SSA820 Online Application

Screen Package

June 25, 2021

Contents

Application Landing Page: 3

Email and Password Landing Page: 4

Email Confirmation Page: 5

First Email: 6

Password Confirmation: 7

SSA820 Cover Sheet: 8

SSA820 Adobe Form: 9

Attachment Fields: 15

Example of Conditional Required Fields: 16

Signature: 17

Completed Signature: 18

SSA Adobe Forms Completion Page: 19

Final Email: 20

Password Request Page: 21

SSA820 Completed Form: 22

Application Landing Page:

Complete the Work Activity Report - Self-Employment (Form SSA-820)

Instructions

This online service allows you to electronically complete, sign and submit the Work Activity Report – Self-Employment (Form SSA-820) to us. You may use this online service as an alternative to completing a paper version of this form. To complete the form online, you will need a valid email address.

PRIOR TO USING THIS OPTION, YOU MAY HAVE RECEIVED A REQUEST TO COMPLETE A WORK ACTIVITY REPORT – SELF-EMPLOYMENT (FORM SSA-820) FROM SSA.

IMPORTANT: We will not process the form until you complete the form, **sign the form electronically,** and select "**Click to Sign**" to submit the form.

Before beginning the form, you (the person completing the online form) will enter and confirm your email address in the online application. You will also create a password that will be required for you to access the form.

You will receive an email from adobesign@adobesign.com containing a link and instructions on how to access the form.

NOTE: The form must be electronically signed and submitted within **fifteen (15) calendar days** of initiating the process online (i.e., when you enter your email address in order to receive an email with a link to the form). After fifteen (15) calendar days, the link will expire and you will have to start a new form.

After successful submission of the form, you will be able to save a copy of the completed form within the application. You will also receive an email from adobesign@adobesign.com with a link to the completed form. You will need your pre-established password to save a copy for your records.

PLEASE NOTE:

- This website is most compatible with the following browsers: Microsoft Edge and Google Chrome.
- When accessing the form, the system will end your session after 60 minutes of inactivity. Use the link in your email and your pre-established password to continue working on your form.
- Every three (3) days, an email reminder will be sent until the form has been submitted or until the time expires (i.e., fifteen (15) calendar days after initiation).
- **You will have to start a new form by returning to this website if *any* of the following situations apply**:
    - You forget or lose the password. The password cannot be reset.
    - You do not receive an email notification within a few minutes of your online submission. Be sure to check your junk folder.
    - You do not electronically sign and submit the form within fifteen (15) calendar days.

- You do not electronically sign and submit the form within fifteen (15) calendar days.

Sections 223(d) and 1633 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 an accurate and timely decision on any claim filed.

We will use the information you provide to determine benefits eligibility. We may also share your information for the following purposes, called routine uses:

- To officers and employees of Federal, State or local agencies upon written request, in accordance with the Internal Revenue Code (IRC) (U.S.C. 6103(l)(7)), tax return information (e.g., information with respect to net earnings from self-employment, wages, payments of retirement income which have been disclosed to the Social Security Administration, and business and employment addresses) for purposes of, and to the extent necessary in, determining an individual's eligibility for, or the correct amount of, benefits under certain programs listed in the IRC; and
- To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes.

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) 60-0059, entitled Earnings Recording and Self-Employment Income System, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819 and 60-0089, Claims Folders System, as published in the FR on October 31, 2019, at 84 FR 58422. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

☐ * **I understand and agree to the above statement**

Email and Password Landing Page:

Work Activity Report - Self Employment

We recommend that you verify the accuracy of your email address and make note of your password prior to submission.

You will have to start a new form by returning to this website if any of the following situations apply:

- You forget or lose the password. The password cannot be reset.
- You do not receive an email notification within a few minutes of your online submission. Be sure to check your junk folder.
- You do not electronically sign and submit the form within fifteen (15) calendar days.

Claimant Email

Enter Claimant Email

Confirm Claimant Email

Confirm Claimant Email

Document Name

Work Activity Report - Self Employment

☑ Password Required

Password must contain at least 8 characters, 1 uppercase, 1 lowercase, and 1 number.

Password

Confirm Password

☐ Show Password

☑ Completion Deadline

06/25/2021

Submit

On this page, the claimant sets the password that will be used to access the form.

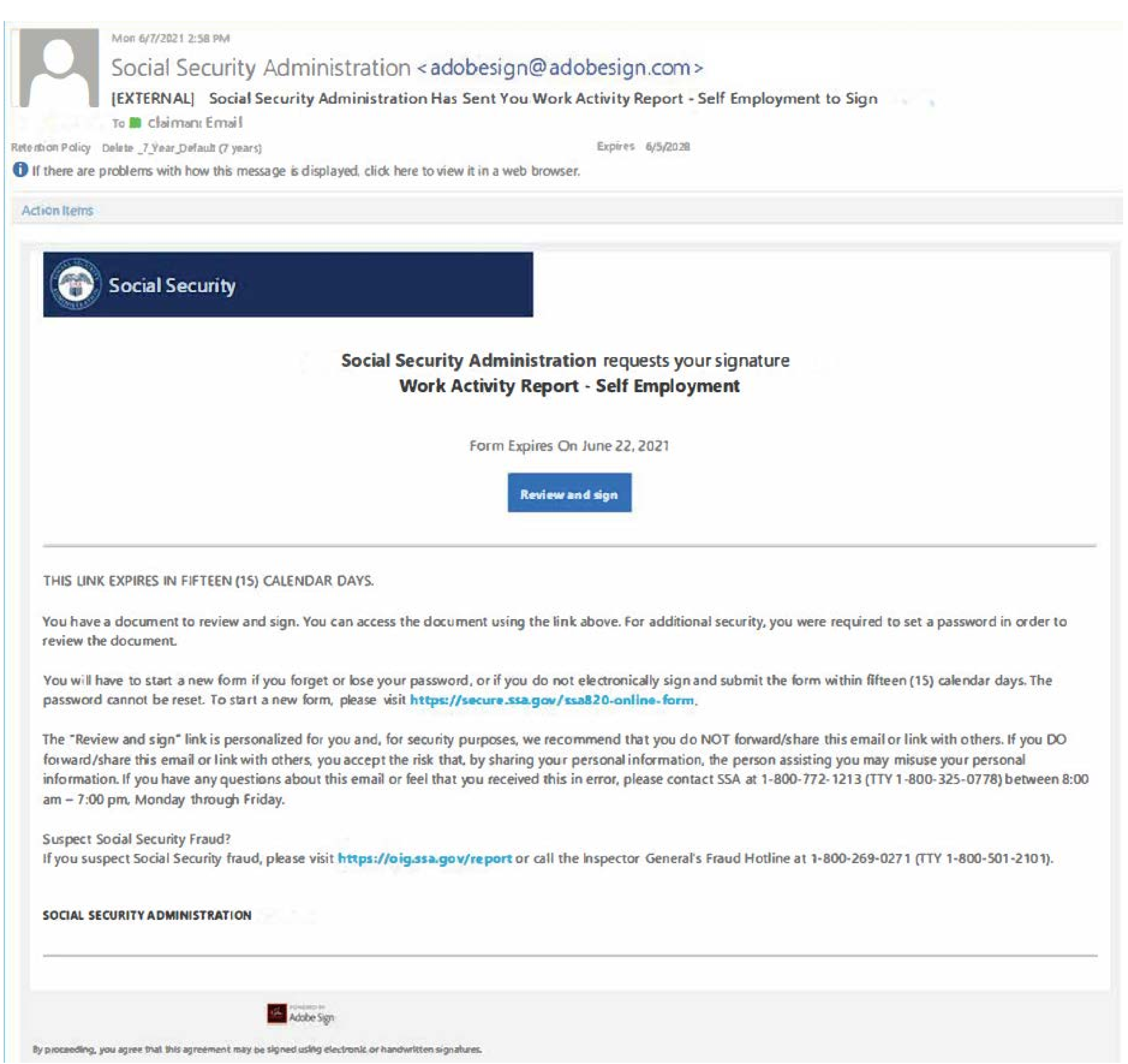
Email Confirmation Page:

Social Security

Work Activity Report - Self Employment

To complete the online form, open the email from adobesign@adobesign.com and click on the "Review and sign" button.

First Email:



Mon 6/7/2021 2:58 PM

Social Security Administration <adobesign@adobesign.com>

[EXTERNAL] Social Security Administration Has Sent You Work Activity Report - Self Employment to Sign

To Claimant Email

Retention Policy Delete _7_Year_Default (7 years) Expires 6/5/2028

If there are problems with how this message is displayed, click here to view it in a web browser.

Action Items

Social Security

Social Security Administration requests your signature
Work Activity Report - Self Employment

Form Expires On June 22, 2021

Review and sign

THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS.

You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document.

You will have to start a new form if you forget or lose your password, or if you do not electronically sign and submit the form within fifteen (15) calendar days. The password cannot be reset. To start a new form, please visit **https://secure.ssa.gov/ssa820-online-form**.

The "Review and sign" link is personalized for you and, for security purposes, we recommend that you do NOT forward/share this email or link with others. If you DO forward/share this email or link with others, you accept the risk that, by sharing your personal information, the person assisting you may misuse your personal information. If you have any questions about this email or feel that you received this in error, please contact SSA at 1-800-772-1213 (TTY 1-800-325-0778) between 8:00 am – 7:00 pm, Monday through Friday.

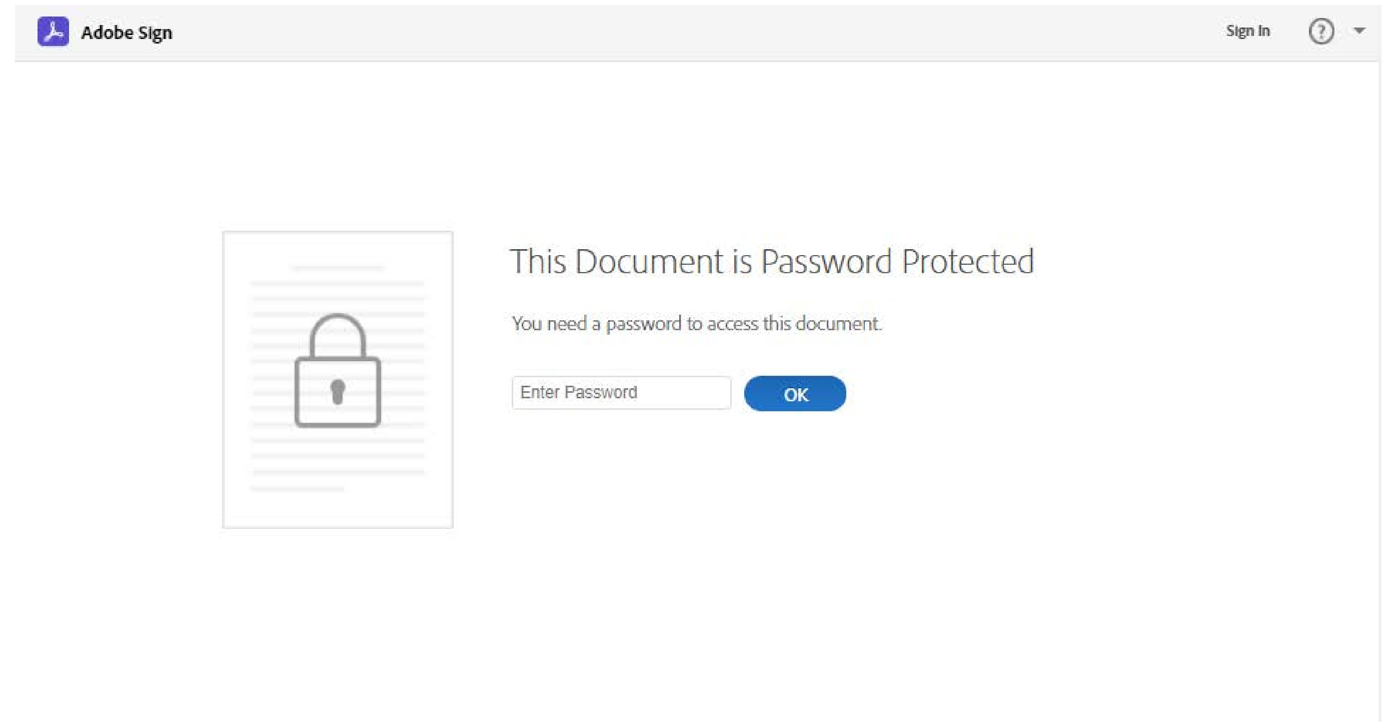
Suspect Social Security Fraud?
If you suspect Social Security fraud, please visit **https://oig.ssa.gov/report** or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-800-501-2101).

SOCIAL SECURITY ADMINISTRATION

Powered by Adobe Sign

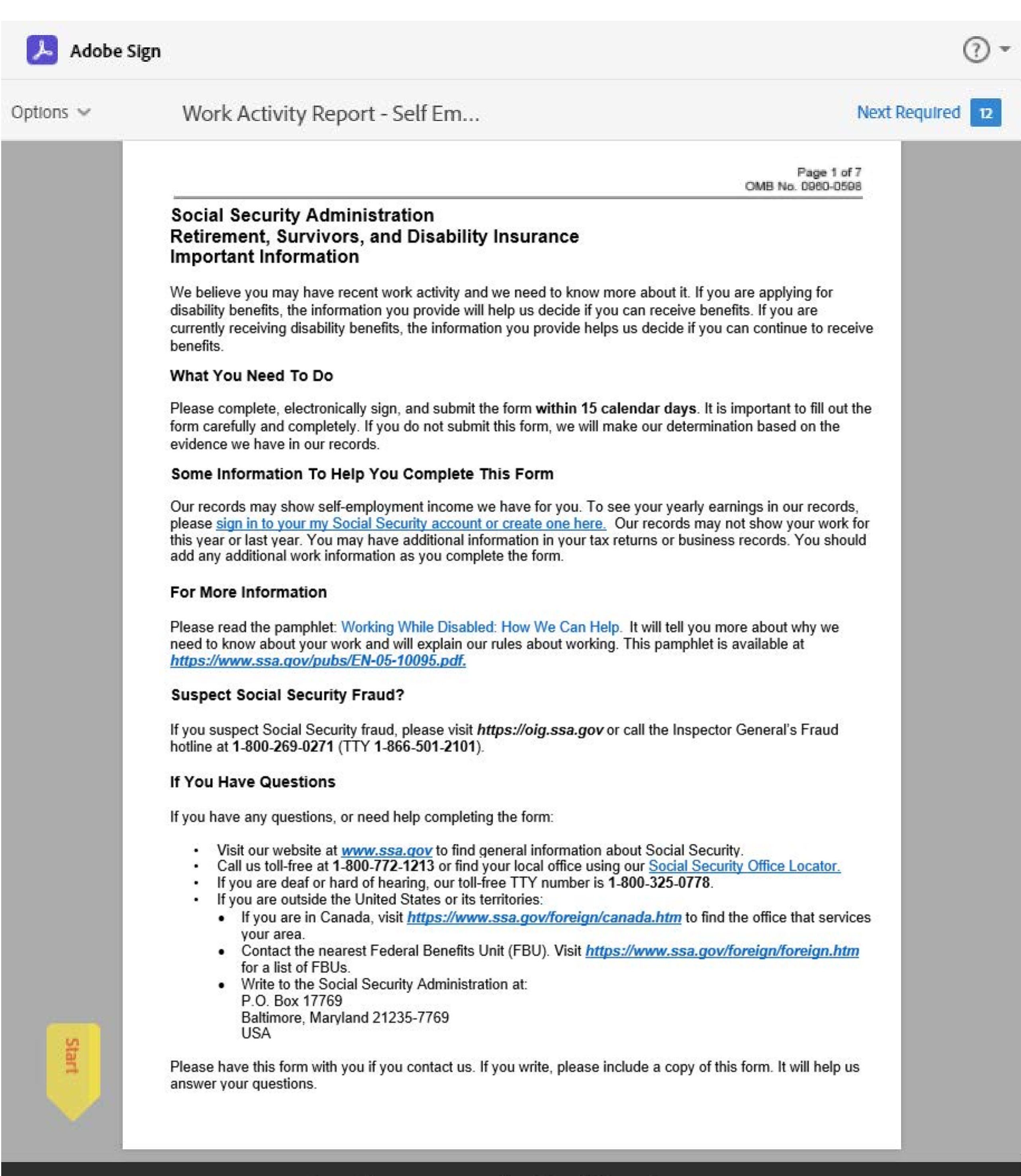
By proceeding, you agree that this agreement may be signed using electronic or handwritten signatures.

Password Confirmation:



The claimant must provide the password to access the form.

SSA820 Cover Sheet:



Adobe Sign

Options | Work Activity Report - Self Em... | Next Required 12

Page 1 of 7
OMB No. 0960-0598

Social Security Administration
Retirement, Survivors, and Disability Insurance
Important Information

We believe you may have recent work activity and we need to know more about it. If you are applying for disability benefits, the information you provide will help us decide if you can receive benefits. If you are currently receiving disability benefits, the information you provide helps us decide if you can continue to receive benefits.

What You Need To Do

Please complete, electronically sign, and submit the form **within 15 calendar days**. It is important to fill out the form carefully and completely. If you do not submit this form, we will make our determination based on the evidence we have in our records.

Some Information To Help You Complete This Form

Our records may show self-employment income we have for you. To see your yearly earnings in our records, please sign in to your my Social Security account or create one here. Our records may not show your work for this year or last year. You may have additional information in your tax returns or business records. You should add any additional work information as you complete the form.

For More Information

Please read the pamphlet: Working While Disabled: How We Can Help. It will tell you more about why we need to know about your work and will explain our rules about working. This pamphlet is available at ***https://www.ssa.gov/pubs/EN-05-10095.pdf.***

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit ***https://oig.ssa.gov*** or call the Inspector General's Fraud hotline at **1-800-269-0271** (TTY **1-866-501-2101**).

If You Have Questions

If you have any questions, or need help completing the form:

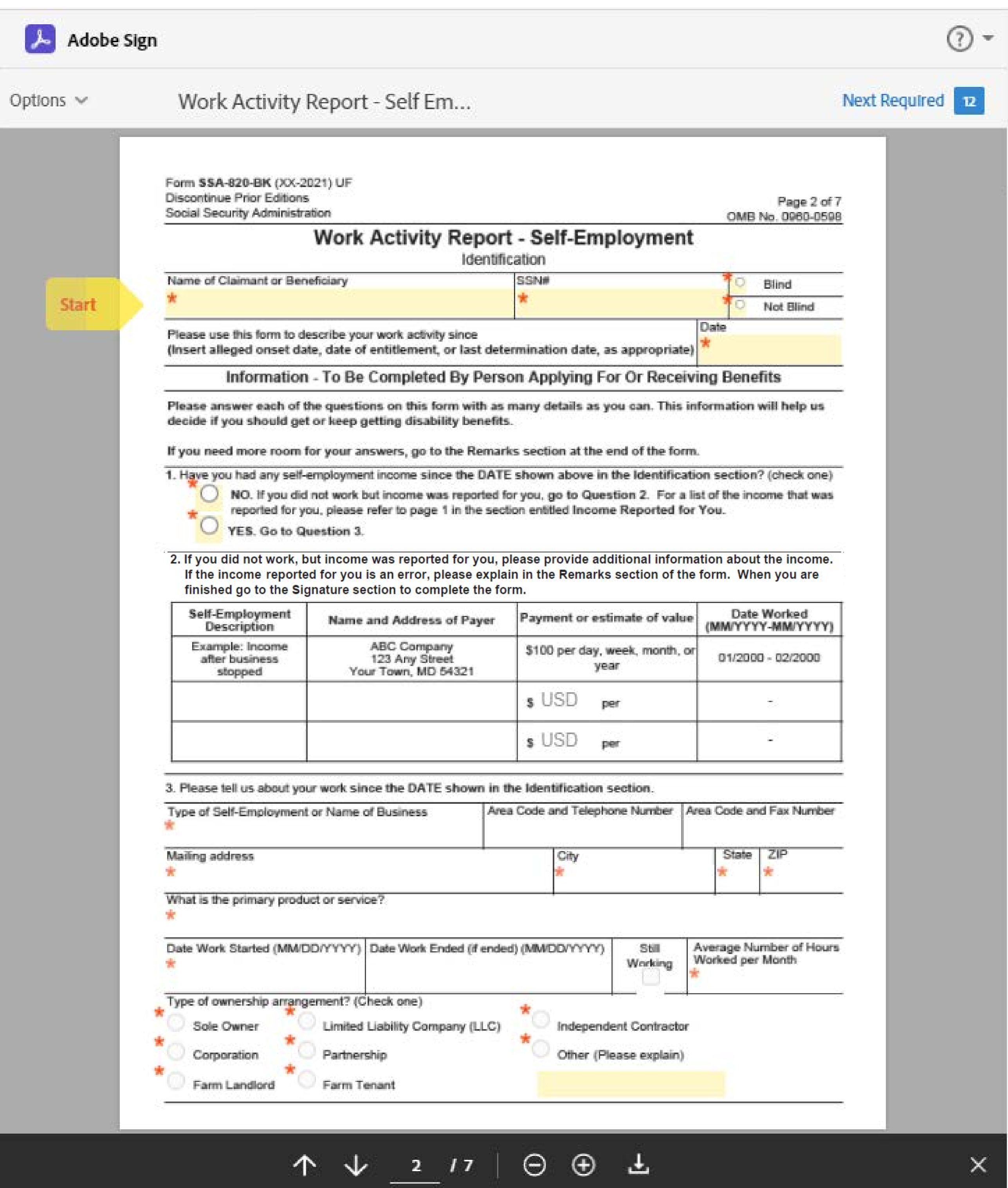
- Visit our website at ***www.ssa.gov*** to find general information about Social Security.
- Call us toll-free at **1-800-772-1213** or find your local office using our Social Security Office Locator.
- If you are deaf or hard of hearing, our toll-free TTY number is **1-800-325-0778**.
- If you are outside the United States or its territories:
  - If you are in Canada, visit ***https://www.ssa.gov/foreign/canada.htm*** to find the office that services your area.
  - Contact the nearest Federal Benefits Unit (FBU). Visit ***https://www.ssa.gov/foreign/foreign.htm*** for a list of FBUs.
  - Write to the Social Security Administration at:
    P.O. Box 17769
    Baltimore, Maryland 21235-7769
    USA

Please have this form with you if you contact us. If you write, please include a copy of this form. It will help us answer your questions.

Start

1 / 7

SSA820 Adobe Form:



Adobe Sign

Options | Work Activity Report - Self Em... | Next Required 12

Form **SSA-820-BK** (XX-2021) UF
Discontinue Prior Editions
Social Security Administration

Page 2 of 7
OMB No. 0960-0598

Work Activity Report - Self-Employment

Identification

Name of Claimant or Beneficiary *	SSN# *	* Blind / * Not Blind

Please use this form to describe your work activity since
(Insert alleged onset date, date of entitlement, or last determination date, as appropriate) | Date *

Information - To Be Completed By Person Applying For Or Receiving Benefits

Please answer each of the questions on this form with as many details as you can. This information will help us decide if you should get or keep getting disability benefits.

If you need more room for your answers, go to the Remarks section at the end of the form.

1. Have you had any self-employment income since the DATE shown above in the Identification section? (check one)
   - * NO. If you did not work but income was reported for you, go to Question 2. For a list of the income that was reported for you, please refer to page 1 in the section entitled Income Reported for You.
   - * YES. Go to Question 3.

2. If you did not work, but income was reported for you, please provide additional information about the income. If the income reported for you is an error, please explain in the Remarks section of the form. When you are finished go to the Signature section to complete the form.

Self-Employment Description	Name and Address of Payer	Payment or estimate of value	Date Worked (MM/YYYY-MM/YYYY)
Example: Income after business stopped	ABC Company 123 Any Street Your Town, MD 54321	$100 per day, week, month, or year	01/2000 - 02/2000
		$ USD per	-
		$ USD per	-

3. Please tell us about your work since the DATE shown in the Identification section.

Type of Self-Employment or Name of Business *	Area Code and Telephone Number	Area Code and Fax Number

Mailing address *	City *	State *	ZIP *

What is the primary product or service? *

Date Work Started (MM/DD/YYYY) *	Date Work Ended (if ended) (MM/DD/YYYY)	Still Working	Average Number of Hours Worked per Month *

Type of ownership arrangement? (Check one)

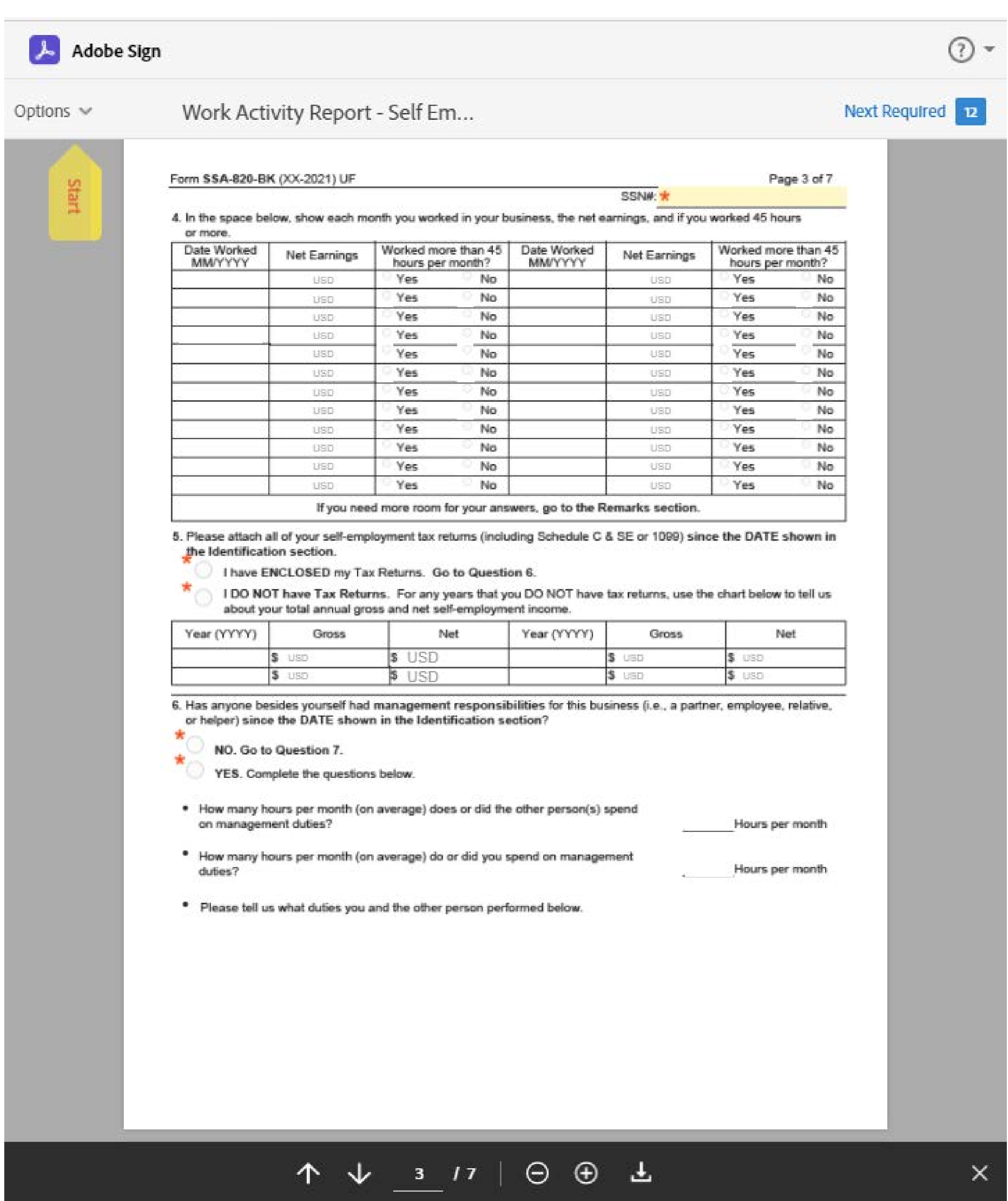
- * Sole Owner
- * Limited Liability Company (LLC)
- * Independent Contractor
- * Corporation
- * Partnership
- * Other (Please explain)
- * Farm Landlord
- * Farm Tenant

Start

2 / 7

Red asterisks notate a required field. Note that some required fields are conditional, based upon how the prior question was answered. Please see page 16 for an example.

SSA820 Adobe Form:


Adobe Sign

Options

Work Activity Report - Self Em...

Next Required 12

Start

Form SSA-820-BK (XX-2021) UF

Page 3 of 7

SSN#: *

4. In the space below, show each month you worked in your business, the net earnings, and if you worked 45 hours or more.

Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?	Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No

If you need more room for your answers, go to the Remarks section.

5. Please attach all of your self-employment tax returns (including Schedule C & SE or 1099) since the DATE shown in the Identification section.

* I have ENCLOSED my Tax Returns. Go to Question 6.

* I DO NOT have Tax Returns. For any years that you DO NOT have tax returns, use the chart below to tell us about your total annual gross and net self-employment income.

Year (YYYY)	Gross	Net	Year (YYYY)	Gross	Net
	$ USD	$ USD		$ USD	$ USD
	$ USD	$ USD		$ USD	$ USD

6. Has anyone besides yourself had management responsibilities for this business (i.e., a partner, employee, relative, or helper) since the DATE shown in the Identification section?

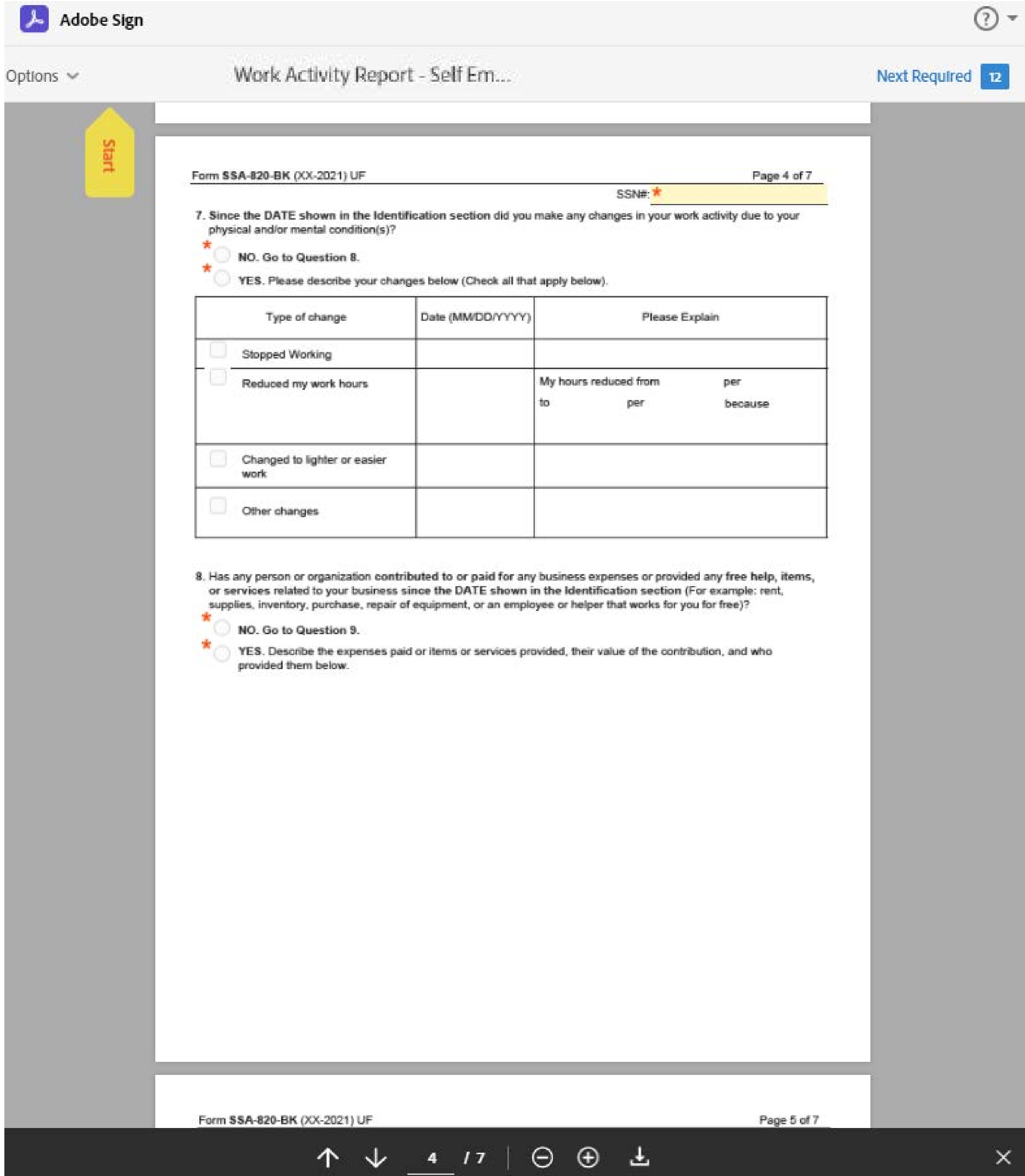
* NO. Go to Question 7.

* YES. Complete the questions below.

- How many hours per month (on average) does or did the other person(s) spend on management duties? ______ Hours per month
- How many hours per month (on average) do or did you spend on management duties? ______ Hours per month
- Please tell us what duties you and the other person performed below.

3 / 7

SSA820 Adobe Form:


Adobe Sign

Options

Work Activity Report - Self Em...

Next Required 12

Start

Form **SSA-820-BK** (XX-2021) UF   Page 4 of 7

SSN#: *

7. **Since the DATE shown in the Identification section** did you make any changes in your work activity due to your physical and/or mental condition(s)?

* **NO. Go to Question 8.**
* **YES.** Please describe your changes below (Check all that apply below).

Type of change	Date (MM/DD/YYYY)	Please Explain
Stopped Working		
Reduced my work hours		My hours reduced from per to per because
Changed to lighter or easier work		
Other changes		

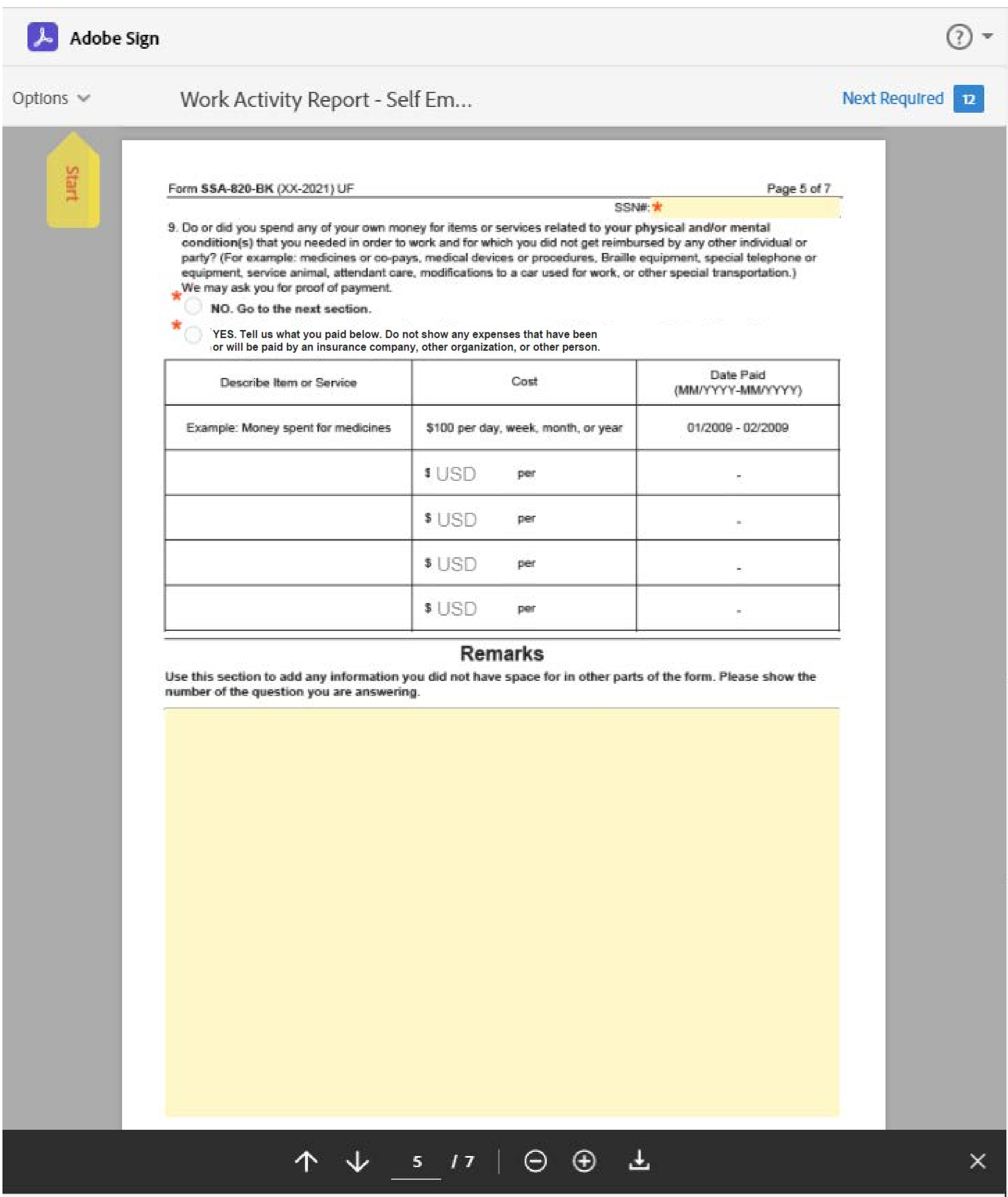
8. Has any person or organization **contributed to or paid for** any business expenses or provided any **free help, items, or services related to your business since the DATE shown in the Identification section** (For example: rent, supplies, inventory, purchase, repair of equipment, or an employee or helper that works for you for free)?

* **NO. Go to Question 9.**
* **YES.** Describe the expenses paid or items or services provided, their value of the contribution, and who provided them below.

Form **SSA-820-BK** (XX-2021) UF   Page 5 of 7

4 / 7

SSA820 Adobe Form:



Adobe Sign

Options | Work Activity Report - Self Em... | Next Required 12

Start

Form **SSA-820-BK** (XX-2021) UF | Page 5 of 7

SSN#: *

9. Do or did you spend any of your own money for items or services related to your physical and/or mental condition(s) that you needed in order to work and for which you did not get reimbursed by any other individual or party? (For example: medicines or co-pays, medical devices or procedures, Braille equipment, special telephone or equipment, service animal, attendant care, modifications to a car used for work, or other special transportation.) We may ask you for proof of payment.

* ◯ **NO. Go to the next section.**

* ◯ YES. Tell us what you paid below. Do not show any expenses that have been or will be paid by an insurance company, other organization, or other person.

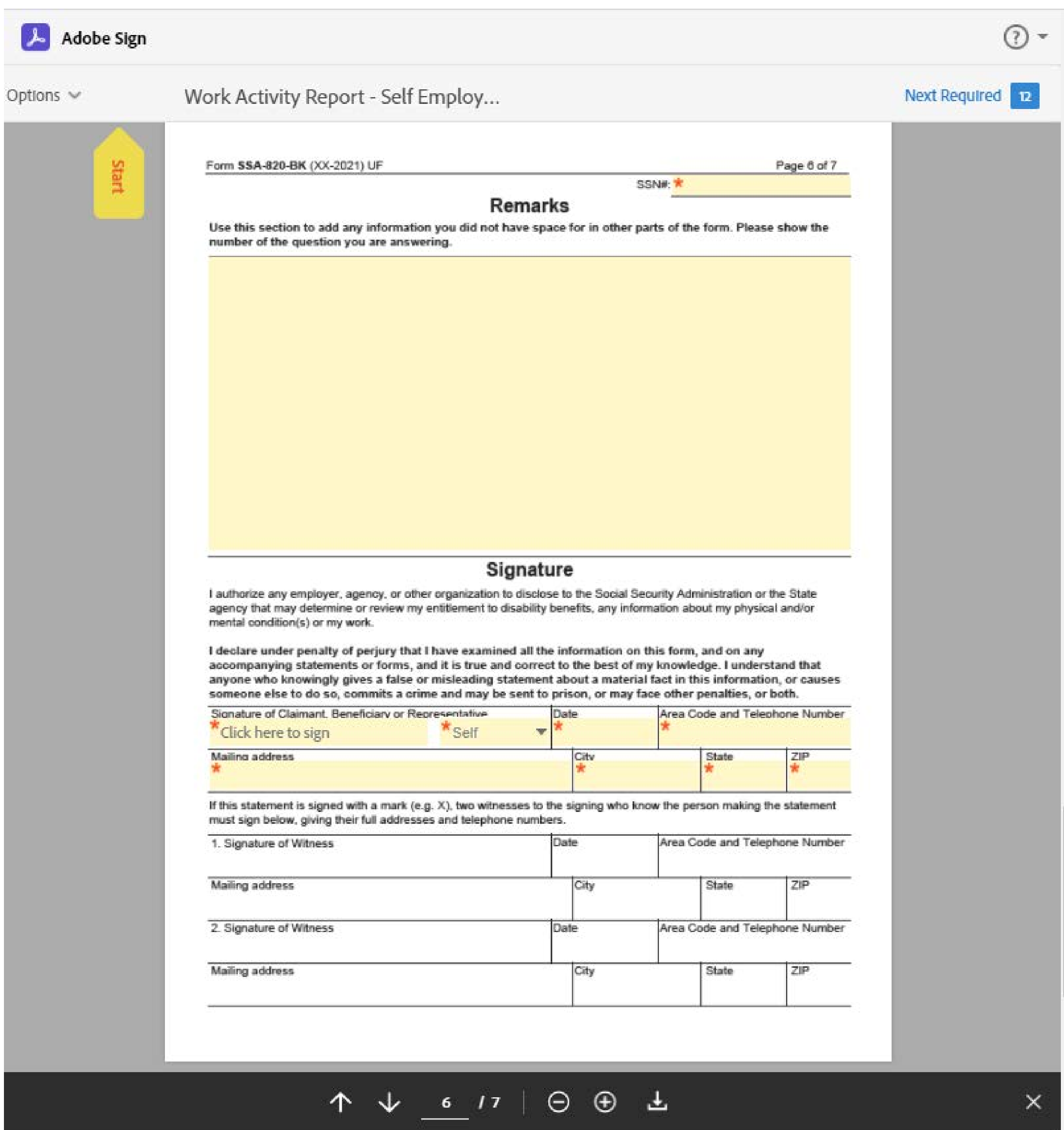
Describe Item or Service	Cost	Date Paid (MM/YYYY-MM/YYYY)
Example: Money spent for medicines	$100 per day, week, month, or year	01/2009 - 02/2009
	$ USD per	-
	$ USD per	-
	$ USD per	-
	$ USD per	-

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

5 / 7

SSA820 Adobe Form:



Adobe Sign

Options

Work Activity Report - Self Employ...

