

Department of Transitional Assistance
Transitional Aid to Families with Dependent Children
Disability Supplement

Do you need help to fill out the attached form? Call DTA at 1-877-382-2363. DTA can help you fill out the form.

You told DTA that you cannot work because of one or more health problems. UMASS/Disability Evaluation Services (DES) decides for DTA if you are disabled under the Transitional Aid to Families with Dependent Children program. DES will look at your medical records and other information to make this decision.

The attached form is called a “Disability Supplement”. DES needs answers to the questions on this form to decide if you are disabled under DTA’s rules. The form asks questions about your health problems and where you get treatment. The form also asks questions about your work history, your time in school, and what you do each day.

To get an exemption from the **TAFDC** work requirement and time limit based on your disability, you must:

- fill out the Disability Supplement and return it to: DTA Document Processing Center, P.O. Box 4406, Taunton MA 02780-0420, or fax to (617) 887-8765; and
- cooperate with DES.

If you do not do these things:

- **DTA may deny your application; or**
- **DTA may lower your benefits.**

Tell DTA right away if you need help to fill out the Disability Supplement.

Tell DTA right away if you need help to find a doctor.

Department of Transitional Assistance
Transitional Aid to Families with Dependent Children
Disability Supplement

HOW TO FILL OUT THE DISABILITY SUPPLEMENT:

- **Sign and date a Medical Records Release Form for each medical and mental health provider listed on page 3, Part 2: Information about all Your Medical and Mental Health Providers. Medical and mental health providers may include doctors, nurses, psychologists, psychiatrists, therapists, nurse practitioners, physical therapists, social workers, chiropractors, hospitals, health centers, or clinics from whom you receive treatment. It is very important that you sign and date a different form for each provider. DES will return the forms to you if you do not sign and date a different form for each provider.**

- Type or print clearly.

- Use a pen. Do not use a pencil.

- Fill out the form the best you can. Call DTA if you have questions or need help to fill out the form. You can also call the DES Help Line at 1-888-497-9890 for help filling out this form.

- Write down details about every medical **and** mental health problem you have.

- Mail the completed original form to: DTA Document Processing Center, P.O. Box 4406, Taunton MA 02780-0420, or fax to (617) 887-8765.

DTA will send the form to DES. DES will review the form. DES will ask for medical records from all of the doctors and other health care providers that you list on the form. DES will call you or send you a letter if it needs more information.

DES will decide your case faster if you fill out every part of the form. DES will decide your case faster if you sign and date a separate Medical Records Release Form for **each** medical and mental health provider.

Disability Supplement

Tell DTA if you need help with this form. You can also call the UMASS/Disability Evaluation Services (DES) Help Line at 1-888-497-9890.

Information about you

Last Name	First Name	Middle Initial	Social Security Number - -
Street Address		Apartment Number/Suite	<input type="checkbox"/> Male <input type="checkbox"/> Female
City/Town		ZIP Code	Date of Birth / /
Home Telephone Number	Cell Phone Number	Work/Other Phone Number	
Case Name (if different)		Case Social Security Number (if different)	

Fill out every section of this form. If you do not fill out every section, we may not be able to decide if you are disabled.

We may need to schedule a doctor's appointment for you. What are the best times for you to go to an appointment? Please check all the times that are best for you.

<input type="checkbox"/> Any time is ok				
<input type="checkbox"/> Monday A.M.	<input type="checkbox"/> Tuesday A.M.	<input type="checkbox"/> Wednesday A.M.	<input type="checkbox"/> Thursday A.M.	<input type="checkbox"/> Friday A.M.
<input type="checkbox"/> Monday P.M.	<input type="checkbox"/> Tuesday P.M.	<input type="checkbox"/> Wednesday P.M.	<input type="checkbox"/> Thursday P.M.	<input type="checkbox"/> Friday P.M.

