[Date]

[Recipient Name/Organization]
[Recipient Address]
[City, State, Zip Code]

RE: Supplemental Security Income (SSI) Disability Verification

To Whom It May Concern,

This letter is to verify the disability status and benefit information for the following individual:

- **Name:** [Claimant Full Name]
- **Date of Birth:** [MM/DD/YYYY]
- **Social Security Number:** [XXX-XX-XXXX]

The Social Security Administration (SSA) has determined that the individual named above meets the medical and non-medical requirements to be considered disabled under the Supplemental Security Income (SSI) program. Disability status was officially established on [Disability Onset Date].

The current benefit details are as follows:

- **Benefit Type:** Supplemental Security Income (SSI)
- **Monthly Benefit Amount:** $[Amount]
- **Effective Date of Current Payment:** [Date]
- **Next Scheduled Review:** [Date or "Not Applicable"]

This information is provided for the purpose of [State Purpose, e.g., Housing Assistance, Loan Application, or Utility Discount].

If you require further authentication or additional details, please contact the Social Security Administration at 1-800-772-1213 or visit [Local SSA Office Address].

Sincerely,

[Signature/Name of Representative]
[Title/Agency]
[Phone Number]