Next Required 12

Start

Form SSA-820-BK (XX-2021) UF Page 6 of 7

SSN#: *

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition(s) or my work.

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.

Signature of Claimant, Beneficiary or Representative		Date	Area Code and Telephone Number
* Click here to sign	* Self	*	*

Mailing address	City	State	ZIP
*	*	*	*

If this statement is signed with a mark (e.g. X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	Date	Area Code and Telephone Number

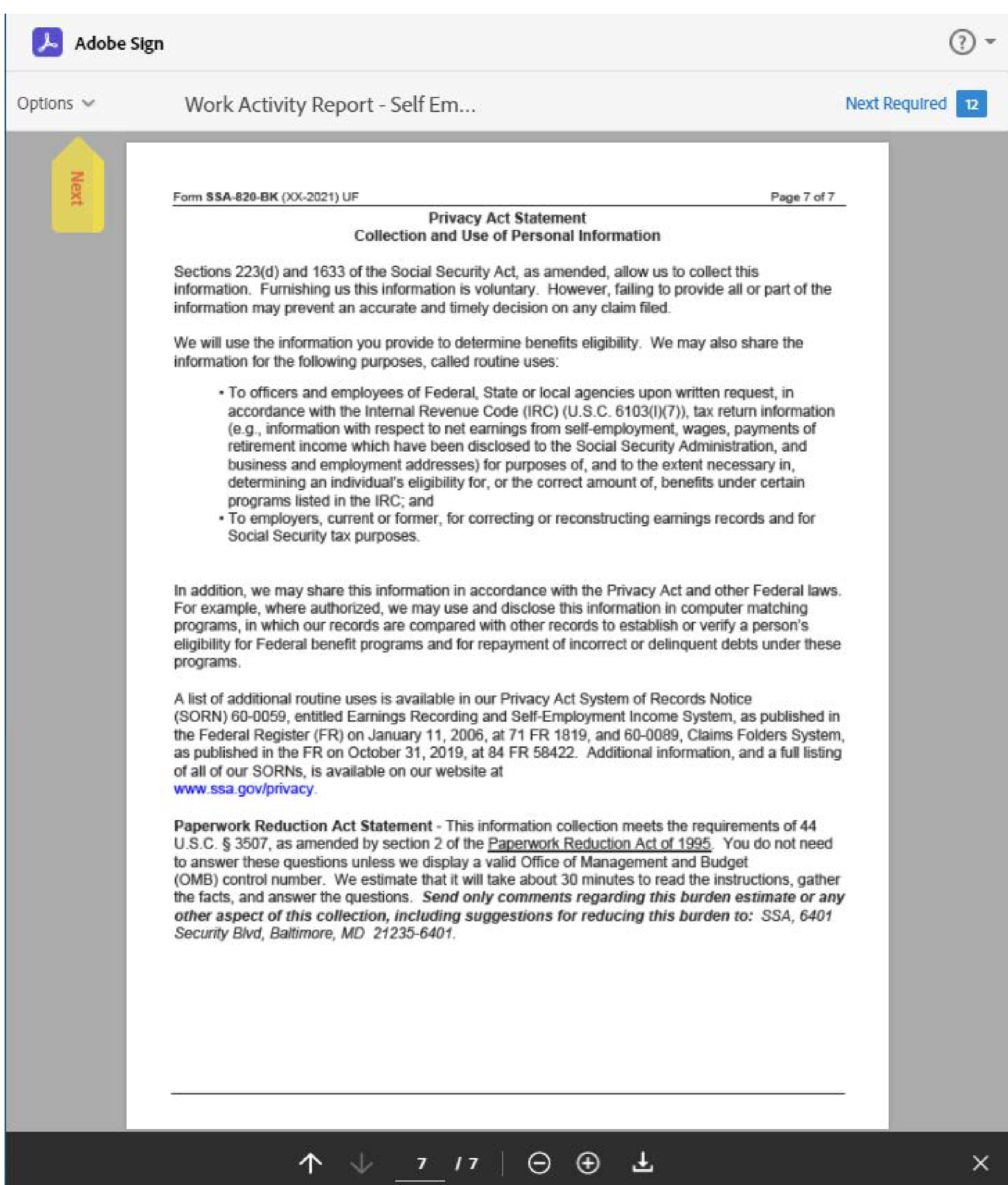
Mailing address	City	State	ZIP

2. Signature of Witness	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

6 / 7

SSA820 Adobe Form:



Form SSA-820-BK (XX-2021) UF Page 7 of 7

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(d) and 1633 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 an accurate and timely decision on any claim filed.

We will use the information you provide to determine benefits eligibility. We may also share the information for the following purposes, called routine uses:

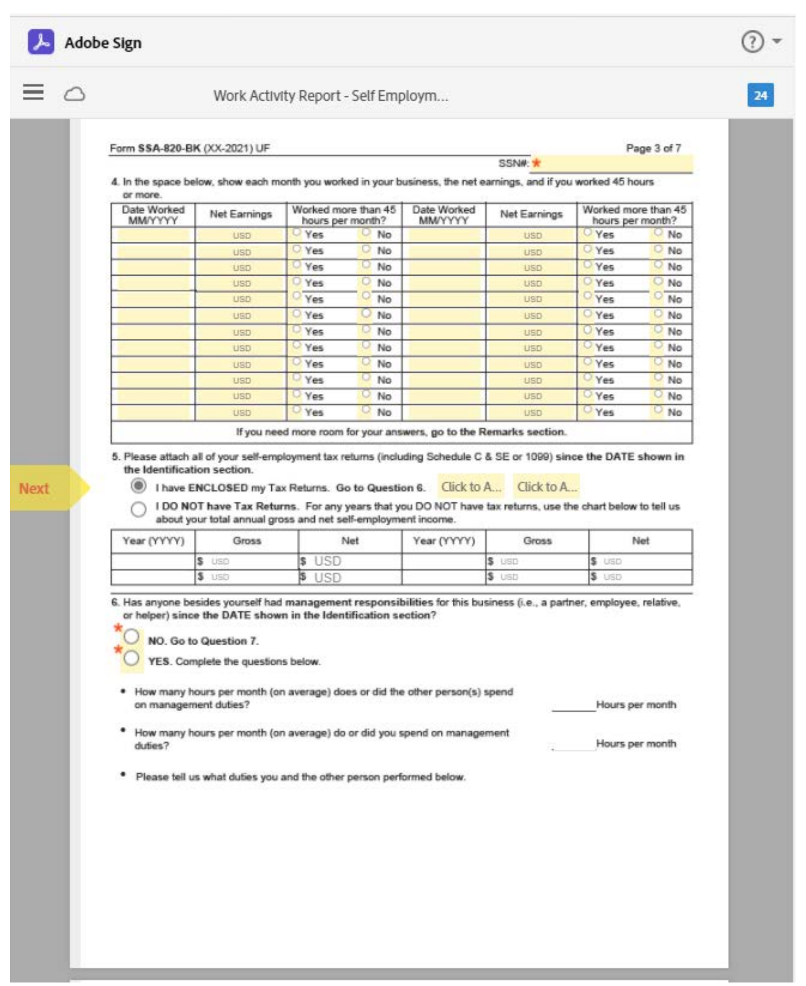
- To officers and employees of Federal, State or local agencies upon written request, in accordance with the Internal Revenue Code (IRC) (U.S.C. 6103(l)(7)), tax return information (e.g., information with respect to net earnings from self-employment, wages, payments of retirement income which have been disclosed to the Social Security Administration, and business and employment addresses) for purposes of, and to the extent necessary in, determining an individual's eligibility for, or the correct amount of, benefits under certain programs listed in the IRC; and
- To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes.

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) 60-0059, entitled Earnings Recording and Self-Employment Income System, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819, and 60-0089, Claims Folders System, as published in the FR on October 31, 2019, at 84 FR 58422. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 30 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.*

Attachment Fields:



Adobe Sign

Work Activity Report - Self Employm...

24

Form **SSA-820-BK** (XX-2021) UF Page 3 of 7

SSN#: *

4. In the space below, show each month you worked in your business, the net earnings, and if you worked 45 hours or more.

Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?	Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
	USD	Yes No		USD	Yes No
If you need more room for your answers, go to the Remarks section.					

5. Please attach all of your self-employment tax returns (including Schedule C & SE or 1099) **since the DATE shown in the Identification section.**

Next

- I have **ENCLOSED** my Tax Returns. **Go to Question 6.** Click to A... Click to A...
- I **DO NOT have Tax Returns**. For any years that you DO NOT have tax returns, use the chart below to tell us about your total annual gross and net self-employment income.

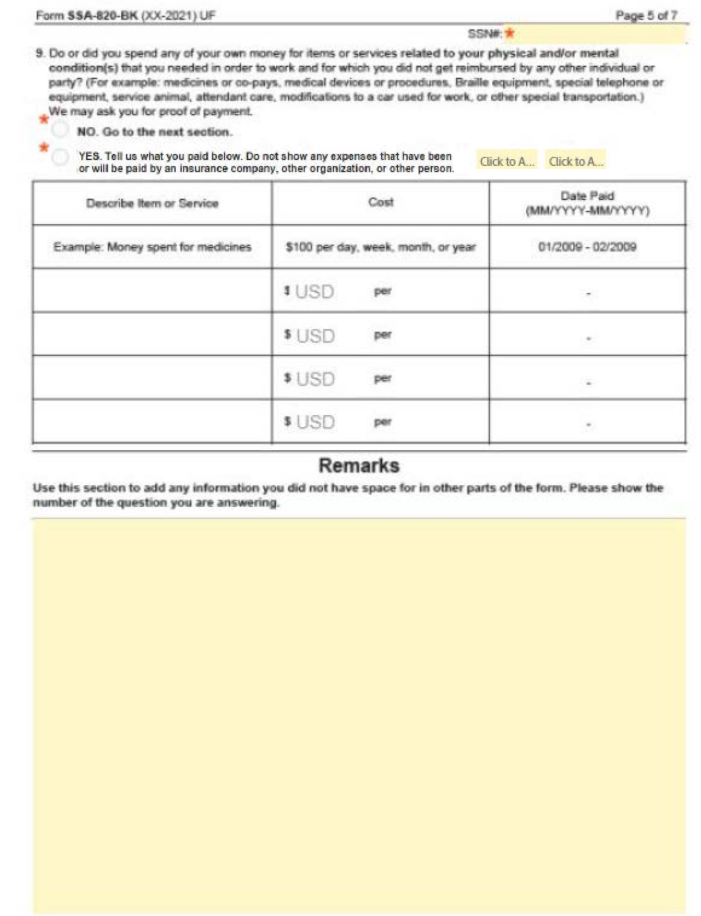
Year (YYYY)	Gross	Net	Year (YYYY)	Gross	Net
	$ USD	$ USD		$ USD	$ USD
	$ USD	$ USD		$ USD	$ USD

6. Has anyone besides yourself had **management responsibilities** for this business (i.e., a partner, employee, relative, or helper) **since the DATE shown in the Identification section?**

* **NO. Go to Question 7.**

* **YES.** Complete the questions below.

- How many hours per month (on average) does or did the other person(s) spend on management duties? ________Hours per month
- How many hours per month (on average) do or did you spend on management duties? ________Hours per month
- Please tell us what duties you and the other person performed below.



Form **SSA-820-BK** (XX-2021) UF Page 5 of 7

SSN#: *

9. Do or did you spend any of your own money for items or services related to **your physical and/or mental condition(s)** that you needed in order to work and for which you did not get reimbursed by any other individual or party? (For example: medicines or co-pays, medical devices or procedures, Braille equipment, special telephone or equipment, service animal, attendant care, modifications to a car used for work, or other special transportation.) We may ask you for proof of payment.

