WHAT TO DO IF YOU RECEIVE A NOTICE OF SSI OVERPAYMENT

If you receive Supplemental Security Income or SSI benefits, it's important that you let us know if there are any changes that might affect your eligibility for SSI and your payments. This includes changes to your income, resources, or living situation. If you don't report changes to Social Security on time, you might have an overpayment. An overpayment happens when we pay your more SSI than you are eligible to receive.

If an overpayment occurs, we will send you a notice, informing you what caused the overpayment, and what action you can take. Generally, if you have an SSI overpayment, you may do one of four things:

1) If you agree that the overpayment is correct, and you wish to repay the excess benefit you received, you don't need to take any action because we will begin to recover the overpayment, as explained in the notice we sent you; or,

2) If you disagree with the overpayment, and do not believe that you were not overpaid, you may appeal the overpayment by filing a Request for Reconsideration, using Form SSA-561. We will review the reasons why the overpayment occurred, and let you know if we agree or disagree; or

3) If you agree that the overpayment occurred, but that it was not your fault, then you may ask for a Waiver of Overpayment, by filing a Request for Waiver of Overpayment, using Form SSA-632; or,

4) If you agree that the overpayment is correct, and you wish to repay the excess, but want us to withhold more or less money from your benefit until the overpayment is recovered, file form number SSA-634, Request for Change in Overpayment Recovery Rate.

SSA-561 REQUEST FOR RECONSIDERATION

INDICATE CLAIMANT'S NAME, AND SSN.

STATE THE REASON WHY YOU DISAGREE WITH SSA'S DECISION

INDICATE THE CLAIMANT'S AND REPRESENTATIVE'S (IF ANY) ADDRESS AND PHONE NUMBER, AS WELL AS THE DATE THE FORM WAS COMPLETED.

NOTE: REPEAT THE INFORMATION ON PAGE 3. PAGE 1 WILL BE RETAINED BY SSA, AND PAGE 3 WILL BE RETURNED TO THE CLAIMANT AFTER IT HAS BEEN SENT TO SSA.

Form **SSA-561-U2** (06-2019) UF (06-2019)
Destroy Prior Editions
Social Security Administration

OMB No. 0960-0622

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:

INDICATE WHAT YOU WISH TO APPEAL.

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.

INDICATE WHETHER YOU ARE ASKING FOR A: CASE REVIEW, WHERE AN SSA EMPLOYEE WHO DID NOT MAKE THE ORIGINAL DECISION REVIEWS THE CASE, OR

INFORMAL CONFERENCE, WHERE YOU MEET WITH ANOTHER SSA EMPLOYEE, AND PRESENT ADDITIONAL INFORMATION OR EVIDENCE, OR,

FORMAL CONFERENCE, WHERE YOU AND OTHER PEOPLE, MEET WITH ANOTHER SSA EMPLOYEE TO PRESENT ADDITIONAL INFORMATION OR EVIDENCE.

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

FIELD OFFICE DEVELOPMENT (GN 03102.300)

- ☐ NO FURTHER DEVELOPMENT REQUIRED
- ☐ REQUIRED DEVELOPMENT ATTACHED
- ☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

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

PAGE 3

PAGE 2 IS AN INFORMATIONAL PAGE THAT SHOWS THE TYPES OF ACTIONS THAT YOU MAY APPEAL USING THIS FORM.

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, u 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 v 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.

SSA-561 REQUEST FOR RECONSIDERATION

INDICATE CLAIMANT'S NAME, AND SSN.

STATE THE REASON WHY YOU DISAGREE WITH SSA'S DECISION

INDICATE THE CLAIMANT'S AND REPRESENTATIVE'S (IF ANY) ADDRESS AND PHONE NUMBER, AS WELL AS THE DATE THE FORM WAS COMPLETED.

NOTE: PAGE 3 IS THE CLAIMANT COPY, OR RECEIPT, AND WILL BE RETURNED TO THE CLAIMANT AFTER IT HAS BEEN SENT TO SSA.

