

REPORT TO THE UNITED STATES SOCIAL SECURITY ADMINISTRATION BY PERSON RECEIVING
 BENEFITS FOR A CHILD OR FOR AN ADULT UNABLE TO HANDLE FUNDS

IMPORTANT: Failure to complete and return this form within 60 days will result in a suspension of benefits. **Sign and return this form in the enclosed envelope.** See instructions enclosed.

1. Print your address here only if it is different from the one shown below.	2. Telephone number at which you may be contacted during the day.
--	---

Name of Representative Payee:

Social Security Number / Claim Number:

Name of Beneficiary:

Current Address:

IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS 3 THROUGH 8 BELOW, PLEASE TURN THIS FORM OVER AND CONTINUE ON THE BACK. YOU MUST SIGN YOUR NAME IN ITEM 11 ON THE BACK OF THIS FORM.

		YES	NO
3.	Has anyone for whom you receive benefits changed his/her citizenship or country of residence in the past 15 months?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has anyone for whom you receive benefits married, had a divorce (or annulment) or died in the past 15 months?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Has the parent (natural, adoptive or stepparent) or any child for whom you receive benefits died, married or had a divorce (or annulment) in the past 15 months? (It is not necessary that the parent have been receiving benefits.)	<input type="checkbox"/>	<input type="checkbox"/>
6.	Did anyone for whom you receive benefits work for someone else or own a business or farm in the past 15 months?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Did any person for whom you receive benefits live apart from you during any of the past 15 months?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Did you give the Social Security checks or the full amount of the benefits to another person (for example, the beneficiary's custodian or the beneficiary himself/herself) during the past 15 months?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Were all Social Security benefits received during the past 15 months used for the beneficiary and/or held for the beneficiary? If " No " explain in "Remarks" on the back of this form what was done with the benefits	<input type="checkbox"/>	<input type="checkbox"/>
10.	A. Show the manner in which any amounts not used for the beneficiary are being held: <input type="checkbox"/> Bank Account <input type="checkbox"/> Other If "Other", explain in "Remarks" on the back of this form.	B. Show the Title or Ownership of the Account:	

OTHER REPORTABLE EVENTS

In addition to the events listed on this form, you are responsible for reporting any other event that may affect benefit payments.

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS 3 THROUGH 8 ON THE OTHER SIDE OF THIS FORM, YOU MUST COMPLETE THE CORRESPONDING BLOCK(S) BELOW. IF YOU ANSWERED "NO" TO ALL OF THE QUESTIONS 3 THROUGH 8 ON THE OTHER SIDE OF THE FORM, YOU SHOULD GO TO ITEM 11, SIGN, DATE AND RETURN THE FORM.

3. If you answered "Yes" to question 3 on the other side, complete the information below.				
(a) Name of person	(b) Country of new citizenship	(c) Date acquired	(d) Current country of residence	(e) Date residence began
4. If you answered "Yes" to question 4 on the other side, complete the information below.				
(a) Name of person	(b) Check which event occurred <input type="checkbox"/> Marriage <input type="checkbox"/> Annulment <input type="checkbox"/> Divorce <input type="checkbox"/> Death		(c) Date event occurred	
5. If you answered "Yes" to question 5 on the other side, complete the information below.				
(a) Name of parent	(b) Check which event occurred <input type="checkbox"/> Marriage <input type="checkbox"/> Annulment <input type="checkbox"/> Divorce <input type="checkbox"/> Death		(c) Date event occurred	
6. If you answered "Yes" to question 6 on the other side, complete the information below.				
(a) Name of person		(b) Check one <input type="checkbox"/> Employee <input type="checkbox"/> Self-Employed		(c) Date work began
(d) If ended, enter date work stopped		(e) List each month that he/she worked 45 hours or less (Explain in Remarks)		
(f) Was this work done in the United States or did he/she pay United States Social Security taxes on earnings from this work? <input type="checkbox"/> Yes <input type="checkbox"/> No		(g) If you answered "Yes to (f), enter his/her total earnings for last year AND give your estimate of this year's earnings.		\$ \$
7. If you answered "Yes" to question 7 on the other side, complete the information below.				
(a) Name of beneficiary who did not live with you	(b) Date beneficiary left	(c) Reason for leaving	(d) Date beneficiary returned	
(e) If you listed someone in (a) above who has not returned, enter the address where he/she can be reached. (Include ZIP code)				
8. If you answered "Yes" to question 8 on the other side, show to whom the funds were given.				

REMARKS

IMPORTANT: I declare under penalty of perjury that I have examined all of the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

11. Signature or mark of beneficiary (<i>Note: If this form is signed with a mark, a witness must sign below.</i>)	Date
12. Signature of witness	Date

Privacy Act Statement Collection and Use of Personal Information

Sections 203, 205, and 1631 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information to determine continued eligibility for benefits and to monitor representative payee performance. We may also share your information for the following purposes, called routine uses:

- To Department of State and its agents for administering the Social Security Act in foreign countries through facilities and services of that agency; and
- To agencies or entities with responsibility for investigating or addressing possible financial exploitation of, an immediate health or safety threat to, or other serious risk to the well-being of the beneficiary, for referral, when these issues are identified during a representative payee review.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.**
