

SOCIAL SECURITY ADMINISTRATION

FORM APPROVED
OMB NO. 0960-0324

Supplemental Security Income

Claim Information

Office Address:

.

Telephone Number:

Contact Person:

Date:

Social Security Number:

We are writing to let you know that you may be able to receive a benefit from the organization shown at the bottom of this page. We need to know if you can receive benefits from this organization so that we can make a decision about your Supplemental Security Income (SSI) payments.

You must apply for and take any action needed to receive benefits from this organization by _____.

If you do not take action by this date:

- You will not be eligible for SSI.
- You will have to pay back any SSI you may have received beginning _____.
- We will send you another letter that explains our decision and what you can do if you think we are wrong before we take any further action on your claim.

If you want to receive SSI payments, you must apply for any benefits you can get now. In some cases, you can get a lower benefit if you apply now but a higher benefit if you apply later. You have to take whatever benefit the organization will give you now to receive SSI.

Please take or mail the enclosed form to the organization shown below right away. When the organization returns the form to us, we will make a decision about your SSI payments.

You also have the option of applying for Social Security benefits online at www.socialsecurity.gov. If you have any questions, please get in touch with the Social Security office shown above.

Manager

Organization Name and Address

.

SOCIAL SECURITY ADMINISTRATION

FORM APPROVED
OMB NO. 0960-0324

Supplemental Security Income

Claim Information

Office Address:

.

Telephone Number:

Contact Person:

Date:

Social Security Number:

Organization Name and Address

.

SOCIAL SECURITY ADMINISTRATION

FORM APPROVED
OMB NO. 0960-0324

Supplemental Security Income

Claim Information

Office Address:

Refer To:

.

Telephone Number:

Contact Person:

Date:

Social Security Number:

The person whose name and address is shown above may be eligible for benefits from you.

We have asked this person to apply for benefits from your organization.

We told this person to apply for benefits from your organization no later than _____.

We need the information about benefits from your organization to decide if this person is eligible to receive Supplemental Security Income (SSI). In some cases, the person can get a lower benefit if they apply now but a higher benefit if they apply later. In order to get SSI, the person whose name is shown above will have to take whatever benefit your organization will give now.

Please fill out Part 3 on the back of this page and return it to us in the enclosed postage paid envelope.

Thank you for your assistance.

Enclosure

Manager

Organization Name and Address

.

**PART 1 -
TO BE COMPLETED
BY THE
INDIVIDUAL**

Please let me know how to file a claim for a pension, annuity, or benefit from your organization.

I hereby authorize the Social Security Administration to release the information shown below. I also authorize your organization to release any information to the Social Security Administration about any claim I have filed or intend to file with your organization.

SIGNATURE	DATE
-----------	------

**PART 2 -
TO BE COMPLETED
BY THE SOCIAL
SECURITY
ADMINISTRATION**

This information refers to Claimant Other

NAME	RELATIONSHIP
------	--------------

SSN	DATE OF BIRTH	SERIAL OR OTHER IDENTIFYING NUMBER
-----	---------------	------------------------------------

DATES OF MILITARY SERVICE	FROM	TO
---------------------------	------	----

BRANCH OF SERVICE

DATES OF EMPLOYMENT	FROM	TO
---------------------	------	----

PLACE OF EMPLOYMENT

**PART 3 -
TO BE COMPLETED
BY THE
ORGANIZATION**

Ineligible Refused to Apply Will Contact Individual

Expect Decision Claim Approved

by _____ (Date)

SIGNATURE	DATE
-----------	------

TITLE	PHONE NO. (Include Area Code)
-------	-------------------------------

Privacy Act and Paperwork Reduction Act Statements

Sections 1611(e)(2) and 1612(a)(2)(B) of the Social Security Act, as amended, authorize us to collect this information. This information is needed to determine if you qualify for benefits from the listed organization and a possible adjustment to your Supplemental Security Income (SSI). The information you provide on this form is voluntary, however, failure to provide the requested information may adversely impact your SSI benefits.

We rarely use the information you supply for any purpose other than for establishing benefit eligibility. 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 Veteran Affairs); (3) To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; (4) To State agencies providing services to disabled children; and (5) 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 programs can be used to establish or verify a person's eligibility for Federally funded and 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 System of Records Notices 60-0103. The notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.ssa.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 0960-0324. We estimate that it will take 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.**