Please Note

This packet does <u>not</u> contain legal advice.
This guide contains legal information, not legal advice. Legal *information* is background information about your rights. Legal *advice* is advice from a lawyer about what to do in your own specific situation. Legal Aid is not your lawyer in your Social Security matter.

Self-Help Guide to Social Security Overpayments

Updated September 2025

What is a Social Security overpayment?

An overpayment is when the Social Security Administration thinks it has paid you too much money. This can happen for many reasons. The Social Security Administration might think that you did not report all of your money. It might think that you are not disabled anymore so you should not have gotten payments during certain months or years.

What should I do if Social Security says I was overpaid?

If Social Security believes you were overpaid, they should send a letter about the overpayment in the mail. You can go to your local office and ask for that letter if you don't get it. **You have 3 choices to try to change the overpayment.** Here is some basic information about each option, and more details can be found below.

Option 1: Appeal	**When does it make sense to appeal?** You can appeal if you do not think you were overpaid. You can also appeal if you think the overpayment amount is wrong. **How do I appeal?** 1. Fill out the appeal form (called a "Request for Reconsideration"), found below. 2. Attach a second page to the form. On this page, explain why you do not think you were overpaid or why you think the overpayment amount is wrong. **Is there a deadline to appeal?** Yes. You must file your appeal within **60 days** of the date you receive the overpayment notice, which they generally assume is five days after the date on the notice.
Option 2: Ask for a Waiver	**When does it make sense to ask for a waiver?** Ask for a waiver if the overpayment wasn't your fault and you can't afford to pay it back. **How do I ask for a waiver?** Fill out a **Request for Waiver of Overpayment Recovery**. This form is below. You must prove (1) the overpayment wasn't your fault **and** (2) you can't afford to pay it back. **Is there a deadline to ask for a waiver?** No. You can ask for a waiver at any time.
Option 3: Ask for a Payment Plan	**When does it make sense to ask for a payment plan?** Ask for a payment plan if you can't afford to pay back the overpayment. **How do I ask for a payment plan?** 1. Write a **letter** to the Social Security Administration. Tell them how much you can afford to pay each month. A sample letter is attached. 2. Fill out a **Request for Change in Overpayment Recovery Rate**. This form is below. It shows the Social Security office how much you can afford to pay each month. **What do I do if I agreed to a payment plan, but I can't pay anymore?** If something happens and you can't pay the same amount anymore, call the Social Security administration **right away** and ask to change the payment plan.

Helpful Tips

1. **Do *something.* If you do nothing, the Social Security Administration will start to take the money out of your benefits.**
2. File your appeal, waiver, or payment plan request **now**. This will stop the Social Security Administration from taking your entire check. But, if they deny your appeal or waiver, they will ask you to pay this money back.
3. Bring your papers to your Social Security office in person. **Keep a copy for yourself.** When you give them your papers, **ask for a receipt** in case SSA loses your papers.
4. **Take notes** any time you talk to the Social Security office. Write down what they tell you. That way, if they tell you things that are different or don't make sense, you know to ask more questions.

On the next pages, you'll find more details about each of the options above and the forms you will need.

Option 1: Appeal

When does it make sense to appeal?

You can appeal if you do not think you were overpaid. You can also appeal if you think the amount of overpayment is wrong.

How do I appeal?

You need to do two things to appeal:

1. **The "Request for Consideration" appeal form is included at the end of this packet.** Fill it out. Attach an extra page if you want more space to explain **why** you do not think you were overpaid or **why** you think the overpayment amount is wrong.
2. File the appeal with your local Social Security office. If you do not know the address of your Social Security office, call **1-800-772-1213** or go to secure.ssa.gov.

How do I file an appeal?

There are 3 ways that you can file an appeal:

1. You can file your appeal online at secure.ssa.gov/iApplNMD/start
2. You can file your appeal in person at your Social Security office.
3. Try to do the first two options. If you can't file online or go in person, you can mail the form to your Social Security office.

Every time you give any papers to the Social Security office, **keep a copy for yourself**. If you go to the office in person, ask for a receipt.

What happens after I file my appeal?

Social Security will mail you a decision.

Is there a deadline to appeal?

Yes. You must file your appeal within **60 days** of the date you receive the overpayment notice.
Social Security assumes you receive it five days after the date on the notice.

