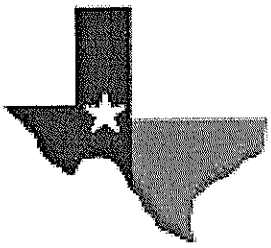
SECTION D



CHILD FORMS

CHECKLIST FOR CHILD DISABILITY APPLICATIONS – FORMS

1. Medical and School Worksheet – Child (SSA-3819) Optional: send to client before appointment.

2. Appointment of Representative (SSA-1696-U4)

3. Application for SSI (SSA-8000-BK)

4. Disability Report Child (SSA-3820-BK
    a. Online

5. Questionnaire for Children Claiming SSI Benefits – SSA-3881-BK

6. Pain Report – Child – SSA-3371-BK

7. Function Report Child –
    a. SSA-3375-BK (birth to 1);
    b. SSA-3376-BK (1-3 yr),
    c. SSA-3377-BK (3-6),
    d. SSA-3378-BK (6-12);
    e. SSA-3379-BK (12 to 18)

8. Authorization to Disclose Information – SSA-827

9. Narrative/Clinical Summary

10. Current Mental Status – send to staff or physician to complete. Physician must sign, staff can complete. Send with medical records.

Completing This Form to Appoint a Representative

Choosing to be Represented

You can choose to have a representative help you when you do business with Social Security. We will work with your representative, just as we would with you. It is important that you select a qualified person because, once appointed, your representative may act for you in most Social Security matters. We give more information, and examples of what a representative may do, in the section titled "Information for Claimants."

Privacy Act Statement
Collection and Use of Personal Information

Sections 206 and 1631(d) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from appointing a representative to act on your behalf.

We will use the information to verify the appointment of your representative and his or her acceptance of the appointment. We may also share your information for the following purposes, called routine uses:

1. To a congressional office in response to an inquiry from that office made on behalf of, and at the request of, the subject of the record or a third party acting on the subject's behalf.
2. To Federal, State, and local law enforcement agencies and private security contractors, as appropriate, information necessary: (a) to enable them to protect the safety of Social Security Administration (SSA) employees and customers, the security of the SSA workplace, and the operation of SSA facilities; or (b) to assist investigations or prosecutions with respect to activities that affect such safety and security or activities that disrupt the operation of SSA facilities; and
3. To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

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 (SORNs) 60-0089, entitled Claims Folders Systems; 60-0320, entitled Electronic Disability Claim File; and 60-0325, entitled Appointed Representative File. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

How to Complete this Form

Please print or type your answers on this form. At the top of the form, provide your full name and your Social Security number. If your claim is based on another person's work and earnings, also provide the "wage earner's" name and Social Security number. If you appoint more than one individual as your representative, you may want to complete a form for each of them.

Part 1 Claimant's Appointment of Representative

Give the name and address of the individual(s) you are appointing. You may appoint an attorney or any other qualified individual to represent you. You also may appoint more than one individual, but please refer to the "Information for Claimants" section "What your Representative(s) May Charge" for more information about payment of fees. You can appoint one or more individuals in a firm, corporation, or other organization as your representative(s), but you may not appoint a law firm, legal aid group, corporation or organization itself. Check the block(s) showing the program(s) under which you have a claim. You may check more than one block. Check:

- Title II (RSDI), if your claim concerns retirement, survivors, or disability insurance benefits.
- Title XVI (SSI), if your claim concerns Supplemental Security Income.
- Title XVIII (Medicare Coverage), if your claim concerns entitlement to Medicare or enrollment in the Supplementary Medical Insurance (SMI) plan.
- Title VIII (SVB), if your claim concerns entitlement to Special Veterans Benefits.

When you give your permission your representative may designate an associate (e.g. a clerk), or other party or entity (e. g. a copying service) to receive information from your claim file on your representative's behalf for the duration of your claim. If you want to give your representative permission to do that, check the block to authorize this release.

If you will have more than one representative, check the appropriate block and give the name of the individual you want to be your principal representative. SSA will make contacts with, and send notices or requests for development to, only the principal representative. The principal representative will provide copies of notices or requests to other co-representatives.

You must sign and date the form. Print or type your address, area code and telephone number.

If you are appointing a representative to replace a representative that you discharged or who withdrew his or her representation, you must notify us in writing that the prior appointment has ended.

Part 2 Representative's Acceptance of Appointment

Each individual you appoint in Part I should also complete Part 2. If the individual is not an attorney, he or she must give his or her name, state that he or she accepts the appointment, and sign the form.

Part 3 Fee Arrangement

To help in processing benefits and fee payments timely you and your representative should complete this section. Your representative should check a box, sign and date the form. Your representative may choose to receive payment, waive direct payment, or waive payment of the fee altogether. If you and your representative change your arrangement before we decide your claim, you can provide a new or amended form so that we can update our records. If you appoint a second representative or co-counsel who also will not charge a fee, he or she should also complete this part or provide a new form, or if not using the form, give us a separate, written waiver statement. If your representative is not eligible for direct payment, or is an attorney or an eligible non-attorney who waives direct payment, you will be responsible for paying any fee we authorize.

Under certain circumstances, we do not have to authorize the fee. These circumstances include where a Court has awarded a fee based on your representative's actions as a legal guardian or court-appointed representative, or where a business (such as an insurance company), other organization or government agency will pay your representative's fee and you and your beneficiaries have no liability to pay any fees or expenses.

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 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND 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.***

References

- 18 U.S.C. §§ 203, 205, and 207; and 42 U.S. C. §§ 406 (a), 1320a-6, and 1383(d)(2)
- 20 CFR §§ 404.1700 et. seq., 408.1101, and 416.1500 et. seq.
- Social Security Rulings 83-27 and 82-39
- 26 U.S.C. §§ 6041 and 6045(f)

Information for Representatives

Fees for Representation

An attorney or other individual who wants to charge or collect a fee for providing services in connection with a claim before the Social Security Administration (SSA) must generally obtain our prior authorization of the fee for representation. The only exceptions are if:

- certain requirements are met and a third-party entity, such as a business, an insurance carrier, a for profit, or nonprofit organization or a government agency will pay the fee and any expenses from its own funds and the claimant and auxiliary beneficiaries incur no liability, directly or indirectly, for the cost (s); or
- a Federal court awarded a fee based on the representative's activities as the claimant's legal guardian or court-appointed representative;
- a Federal court awarded a fee for representational services provided before the court. In those cases, neither the Federal court nor SSA can authorize a fee for the other.

Obtaining Authorization of a Fee

To charge a fee for services, you must use one of two mutually exclusive fee authorization processes. You must file either a fee petition or a fee agreement with us. In either case, you cannot charge more than the fee amount we authorize.

Fee Petition Process

You may file a fee petition after you complete your services to the claimant. This written request must describe in detail the amount of time you spent on each service provided and the amount of the fee you are requesting. In order to directly pay you under a fee petition, you must either file a fee petition or notify us within 60 days after we decide the claim of your intent to file a fee petition.

You must give the claimant a copy of the fee petition and each attachment. The claimant may disagree with the information shown by contacting a Social Security office within 20 days of receiving his or her copy of the fee petition. We will consider the reasonable value of the services provided, and send you notice of the amount of the fee you can charge.

Fee Agreement Process

If you and the claimant have a written fee agreement, one of you must give it to us before we decide the claim(s). We usually will approve the agreement if:

- you both signed it;
- the fee you agreed on is no more than 25 percent of past-due benefits, or $6,000 (or a higher amount we set and announce in the Federal Register), whichever is less;
- we approve the claim(s); and
- the claim results in past-due benefits.

We will send you a copy of the notice we send the claimant telling him or her the amount of the fee you can charge based on the agreement.

If we do not approve the fee agreement, we will tell you in writing. We also will tell you and the claimant that you must file a fee petition if you wish to charge and collect a fee.

After we tell you the amount of the fee you can charge, you or the claimant may ask us in writing to review the authorized fee. If we approved a fee agreement, the person who decided the claim(s) also may ask us to lower the amount. Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

Collecting a Fee

You may accept money for your fee in advance, as long as you hold it in a trust or escrow account. The claimant never owes you more than the fee we authorize, except for:

- any fee a Federal court allows for your services before it; and
- out-of-pocket expenses you incur or expect to incur, for example, the cost of getting evidence. Our authorization is not needed for such expenses.

If you are not an attorney and you are ineligible to receive direct payment, you must collect the authorized fee from the claimant. If you are interested in becoming eligible to receive direct payment, you can find more information about this on our "Representing Social Security Claimants" website: http://www.ssa.gov/representation/.

If you are an attorney or a non-attorney whom SSA has found eligible to receive direct payment and you register with SSA, as described below, we usually withhold 25 percent of any past-due benefits that result from a favorably decided retirement, survivors, disability insurance, or supplemental security income claim. Once we authorize a fee, we pay you all or part of the fee from the funds withheld. We will also charge you the assessment required by section 206(d) and 1631(d)(2)(C) of the Social Security Act. You cannot charge or collect this expense from the claimant. You will need to collect from the claimant:

- **the rest of the fee he or she owes**, if the amount of the authorized fee is more than the amount of money we withheld and paid you for the claimant, plus any amount you held for the claimant in a trust or escrow account.

- **all of the fee he or she owes**, if we did not withhold past-due benefits, (for example, because there are no past-due benefits; you waived direct payment or did not register for direct payment; the claimant discharged you or you withdrew from representing before we issued a favorable decision); or we withheld past-due benefits, but you did not ask us to authorize a fee or tell us that you planned to ask for a fee within 60 days after the date of the notice of award and we released the withheld amount to the claimant.

Registering for Direct Fee Payment

If you are eligible and want to receive direct payment, you must register with us before we effectuate a favorable decision on the claim. To register, you must submit a Form SSA-1699 (Registration of Individuals and Staff for Appointed Representative Services) once and a Form SSA-1695 (Identifying Information for Possible Direct Payment of Authorized Fees) with each appointment. We will use the information you provide on these forms to issue you a Form 1099-MISC if we pay you aggregate fees of $600 or more in a calendar year. The Internal Revenue Code requires that we do this. For information on the registration process, see our "Representing Social Security Claimants" website http://www.ssa.gov/representation/.

Conflict of Interest and Penalties

If you commit improper acts, you can be suspended or disqualified from representing anyone before SSA. You also can face criminal prosecution. Improper acts include:

- If you are or were an officer or employee of the United States, providing services as a representative in certain claims against and other matters affecting the Federal government.

- Knowingly and willingly furnishing false information.

- Charging or collecting an unauthorized fee, or charging or collecting too much for services provided in any claim, including services before a court that made a favorable decision.

References

- 18 U.S.C. §§ 203, 205, and 207; and 42 U.S.C. §§ 406 (a), 1320a-6, and 1383(d)(2)
- 20 CFR §§ 404.1700 et. seq., 408.1101, and 416.1500 et. seq.
- Social Security Rulings 83-27 and 82-39
- 26 U.S.C. §§ 6041 and 6045(f)

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part 1 - Claimant's Appointment of Representation

I appoint this individual, _____

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My principal representative is:

Name of Principal Representative

Signature (Claimant)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part 2 - Representative's Acceptance of Appointment

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part 3 satisfies this requirement.)

Check one: ☐ I am an attorney ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☐ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☐ No

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.

Signature (Representative)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part 3 - Fee Arrangement

(Select an option, sign and date this section.)

☐ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits - I do not qualify for or do not request direct payment. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** - By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). (*SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.*)

☐ **I am waiving fees from any source** - I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

File Copy

6

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part 1 - Claimant's Appointment of Representation

I appoint this individual, _____

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My principal representative is:

Name of Principal Representative

Signature (Claimant)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part 2 - Representative's Acceptance of Appointment

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part 3 satisfies this requirement.)

Check one: ☐ I am an attorney ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☐ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☐ No

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.

Signature (Representative)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part 3 - Fee Arrangement

(Select an option, sign and date this section.)

☐ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits - I do not qualify for or do not request direct payment. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** - By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). (*SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.*)

☐ **I am waiving fees from any source** - I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Claimant Copy

1

Information for Claimants

What Your Representative(s) May Do

We will work directly with your appointed representative unless he or she asks us to work directly with you. Your representative may:

- get information from your claim(s) file;
- with your permission, designate associates who perform administrative duties (e.g. clerks), partners and/or parties under contractual arrangements (e.g., copying services) to receive information from us on his or her behalf (by checking the appropriate block and signing this form, you are providing your permission for your representative to designate such associates, partners, and/or contractual parties);
- give us evidence or information to support your claim;
- come with you, or for you, to any interview, conference, or hearing you have with us;
- request a reconsideration, a hearing, or Appeals Council review; and
- help you and your witnesses prepare for a hearing and question any witnesses.

Also, your representative will receive a copy of the decision(s) we make on your claim(s). We will rely on your representative to tell you about the status of your claim(s), but you still may call or visit us for information.

You and your representative(s) are responsible for giving Social Security accurate information. It is wrong to knowingly and willingly furnish false information. Doing so may result in criminal prosecution.

We usually continue to work with your representative until (1) you notify us in writing that he or she no longer represents you; or (2) your representative tells us that he or she is withdrawing or indicates that his or her services have ended (for example, by filing a fee petition or not pursuing an appeal). We do not continue to work with someone who is suspended or disqualified from representing claimants. We will inform you if we suspend your representative.

What Your Representative(s) May Charge

Each representative you appoint can ask for a fee. To charge you a fee for services, your representative must get our authorization if you or another individual will pay the fee. However, as described in "Completing this form to appoint a representative, Part 3 Fee Arrangement" section of this form, under certain circumstances, we do not have to authorize the representative's fee. To request a fee, your representative must file a fee agreement or a fee petition. In either case, your representative cannot charge you more than the fee amount we authorize. If he or she does, promptly report this to your Social Security office.

Filing A Fee Petition

Your representative may file a fee petition when his or her work on your claim(s) is complete. This written request describes in detail the amount of time your representative spent on each service he or she provided you. The request also gives the amount of the fee the representative wants to charge for these services. Your representative must give you a copy of the fee petition and each attachment. If you disagree with the information shown in the fee petition, contact your Social Security office. Please do this within 20 days of receiving your copy of the petition.

We will review the petition and consider the reasonable value of the services provided. Then we will tell you in writing the amount of the fee we authorize.

Filing A Fee Agreement

If you and your representative have a written fee agreement, one of you must give it to us before we decide your claim(s). We usually will approve the agreement if:

- you both signed it;
- the fee you agreed on is no more than 25 percent of past-due benefits, or $6,000 (or a higher amount we set and announced in the Federal Register), whichever is less;
- we approve your claim(s); and
- your claim results in past-due benefits.

We will tell you in writing the amount of the fee your representative can charge based on the agreement.

If we do not approve the fee agreement, we will tell you and your representative in writing. If your representative wishes to charge and collect a fee, he or she must file a fee petition. After we tell you the amount of the fee your representative can charge, you or your representative can ask us to look at it again if either or both of you disagree with the amount. If we approved a fee agreement, the person who decided your claim (s) also may ask us to lower the amount. Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

How Much You Pay

You never owe more than the fee we authorize, except for:

- any fee a Federal court allows for your representative's services before it; and
- out-of-pocket expenses your representative incurs or expects to incur, for example, the cost of getting your doctor's or hospital's records. Our authorization is not needed for such expenses.

Your representative may accept money in advance as long as he or she holds it in a trust or escrow account. We usually withhold 25 percent of your past-due benefits to pay toward the fee for you if:

- your retirement, survivors, disability insurance, and/or supplemental security income claim(s) results in past- due benefits;
- your representative is an attorney or a non-attorney whom we have determined to be eligible to receive direct payment of fees; and
- your representative registers with us for direct payment before we effectuate a favorable decision on your claim.

You must pay your representative directly:

- **the rest of the fee you owe**, if the amount of the authorized fee is more than the money we withheld and paid to your representative for you plus any amount your representative held for you in a trust or escrow account.
- **all of the fee you owe**, if we did not withhold past-due benefits, (for example, because there are no past-due benefits; your representative waived direct payment, did not register for direct payment, you discharged the representative, or he or she withdrew from representing you, before we issued a favorable decision); or we withheld an amount from your past-due benefits, but your representative did not ask us to authorize a fee or tell us that he or she planned to ask for a fee within 60 days after the date of your notice of award and we released the withheld amount to you.

8

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part 1 - Claimant's Appointment of Representation

I appoint this individual, _____

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My principal representative is:

Name of Principal Representative

Signature (Claimant)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part 2 - Representative's Acceptance of Appointment

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part 3 satisfies this requirement.)

Check one: ☐ I am an attorney ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☐ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☐ No

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.

Signature (Representative)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part 3 - Fee Arrangement

(Select an option, sign and date this section.)

☐ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits - I do not qualify for or do not request direct payment. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** - By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). (*SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.*)

☐ **I am waiving fees from any source** - I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Representative Copy

9

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part 1 - Claimant's Appointment of Representation

I appoint this individual, _____

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My principal representative is:

Name of Principal Representative

Signature (Claimant)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part 2 - Representative's Acceptance of Appointment

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part 3 satisfies this requirement.)

Check one: ☐ I am an attorney ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☐ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☐ No

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.

Signature (Representative)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part 3 - Fee Arrangement

(Select an option, sign and date this section.)

☐ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits - I do not qualify for or do not request direct payment. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** - By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). (*SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.*)

☐ **I am waiving fees from any source** - I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

OHO Copy

10

SOCIAL SECURITY ADMINISTRATION ☐ TEL

Form Approved
OMB No. 0960-0229

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)

Note: Social Security Administration staff or others who help people apply for SSI will fill out this form for you.

Do Not Write in This Space
DATE STAMP

I am/We are applying for Supplemental Security Income and any federally administered state supplementation under Title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under Title XIX of the Social Security Act.

Filing Date (month, day, year)

☐ Receipt ☐ Protective

☐ FS-SSA/APP ☐ FS-REFERRED

Preferred Language
Written: Spoken:

TYPE OF CLAIM ☐ Individual ☐ Individual with Ineligible Spouse ☐ Couple ☐ Child ☐ Child with Parents

PART I--BASIC ELIGIBILITY-- Answer the questions below beginning with the first moment of the filing date month.

1. (a) First Name, Middle Initial, Last Name | Sex ☐ Male ☐ Female | Birthdate (month, day, year) | Social Security Number

(b) Did you ever use any other names (including maiden name) or any other Social Security Numbers? ☐ YES Go to (c) ☐ NO Go to (d)

(c) Other Name(s) | Other Social Security Number(s) used

(d) If you are also filing for Social Security Benefits, go to #2; otherwise complete the following:

Mother's Maiden Name: Father's Name: Go to #2

2. Applicant's Mailing Address (Number & Street, Apt. No. P.O. Box, Rural Route)

City and State | ZIP Code | County

3. Claimant's Residence Address (If different from applicant's mailing address)

City and State | ZIP Code | County

4. **DIRECT DEPOSIT PAYMENT ADDRESS (FINANCIAL INSTITUTION)**

Routing Transit Number | Account Number | ☐ Checking ☐ Savings | ☐ Enroll in Direct Express ☐ Direct Deposit Refused

5.	(a) Are you married?	☐ YES Go to (b)	☐ NO Go to #6
	(b) Date of marriage: (month, day, year)		
	(c) Spouse's Name (First, middle initial, last)	Birthdate (month, day, year)	Social Security Number
	(d) Did your spouse ever use any other names (including maiden name) or Social Security Numbers?	☐ YES Go to (e)	☐ NO Go to (f)
	(e) Other Name(s)	Other Social Security Number(s) Used	
	(f) Are you and your spouse living together?	☐ YES Go to #6	☐ NO Go to (g)
	(g) Date you began living apart : (month, day, year)		
	(h) Address of spouse or name of someone who knows where spouse is. (Complete only if spouse is age 65, blind or disabled.)		

6.	(a) Have you had any other marriages? If never married, check this box ☐	You		Your Spouse, if filing	
		☐ YES Go to (b)	☐ NO Go to #7	☐ YES Go to (b)	☐ NO Go to #7

(b) Give the following information about your former spouse. If there was more than one former marriage, show the remaining information in Remarks and go to #4.

	YOU	YOUR SPOUSE
FORMER SPOUSE'S NAME (including maiden name)		
BIRTHDATE (month, day, year)		
SOCIAL SECURITY NUMBER		
DATE OF MARRIAGE (month, day, year)		
DATE MARRIAGE ENDED (month, day, year)		
HOW MARRIAGE ENDED		

7.	If you are filing for yourself, go to (a); if you are filing for a child, go to (e).				
	(a) Are you unable to work because of illnesses, injuries or conditions?	You ☐ YES Go to (b)	☐ NO Go to #8	Your Spouse ☐ YES Go to (b)	☐ NO Go to #7
	(b) Enter the date you became unable to work.	(month, day, year)		(month, day, year)	

(c) What are your illnesses, injuries or conditions?

You	Your Spouse
Go to (d)	Go to (d)

12

7. (d) If you were unable to work because of illnesses, injuries, or conditions before you were age 22, do you have a parent who is age 62 or older, unable to work because of illnesses, injuries or conditions, or deceased?

☐ YES Parent's Name: _____

Social Security Number: _____

Address: _____

_____

☐ NO Go to #8

(month, day, year)

(e) When did the child become disabled?

Go to (f)

(f) What are the child's disabling illnesses, injuries or conditions?

Go to (g)

(g) Does the child have a parent(s) who is age 62 or older, unable to work because of illness, injuries, or conditions, or deceased?

☐ YES Parent's Name: _____

Social Security Number: _____

Address: _____

_____

☐ NO Go to #8

8.

Birthplace	City	State	Country (if other than the U.S.)
You			
Your Spouse, if filing			

Go to #9

		You		Your Spouse, if filing	
9.	Are you a United States citizen by birth?	☐ YES Go to #15	☐ NO Go to #10	☐ YES Go to #15	☐ NO Go to #10
10.	Are you a naturalized United States citizen?	☐ YES Go to #15	☐ NO Go to #11	☐ YES Go to #15	☐ NO Go to #11
11.	(a) Are you an American Indian born outside the United States?	☐ YES Go to (b)	☐ NO Go to (c)	☐ YES Go to (b)	☐ NO Go to (c)

(b) Check the block that shows your American Indian status.

You	Your Spouse, if filing
☐ American Indian born in Canada Go to #15	☐ American Indian born in Canada Go to #15
☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #15	☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #15
☐ Other American Indian Explain in Remarks, then Go to (c)	☐ Other American Indian Explain in Remarks, then Go to (c)

11. (c) Check the block below that shows your current immigration status

You	Your Spouse, if filing
☐ Amerasian Immigrant — Go to #12	☐ Amerasian Immigrant — Go to #12
☐ Lawful Permanent Resident — Go to #12	☐ Lawful Permanent Resident — Go to #12
☐ Refugee Date of entry: — Go to #14	☐ Refugee Date of entry: — Go to #14
☐ Asylee Date status granted: — Go to #14	☐ Asylee Date status granted: — Go to #14
☐ Conditional Entrant Date status granted: — Go to #14	☐ Conditional Entrant Date status granted: — Go to #14
☐ Parolee for One Year — Go to #14	☐ Parolee for One Year — Go to #14
☐ Cuban/Haitian Entrant — Go to #14	☐ Cuban/Haitian Entrant — Go to #14
☐ Deportation/Removal Withheld Date: — Go to #14	☐ Deportation/Removal Withheld Date: — Go to #14
☐ Other Explain in Remarks, then Go to (d)	☐ Other Explain in Remarks, then Go to (d)

(d) If you have status, or have applied for status as the spouse, child, or parent of a child of a US citizen, or lawfully admitted permanent resident alien, Go to #13; otherwise Go to #15.

12. If you are lawfully admitted for permanent residence:

	You (month, day, year)	Your Spouse (month, day, year)
(a) Date of Admission		
(b) Was your entry into the United States sponsored by any person or promoted by an institution or group?	☐ YES Go to (c) ☐ NO Go to (d)	☐ YES Go to (c) ☐ NO Go to (d)

(c) Give the following information about the person, institution, or group, then Go to (d):

Name	Address	Telephone Number
		( ) -

	You	Your Spouse, if filing
(d) What was your immigration status, if any, before adjustment to lawful permanent resident?	Status:	Status:
	(month, day, year) From: To:	(month, day, year) From: To: Go to (e)
(e) If filing as an adult, did your parents ever work in the United States before you were age 18?	☐ YES Go to (f) ☐ NO Go to #14	☐ YES Go to (f) ☐ NO Go to #14

(f) Name and Social Security Number of parent(s) who worked.

Name	Social Security Number
Name	Social Security Number

		You	Your Spouse, if filing
13.	(a) Have you, your child or your parent, been subjected to battery or extreme cruelty while in the United States?	☐ YES Go to (b) ☐ NO Go to #15	☐ YES Go to (b) ☐ NO Go to #15
	(b) Have you, your child, or your parent filed a petition with the Department of Homeland Security for a change in immigration status because of being subjected to battery or extreme cruelty?	☐ YES Go to #14 ☐ NO Go to #15	☐ YES Go to #14 ☐ NO Go to #15
14.	Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	☐ YES Explain in #60(b), then Go to #15 ☐ NO Go to #15	☐ YES Explain in #60(b), then Go to #15 ☐ NO Go to #15
15.	(a) When did you first make your home in the United States?	(month, day, year)	(month, day, year)
	(b) Have you lived outside of the United States since then?	☐ YES Go to (c) ☐ NO Go to #16	☐ YES Go to (c) ☐ NO Go to #16
	(c) Give the dates of residence outside the United States.	(month, day, year) From: To:	(month, day, year) From: To:
16.	(a) Have you been outside the United States (the 50 states, District of Columbia and Northern Mariana Islands) 30 consecutive days prior to the filing date?	☐ YES Go to (b) ☐ NO Go to #17	☐ YES Go to (b) ☐ NO Go to #17
	(b) Give the date (month, day, year) you left the United States and the date you returned to the United States.	Date Left: Date Returned:	Date Left: Date Returned:

IF YOU ARE FILING ON BEHALF OF YOUR CHILD, GO TO #17.
IF YOU ARE MARRIED AND YOUR SPOUSE IS NOT FILING FOR SUPPLEMENTAL SECURITY INCOME AND YOU LIVED TOGETHER AT ANY TIME SINCE THE FIRST MOMENT OF THE FILING DATE MONTH, GO TO #17; OTHERWISE GO TO #18.

17.	(a) Is your spouse/parent the sponsor of an alien who is eligible for supplemental security income?	☐ YES Go to (b)	☐ No Go to #18
	(b) Eligible Alien's Name	Eligible Alien's Social Security Number	Go to #18

		You	Your Spouse, if filing
18.	(a) Do you have any unsatisfied felony warrants for your arrest?	☐ YES Go to (b) ☐ NO Go to #19	☐ YES Go to (b) ☐ NO Go to #19
	(b) In which state or country was this warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
	(c) Was the warrant satisfied?	☐ YES Go to (d) ☐ NO Go to #19	☐ YES Go to (d) ☐ NO Go to #19
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)
19.	(a) Do you have any unsatisfied Federal or State warrants for violating the conditions of probation or parole?	☐ YES Go to (b) ☐ NO Go to #20	☐ YES Go to (b) ☐ NO Go to #20

19.			
	(b) In which state or country was the warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
	(c) Was the warrant satisfied?	☐ YES Go to (d) ☐ NO Go to #20	☐ YES Go to (d) ☐ NO Go to #20
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)

PART II - LIVING ARRANGEMENTS - The questions in this section refer to the signature date.

20. Check the block which best describes your present living situation:

☐ Household	Since (month, day, year) Go to #25
☐ Non-Institutional Care	Since (month, day, year) Go to #23
☐ Institution	Since (month, day, year) Go to #21
☐ Transient or homeless	Since (month, day, year) Go to #38

INSTITUTION

21. Check the block that identifies the type of institution where you currently reside, then Go to #22:

☐ School	☐ Rehabilitation Center
☐ Hospital	☐ Jail
☐ Rest or Retirement Home	☐ Other (Specify)
☐ Nursing Home	

22. Give the following information about the INSTITUTION:

(a) Name of institution:

(b) Date of admission:

(c) Date you expect to be released from this institution:

Go to #38

NON-INSTITUTIONAL CARE

23. Check the block that best describes your current residence, then Go to #24:

☐ Foster Home ☐ Group Home ☐ Other (Specify)

24. Give the following information about your Noninstitutional Care:

(a) Name of facility where you live:

24.	(b) Name of placing agency	Address	Telephone Number
			( ) -

(c) Does this agency pay for your room and board?

