CHILD-CARE DROPOUT QUESTIONNAIRE  NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON  NAME OF PERSON MAKING STATEMENT (If other than above wage earner or self-employed person)					See Paperwork/Privacy Act Notice on Reverse  SOCIAL SECURITY NUMBER  RELATIONSHIP TO WAGE EARNER OR SELF-EMPLOYED PERSON										
								1 .	Was a child, either your own or your spouse's, living with you while the child was under age 3 in any year after 1950?				YES NO		
									If "Yes," give the following information:						
	Name of Each Child	Child's Date of Birth		Relationship to You or Your Spouse	Years the Child Was Under 3 and Lived With You		No. of Days in Each Year the Child Lived With You								
2.	Did you work in any of th			YES	NO										
	If "Yes," indicate each year in which you worked:				•										
use ir	U I I I I I I I I I I I I I I I I I I I	ment under the Soci													
		SIGNATURE	OF PERSO	N MAKING STA	ATEMEN	T									
SIGNATURE (First name, middle initial, last name) (Write in ink)					DATE (Month, day, year)										
SIGN HERE					TELEPHONE NUMBER (Include Area Code)										
MAIL	ING ADDRESS (Number an	d street, Apt. No., P.	O. Box, Ru	ral Route)	1										
CITY AND STATE					ZIP CODE										
	esses are required ONLY if				ove. If si	gned by mark (	X), two witnesses to the								
signing who know the individual must sign below, giving their full. SIGNATURE OF WITNESS				all addresses.  2. SIGNATURE OF WITNESS											
ADDRESS (Number and Street, City, State, and ZIP Code)				ADDRESS (Number and Street, City, State, and ZIP Code)											

## **COLLECTION AND USE OF INFORMATION**

## PAPERWORK/PRIVACY ACT NOTICE

The Social Security Administration is authorized to collect the information on this form under sections 202(b), 202(c), 205(a), and 1872 of the Social Security Act, as amended (42 U.S.C. 402(b), 402(c), 405(a), and 1395(ii). While it is VOLUNTARY, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage. Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of the Social Security programs or for the administration of programs requiring coordination with the Social Security administration, information may be disclosed to another person or to another governmental agency as follows: 1. enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Veterans Administration); and 3. to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

These and other reasons why information about you may be used or given out are explained in the Federal Register. If you want to learn more about this, contact any Social Security office.

## PAPERWORK REDUCTION ACT STATEMENT

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.