Option 2: Ask for a Waiver

When does it make sense to ask for a waiver?

Ask for a waiver if:

- The overpayment wasn't your fault, and
- You can't afford to pay it back

How do I ask for a waiver?

The waiver form is included at the end of this packet. Fill it out if the original overpayment amount was over $2,000.

The form is 10 pages long. Even though this form is long, it is important that you follow all of the instructions on the form.

What if the original overpayment amount was $2,000 or under?

You can make a verbal request for a waiver by going to your local office or calling 1-800-772-1213.

I filled out the waiver form. What do I do with it?

Take the letter to your Social Security office. If you can't go to the office in-person, you can mail the form to your local Social Security office. If you do not know the address of your Social Security office, call **1-800-772-1213** or go to secure.ssa.gov.

Every time you give any papers to the Social Security office, **keep a copy for yourself**. If you go to the office in person, ask for a receipt.

What happens after I file the waiver form?

Social Security may ask you to give proof of your income and expenses. Social Security also may ask you to go to a meeting. Once they make a decision, Social Security will mail the decision to you.

Is there a deadline to file the waiver?

No. There is no deadline. However, you should file a waiver form as soon as you can. If you wait too long, the Social Security Administration will start to take money out of your checks.

Option 3: Ask for a Payment Plan

What is a payment plan?

A payment plan will let you pay back an overpayment over time, instead of all at once. You can ask to make monthly payments at a rate that you can afford.

If I ask for a payment plan, how much will I need to pay each month?

You get to ask Social Security to pay an amount each month. Social Security has to agree to let you pay this amount.

The **smallest** amount you can pay is $10 per month. If you receive Qualified Medicare Beneficiary (QMB) or another Medicare Part D subsidy, Social Security will usually agree to let you pay $10 per month.

If you get SSI, Social Security **can't** take more than 10% of your Social Security check each month. For example, if you get $967.00 per month in SSI, Social Security **can't** take more than $96.70 per month.

When does it make sense to ask for a payment plan?

Ask for a payment plan if you can't afford to pay back the overpayment.

How do I ask for a payment plan?

Write a letter to the Social Security Administration asking for the payment plan. This packet includes a sample letter that you can use. Fill out the blanks at the top and bottom of the letter. In the middle, put a checkmark next to every line that is true for you.

Do I need to include any other papers with this letter?

You might need to fill out **Form 634**. This form asks about your income and monthly bills. The form is attached right after the letter. The chart below tells you whether you have to fill out **Form 634**.

If you can pay $10 each month	And you owe $600 or less	Do not fill out Form 634
	And you owe more than $600	Fill out Form 634
If you can pay $20 each month	And you owe $1,200 or less	Do not fill out Form 634
	And you owe more than $1,200	Fill out Form 634
If you can pay $30 each month	And you owe $1,800 or less	Do not fill out Form 634
	And you owe more than $1,800	Fill out Form 634
If you can pay $40 each month	And you owe $2,400 or less	Do not fill out Form 634
	And you owe more than $2,400	Fill out Form 634
If you can pay $50 each month	And you owe $3,000 or less	Do not fill out Form 634
	And you owe more than $3,000	Fill out Form 634

What do I do with the letter?

Take the letter to your Social Security office. If you can't go to the office in person, mail it to your Social Security office. If you do not know the address of your Social Security office, call **1-800-772-1213** or go to secure.ssa.gov. Any time you give papers to the Social Security office, **keep a copy**. If you go to the office in person, ask for a receipt.

What happens after I send in the letter?

Social Security will mail you a decision. If you get Social Security benefits, Social Security will take the agreed amount of money out of your check each month.

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:	CLAIMANT SSN:	CLAIM NUMBER: *(If different than SSN)*

ISSUE BEING APPEALED: *(Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)*
I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.
My reasons are:

CONTACT INFORMATION

CLAIMANT SIGNATURE - *OPTIONAL:*		NAME OF CLAIMANT'S REPRESENTATIVE: *(If any)*	
MAILING ADDRESS:		MAILING ADDRESS:	
CITY: STATE: ZIP CODE:		CITY: STATE: ZIP CODE:	
TELEPHONE NUMBER: *(Include area code)*	DATE:	TELEPHONE NUMBER: *(Include area code)*	DATE:

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for **SSI** or **SVB**. I have read about the three ways to appeal. I have checked the box below:

☐ **CASE REVIEW - You can pick this kind of appeal in all cases**. You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.

