

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:			
	ID	BIC	PC	DOC	CF	TAA	FP
	BIC1	CF		BSSN		BIC3 CF	BSSN
	BIC2	CF		BSSN		BIC4 CF	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 child(ren) named below. Please read the enclosed instructions before completing this form to help you answer each question.

**1.** 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.

**YES**  **NO**

**2.** Did **all** the children named below live with you from \_\_\_\_\_ to \_\_\_\_\_ ?

If NO, please explain and provide the child(ren)'s current address in REMARKS on the back of this form.

**3.** Benefits paid to you between \_\_\_\_\_ and \_\_\_\_\_ = \$ \_\_\_\_\_

Benefits you reported as **saved** on last year's report. = \$ \_\_\_\_\_

Total Accountable Amount = \$ \_\_\_\_\_

**A.** Did you (the payee) decide how the \$ \_\_\_\_\_ was spent or saved for **all** the children named below? **→**

If NO, please explain in REMARKS on the back of this form.

**YES**  **NO**

**B.** How much of the \$ \_\_\_\_\_ did you use for the care and support of the child(ren) named below between \_\_\_\_\_ and \_\_\_\_\_ ? **→**

DOLLAR AMOUNT (NO CENTS)  
 ,

**C.** Show how much, if any, of the \$ \_\_\_\_\_ you **saved** for each child named below as of \_\_\_\_\_. If none, show zeros. **↩**

BIC	CHILD'S NAME	DOLLAR AMOUNT	BIC	CHILD'S NAME	DOLLAR AMOUNT
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="text"/> <input type="text"/> <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.C. above, place an "X" in the boxes below to show how you are saving the child(ren)'s 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	Treasury Bills	Other	Child(ren)'s Name by Your Name	Your Name for Child(ren)'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"/>

6230B

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.** Answer the question only if you answered **“OTHER”** in 4.A. or 4.B. on the front page. If you answered **“OTHER”** in 4.A. or B., show the type of account or investment and the title of the account in which you saved each child's benefits.

CHILD'S NAME	TYPE OF ACCOUNT OR INVESTMENT	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)*

**DATE**  
**7.**

**DAYTIME TELEPHONE NUMBER(S)**  
*(Include area code)*  
**8.** \_\_\_\_\_  
 Area Code

**6.**

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

SIGNATURE OF WITNESS

DATE

SIGNATURE OF WITNESS

DATE

***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.***