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. _____ Wheaton Plaza Shopping Center
Rockville, MD 20850 11160 Viers Mill Road
301-413-0400 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: _______

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