☐ **INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment.** You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.

☐ **FORMAL CONFERENCE - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment.** This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No 2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No *(If "NO", attach claimant's explanation for delay. Refer to GN 03101.020)*	**FIELD OFFICE DEVELOPMENT (GN 03102.300)** ☐ NO FURTHER DEVELOPMENT REQUIRED ☐ REQUIRED DEVELOPMENT ATTACHED ☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS
SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:	**SSI CASES ONLY - GOLDBERG KELLY (GK)** **(SI 02301.310)** RECIPIENT APPEALED AN ADVERSE ACTION: ☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE; ☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT ☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS (See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

Title II

1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefit;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf to a representative payee, unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if we determine that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled;
19. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a jail, prison, or other correctional institution for conviction of a criminal offense;
20. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a mental health institution or other medical facility because a court found the individual was not guilty for reason of insanity; a court found that he/she was incompetent to stand trial or was unable to stand trial for some other similar mental defect; or, a court found that he/she was sexually dangerous.

Title XVI

1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

Title VIII (See VB 02501.035)

1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II-items 3, 4, 10, 11 & 16.

Title XVIII

1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI).
4. Initial determinations regarding Medicare Part B income-related premium subsidy reductions.

HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFIT (SVB) DECISION

Now that you picked the kind of appeal that fits your case, fill out this form or we'll help you fill it out. You can have a lawyer, friend, or someone else help you with your appeal. There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (SSA-789) FOR YOUR APPEAL.

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205, 702(a)(5), 809, 1631, 1633, and 1869(b) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from re-evaluating the decision on your claim.

We will use the information to determine your eligibility for benefits and administer our programs. We may also share your information for the following purposes, called routine uses:

- To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his/her affairs or his/her eligibility for or entitlement to benefits under the Social Security program; and

- To the Center for Medicare & Medicaid Services (CMS), for the purpose of administering Medicare Part A, Part B, Medicare Advantage Part C, and Medicare Part D, including but not limited to: Medicare Part C enrollment and premium collection processes; Part D enrollment and premium collection processes; Medicare Part B premium reduction based on participation in a Part C plan; and Medicare Part B enrollment and income-related monthly adjustment amount determinations, appeals of determinations, and premium collections.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folder System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784 and 60-0321, entitled Medicare Database File, as published in the FR on July 25, 2006, at 71 FR 42159. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy/.

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 8 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** **You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Request for Waiver of Overpayment Recovery

When To Complete This Form

Complete this form if any of the following applies:

- You think that you are not at fault for the overpayment and you cannot afford to pay the money back.
- You think that you are not at fault and you think the overpayment is unfair for some other reason.

We will use your answers to decide if you have to pay the money back. If we decide you do not have to pay the money back, we call it a waiver.

When Not To Complete This Form

- You think that you are not at fault and your overpayment is $2,000 or less. Instead, please request a waiver by calling 1-800-772-1213 or your local field office. We may be able to process your request quickly over the phone.
- You think we made a mistake when we decided that you were overpaid, or if you disagree with the amount of your overpayment. Instead, please complete the **SSA-561**, Request for Reconsideration.
- You are requesting a hearing before an Administrative Law Judge. Instead, please complete the **HA-501-U5**, Request for Hearing by Administrative Law Judge.
- You **only** want to change the amount of money you must pay us back each month. Instead, please complete the **SSA-634**, Request for Change in Overpayment Recovery Rate.
- You have been convicted of fraud relating to this overpayment.

IMPORTANT: Please answer the following questions as completely as you can and submit any supporting documents with your waiver request. If you are assisting the person who is requesting a waiver, please answer the questions as if that person was completing the request. If you need more space for answers, use the "REMARKS" section on page 7.

SECTION 1 - IDENTIFYING QUESTIONS

1. A. What is the name, Social Security Number, and claim number (if any) of the overpaid person?

   Name: _____

   SSN: _____ Claim Number: _____

   B. If you are filling out the waiver request for the overpaid person, provide your name and relationship to the person.

   Name: _____

   Relationship: _____

SECTION 2 - WAIVER REQUEST

2. Is the total amount of the overpayment stated on your letter $2,000 or less? ☐ Yes ☐ No

If **Yes**, you do not need to complete the rest of this form. Please call 1-800-772-1213 or your local field office and we may be able to process your waiver request quickly over the phone.

