CERTIFICATE OF RESPONSIBILITY FOR WELFARE AND CARE OF CHILD NOT IN APPLICANT'S CUSTODY

All items on this form requiring an answer must be answered or marked "Unknown."

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	SOCIAL SECURITY NUMBER

I make this statement in support of my application for insurance benefits payable under Title II of the Social Security Act, as amended.

1. Give the following information about **all** unmarried children of the above wage earner or self-employed person who are not living with you and are: (a) under age 16, or (b) age 16 or over, with a disability that began before age 22. Include natural children, adopted children, stepchildren, and dependent grandchildren or step-grandchildren.

FULL NAME OF CHILD	DATE CHILD LEFT YOUR HOME	How Long From today will the child be away from you?	REASON CHILD LEFT YOUR HOME	NAME, ADDRESS, TELEPHONE NUMBER AND RELATIONSHIP (TO CHILD) OF PERSON WITH WHOM CHILD IS NOW LIVING

2. (a) If you contribute to the support of any child named in item 1 above, give the following information:

FIRST NAME OF CHILD	AMOUNTS CONTRIBUTED	HOW OFTEN YOU CONTRIBUTE
	$	
	$	
	$	
	$	

(b) If you are not contributing to the support of any child named in 1 above, give name of child and state why you are not doing so.

3. State how often you do any of the things shown below for any child named in item 1.

FIRST NAME OF CHILD	VISIT	SEND CLOTHING	MAKE OTHER GIFTS	WRITE LETTERS	OTHER (DESCRIBE)

4. Do you give the person or persons with whom the child or children have been placed instructions for the care of such child or children? ☐ Yes ☐ No

If "Yes," explain what those instructions are, how often you give them, and what you do to be sure they are carried out.

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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF APPLICANT SIGNATURE *(First Name, Middle Initial, Last Name) (Write in ink)*	DATE (*Month, day, year)* Telephone Number(s) At Which You May Be Contacted During The Day *(include area code)*

MAILING ADDRESS *(Number and street, P.O. Box, or Rural Route)*

CITY AND STATE	ZIP CODE	Enter Name of County (if any) In Which You Now Live

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)*

PRIVACY ACT STATEMENT:
Collection and Use of Personal Information

Section 202 of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to confirm past and continuing eligibility for benefits. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate and timely decision on your eligibility for benefits, and could result in the loss of some benefits.

We rarely use the information you supply for any purpose other than the reason stated above. However, we may use it for the administration and integrity of our 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 us in establishing rights to Social Security benefits and/or coverage;

2. 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);

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 our programs (e.g., to the Bureau of the Census and private entities under contract with us).

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 our System of Records Notice entitled Claims Folders Systems, 60-0089. 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 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. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *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.***