Consent for Release of Information
by the Social Security Administration

INSTRUCTIONS

Supplemental Security Income (SSI) benefit recipient:
Please complete Sections 1, 2, and 4 and MAIL
THIS FORM TO THE "OFFICE LOCATION" YOU LIST IN SECTION 1.

SECTION 1: List the complete office location (address) below that assisted you with your Supplemental Security Income (SSI) benefits. To locate the address, visit www.ssa.gov and click on "Find a Social Security Office" from the left menu, and type in the zip code. Write that address below.

Office location:
Street address: _____

City, state, and zip: _____

SECTION 2:
Name of SSI benefit recipient (please print): _____

_____ _____
Date of Birth Social Security Number

***Month and year you were hired:** _____
This is the month and year you were hired with the employer for whom you completed forms for the Work Opportunity Tax Credit (WOTC) Program.

SECTION 3:
I authorize the Social Security Administration to release information and supply, using this document, the specific information requested in the table below to the agency/representative listed as:

State WOTC Coordinator – Job Service North Dakota Workforce Programs - PO Box 5507 - Bismarck ND 58506-5507

for the purpose of establishing eligibility for the Work Opportunity Tax Credit (WOTC) Program.

THIS TABLE IS TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION.			
Supplemental Security Income (SSI) Benefits	**Were SSI benefits received by the recipient listed in Section 2 during the following months:**		
	The *hire month as listed in Section 2:	**The month prior to the *hire month:**	**The month that is 2 months prior to the *hire month:**
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 4: SSI BENEFIT RECIPIENT: PLEASE SIGN BELOW AND MAIL THIS FORM TO THE OFFICE YOU LISTED IN SECTION 1.

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

I understand this Consent for Release of Information form is valid for one year from the date I indicate below. If no date is indicated, it will be valid for one year upon receipt by the Social Security Administration.

_____ _____
Signature Date

If the person signing the form is not the individual whose record will be released, list your relationship: _____