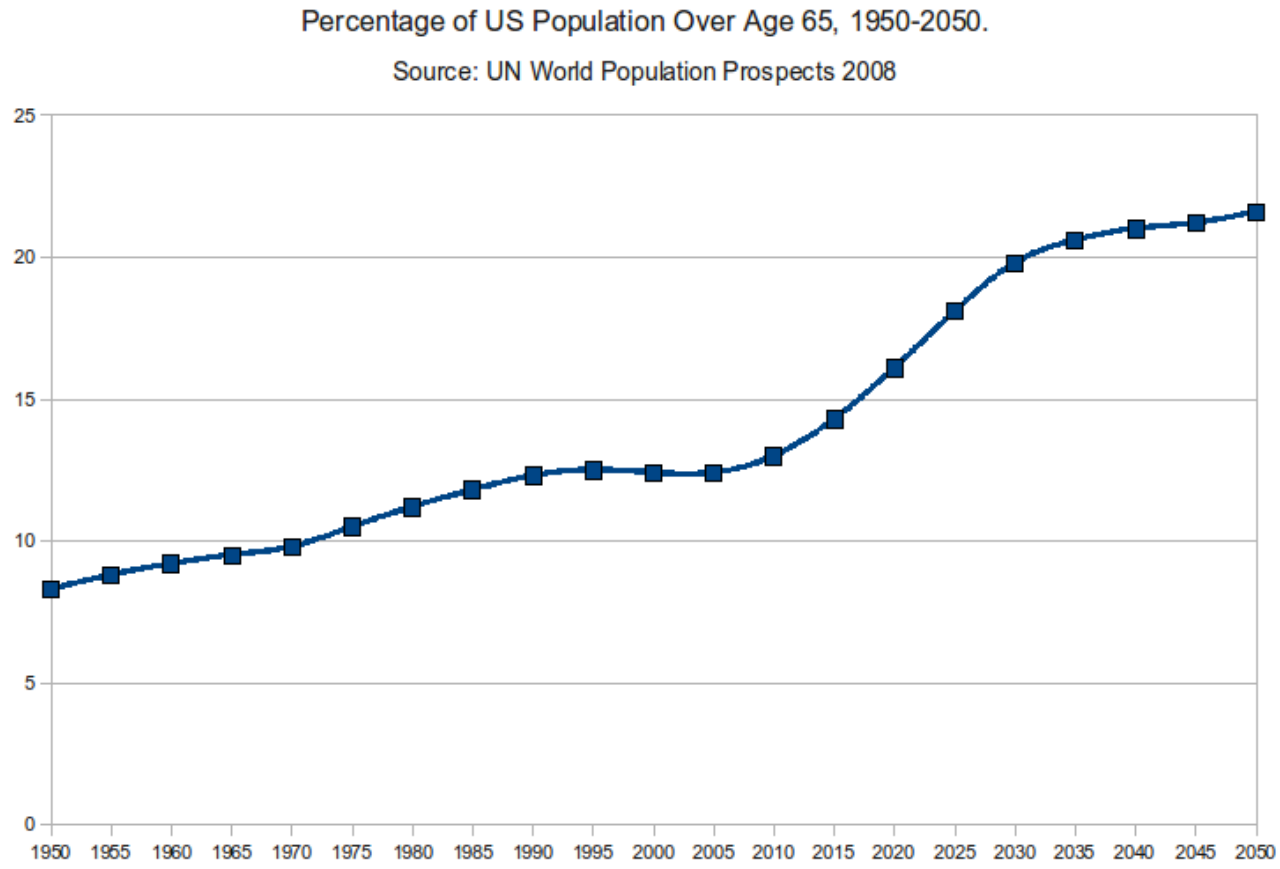


In 1971 when I was born, about 10% of the U.S. population was over the age of 65. Forty years later, it's a little over 13%. In 2036, when I'm 65, it will be around 21%. I don't know how long you all intend to represent injured people, but over the next 25 years roughly 1 in 5 of our clients is likely to be on Medicare.

MEDICARE BEFORE SETTLEMENT:

THE CHECKLIST

The following is a checklist that I've developed in my firm to take staff through the Medicare repayment process. In addition I've included the most common forms that everyone will need to get through your garden variety Medicare reimbursement claim, along with helps and hints to understand what to do and when.

General Rules to live by:

- **Always** fax or email documents – they are responded to more quickly than mailed ones.
- **Always** take notes of conversations with representatives – you will rely on them later.
- **Always** be patient and long-suffering with the representatives – confrontation will never help you.
- **Always** be early – waiting will increase your turn-around time.
- **Always** check http://go.cms.gov/cobro when you have a question or for updates to this process.

STEP 1

Identifying Medicare

To begin your inquiry, **all** clients complete this form at intake:

a. **Medicare Information Collection form [Form A]**

This form helps you determine whether your client is *eligible* for Medicare. It is sent to all insurers who are paying or may pay any benefits for your client's loss (PIP, Health, Liability, UIM), regardless of whether your client is eligible for Medicare or not. Send Form A along with your letter of representation to all payers and potential payers of benefits to your client.

If they *are* eligible, then you have more inquiry to do. What type of Medicare plan are they using?

Medicare Advantage (Part C): **The rest of this checklist is not for you.** Medicare Advantage plans are administered through private health care companies, much like employer ERISA health plans are. The plans administer Medicare dollars through their existing network, and because of that, the plans handle their own reimbursement.

Traditional Medicare (Parts A&B): If the client is using traditional Medicare, continue on.

Clients on Traditional Medicare must complete these additional two forms at intake:

b. **Proof of Representation form [Form B]:** This form is your authorization to speak with Medicare. It has been created using their model language and is necessary to do anything more than report the claim. It should be sent out as soon as you obtain the Case ID number which arrives with the Rights and Responsibilities letter (below).

c. **Authorization to Register and/or Access MyMedicare.gov Profile form [Form C]:** This form ensures that you have your client's permission to access their Medicare profile via the internet at www.mymedicare.gov. Like most health plans, Medicare gives its beneficiaries access to their claims history via the web. Most of your clients will not have signed up for this access, so this form gives you permission to do it for them. To do so, you must have their correct Medicare information from their Medicare card as well as the address where Medicare mails them things.

