

Employment Network Payment Request Form

This form may be used to request Evidentiary Payment Requests (EPRs)
or Certification Payment Requests (CPRs)

**To Ensure Prompt And Accurate Payment To Your Employment Network (EN), Please Complete
The Following Form And Attach Any Acceptable Earnings Information Required**

1. Employment Network Information

EN Organization Name:

DUNS Number:

Is the financial institution and bank account information provided to SAM.GOV current?

- Yes No (if No, please contact SAM @ **1-866-606-8220** before submitting this request)

**Incorrect Or Outdated Information May Delay Or Prevent Payment Issuance
To Your Employment Network**

2. Ticket-holder Information

Ticket-holder's Name:

Ticket Number/Social Security Number:

Name of Ticket Holder's Employer:

Employer's Address (if available):

Payment method for this Ticket Assignment:

- Outcome Payment Method Milestone-Outcome Payment Method

3. Phase 1 Milestone 1 Earnings Information

Select one option only if requesting a Phase 1 Milestone 1 payment.

- The beneficiary achieved Trial Work Level (TWL) earnings during the calendar claim month.
- The beneficiary achieved less than TWL, but expects to achieve TWL earnings within the next 2 months.
- The beneficiary achieved less than TWL earnings and is not expected to achieve TWL earnings within the next 2 months.

4. Evidentiary Earnings Information

Type of earnings documentation submitted: (these items must be included with this form)

- Pay Slips
- Employer prepared and signed employee earnings statement
- The Work Number <http://www.theworknumber.com/>

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.

5. Repayment Agreement (signature required):

By signing below, you as the EN agree to repay any payments received (or allow the amount to be deducted from future payments) if it is determined at a later date that you were not entitled to payment.

Signature:

Date:

6. Contact Information for the Employment Network Representative Submitting this Request

PRINT NAME:

PHONE NUMBER:

FAX:

EMAIL:

Privacy Act Statement Collection and Use of Personal Information

Section 1148 of the Social Security Act authorizes us to collect this information. We will use the information to monitor the progress of a participant in the Ticket to Work and Self Sufficiency Program.

Furnishing us this information is voluntary; however, failing to provide all or part of the information may prevent payment to participant's selected provider of services.

We rarely use the information you supply for any purpose other than what we state above, 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 list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice, 60-0295, entitled Ticket-to-Work and Self-Sufficiency Program Payment Database, and 60-0300, entitled Ticket-to-Work Program Manager (PM) Management Information System. Additional information about this and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

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 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 control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO: OPERATIONS SUPPORT MANAGER (OSM) TICKET TO WORK, Attn: Ticket Assignment, PO BOX 1433, ALEXANDRIA, VA 22313 OR FAX TO 703-893-4149.** 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.**