

METRO PAYEE SERVICES, INC.
P O Box 270190
St Paul, MN 55127

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CONTINUING DISABILITY UPDATE REPORT

Periodically, Social Security conducts Disability Update Reviews to confirm your continuing disability eligibility. Some of the information they require can only be provided by the client. Please complete the following information and return this form to our office. If at any time during a review, we are unable to satisfactorily answer their questions, they will place a hold on your benefits until the information is provided. Therefore, in an effort to help avoid any potential benefit delays, we are now gathering information for your file.

This information is considered private and will not be shared with any other sources.

<u>Y/N</u>	<u>Resource</u>	<u>Resource Value</u>	<u>Additional Info</u>
___	Stocks/Bonds	Value: _____	_____
___	Certificates of Deposit	Value: _____	_____
___	Mutual Funds	Value: _____	_____
___	Burial Funds/Policy	Value: _____	_____
___	Annuity/IRA	Value: _____	_____
___	Savings Account	Balance: _____	Bank Name: _____
___	Checking Account	Balance: _____	Bank Name: _____
___	Cash on hand	Balance: _____	_____
___	Property/Real Estate	Value: _____	Location: _____
___	Cars/Vehicles	Make/Model/Year/Value: _____	_____
___	Rental Properties	Value: _____	Income: _____
___	Married: _____	Single: _____	Widowed: _____
___	Not married, but living as a mutually declared married couple <i>(SSI recipients only)</i>		
___	Been out of the state or country for more than one calendar month		
___	Been in a hospital/treatment facility/correctional facility <small>(for more than one calendar month since 2012)</small>		
___	Income from any other source <small>(other than county)</small>	Value/Source: _____	Date: _____
___	MSA	Value: _____	EBT: _____
___	Food Stamps	Value: _____	EBT: _____
___	MFIP (child/ren's name)	Value: _____	EBT: _____
___	Energy Assistance	Value: _____	Vendor: _____
___	Telephone Assistance	Value: _____	Vendor: _____

List any dependent children/dates of birth living with you: (Please use the back of this form for this information)

CLIENT'S NAME: _____ DOB: _____

SS#: _____ PHONE: _____

ADDRESS: _____

CITY: _____ MN ZIP: _____ COUNTY: _____

CASE MANAGER: _____ AFFILIATE: _____ PHONE: _____

COUNTY FINANCIAL WORKER: _____ PHONE: _____

WORKING: ___Y___N - Mthly Gross Wages: _____ Hourly wage: _____ AVG WKLY HOURS: _____

EMPLOYER: _____ PHONE: _____

ADDRESS: _____ CITY/ZIP: _____

YOUR BIRTHPLACE (City/St): _____ MOTHER'S MAIDEN NAME: _____

Additional information: _____

SIGNATURE: _____ DATE: _____

Thank you for your cooperation in completing this form. Please advise immediately, if any information changes.