

Refer to:

Office Address:

Phone:

Office Hours:

Dear \_\_\_\_\_:

We need some information about money you provided to\_\_\_\_\_.  He  She has authorized us to contact you concerning any funds you may have provided for  his  her use. This information will help us decide if this person is eligible to receive Supplemental Security Income and the amount of the payments. Your response is voluntary. However, if you do not respond, we may not be able to determine if  he  she is entitled to certain payments.

We are authorized to collect the information on the enclosed questionnaire under section 1631 (e) of the Social Security Act, as amended (42 U.S.C. 1383 (e)). We will not give out any of the information you give us unless we are required to by law, or unless a Federal or State agency needs the information to decide whether \_\_\_\_\_ is entitled to some type of benefit. The Federal Register describes other situations when we might use this information. If you would like information about this, call us at the number listed above.

Please fill out the attached questionnaire and return it to us in the enclosed postage paid envelope.

Thank you for your cooperation.

Sincerely yours

Manager

Enclosures

## STATEMENT OF FUNDS YOU PROVIDED TO ANOTHER

The information below refers to: Name of Claimant	SSN
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1. How much money did you provide to _____ \$ _____ (Name of individual)	2. When did you provide money to the person named above? _____ (Month/Year)
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3. Do you expect \_\_\_\_\_ to pay this money back to you?  
(Name of individual)

Yes     No    If "no", stop here. Sign and date the end of the questionnaire

4. Have you received any payments?

Yes    If "yes", when did you receive the first payment? \_\_\_\_\_ (Month/Year)

No    If "no", when will payments begin? \_\_\_\_\_ (Month/Year)

5. How much are the payments? \$ _____	6. How often do you receive payments?
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7. Did \_\_\_\_\_ promise to give up any property if he/she does not keep up the payments?  
(Name of individual)

Yes    If "yes", what? \_\_\_\_\_

No

8. Are you charging interest?

Yes

No    If "no", stop here. Sign and date the end of the questionnaire.

9. How much is the interest payment? \$ _____	10. How often do you receive an interest payment?
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Remarks:

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	Date
Mailing Address	Telephone Number (include area code)

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**Privacy Act Statement**  
**Collection and Use of Personal Information**

Section 1631(e)(1)(B) of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to make a determination of eligibility for Supplemental Security Income and to determine payment amounts.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. 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); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0103, entitled Supplemental Security Income and Special Veterans Benefits. Additional information about this and other system of records notices and our programs are available online at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

**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.***