If **No**, continue completing the rest of the form.

What is your reason for requesting a waiver? (Check all that apply)

A. ☐ The overpayment was not my fault.

B. ☐ I cannot afford to pay the money back.

C. ☐ The overpayment is unfair for other reasons.

Please explain: _____

_____

_____

_____

3. Please provide the date of the notice for the overpayment that you are asking us to waive:

_____ (MM/DD/YYYY)

4. Are you requesting that we waive the entire overpayment, including money that you have already paid back to us? ☐ Yes ☐ No

If **No**, are you requesting that we only waive the remaining amount of money that you owe us? ☐ Yes ☐ No

5. Tell us what you know about why the overpayment may have happened. If there was a reason you did not understand or were not able to report the change to us, please explain why.

Overpayments typically occur when a change happened in your life that we think we did not find out about on time. This happens for many reasons and understanding your opinion helps us decide your waiver request.

_____

_____

_____

SECTION 3 - NEEDS BASED ASSISTANCE

6. A dependent is a person who depends on you for support and whom you can claim on your tax return. Are you or any dependent household family member **currently** receiving any of the following?

☐ Yes ☐ No If **Yes**, (check all that apply) then go to page 9, sign, date, and provide your address and phone number. Please provide proof of TANF, VA pension, or SNAP.

- ☐ Supplemental Security Income (SSI) payments
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Pension based on need from the Department of Veterans Affairs (VA)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Medicare Part D Extra Help

If **No**, complete the rest of the form.

SECTION 4 - HOUSEHOLD FAMILY MEMBER

7. A. If you are an adult requesting a waiver, list your spouse and any other dependent household family members in this section. A dependent is a household family member who depends on you for support and whom you can claim on your income tax return. Complete Sections 5, 6 and 7 with your, your spouse's, and dependents' information.

If you are completing the waiver request for a minor child, does the child's income and assets help with food and household items? ☐ Yes ☐ No

- If **Yes**, list the minor child's parent(s) and other dependents' of the parents in this section. Complete Sections 5, 6 and 7 with the entire household's information.
- If **No**, only provide the child's information in Sections 5, 6 and 7.

Name	Age	Relationship To You

B. Does any household family member live with you whom you cannot claim as a dependent on your tax return? ☐ Yes ☐ No

Does this person pay any rent, household bills, or any other household expense?

☐ Yes, total monthly amount you receive $ _____ ☐ No

Documents to Support Your Statement:
To complete Sections 5, 6 and 7 of this form, you should refer to certain documents to support your statements. Please answer all the questions and submit any supporting documents for you, your spouse, and your dependents. Your supporting documents should be dated no more than 3 months from the date that you are requesting a waiver. Examples of supporting documents are:

- Current Rent or Mortgage Information
- 2 or 3 Recent Utility, Medical, Charge Card, and Insurance Bills
- Your Most Recent Income Tax Return
- Recent Bank Statements
- Current Pay Stubs
- Canceled Checks

SECTION 5 - RESOURCES - THINGS YOU HAVE AND OWN

8. A. How much cash do you, your spouse, and your dependents have in your possession? $

B. List all financial accounts for you, your spouse, and your dependents. Examples of accounts you should list include: Checking, Online (e.g., PayPal), Savings, Certificate of Deposit (CD), Individual Retirement Accounts (IRAs), Money or Mutual Funds, Stocks, Bonds, Trust Funds, Prepaid Debit Cards, or any other accounts.

Type of Account	Name and Address of Institution	Name on Account	Balance or Value	Income Per Month (interest or dividends)	Account Number
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
		TOTALS	$	$	

9. A. Do you, your spouse, or your dependents own more than two family vehicles, including a car, sport utility vehicle (SUV), truck, van, camper, motorcycle, boat, or any other vehicle.

