

Checklist – Adult Disability Interview

You should have as much of the following information as possible ready **for your interview**. **Keep your appointment**, even if you do not have all of the information. We will help you get any missing information.

Check off the items below as you get them together for your interview.

Medical Information:

- Names, addresses and phone numbers of all doctors, hospitals and clinics.
- Patient ID number(s)
- Dates seen
- Name(s) of medicine(s) you are taking
- Medical records in your possession

- An original or certified copy of your birth certificate. If you were born in another country, we also need proof of U.S. citizenship or legal residency.

- If you were in the military service, the original or certified copy of your military discharge papers (Form DD 214) for all periods of active duty.

- If you worked, your W-2 Form from last year; or if you were self-employed, your federal income tax return (IRS 1040 and Schedules C and SE).

- Workers' compensation information, including date of injury, claim number and proof of payment amounts.

- Social Security Number(s) for your spouse and minor children.

- Your checking or savings account number, if you have one.

- Name, address and phone number of a person we can contact if we are unable to get in touch with you.

- Kinds of jobs and dates you worked in the 15 years before you became unable to work.

The enclosed Worksheet will help you collect the information you need for your interview.

E. Medicines

Please list any medicines you take and why you take them. If prescribed, please provide the doctor's name.

NAME OF MEDICINE	WHY YOU TAKE IT	PRESCRIBED BY

F. Medical Tests

Please list any medical tests you had or are going to have in the future.

NAME OF TEST	PROVIDER WHO SENT YOU	DATE(S)

G. Job History

List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

JOB TITLE <i>(e.g., cook)</i>	TYPE OF BUSINESS <i>(e.g., restaurant)</i>	DATES WORKED		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY	
		FROM Mo/Yr	TO Mo/Yr			Amount	Frequency

Bring this worksheet to your appointment or have it with you if your appointment is by telephone. Do not delay filing your application, even if you do not have all of the information. We will help you get any missing information.

WORK HISTORY REPORT-Form SSA-3369-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can. Then call the phone number provided on the letter sent with the form or the phone number of the person who asked you to complete the form for help to finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Print or type.
- A reference to "you," "your," or "the Disabled Person," or "claimant" means the person who is applying for disability benefits. If you are filling out the form for someone else, provide information about him or her.
- **ANSWER ALL OF THE QUESTIONS FOR EACH JOB YOU DESCRIBE.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

WHY THIS INFORMATION IS IMPORTANT

The information we ask for on this form will help us understand how your illnesses, injuries, or conditions might affect your ability to do work for which you are qualified. The information tells us about the kinds of work you did, including the types of skills you needed and the physical and mental requirements of each job. In Section 2, be sure to give us all of the different jobs you did in the 15 years before you became unable to work because of your illnesses, injuries, or conditions. There is a separate page to describe each different job.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

Privacy Act and Paperwork Reduction Act Statements

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices.

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 control number. We estimate that it will take about 1 hour to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE STATE AGENCY THAT REQUESTED IT. If you have questions about how to complete the form, contact the State Agency that requested it. If you need the address or phone number for your State Agency, you can get it by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

**PLEASE REMOVE THIS SHEET BEFORE RETURNING
THE COMPLETED FORM.**

WORK HISTORY REPORT

For SSA Use Only
Do not write in this box.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. Name (First, Middle Initial, Last)

B. SOCIAL SECURITY NUMBER


- - -

C. DAYTIME TELEPHONE NUMBER *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

() -
Area Code Phone Number

Your Number Message Number None

SECTION 2 - INFORMATION ABOUT YOUR WORK

List all the jobs that you have had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions. 

