

Request For Waiver Of Overpayment Recovery Or Change In Repayment Rate

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.

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.

FOR SSA USE ONLY	
ROAR Input	<input type="checkbox"/> Yes <input type="checkbox"/> No
Input Date	
Waiver	<input type="checkbox"/> Approval <input type="checkbox"/> Denial
SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No
AMT OF OP \$	
PERIOD (DATES) OF OP	

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/her Social Security Number(s):

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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.