STEP 2

Notifying Medicare of the Claim

Contact the Benefits Coordination & Recovery Center (BCRC) office to report your client's injury claim. Be prepared to provide them with:

Beneficiary Information:

- Full Name

•Medicare Health Insurance Claim Number (HICN)
•Gender and Date of Birth
•Complete Address and Phone Number

Case Information:

•Date of Injury/Accident, or Date of First Exposure, Ingestion or Implant
•Description of Alleged Injury, Illness or Harm
•Type of Claim (Liability Insurance, No-Fault Insurance, Workers' Compensation)
•Insurer or Workers' Compensation Name and Address

Attorney Information:

•Attorney or Law Firm Name
•Complete Address and Phone Number

a. By Telephone: **1-800-999-1118**; Hours of Operation: Monday –Friday 8am-8pm(ET); or

b. ~~By Mail - MEDICARE - Benefits Coordination & Recovery Center~~**~~; P.O. Box 138832; Oklahoma City, OK, 73113~~**

(So, why is b. lined out? Because mail gets answered *after* phone calls. Time is important in this process. If phones are too new-fangled for you and you find joy in reporting by mail, then you deserve to wait.)

STEP 3

Rights and Responsibilities Letter/Conditional Payments Ledger

Within 30 days you should receive the **Rights and Responsibilities** letter.

On this letter, the most important information is the 15 digit **Case ID** number (sometimes referred to as the ReMas number). This Case ID is what you will use on everything that you send to the BCRC from now on. It routes whatever you send to the right person/place.

OPTION #1 (Old School Paper Driven Version)

Within 65 days of the issuance of the Rights and Responsibilities letter, you will receive the **Conditional Payments** letter. This letter should be accompanied by a ledger of those costs that Medicare considers claim related, if Medicare has identified anything claim related. Immediately begin an audit of client's claim related billings and reconcile with Conditional Payments ledger.

a. If treatment which is not claim related is found in the ledger, immediately fax a response to the **BCRC (Fx. 405-869-3309)** which includes:

    i. Letter explaining which dates of service, along with corresponding CPT codes, are not claim related.
    ii. Copies of chart notes supporting position that treatment was not claim related, or medical report supporting such.

iii. Copy of the Conditional Payments ledger with notations next to those entries which are not claim related.

b. Fax the BCRC the client's signed **Proof of Representation [Form B]**.
c. Register/Access your client's MyMedicare.gov online profile.

i. Go to www.mymedicare.gov.

ii. If your client already has a profile, refer to the authorization you had your client sign, to login to their account.
iii. If your client does not have a MyMedicare.gov account, create one for them.
iv. Once logged in, look for the MSP tab along the top edge of the website.
    a. This tab is usually the last one on the right.

d. You now have access to the same ledger that the BCRC uses. This ledger is updated every 90 days, and will show the date of the most recent update done to it. Check it often to see what Medicare has added to the ledger, and notify the BCRC immediately if some sneak on there that are not claim related.
e. **AND/OR**, use the BCRC's automated phone system to verify the total amount of the current conditional payments ledger, and receipt of key Medicare documents. 855-798-2627.
    i. When you call, be prepared to enter in client's SSN, DOB, name, and Case ID# (15-digit number on ledger).

OPTION #2 (New-fangled, faster internet way of the future)

Get registered for the MSPRP website (instructions below)

Login to the Medicare Secondary Payer Recovery Portal (MSPRP) and add your client to your client list using the 15 digit Case ID number. Once added, complete verification by uploading Proof of Authorization.

Wait about two days and check back in. At this point, you should be able to access your client's conditional payments ledger online (if Medicare has identified any claim related payments), as well as dispute those charges that are not in line with your audit.

STEP 4

The moment you have a firm settlement or verdict amount:

a. Fax the BCRC a completed **Final Settlement Detail [Form D],** or submit via the MSPRP.
b. Two weeks after faxing/submitting the Final Settlement Detail, begin calling the BCRC once every week to check on the status of its receipt of the Final Settlement Detail and the return of the **Final Demand** letter. The automated phone system can update you on receipt of your Final Settlement Detail as well as the date the Demand Letter was sent as well as the amount of the Demand.
c. Upon receipt of the **Final Demand** letter you may issue payment to Medicare.
    i. Medicare will not sign a release or satisfaction of subrogation. Use the cover sheet that you have used with all of your other correspondence and make sure the box labeled "check" is checked.
    ii. Any attempt to bind Medicare with a letter that states, "this is full and final payment," will be responded to that Medicare can collect conditional payments at any time up through the SOL. Don't try it.
    iii. Medicare must receive payment or a request for an appeal within 60 days of the issuance of the Demand Letter.

SPECIAL CIRCUMSTANCES

Requests for Waivers or Reductions

If you know that your settlement will be a deficiency (more medical bills than insurance coverage) or you face a contributory negligence defense (your client shares fault), Medicare will typically not reduce its claim. Medicare may reduce its claim if your client can demonstrate that the injuring event that the claim is based on put them into financial hardship.

i. Complete the **Request for Waiver [Form E]** as soon as this circumstance becomes apparent, and provide sufficient evidence of the financial hardship for Medicare to consider. This process is not short, so start it as soon as you are aware of the need to request the reduction or waiver.

Appealing the Final Demand

If you disagree with the amount that the BCRC is claiming your client owes back to Medicare, follow the procedures outlined in the Final Demand letter. Pay attention to deadlines and keep in mind that Medicare will charge interest on any unpaid balance your client actually owes to Medicare after the 60 days past Final Demand are up. If you know that your client owes Medicare some part of what it's claiming, it may be prudent to pay it as an "undisputed amount" to mitigate interest penalties.

