

<p><b>APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)</b> (Deferred or Abbreviated)</p>	<p style="text-align: center;">Do Not Write in This Space</p>						
<p><b>I am/We are applying for Supplemental Security Income and any federally administered state supplementation under Title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under Title XIX of the Social Security Act.</b></p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;"><input type="checkbox"/></td> <td style="width:50%; text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><b>DEFERRED</b></td> <td style="text-align: center;"><b>ABAP</b></td> </tr> <tr> <td style="text-align: center;"><b>SNAP-SSA/APP</b></td> <td style="text-align: center;"><b>SNAP-REFERRED</b></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<b>DEFERRED</b>	<b>ABAP</b>	<b>SNAP-SSA/APP</b>	<b>SNAP-REFERRED</b>
	<input type="checkbox"/>	<input type="checkbox"/>					
	<b>DEFERRED</b>	<b>ABAP</b>					
	<b>SNAP-SSA/APP</b>	<b>SNAP-REFERRED</b>					
	<p>Filing Date (Month, Day, Year)</p>						
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<p>Preferred Language: <input type="checkbox"/></p>							
<p>Written:</p>							
<p>Spoken:</p>							

**TYPE OF CLAIM**     Individual     Individual with Ineligible Spouse     Couple     Child     Child with Parent(s)

**PART 1 - BASIC ELIGIBILITY- Answer the questions below beginning with the first moment of the filing date month.**

1. First Name, Middle Initial, Last Name	2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Birthdate (month, day, year)	4. Social Security Number
5. If filing as spouse or couple (a) Spouse's Name(s)	6(a). Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7(a). Birthdate (month, day, year)	8(a). Social Security Number(s)
If filing for child (b) Parent 1's Name(s)	6(b). Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7(b). Birthdate (month, day, year)	8(b). Social Security Number(s)
If filing for child (c) Parent 2's Name(s)	6(c). Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7(c). Birthdate (month, day, year)	8(c). Social Security Number(s)

8. (d) Are you married?  Yes, complete (e) and (f) \_\_\_\_\_  
 No, Go to (g)

(e) Date of Marriage (month, day, year)

(f) Are you and your spouse living together?  Yes    No    If no, date you began living apart:

(g) Are you and another person living together in the same household and presenting to others or the community as a married couple?  
 Yes, provide the date holding out began (month, day, year): \_\_\_\_\_. Go to (h)\*

No Go to #9

\*(h) Other person's name (First, middle initial, last) \_\_\_\_\_.

Other person's Social Security Number \_\_\_\_\_. \*Use SSA-4178 to develop the holding out relationship.

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9. Other Name(s) and Social Security Number(s) you or your spouse used. If filing for child benefits go to (c) and (d)

(a). Your Other Name(s) (including Name at Birth)

Social Security Number



(b) Spouse's Other Name(s) (including Name at Birth)	Social Security Number
(c) Parent 1's Other Name(s) (including Name at Birth)	Social Security Number
(d) Parent 2's Other Name(s) (including Name at Birth)	Social Security Number

10. Your Place of Birth (City and State or Foreign Country)

11. Spouse's Place of Birth (City and State or Foreign Country)

12. If you are filing for yourself, go to (a); if you are filing for a child, go to (e).

(a) Are you unable to work <b>or is your work limited</b> because of illnesses, injuries, or conditions?	<b>You</b> <input type="checkbox"/> YES Go to (b) <input type="checkbox"/> NO Go to #13	<b>Your Spouse, if filing</b> <input type="checkbox"/> YES Go to (b) <input type="checkbox"/> NO Go to #13
(b) Enter the date you became unable to work.	(month, day, year) Go to (c)	(month, day, year) Go to (c)
(c) <b>Are you blind or do you have low vision even with glasses or contacts?</b>	<b>YES</b> <b>NO</b> Go to (d)	<b>YES</b> <b>NO</b> Go to (d)
(d) If you were unable to work because of illnesses, injuries, or conditions before age 22, do you have a parent <b>or stepparent</b> who is age 62 or older, unable to work because of illnesses, injuries, or conditions	<input type="checkbox"/> YES Provide name(s) and Social Security Number (s) in Remarks. Go to #13	<input type="checkbox"/> NO Go to #13
(e) When did the child become disabled? (month, day year)	Go to (f)	
(f) <del>What are the child's disabling illnesses, injuries, or conditions?</del>	Go to (g)	

**Is the child blind or does he or she have low vision even with glasses or contacts? YES NO**

Go to (g)

(g) Does the child have a parent or stepparent who is 62 or older, unable to work because of illnesses, injuries, or conditions, or deceased?	<input type="checkbox"/> YES Provide name(s) and Social Security Number (s) in Remarks. Go to #13	<input type="checkbox"/> NO Go to #13
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13. If you (and your spouse filing for benefits) were a United States citizen at birth, go to #17; otherwise go to (a).