Did you apply for Social Security or SSI/SSDI benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, did you see a doctor for an exam? Doctor's Name: _____
Date of exam: ____/____/____

Have you ever experienced domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, are you working with a domestic violence specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please tell us the person's name and phone number:

Disability Supplement

Part 1. Your Health Problems

List and describe all your medical and mental health problems. Write down everything that makes it hard for you to work. Write down details about a problem even if you do not get treatment or take medicine for the problem.

List your medical and/or mental health problems.	Describe the symptoms or pain related to each health problem.	Date when problem started.	Medications
<i>Depression</i> EXAMPLE	<i>Very tired all the time. Hard to get out of bed in the morning. I cry a lot during the day. I can't control when I cry.</i>	<i>April 2007</i>	<i>None</i>
<i>Back pain</i> EXAMPLE	<i>Pain starts in my lower back and goes down my leg</i>	<i>June 2002</i>	<i>Skelexin</i>

Did any of your health problems start because of an accident or injury? Yes No

If yes, please explain:

Disability Supplement

Part 2. Information about all your Medical and Mental Health Providers

Did you get any health care in the past year? Yes No

Please list every doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center, or clinic that treated you for any of your health problems since they started. If you cannot remember them all, do the best you can. You can write on a separate piece of paper if you run out of space.

Name of Doctor, Nurse, Psychologist, Psychiatrist, Therapist, Nurse Practitioner, Physical Therapist, Social Worker, Chiropractor, Hospital, Health Center, or Clinic	Reason for Visit	Was this visit in the past year?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please fill out a Medical Records Release Form for each doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center, or clinic on this list. Be sure to sign and date each form.

These Medical Records Release Forms are at the end of this form.

Part 3. Where You Live

Where do you live? (Check one.)

<input type="checkbox"/> House or apartment	<input type="checkbox"/> Homeless	<input type="checkbox"/> Group Home	<input type="checkbox"/> State Facility
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Rehabilitation Hospital	<input type="checkbox"/> Other (describe)	

Disability Supplement**Part 4. What You Can Do**

Are you:

 Right Handed? Left Handed?Do your medical or mental health problems **make it hard for you** to do any of the following things?

	If Yes, check here	If yes, please explain:
Dress and bathe EXAMPLE	✓	<i>My shoulder pain makes it hard for me to lift my arm over my head. This makes it hard to put on shirts or wash my hair.</i>
Do regular housework EXAMPLE	✓	<i>When I am depressed, I don't care if my house is clean.</i>
Sit	<input type="checkbox"/>	
Stand	<input type="checkbox"/>	
Walk	<input type="checkbox"/>	
Bend	<input type="checkbox"/>	
Reach	<input type="checkbox"/>	
Lift	<input type="checkbox"/>	
Remember	<input type="checkbox"/>	
See	<input type="checkbox"/>	
Hear	<input type="checkbox"/>	
Use your hands	<input type="checkbox"/>	
Dress and bathe	<input type="checkbox"/>	
Do regular housework	<input type="checkbox"/>	
Listen to music	<input type="checkbox"/>	
Watch TV	<input type="checkbox"/>	
Use a computer	<input type="checkbox"/>	
Read	<input type="checkbox"/>	
Talk on the phone	<input type="checkbox"/>	
Arts and Crafts	<input type="checkbox"/>	
Go outside	<input type="checkbox"/>	
Go for a walk	<input type="checkbox"/>	
Get from one place to another	<input type="checkbox"/>	
Go shopping	<input type="checkbox"/>	
Go to the doctor	<input type="checkbox"/>	
Visit friends and family	<input type="checkbox"/>	

Disability Supplement**Part 4. What You Can Do (continued)**

Do your medical or mental health problems make it hard for you to do any of the following things?		
	If Yes, check here	If yes, please explain:
Go out to eat	<input type="checkbox"/>	
Go to school	<input type="checkbox"/>	
Handle money	<input type="checkbox"/>	
Use an ATM	<input type="checkbox"/>	
Drive a car	<input type="checkbox"/>	
Take a bus or train	<input type="checkbox"/>	
Play sports	<input type="checkbox"/>	
Other (describe)	<input type="checkbox"/>	