☐ Yes (list all of the vehicles below) ☐ No (go to 9.B)

Owner	Year, Make/Model	Present Value	Loan Balance (if any)	Main Purpose for Use
		$	$	
		$	$	
		$	$	
	TOTALS $			

B. Do you co-own any real estate with anyone other than your spouse or dependent family member?

☐ Yes (list below) ☐ No (go to 9.C)

Owner	Description	Market Value	Loan Balance (if any)	Income Amount
		$	$	$
		$	$	$
		$	$	$
	TOTALS $			

C. Do you, your spouse, or your dependents own or have an interest in any business, property, or valuables?

☐ Yes (list below) ☐ No (go to 10)

Owner	Description	Market Value	Loan Balance (if any)	Income Amount
		$	$	$
		$	$	$
		$	$	$
	TOTALS $			

D. Can you sell or liquidate any of the resources listed above?

☐ Yes, explain ☐ No

SECTION 6 - MONTHLY HOUSEHOLD INCOME

Enter your, your spouse's, and your dependents' monthly take home pay. Enter the amount on line 11.A.
If you need more space for answers, use the "REMARKS" section on page 7.

10. A. Are you employed? ☐ Yes (provide information below) ☐ No (go to 10.B)

Employer(s) Name, Address, and Phone: (Write "self" if self-employed)	Monthly take home pay or earnings if self-employed:
	$

B. Is your spouse employed? ☐ Yes (provide information below) ☐ No (go to 10.C)

Employer(s) Name, Address, and Phone: (Write "self" if self-employed)	Monthly take home pay or earnings if self-employed:
	$

C. Are any of your dependents employed, including self-employment?
☐ Yes (provide information below) ☐ No (go to 11)

Name(s) of dependents:

Provide total monthly take home pay for dependent(s):
$ _____

11. Income (Be sure to show **monthly** amounts below)		**Overpaid person's income**	**Spouse of Overpaid Person**	**Dependent(s) of Overpaid Person (Total)**
A. Take Home Pay (Net) (from questions 10.A, 10.B, and 10.C)		$	$	$
B. Social Security Benefits (retirement, disability, widows, students, etc.)		$	$	$
C. Pension(s) (VA, Military, Civil Service, Railroad, etc.)	TYPE	$	$	$
	TYPE	$	$	$
D. Income from Real Estate, Business, etc. (from questions 9.B and 9.C)		$	$	$
E. Room and/or Board Payments from a Person who is not a Dependent (from question 7.B). Put the amount in the overpaid person's column.		$	$	$
F. Child Support/Alimony		$	$	$
G. Support or contributions from any person, agency, or organization		$	$	$
H. Income from Assets (from question 8.B)		$ 0	$	$
I. Other (from any source, explain in "REMARKS" on page 7)		$	$	$
TOTALS:		$	$	$
Grand Total $				

SECTION 7 - MONTHLY HOUSEHOLD EXPENSES

Do not list an expense that is withheld from your paycheck (such as medical insurance, child support, alimony, wage garnishments, etc.). **NOTE:** You do not need to provide supporting documents for your household expenses.

12.	Type of Expense	$ Per Month
	A. Rent or Mortgage (if mortgage payment includes property or other local taxes, insurance, etc., **DO NOT** list it again below)	$
	B. Property Tax (State and local) (if included in mortgage payment, do not list it again)	$
	C. Utilities (gas, electric, telephone (cell or land line), Internet, trash collection, water, sewer, oil, propane, coal, wood, etc.)	$
	D. Insurance (life, health, fire, homeowner, renter, car, and any other casualty or liability policies)	$
	E. Food (groceries, including food purchased with SNAP benefits, and food at restaurants, work, etc.)	$
	F. Household and Personal Care Items (clothing, cleaning items, toiletries, salon visits, pet supplies, etc.)	$
	G. Expenses for Family Vehicle (loan, lease, gas, and repairs)	$
	H. Other Transportation (bus, taxi, etc.)	$
	I. Medical/Dental (prescriptions and medical equipment, if not paid by insurance)	$
	J. Tuition and School Expenses	$
	K. Court Ordered Payments Paid Directly to the Court	$
	L. Credit Card Payments (show minimum monthly payment). **DO NOT** include any expenses already listed above	$
	TOTAL	$

If you are not paying your bills, explain which bills have unpaid balances in the "REMARKS" section below.

REMARKS SECTION

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

IMPORTANT: Please review, complete, and sign the statements on pages 8 and 9.

Below is an authorization for the Social Security Administration to obtain your financial account information. We may need to access your financial records in order to determine if we can waive your overpayment.

