

Social Security Overpayments

What is a Social Security overpayment?

An overpayment happens when the Social Security Administration (SSA) thinks it has paid you more than it should have. There are many reasons why this might happen, including: you received money it thinks was not reported or it believes you are not disabled anymore (and have not been for a while) so were not entitled to benefits for certain months/years.

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

Do not ignore it. **If you do nothing, SSA will begin to collect the overpayment out of your benefits.** You have 3 choices:

<p>(1) APPEAL</p>	<ul style="list-style-type: none"> • If you do not think you were overpaid or think the overpayment amount is wrong, you can file an appeal, or a “Request for Reconsideration.” The appeal form is attached. • Say why you do not think you were overpaid or why you think the total overpayment amount is wrong. • THE DEADLINE FOR FILING AN APPEAL IS 60 DAYS FROM THE DATE ON THE OVERPAYMENT NOTICE. If you miss the deadline, you will not be able to appeal the overpayment in the future.
<p>(2) WAIVER</p>	<ul style="list-style-type: none"> • If you think that the overpayment wasn’t your fault and can’t afford to pay it back, you can ask SSA to forgive the overpayment with a “Request for Waiver.” The Waiver form is attached. • To get a waiver, you must show that (1) the overpayment was not your fault AND (2) you cannot afford to pay it back. • You can request a Waiver at any time, even if money is being collected.
<p>(3) PAYMENT PLAN</p>	<ul style="list-style-type: none"> • Ask for a reasonable payment plan. A sample request is attached. • Go to your local SSA Office and offer a monthly amount you are sure you can afford. Sometimes, people who have lower incomes can get into payment plans that are \$10/month. • Fill out an Income and Expense Statement to show that the amount you offer is the most you can afford to pay each month. • If your situation changes and you can no longer afford the agreed upon payment plan, contact SSA immediately to change the plan.

Helpful Tips	<ul style="list-style-type: none">• File your appeal, waiver, or payment plan request <u>immediately</u> to stop SSA from taking your entire check. However, if your appeal or waiver request is denied, SSA will ask you to pay this money back.• File any papers with your SSA Office in-person. Also, keep a copy of them for yourself and ask for a receipt in case SSA loses your papers.• Keep a record of any contact you have with SSA, and what SSA tells you. That way, if an SSA person gives you information that conflicts with information another SSA person gave you, you know to ask more questions.
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Although Legal Aid has been happy to provide you with this information, we are not agreeing to represent you at this time and we are not your lawyers. You are responsible for meeting all your deadlines in this matter.

APPEAL

Request for Reconsideration - Form SSA-561

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:	CLAIMANT SSN:	CLAIM NUMBER: <i>(If different than SSN)</i>
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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:

**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.

CONTACT INFORMATION

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

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. IS THIS REQUEST FILED TIMELY? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "NO", attach claimant's explanation for delay. Refer to GN 03102.125)</i>	FIELD OFFICE DEVELOPMENT (GN 03102.300) <input type="checkbox"/> NO FURTHER DEVELOPMENT REQUIRED <input type="checkbox"/> REQUIRED DEVELOPMENT ATTACHED <input type="checkbox"/> 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: <input type="checkbox"/> WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE; <input type="checkbox"/> AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT <input type="checkbox"/> 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.

WAIVER

Request for Waiver of Overpayment - Form SSA-632

Request For Waiver Of Overpayment Recovery Or Change In Repayment Rate

<p>We will use your answers on this form to decide if we can waive collection of the overpayment or change the amount you must pay us back each month. If we can't waive collection, we may use this form to decide how you should repay the money.</p> <p>Please answer the questions on this form as completely as you can. We will help you fill out the form if you want. If you are filling out this form for someone else, answer the questions as they apply to that person.</p>	<p>FOR SSA USE ONLY</p> <hr/> <p>ROAR Input <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>Input Date</p> <hr/> <p>Waiver <input type="checkbox"/> Approval <input type="checkbox"/> Denial</p> <hr/> <p>SSI <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>AMT OF OP \$</p> <hr/> <p>PERIOD (DATES) OF OP</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; height: 20px;"></td> <td style="width: 50%; height: 20px;"></td> </tr> <tr> <td style="width: 50%; height: 20px;"></td> <td style="width: 50%; height: 20px;"></td> </tr> </table>				

1. A. Name of person on whose record the overpayment occurred: _____

B. Social Security Number: _____

C. Name of overpaid person(s) making this request and his or her Social Security Number(s):

2. Check any of the following that apply. (Also, fill in the dollar amount in B, C, or D.)

A. The overpayment was not my fault and I cannot afford to pay the money back and/or it is unfair for some other reasons.

