SOCIAL SECURITY ADMINISTRATION BENEFITS VERIFICATION
MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

Client Name: _____ District Office: _____

Case Number: _____ Worker: _____

Date: _____ Telephone Number: _____

We received your Medical Report Form (Form 402B). Because your doctor indicated a 12-month disability, there is a possibility that you may be eligible for Social Security Disability, Supplemental Security Income and/or Medicare. Before we can determine if you are eligible to receive or continue to receive _____ Assistance, it will be necessary for you to apply for _____Social Security, _____ SSI benefits, _____ Medicare or to verify your current claim status, if you have already applied.

You are required to do the following:

_____ Take this letter immediately to the Social Security Office at:

_____ 315 N. Washington St.
Rockville, MD 20850
301-413-0400

_____ Wheaton Plaza Shopping Center
11160 Viers Mill Road
Wheaton, MD 20902
301-427-2637

_____ Call the following telephone number for an appointment 1-800-772-1213 for Social Security benefits.
_____ Sign the enclosed Interim Reimbursement Form 340 (per COMAR 07.06.05.06).
_____ Sign the enclosed Authorization to Represent Form, SSA 1696.
_____ Return this form with the bottom portion completed by a Social Security Representative.

Please return all of the above requested information in the enclosed postage paid envelope no later than _____. If we have not received the requested verification by that date we will assume that you are no longer in need of assistance and will close or deny your case.

(To Be Completed by the S.S.A. Representative)

_____ We have taken an application for social security benefits.
_____ We have taken an application for Medicare _____Part A, _____Part B.
_____ We have taken an application for Supplemental Security Income.
_____ It will take approximately _____ weeks/months to process this claim.
_____ This person is receiving _____ benefits in the amount of $_____.
_____ The beginning date of the above amount was $_____.
_____ This person is not entitled to benefits because she/he:
- _____ Is not 65, disabled or blind.
- _____ Has too much income from _____(specify source)
- _____ Has too many resources/assets _____ (specify)
- _____ Other _____

Signature: _____ Telephone No.:_____ Date: _____

MCDSS 269 Rev. 05/03