(a) Are you a naturalized United States citizen?	<b>You</b> <input type="checkbox"/> YES Go to #17 <input type="checkbox"/> NO Go to (b)	<b>Your Spouse, if filing</b> <input type="checkbox"/> YES Go to #17 <input type="checkbox"/> NO Go to (b)
(b) Are you an American Indian born outside the United States?	<b>You</b> <input type="checkbox"/> YES Go to (c) <input type="checkbox"/> NO Go to (d)	<b>Your Spouse, if filing</b> <input type="checkbox"/> YES Go to (c) <input type="checkbox"/> NO Go to (d)

13. (c) Check the block that shows your American Indian status.

You	Your Spouse, if filing
<input type="checkbox"/> American Indian born in Canada Go to #17	<input type="checkbox"/> American Indian born in Canada Go to #17
<input type="checkbox"/> Member of a Federally recognized Indian Tribe; Name of Tribe: Go to #17	<input type="checkbox"/> Member of a Federally recognized Indian Tribe; Name of Tribe: Go to #17
<input type="checkbox"/> Other American Indian Explain in Remarks, then Go to (d)	<input type="checkbox"/> Other American Indian Explain in Remarks, then Go to (d)

(d) Check the block below that shows your current immigration status.

You	Your Spouse, if filing
<input type="checkbox"/> <b>Amerasian Immigrant</b> Go to #14	<input type="checkbox"/> <b>Amerasian Immigrant</b> Go to #14
<input type="checkbox"/> <b>Lawful Permanent Resident</b> Go to #14	<input type="checkbox"/> <b>Lawful Permanent Resident</b> Go to #14
<input type="checkbox"/> <b>Refugee</b> Date of entry (month, day, year): Go to #16	<input type="checkbox"/> <b>Refugee</b> Date of entry (month, day, year): Go to #16
<input type="checkbox"/> <b>Asylee</b> Date status granted (month, day, year): Go to #16	<input type="checkbox"/> <b>Asylee</b> Date status granted (month, day, year): Go to #16
<input type="checkbox"/> <b>Conditional Entrant</b> Date status granted (month, day, year): Go to #16	<input type="checkbox"/> <b>Conditional Entrant</b> Date status granted (month, day, year): Go to #16
<input type="checkbox"/> <b>Parolee for One Year</b> Go to #16	<input type="checkbox"/> <b>Parolee for One Year</b> Go to #16
<input type="checkbox"/> <b>Cuban/Haitian Entrant</b> Go to #16	<input type="checkbox"/> <b>Cuban/Haitian Entrant</b> Go to #16
<input type="checkbox"/> <b>Deportation/Removal Withheld</b> Date (month, day, year): Go to #16	<input type="checkbox"/> <b>Deportation/Removal Withheld</b> Date (month, day, year): Go to #16
<input type="checkbox"/> <b>Other</b> Explain in Remarks, then Go to (e)	<input type="checkbox"/> <b>Other</b> Explain in Remarks, then Go to (e)

(e) If you have status, or have applied for status, as the spouse, child, or parent of a child of a United States citizen, or a lawfully admitted permanent resident, Go to #15; otherwise Go to #17.