B. I cannot afford to use all of my monthly benefit to pay back the overpayment. However I can afford to have \$ _____ withheld each month.

C. I am no longer receiving Supplement Security Income (SSI) payments. I want to pay back \$ _____ each month instead of paying all of the money at once.

D. I am receiving SSI payments. I want to pay back \$ _____ each month instead of paying 10% of my total income.

SECTION I - INFORMATION ABOUT RECEIVING THE OVERPAYMENT

3. A. Did you, as representative payee, receive the overpaid benefits to use for the beneficiary?

Yes No (Skip to Question 4)

B. Name and address of the beneficiary

C. How were the overpaid benefits used?

4. If we are asking you to repay someone else's overpayment:

A. Was the overpaid person living with you when he/she was overpaid? Yes No

B. Did you receive any of the overpaid money? Yes No

C. Explain what you know about the overpayment AND why it was not your fault.

5. Why did you think you were due the overpaid money and why do you think you were not at fault in causing the overpayment or accepting the money?

6. A. Did you tell us about the change or event that made you overpaid? If no, why didn't you tell us? Yes No

B. If yes, how, when and where did you tell us? If you told us by phone or in person, who did you talk with and what was said?

C. If you did not hear from us after your report, and/or your benefits did not change, did you contact us again? Yes No

7. A. Have we ever overpaid you before? Yes No

If yes, on what Social Security number? _____

B. Why were you overpaid before? If the reason is similar to why you are overpaid now, explain what you did to try to prevent the present overpayment.

SECTION II - YOUR FINANCIAL STATEMENT

NAME: _____

SSN: _____

You need to complete this section if you are asking us either to waive the collection of the overpayment or to change the rate at which we asked you to repay it. Please answer all questions as fully and as carefully as possible. We may ask to see some documents to support your statements, so you should have them with you when you visit our office.

EXAMPLES ARE:

- Current Rent or Mortgage Books
- Savings Passbooks
- Pay Stubs
- Your most recent Tax Return
- 2 or 3 recent utility, medical, charge card, and insurance bills
- Cancelled checks
- Similar documents for your spouse or dependent family members

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 7.

- 8.** A. Do you now have any of the overpaid checks or money in your possession (or in a savings or other type of account)? Yes Amount: _____
 No Return this amount to SSA
- B. Did you have any of the overpaid checks or money in your possession (or in a savings or other type of account) at the time you received the overpayment notice? Yes Amount: _____
 No Answer Question 9.

9. Explain why you believe you should not have to return this amount.

ANSWER 10 AND 11 ONLY IF THE OVERPAYMENT IS SUPPLEMENTAL SECURITY INCOME (SSI) PAYMENTS. IF NOT, SKIP TO 12.

- 10.** A. Did you lend or give away any property or cash after notification of the overpayment? Yes (Answer Part B)
 No (Go to question 11.)
- B. Who received it, relationship (if any), description and value:

- 11.** A. Did you receive or sell any property or receive any cash (other than earnings) after notification of this overpayment? Yes (Answer Part B)
 No (Go to question 12.)
- B. Describe property and sale price or amount of cash received:

- 12.** A. Are you now receiving cash public assistance such as Supplemental Security Income (SSI) payments? Yes (Answer B and C and See note below)
 No
- B. Name or kind of public assistance C. Claim Number



IMPORTANT: If you answered "YES" to question 12, DO NOT answer any more questions on this form. Go to page 8, sign and date the form, and give your address and phone number(s). Bring or mail any papers that show you receive public assistance to your local Social Security office as soon as possible.

Members Of Household

13. List any person (child, parent, friend, etc.) who depends on you for support AND who lives with you.

NAME	AGE	RELATIONSHIP (If none, explain why the person is dependent on you)

Assets - Things You Have And Own

14. A. How much money do you and any person(s) listed in question 13 above have as cash on hand, in a checking account, or otherwise readily available? \$ _____

- B. Does your name, or that of any other member of your household appear, either alone or with any other person, on any of the following?

TYPE OF ASSET	OWNER	BALANCE OR VALUE	PER MONTH	SHOW THE INCOME (interest, dividends) EARNED EACH MONTH. (If none, explain in spaces below. If paid quarterly, divide by 3).
SAVINGS (Bank, Savings and Loan, Credit Union)		\$	\$	
CERTIFICATES OF DEPOSIT (CD)		\$	\$	
INDIVIDUAL RETIREMENT ACCOUNT (IRA)		\$	\$	
MONEY OR MUTUAL FUNDS		\$	\$	
BONDS, STOCKS		\$	\$	
TRUST FUND		\$	\$	
CHECKING ACCOUNT		\$	\$	
OTHER (EXPLAIN)		\$	\$	
TOTALS		\$	\$	Enter the "Per Month" total on line (k) of question 18.

15. A. If you or a member of your household own a car, (other than the family vehicle), van, truck, camper, motorcycle, or any other vehicle or a boat, list below.

OWNER	YEAR/MAKE/MODEL	PRESENT VALUE	LOAN BALANCE (if any)	MAIN PURPOSE FOR USE
		\$	\$	
		\$	\$	
		\$	\$	

- B. If you or a member of your household own any real estate (buildings or land), OTHER than where you live, or own or have an interest in, any business, property, or valuables, describe below.

OWNER	DESCRIPTION	MARKET VALUE	LOAN BALANCE (if any)	USAGE-INCOME (rent etc.)
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

Monthly Household Income

If paid weekly, multiply by 4.33 (4 1/3) to figure monthly pay. If paid every 2 weeks, multiply by 2.166 (2 1/6). If self-employed, enter 1/12 of net earnings. Enter monthly TAKE HOME amounts on line A of question 18 also.

16. A. Are you employed? YES (Provide information below) NO (Skip to B)

Employer name, address, and phone: (Write "self" if self-employed)	Monthly pay before deduction (Gross) \$ _____
	Monthly TAKE-HOME pay (NET) \$ _____

B. Is your spouse employed? YES (Provide information below) NO (Skip to C)

Employer(s) name, address, and phone: (Write "self" if self-employed)	Monthly pay before deduction (Gross) \$ _____
	Monthly TAKE-HOME pay (NET) \$ _____

C. Is any other person listed in YES NO (Go to Question 17)
 Question 13 employed? YES NO (Go to Question 17) Name(s) _____

Employer(s) name, address, and phone: (Write "self" if self-employed)	Monthly pay before deduction (Gross) \$ _____
	Monthly TAKE-HOME pay (NET) \$ _____

17. A. Do you, your spouse or any dependent member of your household receive support or contributions from any person or organization? YES (Answer B) NO (Go to question 18)

B. How much money is received each month? \$ _____ SOURCE _____
 (Show this amount on line (J) of question 18)

BE SURE TO SHOW **MONTHLY** AMOUNTS BELOW - If received weekly or every 2 weeks, read the instruction at the top of this page.

18. INCOME FROM #16 AND #17 ABOVE AND OTHER INCOME TO YOUR HOUSEHOLD	YOURS	✓	SPOUSE'S	✓	OTHER HOUSEHOLD MEMBERS	✓	SSA USE ONLY
A. TAKE HOME Pay (Net) (From #16 A, B, C, above)	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	
B. Social Security Benefits		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
C. Supplemental Security Income (SSI)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
D. Pension(s) (VA, Military, Civil Service, Railroad, etc.)	TYPE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
	TYPE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
E. Public Assistance (Other than SSI)	TYPE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
F. Food Stamps (Show full face value of stamps received)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
G. Income from real estate (rent, etc.) (From question 15B)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
H. Room and/or Board Payments (Explain in remarks below)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
I. Child Support/Alimony		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
J. Other Support (From #17 (B) above)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
K. Income From Assets (From question 14)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
L. Other (From any source, explain below)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
REMARKS	TOTALS \$ _____		\$ _____		\$ _____		

GRAND TOTAL \$
 (Add 3 total blocks above)

Monthly Household Expenses

If the expense is paid weekly or every 2 weeks, read the instruction at the top of Page 5. Do NOT list an expense that is withheld from income (Such as Medical Insurance). Only take home pay is used to figure income.

Show "CC" as the expense amount if the expense (such as clothing) is part of CREDIT CARD EXPENSE SHOWN ON LINE (F).

