each month for the beneficiary's room, board, and care	PER MONTH $

5. Does (or did) any agency, including the applicant, pay toward the cost of the beneficiary's care and maintenance?
☐ Yes ☐ No

If "Yes" please supply the information requested below.

NAME AND ADDRESS	AMOUNT CONTRIBUTED	HOW OFTEN CONTRIBUTIONS ARE MADE

6. How often and when was the last time the applicant did any of the things shown below for the beneficiary?

	VISIT	SENDS CLOTHING	SENDS OTHER GIFTS	WRITES LETTERS
How often?				
Last Time?				

7. List the names and relationship of any other relatives or close friends who have provided support and /or show interest in the claimant. Describe the type and amount of support and/or how interest is displayed.

NAME	ADDRESS/PHONE NO.	RELATIONSHIP	SUPPORT/INTEREST

8. Does the beneficiary have any unmet personal needs at this time? ☐ Yes ☐ No

If "Yes," please list the needs.

9. In emergency situations, where the beneficiary needs surgery, becomes seriously ill, etc., who would you notify?

NAME	ADDRESS

10. Does the applicant give you any instructions for the care of the beneficiary? ☐ Yes ☐ No

If "Yes," explain what those instructions are, how often they are given, and what the applicant does to see that they are carried out.

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a) and 205(j) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to help us establish your suitability to serve as a representative payee.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making a decision to select you as a representative payee.

We rarely use the information you supply for any purpose other than for establishing payee suitability. 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 is available in Systems of Records Notice entitled, Master Representative Payee File, 60-0222. This notice, 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. We estimate that it will take about 10 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.*

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 PERSON MAKING STATEMENT

SIGNATURE (First name, middle initial, last name) (Write in ink) **SIGN HERE**	DATE (Month, day, year) TELEPHONE NUMBER (Include area code)

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

CITY AND STATE	ZIP CODE	NAME OF COUNTY (IF ANY)

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 address.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (No. & Street, City, State, and ZIP Code)	ADDRESS (No. & Street, City, State, and ZIP Code)

REMARKS: (This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet)