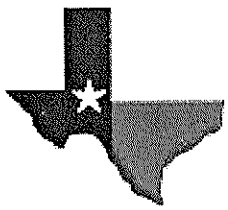
SECTION B



PREPARING FOR:

BEFORE APPLYING FOR SOCIAL SECURITY BENEFITS

Have as much of the following information as possible ready for your interview.

MEDICAL information:

1. Names, address and phone numbers of all doctors, hospitals and clinics
2. Dates seen
3. Names of medication/s you are taking

WORK history:

The type of jobs/work and dates you worked in the last 15 years before you became unable to work.

Please complete the Medical and Job Worksheet (SSA-3381) – it will speed up the appointment time.

Social Security

Substantial Gainful Activity

To be eligible for disability benefits, a person must be unable to engage in substantial gainful activity (SGA). A person who is earning more than a certain monthly amount (net of impairment-related work expenses) is ordinarily considered to be engaging in SGA. The amount of monthly earnings considered as SGA depends on the nature of a person's disability. The Social Security Act specifies a higher SGA amount for statutorily blind individuals; Federal regulations specify a lower SGA amount for non-blind individuals. Both SGA amounts generally change with changes in the national average wage index.

Amounts for 2019

The monthly SGA amount for statutorily blind individuals for 2019 is $2040. For non-blind individuals, the monthly SGA amount for 2019 is $1220. SGA for the blind does *not* apply to Supplemental Security Income (SSI) benefits, while SGA for the non-blind disabled applies to Social Security and SSI benefits. See historical series of SGA amounts below.

Trial work period

After a person becomes eligible for disability benefits, the person may attempt to return to the work force. As an incentive, we provide a *trial work period* in which a beneficiary may have earnings and still collect benefits.

Monthly substantial gainful activity amounts by disability type

Year	Blind	Non-blind	Year	Blind	Non-blind	Year	Blind	Non-blind
1975	$200	$200	1995	$940	$500	2015	$1,820	$1,090
1976	230	230	1996	960	500	2016	1,820	1,130
1977	240	240	1997	1,000	500	2017	1,950	1,170
1978	334	260	1998	1,050	500	2018	1,970	1,180
1979	375	280	1999	1,110	700[a]	2019	2,040	1,220
1980	417	300	2000	1,170	700			
1981	459	300	2001	1,240	740			
1982	500	300	2002	1,300	780			
1983	550	300	2003	1,330	800			
1984	580	300	2004	1,350	810			
1985	610	300	2005	1,380	830			
1986	650	300	2006	1,450	860			
1987	680	300	2007	1,500	900			
1988	700	300	2008	1,570	940			
1989	740	300	2009	1,640	980			
1990	780	500	2010	1,640	1,000			
1991	810	500	2011	1,640	1,000			
1992	850	500	2012	1,690	1,010			
1993	880	500	2013	1,740	1,040			
1994	930	500	2014	1,800	1,070			

[a] $500 amount applied in the first half of 1999.

MEDICAL AND JOB WORKSHEET - ADULT

Please do **not** mail this worksheet to your local office.
Did you know that you can start the application process online?
Visit ***www.socialsecurity.gov/applyfordisability*** for more information!
Complete this worksheet to get ready for the appointment or when filing online. This worksheet is not the application for Social Security disability benefits. You should bring this worksheet to your appointment or have it with you if your appointment is by telephone.

A. Medical Conditions

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.

	CONDITIONS
1.	
2.	
3.	
4.	
5.	

B. If you are not working, when did you stop working?

C. Height without shoes:_____feet_____inches **Weight without shoes:** _____ pounds

D. Medical Sources

Please list any doctors, hospitals, clinics, therapists, or emergency rooms you have visited because of your conditions.

	NAME	ADDRESS	PHONE NUMBER (with area code)	DATE FIRST SEEN OR ADMISSION DATE	DATE LAST SEEN OR DISCHARGE DATE

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 (*e.g., cook*)	TYPE OF BUSINESS (*e.g., restaurant*)	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.

MEDICAL AND SCHOOL WORKSHEET - CHILD

Completing this worksheet will help you get ready for the interview. It will also speed up the interview. We may ask for additional information. *If you need more space, use blank sheets of paper.*

A. Child's height and weight. _____

B. Name, address, phone number, and relationship of another adult who helps care for the child and can help us get information about the child if necessary.

_____

_____

C. The child's illnesses, injuries, or conditions. _____

_____

D. When the child's condition(s) began. _____

E. How they affect the child's activities. _____

F. The child's current grade, if in school. _____

G. Schools or preschools the child is currently attending, and any other schools he or she attended in the last 12 months.

	NAME	ADDRESS, ZIP CODE, and PHONE NUMBER	DATES ATTENDED	KIND(S) OF SPECIAL ED. SERVICES *(if any)*

H. Current teacher's name(s) and school. _____

I. School testing the child has had, such as tests for behavior or learning problems.

NAME OR KIND OF TEST	DATE(S)	NAME OF SCHOOL

J. Name of any school therapist the child is seeing or has seen (*for example, speech, physical, or occupational*) and the school name.

_____

_____

K. Hospitals, clinics, doctors, or therapists that have seen the child within at least the last 12 months.

NAME	ADDRESS, ZIP CODE, and PHONE NUMBER	PATIENT I.D. NUMBER	DATE FIRST SEEN	DATE LAST SEEN

L. Other agencies or programs that tested or examined the child, or that provided services (*such as Headstart, Early Intervention Services or Special Education, Public or Community Health, Welfare or Social Service Agency, Mental Health/Mental Retardation Center*).

NAME	ADDRESS, ZIP CODE, and PHONE NUMBER	KIND OF TEST OR SERVICE	DATE(S)

M. Medicine(s) the child takes, and the doctor's name if it is a prescribed medication.

NAME OF MEDICINE	PRESCRIBED BY

N. All medical tests the child had or will have for his or her illnesses, injuries or conditions. (*For example, hearing test, vision test, IQ testing, blood tests, breathing tests, x-rays.*)

NAME OF TEST	DATE(S)	WHERE DONE	WHO SENT CHILD FOR TEST

HOUSEHOLD EXPENSE WORKSHEET

The following information is needed to process your application or review for services:

Section I – check which ones describes you living arrangement:

_____own or buying my house
_____paying rent
_____living in another person's household
_____ Live in a home/apartment that I do not pay rent or not owned

Section II:

How many people live in your household, including yourself? _____
What is the average monthly cost for the following:

Housing: $ _____
Electricity $ _____
Gas/Propane $_____
Water: $ _____
Property Taxes $ _____
Food $ _____

How much do you, the applicant, contribute towards these expenses? _____

How much do others in the household contribute towards these expenses? _____

Any contributions from others who live outside of your household? Y/N

If yes, please complete:
Name of outside contributor: _____
Expenses paid for: _____

_____

Amount of money contributed towards these expenses? $ _____

Agreement:

If you agree with the above information, please sign and date below.

_____

Applicant: Date:

_____

Head of household Date: