Department of Health and Social Services
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:** _____