SSSI OVERPAYMENTS:

A Self-help Guide for Supplemental Security Income Beneficiaries

Prepared by
Bet Tzedek Legal Services
3250 Wilshire Blvd, 13th Floor
Los Angeles, CA 90010

*The information presented herein is intended for general information purposes only.
This information is not intended as and does not constitute legal advice.
Your use of these materials creates no attorney client relationship between you and Bet Tzedek Legal Services. *
*Because laws and agency policies change over time, you should always check to make sure you have the most current information available. *
# Table of Contents

What is Supplemental Security Income ("SSI")? ................................................................. 1
What is an overpayment? ........................................................................................................ 1
What causes an overpayment? ............................................................................................... 1
How can I prevent an overpayment? ..................................................................................... 2
What will SSA do if they think I was overpaid? ................................................................. 3
What can I do to fight the overpayment? ................................................................................. 4
What is a Reconsideration? ...................................................................................................... 4
What is a Waiver? .................................................................................................................... 6
How do I ask for a Waiver? ..................................................................................................... 8
What do I do if SSA denies my Reconsideration and/or Waiver Requests? ....................... 8
How do I appeal a Reconsideration Denial Determination? .................................................. 9
How do I appeal a Waiver Denial Determination? ................................................................. 9
What if I lose at the hearing? .................................................................................................. 10
What happens if I do nothing or lose all of my appeals? ...................................................... 10
SSI Overpayment Checklist .................................................................................................. 11
SSI Overpayment Appeals Flowchart .................................................................................... 12
Income List for SSI Beneficiaries .......................................................................................... 13
Resources List for SSI Beneficiaries ....................................................................................... 14
Additional Information: ......................................................................................................... 15
Attached Social Security Administration Forms Index ......................................................... 16
Sample SSI Overpayment Notice ......................................................................................... 17
SSA-561-U2: "Request for Reconsideration" ........................................................................ 25
SSA-632-BK: Request for Waiver of Overpayment Recovery: .......................................................... 29
SSA-634: "Request for Change in Overpayment Recovery Rate" ...................................................... 43
Ha-501-U5: "Request for Hearing by Administrative Law Judge" ...................................................... 51
HA-520-U5 "Request for Review of Hearing Decision/Order" .......................................................... 53
SSA-1696-U4: "Appointment of Representative" .................................................................................. 55
SSA-3288: "Consent for Release of Information" .................................................................................. 62
What is Supplemental Security Income ("SSI")?

SSI is a monthly cash benefit for adults who are age 65 or older or who are blind and disabled and have limited income and resources. Children with disabilities may also qualify for SSI.

What is an Overpayment?

An overpayment happens when the Social Security Administration ("SSA") sends you more money than you are supposed to receive. The overpayment amount is the difference between the amount you received and the amount of SSI money you are entitled to receive.

When SSA thinks there has been an overpayment, they will try to get the money back. You do not always have to return the extra money.

What causes an Overpayment?

Common causes of overpayments are:

- Changes in your income or resources. When your income increases, or the value of your resources increases, this can affect how much SSI money you should receive. See pages 13-14 for an explanation of these terms.

- SSA made a mistake calculating your monthly benefit.

To receive SSI, you must have limited income and resources:

- **2020 Income limits in California**: $931.00 for an individual. $1564.00 for a couple.

*There is usually a small cost-of-living increase in the income limits each year.*

- **2020 Resource limits**: $2,000 for an individual and $3,000 for a couple.

---

2 20 C.F.R. § 416.537.
4 See Program Operations Manual System ("POMS") - the detailed manual used by the local SSA offices which is available on SSA’s website w.w.w.ssa.gov - § SI 01415.037(B); POMS§ SI OI l 10.003(A)(2) for income and resource limits in box above.
• Changes in where you live, how many people live with you, or your household's total expenses.

• Changes in your marital status.

• If getting SSI based on disability, your health improves but SSA continues to pay you.

• Changes in the amount you receive from other benefit programs, such as Social Security or Veterans benefits.

• Fleeing to avoid persecution for a crime which is a felony or to avoid custody or confinement for a felony conviction or violating a condition or probation or parole.5

• You enter a nursing home, hospital or mental health care facility for one month or more.6

**How can I prevent an Overpayment?**

It is a good idea to keep track of your monthly SSI checks to make sure the amount you receive is what you think you are owed.

• Report all changes in your income, health, living situation or marital status right away to SSA.

> Things to watch out for:

• Sometimes SSA will deem you as married if you hold yourself out as married in your community.

• Having your name on someone else's bank account.

• Owning property other than the place you live.

> Keep files with these important documents in them:

• All letters or other mail between you and SSA. Keep them in order according to date.

• Receipts or other documents of your monthly expenses.

• Bank statements and other papers showing transactions on all of your bank accounts.

---

5 20 C.F.R. § 416.202(f).
6 20 C.F.R. § 416.211, 212.
• Watch for any unexpected changes in your SSI checks.

• If you are working, keep records of your monthly wages and report any changes to your local SSA office right away.

• Income and Resources that are not counted when determining the correct amount of your SSI check are listed on pages 13-14 of this manual. Also refer to these lists if you have income or resources that exceed the SSI limits and you need to spend down the excess money.

**What will SSA do if they think I was overpaid?**

SSA will first send you a letter called "Notice of Overpayment" that tells you that you were overpaid and what your rights are.

• The "Notice of Overpayment" must tell you:7

  o The amount of the overpayment.

  o Why SSA thinks you were overpaid.

  o How SSA figured the overpayment amount.

  o The dates on which the overpayment occurred.

  o That you have a right to file a Waiver and/or a Reconsideration.

  o The deadlines for filing all necessary papers to contest the overpayment.

  o How much money SSA will take out of your check each month if you do not file a Waiver or Reconsideration.

Even if you eventually have to pay SSA back, you can often negotiate a lower monthly payment based on your financial needs. See pages 8 and 10.

• A sample "Notice of Overpayment" letter is at pages 17-24 of this manual.

---

7 POMS § SI 02201.025
What can I do to fight the Overpayment?

There are two ways to fight the overpayment, Reconsideration and Waiver.

- If you think SSA is wrong and you were not overpaid, or the amount of the overpayment is incorrect, you can file a "Request for Reconsideration."

- If you agree that you were overpaid, but believe you were not at fault and either you cannot afford to pay it back or recovery of the overpayment would not be fair, or the amount of the overpayment is $1,000.00 or less, you can file a "Request for Waiver of Overpayment Recovery."

- You can file both a Reconsideration and a Waiver at the same time. If you are not sure which one to file, it is best to file for both.

What is a Reconsideration?

A Reconsideration is an appeal telling SSA that you think they made a mistake.

- Compare your records (wage stubs, bank statements, etc.) with SSA's figures to determine whether the overpayment is correct.

- You must file a "Request for Reconsideration" within 60 days of the date on your "Notice of Overpayment," plus 5 days for mailing. If you miss the deadline, you will need to show SSA you had a good reason for being late.

- If you file it within 30 days, SSA should not start collecting the overpayment and should not take money out of your check until an initial determination is made. After 30 days, SSA can begin to collect the overpayment. If you file a Reconsideration after 30 days, any collection effort that has already begun should stop until there is a decision on the Reconsideration.

---

8 20 C.F.R. § 416.1409(a); POMS § SI 04005.012(A).
9 20 C.F. R. § 416.141 1.
10 POMS § SI 02220.017(A)(4). / SSA Publication No. 02-1009
11 Id.
**How do I ask for a Reconsideration?**

- Fill out form SSA-561-U2 "Request for Reconsideration." You can add extra pages if there is not enough room on the form. A copy of Form SSA-561-U2 is at pages 25-28. You can also get one from your local SSA office or from the Social Security website - [https://www.ssa.gov/forms/ssa-561-u2.pdf](https://www.ssa.gov/forms/ssa-561-u2.pdf)

- Give a detailed explanation of why you think the overpayment is a mistake.

- Check the box that says "Informal Conference" if you feel it would be helpful to have a face-to-face meeting with a representative at your local SSA office. You can explain why you think SSA made a mistake and you can bring all your documents to show the SSA worker why you were not overpaid. If you don't want to meet face-to-face, check the "Case Review" box and someone will review your file. You can still submit additional records to prove your case when you check "Case Review."

- Mail or hand-deliver the Request for Reconsideration form to your local SSA office. If you mail it, send it certified mail so that you will have proof that it was delivered before the deadline. If you hand-deliver it ask the SSA receptionist for a dated receipt.

› Examples of SSA mistakes are:

- Incorrectly counting your monthly wages or the amount of the total overpayment.
- Incorrectly counting your Resources.
- Failing to use a deduction such as the "Impairment-Related Work Expenses" ("IRWE") deduction or the earnings deductions.
What is a Waiver?

A Waiver is asking SSA to forgive the overpayment because it was not your fault and you satisfy at least one of the three additional requirements explained below.

- In order to get a waiver, you must first show SSA that the overpayment was not your fault.12
- After you show that you are not at fault, you must then meet one of three different tests to show there is a good reason you should not have to pay the money back. The three tests are listed below. The legal words in quotations marks and underlined are examples of the language to use on your Waiver request if they describe your reason(s).

→ Common reasons the overpayment was not your fault are:

- You did not know you were overpaid or that you had to pay the money back; or
- You did not understand what changes you had to report to SSA; or
- You had some other good reason why the reporting was not done at all or not done on time; or
- You have a "representative payee" who handles your money and SSI checks, and the representative payee mishandled your funds.

1. Paying back the money would "create a hardship" for you because you need the money for ordinary living expenses like food and shelter, or because your monthly income is less than the maximum SSI rate.13

→ Note on hardship: If you are still receiving SSI, TANF or VA pension, then repaying the overpayment is automatically a hardship for you. Make sure to check the box on the Waiver form (at question 12 F, on packet) that says you get SSI checks. You do not have to fill out the rest of the form, but you still need to sign and date it at page 13.

12 20 C.F.R. § 416.550; 20 C.F.R. § 416.552; POMS § SI 02206.010
13 20 C.F.R. § 416.550; 20 C.F.R. 416.553. See POMS 02206.001 and SI§ 02206.020 for the hardship policy noted in the box above.
2. Paying the money back is "against equity and good conscience." This means you relied on the money that you got, and you either spent it or gave up something because you expected a certain amount of money in your monthly check.\textsuperscript{14}

3. Paying the money back should be automatically waived because collecting the overpayment would "impede administrative efficiency." This means the amount of overpayment is so small that it would cost SSA more money to try to get it back than it would to just forget about it.\textsuperscript{15}

- There is no deadline for filing a waiver, but if you file it within 30 days, SSA should not start collection the overpayment and should not take money out of your check until an initial decision is reached. If you do not file a waiver within 30 days, SSA can begin to collect the overpayment. If you file a waiver after 30 days, any collection effort that has already begun should stop until an initial decision is reached.\textsuperscript{16}

\textsuperscript{14} 20 C.F.R. § 416.554; POMS § SI 02206.025
\textsuperscript{15} 20 C.F.R. § 416.555; POMS SI§ 022060.030. See 20 C.F.R. § 416.555; POMS § SI 02260.030(C); POMS GN § 02201.013(D) for the administrative waiver provisions noted in box above. See 20 C.F.R. § 416.556(a) for the provisions on exceeding resource limits by $50 or less noted in the box above.
\textsuperscript{16} POMS § SI 02220.017 (A)(4); POMS § GN 02201.01 IAI; SSA Publication No. 05010098.
How do I ask for a Waiver?

• Fill out form SSA-632-BK "Request for Waiver of Overpayment Recovery" and explain why the overpayment was not your fault. Form SSA-632-BK is at pages 29-42 of this manual. You can also get this form from your local SSA office or from the SSA website www.ssa.gov.

• Make sure you check the boxes that say the overpayment was not your fault and you cannot afford to pay it back (section 4, box 5). Check the other boxes in box (section) 5 if they apply.

• Put your signature, the date, your address and your phone number on page 13.

• Mail or hand-deliver the form to your local SSA office. If you mail it, send it certified mail so that you will have proof that it was delivered before the deadline. If you hand-deliver it, ask the SSA worker for a date receipt.

• If you do not want to file a Waiver request or appeal of an overpayment, you may file with the SSA a form SSA-634 "Request For Change in Overpayment Recovery" to request the amount of the monthly collection that SSA collects from your SSI payment(s) until the overpayment is collected in full.

What do I do if SSA denies my Reconsideration and/or Waiver requests?

If your Reconsideration or Waiver request is denied, you can appeal again to a higher level within 60 days. The types of appeals are explained below. For an overview of the appeals process, see the flow chart on page 12.

Note on Appeals and paperwork:
It is sometimes hard to keep track of your original appeal because there are many SSA decision that can be appealed. Make sure to keep track of your main line of appeal and organize all your papers in a file.
How do I appeal a Reconsideration Denial Determination?

File a "Request for Hearing by Administrative Law Judge" form which will allow you to appear before a judge to argue your case.

- You must file a "Request for Hearing," form HA-501-U5, within 60 days of the date on your Reconsideration Determinations, plus five days for mailing.\(^\text{17}\) Send it certified mail or hand-deliver it to your local SSA office. A copy of this form is at pages 51-52.

- At this state, SSA can begin to collect the overpayment (usually by withholding up to 10% of your income from your monthly SSI checks). Requesting a hearing will not stop SSA from recovering the money at this point.\(^\text{18}\)

How do I appeal a Waiver Denial Decision?

To appeal a Waiver Denial Decision, you must:

- File a "Request for Reconsideration" of the Waiver Denial Decision within 60 days of the date on your Waiver Denial Decision, plus 5 days for mailing.\(^\text{19}\)

- If you file it within 30 days, SSA should not start collecting the overpayment. If you file it after 30 days, any collection effort that has begun should stop until a decision is reached.\(^\text{20}\)

- Fill out form SSA-561-U2 "Request for Reconsideration" and send it certified mail or hand-deliver it to your local SSA office. A copy of this form is at pages 25-28 of this manual.

- If your "Request for Reconsideration" of the Waiver Decision is denied, then you ask for a hearing using from HA-501-U-5 "Request for Hearing by Administrative Law Judge," as discussed in the section above on appealing a Reconsideration Determination.

\(^{17}\) 20 C.F.R. 416.1433(b); POMS § SI 04030.020; SI§ 04005.012.
\(^{18}\) POMS § SI 02220.017(4)(e).
\(^{19}\) 20 C.F.R. 416.1409; POMS § SI 04005.012; \textit{See also} 20 C.F.R. § 416.1402.
\(^{20}\) POMS § SI 02220.017(A)(6); POMS § SI 02220.001 (A)(2).
What if I lose at the hearing?

If you get a negative decision from the hearing judge, you can request a review by the Appeals Council. A copy for Form HA-520-U5, "Request for Review of Hearing Decision/Order" is at pages 53-54 of this manual. Your request must be filed within 60 days, plus 5 days for mailing. Contact Bet Tzedek Legal Services or another legal services agency for help with this level of appeal. If you miss the filing deadline, you will have to show the Appeals Council you had a good reason for being late.

After all appeals are finished within the Social Security Administration, your next option is to file a lawsuit in United States District Court within 60 days of the Appeals Council's decision, and to continue through the federal court system if further appeals are necessary.

What happens if I do nothing or lose all my appeals?

There are several ways that SSA can get the money back from you if you do not either pay it back or appeal the overpayment, or if you lose all your appeals.

- SSA can reduce your monthly SSI check by no more than 10% of your total income per month, unless fraud or similar fault is involved. You can, however, negotiate for a much lower rate. SSA may agree to take out as little as $10.00 per month.

- If you are no longer receiving SSI checks, SSA can:
  - Negotiate a monthly payment plan with you.
  - Arrange for the overpayment to be taken out of your benefit check from other SSA programs, such as Social Security. The 10% limit applies here as well in most cases.
  - Take the overpayment debt out of your federal tax refund check.
  - Garnish your current wages by requiring your employer pay a portion of your monthly wages to SSA.
  - File a lawsuit against you. This does not happen often.

---

21 20 C.F.R. § 416.1468(a).
22 20 C.F.R. § 416.1468(b).
23 20 C.F.R. § 416.1481.
24 20 C.F.R. § 416.571.
25 POMS § SI 02220.017(a)(1), (A)(2).
26 POMS § SI 02220.025.
27 20 C.F.R. § 416.572(e).
28 20 C.F.R. § 415.580(b).
29 20 C.F.R. § 422.403(d).
30 POMS § SI 02220.035.
SSI Overpayment Checklist

☐ Keep track of monthly income, resources and changes in your living situation. Keep all correspondence between SSA and you.
☐ Organize your records in separate files by date.
☐ Did you receive a "Notice of Overpayment"? Check the Notice and make sure it says what it is supposed to say (see page 3 of this manual).
☐ Compare SSA's figures with your own records.
  • Request for Reconsideration if you think SSA is wrong:
    ☐ Fill out form SSA-561-U2.
    ☐ File it within 60 days of your "Notice of Overpayment." Use certified mail or get a receipt.
  □ If you file it within 30 days, SSA should not try to collect the overpayment until a decision on your request is reached.
  • Ask for a Waiver if you believe you were not at fault:
    1. Fill out form SSA-632-BK.
    2. Tell SSA why the overpayment was not your fault.
    3. Tell SSA if you still receive SSI checks.
    4. Explain why you need a waiver by using one of three tests:
       5. "creates a hardship," or
       6. "against equity and good conscience," or
       7. "impedes administrative efficiency" or "administrative waiver." See pages 6-7 of this manual for an explanation of these terms.
    8. File it at your local SSA office. There is no deadline for a Waiver.
  □ If you file it within 30 days of your "Notice of Overpayment," SSA should not try to collect the overpayment until a decision on your request is reached. Use certified mail or get a receipt.
  • If SSA denies your Reconsideration or your Waiver, you must file an appeal within 60 days from when you receive SSA's decision. Use certified mail or get a receipt.
  • Appealing a Reconsideration denial:
    1. Fill out form HA-501-US "Request for Hearing by Administrative Law Judge" and submit to SSA within 60 days.
    2. SSA can start collecting the overpayment.
  • Appealing a Waiver denial:
    1. Fill out form SSA-561-U2 "Request for Reconsideration" and submit to SSA within 60 days (30 days to stop SSA from collecting the overpayment until a decision is made).
    2. If the "Request for Reconsideration" is denied, file form HA-501-US "Request for Hearing by Administrative Law Judge" and submit to SSA within 60 days. Collection efforts can begin.
SSI Overpayment Appeals Flowchart

SSA Notice of Overpayment

→ Request for Waiver
  Can be filed anytime (30 days to prevent immediate recovery efforts).

→ Notice of Overpayment Action
  (Waiver Denial Decision)

→ Request for Reconsideration of Waiver Denial Decision
  File within 60 days (30 days to continue to prevent recovery).

→ Reconsideration Denial Decision

→ Request for Hearing
  File within 60 days. (Recovery resumes.)

→ Hearing Decision

→ Request for Review by Appeals Council
  File within 60 days

→ Appeals Council Decision

→ Civil suit in U.S. District Court
  File Complaint within 60 days.
  Continue through the federal court system (U.S. Court of Appeals, U.S. Supreme Court) as needed.

→ Request for Reconsideration of Waiver Denial Decision
  File within 60 days (30 days to continue to prevent recovery efforts).

→ Reconsideration Denial Decision

→ Request for Hearing
  File within 60 days. (Recovery resumes.)

→ Hearing Decision

→ Request for Review by Appeals Council
  File within 60 days

→ Appeals Council Decision

→ Civil suit in U.S. District Court
  File Complaint within 60 days.
  Continue through the federal court system (U.S. Court of Appeals, U.S. Supreme Court) as needed.
Income List for SSI Beneficiaries

Income is money or support for your living expenses that you receive regularly, including paychecks from your job, pensions, and Social Security. The income limits for SSI vary from state to state. In California an aged or disabled person cannot have more than $931.00 in countable monthly income in 2020. For an aged or disabled couple who are both eligible for SSI, the 2020 maximum countable monthly income is $1564. The rates are higher if you are blind, live without cooking facilities, or are in a board and care facility. At the beginning of each year there is usually a small cost-of-living increase in the income limits for both individuals and couples.

