

PRISONER VERIFICATION FORM

**To: Central Records
MA DOC**

From: Social Security Administration

FAX: 978-405-6133

Requestor: _____

Telephone: _____

FAX: _____

Date of Initial Request: _____

Date of Follow-Up to Initial Request: _____

Date of Request for Additional Information: _____

Additional Information Requested:

Name: _____

Inmate Number: _____

SSN: _____

Date of Birth: _____

Date of confinement/Date Committed: _____

Date of conviction/Date Sentence Imposed: _____

Facility: _____

1. SSA is requesting verification of the above incarceration information received from the Massachusetts Department of Correction. Does the above information match the information in the Department of Correction records?

Yes

If no, please briefly explain (Use REMARKS if necessary)

2. Has the above individual been released?

If no:

Current scheduled date of release _____

If yes:

Date of release: _____

If released to another jurisdiction, please specify jurisdiction: _____

3. Remarks _____

Please contact us if you have any questions. Thank you for your cooperation.

Completed by: _____

Date: _____