INDICATE WHAT YOU WISH TO APPEAL.

INDICATE WHETHER YOU ARE ASKING FOR A: CASE REVIEW, WHERE AN SSA EMPLOYEE WHO DID NOT MAKE THE ORIGINAL DECISION REVIEWS THE CASE, OR

INFORMAL CONFERENCE, WHERE YOU MEET WITH ANOTHER SSA EMPLOYEE, AND PRESENT ADDITIONAL INFORMATION OR EVIDENCE, OR,

FORMAL CONFERENCE, WHERE YOU AND OTHER PEOPLE, MEET WITH ANOTHER SSA EMPLOYEE TO PRESENT ADDITIONAL INFORMATION OR EVIDENCE.

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
   (If "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

PAGE 5

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 Pa rt C enrollment and premium collection processes; Part D enrollment and premium collection processes; Medicare Part B premium reduction based on participation in a Part C 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.***

SSA-632 REQUEST FOR WAIVER OF OVERPAYMENT RECOVERY

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 spouse.
☐ I am the overpaid person's representative payee.
☐ I am the overpaid person's legal guardian.
☐ Other, please explain:

(Options continue on next page)

IN 1A, INDICATE THE CLAIMANT'S NAME AND SSN, AND WHETHER HE OR SHE IS THE PERSON WHO IS OVERPAID.

1C INDICATES WHETHER SOMEONE IS HELPING THE CLAIMANT REQUEST A WAIVER, AND IF SO, WHAT THE PERSON'S RELATIONSHIP IS TO THE CLAIMANT.

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1D, THE NAME OF THE PERSON OR ORGANIZATION HELPING THE CLAIMANT COMPLETE THIS FORM. IN 1E, SPECIFY WHETHER YOU ARE THE CLAIMANT'S REPRESENTATIVE PAYEE.

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:

COMPLETE SECTION 2 IF THE CLAIMANT HAS A REPRESENTATIVE PAYEE, INDICATING THE CLAIMANT'S LIVING SITUATION, AND WHETHER THE OVERPAID MONEY WAS USED, AND HOW.

SECTION 3 IS FOR THE CLAIMANT'S FAMILY MEMBER, OR ANOTHER PERSON, WHO WAS NOTIFIED THAT THEY ARE RESPONSIBLE FOR THE OVERPAYMENT, INDICATING WHETHER THE CLAIMANT LIVED WITH THEM, AND IF THEY RECEIVED ANY OF 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)

SECTION 4 IS ABOUT THE OVERPAID PERSON, AND THEIR SITUATION – CHILD OR ADULT WHEN THE OVERPAYMENT OCCURRED, IF THE CLAIMANT WAS RECEIVING SOCIAL SECURITY DISABILITY BENEFITS, AND

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QUESTION 4 (CONT'D) IF THE CLAIMANT WAS RECEIVING ANY TYPE OF SOCIAL SECURITY BENEFIT, OR SSI.

QUESTIONS 6 ASK WHETHER THE CLAIMANT IS ASKING FOR A FULL WAIVER, 7 ASKS IF THE CLAIMANT HAS ASKED FOR OTHE RWAIVERS, AND 8 ASKS IF THE CLAIMANT RECEIVED THE NOTICE OF OVERPAYMENT, AND WHEN. QUESTIONS 9 ASKS THE CLAIMANT TO INDICATE FROM THE NOTICE THE MONTHS DURING WHICH THE OVERPAYMENT OCCURRED, AND 10 ASKS FOR THE AMOUNT OVERPAID.

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

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)

QUESTION 5 STATES THE REASON WHY THE CLAIMANT IS ASKING FOR A WAIVER – NOT MY FAULT, CANNOT AFFORD TO PAY IT BACK, OVERPAYMENT IS UNFAIR, THOUGHT BENEFITS WOULD CONTINUE, AGE 18 AT THE TIME AND RECEIVING SSI, OR OTHER.

