

**INTERIM ASSISTANCE REIMBURSEMENT
FOR INITIAL PAYMENTS
(Authorization)**

IM-3110
Rev. 2-00

Pre Fix	Prior Error	NUMBER HOLDER IDENTIFICATION			SOCIAL SECURITY NUMBER		
		LAST NAME	FIRST NAME	MI			
SS	PR	AH			AN		

GRANT REIMBURSEMENT
GR 1 7 8 8 0

I, the undersigned, authorize the Secretary of the United States Department of Health and Human Services (U.S. DHHS) to send my initial payment of supplemental security income (SSI) benefits to the State of Kansas, Department of Social and Rehabilitation Services.

I further authorize the Department of Social and Rehabilitation Services to deduct from my initial payment an amount equal to the sum of all public assistance benefits (not including assistance payments financed wholly or partly with Federal funds) made to, or on behalf of, me by the Department of Social and Rehabilitation Services beginning with the day of the month I am found eligible for an SSI payment and ending with the month my SSI payments begin.

I understand that after making the above deductions from my first payment, the Department of Social and Rehabilitation Services shall pay to me the balance, if any, no later than 10 working days from the date the Department of Social and Rehabilitation Services receives my initial payment from the Secretary of the U.S. DHHS.

I further understand that I have the right to a fair hearing before the Department of Social and Rehabilitation Services if I feel that the amount deducted from my initial payment of SSI benefits was more than the amount of public assistance benefits paid to, or on behalf of, me by the Department of Social and Rehabilitation Services.

I further understand that this authorization is effective for one (1) year from the date I sign it and that it will cease to have effect at the end of one (1) year unless I file for SSI within that time or one of the following events occurs earlier, in which case the authorization will cease to have effect as of the date of such event: (1) final determination on my claim and no timely request for review is filed by me; or (3) the state and I agree to terminate the authorization.

I further understand that signing this form means: (1) I want to file for SSI payments; (2) I must file for SSI with a social security office and that Social Security will decide if I am eligible for SSI; and (3) my eligibility for SSI can begin as early as the date the Department of Social and Rehabilitation Services receives the signed form if I file the SSI application within 60 days from that date.

Signature _____ Date _____

Address _____ Phone # _____

FOR SRS USE ONLY	FOR SSA USE ONLY
Case Number _____	Protected date of filing: _____
Date Received in Local Office _____	Date of SSI application: _____
	<input type="checkbox"/> Case already in current pay status. <input type="checkbox"/> Failure to file SSI application. <input type="checkbox"/> Failure to make timely request for an appeal of SSI denial. <input type="checkbox"/> Other: _____
IM Worker Signature/Date _____	Signature of SSA Representative _____ Date _____
SRS Office and Address _____	SSA Office and Address _____

Distribution: Original and Copy, SSA; Copy, Applicant; Copy, IM Case File; Copy, Central Office
This form supersedes form IM-3110, Rev. 1-94.