Social Security Administration

8202 1

Form Approved
OMB No. 0960-0145

STATEMENT FOR DETERMINING CONTINUING ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME PAYMENTS

PRIVACY ACT/PAPERWORK ACT NOTICE: I understand that my response is voluntary but: (1) that the information requested below is needed to determine my continuing eligibility to Supplemental Security Income and/or State supplementary payments and may result in an adjustment of my payment; (2) that this information may be used in determining my eligibility for State Medicaid or Social Services; and (3) that no further benefits can be paid under the Supplemental Security Income or State Supplemental programs unless this form is completed and filed as required by existing law and regulations (section 1611(e) of the Social Security Act and regulations 20 CFR 416.204). The routine uses for the information obtained are fully explained and published annually in The Federal Register. The Social Security Administration will further explain these uses upon request.

DRDP:
RUN:
JD:
STC:
WI:
TPI:
FLA:
PROFILE:
DOC:
CFL:
HUN:
FUN:
TMR:
TEL:
LANGPREF:

RETURN THIS FORM WITHIN 30 DAYS

434729850100003200505021101224303632182123101220021015

SOCIAL SECURITY NUMBER (SSN)	HUSBAND'S/WIFE'S NAME
	HUSBAND'S/WIFE'S SOCIAL SECURITY NUMBER

IF YOUR NAME AND ADDRESS SHOWN ABOVE ARE NOT CORRECT, CROSS OUT THE PART THAT IS WRONG AND WRITE IN THE CORRECT INFORMATION

I understand that the Social Security Administration will also compare its records with records from other State and/or Federal agencies to make sure I am paid the correct amount.

PRINT ANSWERS LIKE THIS ► 0 1 2 3 4 5 6 7 8 9 **OR LIKE THIS ►** Yes ☐ No X

1. Since 12/2002, have you moved to a new address? Yes ☐ No ☐
   If "**YES**", please give:

NEW ADDRESS NONE – N/A ☐	**DATE(S) YOU MOVED** Month Day Year
	☐☐ - ☐☐ - ☐☐☐☐

2. Since 12/2002, have you spent a **full calendar month** in a hospital, nursing home, other institution or any place other than where you live? (Include trips outside the U.S.) If "yes" were you in: Yes ☐ No ☐
   ☐ Hospital ☐ Nursing Home ☐ Institution ☐ Outside U.S. ☐ Other _____

DATE(S) ENTERED: Month Day Year	DATE(S) LEFT: Month Day Year
☐☐ - ☐☐ - ☐☐☐☐	☐☐ - ☐☐ - ☐☐☐☐

NAME(S) AND ADDRESS(ES) OF INSTITUTION(S) NONE – N/A ☐