IMPORTANT: If the overpaid individual is a minor child, a parent or legal guardian must complete and sign the form on the child's behalf. If a court has assigned a legal guardian to an adult individual, the legal guardian must complete and sign the form. Adults who do not have a court appointed legal guardian must complete and sign the form, even if they have a representative payee.

AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN ACCOUNT RECORDS FROM A FINANCIAL INSTITUTION AND REQUEST FOR RECORDS

Please review the following, make selection, and sign below:

I understand:

- I have the right to revoke this authorization at any time before any records are disclosed;
- The Social Security Administration may request all records about me from any financial institution;
- Any information obtained will be kept confidential;
- I have the right to obtain a copy of the record which the financial institution keeps concerning the instances when it has disclosed records to a government authority unless the records were disclosed because of a court order;
- This authorization is not required as a condition of doing business with any financial institution.
- The Social Security Administration will request records to determine the ability to repay an overpayment in conjunction with a waiver determination;
- Failing to provide or revoking my authorization may result in the Social Security Administration determining, on that basis, that adjustment or recovery of the overpayment will not deprive me of funds to pay my bills for food, clothing, housing, medical care, or other necessary expenses;
- This authorization is in effect until the earliest of: 1) a final decision on whether adjustment or recovery of my overpayment would deprive me of funds to pay my bills for food, clothing, housing, medical care, or other necessary expenses; or 2) my revocation of this authorization in written notification to the Social Security Administration.

☐ I authorize any custodian of records at any financial institution to disclose to the Social Security Administration any records about my financial business or that of the person named above whom I legally represent or whose benefits I manage.

☐ I do not authorize any custodian of records at any financial institution to disclose to the Social Security Administration any records about my financial business or that of the person named above whom I legally represent or whose benefits I manage. I understand that if I do not give permission to obtain financial records or if I cancel my permission, SSA may not approve my waiver request.

Customer's Signature/Authorization	Mailing Address	Date
Legal Representative's Signature/Authorization	Legal Representative's Mailing Address	Date

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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF OVERPAID PERSON, REPRESENTATIVE PAYEE, LEGAL GUARDIAN, or CUSTODIAL PARENT

Signature (First name, middle initial, last name)	Date (MM/DD/YYYY)

Home Telephone Number (include area code)	Cell Phone Number

Mailing Address (Number and street, Apt. No., PO Box, or Rural Route)

City	State	ZIP Code

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.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, City, State, and ZIP Code)	Address (Number and street, City, State, and ZIP Code)

Privacy Act Statement
Collection and Use of Personal Information

Sections 204 and 1631 of the Social Security Act, as amended, allow us to collect your information or the information you are submitting on behalf of another, which we will use to make a waiver determination on an overpayment and to obtain authorization for financial account information. Providing this information is voluntary, but not providing all or part of the information may prevent us from assisting you with the request. As law permits, we may use and share the information you submit, including with other Federal agencies, employers, third party contacts, and others as outlined in the routine uses within System of Records Notices (SORN) 60-0094, 60-0103, and 60-0320, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs to establish or verify eligibility for Federal benefit programs and to recoup debts under these programs.

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 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate or other aspects of this collection to this address, not the completed form.***

Request for Change in Overpayment Recovery Rate

When To Complete This Form

Complete this form if you are requesting that we adjust the current rate of withholding to recover your overpayment because you are unable to meet your necessary living expenses. We will use your answers to decide if we can reduce the amount you must pay us back each month.

IMPORTANT: Please answer the following questions as completely as you can. If you are answering the questions for someone else, check the boxes and answer each question as it applies to the overpaid person.

SECTION 1 - IDENTIFYING QUESTIONS

1. A. What is the name, Social Security Number, and claim number (if any) of the overpaid person?

Name:

SSN: | Claim Number:

B. Are you the overpaid person? ☐ Yes (go to question 2) ☐ No (go to question 1.C)

C. If you are not the overpaid person, what is your relationship to the overpaid person? (Check all that apply)

- ☐ I am the overpaid person's parent.
- ☐ I am the overpaid person's representative payee.
- ☐ I am the overpaid person's spouse.
- ☐ I am the overpaid person's legal guardian.
- ☐ Other, please explain:

D. If you are not the overpaid person, what is your name or the name of the organization you represent?

Name:

2. Please check all that apply:

- ☐ I am receiving Supplemental Security Income (SSI) benefits.
- ☐ I am receiving Temporary Assistance for Needy Families (TANF)
- ☐ I am receiving a pension based on need from the Department of Veterans Affairs (VA)
- ☐ I am receiving Social Security benefits.
- ☐ I am not receiving benefits.