Part 5. Your Language

Do you speak English?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
Do you understand English?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
Do you read English?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
Do you write English?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
What is your first language?	
Can you read in your first language?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited
Can you write in your first language?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited

Part 6. School

1. Check the highest grade of school you finished.									
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	
<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> GED	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15	<input type="checkbox"/> 16	<input type="checkbox"/> 17+

What year did you finish this grade?	
Where did you go to school?	
Did you repeat any grades?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were you in special education?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Did you finish more than 12 years of school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list your degree and major:	

Disability Supplement

Did you get any other training?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please fill out the sections below.	

Type of Training	Year	Finished	Certified/Licensed?
Building Trades		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electronics		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cooking		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Mechanic		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Computers		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hairdressing		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cosmetology		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nurse's Aide		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Secretarial		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (describe)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part 7. Your Work

Do you work now?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, when did you stop working?	Date: ___/___/___

Did any of your medical or mental health conditions cause problems at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain:	

Disability Supplement

List all your jobs from the last 15 years. Do the best that you can. If you do not know the exact dates, write your best guess. Start with the job you have now or your last job. Add a piece of paper if you need more space. You can attach a resume if you have one. To help you complete this part we included an example below. **Example:**

Job Title		Dates Worked	
<i>Packer</i>		From (Month/Year): <i>March 2004</i>	To (Month/Year): <i>May 2005</i>
Job Duties (List everything you did):			
<i>Put three golf balls into a small box. Packed 24 small boxes into a case. Sealed the case with packing tape. Loaded cases onto a platform.</i>			
How many hours did you work each week?	<i>40</i>	How much did you make an hour?	<i>\$9.00/hour</i>
		Reason for leaving:	
		<i>Moved</i>	

Job Title		Dates Worked	
		From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):			
How many hours did you work each week?		How much did you make an hour?	
		Reason for leaving:	

Job Title		Dates Worked	
		From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):			
How many hours did you work each week?		How much did you make an hour?	
		Reason for leaving:	

Disability Supplement

Job Title	Dates Worked	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	How much did you make an hour?	Reason for leaving:

Job Title	Dates Worked	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	How much did you make an hour?	Reason for leaving:

Job Title	Dates Worked	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	How much did you make an hour?	Reason for leaving:

Disability Supplement

Check each of the things you do in your job. If you do not work, check each thing you did in your last job.

<input type="checkbox"/> Doing paperwork	<input type="checkbox"/> Using a computer	<input type="checkbox"/> Assembling	<input type="checkbox"/> Operating machines
<input type="checkbox"/> Filing	<input type="checkbox"/> Serving people	<input type="checkbox"/> Counting & packing	<input type="checkbox"/> Construction
<input type="checkbox"/> Using phone	<input type="checkbox"/> Driving a car or truck	<input type="checkbox"/> Moving things	<input type="checkbox"/> Cleaning
<input type="checkbox"/> Using office machines	<input type="checkbox"/> Using cash register	<input type="checkbox"/> Driving forklift	<input type="checkbox"/> Using power tools
<input type="checkbox"/> Other (please describe)		<input type="checkbox"/> Using hand tools	

Circle the number of hours you do each thing in your job. If you do not work, circle the number of hours you did each thing in your last job.

