## CERTIFICATE OF RESPONSIBILITY FOR WELFARE AND CARE OF CHILD NOT IN APPLICANT'S CUSTODY

All items on this form requiring an answer must be answered or marked "Unknown."

PRIVACY ACT/PAPERWORK ACT NOTICE: The information requested on this form is sought pursuant to the authority granted in 42 U.S.C. 402(b) and 402(g). The information provided will be used to confirm past and continuing entitlement to benefits and the determine whether such benefits are subject to suspension or termination. While completion of this form is voluntary, failure to provide all or any part of the requested information is cause for suspension of benefit: payments. The information you furnish on this form may be disclosed by Social Security to another person or to another governmental agency for the following purposes: (1) to assist Social Security in establishing the right of an individual to Social Security coverage and/or benefits; (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs; and (3) to comply with Federal laws requiring the exchange of information between Social Security and another agency.

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. May 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.

Explanations about these and other reasons why information you provide us may be used or give out are available in Social Security Offices. 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 10 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.

NAI	ME OF WAGE EARNER OR SELF-EMPL	SOCIAL SECURITY NUMBER								
Ιn	nake this statement in supp	ort of my	application	for insurance	benefits	payable u	nder Tit	tle II of t	he Soc	ial
	curity Act, as amended.	,								
	Give the following informatio who are not living with you a age 22. Include natural childr step-grandchildren).	ınd are: (a)	under age	16, or (b) age	16 or ove	er, with a d	lisability	that bega		е
	FULL NAME OF CHILD	DATE CHILD LEFT YOUR HOME	How Long From to- day will the child be away from you?	REASON ( LEFT YOUR			JMBER AN (TO CHILI WITH W	RESS, TELEP D RELATION D) OF PERSO /HOM CHILE DW LIVING	NSHIP DN	
2.	(a) If you contribute to the su	apport of ar	ny child na	med in item 1 a	above, giv	e the follo	wing inf	ormation		
FIRST NAME OF CHILD			AMOUNTS CONTRIBUTED			HOW OFTEN YOU CONTRIBUTE				
		\$								
			\$							
			\$							
		\$								
	(b) If you are not contributing you are not doing so.	g to the sup	port of an	y child named i	n 1 above	e, give nan	ne of chi	ld and sta	ate why	

3.	State how often you do ar	ny of the things	shown below for	any child named i	n 1 above.					
	FIRST NAME OF CHILD	VISIT	SEND CLOTHING	MAKE OTHER GIFTS	WRITE LETTERS	OTHER (DESCRIBE)				
1.	Do you give the person or persons with whom the child or children have been placed Yes No instructions for the care of such child or children?  If "Yes," explain what those instructions are, how often you give them, and what you do to be sure they are carried out.									
dete Sec oay	ow that anyone who (a) makes ermining a right to or the amou urity Act, or (b) who, having re ment for other than the person eral law by fine, imprisonment	nt of any paymer eceived a paymen for whom it is re	nt, or in determining t for the use and be ceived, under the S	an individual's disab nefit of another pers ocial Security Act, co	ility, under Title II on, knowingly and ommits a crime Po	of the Social d willfully uses such				
SIG	SIGNAT NATURE <i>(First Name, Middle II</i>	URE OF APPLICA		DATE (Mo	onth, day, year)					
	IGN ERE		MAY BE C	TELEPHONE NUMBER(S) AT WHICH YOU MAY BE CONTACTED DURING THE DAY (include area code)						
MΑ	LING ADDRESS (Number and	street, P.O. Box,	or Rural Route)	I						
CIT	Y AND STATE		ZIP CODE	ENTER NAME O	OF COUNTY (IF ANY	) IN WHICH YOU NOW				
	nesses are required ONLY inesses to the signing who l		_			mark (X), two				
	SIGNATURE OF WITNESS		_	SIGNATURE OF WIT						
	ADDRESS (Number and street,	City, State and .	ZIP Code)	ADDRESS (Number	and street, City, S	State and ZIP Code)				