Late notification to Medicare regarding claim

If you discover payments made by Medicare close to or at the time of settlement (or you are REALLY lazy), then Medicare does have an expedited process to determine what your client owes it. Keep in mind, however, that time frames for objecting to non-claim related items are short and if you

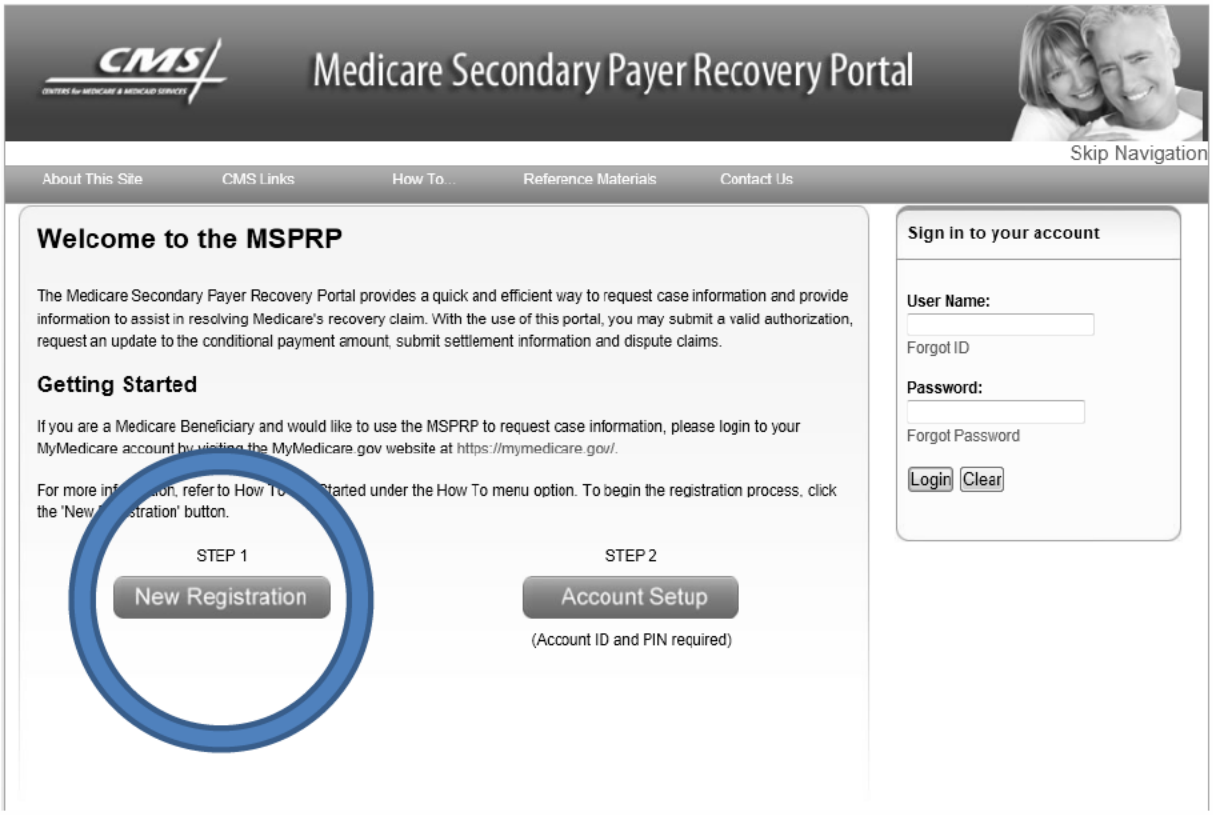
miss deadlines you WAIVE your client's right to dispute them. Instructions for that process, called **Conditional Payments Notice** are attached to these materials.

MEDICARE SECONDARY PAYER RECOVERY PORTAL

Getting started with the MSPRP means that you must first sign up. Do that by going to:

https://ww.cob.cms.hhs.gov/MSPRP/login

Once there, you will be presented with some intern's summer disclosure project, which you will ignore, and then proceed to scroll down, where you will click on "I accept." Doing so will deduct $100 from your personal bank account (I kid, I KID!!!). After accepting, you are taken to the Welcome page, which gives you three options – Register, Setup, or Sign in. If this is your first time, you need to Register.



When you click on the New Registration page, it will take you to a page that asks you to designate your profile as one of a Representative or Corporate. Unless you are a large employer working on employee benefits or a first party insurer, pick **Representative**.

After clicking on Continue, you will be taken to a page where you will fill out your information. That is, you the Representative. The Representative is the lawyer – whether there is a staff person at your firm that handles this stuff or not, the lawyer's name and info goes here.

After you enter in your information, you will be sent an email verifying your submission to CMS with an attachment. That attachment is both an information verification form and an agreement which you must sign, scan, and send back to CMS for approval.

Medicare Secondary Payer

Recovery Portal

Profile Report

Account ID:31233 Account Type:Representative Date:Jul 11, 2012

EDI Contact Information:
Email: COBVA@GHIMedicare.com Phone: (646) 458-6740

Representative:

Name: Steven Shaw Phone: (425)214-4946
Address: 11417 124th Ave NE Suite 201A
Kirkland WA 98033
Email: steve@shawfirm.com

Account Manager:

Name: Steven Shaw Phone: (425)214-4946
Address: 11417 124th Ave NE Suite 201A
Kirkland WA 98033
Email: steve@shawfirm.com

Account ID:31233 Account Type:Representative Date:Jul 11, 2012
EDI Contact Information:
Email: COBVA@GHIMedicare.com Phone: (646) 458-6740