SSA excludes many types of income from being counted. The following are the most common exclusions:31

General exclusions:
- First $20 a month of most income received.
- First $65 of all earnings, and ½ of the rest of monthly earnings.

Examples of some (not all) additional income exclusions:
- Income tax refunds.
- Money from the sale or exchange of an excludable resource.
- Weatherization assistance, such as insulation or storm windows.
- Payment of your bills by someone else paid directly to the supplier, except for payments for your food and shelter.
- Home energy assistance.
- Money from loans, but will become countable resources if held into the following month.
- Small amounts of infrequent income, such as gifts.
- Up to $20 of unearned income in a month if you receive it only once during a calendar quarter. For example: bank accounts where the interest is posted quarterly.
- Interest earned on excluded burial accounts.
- Money someone else spends for your medical care or services, including payment made by the Veterans Administration.
- Housing assistance provided by the federal government, such as Section 8.
- Agent Orange settlement payments.
- German, Austrian, and Japanese reparations payments.
- Gifts of commercial transportation tickets for travel within the U.S. and to some territories that are not converted by you to cash.
- Earned Income Tax Credit payments.
- Value of impairment-related work ("IRWEs").
- Value of work expenses that a blind person incurs in order to work.

---

Resources List for SSI Beneficiaries.

Resources include, among other things, money in checking or savings accounts, personal property, stocks, bonds, and land you don't live on. In order to be eligible to receive SSI, the total value of your resources must be limited. For an individual, the limit is $2,000 in 2020. For a couple, the limit is $3,000 in 2020.

SSA excludes many resources when it figures out your total resources. Below are the most common resource exclusions:

- Your home, if you both live there and own at least a portion of it.
- Household goods and personal effects.
- Burial spaces for you and your immediate family.
- Burial funds for you and your spouse ($1,500 or less each).
- Term life insurance policies.
- Whole life insurance policies that have a combined face value of $1,500 or less.
- One car, regardless of value, if it is used for transportation for you and/or a member of your family.
- Federal Housing Assistance Payments.
- Earned Income Tax Credit payments held for more than one month.
- Cash held nine months or less for repair or replacement of excluded resources that are lost, damaged or stolen.
- Agent Orange Settlement payments held more than one month.
- Payments to victims of Nazi persecution held more than one month.
- Japanese-American restitution payments held more than one month.
- Low-income energy assistance payments held more than one month.

Note: Many beneficiaries have overpayment problems because of joint bank accounts. If you have a joint account with someone who is not on SSI, all of the money in the account is presumed to be yours, whether or not you own all of the money.

---

32 See 20 C.F.R. § 416.1208 and POMS § SI 00810.130 for the joint bank account policy noted in box above.
33 20 C.F.R. § 416.1210
Additional Information:

If you need help with your overpayment case, especially if you were denied a Reconsideration or a Waiver request, contact a local legal services organization at the numbers below.

Bet Tzedek - The House of Justice
3250 Wilshire Blvd., 13th Floor
Los Angeles, CA 90010
Tel. (323) 939-0506, (Please call to make an appointment as Bet Tzedek does not take walk-ins.)

Protection & Advocacy, Inc. (legal help for people with developmental disabilities)
3580 Wilshire Blvd., Suite 902
Los Angeles, CA 90010
Tel. (213) 427-8747

Legal Aid Foundation of Los Angeles
Government Benefits Unit
5228 Whittier Blvd.
Los Angeles, CA 90022
Tel. (213) 640-3883

If you need to contact your local Social Security office, you can call SSA's toll-free number or go to the SSA website (see below).

Social Security Administration:
1-800-772-1213 or 1-800-325-0778 (TTY)
www.ssa.gov
### Attached Social Security Administration Forms*

<table>
<thead>
<tr>
<th><strong>Forms</strong></th>
<th><strong>Page</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sample Overpayment Notice from SSA</td>
<td>17-24</td>
</tr>
<tr>
<td>2. SSA-561-02: &quot;Request for Reconsideration,&quot; used to contest initial</td>
<td>25-28</td>
</tr>
<tr>
<td>overpayment decision or to appeal a Waiver decision</td>
<td></td>
</tr>
<tr>
<td>3. SSA-632-BK: &quot;Request for Waiver of Overpayment Recovery,&quot; used to</td>
<td>29-42</td>
</tr>
<tr>
<td>request a waiver of overpayment</td>
<td></td>
</tr>
<tr>
<td>4. SSA-634: &quot;Request for Change in Overpayment Recovery Rate,&quot; Used to</td>
<td>43-50</td>
</tr>
<tr>
<td>request change in collection recovery rate</td>
<td></td>
</tr>
<tr>
<td>5. HA-501-US: &quot;Request for Hearing by Administrative Law Judge,&quot; used</td>
<td>51-52</td>
</tr>
<tr>
<td>to appeal a Reconsideration Determination or to appeal a Reconsideration</td>
<td></td>
</tr>
<tr>
<td>of a Waiver Decision</td>
<td></td>
</tr>
<tr>
<td>6. HA-520-US &quot;Request for Review of Hearing Decision/Order,&quot; used to</td>
<td>53-54</td>
</tr>
<tr>
<td>request review of an unfavorable hearing decision</td>
<td></td>
</tr>
<tr>
<td>7. SSA-1696-04: &quot;Appointment of Representative,&quot; used to select a</td>
<td>55-63</td>
</tr>
<tr>
<td>Person to represent you when dealing with the SSA. This person can</td>
<td></td>
</tr>
<tr>
<td>Be a lawyer or a non-lawyer</td>
<td></td>
</tr>
<tr>
<td>8. SSA-3288: &quot;Consent for Release of Information,&quot; used to tell SSA</td>
<td>62-63</td>
</tr>
<tr>
<td>To release certain private information to your representative</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Most of these forms are available on the Social Security website at [www.ssa.gov](http://www.ssa.gov).
We are writing to let you know that we've paid you $376.40 too much Supplemental Security Income (SSI) money. The overpayment happened in December 2016 and January 2017. You were overpaid for the following reasons. The first reason was because you were not due the Federal part of your SSI payment. The second reason was because of an increase in your wages. The third reason was because of an increase in your estimated wages.

We have attached to this letter a detailed explanation of your overpayment.

You must pay us back unless we decide you shouldn't have to pay us back or we're wrong about the overpayment. If you think you shouldn't have to pay us back or you disagree with the decision about the overpayment, you can:

- Ask for a waiver,
- Ask for an appeal, or
- Do both.

This letter will tell you more about these things you can do.

If We Don't Hear From You In The Next 30 Days

We plan to collect this overpayment from your SSI checks. We'll hold back your check each month starting with May 2017 until you have paid us back. If you ask for waiver or appeal in the next 30 days, we won't change your check until we decide your case.
Do You Think That You Do Not Owe This Money?

You may ask us to review our finding that you still owe SSI money. You may have evidence to show that you already paid some or all of the money or that we previously waived collection of it. If so, give us this evidence when you ask for review. We will review the evidence you give us and the information we have. We will send you a letter with our decision. If we find that you do not owe us this amount, then we will correct our records.

For more information on requesting review, see "If You Disagree With The Decision" below.

If You Think You Should Not Have To Pay Us Back

You may not have to pay us back. Sometimes we can waive the collection of an overpayment, which means you won’t have to pay us back. For us to waive the collection of the overpayment, two things have to be true:

- It wasn’t your fault that you got too much SSI money.

AND

- Paying us back would mean you can’t pay your bills for food, clothing, housing, medical care or other necessary expenses, or it would be unfair for some other reason.

If you think these are true about you, contact any Social Security office. You can ask for waiver at any time by completing the waiver form and returning it to us. The form is called “Request for Waiver of Recovery or Change in Repayment Rate”, Form SSA-632. We will be happy to help you fill out the form. If you request waiver, we may need a statement of your assets and monthly income and expenses.

We will stop withholding benefits while we consider your waiver request. If we can’t approve your request for waiver, we will contact you to schedule a time for you to review your folder and a time to have a personal conference. At the conference, you can explain why you think you shouldn’t have to pay us back.

If You Disagree With The Decision

If you disagree with the decision, you have the right to appeal. We will review your case and consider any new facts you have.

- You have 60 days to ask for an appeal. If you ask in the next 30 days, we won’t change your check until we decide your case.

- Both the 30 day and 60 day periods start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
• You must have a good reason for waiting more than 60 days to ask for an appeal.

• To appeal, you must fill out a form called "Request for Reconsideration." The form number is SSA-561. To get this form, contact one of our offices. We can help you fill out the form.

How To Appeal

There are three ways to appeal. You can pick the one you want. If you meet with us in person, it may help us decide your case.

• Case Review. You have a right to review the facts in your file. You can give us more facts to add to your file. Then we'll decide your case again. You won't meet with the person who decides your case.

• Informal Conference. You'll meet with the person who decides your case. You can tell that person why you think you're right. You can give us more facts to help prove you're right. You can bring other people to help explain your case.

• Formal Conference. This is a meeting like an informal conference. The difference is we can make people come to help prove you're right. We can make them bring important papers about your case, even if they don't want to help you. You can question these people at your meeting.

If You Want Help With Your Appeal

You can have a friend, representative or someone else help you. There are groups that can help you find a representative or give you free legal services if you qualify. There are also representatives who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

How To Pay Us Back

There are two ways you can pay us back.

• As we said earlier, we plan to hold back money from your SSI check. We'll hold back your check each month starting with May 2017 until you have paid us back. The amount of your SSI check is less than 10 percent of your total income. Ten percent is the most we can hold back without your consent. Contact us if you want a different amount held back.
• Another way to pay us back is to send us a check or money order for the full amount of your overpayment of $376.40. Paying us this way is voluntary. Make your check or money order out to the Social Security Administration. Be sure to put your Social Security number on it. Please use the enclosed envelope to mail the check or money order to us. Also, be sure to enclose the payment stub with your check or money order.

Suspect Social Security Fraud?