14. (a) Date of admission:	<b>You</b> (month, day, year)	<b>Your Spouse, if filing</b> (month, day, year)
(b) Was your entry into the United States sponsored by any person or promoted by an institution or group?	<input type="checkbox"/> YES Go to (c) <input type="checkbox"/> NO Go to (d)	<input type="checkbox"/> YES Go to (c) <input type="checkbox"/> NO Go to (d)
(c) Give the following information about the person, institution or group:		
Name	Address	Telephone Number
(d) What was your immigration status, if any, before adjustment to lawful permanent resident?	<b>You</b> (month, day, year)  From: _____ To: _____	<b>Your Spouse, if filing</b> (month, day, year)  From: _____ To: _____
(e) If filing as an adult, did your parents ever work in the United States before you were 18?	<input type="checkbox"/> YES Go to (f) <input type="checkbox"/> NO Go to #16	<input type="checkbox"/> YES Go to (f) <input type="checkbox"/> NO Go to #16
(f) Name and Social Security Number of parent(s) who worked.		
Name	Social Security Number	
Name	Social Security Number	
15 (a) Have you, your child, or your parent, been subjected to battery or extreme cruelty while in the United States?	<input type="checkbox"/> YES Go to (b) <input type="checkbox"/> NO Go to #17	<b>Your Spouse, if filing</b> <input type="checkbox"/> YES Go to (b) <input type="checkbox"/> NO Go to #17
(b) Have you, your child, or your parent filed a petition with the Department of Homeland Security for a change in immigration status because of being subjected to battery or extreme cruelty?	<input type="checkbox"/> YES Go to #16 <input type="checkbox"/> NO Go to #17	<input type="checkbox"/> YES Go to #16 <input type="checkbox"/> NO Go to #17
16. Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	<input type="checkbox"/> YES Explain in Remarks, then Go to #17 <input type="checkbox"/> NO Go to #17	<input type="checkbox"/> YES Explain in Remarks, then Go to #17 <input type="checkbox"/> NO Go to #17
17. (a) When did you first make your home in the United States?	<input type="checkbox"/> (month, day, <input type="checkbox"/> year)	<input type="checkbox"/> (month, day, <input type="checkbox"/> year)
(b) Have you lived outside of the United States since then?	<input type="checkbox"/> YES Go to (c) <input type="checkbox"/> NO Go to #18  (month, day, year)	<input type="checkbox"/> YES Go to (c) <input type="checkbox"/> NO Go to #18  (month, day, year)
(c) Give the date(s) of residence outside the United States.	Date <input type="checkbox"/> Left: _____ (month, day, year)	Date <input type="checkbox"/> Left: _____ (month, day, year)
18. (a) Have you been outside the United States (the 50 States, District of Columbia and Northern Mariana Islands) 30 days prior to the filing date?	<input type="checkbox"/> YES Go to (b) <input type="checkbox"/> NO Go to #19	<input type="checkbox"/> YES Go to (b) <input type="checkbox"/> NO Go to #19

(b) Give the date (month, day, year) you left the United States and the date you returned to the United States.

(month, day, year)	(month, day, year)
Date	Date
Left:	Left:
(month, day, year)	(month, day, year)
Date	Date
Returned: _____	Returned: _____

19. Claimant's Mailing Address (Number & Street, Apt. No., P.O. Box, or Rural Route)

City and State (U.S.)	ZIP Code	Name of County (if any) in which Number you live	Telephone
State/Province/Region (Foreign)	Postal Code	Country	

20. If you are blind or visually impaired, check the type of mail you want to receive from us
- Standard notice First-Class                       Standard notice First-Class with a follow-up phone call  
 Standard notice & data CD by First-Class                       Standard notice Certified  
 Standard & Braille notices by First-Class                       Standard & large print notices                       Standard notice & audio CD

21. (a) Do you have any felony warrants for escape from custody, flight to avoid prosecution or confinement, or flight escape?	<b>You</b>		<b>Your Spouse, if filing</b>	
	<input type="checkbox"/> YES Go to (b)	<input type="checkbox"/> NO Go to #22	<input type="checkbox"/> YES Go to (b)	<input type="checkbox"/> NO Go to #22
(b) In which State or country was the warrant issued?	Name of State/Country		Name of State/Country	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Go to (c)		Go to (c)	
(c) Was the warrant satisfied?	<b>You</b>		<b>Your Spouse, if filing</b>	
	<input type="checkbox"/> YES Go to (d)	<input type="checkbox"/> NO Go to #22	<input type="checkbox"/> YES Go to (d)	<input type="checkbox"/> NO Go to #22
(d) Date warrant satisfied:	(month, day, year)		(month, day, year)	

**PART 2 - LIVING ARRANGEMENT (Use "Remarks" to explain any change between the first moment of the filing date month and today.)**

22. Claimant's Residence Address

City and State (U.S.)	ZIP Code	Name of County (if any) in which you live
State/Province/Region(Foreign)	Postal Code	Country

23. (a) Mark the box that describes where you live.
- House, apartment, mobile home, houseboat                       Noninstitution (rest home, retirement home, foster home, or group home)  
 Room in commercial establishment                       Institution (hospital, rehabilitation center, prison, or school)  
 Room in private home                       Transient or homeless

(b) Date you began living there: (month, day, year)

24. Mark the box that describes with whom you live. If you live in a foster home, group home, or an institution, or if you are a transient or homeless, do not answer but explain in remarks.

- Alone                       Spouse/Parents and/or Children                       Other People



**PART 3 - RESOURCES (Show resources as of the first moment of the filing date month. Use "Remarks" to explain any changes.)**

25. If you own, or your name or your spouse's/parent's name(s) appear on any of the following items (either alone or with other people's name(s)), enter the total cash value of item(s) on each line.

	YES	NO	Description of Items Marked YES	Co-owned With Others		Dollar Value You Own	Dollar Value Spouse or Parents Own
				Yes	No		
(a) Trusts						\$	\$
(b) Vehicles (auto, truck, camper, boat, motorcycle). How many?						\$	\$
(c) Property other than the home you live in (land, houses, buildings, property in foreign countries)						\$	\$
(d) Savings, checking accounts, stocks, bonds						\$	\$
(e) Cash at home, with you, or anywhere else						\$	\$
(f) Items held for potential value or investment (for example, coin or card collection, jewelry in safe deposit box)						\$	\$
(g) Insurance policies						\$	\$
(h) Other items that can be turned into cash						\$	\$
(i) <b>Achieving a Better Life Experience</b>						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

26. Are there any assets set aside to meet burial expenses for you or your spouse/parent(s)? (If "Yes" describe the item in "Remarks".)	Your Answer		<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Spouse's Answer		<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<b>Parent 1's Answer</b>		YES	NO
	<b>Parent 2's Answer</b>		YES	NO
(a) Have you or your spouse sold, transferred title, disposed of or given away, any money or other property, including money or property in foreign countries, since the first moment of the filing date month or within the 36 months prior to the filing date month?	<input type="checkbox"/> <b>You</b> <input type="checkbox"/>	<input type="checkbox"/> <b>Your Spouse</b> <input type="checkbox"/>		
	YES NO	YES NO		
(b) If you co-owned any money or property with another person(s), did you or any co-owner sell, transfer, or	<input type="checkbox"/> <b>You</b> <input type="checkbox"/>	<input type="checkbox"/> <b>Your Spouse</b> <input type="checkbox"/>		

**IF YOU ANSWERED "YES" TO (a) OR (b), GO TO (c). IF "NO" TO BOTH, GO TO #28.**

27 (c)	<b>OWNER'S/CO-OWNER'S NAME</b>	<b>DESCRIPTION OF PROPERTY</b>	<b>DATE OF DISPOSAL</b>
	Item#1		
	Item #2		
	Item #3		
	<b>NAME AND ADDRESS OF PURCHASER OR RECIPIENT</b>	<b>RELATIONSHIP TO OWNER</b>	<b>VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT</b>
	Item #1		\$
	Item #2		\$
	Item #3		\$
	<b>SALE PRICE OR OTHER CONSIDERATION</b>	<b>ARE OTHER CONSIDERATIONS OR PROCEEDS EXPECTED? EXPLAIN</b>	<b>DO YOU STILL OWN PART OF THE PROPERTY?</b>
	Item #1		<input type="checkbox"/> YES <input type="checkbox"/> NO
	Item #2		<input type="checkbox"/> YES <input type="checkbox"/> NO
	Item #3		<input type="checkbox"/> YES <input type="checkbox"/> NO
	<b>SOLD ON OPEN MARKET?</b>	<b>GIVEN AWAY?</b>	<b>TRADED FOR GOODS/SERVICES?</b>
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
28. Do you give us permission to obtain any financial records from any financial institution?	<b>You</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>Your Spouse, if filing</b> <input type="checkbox"/> YES <input type="checkbox"/> NO

**PART 4 - INCOME (List all income received since the first moment of the filing date month or expected in the next 3 months.) Include you, your spouse/parents.**

29. List cash, checks, and direct payment to bank accounts you (your spouse/parents) received or expect to receive. Include income from wages, sick pay, self-employment, interest, social security, assistance based on need, VA, gifts, pensions, and any other type of income. Give date last paid if income will stop in the next 3 months.

Person Receiving Income	Type of Income	Amount	Frequency Received	Date Last Paid	Source of Income
		\$			
		\$			
		\$			

Also, note here if anyone pays any bills for you directly or gives you money to pay them.

30 (a) Does your spouse/parent pay court ordered child support?

YES  
Go to (b)

NO  
Go to #3

(b) Give the amount and frequency of payment:

\$

**PART 5 – POTENTIAL ELIGIBILITY FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)/MEDICAL ASSISTANCE**

31 (a) Are you currently receiving SNAP benefits (formerly food stamps)?	<input type="checkbox"/> YES Go to (b)	<input type="checkbox"/> NO Go to (c)	<input type="checkbox"/> YES Go to (b)	<input type="checkbox"/> NO Go to (c)
(b) Have you received a recertification notice within the past 30 days?	<input type="checkbox"/> YES Go to (e)	<input type="checkbox"/> NO Go to #32	<input type="checkbox"/> YES Go to (e)	<input type="checkbox"/> NO Go to #32
(c) Have you filed for SNAP benefits in the last 60 days?	<input type="checkbox"/> YES Go to (d)	<input type="checkbox"/> NO Go to (e)	<input type="checkbox"/> YES Go to (d)	<input type="checkbox"/> NO Go to (e)
(d) Have you received a favorable decision?	<input type="checkbox"/> YES Go to #32	<input type="checkbox"/> NO Go to (e)	<input type="checkbox"/> YES Go to #32	<input type="checkbox"/> NO Go to (e)
(e) May I take your SNAP application today?	<input type="checkbox"/> YES Go to #32	<input type="checkbox"/> NO Explain in (f)	<input type="checkbox"/> YES Go to #32	<input type="checkbox"/> NO Explain in (f)

(f) Explanation:

32.

**You may be eligible for Medicaid. However, you must help your State identify other sources that pay for medical care. Also, you must give information to help the State get medical support for any child(ren) who is your legal responsibility. This includes information to help the State determine who a child's parent is. If you want Medicaid, you must agree to allow your State to seek payments from sources, such as insurance companies, that are available to pay for your medical care. This includes payments for medical care for you or any person who receives Medicaid and is your legal responsibility. The State cannot provide you Medicaid if you do not agree to this Medicaid requirement. If you need further information, you may contact your Medicaid Agency.**

**IN STATES WITH AUTOMATIC ASSIGNMENT OF RIGHTS LAWS, Go to (b).**

(a) Do you agree to assign your rights (or the rights of anyone for whom you can legally assign rights) to payments for medical support and other medical care to the State Medicaid agency?	<input type="checkbox"/> YES Go to (b)	<input type="checkbox"/> NO Go to #33	<input type="checkbox"/> YES Go to (b)	<input type="checkbox"/> NO Go to #33
(b) Do you, your spouse, parent or stepparent have any private, group, or governmental health insurance that pays the cost of your medical care? (Do not include Medicare or Medicaid.)	<input type="checkbox"/> YES Go to (c)	<input type="checkbox"/> NO Go to (c)	<input type="checkbox"/> YES Go to (c)	<input type="checkbox"/> NO Go to (c)
(c) Do you have any unpaid medical expenses for the 3 months prior to the filing date month?	<input type="checkbox"/> YES Go to #33	<input type="checkbox"/> NO Go to #33	<input type="checkbox"/> YES Go to #33	<input type="checkbox"/> NO Go to #33

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**PART 6 – MISCELLANEOUS**

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ANSWER #33(a) ONLY IF YOU ARE REQUESTING BENEFITS ON BEHALF OF SOMEONE ELSE;  
OTHERWISE GO TO #33(b).

33(a). Name of Person Requesting Benefits	Relationship to Claimant	Your Social Security Number

**33(b). Have you ever served as representative payee for a Social Security beneficiary or SSI claimant?**

**YES,**

**No,**

**Go to #34**

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PART 7 -REMARKS -(You may use this space for any explanations. Enter the item number before each explanation. If you need more space, use a signed form SSA-795.)

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**RECEIPT FOR YOUR CLAIM FOR SUPPLEMENTAL SECURITY INCOME**

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Name	Social Security Number	Date
Name	Social Security Number	Date
If you have a question or something to report call:	Social Security Office you may visit or write to:	

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Your application for Supplemental Security Income will be processed as quickly as possible. You should hear from us within \_\_\_\_ days. If you do not hear from us within that time, please get in touch with us in person, by mail, or call us at the telephone number shown at the top of this page.

We may need more information before we can decide whether or not you are eligible for SSI payments. If we need more information, we will contact you. In the meantime, if you move or change your mailing address, you (or someone for you) should report the change to the office shown at the top of this page.

You (or someone for you) must let us know if your immigration status changes.

Also, you (or someone for you) must let us know if you are admitted to a hospital or other medical facility. You could lose some SSI payments if you do not let us know right away.

Always give your Social Security Number when writing or telephoning about your claim. If you have any questions about your claim, we will be glad to help you.

## PRIVACY ACT STATEMENT Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. The information you provide will be used to enable the Social Security Administration to determine if you are eligible for Supplemental Security Income (SSI) payments.

**See Revised Privacy Act Statement Attached**

The information you furnish on this form is voluntary. However, failure to provide the requested information may keep us from making an accurate and timely decision on your claim, which in turn may result in loss of some payments.

We rarely use the information you supply for any purpose other than for determining eligibility for SSI. 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 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 and audit activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Complete lists of routine uses for this information are available in System of Records Notice 60-0103, Supplemental Security Income Record and Special Veterans Benefits, and also in System of Records Notice 60-0089, Claims Folder Systems. The Notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at [www.ssa.gov](http://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 control number. We estimate that it will take about 19-20 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](http://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.