	Job Title	Type of Business	Dates Worked	
			From	To
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Work History Report - Form SSA-3369-BK

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1			
Rate of Pay \$ _____	Per (Check One) <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Hours per day _____	Days per week _____

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use machines, tools or equipment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Use technical knowledge or skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

In **this job**, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:

Less than 10 lbs
 10 lbs
 20 lbs
 50 lbs
 100 lbs. or more
 Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

Less than 10 lbs
 10 lbs
 25 lbs
 50 lbs. or more
 Other _____

Did you supervise other people in this job? YES (Complete the next 3 items.) NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

Were you a lead worker? YES NO

Give us more information about Job No. 2 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 2

Rate of Pay Per (Check One) \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Hours per day _____	Days per week _____
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Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

In this job, did you:	Use machines, tools or equipment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Use technical knowledge or skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

In **this job**, how many total hours each day did you:

Walk? _____	Kneel? <i>(Bend legs to rest on knees)</i> _____
Stand? _____	Crouch? <i>(Bend legs & back down & forward)</i> _____
Sit? _____	Crawl? <i>(Move on hands & knees)</i> _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? <i>(Bend down and forward at waist)</i> _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

Check the **heaviest** weight lifted:

Less than 10 lbs
 10 lbs
 20 lbs
 50 lbs
 100 lbs. or more
 Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

Less than 10 lbs
 10 lbs
 25 lbs
 50 lbs. or more
 Other _____

Did you supervise other people in this job?
 YES (Complete the next 3 items.)
 NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

Were you a lead worker? YES NO

Give us more information about Job No. 3 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 3

Rate of Pay \$ _____	Per (Check One) <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Hours per day _____	Days per week _____
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Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use machines, tools or equipment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Use technical knowledge or skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

In **this job**, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:

Less than 10 lbs 10 lbs 20 lbs 50 lbs 100 lbs. or more Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

Less than 10 lbs 10 lbs 25 lbs 50 lbs. or more Other _____

Did you supervise other people in this job? YES (Complete the next 3 items.) NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

Were you a lead worker? YES NO

Give us more information about Job No. 4 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 4							
Rate of Pay	Per (Check One)			Hours per day	Days per week		
\$ _____	<input type="checkbox"/> Hour	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Year	_____	_____

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:	Use machines, tools or equipment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Use technical knowledge or skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

In **this job**, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:

Less than 10 lbs 10 lbs 20 lbs 50 lbs 100 lbs. or more Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

Less than 10 lbs 10 lbs 25 lbs 50 lbs. or more Other _____

Did you supervise other people in this job? YES (Complete the next 3 items.) NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

Were you a lead worker? YES NO

Give us more information about Job No. 5 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 5

Rate of Pay \$ _____	Per (Check One) <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Hours per day _____	Days per week _____
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Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use machines, tools or equipment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Use technical knowledge or skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

In **this job**, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:

Less than 10 lbs 10 lbs 20 lbs 50 lbs 100 lbs. or more Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

Less than 10 lbs 10 lbs 25 lbs 50 lbs. or more Other _____

Did you supervise other people in this job? YES (Complete the next 3 items.) NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

Were you a lead worker? YES NO

Give us more information about Job No. 6 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 6

Rate of Pay Per (Check One) \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Hours per day _____	Days per week _____
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Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

In this job, did you:	Use machines, tools or equipment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Use technical knowledge or skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

In **this job**, how many total hours each day did you:

Walk? _____	Kneel? <i>(Bend legs to rest on knees)</i> _____
Stand? _____	Crouch? <i>(Bend legs & back down & forward)</i> _____
Sit? _____	Crawl? <i>(Move on hands & knees)</i> _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? <i>(Bend down and forward at waist)</i> _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

Check the **heaviest** weight lifted:

Less than 10 lbs
 10 lbs
 20 lbs
 50 lbs
 100 lbs. or more
 Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

Less than 10 lbs
 10 lbs
 25 lbs
 50 lbs. or more
 Other _____

Did you supervise other people in this job? YES (Complete the next 3 items.) NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

Were you a lead worker? YES NO

**Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT

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 control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

NAME (First, Middle, Last)

SSN

– –
Birthday
(mm/dd/yy)



AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV.
 - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM

The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

Determining whether I am capable of managing benefits ONLY (check only if this applies)

EXPIRES WHEN

This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY

IF not signed by subject of disclosure, specify basis for authority to sign

INDIVIDUAL authorizing disclosure

Parent of minor Guardian Other personal representative (explain)

SIGN ►

(Parent/guardian/personal representative sign here if two signatures required by State law) ►

Date Signed

Street Address

Phone Number (with area code)

City

State

ZIP

WITNESS

I know the person signing this form or am satisfied of this person's identity:

SIGN ►

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ►

Phone Number (or Address)

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

FUNCTION REPORT - ADULT - Form SSA-3373-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

It is important that you tell us about your activities and abilities.

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

Privacy Act and Paperwork Reduction Act Statements

Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. We generally use the information you supply for the purpose of making decisions regarding claims. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs. We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at any local Social Security office.

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 control number. We estimate that it will take about 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not have that address, you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.***

**PLEASE REMOVE THIS SHEET BEFORE RETURNING
THE COMPLETED FORM.**

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only
Do not write in this box.

Related SSN - -

Number Holder _____

SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle Initial, Last)*

2. **SOCIAL SECURITY NUMBER**

- -

3. **YOUR DAYTIME TELEPHONE NUMBER** *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

() - _____
Area Code Phone Number

Your Number Message Number None

4. a. Where do you live? *(Check one.)*

House Apartment Boarding House Nursing Home
 Shelter Group Home Other *(What?)* _____

b. With whom do you live? *(Check one.)*

Alone With Family With Friends
 Other *(Describe relationship.)* _____

SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

5. How do your illnesses, injuries, or conditions limit your ability to work?

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? Yes No

If "YES," for whom do you care, and what do you do for them? _____

8. Do you take care of pets or other animals? Yes No

If "YES," what do you do for them? _____

9. Does anyone help you care for other people or animals? Yes No

If "YES," who helps, and what do they do to help? _____

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

11. Do the illnesses, injuries, or conditions affect your sleep? Yes No

If "YES," how? _____

12. **PERSONAL CARE** (Check here if **NO PROBLEM** with personal care.)

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress _____

Bathe _____

Care for hair _____

Shave _____

Feed self _____

Use the toilet _____

Other _____

b. Do you need any special reminders to take care of personal needs and grooming? Yes No

If "YES," what type of help or reminders are needed? _____

c. Do you need help or reminders taking medicine? Yes No

If "YES," what kind of help do you need? _____

13. MEALS

a. Do you prepare your own meals? Yes No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.) _____

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

How long does it take you? _____

Any changes in cooking habits since the illness, injuries, or conditions began?

b. If "No," explain why you cannot or do not prepare meals. _____

14. HOUSE AND YARD WORK

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.) _____

b. How much time does it take you, and how often do you do each of these things?

c. Do you need help or encouragement doing these things? Yes No

If "YES," what help is needed? _____

d. If you don't do house or yard work, explain why not. _____

15. GETTING AROUND

a. How often do you go outside? _____

If you don't go out at all, explain why not. _____

b. When going out, how do you travel? *(Check all that apply.)*

Walk Drive a car Ride in a car Ride a bicycle

Use public transportation Other *(Explain)* _____

c. When going out, can you go out alone? Yes No

If "NO," explain why you can't go out alone. _____

d. Do you drive? Yes No

If you don't drive, explain why not. _____

16. SHOPPING

a. If you do any shopping, do you shop: *(Check all that apply.)*

In stores By phone By mail By computer

b. Describe what you shop for. _____

c. How often do you shop and how long does it take? _____

17. MONEY

a. Are you able to:

Pay bills Yes No Handle a savings account Yes No

Count change Yes No Use a checkbook/money orders Yes No

Explain all "NO" answers. _____

- b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? Yes No

If "YES," explain how the ability to handle money has changed. _____

18. HOBBIES AND INTERESTS

- a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.) _____

- b. How often and how well do you do these things? _____

- c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

19. SOCIAL ACTIVITIES

- a. Do you spend time with others? (*In person, on the phone, on the computer, etc.*) Yes No

If "YES," describe the kinds of things you do with others. _____

How often do you do these things? _____

- b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.) _____

Do you need to be reminded to go places? Yes No

How often do you go and how much do you take part? _____

Do you need someone to accompany you? Yes No

c. Do you have any problems getting along with family, friends, neighbors, or others? Yes No
If "YES," explain. _____

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

SECTION D - INFORMATION ABOUT ABILITIES

20. a. Check any of the following items that your illnesses, injuries, or conditions affect:
- | | | | |
|------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Walking | <input type="checkbox"/> Stair Climbing | <input type="checkbox"/> Understanding |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Seeing | <input type="checkbox"/> Following Instructions |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Memory | <input type="checkbox"/> Using Hands |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Talking | <input type="checkbox"/> Completing Tasks | <input type="checkbox"/> Getting Along With Others |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Hearing | <input type="checkbox"/> Concentration | |

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far])

b. Are you: Right Handed? Left Handed?
c. How far can you walk before needing to stop and rest? _____
If you have to rest, how long before you can resume walking? _____

d. For how long can you pay attention? _____

e. Do you finish what you start? (For example, a conversation, chores, reading, watching a movie.) Yes No

f. How well do you follow written instructions? (For example, a recipe.) _____

g. How well do you follow spoken instructions? _____

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.) _____

i. Have you ever been fired or laid off from a job because of problems getting along with other people? Yes No

If "YES," please explain. _____

If "YES," please give name of employer. _____

j. How well do you handle stress? _____

k. How well do you handle changes in routine? _____

l. Have you noticed any unusual behavior or fears? Yes No

If "YES," please explain. _____

21. Do you use any of the following? (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Brace/Splint | <input type="checkbox"/> Glasses/Contact Lenses |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Artificial Limb | <input type="checkbox"/> Artificial Voice Box |
| <input type="checkbox"/> Other (Explain) _____ | | |

Which of these were prescribed by a doctor? _____

When was it prescribed? _____

When do you need to use these aids? _____

DISABILITY REPORT - ADULT SSA-3368-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The information you give us on this report will be used by the office that makes the disability decision on your disability claim. Completing this report accurately and completely will help us expedite your claim. Please complete as much of the report as you can.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. Please do **not** ask your health care provider to complete this report. If you cannot complete the report, a Social Security Representative will assist you. If you have an appointment, please have the completed report ready when we contact you. If we ask you to do so, please mail the completed report to us ahead of time.

Note: If you are assisting someone else with this report, please answer the questions as if that person were completing the report.

HOW TO COMPLETE THIS REPORT

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION**, unless the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any question, please use Section 11 - Remarks on the last page to finish your answer. Write the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any of your medical records, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and the completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or is expected to result in death. So when we ask "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

The Privacy Act

Sections 205(a), 223(d), and 1631(e) (1) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to make a decision on the named claimant's claim. While giving us the information on this report is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. We generally use the information you supply for the purpose of making decisions regarding claims. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information about Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at any local Social Security office.

The Paperwork Reduction Act

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 control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions.

SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not have that address, you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.***

**AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND
KEEP IT FOR YOUR RECORDS**

<h2 style="margin: 0;">DISABILITY REPORT ADULT</h2>	<p>For SSA Use Only - Do not write in this box.</p> <p>Related SSN _____</p> <p>Number Holder _____</p>
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If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle Initial, Last) _____	1.B. Social Security Number _____
---	-----------------------------------

1.C. Mailing Address (Street or P O Box) Include apartment number or unit if applicable. _____

City _____	State/Province _____	ZIP/Postal Code _____	Country (If not USA) _____
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1.D. Email Address _____

1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada.

