Social Security Administration
Retirement, Survivors, and Disability Insurance
Important Information

Date: _____ BNC#: _____

We are writing to you because we believe you may have recent self-employment work activity and we need to know more about this work activity.

One of Social Security's top priorities is to support the efforts of applicants and beneficiaries with disabilities who are or who want to work. The Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs include several employment support provisions commonly referred to as work incentives, or special rules that help you to receive, or continue to receive benefits even if you are working. We need more information to see if any of these incentives apply to you. If you are just now applying for disability benefits, the information you provide helps us decide if you can receive benefits. If you are currently receiving disability benefits, the information you provide helps us decide if your benefits can continue.

Information about Work and Earnings

Our records show that you may have self-employment income.

Common types of self-employment include:

- Owning your own business, Sole Proprietorship/Corporation
- Owning a business with another person, Business Partnership
- Independent Contractor
- Freelancing for another business
- Gig Work, such as:
  - Ride share driving services
  - Food delivery services
  - Internet content creator/influencer
  - Musicians/Photographer/Artists
- Any job for which one receives form 1099-NEC instead of form W2 for IRS tax filing purposes.

The information we ask for includes:

- **Self-Employment History:** This includes the dates you worked, net earnings from self-employment, and any pay you received working as an independent contractor for another person or company (e.g., driver, delivery, consulting, etc.).
- **Special Self-employment Conditions:** If you receive free help in your business, we may be able to deduct the reasonable value of that help from your net income. Also, if another person, agency or business provides items or services to you, free of charge, we may be able to deduct the reasonable value of those items or services from your net income.
- **Work Expenses related to your disability:** If you are self-employed and have a disability, you may need certain items or services to assist you (e.g., co-pays for prescription drugs, medical device expenses, special transportation, counseling fees, expenses related to a service animal, etc.) ***Note: Do not include anything that you will include as a business expense on your annual tax return.***

Our records show that the following self-employment income was reported for you.

Income Reported for You		
Self-Employment	**Year**	**Yearly Income**

We may ask for proof of any of the information you provide.

What You Need To Do

Please complete and return this form **within 15 days.** It is important to fill out the form carefully and completely even if you receive additional forms requesting authorization to obtain wage and employment information from payroll data providers. If you do not return this form, we may make our decision based on the information we have in our records.

For More Information

Please read the pamphlet, “Working While Disabled: How We Can Help.” It will tell you more about why we need to know about your work and will explain our rules about working. This pamphlet is available online at www.ssa.gov/pubs/EN-05-10095.pdf. You may also visit www.choosework.ssa.gov or contact the Ticket to Work Help Line at 1-866-968-7842 (TTY 1-866-833-2967) to learn more about work incentives and find service providers who can explain how work can affect your benefits.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit https://oig.ssa.gov/report or call the Inspector General's Fraud Hotline at **1-800-269-0271** (TTY **1-866-501-2101**).

Need more help?

1. Visit www.ssa.gov for fast, simple, and secure online service.
2. Call us at 1-800-772-1213, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call TTY 1-800-325-0778. Please mention this letter when you call.
3. You may also call your local office at _____.

How are we doing? Go to www.ssa.gov/feedback to tell us.

Social Security Administration

Enclosures:
Pre-addressed Envelope

Work Activity Report - Self-Employment

IDENTIFICATION

Name of Claimant or Beneficiary	BNC# or SSN	☐ Blind ☐ Not Blind

We have information that you have been self-employed since your disability began, since your date of entitlement to benefits, or since your last work review. Please answer the questions below. This will help us decide if you can receive or continue to receive benefits, and if work incentives apply to you. Please provide information since the date shown below.

Date: (to be completed by SSA)	***If a date is not shown, please provide information for the last two years*.**

SELF-EMPLOYMENT INFORMATION

1. Have you engaged in any self-employment activity or had any self-employment income since the date shown in the **IDENTIFICATION** section, or within the last two years? (check one)

☐ **NO.** If you **were not self-employed,** go to question 2.

☐ **YES**. If you have been self-employed, go to the **SELF-EMPLOYMENT INFORMATION** section, question 3.

2. The information we have may include reports of other types of income for you even if you are not self-employed. Other types of income include income after your business closed, income from sale of the business, and disability pay/ insurance. We may ask for verification of the income that has been reported.

Did you receive other types of income since the date shown above or within the last two years?

☐ **NO**. If you did not receive any other type of income and have not worked, please specify any possible source of reported income below, then go to the **SIGNATURE** section, complete, sign and return the form.