☐ YES Go to #38 ☐ NO If NO, who pays?

Go to #38

HOUSEHOLD ARRANGEMENTS

25. Check the block that describes your current residence, then Go to #26:

☐ House	☐ Mobile Home
☐ Apartment	☐ Houseboat
☐ Room (private home)	☐ Other (Specify)
☐ Room (commercial establishment)	

26. Do you live alone or only with your spouse? ☐ YES Go to #28 ☐ NO Go to #27

27. (a) Give the following information about everyone who lives with you:

Name	Relationship	Public Assistance		Sex		Birthdate mm/dd/yy	Blind or Disabled		If Under 22				Social Security Number
									Married		Student		
		YES	NO	M	F		YES	NO	YES	NO	YES	NO	

If anyone listed is under age 22 and not married, Go to (b); otherwise, Go to #28.

27. (b) Does anyone listed in 27(a) who is under age 18, OR between ages 18-22 and a student, receive income? ☐ YES Go to (c) ☐ NO Go to #28

(c) Child Receiving Income	Source and Type	Monthly Amount
		$
		$
		$
		$
		$
		$

28. (a) Do you (or does anyone who lives with you) own or rent the place where you live? ☐ YES Go to #29 ☐ No Go to (b)

(b) Name of person who owns or rents the place where you live	Address	Telephone Number
		( ) -

(c) If you live alone or only with your spouse, and do not own or rent, Go to #38; otherwise, Go to #32.

29. (a) Are you (or your living with spouse) buying or do you own the place where you live? ☐ YES Go to (c) ☐ No If you are a child living with your parent(s) Go to (b); otherwise Go to #30

(b) Are your parent(s) buying or do they own the place where you live? ☐ YES Go to (c) ☐ NO Go to #30

(c) What is the amount and frequency of the mortgage payment?

Amount: $ Frequency of Payment:

Go to (d)

(d) If you are a child living only with your parents, or only with your parents and their other children who are subject to deeming, or with others in a public assistance household, or living alone or with your spouse, Go to #38; otherwise Go to #32.

30. (a) Do you (or your living with spouse) have rental liability for the place where you live? ☐ YES Go to (d) ☐ NO If you are a child living with your parent(s) Go to (b); otherwise Go to (c)

(b) Does your parent(s) have rental liability? ☐ YES Go to (d) ☐ NO Go to (c)

30. (c) Does anyone who lives with you have rental liability for the place where you live?

☐ YES Give name of person with rental liability: _____ Go to #31

☐ NO Give name of person with home ownership: _____ Go to #32

(d) What is the amount and frequency of the rent payment?

Amount: $ Frequency of Payment:

Go to #31

31. (a) Are you (or anyone who lives with you) the parent or child of the landlord or the landlord's spouse? ☐ YES Go to (b) ☐ NO Go to (c)

(b) Name of person related to landlord or landlord's spouse	Relationship	Name and address of landlord (include telephone number and area code, if known):

(c) If you are a child living only with your parents, or only with your parents and their other children who are subject to deeming, or with others in a public assistance household, or living alone or with your spouse, Go to #38.

32. (a) Does anyone living with you contribute to the household expenses? (NOTE: See list of household expenses in #37) ☐ YES Go to (b) ☐ NO Go to #33

(b) Amount others contribute: $

Go to #33

33. (a) Do you eat all your meals out? ☐ YES Go to #34 ☐ NO Go to (b)

(b) Do you buy all your food separately from other household members: ☐ YES Go to #34 ☐ NO Go to #34

34. Do you contribute to household expenses?

☐ YES Average Monthly Amount: $ _____ Go to #35

☐ NO Go to #35

35. (a) Do you have a loan agreement with anyone to repay the value of your share of the household expenses? ☐ YES Go to (b) ☐ NO Go to #35(d)

(b) Give the name, address and telephone number of the person with whom you have a loan agreement :

(c) Will the amount of this loan cover your share of the household expenses? ☐ YES Go to #38 ☐ NO Go to (d)

(d) **If you contribute** toward household expenses and you answered "NO" to both 33(a) & (b), Go To #36. If you answered "YES" to either 33(a) or 33(b), Go to #37.

If you do not contribute toward household expenses, go to #38.

36. (a) Is part or all of the amount in #34 just for food?

☐ YES Give Amount: $ _____ Go to (b) ☐ NO Go to (b)

(b) Is part or all of the amount in #34 just for shelter?

☐ YES Give Amount: $ _____ Go to #37 ☐ NO Go to #37

37. What is the average monthly amount of the following household expenses:
(Show average over the past 12 months unless you have been residing at your present address less than 12 months. If so, show average for the months you have resided at your present address.)

CASH EXPENSES	AVERAGE MONTHLY AMOUNT
Food (complete only if #33(a) & (b) are answered NO)	$
Mortgage or Rent	$
Property Insurance (if required by mortgage lender)	$
Real Property Taxes	$
Electricity	$
Heating Fuel	$
Gas	$
Sewer	$
Garbage Removal	$
Water	$
TOTAL	$

Go to #38

38. (a) Does anyone who does NOT LIVE with you pay for, or provide you or your household (if applicable), any of your food or shelter items?

☐ YES Name of Provider (Person or Agency) _____

List of Items _____

Monthly Value: $ _____

☐ NO

Go to (b)

(b) Does anyone who does NOT LIVE with you give you, or your household (if applicable), money to pay for any of your or your household's food or shelter items?