3. Enter the total amount you owe: $

4. Enter the amount you can afford to pay or have withheld from your payment each month: $

YOUR FINANCIAL STATEMENT

Documents to Support Your Statements

Please answer all questions and submit any supporting documents with your request. Your supporting documents should be no older than 3 months from the date you are requesting a change in the repayment rate.

Examples of supporting documents are:

- Current Rent or Mortgage Information
- 2 or 3 Recent Utility, Medical, Charge Card, and Insurance Bills
- Canceled Checks
- Recent Bank Statements (checking or savings account)
- Current Pay Stubs
- Your Most Recent Income Tax Return

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 6.

SECTION 2 - ASSETS - THINGS YOU HAVE AND OWN

5. A. How much cash do you have in your possession? $

B. List all of your financial accounts. Examples of accounts you should list include: Checking, Online (e.g., PayPal), Savings, Certificate of Deposit (CD), Individual Retirement Accounts (IRAs), Money or Mutual Funds, Stocks, Bonds, Trust Funds, Prepaid Debit Cards, or any other accounts.

Type of Account	Name and Address of Institution	Name on Account	Balance or Value	Income Per Month (interest or dividends)	Account Number
		TOTALS $			

6. A. Do you own more than one family vehicle, including a car, sport utility vehicle (SUV), truck, van, camper, motorcycle, boat, or any other vehicle?

☐ Yes (list all the vehicles below) ☐ No (go to 6.B)

Owner	Year/Make/Model	Present Value	Loan Balance (if any)	Main Purpose for Use
	TOTAL COUNTABLE VALUE $			

(Options continue on next page)

6. B. Do you own any real estate other than where you live? ☐ Yes (list below) ☐ No (go to 6.C)

Owner	Description	Market Value	Loan Balance (if any)	Income Amount
	TOTALS $			

C. Do you own or have an interest in any business, property, or valuables?

☐ Yes (list below) ☐ No (go to 7)

Owner	Description	Market Value	Loan Balance (if any)	Income Amount
	TOTALS $			

SECTION 3 - MONTHLY HOUSEHOLD INCOME

The next question asks about monthly take home pay. Enter your take home pay, and check the box to show whether you are paid weekly, every 2 weeks, twice a month, or monthly. Add the monthly amount on line 9.A.

7. Are you employed? ☐ Yes (provide information below) ☐ No

Employer Name, Address, and Phone: (Write "self" if self-employed)	Take home pay or earnings if self-employed (Net) Choose one: ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly	$

8. A. Do you receive support or contributions from any person or organization?
☐ Yes (go to question 8.B) ☐ No (go to question 9)

B. Is the support received under a loan agreement?
☐ Yes (go to question 9) ☐ No (go to question 8.C)

C. How much money do you receive each month? (Show this amount on line I of question 9)

$	**Source**

9.

Income (Be sure to show **monthly** amounts below)	Your Income	SSA USE ONLY
A. Take Home Pay (Net) (from question 7)		
B. Social Security Benefits (retirement, disability, widows, students, etc.)		
C. Supplemental Security Income (SSI)		

(Options continue on next page)

9.				
	D. Pension(s) (VA, Military, Civil Service, Railroad, etc.)	TYPE		
		TYPE		
	E. Supplemental Nutrition Assistance Program (SNAP) Benefits			
	F. Income from Real Estate, Business, etc. (from question 6.B and 6.C)			
	G. Room and/or Board Payments from a person who is not a Dependent. Explain in Remarks below.			
	H. Child Support/Alimony			
	I. Other Support (from question 8.C)			
	J. Income from Assets (from question 5.B)			
	K. Other (from any source, explain in REMARKS below)			
	TOTAL:			
	REMARKS:			

SECTION 4 - MONTHLY HOUSEHOLD EXPENSES

DO NOT list an expense that is withheld from your paycheck (such as medical insurance, child support, alimony, wage garnishments, etc.). (Be sure to show **monthly** average amounts in number 10).
Please write only whole dollar amount and round any cents to the nearest dollar.

