Request for Waiver of Overpayment Recovery

When To Complete This Form

Complete this form if any of the following applies:

- You think that you are not at fault for the overpayment and you cannot afford to pay the money back.
- You think that you are not at fault and you think the overpayment is unfair for some other reason.

We will use your answers to decide if you have to pay the money back. If we decide you do not have to pay the money back, we call it a waiver.

When Not To Complete This Form

- You think that you are not at fault and your overpayment is $1,000 or less. Instead, please request a waiver by calling 1-800-772-1213 or your local field office. We may be able to process your request quickly over the phone.
- You think we made a mistake when we decided that you were overpaid, or if you disagree with the amount of your overpayment. Instead, please complete the **SSA-561**, Request for Reconsideration.
- You are requesting a hearing before an Administrative Law Judge. Instead, please complete the **HA-501-U5**, Request for Hearing by Administrative Law Judge.
- You **only** want to change the amount of money you must pay us back each month. Instead, please complete the **SSA-634**, Request for Change in Overpayment Recovery Rate.
- You have been convicted of fraud relating to this overpayment.

IMPORTANT: Please answer the following questions as completely as you can and submit any supporting documents with your waiver request. If you are assisting the person who is requesting a waiver, please answer the questions as if that person was completing the request. If you need more space for answers, use the "REMARKS" section on page 7.

SECTION 1 - IDENTIFYING QUESTIONS

1. A. What is the name, Social Security Number, and claim number (if any) of the overpaid person?

   Name: _____

   SSN: _____ Claim Number: _____

   B. If you are filling out the waiver request for the overpaid person, provide your name and relationship to the person.

   Name: _____

   Relationship: _____

SECTION 2 - WAIVER REQUEST

2. Is the total amount of the overpayment stated on your letter $1,000 or less? ☐ Yes ☐ No

If **Yes**, you do not need to complete the rest of this form. Please call 1-800-772-1213 or your local field office and we may be able to process your waiver request quickly over the phone.

If **No**, continue completing the rest of the form.

What is your reason for requesting a waiver? (Check all that apply)

A. ☐ The overpayment was not my fault.

B. ☐ I cannot afford to pay the money back.

C. ☐ The overpayment is unfair for other reasons.

Please explain: _____

_____

_____

_____

3. Please provide the date of the notice for the overpayment that you are asking us to waive:

_____ (MM/DD/YYYY)

4. Are you requesting that we waive the entire overpayment, including money that you have already paid back to us? ☐ Yes ☐ No

If **No**, are you requesting that we only waive the remaining amount of money that you owe us? ☐ Yes ☐ No

5. Tell us what you know about why the overpayment may have happened. If there was a reason you did not understand or were not able to report the change to us, please explain why.

Overpayments typically occur when a change happened in your life that we think we did not find out about on time. This happens for many reasons and understanding your opinion helps us decide your waiver request.

_____

_____

_____

SECTION 3 - NEEDS BASED INCOME

6. Are you **currently** receiving SSI payments? ☐ Yes ☐ No

If **Yes**, go to page 9, sign, date, and provide your address and phone number.
If **No**, complete the rest of the form.

7. A dependent is a person who depends on you for support and whom you can claim on your tax return. If you have a Title II overpayment, are you or any dependent household member **currently** receiving any of the following?

- Supplemental Security Income (SSI) payments
- Temporary Assistance for Needy Families (TANF)
- Pension based on need from the Department of Veterans Affairs (VA)

☐ Yes ☐ No

If **Yes**, go to page 9, sign, date, and provide your address and phone number. Please, provide proof of the TANF or VA pension.
If **No**, complete the rest of the form.

SECTION 4 - MEMBERS OF HOUSEHOLD

8. A. If you are an adult requesting a waiver, list your spouse and dependents in this section. A dependent is a person who depends on you for support and whom you can claim on your income tax return. Complete Sections 5, 6 and 7 with your, your spouse's, and dependents' information.

If you are completing the waiver request for a minor child, does the child's income and assets help with food and household items?

- If **Yes**, list the minor child's parent (s) and other dependents' of the parents in this section. Complete Sections 5, 6 and 7 with the entire household's information.
- If **No**, only provide the child's information in Sections 5, 6 and 7.

Name	Age	Relationship To You

B. Does any adult or child live with you whom you cannot claim as a dependent on your tax return?

☐ Yes ☐ No

Does this person pay any rent, household bills, or any other household expense?

☐ Yes, total monthly amount you receive $ _____ ☐ No

Documents to Support Your Statement:
To complete Sections 5, 6 and 7 of this form, you should refer to certain documents to support your statements. Please answer all the questions and submit any supporting documents for you, your spouse, and your dependents. Your supporting documents should be dated no more than 3 months from the date that you are requesting a waiver. Examples of supporting documents are:

- Current Rent or Mortgage Information
- 2 or 3 Recent Utility, Medical, Charge Card, and Insurance Bills
- Your Most Recent Income Tax Return
- Recent Bank Statements
- Current Pay Stubs
- Canceled Checks

SECTION 5 - ASSETS - THINGS YOU HAVE AND OWN

9. A. How much cash do you, your spouse, and your dependents have in your possession? $

B. List all financial accounts for you, your spouse, and your dependents. Examples of accounts you should list include: Checking, Online (e.g., PayPal), Savings, Certificate of Deposit (CD), Individual Retirement Accounts (IRAs), Money or Mutual Funds, Stocks, Bonds, Trust Funds, Prepaid Debit Cards, or any other accounts.

Type of Account	Name and Address of Institution	Name on Account	Balance or Value	Income Per Month (interest or dividends)	Account Number
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
		TOTALS	$	$	

10. A. Do you, your spouse, or your dependents own more than one family vehicle, including a car, sport utility vehicle (SUV), truck, van, camper, motorcycle, boat, or any other vehicle?

☐ Yes (list all of the vehicles below) ☐ No (go to 10.B)

Owner	Year, Make/Model	Present Value	Loan Balance (if any)	Main Purpose for Use
		$	$	
		$	$	
		$	$	
	TOTALS $			

B. Do you co-own any real estate with anyone other than your spouse or dependent family member?

☐ Yes (list below) ☐ No (go to 10.C)

Owner	Description	Market Value	Loan Balance (if any)	Income Amount
		$	$	$
		$	$	$
		$	$	$
	TOTALS $			

C. Do you, your spouse, or your dependents own or have an interest in any business, property, or valuables?

☐ Yes (list below) ☐ No (go to 11)

Owner	Description	Market Value	Loan Balance (if any)	Income Amount
		$	$	$
		$	$	$
		$	$	$
	TOTALS $			

D. Can you sell or liquidate any of the assets listed above?

☐ Yes, explain ☐ No

SECTION 6 - MONTHLY HOUSEHOLD INCOME

Enter your, your spouse's, and your dependents' monthly take home pay. Enter the amount on line 12.A. If you need more space for answers, use the "REMARKS" section on page 7.

11. A. Are you employed? ☐ Yes (provide information below) ☐ No (go to 11.B)

Employer(s) Name, Address, and Phone: (Write "self" if self-employed)	Monthly take home pay or earnings if self-employed:
	$

B. Is your spouse employed? ☐ Yes (provide information below) ☐ No (go to 11.C)

Employer(s) Name, Address, and Phone: (Write "self" if self-employed)	Monthly take home pay or earnings if self-employed:
	$

C. Are any of your dependents employed, including self-employment?

☐ Yes (provide information below) ☐ No (go to 12)

Name(s) of dependents:

Provide total monthly take home pay for dependent(s):

$ _____

12. Income (Be sure to show **monthly** amounts below)		**Overpaid person's income**	**Spouse of Overpaid Person**	**Dependent(s) of Overpaid Person (Total)**
A. Take Home Pay (Net) (from questions 11.A, 11.B, and 11.C)		$	$	$
B. Social Security Benefits (retirement, disability, widows, students, etc.)		$	$	$
C. Supplemental Security Income (SSI)		$	$	$
D. Pension(s) (VA, Military, Civil Service, Railroad, etc.)	TYPE	$	$	$
	TYPE	$	$	$
E. Supplemental Nutrition Assistance Program (SNAP) Benefits		$	$	$
F. Income from Real Estate, Business, etc. (from questions 10.B and 10.C)		$	$	$
G. Room and/or Board Payments from a Person who is not a Dependent (from question 8.B). Put the amount in the overpaid person's column.		$	$	$
H. Child Support/Alimony		$	$	$
I. Support or contributions from any person, agency, or organization		$	$	$
J. Income from Assets (from question 9.B)		$	$	$
K. Other (from any source, explain in "REMARKS" on page 7)		$	$	$
TOTALS:		$	$	$
Grand Total $				

SECTION 7 - MONTHLY HOUSEHOLD EXPENSES

Do not list an expense that is withheld from your paycheck (such as medical insurance, child support, alimony, wage garnishments, etc.).

	Type of Expense	$ Per Month
13.	A. Rent or Mortgage (if mortgage payment includes property or other local taxes, insurance, etc., **DO NOT** list it again below)	$
	B. Property Tax (State and local) (if included in mortgage payment, do not list it again)	$
	C. Utilities (gas, electric, telephone (cell or land line), Internet, trash collection, water, sewer, oil, propane, coal, wood, etc.)	$
	D. Insurance (life, health, fire, homeowner, renter, car, and any other casualty or liability policies)	$
	E. Food (groceries, including food purchased with SNAP benefits, and food at restaurants, work, etc.)	$
	F. Household and Personal Care Items (clothing, cleaning items, toiletries, salon visits, pet supplies, etc.)	$
	G. Expenses for Family Vehicle (loan, lease, gas, and repairs)	$
	H. Other Transportation (bus, taxi, etc.)	$
	I. Medical/Dental (prescriptions and medical equipment, if not paid by insurance)	$
	J. Tuition and School Expenses	$
	K. Court Ordered Payments Paid Directly to the Court	$
	L. Credit Card Payments (show minimum monthly payment). **DO NOT** include any expenses already listed above	$
	TOTAL	$

If you are not paying your bills, explain which bills have unpaid balances in the "REMARKS" section below.

REMARKS SECTION

If you are continuing an answer to a question, please write the number (and letter, if any) of the question first.

IMPORTANT: Please review, complete, and sign the statements on pages 8 and 9.

Below is an authorization for the Social Security Administration to obtain your financial account information. We may need to access your financial records in order to determine if we can waive your overpayment.

IMPORTANT: If the overpaid individual is a minor child, a parent or legal guardian must complete and sign the form on the child's behalf. If a court has assigned a legal guardian to an adult individual, the legal guardian must complete and sign the form. Adults who do not have a court appointed legal guardian must complete and sign the form, even if they have a representative payee.

AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN ACCOUNT RECORDS FROM A FINANCIAL INSTITUTION AND REQUEST FOR RECORDS

Please review the following, make selection, and sign below:

I understand:

- I have the right to revoke this authorization at any time before any records are disclosed;
- The Social Security Administration may request all records about me from any financial institution;
- Any information obtained will be kept confidential;
- I have the right to obtain a copy of the record which the financial institution keeps concerning the instances when it has disclosed records to a government authority unless the records were disclosed because of a court order;
- This authorization is not required as a condition of doing business with any financial institution.
- The Social Security Administration will request records to determine the ability to repay an overpayment in conjunction with a waiver determination;
- Failing to provide or revoking my authorization may result in the Social Security Administration determining, on that basis, that adjustment or recovery of the overpayment will not deprive me of funds to pay my bills for food, clothing, housing, medical care, or other necessary expenses;
- This authorization is in effect until the earliest of: 1) a final decision on whether adjustment or recovery of my overpayment would deprive me of funds to pay my bills for food, clothing, housing, medical care, or other necessary expenses; or 2) my revocation of this authorization in written notification to the Social Security Administration.

☐ I authorize any custodian of records at any financial institution to disclose to the Social Security Administration any records about my financial business or that of the person named above whom I legally represent or whose benefits I manage.

☐ I do not authorize any custodian of records at any financial institution to disclose to the Social Security Administration any records about my financial business or that of the person named above whom I legally represent or whose benefits I manage. I understand that if I do not give permission to obtain financial records or if I cancel my permission, SSA may not approve my waiver request.

Customer's Signature/Authorization	Mailing Address	Date
Legal Representative's Signature/Authorization	Legal Representative's Mailing Address	Date

PENALTY CLAUSE, CERTIFICATION, AND PRIVACY ACT STATEMENT

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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF OVERPAID PERSON, REPRESENTATIVE PAYEE, LEGAL GUARDIAN, or CUSTODIAL PARENT

Signature (First name, middle initial, last name)	Date (MM/DD/YYYY)

Home Telephone Number (include area code)	Cell Phone Number

Mailing Address (Number and street, Apt. No., PO Box, or Rural Route)

City	State	ZIP Code

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, City, State, and ZIP Code)	Address (Number and street, City, State, and ZIP Code)

Privacy Act Statement
Collection and Use of Personal Information

Sections 204, 1631, and 1879 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 your overpayment waiver request.

We will use the information to make a waiver determination and to obtain your financial account information. We may also share your information for the following purposes: called routine uses:

- To student volunteers and other worker, who technically do not have the status of Federal employees, when they are performing work for Social Security Administration (SSA) as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned agency functions; and

- To third party contacts such as private collection agencies and credit reporting agencies under contract with SSA and other agencies, including the Veterans Administration, the Armed Forces, the Department of the Treasury, and State motor vehicle agencies, for the purposes of their assisting SSA in recovering program debt.

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) 60-0094, entitled Recovery of Overpayments, Accounting and Reporting/Debt Management System, as published in the Federal Register (FR) on August 23, 2005, at 70 FR 49354; 60-0231, entitled Financial Transactions of SSA Accounting and Finance Offices, as published in the FR on January 11, 2006, at 71 FR 1849; and 60-0320, entitled Electronic Disability Claims File, as published in the FR on July 25, 2006, at 71 FR 42159. 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 clearance 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 120 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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, 1338 Annex Building, Baltimore, MD 21235-0001.* ***Send only comments relating to our time estimate to this address, not the completed form.***