☐ YES Name of Provider (Person or Agency) _____

List of Items _____

Monthly Value: $ _____

☐ NO

Go to #39

39. (a) Has the information given in #20-38 been the same since the first moment of the filing date month?	☐ YES Go to (b)	☐ NO Explain in Remarks, then Go to (b)
(b) Do you expect any of this information to change?	☐ YES Explain in Remarks, then Go to #40	☐ NO Go to #40

PART III - RESOURCES - The questions in this section pertain to the first moment of the filing date month.

	You	Your Spouse
40. (a) Do you own, or does your name appear (alone or with any other person's name) on the title of any vehicles (auto, truck, motorcycle, camper, boat, etc.)?	☐ YES Go to (b) ☐ NO Go to #41	☐ YES Go to (b) ☐ NO Go to #41

40.

(b) Owner's Name	Description (Year, Make & Model)	Used For	Current Market Value	Amount Owed
			$	$
			$	$
			$	$
			$	$

41. (a) Do you own or are you buying any life insurance policies?

You		Your Spouse	
☐ YES	☐ NO	☐ YES	☐ NO
Go to (b)	Go to #42	Go to (b)	Go to #42

(b) Owner's Name		Name of Insured	Name & Address of Insurance Company	Policy Number
Policy (#1)				
Policy (#2)				
Policy (#3)				

	Face Value	Cash Surrender Value	Date of Purchase	Dividends		Accumulations	
				YES	NO	YES	NO
Policy (#1)	$	$					
Policy (#2)	$	$					
Policy (#3)	$	$					

(c) Loans Against Policy? ☐ YES ☐ NO

Policy Number: _____

Amount: $_____

Go to #42

42.

(a) Do you (either alone or jointly with any other person) own any:	You		Your Spouse	
	YES	NO	YES	NO
Life estates or ownership interest in an unprobated estate?				
Items acquired or held for their value as an investment?	☐	☐	☐	☐

21

42. (b) Give the following information for any "Yes" answer in #42(a); otherwise, Go to #43.

Owner's Name	Name of Item	Value	Amount Owed	Give Name & Address of Bank or Other Organization
		$	$	
		$	$	
		$	$	
		$	$	

43. (a) Do you own, or does your name appear on (either alone or with any other person's name) any of the following items?

	You		Your Spouse	
	YES	NO	YES	NO
Cash at home, with you, or anywhere else				
Financial Institution Accounts				
Checking				
Savings				
Credit Union				
Christmas Club				
Time Deposits/Certificates of Deposit				
Individual Indian Money Account				
Other (Including IRAs and Keough Accounts)				

(b) If all the items in #43(a) are answered "NO", Go to #44. For any "YES" answer, give the following information:

Owner's/Trustee's Name	Name of Item	Value	Name & Address of Bank or Other Organization	Identifying Number
		$		
		$		
		$		

44.	(a) Do you give us permission to obtain any financial records from any financial institution?	You		Your Spouse, if filing	
		☐ YES Go to (b)	☐ NO Go to (b)	☐ YES Go to (b)	☐ NO Go to (b)

(b) Do you own or does your name appear on any of the following items:	You		Your Spouse	
	YES	NO	YES	NO
Stocks or Mutual Funds				
Bonds (Including U.S. Savings Bonds)				
Promissory Notes				
Trusts				
Other items that can be turned into cash				

(c) If all the items in #44(b) are answered "NO", Go to #45. For any "YES" answer, give the following information:

Owner's/Trustee's Name	Name of Item	Value	Name & Address of Bank or Other Organization	Identifying Number
		$		
		$		
		$		
		$		

45.	(a) Do you own, or does your name appear (alone or with any other person's name) on any land, houses, buildings, real property, property in foreign country, equipment, mineral rights, items in a safe deposit box, assets set aside for emergencies or heirs, or any other property of any kind that has not been shown anywhere else on the application	You		Your Spouse	
		☐ YES Go to (b)	☐ NO Go to #46	☐ YES Go to (b)	☐ NO Go to #46

(b) Describe the property (including size, location, and how it is used. If the property is not used now, when was it last used? Do you plan to use the property in the future?

Item #1

Item #2

45.

Owner's Name	Estimated Current Market Value	Tax Assessed Value	Mortgage	Owed on Item
	$	$	$	$
	$	$	$	$
	$	$	$	$

46. (a) Have you or your spouse acquired any assets since the first moment of the filing date month? ☐ YES Go to (b) ☐ NO Go to (c)

(b) Explain:

(c) Has there been any increase or decrease in the value of you or your spouse's resources since the first moment of the filing date month? ☐ YES Go to (d) ☐ NO Go to #47

(d) Explain:

47.

	You	Your Spouse
(a) Have you or your spouse sold, transferred title, disposed of or given away, any money or other property, (including money or property in foreign countries), since the first moment of the filing date month or within the 36 months prior to the filing date month?	☐ YES ☐ NO Go to (b)	☐ YES ☐ NO Go to (b)
(b) If you co-owned any money or property with another person(s), did you or any co-owner sell, transfer, or give away any co-owned money or property within the 36 months prior to the filing date month?	☐ YES ☐ NO	☐ YES ☐ NO

IF YOU ANSWERED "YES" TO (a) OR (b), GO TO (c). IF "NO" TO BOTH, GO TO #48.

(c)	OWNER'S/CO-OWNERS NAME	DESCRIPTION OF PROPERTY	DATE OF DISPOSAL
ITEM #1			
ITEM #2			
ITEM #3			
	NAME AND ADDRESS OF PURCHASER OR RECIPIENT	RELATIONSHIP TO OWNER	VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT
ITEM #1			$

47.

