

# CHILD-CARE DROPOUT QUESTIONNAIRE

**See Paperwork/Privacy Act Notice  
on Reverse**

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER

NAME OF PERSON MAKING STATEMENT (If other than above wage earner or self-employed person)

RELATIONSHIP TO WAGE EARNER OR SELF-EMPLOYED PERSON

1.

Was a child, either your own or your spouse's, living with you while the child was under age 3 in any year after 1950? →

YES

NO

If "Yes," give the following information:

| Name of Each Child | Child's Date of Birth | Relationship to You or Your Spouse | Years the Child Was Under 3 and Lived With You | No. of Days in Each Year the Child Lived With You |
|--------------------|-----------------------|------------------------------------|------------------------------------------------|---------------------------------------------------|
|                    |                       |                                    |                                                |                                                   |
|                    |                       |                                    |                                                |                                                   |
|                    |                       |                                    |                                                |                                                   |
|                    |                       |                                    |                                                |                                                   |

2.

Did you work in any of the years listed in item 1? →

YES

NO

If "Yes," indicate each year in which you worked:

|  |  |  |  |  |  |
|--|--|--|--|--|--|
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**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.**

### SIGNATURE OF PERSON MAKING STATEMENT

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, Rural Route)

CITY AND STATE

ZIP CODE

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.

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)

## Privacy Act Statement Collection and Use of Personal Information

Sections 202(b), (c), and 205(a), and 1872 of the Social Security Act as amended, [42 U.S.C. 402(b), (c), and 405(a), and 1395ii] authorize us to collect this information. We will use the information you provide to help us determine if you and your dependents are eligible for insurance coverage or monthly benefits. The information you provide on this form is voluntary. However, failure to provide all or part of the requested information may prevent us from making an accurate and timely decision on your claim or your dependent's claim.

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 or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records to other agencies (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, Claims Folder System, 60-0089. The notice, additional information regarding this form, and information regarding our system and programs, are available on-line at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at any 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 control number. We estimate that it will take about 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.***