Please visit http://oig.ssa.gov/r 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, please:

• Visit our website at www.socialsecurity.gov to find general information about SSI;

• Visit our website at www.socialsecurity.gov/SSIrules/ to find the law and regulations about SSI eligibility and payments;

• Call us toll-free at 1-800-772-1213 or call your local office at 877-319-0732. We can answer most questions over the phone. If you are deaf or hard of hearing, our toll-free TTY number is 1-800-325-0778; or

• Write or visit any Social Security office. If you plan to visit an office, you may call ahead to make an appointment. The office that serves your area is located at:

SOCIAL SECURITY
22600 CRENSHAW BLVD
TORRANCE CA 90505
Please have this letter with you if you call or visit an office. If you write, please include a copy of the first page of this letter. It will help us answer your questions. We are busiest early in the week and early in the month. If your business can wait, it is best to call or visit at other times.

Social Security Administration

Enclosure(s):
A Detailed Explanation of Your Overpayment
Payment Stub
Refund Envelope
A Detailed Explanation Of Your Overpayment

Overpayment Summary

You were overpaid $376.40. We looked at the money amounts we paid and the money amounts we should have paid for each month listed below in determining the overpayment amount. The following chart shows how much your payment changed each month. The first column lists the month(s) we paid you incorrectly. The next column shows the incorrect amount paid for each month. The last column shows the amount we should have paid you for each month.

The SSI we paid you included some payments we made for your State. We show your total SSI below, and then the part of this money that is from your State. We added all of the incorrect money amounts. Then we added all of the correct money amounts we should pay. We subtracted the total incorrect money amount from the total correct money amount to get the total overpayment.

<table>
<thead>
<tr>
<th>Month</th>
<th>Amount Paid</th>
<th>Correct Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2016</td>
<td>$156.40 ($156.40 is California's)</td>
<td>$0.00</td>
</tr>
<tr>
<td>January 2017</td>
<td>$260.36 ($160.72 is California's)</td>
<td>$40.36 ($40.36 is California's)</td>
</tr>
<tr>
<td>Total</td>
<td>$416.76</td>
<td>$40.36</td>
</tr>
</tbody>
</table>

Why You Were Overpaid

Based on your income for the month of January 2017 you were not due the Federal part of your SSI payment.

For the month(s) listed below, your income on our records was wrong. Because we didn't know about all your income, we paid you too much SSI.

Under "Type of Income," we list only the income which we corrected on our records. Under the column called "Amount We Used," we show the amount we used earlier to figure your payment. Under the column called "Correct Amount," we show the amount we should have used to figure your payment. Please check that column against your records. If the amount is wrong, the amount of your overpayment is wrong.

<table>
<thead>
<tr>
<th>Month</th>
<th>Amount We Used</th>
<th>Correct Amount</th>
<th>Type of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2016</td>
<td>$429.73</td>
<td>$869.73</td>
<td>Your wages</td>
</tr>
<tr>
<td>January 2017</td>
<td>$429.73</td>
<td>$869.73</td>
<td>Your estimated wages</td>
</tr>
</tbody>
</table>
PAYMENT STUB

- Return the bottom portion of the stub with your payment.
- Use the enclosed envelope to mail your payment to us.
- Do not send cash.
- Do not enclose any correspondence with your remittance. Send any correspondence to your local Social Security office.
- If you pay by check or money order, include the Social Security Account Number as shown below and make the check or money order payable to "Social Security Administration."
- If paying by credit card, complete the appropriate information below and return it in the enclosed envelope

OR
to pay by phone, call 1-866-601-9679 TOLL FREE during the hours 8:00 AM to 4:30 PM CT. Please have this notice and your credit card available when you call.

SSA-53-EP

ACCOUNT NUMBER:

AMOUNT DUE: $376.40
DATE DUE: March 22, 2017

PAYMENT AMOUNT $___

[ ] MASTERCARD [ ] VISA [ ] DISCOVER

Credit Card Number

__________________________

Cardholder’s Signature

__________________________

Exp Date

Date

SOCIAL SECURITY ADMINISTRATION
PO BOX 3430
PHILADELPHIA PA 19122-9985
Privacy Act and Paperwork Reduction Act Statements

The Social Security Administration (SSA) has authority to collect the information requested on the PAYMENT STUB under section 204 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out the credit card information if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA’s account. This will allow you to repay your overpayment with your credit card. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security office.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

This information collection meets the clearance requirements of 44 U.S.C. section 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management Budget control number. We estimate that it will take you about 6 minutes to read the instructions, gather the necessary facts, and answer the questions.
REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:

CLAIMANT SSN:

CLAIM NUMBER: (If different than SSN)

ISSUE BEING APPEALED: (Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for SSI or SVB. I have read about the three ways to appeal. I have checked the box below:

☐ CASE REVIEW - You can pick this kind of appeal in all cases. You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.

☐ INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment. You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.

☐ FORMAL CONFERENCE - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment. This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

CONTACT INFORMATION

CLAIMANT SIGNATURE - OPTIONAL:  

NAME OF CLAIMANT'S REPRESENTATIVE: (If any)

MAILING ADDRESS:

MAILING ADDRESS:

CITY:  STATE:  ZIP CODE:

CITY:  STATE:  ZIP CODE:

TELEPHONE NUMBER: (Include area code)  DATE:

TELEPHONE NUMBER: (Include area code)  DATE:

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE?  ☐ Yes  ☐ No

2. IS THIS REQUEST FILED TIMELY?  ☐ Yes  ☐ No

(Fill "NO", attach claimant's explanation for delay.
Refer to GN 03101.020)

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

FIELD OFFICE DEVELOPMENT (GN 03102.300)

☐ NO FURTHER DEVELOPMENT REQUIRED

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SSI CASES ONLY - GOLDBERG KELLY (GK)

(SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:

☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;

☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT

☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the completed original to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claims Folder
ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS
(See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

Title II
1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefit;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf to a representative payee, unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if we determine that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled;
19. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a jail, prison, or other correctional institution for conviction of a criminal offense;
20. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a mental health institution or other medical facility because a court found the individual was not guilty for reason of insanity; a court found that he/she was incompetent to stand trial or was unable to stand trial for some other similar mental defect; or, a court found that he/she was sexually dangerous.

Title XVI
1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

Title VIII (See VB 02501.035)
1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II-items 3, 4, 10, 11 & 16.

Title XVIII
1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI);
4. Initial determinations regarding Medicare Part B income-related premium subsidy reductions.
REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT: CLAIMANT SSN: CLAIM NUMBER: (If different than SSN)

ISSUE BEING APPEALED: (Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for SSI or SVB. I have read about the three ways to appeal.

I have checked the box below:

☐ CASE REVIEW - You can pick this kind of appeal in all cases. You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.

☐ INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment. You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.

☐ FORMAL CONFERENCE - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment. This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

CONTACT INFORMATION

CLAIMANT SIGNATURE - OPTIONAL: NAME OF CLAIMANT'S REPRESENTATIVE: (If any)

MAILING ADDRESS:

MAILING ADDRESS:

CITY: STATE: ZIP CODE:

CITY: STATE: ZIP CODE:

TELEPHONE NUMBER: (Include area code) DATE:

TELEPHONE NUMBER: (Include area code) DATE:

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No

2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No

(Field "NO", attach claimant’s explanation for delay. Refer to GN 03101.020)

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

FIELD OFFICE DEVELOPMENT (GN 03102.300)

☐ NO FURTHER DEVELOPMENT REQUIRED

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SSI CASES ONLY - GOLDBERG KELLY (GK) (SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:

☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;

☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT

☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the completed original to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claimant
HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFIT (SVB) DECISION

Now that you picked the kind of appeal that fits your case, fill out this form or we'll help you fill it out. You can have a lawyer, friend, or someone else help you with your appeal. There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (SSA-789-U4) FOR YOUR APPEAL.

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

Privacy Act Statement
Request for Reconsideration

Sections 205, 702(a)(5), 809(a), 809(b), 1631, 1633, and 1869(b) 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 re-evaluating the decision on your claim.

We will use the information to determine your eligibility for benefits and administer our programs. We may also share your information for the following purposes, called routine uses:

1. To third party contacts 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.

2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

3. To the Center for Medicare & Medicaid Services (CMS), for the purpose of administering Medicare Part A, Part B, Medicare Advantage Part C, and Medicare Part D, including but not limited to: Medicare Part C enrollment and premium collection processes; Part D enrollment and premium collection processes; Medicare Part B premium reduction based on participation in a Part D plan; and Medicare Part B enrollment and income-related monthly adjustment amount determinations, appeals of determinations, and premium collections.

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 (SORNs). There are several SORNs that govern the collection of this information, including 60-0089, entitled Claims Folder System, and 60-0321, entitled Medicare Database File. Additional information and a full listing of all our SORNs and applicable routine uses are available on our website at www.socialsecurity.gov/foia/bluebook.

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 control number. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions.

SEND 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 (TTY 1-800-325-0778). 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.
An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

5. I have additional evidence to submit. ☐ Yes ☐ No
   Name and source of additional evidence, if not included.

6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks
   □ I wish to appear at a hearing.
   □ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

Representation: You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

7. CLAIMANT SIGNATURE (OPTIONAL) DATE
8. NAME OF REPRESENTATIVE (if any) DATE

RESIDENCE ADDRESS

CITY STATE ZIP CODE CITY STATE ZIP CODE

TELEPHONE NUMBER FAX NUMBER TELEPHONE NUMBER FAX NUMBER

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION - ACKNOWLEDGMENT OF REQUEST FOR HEARING

9. Request received on (Date) by: (Print Name) (Title)

   (Address) (Servicing FO Code) (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination? ☐ Yes ☐ No
    If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided? ☐ Yes ☐ No

12. Interpreter needed ☐ Yes ☐ No

Language (including sign language):

13. Check one: ☐ Initial Entitlement Case ☐ Disability Cessation Case or ☐ Other Postentitlement Case

14. HO COPY SENT TO: HO on
   ☐ Claims Folder (CF) Attached: ☐ Title (T) II; ☐ T XVI; ☐ T VIII; ☐ T X VIII; ☐ T II CF held in FO ☐ Electronic Folder
   ☐ CF requested ☐ T II; ☐ T XVI; ☐ T VIII; ☐ T X VIII
   (Copy of email or phone report attached)

15. Check all claim types that apply:
   ☐ Retirement and Survivors Insurance Only (RSI)
   ☐ Title II Disability - Worker or child only (DIWC)
   ☐ Title II Disability - Widow(er) only (DIWW)
   ☐ Title XVI (SSI) Aged only (SSIA)
   ☐ Title XVI Blind only (SSIB)
   ☐ Title XVI Disability only (SSID)
   ☐ Title XVI/Title II Concurrent Aged Claim (SSAC)
   ☐ Title XVI/Title II Concurrent Blind (SSBC)
   ☐ Title XVI/Title II Concurrent Disability (SSDC)
   ☐ Title XVII Hospital/Supplementary Insurance (HI/SMI)
   ☐ Title VIII Only Special Veterans Benefits (SVB)
   ☐ Title VIII/Title XVI (SVB/SSI)
   ☐ Other - Specify:

PRIVACY ACT STATEMENT
Request for Hearing by Administrative Law Judge

Sections 205(a) (42 U.S.C. 405 (a)), 702 (42 U.S.C. 902), 1631(e) (1) (A), and; (B) (42 U.S.C. 1383(e) (1) (A) and (B)), 1839(i) (42 U.S.C. 1395r), 1869(b) (1), and (c) (42 U.S.C. 1395ff) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to continue processing your claim.