☐ **YES**. Tell us about that income below and then go to the **SIGNATURE** section, complete, sign and return the form.

Please use this space to tell us more about the income you received (type of income, source of income, amount, date(s) paid, etc.)

3. Please tell us about your self-employment since the date shown in the **IDENTIFICATION** section, or within the last two years. **If we have not already received proof of your income, we may ask you to submit it.**

Name of Business (if applicable)				Telephone # (include area code)
Mailing address	City	State	ZIP Code	Fax # (include area code)

Primary Product or Service

Average Hours (hrs) Worked Per Month:

☐ 80 hrs or more per month ☐ At least 45 but less than 80 hrs per month ☐ Less than 45 hrs per month

Date Work Started (MM/DD/YYYY)	☐ Still Working	Date Work Ended (MM/DD/YYYY)

Reason Work Ended (if applicable)

☐ Because of my disability ☐ other reason(s) _____

What best describes your type of self-employment/business arrangement? (Check One)

☐ Sole Owner ☐ Partnership ☐ Limited Liability Company (LLC)

☐ Corporation ☐ Independent Contractor ☐ Gig Work*

☐ Farm Landlord ☐ Farm Tenant ☐ Other (Please explain below)

Examples of Gig Work include ride share driving services, food delivery services, internet content creator or influencer and work as a musician, photographer, or artist.

Please use this space to tell us more about the business arrangement(s) you checked above (if other, type of business arrangement.)

If you have another type of self-employment or business arrangement, please continue here. If not, you may skip this section and go to question 4.

Name of Business (if applicable)				Telephone # (include area code)
Mailing address	City	State	ZIP Code	Fax # (include area code)

Primary Product or Service?

Average Hours (hrs) Worked Per Month:

☐ 80 hrs or more per month ☐ At least 45 but less than 80 hrs per month ☐ Less than 45 hrs per month

Date Work Started (MM/DD/YYYY)	☐ Still Working	Date Work Ended (MM/DD/YYYY)

Reason Work Ended (if applicable)

☐ Because of my disability ☐ other reason(s) _____

What best describes your type of self-employment/business arrangement? (Check One)

☐ Sole Owner ☐ Partnership ☐ Limited Liability Company (LLC)

☐ Corporation ☐ Independent Contractor ☐ Gig Work*

☐ Farm Landlord ☐ Farm Tenant ☐ Other (Please explain below)

Examples of Gig Work include ride share driving services, food delivery services, internet content creator or influencer and work as a musician, photographer, or artist.

Please use this space to tell us more about the business arrangement(s) you checked above (if other, type of business arrangement.)

4A. Please attach all your self-employment tax returns (including Schedule C & SE, 1099s, etc.) since the date shown in the **IDENTIFICATION** section, or for the last two years.

☐ I have **ENCLOSED** my Tax Returns.

☐ **I DO NOT have Tax Returns.** For any years that you DO NOT have tax returns, use the chart below to tell us about your total annual gross and net self-employment income.

Year (YYYY)	Gross	Net
	$	$
	$	$
	$	$
	$	$

4B. If you are currently self-employed, please provide an estimate of your expected income.

Year (YYYY)	Gross	Net
	$	$
	$	$

5A. Did anyone other than you have management responsibilities for any business shown in question 3 (i.e., a partner, employee, relative, or helper) since the DATE shown in the IDENTIFICATION section, or within the last two years?

☐ **NO.** Go to Question 6A.

☐ **YES.** Go to question 5B

5B. If someone other than you had management responsibilities for any business shown in question 3, please provide the following information:

Business name as shown in question 3:

Other individual's name(s):	Their relationship to you:
Hours per month ***THEY*** had management responsibilities (average):	Hours per month ***YOU*** had management responsibilities (average):
Other individual's address:	Phone: (include area code)

Business name as shown in question 3:

Other individual's name(s):	Their relationship to you:
Hours per month ***THEY*** had management responsibilities (average):	Hours per month ***YOU*** had management responsibilities (average):
Other individual's address:	Phone: (include area code)

Please use this space to tell us what duties you and the other individual performed below.

WORK INCENTIVES

6A. We may not count short periods of work (6 months or less) when we decide if you are eligible for benefits.

For any work that you told us about in the **SELF-EMPLOYMENT INFORMATION** section, did you make any changes to your work due to your disability, or due to the removal of special conditions that allowed you to work?