QUESTION 11 ASKS FOR THE REASON FOR THE OVERPAYMENT, WHICH INCLUDE CHANGES IN INCOME, RESOURCES, OR LIVING ARRANGEMENT.

PAGE 9

QUESTION 12 ASKS WHETHER THIS TYPE OF OVERPAYMENT HAS HAPPENED BEFORE, AND WHETHER THE CLAIMANT IS RECEIVE SSI BENEFITS, TANF, OR A VA PENSION BASED ON NEED.

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

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: $ _____

SECTION 5 ASKS ABOUT THE CLAIMANT'S FINANCIAL STATEMENT, FOR EXAMPLE WHETHER THE APPLICANT STILL HAD ANY OF THE OVERPAID MONEY WHEN THEY RECEIVED THE NOTICE, OR CURRENTLY HAVE ANY OF THE OVERPAID MONEY, AND IF ANY REAL ESTATE WAS GIVEN TO OR BY THE CLAIMANT AFTER THEY RECEIVED THE NOTICE.

PAGE 10

QUESTION 16 ASKS IF THE CLAIMANT GAVE AWAY OR WAS GIVEN ANY MONEY AFTER THEY RECEIVED THE NOTICE.

SECTION 7 ASKS ABOUT THE CLAIMANT'S ASSETS, WHICH INCLUDE CASH, FINANCIAL ACCOUNTS, ETC.

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.

Name	Age	Relationship To You

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 6 ASKS ABOUT OTHER MEMBERS OF THE CLAIMANT'S HOUSEHOLD – NAME, AGE, RELATIONSHIP, AND WHETHER ANY OF THOSE PEOPLE CANNOT BE CLAIMED ON THE CLAIMANT'S TAX RETURN.

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.

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

PAGE 11

QUESTION 19 ASKS ABOUT VEHICLES, REAL ESTATE, AND INTERESTS IN BUSINESS, PROPERTY OR OTHER VALUABLES.

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)

Owner	Year, Make/Model	Present Value	Loan Balance (if any)	Main Purpose for Use
TOTAL COUNTABLE VALUE $		0.00		

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)

Owner	Description	Market Value	Loan Balance (if any)	Income Amount
TOTALS $		0.00		

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)

Owner	Description	Market Value	Loan Balance (if any)	Income Amount
TOTALS $		0.00		

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)

SECTION 8 IS ABOUT INCOME. WHICH INCLUDES WAGES, IF WORKING.

PAGE 12

QUESTION 20 IS ABOUT THE CLAIMANT'S DEPENDENTS, AND WHETHER ANY ARE SELF EMPLOYED.

QUESTION 21 IS ABOUT THE CLAIMANT, SPOUSE OR DEPENDENTS AND WHETHER THEY RECEIVE SUPPORT FROM ANOTHER PERSON OR GROUP.

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 I of question 22)

$ **Source**

22.

Income (Be sure to show **monthly** amounts below)	Overpaid person's income	SSA Use Only	Spouse of Overpaid Person	SSA Use Only	Dependent(s) of Overpaid Person (Total)	SSA Use Only
A. Take Home Pay (Net) (from questions 20.A, 20.B, and 20.C)						
B. Social Security Benefits (retirement, disability, widows, students, etc.)						
C. Supplemental Security Income (SSI)						
D. Pension(s) (VA, Military, Civil Service, Railroad, etc.) TYPE						
TYPE						
E. Supplemental Nutrition Assistance Program (SNAP) Benefits						
F. Income from Real Estate, Business, etc. (from questions 19.B and 19.C)						
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.						
H. Child Support/Alimony						
I. Other Support (from question 21.C)						
J. Income from Assets (from question 18.B)						
K. Other (from any source, explain in REMARKS on next page)						
TOTALS:						

Grand Total $
(Add all TOTAL blocks above)

(Options continue on next page)

QUESTION 22 IS ABOUT THE CLAIMANT, SPOUSE, AND DEPENDENTS INCOME FROM WAGES (NET), SOCIAL SECURITY, SSI, PENSION, SNAP, REAL ESTATE OR BUSINESS, ROOM OR BOARD FROM A NON-DEPENDENT, CHILD SUPPORT OR ALIMONY, AND ANY OTHER TYPE OF INCOME.