Providing this information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim.

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigate activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in System of Records Notices 60-0089, Claims Folder System and 60-0050, Completed Determination-Continuing Disability Determinations. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or any local Social Security office.

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 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. 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 (TTY 1-800-325-0778). 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.

Form HA-501-U5 (01-2015) ef (01-2015)
# REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended ALJ decision.)

Either mail the signed original form to the Appeals Council at the address shown below, or take or mail the signed original to your local Social Security office, the Department of Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service Post and keep a copy for your records.

1. CLAIMANT NAME
2. CLAIMANT SSN
3. CLAIM NUMBER (If different than SSN)

4. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

☐ Please grant me an extension of time to submit evidence or argument.

## ADDITIONAL EVIDENCE

If you have additional evidence that relates to the period on or before the date of the hearing decision, you must inform the Appeals Council about it or submit it. If you have a representative, then your representative must help you obtain the evidence unless the evidence falls under an exception. You may also submit any other additional evidence to the Appeals Council. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. This will ensure that the Appeals Council has the opportunity to consider the additional evidence before taking its action. If you submit neither evidence nor legal argument now or within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence currently in your file.

IMPORTANT: WRITE YOUR SOCIAL SECURITY NUMBER ON ANY LETTER OR MATERIAL YOU SEND US. IF YOU RECEIVED A BARCODE FROM US, THE BARCODE SHOULD ACCOMPANY THIS DOCUMENT AND ANY OTHER MATERIAL YOU SUBMIT TO US.

SIGNATURE BLOCKS: You should complete No. 5 and your representative (if any) should complete No. 6. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 6.

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.

5. CLAIMANT’S SIGNATURE

6. REPRESENTATIVE’S SIGNATURE

PRINT NAME

DATE

DATE

ATTORNEY

NON-ATTORNEY

ADDRESS

CITY, STATE, ZIP

ADDRESS

CITY, STATE, ZIP

TELEPHONE NUMBER

FAX NUMBER

TELEPHONE NUMBER

FAX NUMBER

## THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

7. Request received for the Social Security Administration on (Date) by: (Print Name)

8. Is the request for review received within 65 days of the ALJ’s Decision/Dismissal? ☐ Yes ☐ No

9. If "No" checked:

☐ (1) attach claimant's explanation for delay; and

☐ (2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

10. Check one:

☐ Initial Entitlement

☐ Termination or other

11. Check all claim types that apply:

☐ Retirement or survivors (RSI)

☐ Disability-Worker (DIWC)

☐ Disability-Widow(er) (DIWW)

☐ Disability-Child (DIWC)

☐ SSI Aged (SSA)

☐ SSI Blind (SSIB)

☐ SSI Disability (SSID)

☐ Title VIII Only (SVB)

☐ Title VIII/Title XVI (SVB/SSI)

☐ Other - Specify:
Privacy Act Statement
Request for Review of Hearing Decision/Order

Sections 205(a), 702, 1631(e), and 1869(b) and (c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to complete our claims process.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent the continued processing of your claim.

We rarely use the information you supply for any purpose other than to complete our claims process. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0005, entitled Administrative Law Judge Working Files and 60-0089, entitled Claims Folder. Additional information about these and other system of records notices and our programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 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. 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 (TTY 1-800-325-0778). Send only comments relating to our time estimate to this address, not the completed form.
Instructions for Completing Form SSA-1696

Keep a copy of this form for your records

DO NOT FILE form SSA-1696 if you do not have a claim, you are not filing a claim with this form, or there is no other issue pending decision with us. In this document, "you" means the claimant, beneficiary, auxiliary or spouse. "Us" and "SSA" means the Social Security Administration.

General Information About This Form

• You have the right to appoint a qualified representative of your choice to represent you on any claim or asserted right under any of our programs. For more information on who can qualify to be an appointed representative, when your representative's appointment begins or ends, payment of fees to appointed representative(s), and other helpful information, or to locate your local field office, you can visit our website at www.ssa.gov/locator. Call us, toll-free, at 1-800-772-1213.

• You and your representative(s) may use this form to start the representation. Your representative may also use this form to waive a fee, waive direct payment of the fee, or tell us that a third party will pay the fee.

• You may also choose to be unrepresented. We handle your case in the same manner whether you are represented or unrepresented. You do not need to appoint someone who simply helps you through the process. For example, you do not need to appoint someone who helps you come to our office, reads to you from documents, or interprets for you if you speak another language. You only need to appoint someone if he or she will be acting or appearing on your behalf, or will be making decisions about your case for you.

• You and your representative(s) must give us accurate information as quickly as possible. Providing misleading or false evidence on this form or your application, or withholding or delaying giving us evidence, could lead to possible criminal charges or administrative sanctions against you or your representative.

Appointing a Representative

If you are using this form to appoint a representative, you must complete Sections 1, 2, and 3. Your representative must complete Sections 5 and 7 of this form. Both you and your representative must complete Section 4, either of you can complete section 6. You or your representative must file the completed form with us, in-person at your local field office, by mail, or by fax. Review and complete all required sections. If you are appointing multiple representatives, use separate forms for each representative. Your representative or someone else can help you complete the form but you must sign and date Section 8. Your representative must also sign the form if he or she is a non-attorney. You or your representative must submit the completed form to us before we will recognize your representative. You can file it in-person at your local field office, mail it, or fax it to us. Do not file this form with your local State Disability Determination Services office.

Section 1 - Claimant's Information and Number Holder's Information

Complete all of the information, including your Social Security Number. If you are filing your claim on someone else's Social Security record, this person is the "number holder" and we need his or her information to process your claim.

Section 2 - Authorization for Disclosure

By selecting the disclosure box, you are authorizing us to give information to your representative's staff, partners, associates and other individuals who work for or with your representative (such as contractors and copying services). We will check the credentials of the individuals requesting information on behalf of your representative for authentication purposes.

Section 3 - Principal Representative

If you appoint or have appointed multiple representatives, you must name your principal representative who will be our main point of contact. We will send copies of your notices to this individual and communicate directly with him or her.

Section 4 - Representative's Information

Both you and your representative must complete all of the information in this section. It is important to fill in all the boxes, including the Representative Identification Number (Rep ID). Ask your representative for his or her Rep ID, if you do not know it. This box should only be left blank if your representative does not have a Rep ID.

Section 5 - Representative's Status, Affiliations, and Certifications

Your representative must complete this section to let us know his or her status as a professional. If your representative is seeking a fee and is working for an employer, entity or firm, he or she must also complete the affiliation section and give us the Employer's Identification Number (EIN). We will provide both your representative and the employer, entity, or firm with a copy of the form IRS 1099-MISC showing the reported income. For more information on form 1099-MISC and employer registration, visit our website at www.ssa.gov/representation. Your representative should also certify the accuracy of all statements in this section.
Section 6 - Claim Type
Either you or your representative can complete this section. Check all types of claims for which you seek representation.

Section 7 - Fee Arrangement
Complete this section, if your representative is or will be asking for a fee for services performed on your claim. Generally, to charge a fee for services, your representative must get our approval. Your representative may waive the right to charge you a fee or tell us that a third party entity (business, government agency, or organization) will pay the fee. In these situations, the third party must pay out of its own funds the fee and any expenses, and you and any auxiliary beneficiaries (e.g., children or spouse) must be free of responsibility to pay any fees or expenses. If your representative is eligible for direct payment, he or she also may waive the right to direct payment.

Section 8 - Signatures
You must sign and date this section. If your representative is not an attorney, he or she also must sign and date this section. We also encourage attorneys to sign this section to confirm that they will abide by our rules.

Privacy Act Statement - Collection and Use of Personal Information
Sections 206 and 1631(d) 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 appointing a representative to act on your behalf.

We will use the information to verify the appointment of your representative and his or her acceptance of the appointment. We may also share your information for the following purposes, called routine uses:

- To a congressional office in response to an inquiry from that office made on behalf of, and at the request of, the subject of the record or a third party acting on the subject’s behalf;

- To Federal, State, and local law enforcement agencies and private security contractors, as appropriate, information necessary:
  
  (a) to enable them to protect the safety of Social Security Administration (SSA) employees and customers, the security of the SSA workplace, and the operation of SSA facilities; or
  
  (b) to assist investigations or prosecutions with respect to activities that affect such safety and security or activities that disrupt the operation of SSA facilities; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

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; 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210; and 60-0325, entitled Appointed Representative File, as published in the FR on October 8, 2009, at 74 FR 51940. Additional information and a full listing of all our SORNs are 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 30 minutes to read the instructions, gather the facts, and answer the questions. You may send us your comments on our estimated completion time to SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

References
- 18 U.S.C. §§ 203, 205, and 207; 42 U.S.C. §§ 406, 1320a-6, 1383(d)(2) and 1631;
- 26 U.S.C. §§ 6041 and 6045(f) and 20 CFR §§ 404.1700 et. seq. and 416.1500 et. seq.
Claimant's Social Security Number: 

Appointed Representative's Rep ID: 

Claimant's Appointment of a Representative

Section 1 - Claimant's Information

Social Security Number:

First Name: Initial | Last Name

Mailing Address:

City: State | ZIP/Postal Code | Country - if outside the U.S.

Phone Number: Alternate Phone Number (Optional):

Country/Area Code: Phone Number | Country/Area Code: Phone Number

Number Holder's Information (Complete when applicable)

My claim is based on another person’s work or earnings (e.g., spouse or parent). This person’s information is different from mine.

Number Holder’s Social Security Number:

First Name: Initial | Last Name

Section 2 - Disclosure (Claimant Only)

☐ By selecting this box, I, the claimant listed in Section 1, whose signature appears in Section 8, authorize SSA to release information in relation to my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g., clerks, assistants), partners, or parties under contractual arrangements for or with my representative. (The appointed representative’s partners, associates, delegates and designees must be prepared to provide information in order to be authenticated.)

Section 3 - Principal Representative (Claimant only – Complete when applicable)

I have appointed before, or appoint now, more than one representative. I ask SSA to make contacts or send notices to this individual. My principal representative is:

Name
Section 4 - Representative's Information (Claimant and Representative)

Representatives who are eligible and seek direct payment of their fee must register and receive a Rep ID before the appointment. For more information about registration visit us on-line at www.socialsecurity.gov/ar, contact us at 1-800-772-1213 (TTY 1-800-325-0778), or visit your local Social Security office.

Representative's Rep ID

First Name | Initial | Last Name

Mailing Address

City | State | ZIP/Postal Code | Country - if outside the U.S.

Phone Number | Alternate Phone Number (Optional)

Country/Area Code | Phone Number | Country/Area Code | Phone Number

Section 5 - Representative’s Status, Affiliations, and Certifications (Representative Only)

Representative’s Status Part A - Type of Representative (Representatives have a duty to keep their information current)

☐ I am an attorney (SSA regulation states that an attorney is someone in good standing who has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States.)

☐ I am a non-attorney eligible for direct payment (SSA law requires that non-attorneys meet certain criteria to qualify for direct payment. Refer to our website at www.ssa.gov/representation for criteria).

☐ I am a non-attorney not eligible for direct payment.

Representative’s Status Part B - Disqualification

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice law.

☐ Yes ☐ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency.

☐ Yes ☐ No
Section 5 - Continued (Representative Only)

Affiliation Information
If you are representing the claimant(s) as a partner or employee of a business entity, firm or other organization you may provide your Employer Identification Number (EIN) here, if one exists for tax purposes. This number is not your Social Security Number (SSN). This is your employer’s tax identification number. (Do not complete this section if you do not qualify for direct payment.)

EIN 

Organization’s Name (Enter the full name of the business, entity, firm or organization with which you want to be affiliated while representing this claim)

Representative’s Business Address (if different than mailing address)

City State ZIP/Postal Code

Country - if outside the U.S.

Representative’s Certification

I accept this appointment and certify the following:

- I understand and agree that I will comply with SSA’s laws and rules on the representation of parties, including the Rules of Conduct and Standards of Responsibility for Representatives; I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved unless a regulatory exclusion applies.
- I understand that if I fail to comply with any of SSA’s laws and rules I may be suspended or disqualified as a representative before SSA.
- I will not disclose any information to any unauthorized party without the claimant’s specific written consent.
- I am not currently suspended or prohibited, for any reason, from practicing before the Social Security Administration.
- I am not disqualified from representing the claimant as a current or former officer or employee of the United States.
- I accept appointment as the representative for the claimant named in Section 2 of this form in connection with the claims and asserted rights described in Section 6 of this form.
- I agree that a copy of this signed form SSA-1696 will have the same force and effect as the original.
- I declare under penalty of perjury that I have examined all of the information on this form and on all accompanying statements or forms, including any information, attestations and certifications provided to SSA in registration, and that they are all currently true and correct to the best of my knowledge.

If I intend to seek direct payment of the authorized fee on this claim -
- I have registered for and obtained a Rep ID, and my registration information is up-to-date.
- I have provided up-to-date information on my registration concerning whether I have been suspended or prohibited from practice before SSA or any other Federal program or agency, disbarred or suspended by a court or bar, and convicted of a violation under Section 206 or 1631(d) of the Social Security Act.

I CERTIFY TO ALL OF THE ABOVE (Representative’s Initials)
Section 6 - Claim Type (Claimant or Representative)

I appoint the individual named in Section 4 to act as my representative in connection with my claim(s) or asserted right(s) under Title II (RSDI), Title XVI (SSI), Title XVIII (Medicare Coverage), and Title VIII (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (Check all that apply)

☐ Claim/Appeal for Title II Disability Benefits
☐ Claim/Appeal for Title XVI Disability Benefits
☐ Concurrent Title II and Title XVI Disability Benefits
☐ Claim/Appeal for Retirement Benefits
☐ Claim/Appeal for Title XVIII (Medicare), VIII (Special Veteran’s Benefits)
☐ Continuing Disability Review (CDR)
☐ Post-Entitlement Issue (a new issue you raise after eligibility for other benefits)

(E.g., benefit amount, month of entitlement, representative payee, suspension, termination, overpayment)

Section 7 - Fee Arrangement (Representative Only)

Check one box below:

☐ I will request a fee and direct payment of this fee. Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to pay you the fee we may authorize. (We must authorize the fee.)

☐ I will request a fee but not direct payment. Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You must collect any fee we may authorize on your own. (We must authorize the fee.)

☐ I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual. Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. (We do not need to authorize the fee if all regulatory conditions apply.)

☐ I waive the right to a fee.

Section 8 - Signatures (Claimant and Representative)

Representative’s Signature

Date

Claimant’s Signature

Date
Instructions for Using this Form
Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor’s non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:
- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY 1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.govonline/ssa-7050.pdf.

How to Complete this Form
We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for “any and all records” or the “entire file.” You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT
Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person’s eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

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 control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING 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 1-800-772-1213 (TTY 1-800-325-0778). 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.
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. If you also think we made a mistake when we decided that you were overpaid, or if you disagree with the amount of your overpayment, please also complete the SSA-561, Request for Reconsideration. We call this action an appeal.

When Not To Complete This Form

- If you do not wish to request a waiver, but 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.

SECTION 1 - IDENTIFYING QUESTIONS

IMPORTANT: Please answer the following questions as completely as you can and submit any supporting documents with your waiver request. If you need more space for answers, use the "REMARKS" section on page 11.

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

B. Are you the overpaid person?  
   ☐ Yes (go to 4)  
   ☐ No (go to 1.C)

C. If you are filling out the waiver request for the overpaid person, what is your relationship to the overpaid person? (check all that apply)
   ☐ I am the overpaid person's parent.  
   ☐ I am the overpaid person's representative payee.  
   ☐ I am the overpaid person's spouse.  
   ☐ I am the overpaid person's legal guardian.  
   ☐ Other, please explain:

   (Options continue on next page)
1. D. If you are not the overpaid person, what is your name or the name of the organization you represent?
   Name:

E. If you are the overpaid person's representative payee, were you the representative payee when the overpayment occurred?  □ Yes  □ No

SECTION 2 - QUESTIONS FOR REPRESENTATIVE PAYEE

IMPORTANT: If you were the representative payee for the overpaid person when the overpayment occurred, complete Section 2 as it applies to you as the representative payee. Otherwise, go to Section 4.

2. A. Was the overpaid person living with you when he or she was overpaid?  □ Yes  □ No

B. Does the overpaid person currently live with you?  □ Yes  □ No

C. Are you requesting a waiver for a minor child?  □ Yes  □ No

D. Did you tell us about the change or event that caused the overpayment?  □ Yes  □ No

E. Do you still have any of the overpaid money?
   □ Yes (go to 2.F)  □ No (go to 2.G)

F. How much of the overpaid money do you still have?  $

G. Did you use the overpaid money for the beneficiary?  □ Yes  □ No (go to 2.H)

H. Explain how you used the overpaid money:

SECTION 3 - IF YOU ARE RESPONSIBLE FOR A FAMILY MEMBER’S OR ANOTHER INDIVIDUAL’S OVERPAYMENT

IMPORTANT: If we told you in the overpayment notice that you are responsible for a family member's overpayment, complete Section 3. Otherwise, go to Section 4.

3. A. Did we tell you in the overpayment notice that you are responsible for paying back another individual's overpayment?  □ Yes (go to 3.B)  □ No (go to 4)

B. Was the overpaid person living with you when he or she was overpaid?  □ Yes  □ No

C. Did you receive any of the overpaid money?  □ Yes  □ No

SECTION 4 - INFORMATION ABOUT RECEIVING THE OVERPAYMENT

IMPORTANT: Please complete questions 4 through 26 as completely as you can. If you are answering the questions for someone else or if you are helping someone fill out the form, check the boxes and answer each question as it applies to the overpaid person.

4. What was your situation when the overpayment occurred? (Check all that apply)
   □ I was a child when the overpayment occurred.
   □ I was an adult when the overpayment occurred.
   □ I was receiving disability benefits from Social Security.  (Options continue on next page)
4. □ I was receiving retirement benefits from Social Security.  
□ I was receiving Social Security benefits from a parent’s record.  
□ I was receiving Social Security benefits as a widow/widower.  
□ I was receiving Social Security benefits as a spouse.  
□ I was receiving Supplemental Security Income (SSI) payments.  
□ None of the above, please explain: ____________________________________________________________________________

5. 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: ____________________________________________________________________________
D. □ I thought I still had a disability that would make me eligible for benefits. I filed an appeal and I fully cooperated with Social Security.  
E. □ I was age 18 and receiving SSI when the overpayment occurred.  
F. □ None of the above, please explain: ____________________________________________________________________________

6. Are you requesting a waiver for your entire overpayment amount? □ Yes □ No

7. Have you previously filed a waiver request for this overpayment? □ Yes □ No (go to 11)

8. Do you have the notice for this overpayment? □ Yes □ No (go to 11)  
If you have the notice for this overpayment, please provide the date on that notice. (MM/DD/YYYY)

9. If you have the notice for this overpayment, please provide the following information:  
First month you were overpaid ________________________________________________________________________  
Last month you were overpaid ________________________________________________________________________  
If you were overpaid only one month, please provide the month ________________________________________________________________________

10. If you have the notice for this overpayment, please provide the amount of the overpayment. $ __________

11. What was the cause of the overpayment? (Check all that apply)  
A. □ I received too much income.  
B. □ My household received too much income.  
C. □ My resources were over the amount for SSI.  
D. □ I received help for food and shelter.  
E. □ I received more than one benefit payment for the same month.  
F. □ The Social Security Administration determined that I was no longer disabled.  
G. □ My marital status changed.  
H. □ I received workers’ compensation.  
I. □ I was in a nursing home.  
J. □ I was in jail or prison.  
(Options continue on next page)
11. K. [ ] I lived outside the U.S. for 30 consecutive days.
   L. [ ] My immigration status changed.
   M. [ ] Another person became entitled on the same record.
   N. [ ] My attorney fee was not withheld from my benefits.
   O. [ ] I was no longer a student.
   P. [ ] I no longer had a child under age 16 or a disabled child in my care.
   Q. [ ] I was overpaid because:

   [ ] I do not know why I was overpaid.

