

6234

See Revised PRA  
Statement attached

# Representative Payee Report

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

FORM APPROVED  
OMB NO. 0960-0691

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	FFS	DAA	MFA					

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> 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.	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>2.</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> Did you (the payee) charge the beneficiary a fee for payee or guardianship services you provided between _____ and _____ ? $\longrightarrow$	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
If YES, how much of the \$ _____ did you collect from the beneficiary for these services between _____ and _____ ? $\longrightarrow$	DOLLAR AMOUNT (NO CENTS)	
	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	
<b>C.</b> How much of the \$ _____ did you spend for the beneficiary's food and housing 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 of the \$ _____ 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>E.</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"/>	



***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.***