SAFEGUARDING & LIMITING ACCESS TO DATA

I, the undersigned Account Manager for the MSPRP representative account defined above, certify that the information contained in this Registration is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS to verify this information. I agree to establish and implement proper safeguards against unauthorized use and disclosure of the data for the purposes of MSPRP proposal(s) review and processing. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. ? 1306], Section 1874(b) of the Social Security Act [42 U.S.C. ? 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. ? 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. ? 552a]. Users shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by the CMS. You agree that the authorized representatives of the CMS shall be granted access to premises where the Medicare data are kept for the purpose of inspecting security arrangements and confirming whether the user is in compliance with the security requirements specified above. Access to any information exchanged during the MSP Recovery process shall be restricted to CMS, COBC, and MSPRC personnel, and other authorized users who require access to 1) perform their official duties in accordance with the approved uses of the information; (2) respond to authorized law enforcement investigations; or (3) respond to any required legal process. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information; and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

Signature of Account Manager: _____

Date: 7/11/12

Once received and approved by CMS, you will be send a letter in the mail with your account number, and a PIN. You need those two pieces of information to set up your profile.

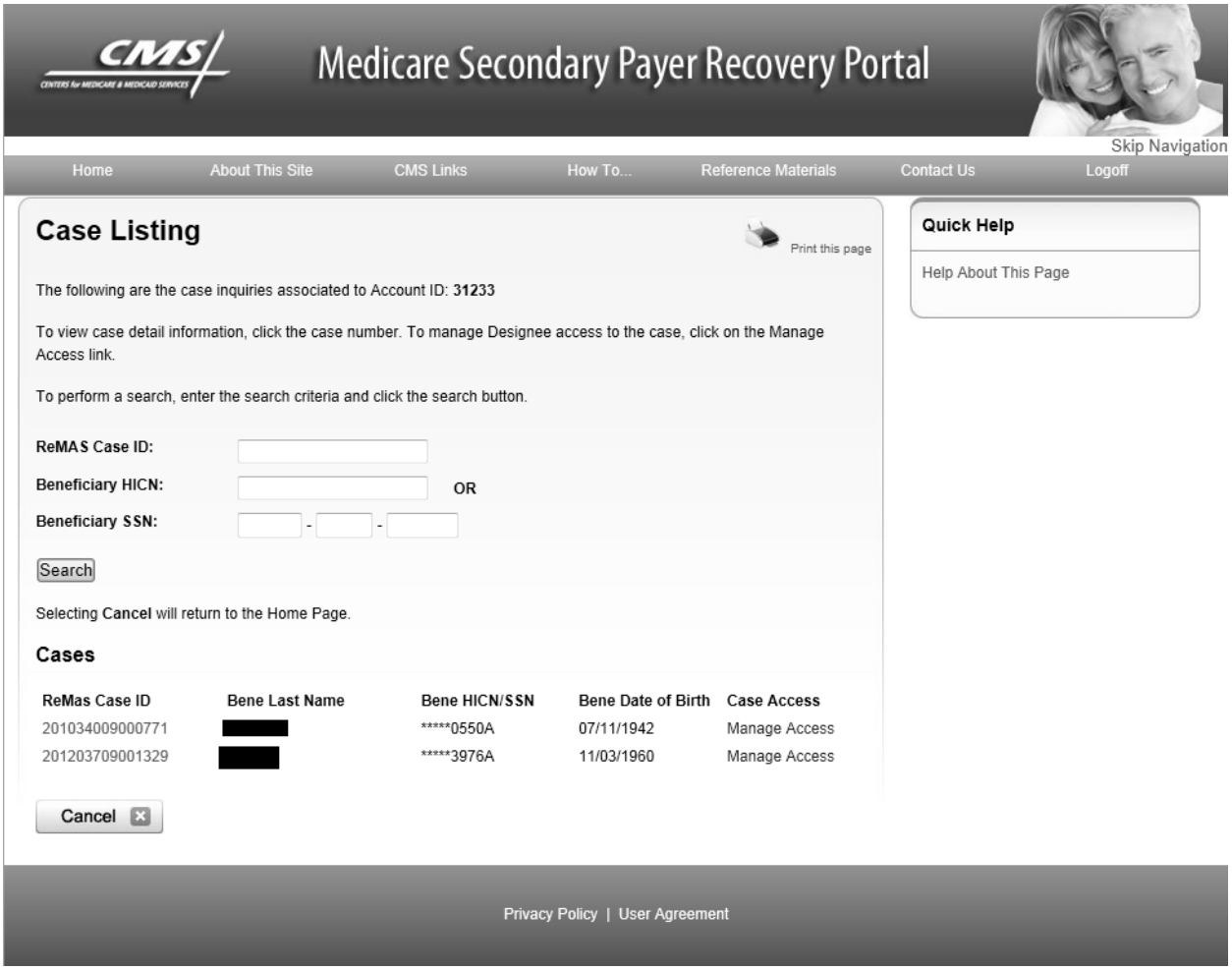
As you can see, now it is asking for the email address of the **Account Manager**. The account manager can be you, if you are the one at your firm that deals with all of your subrogated interests. If not, this is the perfect time to pass the buck, because the Account Manager can be different from the Representative.

Following the entry of the Account Manager's information, you choose a username and a password, which operates like any other website where you have to login.

Here is the welcome screen once you've logged in. Spectacular, no? CMS is not into pleasing the eye, so get used to the textual interface.

On the right, you will notice links that let you update your representative and Account Manager's information, passwords, view account activity, set up Designees, etc. At the bottom of the page, you will see two links: Request Case Access, and Case Listing. There will not be any cases in the listing, until you have added at least one under the Request Case Access tab, so go there first.

To get Case Access, you need four pieces of information: Case ID (from the Rights and Resp. letter), Medicare number or SSN, client's last name, and date of birth. With that, the case will be listed on your
Case Listings page.