12. A. Do you understand that you are supposed to report changes to us, for example:
   - working
   - marriage
   - divorce
   - moving
   - a change in resources
   - a change in income
   - a change in school attendance
   - any other changes that may affect your benefits
   [ ] Yes
   [ ] No, explain:

   [ ] Yes, please explain:

   B. Is there anything that prevents you from reporting your changes to us?
   [ ] Yes, please explain:
   [ ] No

   C. Did you tell us about the change or event that led to the overpayment?
   [ ] Yes, please check one or more reasons below
   [ ] No, please explain:
   [ ] I called in
   [ ] I sent a fax or letter
   [ ] I visited a local field office
   [ ] I used electronic wage reporting
   [ ] Other, please explain:

   Date(s) you told us about the change or event that led to the overpayment:

   Do you have any documentation indicating that you told us about the change or event that led to the overpayment?
   [ ] Yes, please send it with your waiver request
   [ ] No, please explain:

   D. Have you ever been overpaid before?
   [ ] Yes (go to 12.E)
   [ ] No (go to 12.F)
12. E. If you were overpaid before, is this overpayment for the same reason?
   □ Yes □ No □ I do not know

F. Are you currently receiving any of the following? (Check all that apply)
   □ I am receiving Supplemental Security Income (SSI) payments.
   □ I am receiving Temporary Assistance for Needy Families (TANF).
      My claim number is: ____________________________
   □ I am receiving a pension based on need from the Department of Veterans Affairs (VA)
      My claim number is: ____________________________

IMPORTANT: If you checked any boxes in question 12.F, go to page 13. Please sign, date, provide your address and phone number(s), and proof that you receive TANF or VA pension, if applicable. If this statement does not apply, go to question 13.A.

SECTION 5 - YOUR FINANCIAL STATEMENT

Documents to Support Your Statements

IMPORTANT: To complete Sections 5 through 8 of this form, you should refer to certain documents to support your statements. Please answer all questions and submit any supporting documents with your request. Your supporting documents should be no older than 3 months from the date you are requesting a waiver. Submit similar documents for your spouse and your dependents. A dependent is a person who depends on you for support and whom you can claim on your tax return. Examples of supporting documents are:
   • Current Rent or Mortgage Information
   • 2 or 3 Recent Utility, Medical, Charge Card, and Insurance Bills
   • Canceled Checks
   • Recent Bank Statements (checking or savings account)
   • Current Pay Stubs
   • Your Most Recent Income Tax Return

Please write only whole dollar amounts. Round any cents to the nearest dollar.

13. A. Did you still have any of the overpaid money at the time you received the overpayment notice?
   □ Yes Amount $ ___________ (go to 13.B) □ No (go to 14)

B. Do you still have any of the overpaid money?
   □ Yes Amount $ ___________ □ No
   (If yes, return the money to SSA following the instructions in the overpayment notice or contact SSA at 1-800-772-1213.)

14. Did you receive any real estate after you received the overpayment notice?
   □ Yes (provide the value) □ No
   Value: $ ___________

15. A. Did you give away any real estate after you received your overpayment notice?
   □ Yes (provide the value) □ No
   Value: $ ___________

B. Did you sell any real estate after you received your overpayment notice?
   □ Yes (provide the amount) □ No
   Amount you received after selling: $ ___________
16. A. Did you give away any money after you received the overpayment notice?
   [ ] Yes (provide the amount) Amount: $ ________________ [ ] No

   B. Did anyone give you money after you received your overpayment notice?
   [ ] Yes (provide the amount) Amount: $ ________________ [ ] No

SECTION 6 - MEMBERS OF HOUSEHOLD

17. A. If you are an adult requesting a waiver, list your spouse and dependents below. A dependent is a person who depends on you for support and whom you can claim on your income tax return.

   If you are completing the waiver request for a minor child, only provide the child's name in Section 6 and the child's information is Sections 7, 8, and 9. If the child's income and assets help with food and household expenses, complete Sections 6, 7, 8, and 9 with the parents' and their dependents' information.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship To You</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   B. Does anyone live with you who you cannot claim on your income tax return?
   [ ] Yes [ ] No (go to 18.A)

   If yes, does this person or persons give you any money to live with you or pay any of the household bills or expenses?
   [ ] Yes, total amount you receive $ ________________ [ ] No

SECTION 7 - ASSETS - THINGS YOU HAVE AND OWN

18. 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.

<table>
<thead>
<tr>
<th>Type of Account</th>
<th>Name and Address of Institution</th>
<th>Name on Account</th>
<th>Balance or Value</th>
<th>Income Per Month (interest or dividends)</th>
<th>Account Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   TOTALS
19. 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 19.B)

<table>
<thead>
<tr>
<th>Owner</th>
<th>Year, Make/Model</th>
<th>Present Value</th>
<th>Loan Balance (if any)</th>
<th>Main Purpose for Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL COUNTABLE VALUE $**

B. Do you, your spouse, or your dependents own any real estate other than where you live?
   - [ ] Yes (list below)
   - [ ] No (go to 19.C)

<table>
<thead>
<tr>
<th>Owner</th>
<th>Description</th>
<th>Market Value</th>
<th>Loan Balance (if any)</th>
<th>Income Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 20)

<table>
<thead>
<tr>
<th>Owner</th>
<th>Description</th>
<th>Market Value</th>
<th>Loan Balance (if any)</th>
<th>Income Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS $**

**SECTION 8 - MONTHLY HOUSEHOLD INCOME**

The next set of questions are about monthly take home pay. Enter your, your spouse, and your dependents' take home pay and check the box to show whether payment is received weekly, every 2 weeks, twice a month, or monthly. Add the monthly amount on line 22.A. If you need more space for answers, use the "REMARKS" section on page 11.

20. A. Are you employed?
   - [ ] Yes (provide information below)
   - [ ] No (go to 20.B)

Employer(s) Name, Address, and Phone: (Write "self" if self-employed)

| Take home pay or earnings if self-employed (Net) Choose one: |
|---------------------|-----------------|
| [ ] Weekly         | [ ] Every 2 Weeks |
| [ ] Monthly        | [ ] Twice a Month |

**$**

B. Is your spouse employed?
   - [ ] Yes (provide information below)
   - [ ] No (go to 20.C)

Employer(s) Name, Address, and Phone: (Write "self" if self-employed)

| Take home pay or earnings if self-employed (Net) Choose one: |
|---------------------|-----------------|
| [ ] Weekly         | [ ] Every 2 Weeks |
| [ ] Monthly        | [ ] Twice a Month |

**$**

(Options continue on next page)
20. C. Are any of your dependents employed, including self-employment?  
☐ Yes (provide information below)  ☐ No (go to 21)  
Name(s) of dependents:

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

$ 

21. A. Do you, your spouse, or your dependents receive support or contributions from any person, agency, or organization?  ☐ Yes (go to 21.B)  ☐ No (go to 22)  
B. Is the support received under a loan agreement?  ☐ Yes (go to 22)  ☐ No (go to 21.C)  
C. How much money do you, your spouse, or your dependents receive each month? (Show this amount on line 1 of question 22)  

$  

| Source | 

<table>
<thead>
<tr>
<th>Income (Be sure to show monthly amounts below)</th>
<th>Overpaid person's income</th>
<th>Spouse of Overpaid Person</th>
<th>Dependent(s) of Overpaid Person (Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Social Security Benefits (retirement, disability, widows, students, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Supplemental Security Income (SSI)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Pension(s) (VA, Military, Civil Service, Railroad, etc.)</td>
<td>TYPE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Supplemental Nutrition Assistance Program (SNAP) Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Income from Real Estate, Business, etc. (from questions 19.B and 19.C)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Room and/or Board Payments from a Person who is not a Dependent (from question 17.B). Put the amount in the overpaid person's column.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Child Support/Alimony</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Other Support (from question 21.C)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Income from Assets (from question 18.B)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Other (from any source, explain in REMARKS on next page)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS:**

Grand Total $  
(Add all TOTAL blocks above)  

(Options continue on next page)
SECTION 9 - MONTHLY HOUSEHOLD EXPENSES

Do not list an expense that is withheld from your paycheck (such as medical insurance, child support, alimony, wage garnishments, etc.) (Be sure to show monthly amounts in number 23) Please write only whole dollar amounts and round any cents to the nearest dollar.

<table>
<thead>
<tr>
<th>Type of Expense</th>
<th>$ Per Month</th>
<th>SSA Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Rent or Mortgage (if mortgage payment includes property or other local taxes, insurance, etc., DO NOT list it again below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Food (groceries, including food purchased with SNAP benefits, and food at restaurants, work, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Utilities (gas, electric, telephone (cell or land line), internet, trash collection, water, and sewer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Other Heating/Cooking Fuel (oil, propane, coal, wood, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Clothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Household Items (personal hygiene items, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Property Tax (State and local)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Insurance (life, health, fire, homeowner, renter, car, and any other casualty or liability policies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Medical/Dental (prescriptions and medical equipment, if not paid by insurance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Loan/Lease Payment for Family Vehicle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Expenses (gas and repairs) for Family Vehicle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. Other Transportation (bus, taxi, etc., used for medical appointments, work, or other necessary travel)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. Tuition and School Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N. Court Ordered Payments Paid Directly to the Court</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O. Credit Card Payments (show minimum monthly payment). DO NOT include any expenses already listed above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P. Any expenses not shown above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Options continue on next page)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL
23. EXPENSE REMARKS (Please provide any additional information not captured in Section 9)


SECTION 10 - INCOME AND EXPENSES COMPARISON

24. A. Monthly Income
   Write the amount here from the **Grand Total** from number 22.
   $

B. Monthly Expenses
   Write the amount here from the **Total** from number 23.
   $

C. Add this amount to your expenses.

D. Adjusted Monthly Expenses (Add B and C)
   $

E. **TOTAL** (Subtract D from A)
   $

25. If your expenses in 24.D are more than your income in 24.A, explain how you are paying your bills.
   If you are not paying your bills, explain which bills have unpaid balances.


