CERTIFICATE OF RESPONSIBILITY FOR WELFARE

					PLICANT'S					
N/	All Items on this AME OF WAGE EARNER OR SEL		SOCIAL SECURITY NUMBER							
	nake this statement in support of mamended.	y application fo	or insurance l	penefits	payable under	Title II of	f the Social Security Act,			
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 CHIL LEFT YOUI HOME	How Lo	ong day child ay	REASON CHILD LEFT YOUR HOM		NAME, ADDRESS, TELEPHONE NUMBER AND RELATIONSHIP (TO CHILD) OF PERSON WITH WHOM CHILD			
			nom y	<i>y y y y y y y y y y</i>	Change the F to lower		IO IVOVV EIVIIVO			
	(a) If you contribute to the suppor	t of any child n	amed in item	1 abov	re give the follo	wing info	rmation:			
	FIRST NAME OF CHILD		AMOUNTS			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 (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? If "Yes," explain what those instructions are, how often you give them, and what you do to be sure they are carried out.											
	ii res, explain what those instructions are, now often you give them, and what you do to be sure they are carried out.											
sta giv	eclare under penalty of perjuinatements or forms, and it is traves a false statement about a gray be subject to a fine or impr	ue and correct material fact in	to the best of	my knowle	edge. I u	nderstand that any	one who knowingly					
	SIGNATU	JRE OF APPLIC	CANT		DAT	E (Month, day, year)						
SIC	GNATURE (First Name, Middle	Initial, Last Nan	ne) (Write in ink	·)								
						phone Number(s) At W acted During The Day						
MA	AILING ADDRESS (Number and	d street, P.O. Bo	ox, or Rural Rou	ıte)								
CI	TY AND STATE		ZIP C	ODE	Enter Na	me of County (if any) In Which You Now Live					
	tnesses are required ONLY if th ning who know the applicant m					If signed by mark (X	K), two witnesses to the					
1.	SIGNATURE OF WITNESS			2. SIGNATURE OF WITNESS								
Ad	dress (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

See Revised Privacy Act Statement

Section 202 of the Social Security Act, as amended, authorizes us to collect this information. We have a supposed 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 <u>Paperwork Reduction Act of 1995</u>. 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.