- ☐ **NO.** Go to Question 7A.
- ☐ **YES.** Go to Question 6B.

6B. Mark any that apply, provide requested information, then go to question 7A.

- ☐ I stopped working within 6 months or less due to my disability, or due to the removal of special conditions that allowed me to work.
- ☐ I changed to fewer hours of work or less earnings within 6 months or less due to my disability or due to the removal of special conditions that allowed me to work.
- ☐ I changed to a lighter or easier type of work due to my disability, or due to the removal of special conditions that allowed me to work.

For any items checked above, please provide:

Date(s) of any Change:

Please use this space to tell us details about changes in your work activity due to your disability, or due to the removal of special conditions that allowed you to work. Please include information about the special conditions that were removed.

7A. We may be able to deduct certain expenses from your net earnings from self-employment before we decide if you are eligible to receive or continue to receive benefits. Deducting expenses may help you become eligible for a benefit or may increase the amount of a benefit to which you are already eligible. The expenses must be for items or services that **you pay for**, that are **needed because of your disability**, and that are **needed for you to work**. The expenses must be paid for out of pocket. We cannot count expenses that Medicare, Medicaid, an insurance company, or another person paid or will pay back to you. Also, do not include any expenses, including business expenses, that you will claim as an expense on your tax return filed with the Internal Revenue Service (IRS).

Examples of allowable expenses include medicines or co-pays, medical devices or procedures, special transportation, special telephone or other equipment, service animal, attendant care, or special equipment if you are blind, etc.

Did you spend any of your own money for items or services related to your disability that you needed for you to work?

☐ **NO**. Go to **SIGNATURE** section, complete, sign and return the form.

☐ **YES.** Go to question 7B.

For each expense, we may ask you for proof of payment, that you needed the item or service because of an impairment(s) being treated by a healthcare provider, and how it helps you do your job.

7B. Please, use this section to tell us about the item(s) or service(s), the date(s) you purchased them and what they cost. You should also tell us about recurring expenses.

Describe Item or Service	Cost per (day, week, month, or year)	Date Paid (MM/YYYY-MM/YYYY)	Recurring Expense Y/N
Example: Medication	*$25 per month*	*01/2024 - 02/2024*	*Y*
	$_____ per_____		
	$_____ per_____		
	$_____ per_____		

Please use this space to tell us more about additional expenses or to provide additional information about the expenses listed above.

8. When we determine your countable income, we may be able to deduct from your net income any business expenses which were incurred and paid by another person or agency.

Examples include business related rent, supplies, inventory, purchase or repair of equipment, or an employee or helper that works for you for free.

Has any person or organization (i.e., Vocational Rehabilitation or other State or local agency) contributed to or paid for business expenses or provided any free help, items or services related to your business since the date shown in the IDENTIFICATION section?

☐ **NO**. Please go to **SIGNATURE** section, complete, sign and return the form.

☐ **YES.** Please explain below.

Describe Contribution	Value of Contribution per (day, week, month, or year)	Date Paid (MM/YYYY-MM/YYYY)	Continuing Expense Y/N
Example: Rent	*$1,000 per month*	*01/2024 - Present*	*Y*
	$_____ per_____		
	$_____ per_____		
	$_____ per_____		

Name(s) of contributor:

Phone (including area code):

Address:

Please use this space to tell us any additional contributions provided by others.

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition or my work.

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 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.

Signature of Claimant, Beneficiary or Representative Payee	Date	Area Code and Telephone Number

Mailing Address (Number and Street, Apt. No., P.O. Box, or Rural Route)	City	State	ZIP Code

If this statement is signed with a mark (e.g., X), two individuals who know the person making the statement must witness the signature and sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	Date	Area Code and Telephone Number

Mailing Address (Number and Street, Apt. No., P.O. Box, or Rural Route)	City	State	ZIP Code

2. Signature of Witness	Date	Area Code and Telephone Number

Mailing Address (Number and Street, Apt. No., P.O. Box, or Rural Route)	City	State	ZIP Code

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(d) and 1633 of the Social Security Act, as amended, allow us to collect your information or the information you are submitting on behalf of another, which we will use to determine benefit eligibility. Providing the information is voluntary, but not providing all or part of the information may prevent us from making an accurate determination on eligibility. As law permits, we may use and share the information you submit, including with other Federal agencies, contractors, and others, as outlined in the routine uses within System of Records Notices 60-0059 and 60-0089, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs for Federal benefits eligibility and to recoup 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 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*