STATEMENT OF HOUSEHOLD EXPENSES AND CONTRIBUTIONS

CLAIMANT'S / BENEFICIARY'S NAME	SOCIAL SECURITY NUMBER

NAME OF SPOUSE OR PARENT(S) OF INDIVIDUAL NAMED ABOVE

NAME OF PERSON MAKING THIS STATEMENT

The questions on this form are divided into four sections. Answer the questions where we have checked the block. Then sign the form and return to Social Security.

☐ **PART I - MONTHLY HOUSEHOLD EXPENSES**

For household expenses that change from month to month, show the **average** monthly amount of money your household has spent per month for the period _____ through _____.

For the household expenses that are usually the same from month to month (like rent), show the amount your household spent per month as of _____.

Write "0" under amount if your household has not spent any money for one of the expenses.

HOUSEHOLD EXPENSES		MONTHLY TOTAL SPENT
1. Food (Do not include food bought with food stamps.)	$	
2. Rent or Mortgage Payment	$	
3. Property Insurance (if not included in mortgage payment and if required by mortgage holder)	$	
4. Real property taxes (if not included in mortgage payment). Subtract any rebate or credit.	$	
5. Electricity	$	
6. Gas	$	
7. Heating fuel (wood, coal, oil, kerosene, etc.)	$	
8. Water	$	
9. Sewerage	$	
10. Garbage Removal	$	

☐ **PART II-CONTRIBUTIONS TO HOUSEHOLD EXPENSES**

In the spaces below, show the amount of money the person(s) named gave for the household expenses listed in Part I. Provide your answer for the blocks we have checked.

NAME	☐ AVERAGE MONTHLY AMOUNT GIVEN from through	☐ AMOUNT GIVEN in
	$	$
	$	$
	$	$

PART III - OTHER ARRANGEMENTS

1. ☐ Do(es)	eat every meal during the month some where else?	☐ YES ☐ NO
2. ☐ Do(es)	buy all his/her/their own food with his/her/their own money?	☐ YES ☐ NO
3. ☐ Do(es)	pay a certain amount just for household food?	☐ YES* ☐ NO
*If "Yes" how much each month?		AMOUNT
Name		$
Name		$
Name		$
4. ☐ Do(es)	pay a certain amount for the household shelter expenses (the expenses other than food)?	☐ YES* ☐ NO
*If "Yes" how much each month?		AMOUNT
Name		$
Name		$
Name		$

PART IV-REMARKS-Use this space for any additional explanations.

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.

SIGNATURE

Your Signature (First name, middle initial, last name)	Date (Month, Day, Year)	Day Time Telephone No. (Include Area Code)

WITNESSES

If you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (Number and Street)	ADDRESS (Number and Street)
CITY,STATE, AND ZIP CODE	CITY,STATE, AND ZIP CODE

Privacy Act Statement
Collection and Use of Personal Information

Sections 1612(a)(2)(A) and 1631(e)(1)(A)-(B) 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 benefit eligibility and benefit payment amount or could result in the loss of benefits of the named claimant.

We will use the information to verify household income of the named Supplemental Security Income claimant or recipient to determine eligibility and benefit payment amount. We may also share your information for the following purposes, called routine uses:

- To representative payees, when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting the Social Security Administration in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and

- To third party contacts (e.g., employers and private pension plans) in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his/her affairs or his/her eligibility for, or entitlement to, benefits under the Social Security program when the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns one or more of the following, his/her eligibility for benefits under the Social Security program or the amount of his/her benefit payment.

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 Notices (SORN) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits, as published in the FR on January 11, 2006, at 71 FR 1830, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy
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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 2 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.*