* **NO. Go to the next section.**

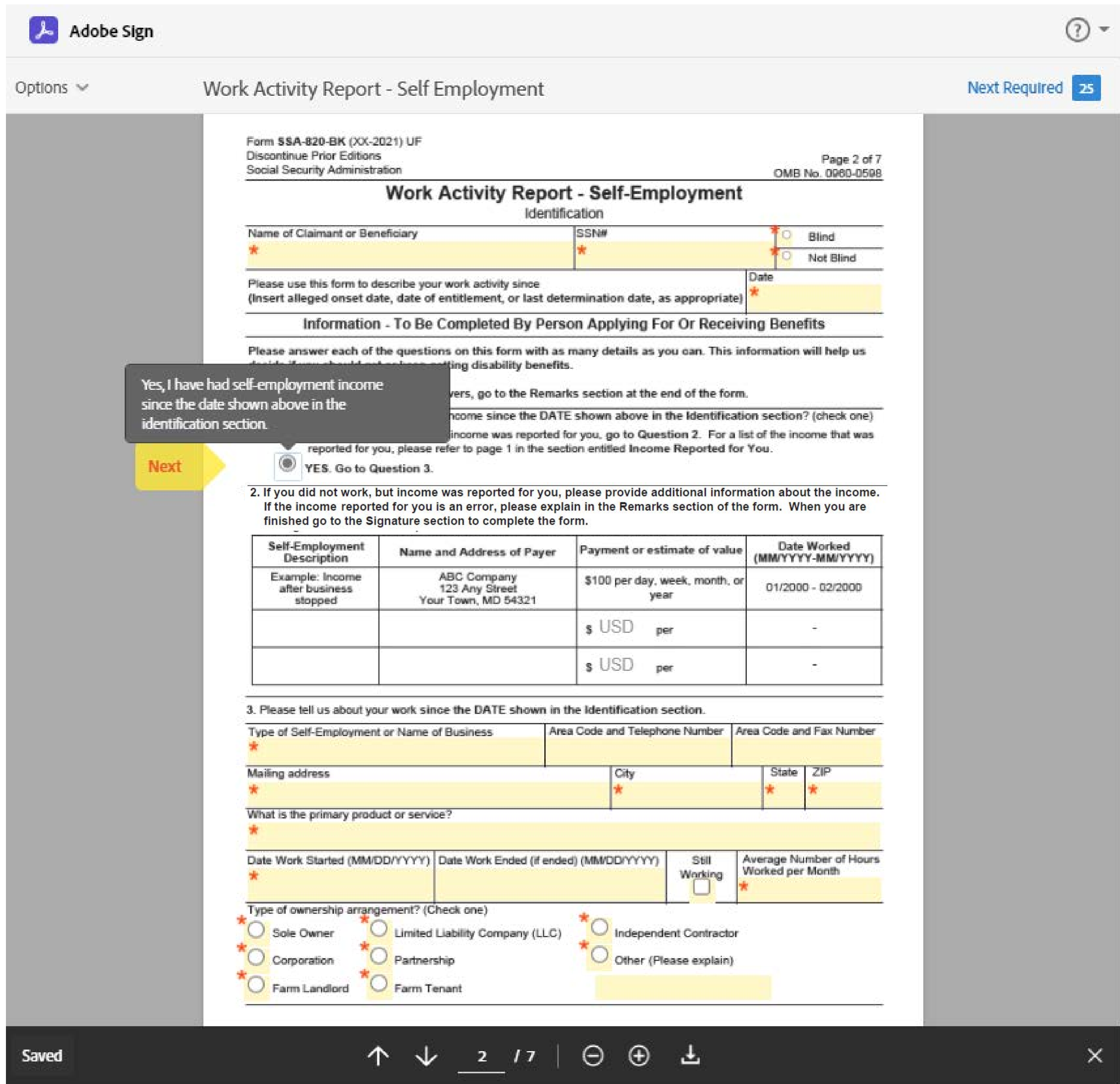
* **YES.** Tell us what you paid below. Do not show any expenses that have been or will be paid by an insurance company, other organization, or other person. Click to A... Click to A...

Describe Item or Service	Cost	Date Paid (MM/YYYY-MM/YYYY)
Example: Money spent for medicines	$100 per day, week, month, or year	01/2009 - 02/2009
	$ USD per	-
	$ USD per	-
	$ USD per	-
	$ USD per	-

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

Example of Conditional Required Fields:



Adobe Sign

Options

Work Activity Report - Self Employment

Next Required 25

Form SSA-820-BK (XX-2021) UF
Discontinue Prior Editions
Social Security Administration

Page 2 of 7
OMB No. 0960-0598

Work Activity Report - Self-Employment

Identification

Name of Claimant or Beneficiary	SSN#	Blind / Not Blind
*	*	* Blind * Not Blind

Please use this form to describe your work activity since (Insert alleged onset date, date of entitlement, or last determination date, as appropriate)	Date *

Information - To Be Completed By Person Applying For Or Receiving Benefits

Please answer each of the questions on this form with as many details as you can. This information will help us ...ing disability benefits.

Yes, I have had self-employment income since the date shown above in the identification section.

...ers, go to the Remarks section at the end of the form.

...ncome since the DATE shown above in the Identification section? (check one)

...income was reported for you, go to Question 2. For a list of the income that was reported for you, please refer to page 1 in the section entitled Income Reported for You.

Next

YES. Go to Question 3.

2. If you did not work, but income was reported for you, please provide additional information about the income. If the income reported for you is an error, please explain in the Remarks section of the form. When you are finished go to the Signature section to complete the form.

Self-Employment Description	Name and Address of Payer	Payment or estimate of value	Date Worked (MM/YYYY-MM/YYYY)
Example: Income after business stopped	ABC Company 123 Any Street Your Town, MD 54321	$100 per day, week, month, or year	01/2000 - 02/2000
		$ USD per	-
		$ USD per	-

3. Please tell us about your work since the DATE shown in the Identification section.

Type of Self-Employment or Name of Business	Area Code and Telephone Number	Area Code and Fax Number
*		

Mailing address	City	State	ZIP
*	*	*	*

What is the primary product or service? *

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY)	Still Working	Average Number of Hours Worked per Month
*		☐	*

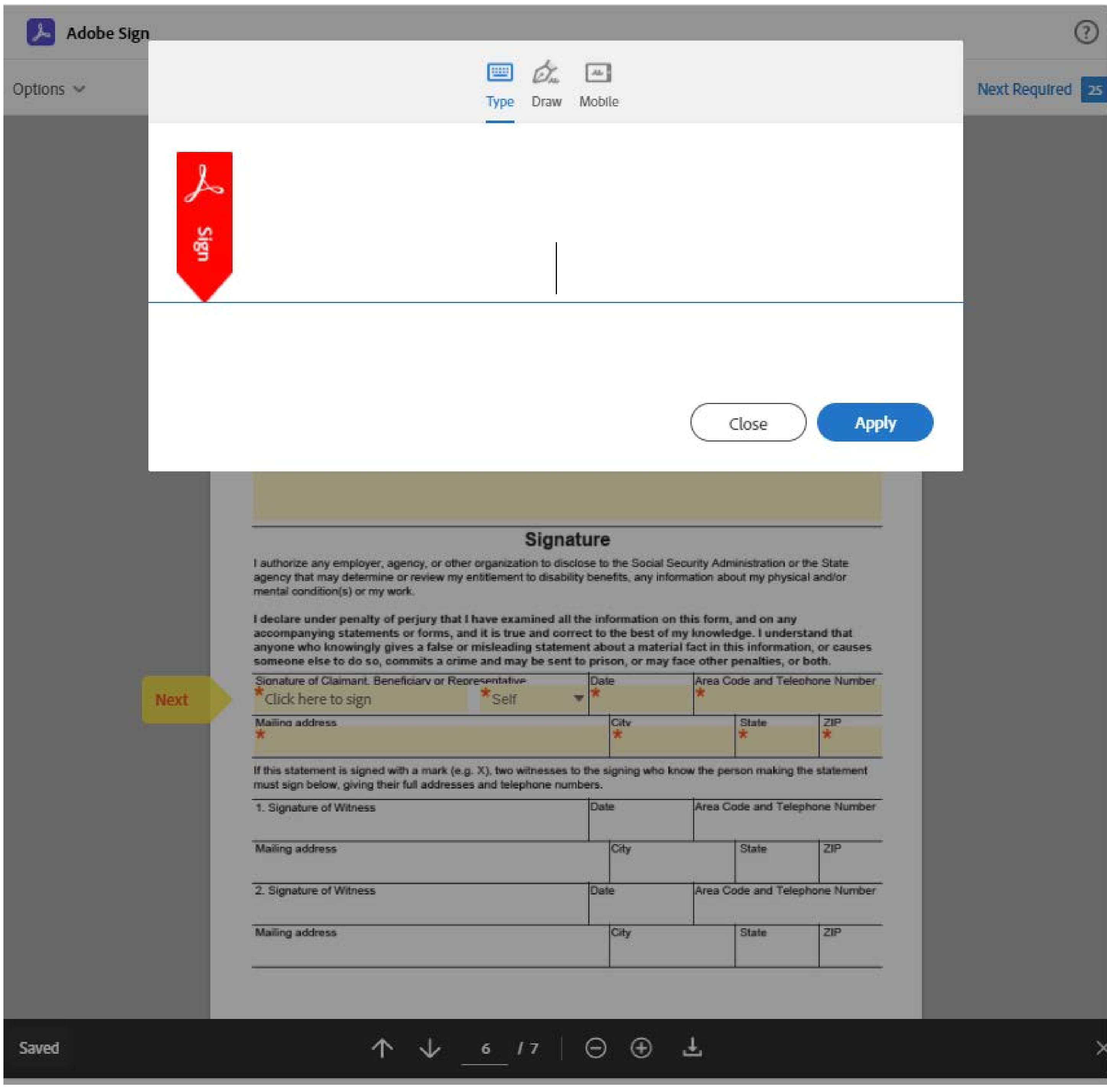
Type of ownership arrangement? (Check one)

- Sole Owner
- Limited Liability Company (LLC)
- Independent Contractor
- Corporation
- Partnership
- Other (Please explain)
- Farm Landlord
- Farm Tenant

Saved 2 / 7

The SSA820's questions are based on conditional values. The example displayed above shows that by selecting "YES" to question 1, question 2 is not available to enter information in, and the user can move onto question 3.

Signature:



By clicking in the Signature field the user can type their name to sign the document.

Completed Signature:

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition(s) or my work.

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.

Signature of Claimant, Beneficiary or Representative		Date	Area Code and Telephone Number
Test Test	Self	06/10/2021	1234567890

Mailing address	City	State	ZIP
123 ABC Lane	Test	MD	12345

If this statement is signed with a mark (e.g. X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

2. Signature of Witness	Date	Area Code and Telephone Number

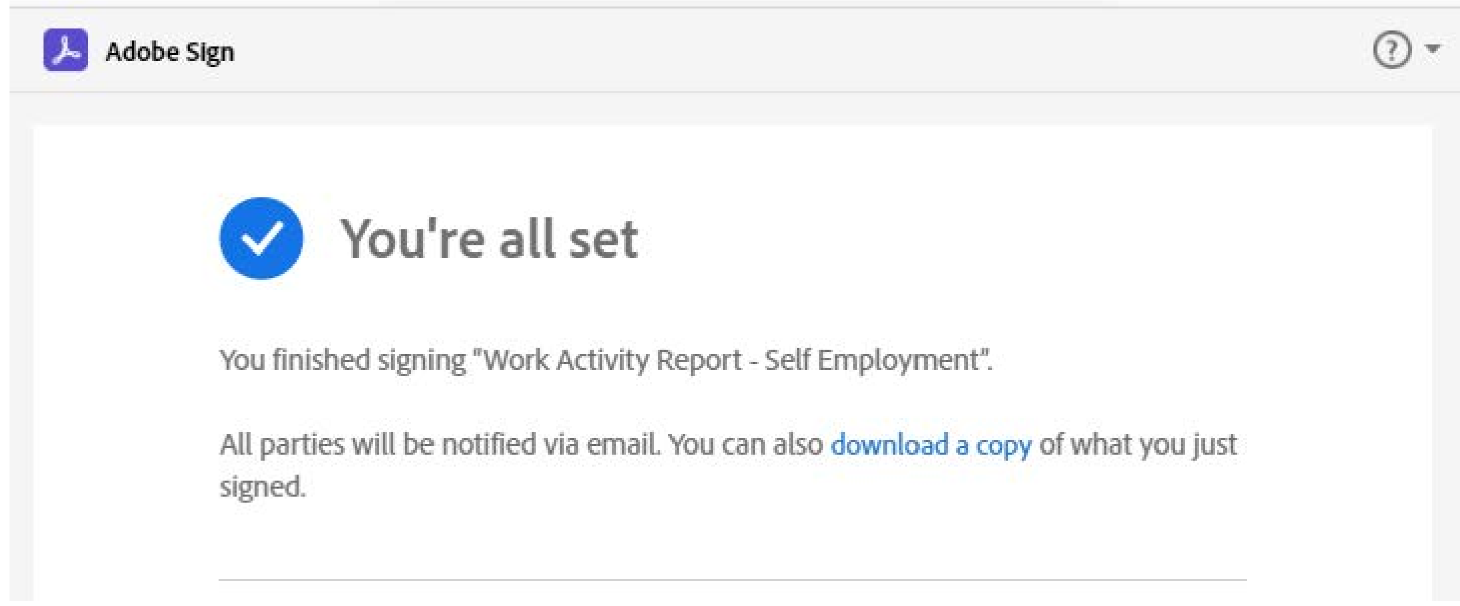
Mailing address	City	State	ZIP

By signing, I agree to both this agreement and the Consumer Disclosure. My use of Adobe Sign is governed by the Adobe Terms of Use.

Click to Sign

Signature now appears on the form with the date it was signed appearing below signature. If all required fields are filled out, user can "Click to Sign".

SSA820 Adobe Form Completion Page:



Final Email:

Tue 6/8/2021 8:47 AM

Social Security Administration <adobesign@adobesign.com>

[EXTERNAL] Work Activity Report - Self Employment has been Signed and Filed

To Claimant Email

Retention Policy Delete_7_Year_Default (7 years) Expires 6/6/2028

If there are problems with how this message is displayed, click here to view it in a web browser.

You're done signing

Work Activity Report - Self Employment

Open Document

The document is complete.

You can **open the final document** to review its activity history or download a copy for reference.

For additional security, you set a password for this document. You will need the password to review this document. If you forget or lose the password, it cannot be reset.

This link is personalized for you and, for security purposes, we recommend you do NOT forward/share this email or link with others. If you DO forward/share this email or link with others, you accept the risk that, by sharing your personal information, the person assisting you may misuse your personal information. If you have any questions about this email or feel that you received this in error, please contact SSA at 1-800-772-1213 (TTY 1-800-325-0778) between 8:00 am – 7:00 pm, Monday through Friday.

