Department of Health
Division of Public Assistance

*** *This information is being requested because it is not available in the Social Security Administration's interface, or the information available conflicts with our case file.***

From: _____ Date: _____

Please fax completed form to _____

Please provide the following information I have selected below for (client name) _____
Client SSN_____. Thank you for your assistance.

☐ **SSI** ☐ **SSA** ☐ **SSI and SSA**

****

☐ **Date of Protective Filing Date:** _____

☐ **Level of Claim (circle):** ☐ **Initial** ☐ **Admin Law Judge** ☐ **Appeals Council**

☐ **What is the status of the claim (circle)?**

☐ **Pending**
☐ **Denied** **Date of most recent denial:** _____
☐ **Approved** **Date approval notice mailed:** _____

☐ **Type of SSA benefit (circle): RIB DIB WIB SUR** **Gross amount $** _____

☐ **Date of entitlement:** _____ **Medicare eligible: A date:** _____

☐ **Date of onset:** _____ **B date:** _____

☐ **Amount $** _____ **Living arrangement (circle): A B D**

☐ **Why do gross and net differ?** _____

☐ **Is there other income? Y** ☐ **N** ☐ **If yes, what is the source?** _____

☐ **Is there more than one source? Y** ☐ **N** ☐ **If yes, what is the source?** _____

☐ **Garnishment? Y** ☐ **N** ☐ **Recoupment? Y** ☐ **N** ☐ **If yes, reason and length of time:** _____

☐ **Why is the payment reduced or stopped?** _____

☐ **Why did SSI stop?** _____

☐ **Date last payment received:** _____ ☐ **Medical Diary Date:** _____

☐ **If denied for excess resource, please provide the type and value of the resource.** _____

Comments:

Verified by (SSA Rep): _____ **Date:** _____