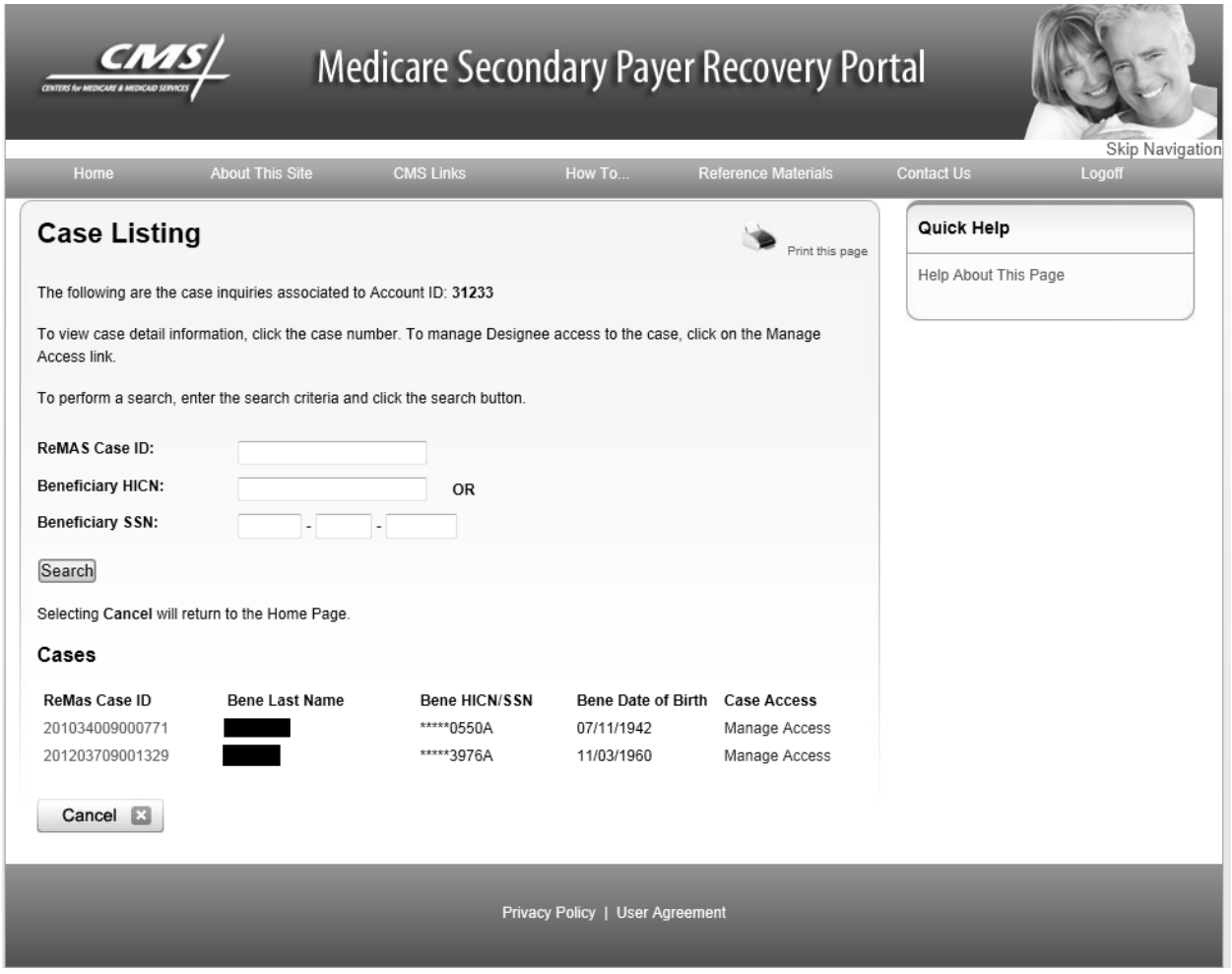
By clicking on one of the cases that you've added, you will be taken to your client's profile page. This is the page that you will use most often with this tool.

Only the client's last name, last 4 of their Medicare number, and their birthdate are used to identify the beneficiary. From this screen, you will see below the client's name that an authorization has been filed with the MSPRP for this client, which makes certain tasks below the identification pane available, such as requesting an update of the conditional payment amount. Requesting a ledger is not available, however, because Medicare has not found any conditional payments for her.

If we look at a different client, we can see that there is a balance owed, but there are still some tasks that have not been made available because the Proof of Representation has been received, but not verified.

Designees

Within the portal, you can assign different staff to monitor particular clients. First they must be added by clicking on the Designee Maintenance link from the Welcome screen after login. Once added, by clicking on Case Listing, you can added one or more designees to each client by clicking on the Manage Access link next to their entry on the Cases listing.



Getting help

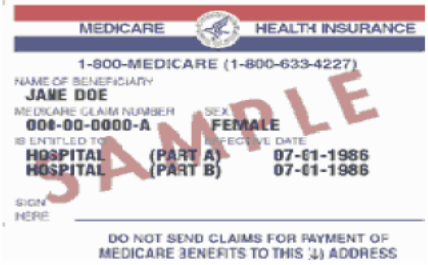
The help desk for this application is called the EDI Help Desk Department. Their phone number and email address is on the Contact Us link on the login page. I have emailed them on three different occasions, and have received follow-up phone calls within 24 hours, which is industry standard and pretty good.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐Yes	☒No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number:	**Date of Birth (Mo/Day/Year)**	- -
Social Security Number: *(If Medicare Claim Number is Unavailable)* - -	**Sex**	☐Female ☐Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Claim Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

_____ _____

Claimant Name (Please Print) Claim Number

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____ _____

Signature of Person Completing This Form Date

PROOF OF REPRESENTATION

This document is to inform the Centers for Medicare & Medicaid Services (CMS) that the below-named Medicare Beneficiary has given another individual the authority to represent and act on his or her behalf with respect to a claim for liability insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award or other payment.

