

## APPLICATION TO COLLECT A FEE FOR PAYEE SERVICES

**I/We, as representative of the organization named below, request authorization from the Social Security Administration to collect a fee for providing payee services in accordance with section 205(j)(4)(A) of the Social Security Act. (42 USC 405(j)(4)(A))**

I understand that I must provide the following documents along with this application:

Revised Language

- Our organization's mission statement; and
- A list of current beneficiaries being served (if applicable) including name, address, and SSN.

If my organization is NOT a state or local government agency, I must also provide the following:

- Proof of tax exempt status under Sec. 501(c) of the Internal Revenue Code;
- A copy of our bonding and/or insurance policy;
- A copy of our state license (provided that licensing is available in the state); and
- A letter describing that our organization meets the community-based criteria.

1. Name of Organization		2. EIN
3. Type of Organization <input type="checkbox"/> Community based, non-profit social service agency <input type="checkbox"/> State/Local Government Agency		
4. Address		
5. City, State, ZIP Code		Phone Number
6. Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Licensor name and type of license		Exp. Date
Licensor Address		Phone Number
7. Bond/Insured <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Bond/Insurance Company name		
Address		Phone Number
Bond/Policy Type		Exp. Date
Amount	Serial/Policy Number	
8. Maximum number of beneficiaries that you are able to serve		
9. Is your organization currently charging a fee for providing payee services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
10. Number of employees that handle affairs for the SSA beneficiaries		
11. Indicate your service area by counties served or ZIP Codes		

12. Do you serve any beneficiaries who owe you money now, or will owe you in the future?

 Yes  No

If Yes, please describe the amount and reason for the debt:

**PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM**

I understand the information furnished in this form is subject to verification by the Social Security Administration (SSA) at the time of initial application and during subsequent recertifications as a fee-for-service organizational payee.

I understand I may not collect a fee for payee services unless and until I have received written authorization to do so by SSA. If granted authorization, I agree not to collect a fee higher than the amount authorized by SSA.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and that the information is true and correct to the best of my knowledge. I understand that if I knowingly and willfully make a false, fictitious, or fraudulent statement or representation on this form, or cause someone else to do so, I may be fined and/or imprisoned (18 U.S.C. § 1001).

Signature:

Date:

Print Your Name and Title:

Phone:

Signature of Director/CEO (if different than above):

Print Your Name and Title:

Phone:

Signature of SSA Official:

Title:

DO Code:

Date:

**Privacy Act Statement - Collection and Use of Personal Information**

Sections 205(j) and 1631(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from authorizing your organization to become a fee-for-service representative payee. We will use the information you provide to help us determine your organization's eligibility as a fee-for-service representative payee. We may also share the information for the following purposes, called routine uses: 1. To a claimant or other individual authorized to act on his or her behalf information concerning the status of his or her representative payee or the status of the application of a person applying to be his or her representative payee, and information pertaining to the address of a representative payee applicant or a selected representative payee when this information is needed to pursue a claim for recovery of misapplied or misused benefits; and 2. To third parties, contractors, or other Federal Agencies, as necessary, to conduct criminal background checks and to obtain criminal history information on representative payees and representative payee applicants. In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs. A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0222, entitled Master Representative Payee File. Additional information and a full listing of all our SORNs are available on our website at <https://www.ssa.gov/privacy/sorn.html>.

**Paperwork Reduction Act Statement**

See Revised PRA  
Statement attached

~~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 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** 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.~~