Phone number _____

Check this box if you do not have a phone or a number where we can leave a message.

1.F. Alternate Phone Number - another number where we may reach you, if any.

Alternate phone number _____

1.G. Can you speak and understand English? YES NO

If no, what language do you prefer? _____
If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.H. Can you read and understand English? YES NO

1.I. Can you write more than your name in English? YES NO

1.J. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname. YES NO

If yes, please list them here: _____

SECTION 2 - CONTACTS

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim.

2.A. Name (First, Middle Initial, Last) _____	2.B. Relationship to you _____
---	--------------------------------

2.C. Daytime Phone Number (as described in 1.E. above) _____

2.D. Mailing Address (Street or P O Box) Include apartment number or unit if applicable. _____

City _____	State/Province _____	ZIP/Postal Code _____	Country (If not USA) _____
------------	----------------------	-----------------------	----------------------------

2.E. Can this person speak and understand English? YES NO

If no, what language is preferred? _____

SECTION 2 - CONTACTS (continued)

2.F. Who is completing this report?

- The person who is applying for disability. (Go to Section 3 - Medical Conditions)
- The person listed in 2.A. (Go to Section 3 - Medical Conditions)
- Someone else (Complete the rest of Section 2 below)

2.G. Name (First, Middle Initial, Last) _____

2.H. Relationship to Person Applying _____

2.I. Daytime Phone Number _____

2.J. Mailing Address (Street or P O Box) Include apartment number or unit if applicable. _____

City	State/Province	ZIP/Postal Code	Country (If not USA)
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SECTION 3 - MEDICAL CONDITIONS

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1.
2.
3.
4.
5.

If you need more space, go to Section 11 - Remarks on the last page

3.B. What is your height without shoes? _____ OR _____
feet inches centimeters (if outside USA)

3.C. What is your weight without shoes? _____ OR _____
pounds kilograms (if outside USA)

3.D. Do your conditions cause you pain or other symptoms? YES NO

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

- No, I have never worked (Go to question **4.B.** below)
- No, I have stopped working (Go to question **4.C.** below)
- Yes, I am currently working (Go to question **4.F.** on page 3)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year) _____ (Go to Section 5 on page 3)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year) _____

Why did you stop working?

- Because of my condition(s).
- Because of other reasons. Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed) _____

Even though you stopped working for other reasons, when do you believe your condition(s) became severe enough to keep you from working? (month/day/year) _____

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours, or rate of pay)

- No (Go to Section 5 - Education and Training on page 3)
- Yes When did you make changes? (month/day/year) _____

SECTION 4 - WORK ACTIVITY (continued)

4.E. Since the date in 4.D. above, have you had gross earnings greater than \$980 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

No (Go to Section 5) Yes (Go to Section 5)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

No When did your condition(s) first start bothering you? (month/day/year) _____

Yes When did you make changes? (month/day/year) _____

4.G. Since your condition(s) first bothered you, have you had gross earnings greater than \$980 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

NO YES

SECTION 5 - EDUCATION AND TRAINING

5.A. Check the highest grade of school completed.

College:

0 1 2 3 4 5 6 7 8 9 10 11 12 GED 1 2 3 4 or more

Date completed: _____

5.B. Did you attend special education classes?

YES NO (Go to 5.C.)

Name of School _____

City _____ State/Province _____ Country (If not USA) _____

Dates attended special education classes: from _____ to _____

5.C. Have you completed any type of specialized job training, trade, or vocational school?

YES NO

If "Yes," what type? _____ Date completed: _____

If you need to list other education or training use Section 11 - Remarks on the last page.

SECTION 6 - JOB HISTORY

6.A. List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

Job Title	Type of Business	Dates Worked		Hours Per Day	Days Per Week	Rate of Pay	
		From MM/YY	To MM/YY			Amount	Frequency
1.							
2.							
3.							
4.							
5.							