Type of Representative (Check one):	**Representative Contact Information:**
☐ Attorney	Name: _____
☐ Guardian	Relationship to Medicare Beneficiary: _____
☐ Conservator	Firm Name: _____
☐ Power of Attorney	Address: _____
☐ Other Individual (Non-Attorney)	Telephone: _____

Medicare Beneficiary: (Must match information on Beneficiary's Medicare Card)

Name: _____

HIC Number: _____

Date of Loss: _____

Beneficiary Signature: _____ **Date**: _____

Representative Signature: _____ **Date**: _____

NGHP

P.O. Box 138832 | Oklahoma City, OK 73113 | Fax: (405) 869-3309

Authorization to Access MyMedicare.Gov Profile

I, _____, authorize the _____ Law Firm to access my "MyMedicare.Gov" profile to obtain information necessary for their representation of me. This authorization expires upon the fulfillment or termination of my client agreement with the _____ Law Firm.

_____ _____

Signature Date

☐ I already have a MyMedicare.Gov profile, and provide below the current username and password.

Username: _____

Password: _____

☐ I do not currently have a MyMedicare.Gov profile, but authorize the _____ Law Firm to create one for me.

Final Settlement Detail Document

Beneficiary Name:
Medicare Number:
Date of Incident:

When a beneficiary receives a settlement, judgment, award, or other payment, Medicare is entitled to recover associated payments made by the Medicare program. If certain conditions are met, Medicare reduces its conditional payment to take into account a proportionate share of the costs incurred in resolving the beneficiary's claim. **See 42 C.F.R. 411.37.** In general, the recovery demand must be against the individual or entity that received payment, the costs must have been incurred because the matter was disputed, and the costs must be paid by the individual or entity against whom/which Medicare seeks recovery. There is no proportionate reduction if payment is not in dispute – for example a payment for no-fault insurance.

In order for Medicare to properly calculate the net refund it is due, please supply the information outlined below. This information will also be used to update the beneficiary's records to show resolution of this matter. If you have a representative, this information should be submitted by your representative on his/her letterhead.

Total Amount of the Settlement: _____
Total Amount of Med-Pay or PIP: _____
Attorney Fee Amount Paid by the Beneficiary: _____
Additional Procurement Expenses Paid by the Beneficiary: _____
(Please submit an itemized listing of these expenses)
Date the Case Was Settled: ____/____/____

This information should be submitted **along with a copy of this notice** to:

Benefits Coordination & Recovery Center
NGHP
Post Office Box 138832
Oklahoma City, OK 73113

If you have any questions concerning this matter, please call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired) or you may contact us in writing at the address above. If you contact us in writing, please be sure to include the beneficiary's name and his/her Medicare health insurance claim number.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0037

Request For Waiver Of Overpayment Recovery Or Change In Repayment Rate

We will use your answers on this form to decide if we can waive collection of the overpayment or change the amount you must pay us back each month. If we can't waive collection, we may use this form to decide how you should repay the money.

Please answer the questions on this form as completely as you can. We will help you fill out the form if you want. If you are filling out this form for someone else, answer the questions as they apply to that person.

FOR SSA USE ONLY	
ROAR Input	☐ Yes ☐ No
Input Date	
Waiver	☐ Approval ☐ Denial
SSI	☐ Yes ☐ No
AMT OF OP $	
PERIOD (DATES) OF OP	

1. A. Name of person on whose record the overpayment occurred:

_____

B. Social Security Number

☐☐☐—☐☐—☐☐☐☐

C. Name of overpaid person(s) making this request and his/her Social Security Number(s):

_____ ☐☐☐—☐☐—☐☐☐☐

_____ ☐☐☐—☐☐—☐☐☐☐

_____ ☐☐☐—☐☐—☐☐☐☐

_____ ☐☐☐—☐☐—☐☐☐☐

2. Check any of the following that apply. (Also, Fill in the dollar amount in B, C, or D.)

A. ☐ The overpayment was not my fault and I cannot afford to pay the money back and/or it is unfair for some other reasons.

B. ☐ I cannot afford to use all of my monthly benefit to pay back the overpayment. However I can afford to have $ _____ withheld each month

C. ☐ I am no longer receiving Supplement Security Income (SSI) payments. I want to pay back $ _____ each month instead of paying all of the money at once.

D. ☐ I am receiving SSI payments. I want to pay back $ _____ each month instead of paying 10% of my total income.

SECTION I-INFORMATION ABOUT RECEIVING THE OVERPAYMENT

3. A. Did you, as representative payee, receive the overpaid benefits to use for the beneficiary?

☐ Yes ☐ No (Skip to Question 4)

B. Name and address of the beneficiary

C. How were the overpaid benefits used?

4. If we are asking you to repay someone else's overpayment:

A. Was the overpaid person living with you when he/she was overpaid? ☐ Yes ☐ No

B. Did you receive any of the overpaid money? ☐ Yes ☐ No

C. Explain what you know about the overpayment AND why it was not your fault.

5. Why did you think you were due the overpaid money and why do you think you were not at fault in causing the overpayment or accepting the money?

6. A. Did you tell us about the change or event that made you overpaid? ☐ Yes ☐ No
If no, why didn't you tell us?

B. If yes, how, when and where did you tell us? If you told us by phone or in person, who did you talk with and what was said?

C. If you did not hear from us after your report, and/or your benefits did not change, did you contact us again? ☐ Yes ☐ No

7. A. Have we ever overpaid you before? ☐ Yes ☐ No

If yes, on what Social Security number? ☐☐☐—☐☐—☐☐☐☐

B. Why were you overpaid before? If the reason is similar to why you are overpaid now, explain what you did to try to prevent the present overpayment.

SECTION II-YOUR FINANCIAL STATEMENT

NAME:

SSN:

You need to complete this section if you are asking us either to waive the collection of the overpayment or to change the rate at which we asked you to repay it. Please answer all questions as fully and as carefully as possible. We may ask to see some documents to support your statements, so you should have them with you when you visit our office.