The document is fully executed. The Social Security Administration has control over the retention period for this document, which determines the amount of time it will be available for download from Adobe Sign. Adobe recommends that you save a local copy of this fully-executed document for your records.

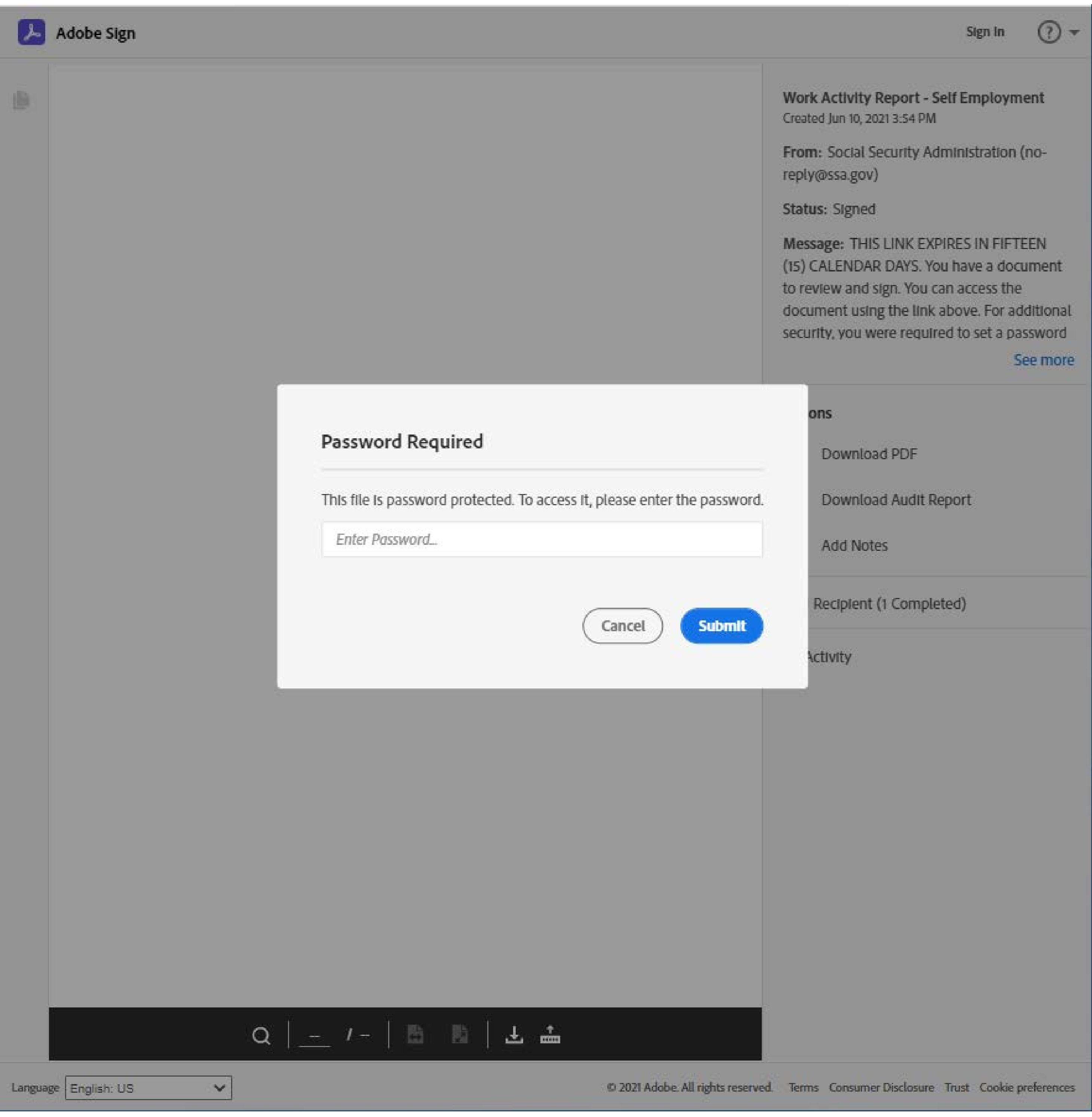
Powered by Adobe Sign

Need your own documents signed? Adobe Sign can help save you time. **Learn more.**

To ensure that you continue receiving our emails, please add **adobesign@adobesign.com** to your address book or safe list.

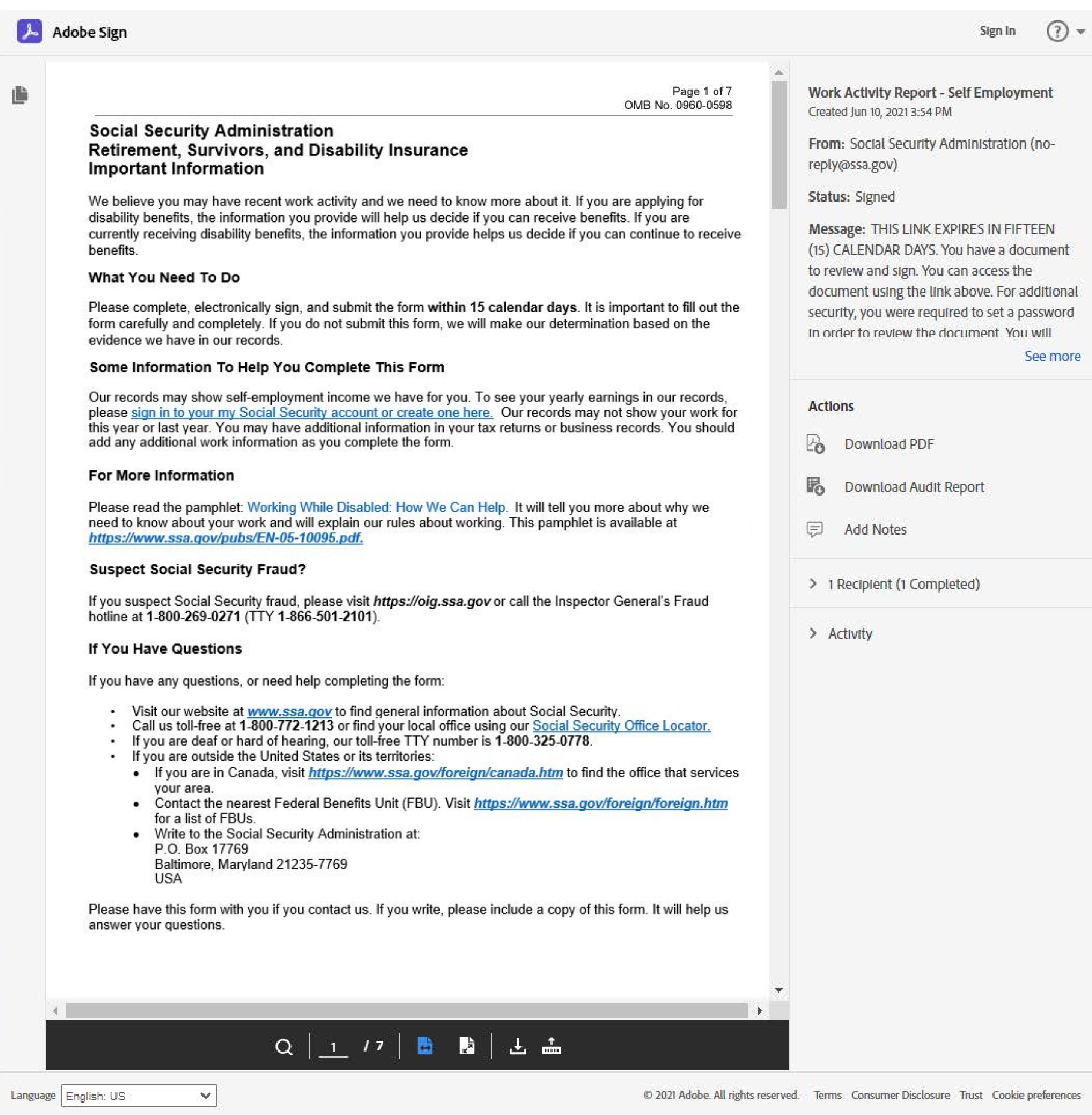
© 2019 Adobe. All rights reserved.

Password Request Page:



In order to view the completed form, the user must enter their pre-established password .

SSA820 Completed Form:



Adobe Sign

Sign In

Page 1 of 7
OMB No. 0960-0598

Social Security Administration
Retirement, Survivors, and Disability Insurance
Important Information

We believe you may have recent work activity and we need to know more about it. If you are applying for disability benefits, the information you provide will help us decide if you can receive benefits. If you are currently receiving disability benefits, the information you provide helps us decide if you can continue to receive benefits.

What You Need To Do

Please complete, electronically sign, and submit the form **within 15 calendar days**. It is important to fill out the form carefully and completely. If you do not submit this form, we will make our determination based on the evidence we have in our records.

Some Information To Help You Complete This Form

Our records may show self-employment income we have for you. To see your yearly earnings in our records, please sign in to your my Social Security account or create one here. Our records may not show your work for this year or last year. You may have additional information in your tax returns or business records. You should add any additional work information as you complete the form.

For More Information

Please read the pamphlet: Working While Disabled: How We Can Help. It will tell you more about why we need to know about your work and will explain our rules about working. This pamphlet is available at ***https://www.ssa.gov/pubs/EN-05-10095.pdf.***

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit ***https://oig.ssa.gov*** or call the Inspector General's Fraud hotline at **1-800-269-0271** (TTY **1-866-501-2101**).

If You Have Questions

If you have any questions, or need help completing the form:

- Visit our website at ***www.ssa.gov*** to find general information about Social Security.
- Call us toll-free at **1-800-772-1213** or find your local office using our Social Security Office Locator.
- If you are deaf or hard of hearing, our toll-free TTY number is **1-800-325-0778**.
- If you are outside the United States or its territories:
  - If you are in Canada, visit ***https://www.ssa.gov/foreign/canada.htm*** to find the office that services your area.
  - Contact the nearest Federal Benefits Unit (FBU). Visit ***https://www.ssa.gov/foreign/foreign.htm*** for a list of FBUs.
  - Write to the Social Security Administration at:
    P.O. Box 17769
    Baltimore, Maryland 21235-7769
    USA

Please have this form with you if you contact us. If you write, please include a copy of this form. It will help us answer your questions.

1 / 7

Work Activity Report - Self Employment
Created Jun 10, 2021 3:54 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. You will

See more

Actions

Download PDF

Download Audit Report

Add Notes

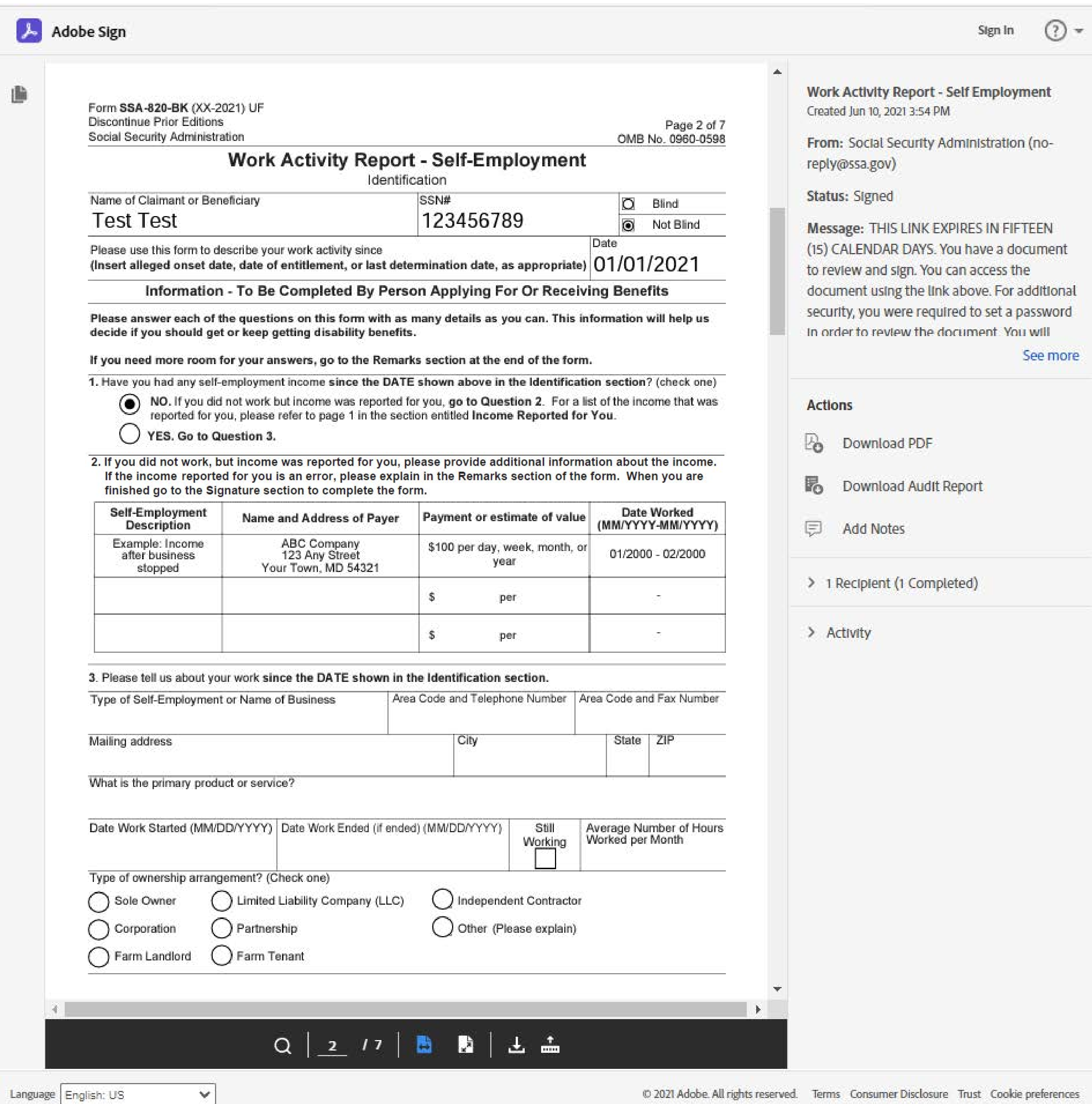
1 Recipient (1 Completed)

Activity

Language English: US

© 2021 Adobe. All rights reserved. Terms Consumer Disclosure Trust Cookie preferences

SSA820 Completed Form:


Adobe Sign

Sign In

Form **SSA-820-BK** (XX-2021) UF
Discontinue Prior Editions
Social Security Administration

Page 2 of 7
OMB No. 0960-0598

Work Activity Report - Self-Employment

Identification

Name of Claimant or Beneficiary	SSN#	
Test Test	123456789	○ Blind / ◉ Not Blind

Please use this form to describe your work activity since
(Insert alleged onset date, date of entitlement, or last determination date, as appropriate) Date 01/01/2021

Information - To Be Completed By Person Applying For Or Receiving Benefits

Please answer each of the questions on this form with as many details as you can. This information will help us decide if you should get or keep getting disability benefits.