SECTION 11 - FINANCIAL EXPECTATION AND FUNDS AVAILABILITY

26. A. Do you expect to receive an inheritance within the next 6 months?
   □ Yes, explain
   □ No (go to 26.B)

   Yes, explain
   
   
   
   


   **Total $:**
   
   
   
   (Options continue on next page)

☐ Yes, explain

☐ No

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

<table>
<thead>
<tr>
<th>Customer's Signature/Authorization</th>
<th>Mailing Address</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Representative's Signature/Authorization</td>
<td>Legal Representative's Mailing Address</td>
<td>Date</td>
</tr>
</tbody>
</table>

51
## 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 OR REPRESENTATIVE PAYEE

<table>
<thead>
<tr>
<th>Signature (First name, middle initial, last name) (Write in ink)</th>
<th>Date (MM/DD/YYYY)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Telephone Number (include area code)</th>
<th>Work Telephone Number If We May Call You At Work (include area code)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address (Number and street, Apt. No., PO Box, or Rural Route)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

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 (Write in ink)  
2. Signature of Witness (Write in ink)

<table>
<thead>
<tr>
<th>Address (Number and street, City, State, and ZIP Code)</th>
<th>Address (Number and street, City, State, and ZIP Code)</th>
</tr>
</thead>
</table>
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.
Request for Change in Overpayment Recovery Rate

When To Complete This Form

Complete this form if you are requesting that we adjust the current rate of withholding to recover your overpayment because you are unable to meet your necessary living expenses. We will use your answers to decide if we can reduce the amount you must pay us back each month.

IMPORTANT: Please answer the following questions as completely as you can. If you are answering the questions for someone else, check the boxes and answer each question as it applies to the overpaid person.

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:

2. B. Are you the overpaid person? □ Yes (go to question 2) □ No (go to question 1.C)

3. C. If you are not the overpaid person, what is your relationship to the overpaid person?
   (Check all that apply)
   - □ I am the overpaid person's parent.
   - □ I am the overpaid person's representative payee.
   - □ I am the overpaid person's spouse.
   - □ I am the overpaid person's legal guardian.
   - □ Other, please explain:

4. D. If you are not the overpaid person, what is your name or the name of the organization you represent?
   - Name:

2. Please check all that apply:
   - □ I am receiving Supplemental Security Income (SSI) benefits.
   - □ I am receiving Temporary Assistance for Needy Families (TANF)
   - □ I am receiving a pension based on need from the Department of Veterans Affairs (VA)
   - □ I am receiving Social Security benefits.
   - □ I am not receiving benefits.

3. Enter the total amount you owe: $

4. Enter the amount you can afford to pay or have withheld from your payment each month: $
YOUR FINANCIAL STATEMENT

Documents to Support Your Statements

Please answer all questions and submit any supporting documents with your request. Your supporting
documents should be no older than 3 months from the date you are requesting a change in the repayment
rate.

Examples of supporting documents are:

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

Please write only whole dollar amounts. Round any cents to the nearest dollar. If you need more space for
answers, use the "Remarks" section at the bottom of page 6.

SECTION 2 - ASSETS - THINGS YOU HAVE AND OWN

5. A. How much cash do you have in your possession? $

B. List all of your financial accounts. 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.

<table>
<thead>
<tr>
<th>Type of Account</th>
<th>Name and Address of Institution</th>
<th>Name on Account</th>
<th>Balance or Value</th>
<th>Income Per Month (interest or dividends)</th>
<th>Account Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTALS $

6. A. Do you 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 the vehicles below)  [ ] No (go to 6.B)

<table>
<thead>
<tr>
<th>Owner</th>
<th>Year/Make/Model</th>
<th>Present Value</th>
<th>Loan Balance (if any)</th>
<th>Main Purpose for Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL COUNTABLE VALUE $

(Options continue on next page)
6. B. Do you own any real estate other than where you live? □ Yes (list below) □ No (go to 6.C)

<table>
<thead>
<tr>
<th>Owner</th>
<th>Description</th>
<th>Market Value</th>
<th>Loan Balance (if any)</th>
<th>Income Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTALS $

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

□ Yes (list below) □ No (go to 7)

<table>
<thead>
<tr>
<th>Owner</th>
<th>Description</th>
<th>Market Value</th>
<th>Loan Balance (if any)</th>
<th>Income Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTALS $

SECTION 3 - MONTHLY HOUSEHOLD INCOME

The next question asks about monthly take home pay. Enter your take home pay, and check the box to show whether you are paid weekly, every 2 weeks, twice a month, or monthly. Add the monthly amount on line 9.A.

7. Are you employed? □ Yes (provide information below) □ No

Employer Name, Address, and Phone: (Write "self" if self-employed)

Take home pay or earnings if self-employed (Net) Choose one:

□ Weekly □ Every 2


□ Twice a Month □ Monthly

8. A. Do you receive support or contributions from any person or organization?

□ Yes (go to question 8.B) □ No (go to question 9)

B. Is the support received under a loan agreement?

□ Yes (go to question 9) □ No (go to question 8.C)

C. How much money do you receive each month? (Show this amount on line 1 of question 9)

$ Source

9. Income (Be sure to show monthly amounts below)

A. Take Home Pay (Net) (from question 7)

B. Social Security Benefits (retirement, disability, widows, students, etc.)

C. Supplemental Security Income (SSI)

Your Income SSA USE ONLY

(Options continue on next page)
SECTION 4 - MONTHLY HOUSEHOLD EXPENSES

DO NOT list an expense that is withheld from your paycheck (such as medical insurance, child support, alimony, wage garnishments, etc.). (Be sure to show monthly average amounts in number 10). Please write only whole dollar amount and round any cents to the nearest dollar.

<table>
<thead>
<tr>
<th>Type of Expense</th>
<th>$ Per Month</th>
<th>SSA USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Rent or Mortgage (if mortgage payment includes property or other local taxes, insurance, etc., DO NOT list again below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Food (groceries, including food purchased with SNAP benefits, and food at restaurants, work, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Utilities (Gas, electric, telephone (cell or land line), Internet, trash collection, water, and sewer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Other Heating/Cooking Fuel (oil, propane, coal, wood, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Clothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Household Items (personal hygiene items, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Property Tax (State and local)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Insurance (life, health, fire, homeowner, renter, car, and any other casualty or liability policies)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Options continue on next page)
### SECTION 5 - INCOME AND EXPENSES COMPARISON

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td></td>
</tr>
</tbody>
</table>
| A. Your Monthly Income  
Write the amount here from "Total" of question 9. | $ |
| B. Your Monthly Expenses  
Write the amount here from "Total" of question 10. | $ |
| C. Total  
Subtract B from A. | $ |

12. If your expenses in 11.B are more than your income in 11.A, explain how you are paying your bills. If you are not paying your bills, explain which bills have unpaid balances.
SECTION 6 - FINANCIAL EXPECTATION AND FUNDS AVAILABILITY

13. A. Do you expect to receive an inheritance within the next 6 months?
   □ Yes (Explain on line below)  □ No (go to 13.B)

B. Is there any reason you cannot convert or sell the “Balance or Value” of any financial assets shown in items 5.B, 6.A, 6.B, or 6.C to cash?
   □ Yes (Explain on line below)  □ No

   
   Total $:

REMARKS SPACE - If you are continuing an answer to a question, please write the number (and letter, if any) of the question first.
**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 OR REPRESENTATIVE PAYEE**

<table>
<thead>
<tr>
<th>Signature (First name, middle initial, last name) (Write in ink)</th>
<th>Date (MM/DD/YYYY)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Telephone Number (include area code)</th>
<th>Work Telephone Number If We May Call You At Work (include area code)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address (Number and street, Apt. No., PO Box, or Rural Route)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

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 (Write in ink)  
2. Signature of Witness (Write in ink)

<table>
<thead>
<tr>
<th>Address (Number and street, City, State, and ZIP Code)</th>
<th>Address (Number and street, City, State, and ZIP Code)</th>
</tr>
</thead>
</table>
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 request for change in overpayment recovery rate.

We will use the information to make a determination regarding overpayment recovery. We may also share your information for the following purposes, called routine uses:

- To employers to assist the Social Security Administration (SSA) in the collection of debts owed by former beneficiaries and representative payees of Social Security payments who received an overpayment and owe a delinquent debt to the SSA; and

- To another Federal agency that has asked SSA to effect an administrative offset under common law or under 31 U.S.C. § 3716 to help collect a debt owed the United States.

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 1847; and 60-0320, entitled Electronic Disability Claims File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/privacy.

Paperwork Reduction Act

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 45 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING 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 (TTY 1-800-325-0778). 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.
Social Security Administration

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).

TO: Social Security Administration

*My Full Name

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:

*ADDRESS OF PERSON OR ORGANIZATION:

*I want this information released because:

We may charge a fee to release information for non-program purposes.

*Please release the following information selected from the list below:

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date ________ to date ________
5. ☐ My Medicare entitlement from date ________ to date ________
6. ☐ Medical records from my claims folder(s) from date ________ to date ________
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social
   Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file. (We will not honor a request for "any and all records" or "the entire file." You must specify
   other records, e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires,
   doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the
legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined
all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly
or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to
$5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

*Signature: ____________________________

*Date: ____________________________

**Address: ____________________________

**Daytime Phone: ____________________________

Relationship (If not the subject of the record): ____________________________

**Daytime Phone: ____________________________

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing
who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the
signature line above.

1. Signature of witness
   Address(Number and street, City, State, and Zip Code)

2. Signature of witness
   Address(Number and street, City, State, and Zip Code)

Form SSA-3288 (11-2016)