10.	**Type of Expense**	**$ 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, including food purchased with SNAP benefits, and food at restaurants, work, etc.)		
	C. Utilities (Gas, electric, telephone (cell or land line), Internet, trash collection, water, and sewer)		
	D. Other Heating/Cooking Fuel (oil, propane, coal, wood, etc.)		
	E. Clothing		
	F. Household Items (personal hygiene items, etc.)		
	G. Property Tax (State and local)		
	H. Insurance (life, health, fire, homeowner, renter, car, and any other casualty or liability policies)		

(Options continue on next page)

10.			
	I. Medical/Dental (prescriptions and medical equipment, if not paid by insurance)		
	J. Vehicle Loan/Lease Payment		
	K. Vehicle Expenses (gas and repairs)		
	L. Other Transportation (bus, taxi, etc., used for medical appointments, work, or other necessary travel)		
	M. Tuition and School Expenses		
	N. Court Ordered Payments Paid Directly to the Court		
	O. Credit Card Payments (show minimum monthly payment). **DO NOT** include any expenses already listed above		
	P. Any expense not shown above		
	TOTAL		

EXPENSE REMARKS: (Please provide any additional information not included above. Also, explain any unusual or very large expenses such as medical, college, etc.)

SECTION 5 - INCOME AND EXPENSES COMPARISON

11.		
	A. Your Monthly Income Write the amount here from "**Total**" of question 9.	$
	B. Your Monthly Expenses Write the amount here from "**Total**" of question 10.	$
	C. Total Subtract B from A.	$

12. If your expenses in 11.B are more than your income in 11.A, explain how you are paying your bills. If you are not paying your bills, explain which bills have unpaid balances.

SECTION 6 - FINANCIAL EXPECTATION AND FUNDS AVAILABILITY

13. A. Do you expect to receive an inheritance within the next 6 months?

☐ Yes (Explain on line below) ☐ No (go to 13.B)

B. Is there any reason you **cannot** convert or sell the "Balance or Value" of any financial assets shown in items 5.B, 6.A, 6.B, or 6.C to cash?

☐ Yes (Explain on line below) ☐ No

C. Please provide the total of your assets from questions, 5.A, 5.B, 6.A, 6.B, and 6.C

Total $: _____

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

Privacy Act Statement
Collection and Use of Personal Information

Sections 204 and 1631 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from negotiating a repayment agreement and an accurate and timely determination on your request for a change in your overpayment recovery rate.

We will use the information you provide to determine if we can approve your request for a change in your overpayment recovery rate. We may also share the information for the following purposes, called routine uses:

- To student volunteers and other workers, who technically do not have the status of Federal employees, when they are performing work for SSA as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned Agency functions; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting us in the efficient administration of its programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement to obtain assistance in accomplishing an SSA function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0094, entitled Recovery of Overpayments, Accounting and Reporting/Debt Management System (ROAR/DMS), as published in the Federal Register (FR) on August 23, 2005, at 70 FR 49354; 60-0231, entitled Social Security Online Accounting and Reporting System, as published in the FR on January 14, 2020 at 85 FR 2224; and 60-0320, entitled Electronic Disability (eDIB) Claim File, as published in the FR on June 4, 2020, at 85 FR 34477. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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 45 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate or other aspects of this collection to this address, not the completed form.***

Name: _____

SSN: _____

Date: _____

Phone Number:_____

Address:_____

Request for $10 Payment Plan of Overpayment

Dear Social Security Claims Representative:

I get Social Security/SSI benefits. You told me that I have an overpayment on my record. I am asking for a payment plan. Please do not take more than $10 per month, because:

_____ I receive Qualified Medicare Beneficiary (QMB) or another Medicare Part D subsidy.[1]

_____ I owe $600 or less and I can't afford to pay more than $10 per month for the overpayment.[2]

_____ I can't afford to pay more than $10 per month for the overpayment.[3] I filled out Form 634 "Request for Change in Overpayment Recovery Rate." I attached that form to this letter.

Thank you for your help.

Sincerely,

_____
Name

[1] *See* POMS GN 02210.030(C).
[2] See POMS GN 02210.030(B).
[3] See POMS GN 02210.030(C).