	\$ PER MONTH	SSA USE ONLY
19. A. Rent or Mortgage (If mortgage payment includes property or other local taxes, insurance, etc. DO NOT list again below.)		
B. Food (Groceries (include the value of food stamps) and food at restaurants, work, etc.)		
C. Utilities (Gas, electric, telephone)		
D. Other Heating/Cooking Fuel (Oil, propane, coal, wood, etc.)		
E. Clothing		
F. Credit Card Payments (show minimum monthly payment allowed)		
G. Property Tax (State and local)		
H. Other taxes or fees related to your home (trash collection, water-sewer fees)		
I. Insurance (Life, health, fire, homeowner, renter, car, and any other casualty or liability policies)		
J. Medical-Dental (After amount, if any, paid by insurance)		
K. Car operation and maintenance (Show any car loan payment in (N) below)		
L. Other transportation		
M. Church-charity cash donations		
N. Loan, credit, lay-away payments (If payment amount is optional, show minimum)		
O. Support to someone NOT in household (Show name, age, relationship (if any) and address)		
P. Any expense not shown above (Specify)		
EXPENSE REMARKS (Also explain any unusual or very large expenses, such as medical, college, etc.)	TOTAL \$	

Income And Expenses Comparison

20. A. Monthly income (Write the amount here from the "Grand Total" of #18.) \$ _____
- B. Monthly Expenses (Write the amount here from the "Total" of #19.) \$ _____
- C. Adjusted Household Expenses _____
- D. Adjusted Monthly Expenses (Add (B) and (C)) \$ _____

21. If your expenses (D) are more than your income (A), explain how you are paying your bills.	FOR SSA USE ONLY	
	<input type="checkbox"/>	INC. EXCEEDS ADJ EXPENSE
		\$ +
	<input type="checkbox"/>	INC LESS THAN ADJ EXPENSE
		\$ -

Financial Expectation And Funds Availability

22. A. Do you, your spouse or any dependent member of your household expect your or their financial situation to change (for the better or worse) in the next 6 months? (For example: a tax refund, pay raise or full repayment of a current bill for the better-major house repairs for the worse). YES (Explain on line below)
 NO

- B. If there is an amount of cash on hand or in checking accounts shown in item 14A, is it being held for a special purpose? NO (Amount on hand)
 NO (Money available for any use)
 YES (Explain on line below)

- C. Is there any reason you CANNOT convert to cash the "Balance or Value" of any financial asset shown in item 14B. YES (Explain on line below)
 NO

- D. Is there any reason you CANNOT SELL or otherwise convert to cash any of the assets shown in items 15A and B? YES (Explain on line below)
 NO

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

REMARKS SPACE (Continued)

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 or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF OVERPAID PERSON OR REPRESENTATIVE PAYEE

SIGNATURE (First name, middle initial, last name) (Write in ink)

**SIGN
HERE**

DATE (Month, Day, Year)

WORK TELEPHONE NUMBER IF WE MAY CALL YOU AT WORK (Include area code)

HOME TELEPHONE NUMBER (Include area code)

MAILING ADDRESS (Number and street, Apt. No., P.O. Box, or Rural Route)

CITY AND STATE

ZIP CODE

ENTER NAME OF COUNTY (IF ANY) IN WHICH YOU NOW LIVE

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.

SIGNATURE OF WITNESS

SIGNATURE OF WITNESS

ADDRESS (Number and street, City, State, and ZIP Code)

ADDRESS (Number and street, City, State, and ZIP Code)

PAYMENT PLAN

Sample Request for Negotiating Repayment

NAME: _____

SSN: _____

DATE: _____

TEL: _____

REQUEST FOR \$10 WITHHOLDING OF OVERPAYMENT

Dear SSA Claims Representative:

I currently receive Social Security/SSI benefits. I understand that I have an overpayment on my record. Please limit withholding to \$10 per month, because I meet one or more of the following criteria:

_____ I receive QMB or another Medicare Part D subsidy.¹

_____ I receive other cash public assistance, such as TANF.²

_____ Paying back the overpayment at a rate of more than \$10 per month would be a great hardship to me.³

_____ The amount I owe is \$360 or less and paying back the overpayment at a rate of more than \$10 per month would be a great hardship to me.⁴

Thank you for your attention to this matter.

Sincerely,

Name

¹ See POMS GN 02210.030(B)(6).

² See POMS GN 02210.030(B)(5).

³ See POMS GN 02210.045.

⁴ See POMS GN 02210.030(B)(3).