



**SUNY BROCKPORT**  
Office of Financial Aid

**SOCIAL SECURITY VERIFICATION FORM**

**INSTRUCTIONS:** The Financial Aid Office at SUNY Brockport must verify the amount of Social Security benefits received by you and/or all members of your household in the calendar year noted below. Please sign the release form and list all person(s) residing in the household along with their Social Security numbers. Mail or take this form to a Social Security Office for completion. You may attach copies of all 1099 Forms for the year in question rather than have this form completed by the Social Security Office. Return the form to the Financial Aid Office when completed.

**RELEASE AUTHORIZATION:** I authorize the Social Security Administration to disclose the amount of Social Security benefits paid in the calendar year noted below for myself and/or all members of my household. I also authorize SUNY Brockport to update my records according to the information provided by the Social Security Administration or myself.

Student Name (Print): \_\_\_\_\_  
Student Signature: \_\_\_\_\_ SSN: \_\_\_\_\_  
Spouse Signature (if applicable): \_\_\_\_\_ SSN: \_\_\_\_\_  
Mother (stepmother) Signature: \_\_\_\_\_ SSN: \_\_\_\_\_  
Father (stepfather) Signature: \_\_\_\_\_ SSN: \_\_\_\_\_

**Notice to Social Security Office:**

**NOTICE TO FIELD OFFICES:** You are permitted by the privacy act (5 USC 552a (d) (h)) to provide a statement of the total benefits paid last year to (1) the student, (2) anyone receiving benefits on the student's own Social Security number, (3) the student's minor children or individuals for whom he/she is the legal guardian and (4) any other individual who has consented in writing to the disclosure. Presentation of this document constitutes a written, formal request.

**Total Amount Received in Calendar Year 2007**

<u>Name</u>	<u>Total Benefit Received</u>	<u>Checks Payable To</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Authorized Social Security Official \_\_\_\_\_ Address of District Office \_\_\_\_\_

Title of Authorized Social Security Official \_\_\_\_\_ Telephone Number \_\_\_\_\_ Date \_\_\_\_\_

V04 (1/08/08)