SECTION 6 - JOB HISTORY (continued)

Check the box below that applies to you.

- I had **only one job** in the last 15 years before I became unable to work. Answer the questions below.
- I had **more than one job** in the last 15 years before I became unable to work. Do **not** answer the questions on this page; go to Section 7 on page 5. (We may contact you for more information.)

Do not complete this page if you had **more than one job** in the last 15 years before you became unable to work.

6.B. Describe this job. What did you do all day? _____

(If you need more space, use Section 11 - Remarks on the last page.)

6.C. In this job, did you:

- Use machines, tools or equipment? YES NO
- Use technical knowledge or skills? YES NO
- Do any writing, complete reports, or perform any duties like this? YES NO

6.D. In this job, how many total hours each day did you do each of the tasks listed:

Task	Hours	Task	Hours	Task	Hours
Walk		Stoop (<i>Bend down & forward at waist.</i>)		Handle large objects	
Stand		Kneel (<i>Bend legs to rest on knees.</i>)		Write, type, or handle small objects	
Sit		Crouch (<i>Bend legs & back down & forward.</i>)		Reach	
Climb		Crawl (<i>Move on hands & knees.</i>)			

6.E. Lifting and carrying (*Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job.*) _____

6.F. Check **heaviest** weight lifted:

- Less than 10 lbs. 10 lbs. 20 lbs. 50 lbs. 100 lbs. or more Other _____

6.G. Check weight **frequently** lifted: (*by frequently, we mean from 1/3 to 2/3 of the workday.*)

- Less than 10 lbs. 10 lbs. 25 lbs. 50 lbs. or more Other _____

6.H. Did you supervise other people in this job? YES (Complete items below.) NO (if No, go to **6.I.**)

How many people did you supervise? _____
 What part of your time did you spend supervising people? _____

Did you hire and fire employees? YES NO

6.I. Were you a lead worker? YES NO

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office	Name of health care professional who treated you
--	--

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)
--------------	------------------------

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)
------	----------------	-----------------	----------------------

Dates of Treatment		
1. Office, Clinic or Outpatient visits First Visit _____ Last Visit _____ Next scheduled appointment (if any) _____	2. Emergency Room visits List the most recent date first A. _____ B. _____ C. _____	3. Overnight hospital stays List the most recent date first A. Date in _____ Date out _____ B. Date in _____ Date out _____ C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

Check this box if no tests by this provider or at this facility.

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
<input type="checkbox"/> EKG (heart test)		<input type="checkbox"/> EEG (brain wave test)	
<input type="checkbox"/> Treadmill (exercise test)		<input type="checkbox"/> HIV Test	
<input type="checkbox"/> Cardiac Catheterization		<input type="checkbox"/> Blood Test (not HIV)	
<input type="checkbox"/> Biopsy (list body part) _____		<input type="checkbox"/> X-Ray (list body part) _____	
<input type="checkbox"/> Hearing Test		<input type="checkbox"/> MRI/CT Scan (list body part) _____	
<input type="checkbox"/> Speech/Language Test		<input type="checkbox"/> Other (please describe) _____	
<input type="checkbox"/> Vision Test			
<input type="checkbox"/> Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.D. Name of Facility or Office	Name of health care professional who treated you
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Mailing Address

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<input type="checkbox"/> Cardiac Catheterization		<input type="checkbox"/> Blood Test (not HIV)	
<input type="checkbox"/> Biopsy (list body part) _____		<input type="checkbox"/> X-Ray (list body part) _____	
<input type="checkbox"/> Hearing Test		<input type="checkbox"/> MRI/CT Scan (list body part) _____	
<input type="checkbox"/> Speech/Language Test		<input type="checkbox"/> Other (please describe) _____	
<input type="checkbox"/> Vision Test			
<input type="checkbox"/> Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

