

6232

See Revised PRA  
Statement attached

# Representative Payee Report

Social Security Administration, P.O. Box 6230, Wilkes-Barre, PA 18767-9956

FORM APPROVED  
OMB NO. 0960-0068

PAYEE'S NAME AND ADDRESS

REPORT PERIOD

SOCIAL SECURITY NUMBER

FROM:

TO:

BENEFICIARY

FP

ID

BIC

D

TP

CC

GS

PC

DOC

CF

TAA

PF

BSSN

If change of address, check box and enter new address on back of report.

This report is about the benefits you received between \_\_\_\_\_ and \_\_\_\_\_ for the beneficiary, \_\_\_\_\_ . Please read the enclosed instructions before completing this form to help you answer each question.

<b>1.</b>	Were you (the payee) convicted of a crime considered to be a felony between _____ and _____ ? If YES, please explain in REMARKS on the back of this form.	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>2.</b>	Did the beneficiary continue to live alone, or with the same person, or in the same institution from _____ to _____ ? If NO, please explain and provide the beneficiary's current address in REMARKS on the back of this form.	<input type="checkbox"/>	<input type="checkbox"/>
<b>3.</b>	Benefits paid to you between _____ and _____ = \$ _____ Benefits you reported as <b>saved</b> on last year's report. = \$ _____ Total Accountable Amount = \$ _____	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>A.</b>	Did you (the payee) decide how the \$ _____ was spent or saved? $\longrightarrow$ If NO, please explain in REMARKS on the back of this form.	<input type="checkbox"/>	<input type="checkbox"/>
<b>B.</b>	How much of the \$ _____ did you spend for the beneficiary's food and housing between _____ and _____ ? $\longrightarrow$	DOLLAR AMOUNT (NO CENTS)	
<b>C.</b>	How much of \$ _____ did you spend on other things for the beneficiary such as clothing, education, medical and dental expenses, recreation, or personal items between _____ and _____ ? $\longrightarrow$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	
<b>D.</b>	How much, if any, of the \$ _____ did you <b>save</b> for the beneficiary as of _____ ? If none, show zeros. $\longrightarrow$	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	

**4.** If you showed an amount in 3.D. above, place an "X" in the boxes below to show how you are saving the benefits. If you have more than one account, you may mark more than one box in each section.

A. TYPE OF ACCOUNT						B. TITLE OF ACCOUNT		
Savings/Checking Account	U.S. Savings Bonds	Certificates of Deposit	Collective Savings/Checking Account	Treasury Bills	Other	Beneficiary's Name by Your Name	Your Name for Beneficiary's Name	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6232B

FOR SSA USE ONLY		
ATT <input type="checkbox"/>	MARK <input type="checkbox"/>	SIG <input type="checkbox"/>
UND1 <input type="checkbox"/>	UND2 <input type="checkbox"/>	OTH <input type="checkbox"/>

**5.A.** Answer this question only if you answered **“OTHER”** in 4.A. on the front page. If you answered **“OTHER”** in 4.A., show the type of account or investment in which the benefits are saved. →

**B.** Answer this question only if you answered **“OTHER”** in 4.B. on the front page. If you answered **“OTHER”** in 4.B., show the title of the account in which the benefits are saved. →

TYPE OF ACCOUNT
TITLE OF ACCOUNT

**REMARKS**

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**NEW ADDRESS**

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**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 or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

**PAYEE'S SIGNATURE**  
*(If signed by mark ("X"), two witnesses must sign below)*

**6.**

**7.** DATE

DAYTIME TELEPHONE NUMBER(S)  
*(Include area code)*

**8.** \_\_\_\_\_  
 Area Code

**WITNESS SIGNATURES ARE REQUIRED ONLY IF THE PAYEE'S SIGNATURE ABOVE HAS BEEN SIGNED BY MARK ("X").**

SIGNATURE OF WITNESS

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DATE

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SIGNATURE OF WITNESS

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DATE

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***SSA will insert the following revised PRA Statement into the form as soon as possible:***

**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 15 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.***