If you need more room for your answers, go to the Remarks section at the end of the form.

1. Have you had any self-employment income **since the DATE shown above in the Identification section**? (check one)

◉ **NO.** If you did not work but income was reported for you, **go to Question 2**. For a list of the income that was reported for you, please refer to page 1 in the section entitled **Income Reported for You**.

○ **YES. Go to Question 3.**

2. If you did not work, but income was reported for you, please provide additional information about the income. If the income reported for you is an error, please explain in the Remarks section of the form. When you are finished go to the Signature section to complete the form.

Self-Employment Description	Name and Address of Payer	Payment or estimate of value	Date Worked (MM/YYYY-MM/YYYY)
Example: Income after business stopped	ABC Company 123 Any Street Your Town, MD 54321	$100 per day, week, month, or year	01/2000 - 02/2000
		$ per	-
		$ per	-

3. Please tell us about your work **since the DATE shown in the Identification section.**

Type of Self-Employment or Name of Business	Area Code and Telephone Number	Area Code and Fax Number

Mailing address	City	State	ZIP

What is the primary product or service?

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY)	Still Working	Average Number of Hours Worked per Month
		☐	

Type of ownership arrangement? (Check one)

○ Sole Owner ○ Limited Liability Company (LLC) ○ Independent Contractor
○ Corporation ○ Partnership ○ Other (Please explain)
○ Farm Landlord ○ Farm Tenant

2 / 7

Work Activity Report - Self Employment
Created Jun 10, 2021 3:54 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. You will

See more

Actions

Download PDF

Download Audit Report

Add Notes

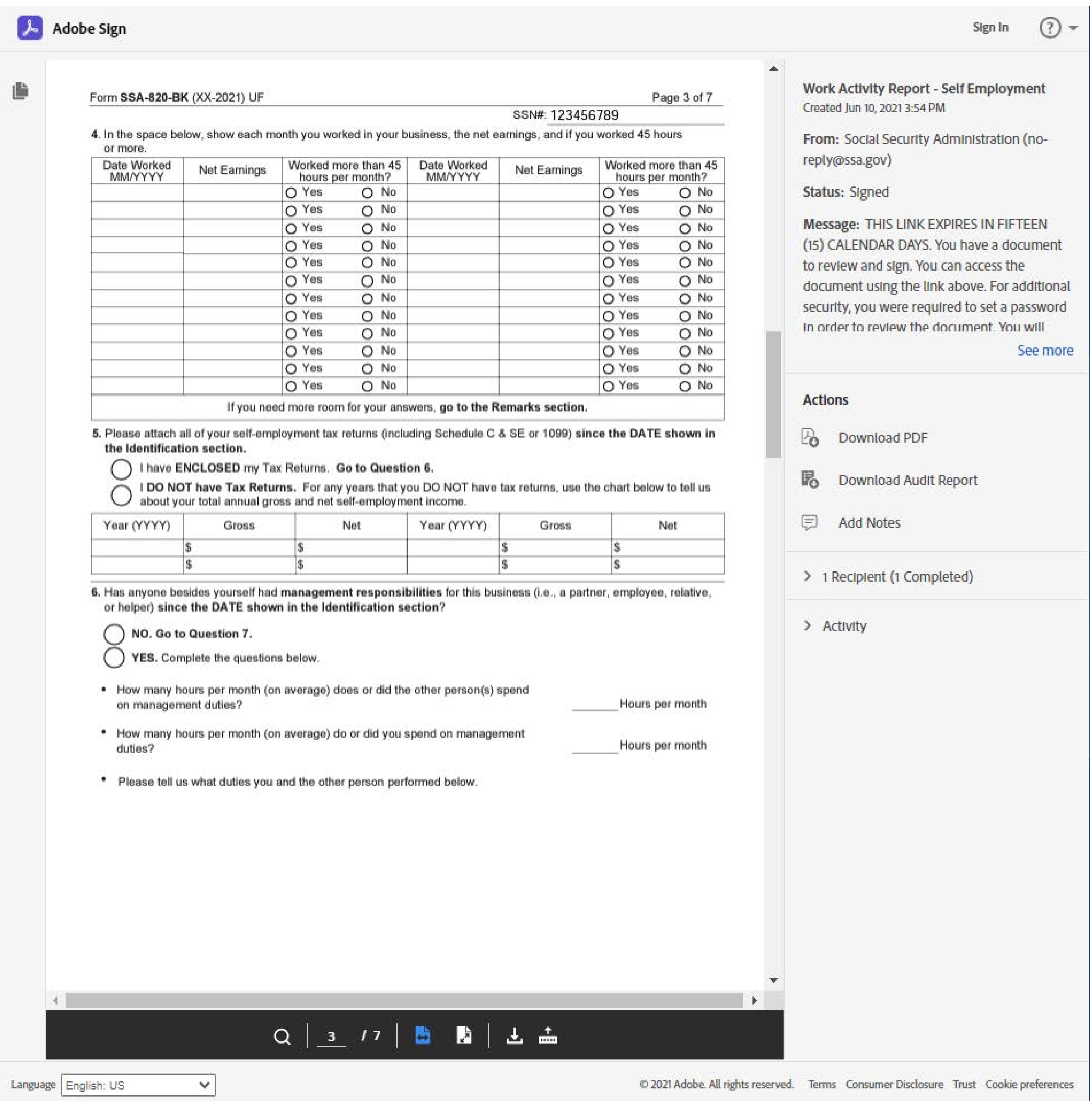
1 Recipient (1 Completed)

Activity

Language English: US

© 2021 Adobe. All rights reserved. Terms Consumer Disclosure Trust Cookie preferences

SSA820 Completed Form:



Adobe Sign — Sign In

Form **SSA-820-BK** (XX-2021) UF — Page 3 of 7

SSN#: 123456789

4. In the space below, show each month you worked in your business, the net earnings, and if you worked 45 hours or more.

Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?	Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No
		○ Yes ○ No			○ Yes ○ No

If you need more room for your answers, **go to the Remarks section.**

5. Please attach all of your self-employment tax returns (including Schedule C & SE or 1099) **since the DATE shown in the Identification section.**

○ I have **ENCLOSED** my Tax Returns. **Go to Question 6.**

○ I **DO NOT have Tax Returns.** For any years that you DO NOT have tax returns, use the chart below to tell us about your total annual gross and net self-employment income.

Year (YYYY)	Gross	Net	Year (YYYY)	Gross	Net
	$	$		$	$
	$	$		$	$

6. Has anyone besides yourself had **management responsibilities** for this business (i.e., a partner, employee, relative, or helper) **since the DATE shown in the Identification section?**

○ **NO. Go to Question 7.**

○ **YES.** Complete the questions below.

- How many hours per month (on average) does or did the other person(s) spend on management duties? ______ Hours per month
- How many hours per month (on average) do or did you spend on management duties? ______ Hours per month
- Please tell us what duties you and the other person performed below.

3 / 7

Work Activity Report - Self Employment

Created Jun 10, 2021 3:54 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. You will

See more

Actions

Download PDF

Download Audit Report

Add Notes

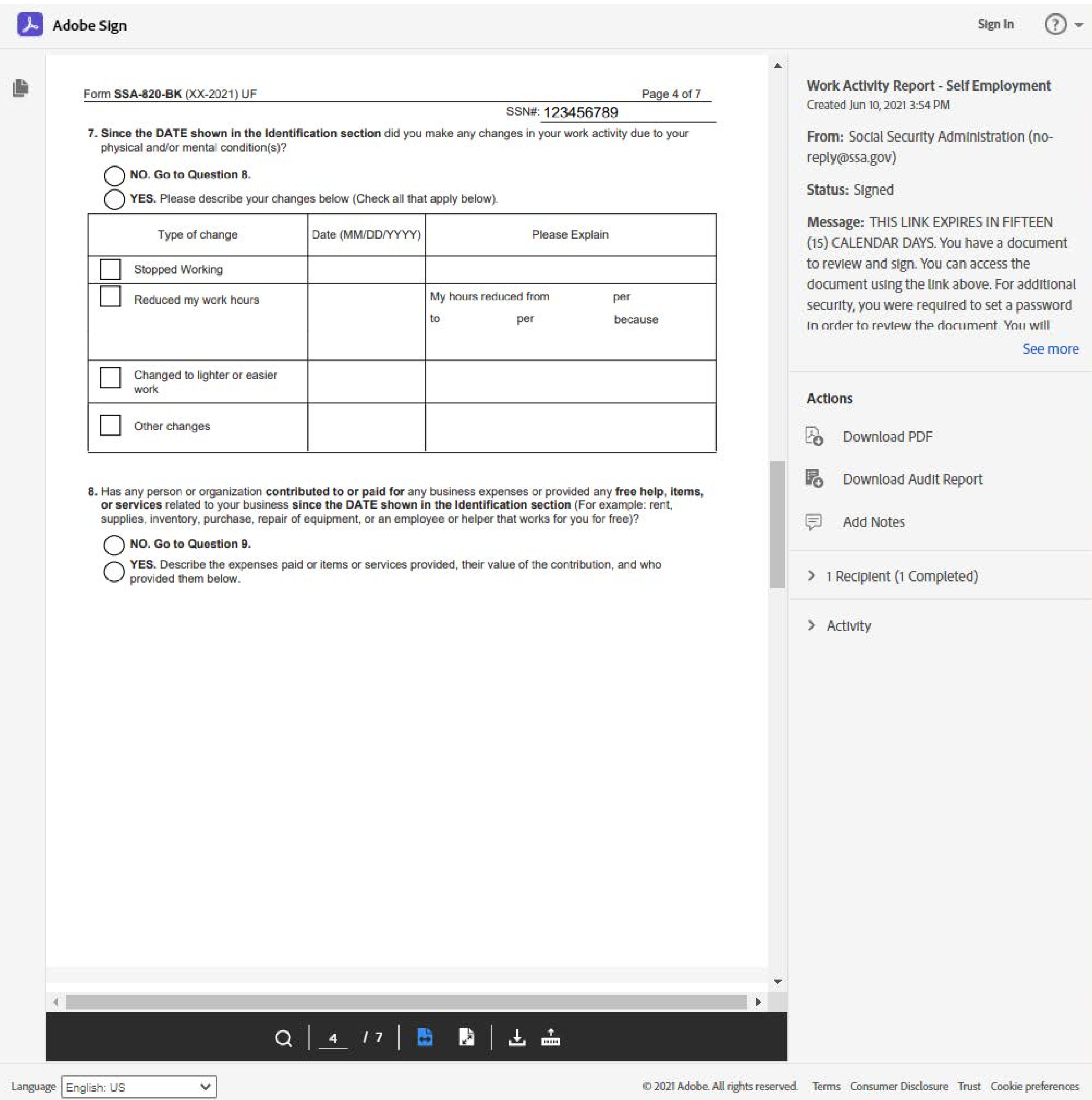
› 1 Recipient (1 Completed)

› Activity

Language English: US

© 2021 Adobe. All rights reserved. Terms Consumer Disclosure Trust Cookie preferences

SSA820 Completed Form:


Adobe Sign

Sign In

Form **SSA-820-BK** (XX-2021) UF Page 4 of 7

SSN#: 123456789

7. **Since the DATE shown in the Identification section** did you make any changes in your work activity due to your physical and/or mental condition(s)?

◯ **NO. Go to Question 8.**

◯ **YES.** Please describe your changes below (Check all that apply below).

Type of change	Date (MM/DD/YYYY)	Please Explain
☐ Stopped Working		
☐ Reduced my work hours		My hours reduced from per to per because
☐ Changed to lighter or easier work		
☐ Other changes		

8. Has any person or organization **contributed to or paid for** any business expenses or provided any **free help, items, or services** related to your business **since the DATE shown in the Identification section** (For example: rent, supplies, inventory, purchase, repair of equipment, or an employee or helper that works for you for free)?

◯ **NO. Go to Question 9.**

◯ **YES.** Describe the expenses paid or items or services provided, their value of the contribution, and who provided them below.

