

Date: _____

To: _____

Social Security Number: _____

Security Claim Number: _____

I do hereby authorize the Social Security Administration to furnish to the _____
(Project Name) information regarding the amount of the monthly payment made to me.

Signature _____

Date _____

Indicate information needed by checking spaces below:

The gross amount of the monthly Social Security benefit is \$ _____

The amount deducted for Medicare is \$ _____

The net amount of the Social Security Check each month is \$ _____

Month _____ Year _____

The monthly amount of the supplemental security income payment is \$ _____

Month _____ Year _____

Other information needed - please specify on reverse side.

Complete only if you are unable to verify information requested:

- Claim still pending
- No record based on identifying information
- Other – Please explain on reverse side of form

Signature and Title of Authorized Social Security Official

Date

PLEASE RETURN TO:

Phone