PAGE 13

QUESTION 22 IS A REMARKS SECTION THAT ALLOWS THE CLAIMANT TO CLARIFY ANY INCOME IDENTIFIED IN QUESTION 21

22. REMARKS:

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.

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

SECTION 9 IS FOR THE CLAIMANT'S MONTHLY HOUSEHOLD EXPENSES. QUESTION 23 IS A WORKSHEET OF THEIR MONTHLY EXPENSES, LIKE RENT OR MORTGAGE, FOOD, UTILITIES, ETC.

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QUESTION 23 IS A REMARKS SECTION WHERE THE CLAIMANT MAY CLARIFY ANY EXPENSES CITED IN QUESTION 22.

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.	+ $25
	D. Adjusted Monthly Expenses (Add B and C)	$ 25.00
	E. **TOTAL** (Subtract D from A)	$ (25.00)

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 10 IS A COMPARISON BETWEEN THE CLAIMANT'S INCOME AND EXPENSES. IF THE CLAIMANT'S EXPENSES ARE HIGHER THAN THEIR INCOME, PLEASE EXPLAIN HOW THE DIFFERENCE IS RESOLVED.

SECTION 11 - FINANCIAL EXPECTATION AND FUNDS AVAILABILITY

SECTION 11 IS ABOUT THE CLAIMANT'S FINANCIAL EXPECTATION, AND ASKS WHETHER THEY EXPECT TO INHERIT ANYTHING WITHIN THE NEXT SIX MONTHS.

26. A. Do you expect to receive an inheritance within the next 6 months?

☐ Yes, explain ☐ No (go to 26.B)

B. Please provide the total of you, your spouse, and your dependents' assets from questions, 18.A, 18.B, 19.A, 19.B, and 19.C.

Total $: _____

(Options continue on next page)

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QUESTION 26 ASKS IF THERE IS ANY REASON WHY THE CLAIMANT CANNOT CONVERT ANY OF THEIR ASSETS INTO CASH.

26. C. Is there any reason you cannot convert or sell the "Balance or Value" of any financial assets shown in items 18.B, 19.A, 19.B or 19.C to cash?

☐ 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.

IMPORTANT: Please provide your documents to support the information you provided. Complete and sign the following statements.

THE REMARKS SECTION IS WHERE THE CLAIMANT MAY CLARIFY ANY OF THEIR RESPONSES TO DIFFERENT QUESTIONS. PLEASE REMEMBER TO INDICATE THE QUESTION NUMBER BEFORE PROVIDING CLARIFICATION OR EXPLANATION.

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THIS SECTION IS WHERE THE CLAIMANT AUTHORIZES SSA TO CONTACT FINNANCIAL INSTITUTIONS TO OBTAIN INFORMATION ABOUT THEIR ACCOUNTS. THE CLAIMANT MUST INDICATE THAT THEY AUTHORIZE OR DO NOT AUTHORIZE THE CUSTODIAN TO DISCLOSE INFORMATION TO SSA, AND PROVIDE THEIR SIGNATURE AND ADDRESS, AND DATE THE FORM.

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

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

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

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

I understand:

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

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

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

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

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THE CLAIMANT MUST REVIEW THE PENALTY CLAUSE, CERTIFICATION, AND PRIVACY STATEMENT, THEN SIGN AND DATE THIS FORM, PROVIDING THEIR PHONE NUMBER(S), AND MAILING ADDRESS. IF THE CLAIMANT SIGNS WITH AN X, IT MUST BE WITNESSED BY TWO PEOPLE WHO SIGN BELOW, AND PROVIDE THEIR ADDRESS.