4 / 7

Work Activity Report - Self Employment

Created Jun 10, 2021 3:54 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. You will

See more

Actions

Download PDF

Download Audit Report

Add Notes

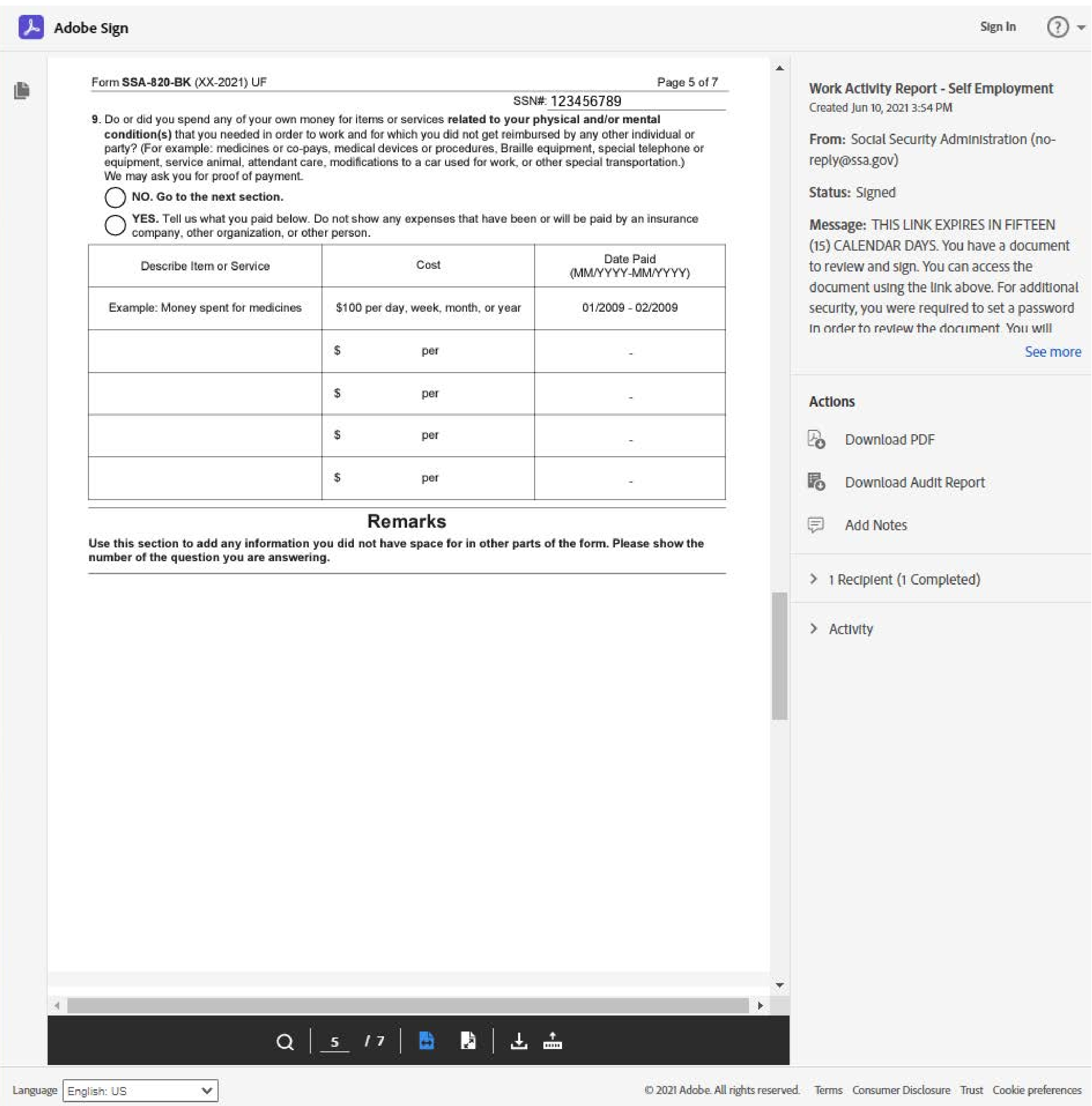
› 1 Recipient (1 Completed)

› Activity

Language English: US

© 2021 Adobe. All rights reserved. Terms Consumer Disclosure Trust Cookie preferences

SSA820 Completed Form:



Adobe Sign

Sign In

Form **SSA-820-BK** (XX-2021) UF   Page 5 of 7

SSN#: 123456789

9. Do or did you spend any of your own money for items or services **related to your physical and/or mental condition(s)** that you needed in order to work and for which you did not get reimbursed by any other individual or party? (For example: medicines or co-pays, medical devices or procedures, Braille equipment, special telephone or equipment, service animal, attendant care, modifications to a car used for work, or other special transportation.) We may ask you for proof of payment.

◯ **NO. Go to the next section.**

◯ **YES.** Tell us what you paid below. Do not show any expenses that have been or will be paid by an insurance company, other organization, or other person.

Describe Item or Service	Cost	Date Paid (MM/YYYY-MM/YYYY)
Example: Money spent for medicines	$100 per day, week, month, or year	01/2009 - 02/2009
	$ per	-
	$ per	-
	$ per	-
	$ per	-

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

5 / 7

Work Activity Report - Self Employment

Created Jun 10, 2021 3:54 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. You will

See more

Actions

Download PDF

Download Audit Report

Add Notes

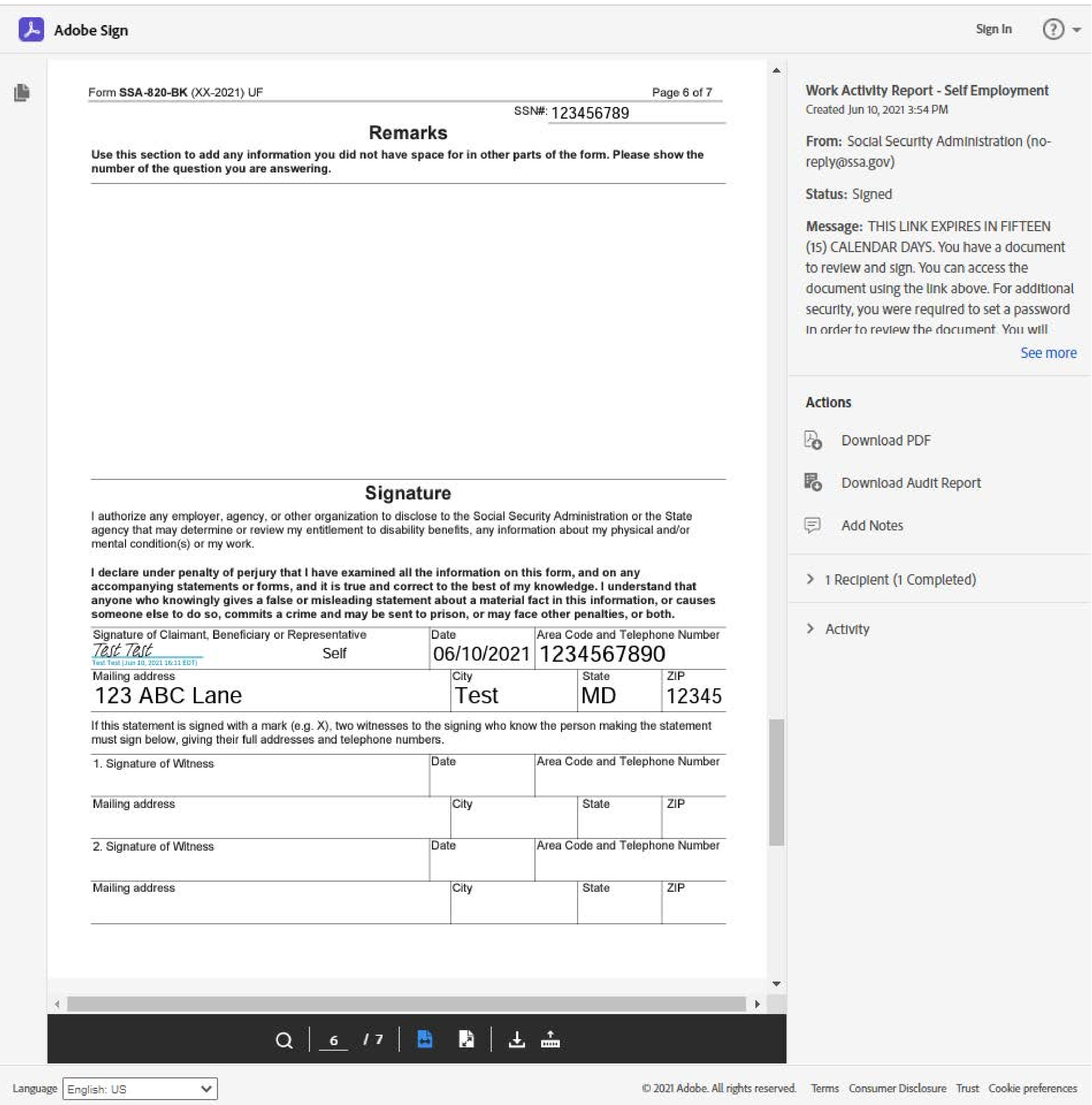
1 Recipient (1 Completed)

Activity

Language English: US

© 2021 Adobe. All rights reserved. Terms Consumer Disclosure Trust Cookie preferences

SSA820 Completed Form:


Adobe Sign

Sign In

Form **SSA-820-BK** (XX-2021) UF

Page 6 of 7

SSN#: 123456789

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition(s) or my work.

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.

Signature of Claimant, Beneficiary or Representative	Date	Area Code and Telephone Number
Test Test (Test Test (Jun 10, 2021 16:11 EDT)) Self	06/10/2021	1234567890

Mailing address	City	State	ZIP
123 ABC Lane	Test	MD	12345

If this statement is signed with a mark (e.g. X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

2. Signature of Witness	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

6 / 7

Work Activity Report - Self Employment

Created Jun 10, 2021 3:54 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. You will

See more

Actions

Download PDF

Download Audit Report

Add Notes

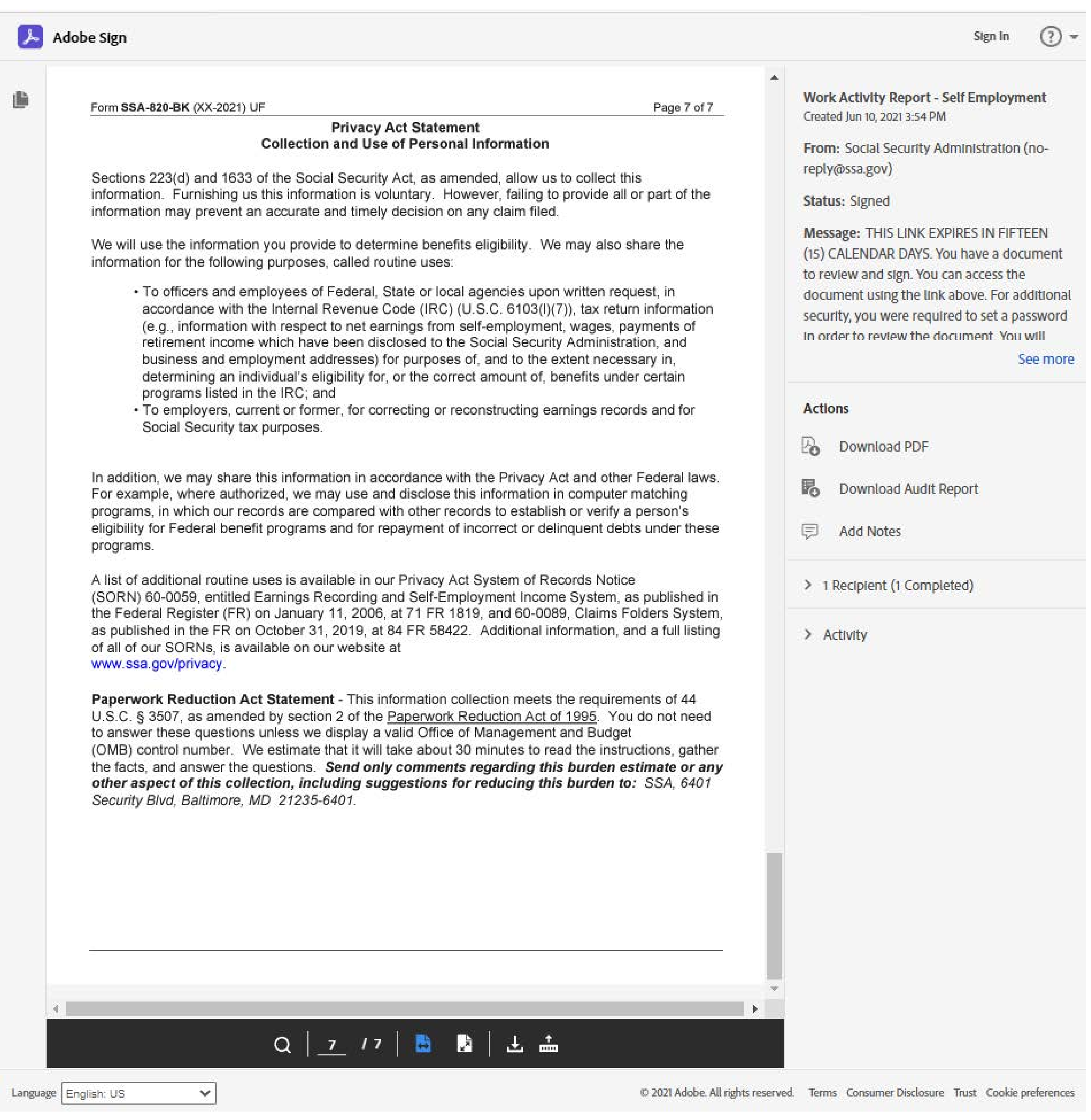
1 Recipient (1 Completed)

Activity

Language English: US

© 2021 Adobe. All rights reserved. Terms Consumer Disclosure Trust Cookie preferences

SSA820 Completed Form:



Adobe Sign

Sign In

Form **SSA-820-BK** (XX-2021) UF — Page 7 of 7

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(d) and 1633 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 an accurate and timely decision on any claim filed.

We will use the information you provide to determine benefits eligibility. We may also share the information for the following purposes, called routine uses:

- To officers and employees of Federal, State or local agencies upon written request, in accordance with the Internal Revenue Code (IRC) (U.S.C. 6103(l)(7)), tax return information (e.g., information with respect to net earnings from self-employment, wages, payments of retirement income which have been disclosed to the Social Security Administration, and business and employment addresses) for purposes of, and to the extent necessary in, determining an individual's eligibility for, or the correct amount of, benefits under certain programs listed in the IRC; and
- To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes.

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) 60-0059, entitled Earnings Recording and Self-Employment Income System, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819, and 60-0089, Claims Folders System, as published in the FR on October 31, 2019, at 84 FR 58422. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 30 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.*

7 / 7

Work Activity Report - Self Employment
Created Jun 10, 2021 3:54 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document. You will

See more

Actions

Download PDF

Download Audit Report

Add Notes

1 Recipient (1 Completed)

Activity

Language English: US

© 2021 Adobe. All rights reserved. Terms Consumer Disclosure Trust Cookie preferences