STATEMENT REGARDING CONTRIBUTIONS

All items on this form requiring an answer must be answered or marked "Unknown."
If you need more space for explaining any answers to the questions, attach a separate sheet.

PRINT NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	ENTER SOCIAL SECURITY NUMBER

I understand that information given by me will be used in connection with an application for insurance benefits payable under the provisions of Title II of the Social Security Act, as amended, on the record of the wage earner or self-employed person named above.

PRINT YOUR FULL NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	RELATIONSHIP TO CLAIMANT
PRINT NAME OF CLAIMANT	RELATIONSHIP TO WAGE EARNER OR SELF-EMPLOYED PERSON

1. (a) Give the following information (for the period indicated below) about each person or agency who contributed to the claimant's support.

FROM		TO					
NAME AND ADDRESS OF CONTRIBUTORS	RELATIONSHIP TO CLAIMANT	CONTRIBUTIONS				HOW OFTEN MADE (Weekly, monthly or occasionally)	AVERAGE AMOUNT OF CONTRIBUTION
		BEGAN		ENDED			
		MO.	YR.	MO.	YR.		
							$
							$
							$

b) Was there any break in contributions by any contributor within the period? ☐ Yes ☐ No
If "Yes," give name of contributor, months in which no contributions were made, and reason:

(c) If any contributions ended before the wage earner's or self-employed person's death or, if living, before application was filed, give name of contributor and why contributions stopped:

(d) If other than cash was contributed, such as clothing, board or room, give the following information regarding items supplied during the period in 1(a).

NAME OF CONTRIBUTOR	ITEMS CONTRIBUTED	APPROXIMATE VALUE

(e) Give name and address of person or agency to which payments were made for claimant's support:

2. Did the claimant have wages or income of his or her own? ☐ Yes ☐ No If "Yes," how much per month? $ _____

IN WHICH MONTHS (Specify)

3. (a) Is claimant a child who lived with more than one parent (Including Stepparents)?

☐ Yes *"If "Yes," answer (b), (c) and (d) below* ☐ No *If "No," go on to item 4*

(b) If both parents with whom child lived contributed to child's support, did they use their monies as one household fund? ☐ Yes ☐ No

If "Yes," how much did each contribute the fund?	Mother/Father $	Mother/Father $

(c) If their monies were not combined, what understanding did they have as to how much each would contribute to the child's support?

(d) What was the monthly income of each?	Mother/Father $	Mother/Father $

4. How did you learn of the facts you gave in questions 1,2, and 3?

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 PERSON MAKING STATEMENT

SIGNATURE (First name, middle initial, last name) *(Write in ink)*	DATE (*Month, day, year*)
	TELEPHONE NUMBER (*Including Area Code*)

MAILING ADDRESS (Number and street, Apt No., P.O. Box, or Rural Route)

CITY AND STATE	ZIP CODE	Enter name of county (if any) in which you now live

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 person making the statement must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (Number and street, City, State, and ZIP Code)	ADDRESS (Number and street, City, State, and ZIP Code)

Privacy Act Statement
Collection and Use of Personal Information

Sections 202(d), 202(h), and 216(e) 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 making an accurate and timely decision in determining the child applicant's eligibility for benefits.

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

- To third party contacts (e.g., employers and private pension plans) in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his or her benefits or payments, or his or her eligibility for or entitlement to benefits or eligibility for payments, under the Social Security program; and

- To Federal, State, or local agencies (or agents on their behalf) for income maintenance or health maintenance programs including programs under the Social Security Act.

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) 60-0089, Claims Folders Systems, as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422; 60-0090, Master Beneficiary Record, as published in the FR on January 11, 2006, at 71 FR 1826; and 60-0320, Electronic Disability (eDIB) Claim File, as published in the FR on June 4, 2020, at 85 FR 34477. 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 15 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 regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to*: *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate or other aspects of this collection to this address, not the completed form.***