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

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

Home Telephone Number (include area code)	Work Telephone Number If We May Call You At Work (include area code)

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

City	State	ZIP Code

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

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

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THE CLAIMANT SHOULD REVIEW THE PRIVACY ACT STATEMENT TO UNDERSTAND WHY SSA IS ASKING FOR THIS INFORMATION, AND HOW IT WILL BE USED.

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.***

SSA-634
REQUEST FOR CHANGE IN OVERPAYMENT RECOVERY RATE

Form **SSA-634** (09-2019)
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0037

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:

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

   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:

   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: $

SECTION 1 CONTAINS THE CLAIMANT'S IDENTIFYING INFORMATION, INCLUDING: NAME, SSN, AND IDENTITY. IF SOMEONE IS HELPING THE CLAIMANT WITH THIS FORM, PLEASE INDICATE YOUR NAME OR ORGANIZATION, AND RELATIONSHIP TO THE CLAIMANT.

QUESTION 2 ASKS WHETHER THE CLAIMANT CURRENTLY RECEIVE BENEFITS, HOW MUCH THE CLAIMANT OWES IN OVERPAID MONEY, AND HOW MUCH THEY CAN AFFORD TO HAVE DEDUCTED FROM THEIR CURRENT BENEFIT.

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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 IS ABOUT THE CLAIMANT'S ASSETS, INCLUDING CASH, FINANCIAL ACCOUNTS, AND VEHICLES.

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.

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

Owner	Year/Make/Model	Present Value	Loan Balance (if any)	Main Purpose for Use
	TOTAL COUNTABLE VALUE $			

(Options continue on next page)

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QUESTION 6 ASKS WHETHER THE CLAIMANT OWNS ANY REAL ESTATE OR OTHER PROPERTY, INCLUDING BUSINESS OR OTHER VALUABLES.

6. B. Do you own any real estate other than where you live? ☐ Yes (list below) ☐ No (go to 6.C)

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

C. Do you own or have an interest in any business, property, or valuables?
☐ Yes (list below) ☐ No (go to 7)

Owner	Description	Market Value	Loan Balance (if any)	Income Amount
		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 Weeks ☐ 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 I of question 9)

$ **Source**

9.

Income (Be sure to show **monthly** amounts below)	Your Income	SSA USE ONLY
A. Take Home Pay (Net) (from question 7)		
B. Social Security Benefits (retirement, disability, widows, students, etc.)		
C. Supplemental Security Income (SSI)		

(Options continue on next page)

QUESTION 8 ASKS WHETHER THE CLAIMANT RECEIVES ANY FINANCIAL SUPPORT, AND IF SO HOW MUCH.
QUESTION 9 IS AN INCOME WORKSHEET, SHOWING MONTHLY INCOME SOURCES AND AMOUNTS.

SECTION 3 IS ABOUT THE CLAIMANT'S HOUSEHOLD INCOME. FOR EXAMPLE, IS THE CLAIMANT EMPLOYED, AND IF SO, WHAT IS THEIR NET INCOME, AND FREQUENCY OF PAY?

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QUESTION 9, CONTINUED, CLARIFIES THE CLAIMANT'S MONTHLY INCOME.

9.				
	D. Pension(s) (VA, Military, Civil Service, Railroad, etc.)	TYPE		
		TYPE		
	E. Supplemental Nutrition Assistance Program (SNAP) Benefits			
	F. Income from Real Estate, Business, etc. (from question 6.B and 6.C)			
	G. Room and/or Board Payments from a person who is not a Dependent. Explain in Remarks below.			
	H. Child Support/Alimony			
	I. Other Support (from question 8.C)			
	J. Income from Assets (from question 5.B)			
	K. Other (from any source, explain in REMARKS below)			
		TOTAL:		

REMARKS:

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.