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Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)
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Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
<input type="checkbox"/> EKG (heart test)		<input type="checkbox"/> EEG (brain wave test)	
<input type="checkbox"/> Treadmill (exercise test)		<input type="checkbox"/> HIV Test	
<input type="checkbox"/> Cardiac Catheterization		<input type="checkbox"/> Blood Test (not HIV)	
<input type="checkbox"/> Biopsy (list body part) _____		<input type="checkbox"/> X-Ray (list body part) _____	
<input type="checkbox"/> Hearing Test		<input type="checkbox"/> MRI/CT Scan (list body part) _____	
<input type="checkbox"/> Speech/Language Test		<input type="checkbox"/> Other (please describe) _____	
<input type="checkbox"/> Vision Test			
<input type="checkbox"/> Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.F. Name of Facility or Office	Name of health care professional who treated you
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ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)
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Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)
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Dates of Treatment

1. Office, Clinic or Outpatient visits	2. Emergency Room visits	3. Overnight hospital stays
First Visit	List the most recent date first	List the most recent date first
_____	A. _____	A. Date in _____ Date out _____
Last Visit	B. _____	B. Date in _____ Date out _____
_____	C. _____	C. Date in _____ Date out _____
Next scheduled appointment (if any)		

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

Check this box if no tests by this provider or at this facility.

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
<input type="checkbox"/> EKG (heart test)		<input type="checkbox"/> EEG (brain wave test)	
<input type="checkbox"/> Treadmill (exercise test)		<input type="checkbox"/> HIV Test	
<input type="checkbox"/> Cardiac Catheterization		<input type="checkbox"/> Blood Test (not HIV)	
<input type="checkbox"/> Biopsy (list body part)		<input type="checkbox"/> X-Ray (list body part)	
<input type="checkbox"/> Hearing Test		<input type="checkbox"/> MRI/CT Scan (list body part)	
<input type="checkbox"/> Speech/Language Test		<input type="checkbox"/> Other (please describe)	
<input type="checkbox"/> Vision Test			
<input type="checkbox"/> Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.G. Name of Facility or Office	Name of health care professional who treated you
--	--

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)
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Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)
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Dates of Treatment		
1. Office, Clinic or Outpatient visits First Visit _____ Last Visit _____ Next scheduled appointment (if any) _____	2. Emergency Room visits List the most recent date first A. _____ B. _____ C. _____	3. Overnight hospital stays List the most recent date first A. Date in _____ Date out _____ B. Date in _____ Date out _____ C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

Check this box if no tests by this provider or at this facility.

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
<input type="checkbox"/> EKG (heart test)		<input type="checkbox"/> EEG (brain wave test)	
<input type="checkbox"/> Treadmill (exercise test)		<input type="checkbox"/> HIV Test	
<input type="checkbox"/> Cardiac Catheterization		<input type="checkbox"/> Blood Test (not HIV)	
<input type="checkbox"/> Biopsy (list body part) _____		<input type="checkbox"/> X-Ray (list body part) _____	
<input type="checkbox"/> Hearing Test		<input type="checkbox"/> MRI/CT Scan (list body part) _____	
<input type="checkbox"/> Speech/Language Test		<input type="checkbox"/> Other (please describe) _____	
<input type="checkbox"/> Vision Test			
<input type="checkbox"/> Breathing Test			

If you have been treated by more than five doctors or hospitals, use Section 11 - Remarks on the last page and give the same detailed information as above for each healthcare provider.

SECTION 9 - OTHER MEDICAL INFORMATION

9. Does **anyone else** have medical information about your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

YES (Please complete the information below.)

NO (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11 on the last page.)

Name of Organization	Phone Number
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Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)
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Name of Contact Person	Claim or ID number (if any)
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Date of First Contact	Date of Last Contact	Date of Next Contact (if any)
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Reasons for Contacts

If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.

**COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.
SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES**

10.A. Have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- An Individualized Education Program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

YES (Complete the following information) **NO** (Go to Section 11)

10.B. Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number
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Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)
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10.C. When did you start participating in the plan or program? _____