Activity	Hours in a Day								
	0	1	2	3	4	5	6	7	8
Walk or stand									
Sit									
Reach									

Check the weight you lift or carry most:	Check the heaviest weight you lift:
<input type="checkbox"/> Less than 10 lbs.	<input type="checkbox"/> Less than 10 lbs.
<input type="checkbox"/> 10 lbs.	<input type="checkbox"/> 10 lbs.
<input type="checkbox"/> 20 lbs.	<input type="checkbox"/> 20 lbs.
<input type="checkbox"/> 25 lbs.	<input type="checkbox"/> 25 lbs.
<input type="checkbox"/> 50 lbs.	<input type="checkbox"/> 50 lbs.
<input type="checkbox"/> 100 lbs.	<input type="checkbox"/> 100 lbs.
<input type="checkbox"/> More than 100 lbs.	<input type="checkbox"/> More than 100 lbs.

Part 8. Your Comments

Use this space to write more information needed, including information about why you cannot work.

Disability Supplement**Part 9. Help with This Form**

Did you need help to fill out this form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, why did you need help?		

Part 10. Your Signature

THIS SECTION MUST BE COMPLETED.	
_____ Signature of Applicant/Client/Guardian	_____ Date

If this form is being filled out by someone with the legal authority to act on behalf of the applicant/client or a legal guardian, give us the following information:

Signature of person filling out this form: _____
Print name: _____
Authority of person filling out this form on behalf of the applicant/client: _____

Part 11. Your Permission to Share Information

Do you give permission to share information about this application with anyone besides your health care providers? (For example: relative, friend, legal representative.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DES may send copies of notices to this person. This does not authorize release of medical records.		
If yes, person's name: _____	Relationship to you: _____	
Address: _____	Phone number(s): _____	
_____ Signature of Applicant or Client	_____ Date	

**For Office Use Only
DTA Comments and Signature**

_____ Authorized Signature	_____ Date

Department of Transitional Assistance (DTA) and Disability Evaluation Services (DES) Medical Records Release Form

Sign this form to let your medical or mental health care provider share information with UMASS/Disability Evaluation Services (DES).

HOW TO FILL OUT THIS FORM

Your medical or mental health care provider will only send medical records to UMASS/Disability Evaluation Services if you fill out the form right. Follow these steps:

- 1. Fill out a separate Medical Records Release Form for each medical or mental health care provider. A medical provider is a doctor, nurse, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center or clinic from whom you receive treatment. A mental health care provider is a psychologist, psychiatrist or therapist.**
- 2. Fill out every section of the form. DES can only get your medical information if you fill out every section. DES will decide your case without the information if DES cannot get it.**
- 3. Sign and date the form with a pen. Do not sign with a pencil. Sign the form yourself. You cannot use a copy or stamp of your signature.**

SECTION I

Your Name and Address

Print name of applicant/client:		Telephone Number: ()
Street address:		Date of birth:
City/Town	State:	ZIP:

SECTION II

Health Care Provider's Name and Address

Name of doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center or clinic from whom you receive treatment:		
Street address:		
City/Town	State:	ZIP:
Telephone Number: ()		

(continued on back) ►

SECTION III

I allow the medical or mental health care provider listed in Section II to share with DTA and Disability Evaluation Services (DES):

- my medical records;
- other information about my time in a hospital; and
- other information about any of my medical care.

I allow the medical or mental health care provider to share all information about my health. This includes information about:

- my mental health;
- my AIDS/HIV status;
- drug and alcohol abuse;
- how my health problems affect my ability to work; and
- how my health problems affect what I do every day.

✓ Check here if you do NOT allow the medical or mental health care provider to share your AIDS/HIV status:

SECTION IV

Any medical information that the health care provider releases to DTA and the Disability Evaluation Service will continue to be protected by federal privacy laws.

I understand that I can cancel this permission at any time. I can cancel this permission by sending a letter to my medical or mental health care provider. I understand that this permission ends six months from the date I sign this Medical Records Release Form, if I do not cancel it before then.

I understand that my medical or mental health care provider may send information to DTA and DES before I cancel my permission. I understand that my medical or mental health care provider cannot get the information back after sending it.

I understand that it is my choice to let my medical or mental health care provider share medical information with DTA and DES. I do not have to give permission. I also understand that DTA and DES will decide about my disability without the information if I do not let my medical or mental health care provider share it.

SECTION V

Signature of applicant/client:	Date:
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If the person signing this form has legal authority to act for the applicant/client (such as a legal guardian), give us the following information:

Signature of person completing this form:	
Printed name:	Date:
What kind of authority do you have to sign for the applicant/client?	

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I understand that I can cancel this permission at any time. I can cancel this permission by sending a letter to my medical or mental health care provider. I understand that this permission ends six months from the date I sign this Medical Records Release Form, if I do not cancel it before then.

I understand that my medical or mental health care provider may send information to DTA and DES before I cancel my permission. I understand that my medical or mental health care provider cannot get the information back after sending it.

I understand that it is my choice to let my medical or mental health care provider share medical information with DTA and DES. I do not have to give permission. I also understand that DTA and DES will decide about my disability without the information if I do not let my medical or mental health care provider share it.

SECTION V

Signature of applicant/client:	Date:
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If the person signing this form has legal authority to act for the applicant/client (such as a legal guardian), give us the following information:

Signature of person completing this form:	
Printed name:	Date:
What kind of authority do you have to sign for the applicant/client?	

Department of Transitional Assistance (DTA) and Disability Evaluation Services (DES) Medical Records Release Form

Sign this form to let your medical or mental health care provider share information with UMASS/Disability Evaluation Services (DES).

HOW TO FILL OUT THIS FORM

Your medical or mental health care provider will only send medical records to UMASS/Disability Evaluation Services if you fill out the form right. Follow these steps:

- 1. Fill out a separate Medical Records Release Form for each medical or mental health care provider. A medical provider is a doctor, nurse, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center or clinic from whom you receive treatment. A mental health care provider is a psychologist, psychiatrist or therapist.**
- 2. Fill out every section of the form. DES can only get your medical information if you fill out every section. DES will decide your case without the information if DES cannot get it.**
- 3. Sign and date the form with a pen. Do not sign with a pencil. Sign the form yourself. You cannot use a copy or stamp of your signature.**

SECTION I

Your Name and Address

Print name of applicant/client:		Telephone Number: ()
Street address:		Date of birth:
City/Town	State:	ZIP:

SECTION II

Health Care Provider's Name and Address

Name of doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center or clinic from whom you receive treatment:		
Street address:		
City/Town	State:	ZIP:
Telephone Number: ()		

(continued on back) ►

SECTION III

I allow the medical or mental health care provider listed in Section II to share with DTA and Disability Evaluation Services (DES):

- my medical records;
- other information about my time in a hospital; and
- other information about any of my medical care.

I allow the medical or mental health care provider to share all information about my health. This includes information about:

- my mental health;
- my AIDS/HIV status;
- drug and alcohol abuse;
- how my health problems affect my ability to work; and
- how my health problems affect what I do every day.

✓ Check here if you do NOT allow the medical or mental health care provider to share your AIDS/HIV status:

SECTION IV

Any medical information that the health care provider releases to DTA and the Disability Evaluation Service will continue to be protected by federal privacy laws.

I understand that I can cancel this permission at any time. I can cancel this permission by sending a letter to my medical or mental health care provider. I understand that this permission ends six months from the date I sign this Medical Records Release Form, if I do not cancel it before then.

I understand that my medical or mental health care provider may send information to DTA and DES before I cancel my permission. I understand that my medical or mental health care provider cannot get the information back after sending it.

I understand that it is my choice to let my medical or mental health care provider share medical information with DTA and DES. I do not have to give permission. I also understand that DTA and DES will decide about my disability without the information if I do not let my medical or mental health care provider share it.

SECTION V

Signature of applicant/client:	Date:
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If the person signing this form has legal authority to act for the applicant/client (such as a legal guardian), give us the following information:

Signature of person completing this form:	
Printed name:	Date:
What kind of authority do you have to sign for the applicant/client?	

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

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

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