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

(Options continue on next page)

SECTION 4 LISTS THE CLAIMANT'S MONTHLY HOUSEHOLD EXPENSES, LIKE RENT, FOOD, UTILITIES, ETC.

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SECTION 4, CONTINUED, LISTS THE CLAIMANT'S MONTHLY EXPENSES.

10.			
	I. Medical/Dental (prescriptions and medical equipment, if not paid by insurance)		
	J. Vehicle Loan/Lease Payment		
	K. Vehicle Expenses (gas and repairs)		
	L. Other Transportation (bus, taxi, etc., used for medical appointments, work, or other necessary travel)		
	M. Tuition and School Expenses		
	N. Court Ordered Payments Paid Directly to the Court		
	O. Credit Card Payments (show minimum monthly payment). DO **NOT** include any expenses already listed above		
	P. Any expense not shown above		
	TOTAL		

EXPENSE REMARKS: (Please provide any additional information not included above. Also, explain any unusual or very large expenses such as medical, college, etc.)

SECTION 5 - INCOME AND EXPENSES COMPARISON

11.		
	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 5 IS AN INCOME AND EXPENSES COMPARISON. IF THE CLAIMANT'S EXPENSES ARE HIGHER THAN THEIR INCOME, PLEASE EXPLAIN HOW THE DIFFERENCE IS RESOLVED.

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SECTION 6 IS ABOUT THE CLAIMANT'S FINANCIAL EXPECTATION, AND ASKS WHETHER THEY EXPECT TO INHERIT ANYTHING WITHIN THE NEXT SIX MONTHS.

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

C. Please provide the total of your assets from questions, 5.A, 5.B, 6.A, 6.B, and 6.C
Total $: _____

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

"Screenshot of Form SSA-634"

QUESTION 13B ASKS IF THERE IS ANY REASON WHY THE CLAIMANT CANNOT CONVERT ANY OF THEIR ASSETS INTO CASH.

THE REMARKS SECTION IS WHERE THE CLAIMANT MAY CLARIFY ANY OF THEIR RESPONSES TO DIFFERENT QUESTIONS. PLEASE REMEMBER TO INDICATE THE QUESTION NUMBER BEFORE PROVIDING CLARIFICATION OR EXPLANATION.

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THE CLAIMANT MUST REVIEW THE PENALTY CLAUSE, CERTIFICATION, AND PRIVACY STATEMENT, THEN SIGN AND DATE THIS FORM, PROVIDING THEIR PHONE NUMBER(S), AND MAILING ADDRESS. IF THE CLAIMANT SIGNS WITH AN X, IT MUST BE WITNESSED BY TWO PEOPLE WHO SIGN BELOW, AND PROVIDE THEIR ADDRESS.

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

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

Home Telephone Number (include area code)	Work Telephone Number If We May Call You At Work (include area code)

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

City	State	ZIP Code

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

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

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THE CLAIMANT SHOULD REVIEW THE PRIVACY ACT STATEMENT TO UNDERSTAND WHY SSA IS ASKING FOR THIS INFORMATION, AND HOW IT WILL BE USED.

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:

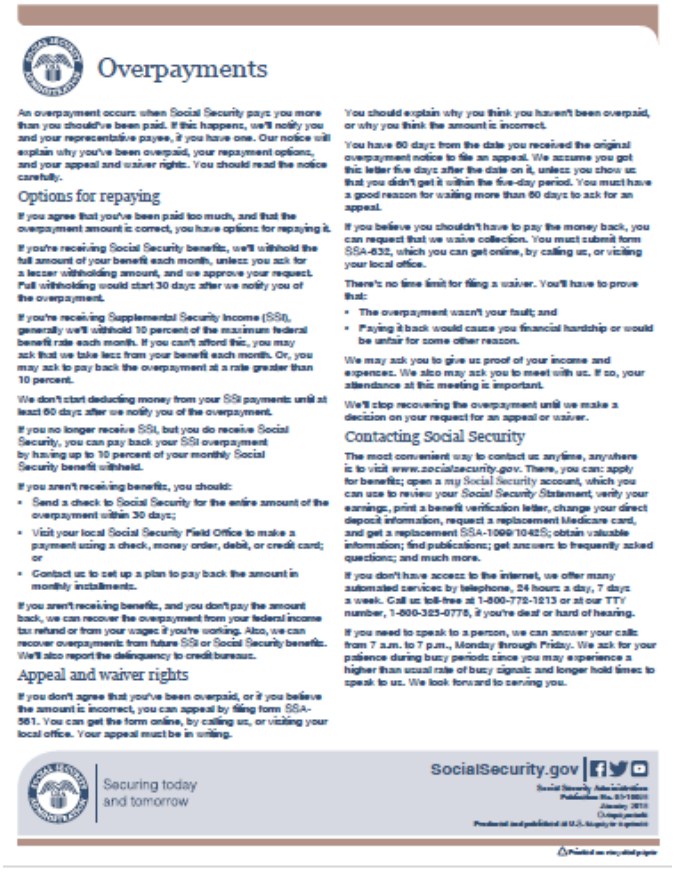
- To employers to assist the Social Security Administration (SSA) in the collection of debts owed by former beneficiaries and representative payees of Social Security payments who received an overpayment and owe a delinquent debt to the SSA; and
- To another Federal agency that has asked SSA to effect 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.***



Overpayments

An overpayment occurs when Social Security pays you more than you should've been paid. If this happens, we'll notify you and your representative payee, if you have one. Our notice will explain why you've been overpaid, your repayment options, and your appeal and waiver rights. You should read the notice carefully.

Options for repaying

If you agree that you've been paid too much, and that the overpayment amount is correct, you have options for repaying it.

If you're receiving Social Security benefits, we'll withhold the full amount of your benefit each month, unless you ask for a lesser withholding amount, and we approve your request. Full withholding would start 30 days after we notify you of the overpayment.

If you're receiving Supplemental Security Income (SSI), generally we'll withhold 10 percent of the maximum federal benefit rate each month. If you can't afford this, you may ask that we take less from your benefit each month. Or, you may ask to pay back the overpayment at a rate greater than 10 percent.

We don't start deducting money from your SSI payments until at least 60 days after we notify you of the overpayment.

If you no longer receive SSI, but you do receive Social Security, you can pay back your SSI overpayment by having up to 10 percent of your monthly Social Security benefit withheld.

If you aren't receiving benefits, you should:

- Send a check to Social Security for the entire amount of the overpayment within 30 days;
- Visit your local Social Security Field Office to make a payment using a check, money order, debit, or credit card; or
- Contact us to set up a plan to pay back the amount in monthly installments.

If you aren't receiving benefits, and you don't pay the amount back, we can recover the overpayment from your federal income tax refund or from your wages if you're working. Also, we can recover overpayments from future SSI or Social Security benefits. We'll also report the delinquency to credit bureaus.

Appeal and waiver rights

If you don't agree that you've been overpaid, or if you believe the amount is incorrect, you can appeal by filing form SSA-561. You can get the form online, by calling us, or visiting your local office. Your appeal must be in writing.

You should explain why you think you haven't been overpaid, or why you think the amount is incorrect.

You have 60 days from the date you received the original overpayment notice to file an appeal. We assume you got this letter five days after the date on it, unless you show us that you didn't get it within the five-day period. You must have a good reason for waiting more than 60 days to ask for an appeal.

If you believe you shouldn't have to pay the money back, you can request that we waive collection. You must submit form SSA-632, which you can get online, by calling us, or visiting your local office.

There's no time limit for filing a waiver. You'll have to prove that:

- The overpayment wasn't your fault; and
- Paying it back would cause you financial hardship or would be unfair for some other reason.

