Form Approved – OMB No. 0560-0183
Expiration date (xx-xx-xxxx)

This form is available electronically.

CCC-40 (proposal 20)

U.S. DEPARTMENT OF AGRICULTURE

REQUEST FOR FSA AND NRCS PAYMENTS OF FEDERAL BENEFITS BY CHECK *(Request for Waiver)*

Return the completed form to:
[County FSA/NRCS Office Name and Address (Include Zip code)]

INSTRUCTIONS:
- Producer/Representative must complete Parts A, B, C and D.
- This Request for Waiver must be signed by the payment recipient. In cases where a representative payee has been designated, the representative payee is the payment recipient who should sign the form.
- Submit the completed original form to your local FSA/NRCS County Office.

***NOTE**:* Incomplete forms cannot be processed.

PART A – FEDERAL PAYMENT RECIPIENT INFORMATION *(Print Name(s) and Address exactly as it appears on your benefit check)*

1A. NAME AND ADDRESS OF THE PERSON ENTITLED TO GOVERNMENT BENEFITS *(Producer) (Street, Route, P.O. Box, Apartment Number, City (or APO/FPO), State and Zip Code)*

1B. TELEPHONE NO. *(INCLUDE AREA CODE)*

1C. TAX IDENTIFICATION NO. *(9 Digit)*

2A. REPRESENTATIVE PAYEE *(Check Applicable Box):*

☐ **YES** *(If "YES" complete Items 2B and 2C)* ☐ **NO**

2B. NAME AND ADDRESS OF REPRESENTATIVE PAYEE *(Street, Route, P.O. Box, Apartment Number, City (or APO/FPO), State and Zip Code)*

2C. TELEPHONE NO. *(INCLUDE AREA CODE):*

PART B - REASON FOR WAIVER REQUEST

☐ I am unable to manage an account at a financial institution to a mental impairment.

☐ I am unable to manage an account at a financial institution because I live in a remote geographic location lacking the infra-structure to support electronic financial transactions.

NOTE: Hardship Waiver request for either of the above reasons must complete Part C.

☐ I was born on or before May 1, 1921. My date of birth is *(MM-DD-YYYY):* .

PART C – REQUEST FOR WAIVER SUPPORTING INFORMATION

Write 1 – 2 sentences to explain why your mental impairment or remote geographic location make you unable to receive payments electronically:

PART D. CERTIFICATION

I certify that all of the statements in this Request for Waiver are true. I understand that any person who knowingly or willfully makes false or fraudulent statements or representations to the United States government in connection with this Request for Waiver may be subject to fines and / or imprisonment (18 U.S.C. 1001).

1A. SIGNATURE	1B. TITLE/RELATIONSHIP IF SIGNING IN A REPRESENTATIVE CAPACITY	1C. DATE SIGNED *(MM-DD-YYYY)*

NOTE: *The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a - as amended). The authority for requesting the information identified on this form is 31 U.S.C. 3332 and 31 CFR Part 208. The information will be used by the person entitled to government benefits (beneficiary) to request a waiver to receive payments by check instead of receiving the payments electronically. The information collected on this form may be disclosed to other Federal, State, Local government agencies, Tribal agencies, and nongovernmental entities that have been authorized access to the information by statute or regulation and/or as described in applicable Routine Uses identified in the System of Records Notice for USDA/FSA-2, Farm Records File (Automated). Providing the requested information is voluntary. However, failure to furnish the requested information will result in a determination that the waiver request cannot be granted.*

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0560-0183. The time required to complete this information collection is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. ***RETURN THIS COMPLETED FORM TO YOUR LOCAL COUNTY FSA/NRCS OFFICE.***

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at http://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. USDA is an equal opportunity provider, employer, and lender.