EXAMPLES ARE:

- Current Rent or Mortgage Books
- Savings Passbooks
- Pay Stubs
- Your most recent Tax Return
- 2 or 3 recent utility, medical, charge card, and insurance bills
- Cancelled checks
- Similar documents for your spouse or dependent family members

Please write only whole dollar amounts-Round any cents to the nearest dollar. If you need more space for answers, use the "Remarks" section at the bottom of page 7.

9. A. Do you now have any of the overpaid checks or money in your possession (or in a savings or other type of account)?

☐ Yes Amount:$ _____
Return this amount to SSA
☐ No

B. Did you have any of the overpaid checks or money in your possession (or in a savings or other type of account) at the time you received the overpayment notice?

☐ Yes Amount:$ _____
Answer Question 10.
☐ No

10. Explain why you believe you should not have to return this amount.

_____

_____

ANSWER 11 AND 12 ONLY IF THE OVERPAYMENT IS SUPPLEMENTAL SECURITY INCOME PAYMENTS (SSI). IF NOT, SKIP TO 13.

11. A. Did you lend or give away any property or cash after notification of the overpayment?

☐ Yes (Answer Part B)
☐ No (Go to question 12.)

B. Who received it, relationship (if any), description and value:

_____

12. A. Did you receive or sell any property or receive any cash (other than earnings) after notification of this overpayment?

☐ Yes (Answer Part B)
☐ No (Go to Question 13.)

B. Describe property and sale price or amount of cash received:

_____

13. A. Are you now receiving cash public assistance such as Supplemental Security Income (SSI) payments?

☐ Yes (Answer B and C and See note below)
☐ No

B. Name or kind of public assistance

_____

C. Claim Number

_____

IMPORTANT: If you answered "YES" to question 13, DO NOT answer any more questions on this form.
Go to page 8, sign and date the form, and give your address and phone number(s). Bring or mail any papers that show you receive public assistance to your local Social Security office as soon as possible.

Members Of Household

14. List any person (child, parent, friend, etc.) who depends on you for support AND who lives with you.

NAME	AGE	RELATIONSHIP (If none, explain why the person is dependent on you)

Assets-Things You Have And Own

15. A. How much money do you and any person(s) listed in question 14 above have as cash on hand, in a checking account, or otherwise readily available?

$

B. Does your name, or that of any other member of your household appear, either alone or with any other person, on any of the following?

TYPE OF ASSET	OWNER	BALANCE OR VALUE	PER MONTH	SHOW THE INCOME (Interest, dividends) EARNED EACH MONTH. (If none explain in spaces below) If paid quarterly, divide by 3.
SAVINGS (Bank, Savings and Loan, Credit Union)		$	$	
		$	$	
CERTIFICATES OF DEPOSIT (CD)		$	$	
INDIVIDUAL RETIREMENT ACCOUNT (IRA)		$	$	
MONEY OR MUTUAL FUNDS		$	$	
BONDS, STOCKS		$	$	
TRUST FUND		$	$	
CHECKING ACCOUNT		$	$	
OTHER (EXPLAIN)		$	$	
TOTALS →		$	$	Enter the "Per Month" total on line (k) of question 19.

16. A. If you or a member of your household own a car, (other than the family vehicle), van, truck, camper, motorcycle, or any other vehicle or a boat, list below.

OWNER	YEAR, MAKE/MODEL	PRESENT VALUE	LOAN BALANCE (if any)	MAIN PURPOSE FOR USE
		$	$	
		$	$	
		$	$	

B. If you or a member of your household own any real estate (buildings or land), OTHER than where you live, or own or have an interest in, any business, property, or valuables, describe below.

OWNER	DESCRIPTION	MARKET VALUE	LOAN BALANCE (if any)	USAGE-INCOME (rent etc.)
		$	$	
		$	$	
		$	$	
		$	$	

Monthly Household Income

If paid weekly, multiply by 4.33 (4 1/3) to figure monthly pay. If paid every 2 weeks, multiply by 2.166 (2 1/6) If self-employed, enter 1/12 of net earnings. Enter monthly TAKE HOME amounts on line A of question 19 also.

17. A. Are you employed? ☐ YES (Provide information below) ☐ NO (Skip to B)

Employer name, address, and phone: (Write "self" if self-employed)	Monthly pay before deduction (Gross) $
	Monthly TAKE-HOME pay (NET) $

B. Is your spouse employed? ☐ YES (Provide information below) ☐ NO (Skip to C)

Employer(s) name, address, and phone: (Write "self" if self-employed)	Monthly pay before deduction (Gross) $
	Monthly TAKE-HOME pay (NET) $

C. Is any other person listed in Question 14 employed? ☐ YES ☐ NO (Go to Question 18) Name(s)

Employer(s) name, address, and phone: (Write "self" if self-employed)	Monthly pay before deduction (Gross) $
	Monthly TAKE-HOME pay (NET) $

18. A. Do you, your spouse or any dependent member of your household receive support or contributions from any person or organization? ☐ YES (Answer B) ☐ NO (Go to question 19)

B. How much money is received each month? (Show this amount on line (J) of question 19) $ SOURCE

BE SURE TO SHOW **MONTHLY** AMOUNTS BELOW - If received weekly or every 2 weeks, read the instruction at the top of this page.

19.