We may ask you to give us proof of your income and expenses. We also may ask you to meet with us. If so, your attendance at this meeting is important.

We'll stop recovering the overpayment until we make a decision on your request for an appeal or waiver.

Contacting Social Security

The most convenient way to contact us anytime, anywhere is to visit www.socialsecurity.gov. There, you can: apply for benefits; open a my Social Security account, which you can use to review your Social Security Statement, verify your earnings, print a benefit verification letter, change your direct deposit information, request a replacement Medicare card, and get a replacement SSA-1099/1042S; obtain valuable information; find publications; get answers to frequently asked questions; and much more.

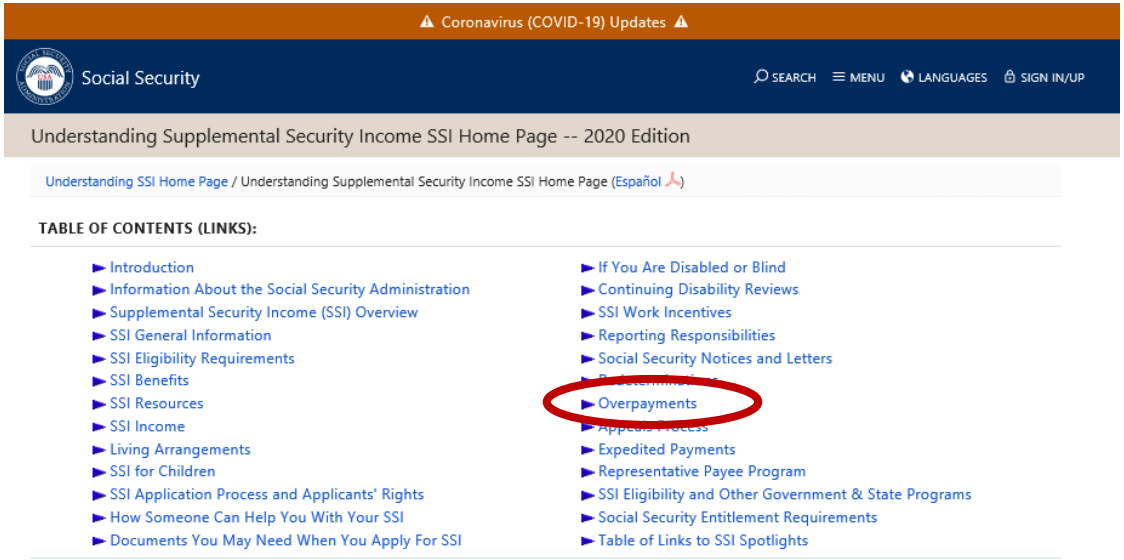
If you don't have access to the internet, we offer many automated services by telephone, 24 hours a day, 7 days a week. Call us toll-free at 1-800-772-1213 or at our TTY number, 1-800-325-0778, if you're deaf or hard of hearing.

If you need to speak to a person, we can answer your calls from 7 a.m. to 7 p.m., Monday through Friday. We ask for your patience during busy periods since you may experience a higher than usual rate of busy signals and longer hold times to speak to us. We look forward to serving you.

Securing today and tomorrow

SocialSecurity.gov

FOR MORE INFORMATION ABOUT OVERPAYMENTS, AND WHAT YOU CAN DO, GO TO SSA.GOV, AND SELECT PUBLICATIONS. THEN, ENTER OVERPAYMENTS IN THE SEARCH BOX TO FIND OUR FACT SHEET, OVERPAYMENTS, PUBLICATION NUMBER 05-10098, OR, VISIT THE UNDERSTANDING SSI HOME PAGE AT WWW.SSA.GOV/SSI/TEXT-UNDERSTANDING-SSI.HTM, AND SELECT OVERPAYMENTS.



FOR MORE INFORMATION, VISIT SSA.GOV