STATEMENT OF CLAIMANT OR OTHER PERSON

Name of Wage Earner, Self-employed Person, or SSI Claimant	Social Security Number
Name of Person Making Statement *(If other than above wage earner, self-employed person, or SSI claimant)*	Relationship to Wage Earner, Self-Employed Person, or SSI Claimant

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

I have out-of-pocket expenses per month for which I am not reimbursed and which I do not (will not) claim as a deduction on my income tax return (if self-employed). I would like to request these expenses as an IRWE. I understand it is my responsibility to supply required proof (e.g. receipts, bank statements) of these out-of-pocket expenses. (A printout from your pharmacist documenting the out of pocket expenses is the preferred proof.) I further understand that any IRWE I allege must directly relate to my disability and enable me to work.

I routinely (e.g. daily) take medications to help my disability(ies)(please write in your SSA established disability(ies))which enable me to work. Following is a list of these routine medications and the average monthly out-of-pocket expense for each medication. Also included with this form is proof of the out-of-pocket expense for this medication(s). (Please list the names of the medications which you routinely take and the condition which each medication is meant to manage and enable you to work):

Medication	Disability	Cost Monthly out-of-pocket expense
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

[If I am under a physician's care for a non SSA established disability which adversely affects my ability to work, I am also including a statement from the attending physician which establishes that they are treating me for the ___ condition and that I must take _____ medication to enable me to work.]

I am completing the front of this form, attaching the proof (receipt/pharmacy printout--required), and signing and dating the form.

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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
	Telephone Number *(Include Area Code)*

Mailing Address *(Number and street, Apt. No.,P.O.Box, Rural Route)*

City and State	ZIP Code

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.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State, and ZIP Code)*	Address *(Number and street, City, State, and ZIP Code)*

Privacy Act Statement

Collection and Use of Personal Information

Section 205(a) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use this information you provide to determine benefits eligibility. We may also share the information for the following purposes, called routine uses:

- To third party contacts (including private collection under contract with us), for the purpose of their assisting us in recovering overpayments; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting us in the efficient administration of our programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement to obtain assistance in accomplishing an SSA function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422; 60-0090, Master Beneficiary Record, as published in the FR on January 11, 2006, at 71 FR 1826; 60-0103, Supplemental Security Income Record and Special Veterans Benefits, as published in the FR on January 11, 2006, at 71 FR 1830; and 60-0320, entitled Electronic Disability Claim File, as published in the FR on June 4, 2020, at 85 FR 34477. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*