INCOME FROM #17 AND #18 ABOVE AND OTHER INCOME TO YOUR HOUSEHOLD		YOURS	V	SPOUSE'S	V	OTHER HOUSEHOLD MEMBERS	V	SSA USE ONLY
A. TAKE HOME Pay (Net) (From #17 A, B, C, above)		$	☐	$	☐	$	☐	
B. Social Security Benefits			☐		☐		☐	
C. Supplemental Security Income (SSI)			☐		☐		☐	
D. Pension(s) (VA, Military, Civil Service, Railroad, etc.)	TYPE		☐		☐		☐	
	TYPE		☐		☐		☐	
E. Public Assistance (Other than SSI)	TYPE		☐		☐		☐	
F. Food Stamps (Show full face value of stamps received)			☐		☐		☐	
G. Income from real estate (rent, etc.) (From question 16B)			☐		☐		☐	
H. Room and/or Board Payments (Explain in remarks below)			☐		☐		☐	
I. Child Support/Alimony			☐		☐		☐	
J. Other Support (From #18 (B) above)			☐		☐		☐	
K. Income From Assets (From question 15)			☐		☐		☐	
L. Other (From any source, explain below)			☐		☐		☐	
REMARKS	TOTALS	$		$		$		
						GRAND TOTAL (Add 3 total blocks above)		$

MONTHLY HOUSEHOLD EXPENSES

If the expense is paid weekly or every 2 weeks, read the instruction at top of Page 5. Do NOT list an expense that is withheld from income (Such as Medical Insurance). Only take home pay is used to figure income.

Show "CC" as the expense amount if the expense (such as clothing) is part of CREDIT CARD EXPENSE SHOWN ON LINE (F).

20.

	$ PER MONTH	SSA USE ONLY
A. Rent or Mortgage (If mortgage payment includes property or other local taxes, insurance, etc. DO NOT list again below.		
B. Food (Groceries (include the value of food stamps) and food at restaurants, work, etc.)		
C. Utilities (Gas, electric, telephone)		
D. Other Heating/Cooking Fuel (Oil, propane, coal, wood, etc.)		
E. Clothing		
F. Credit Card Payments (show minimum monthly payment allowed)		
G. Property Tax (State and local)		
H. Other taxes or fees related to your home (trash collection, water-sewer fees)		
I. Insurance (Life, health, fire, homeowner, renter, car, and any other casualty or liability policies)		
J. Medical-Dental (After amount, if any, paid by insurance)		
K. Car operation and maintenance (Show any car loan payment in (N) below)		
L. Other transportation		
M. Church-charity cash donations		
N. Loan, credit, lay-away payments (If payment amount is optional, show minimum)		
O. Support to someone NOT in household (Show name, age, relationship (if any) and address)		
P. Any expense not shown above (Specify)		
EXPENSE REMARKS Also explain any unusual or very large expenses, such as medical, college, etc.) — TOTAL	$	

INCOME AND EXPENSES COMPARISON

21. A. Monthly income
(Write the amount here from the "Grand Total" of #19. → $

B. Monthly Expenses
Write the amount here from the "Total" of #20. → $

C. Adjusted Household Expenses → + $25

D. Adjusted Monthly Expenses (Add (B) and (C)) → $

22. If your expenses (D) are more than your income (A), explain how you are paying your bills.

FOR SSA USE ONLY	
☐ INC. **EXCEEDS** ADJ EXPENSE	$ +
☐ INC **LESS THAN** ADJ EXPENSE	$ -

FINANCIAL EXPECTATION AND FUNDS AVAILABILITY

23. A. Do you, your spouse or any dependent member of your household expect your or their financial situation to change (for the better or worse) in the next 6 months? (For example: a tax refund, pay raise or full repayment of a current bill for the better-major house repairs for the worse).

☐ YES (Explain on line below)
☐ NO

B. If there is an amount of cash on hand or in checking accounts shown in item 15A, is it being held for a special purpose?

☐ No amount on hand
☐ NO (Money available for any use)
☐ YES (Explain on line below)

C. Is there any reason you CANNOT convert to cash the "Balance or Value" of any financial asset shown in item 15B.

☐ YES (Explain on line below)
☐ NO

D. Is there any reason you CANNOT SELL or otherwise convert to cash any of the assets shown in items 16A and B?

☐ YES (Explain on line below)
☐ NO

REMARKS SPACE – If you are continuing an answer to a question, please write the number (and letter, if any) of the question first.

(MORE SPACE ON NEXT PAGE)

(REMARKS SPACE (Continued)

PENALTY CLAUSE, CERTIFICATION AND PRIVACY ACT STATEMENT

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF OVERPAID PERSON OR REPRESENTATIVE PAYEE

SIGNATURE (First name, middle initial, last name) (Write ink)	DATE (Month, Day, Year)
	HOME TELEPHONE NUMBER (Include area code) ( ) -
SIGN HERE ▶	WORK TELEPHONE NUMBER IF WE MAY CALL YOU AT WORK (Include area code) ( ) -

MAILING ADDRESS (Number and street, Apt. No., P.O. Box, or Rural Route)

CITY AND STATE	ZIP CODE -	ENTER NAME OF COUNTY (IF ANY) IN WHICH YOU NOW LIVE

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

SIGNATURE OF WITNESS	SIGNATURE OF WITNESS
ADDRESS (Number and street, City, State, and ZIP Code)	ADDRESS (Number and street, City, State, and ZIP Code)

About the Privacy Act

The Social Security Act (Sections 204, 1631(b), and 1870) and the Federal Coal Mine Health and Safety Act of 1969 allow us to collect the facts on this form. This form is voluntary. However, if you do not give us the facts we ask for, we may not be able to approve your waiver request. If we cannot collect the overpayment, we may ask the Justice Department to collect it.

Sometimes the law requires us to give out the facts on this form without your consent. We must give these facts to another person or government agency if Federal law requires that we do so or to do the research and audits needed to monitor and improve the programs we manage.

We may also give these facts to the Justice Department to investigate and prosecute violations of the Social Security Act or we may use the facts in computer matching programs. Matching programs compare our records with those of other Federal, State, or local government agencies. All the Agencies may use matching programs to find or prove that a person qualifies for benefits paid for or managed by the Federal government. Another use is to identify and collect overpayments or to collect overdue loans under these benefits programs.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 2 hours to read the instructions, gather the facts, and answer the questions. SEND **OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed underU. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** You may send comments on our time estimate above to: SSA, 6401 Security Blvd.,Baltimore,MD21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***