

REQUEST FOR ASSISTANCE - _____

(Check One)

PRIORITY REGULAR

DO/BO
USE
NUMBER
HOLDER

<input checked="" type="checkbox"/> TO (DO/BO City and State)		<input checked="" type="checkbox"/> DO/BO Code	
<input checked="" type="checkbox"/> NUMBER HOLDER (NH)		<input checked="" type="checkbox"/> CLAIM NO. (SSN, BIC/ARC) - -	
<input type="checkbox"/> CLAIMANT (if other than NH) <input type="checkbox"/> BENEFICIARY		<input type="checkbox"/> OWN SSN - -	
<input checked="" type="checkbox"/> CONTACT <input type="checkbox"/> NH <input type="checkbox"/> ATTORNEY <input type="checkbox"/> OTHER _____ <input type="checkbox"/> CLAIMANT <input type="checkbox"/> PAYEE _____ <input type="checkbox"/> BENEFICIARY <input type="checkbox"/> DEBTOR _____		<input checked="" type="checkbox"/> CONTACT <input type="checkbox"/> NH <input type="checkbox"/> ATTORNEY <input type="checkbox"/> OTHER _____ <input type="checkbox"/> CLAIMANT <input type="checkbox"/> PAYEE _____ <input type="checkbox"/> BENEFICIARY <input type="checkbox"/> DEBTOR _____	
NAME		NAME	
ADDRESS (include ZIP code)		ADDRESS (include ZIP code)	
TELEPHONE NUMBER (include area code) <input type="checkbox"/> NOT IN FILE <input type="checkbox"/> DIRECT CONTACT ATTEMPTED () -		TELEPHONE NUMBER (include area code) <input type="checkbox"/> NOT IN FILE <input type="checkbox"/> DIRECT CONTACT ATTEMPTED () -	
<input checked="" type="checkbox"/> STATUS OF <input type="checkbox"/> _____ FOLLOWS			
<input checked="" type="checkbox"/> ASSISTANCE NEEDED			
<input type="checkbox"/> Text continued on SSA-5524A-U3			
<input checked="" type="checkbox"/> PROCEDURAL REFERENCES (List)		<input type="checkbox"/> ATTACHMENTS (List)	
<input checked="" type="checkbox"/> FROM <input type="checkbox"/> PSC <input type="checkbox"/> OIO <input checked="" type="checkbox"/> <input type="checkbox"/> ODO <input type="checkbox"/> MOD _____		<input checked="" type="checkbox"/> "PARENT" FOLDER'S SSN - -	
<input checked="" type="checkbox"/> BY (Print name)		<input type="checkbox"/> CA <input type="checkbox"/> BA <input type="checkbox"/> XREF SSN (Optional) - -	
<input checked="" type="checkbox"/> COMM. NO. (include area code) () -		<input checked="" type="checkbox"/> DATE OF REQUEST	
		<input checked="" type="checkbox"/> DIARY DUE DATE	
		<input checked="" type="checkbox"/> TYPE-OF-EVENT CODE TOEL1 TOEL2	

CLAIM
NUMBER