ITEM #2			$
ITEM #3			$
	SALES PRICE OR OTHER CONSIDERATION	ARE OTHER CONSIDERATION OR PROCEEDS EXPECTED? EXPLAIN.	DO YOU STILL OWN PART OF THE PROPERTY?
ITEM #1			
ITEM #2			
ITEM #3			

	SOLD ON OPEN MARKET?	GIVEN AWAY?	TRADED FOR GOODS/SERVICES?
ITEM #1	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ITEM #2	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ITEM #3	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

48. (a) Do you have any assets set aside for burial expenses such as burial contracts, trusts, agreements, or anything else you intend for your burial expenses? Include any items mentioned in #41 and #43-47.

You	Your Spouse
☐ YES ☐ NO	☐ YES ☐ NO
Go to (b) Go to #49	Go to (b) Go to #49

(b) DESCRIPTION (Where appropriate, give name & address of organization and account/ policy number.)	VALUE	WHEN SET ASIDE (month, day, year)	OWNER'S NAME
Item 1	$		
Item 2	$		

FOR WHOSE BURIAL	IS ITEM IRREVOCABLE?	WILL INTEREST EARNED OR APPRECIATION IN VALUE REMAIN IN THE BURIAL FUND?
Item 1	☐ YES ☐ NO	☐ YES Go to #49 ☐ NO Explain in (c)
Item 1	☐ YES ☐ NO	☐ YES Go to #49 ☐ NO Explain in (c)

(c) EXPLANATION

49.	(a) Do you own any cemetery lots, crypts, caskets, vaults, urns, mausoleums, or other repositories for burial or any headstones or markers?	You		Your Spouse	
		☐ YES	☐ NO	☐ YES	☐ NO
		Go to (b)	Go to #50	Go to (b)	Go to #50

(b) Owner's Name	Description	For Whose Burial	Relationship to You or Your Spouse	Current Market Value
				$
				$
				$

Go to #50

PART IV -- INCOME

50.	(a) Since the first moment of the filing date month, have you (or your spouse) received or do you (or your spouse) expect to receive income in the next 14 months from any of the following sources?	You		Your Spouse	
		YES	NO	YES	NO
	State or Local Assistance Based on Need				
	Refugee Cash Assistance				
	Temporary Assistance for Needy Families				
	General Assistance from the Bureau of Indian Affairs				
	Disaster Relief				
	Veteran Benefits Based on Need (Paid Directly or Indirectly as a Dependent)				
	Veteran Payments Not Based on Need (Paid Directly or Indirectly as a Dependent)				
	Other Income Based on Need				
	Social Security				
	Black Lung				
	Railroad Retirement Board Benefits				
	Office of Personnel Management (Civil Service)				
	Pension (Foreign Military, State, Local, Private, Union, Retirement or Disability)				
	Military Special Pay or Allowance				
	Unemployment Compensation				

50.					
	Workers' Compensation				
	State Disability				
	Insurance or Annuity Payments				
	Dividends/Royalties				
	Rental/Lease Income Not from a Trade or Business				
	Alimony				
	Child Support				
	Other Bureau of Indian Affairs Income				
	Gambling/Lottery Winnings				
	Other Income or Support				

(b) Give the following information for any block checked YES in #50(a); otherwise, Go to #51

Person Receiving Income	Type of Income	Amount Received	Frequency of Payment	Date Expected or Received	Source (Name, Address of Person, Bank, Organization or Company)	Identifying Number
		$				
		$				
		$				

IF YOU EVER RECEIVED SSI BEFORE, GO TO #51; OTHERWISE GO TO #52

		You		Your Spouse	
51.	Are any overpayments being collected from benefits you receive from the Social Security Administration, Railroad Retirement Board, Office of Personnel Management, Veterans' Affairs, Military Pensions, Military Special Pay Allowances, Black Lung, Workers' Compensation, or State Disability or Unemployment Benefits?	☐ YES Explain in Remarks, then Go to #52	☐ NO Go to #52	☐ YES Explain in Remarks, then Go to #52	☐ NO Go to #52
52.	Since the first moment of the filing date month, have you received or do you expect to receive any meals or other gifts which are not cash?	☐ YES Explain in Remarks, then Go to #53	☐ NO Go to #53	☐ YES Explain in Remarks, then Go to #53	☐ NO Go to #53
53.	(a) Have you (or your spouse) received wages or sick pay since the first moment of the filing date month through the current month?	☐ YES Go to (b)	☐ NO Go to (e)	☐ YES Go to (b)	☐ NO Go to (e)

(b) Name and Address of Employer (include telephone number and area code, if known)

You	Your Spouse
Go to (c)	Go to (c)

53. (c)

	Date last worked (month, day, year)	Date last paid (month, day, year)	Date next paid (month, day, year)
You			
Your Spouse			

(d) Total monthly wages received (before any deductions)

Your Amount	Your Spouse's Amount
$	$

(e) Do you (or your spouse) expect to receive any wages in the next 14 months?

You		Your Spouse	
☐ YES	☐ NO	☐ YES	☐ NO
Go to (f)	Go to #54	Go to (f)	Go to #54

(f) Name and address of employer if different from #53(b) (include telephone number, if known)

You	Your Spouse

(g) Give the following information:

	RATE OF PAY	AMOUNT WORKED PER PAY PERIOD	HOW OFTEN PAID	PAY DAY OR DATE PAID	DATE LAST PAID (month, day, year)
You	$				
Your Spouse	$				

(h) Do you expect any change in wage information provided in #53(g)

You		Your Spouse	
☐ YES	☐ NO	☐ YES	☐ NO
Go to (i)	Go to #54	Go to (i)	Go to #54

(i) Explain Change:

You	Your Spouse

54. (a) Have you been self-employed at any time since the beginning of the taxable year in which the filing date month occurs or do you expect to be self-employed in the current taxable year?

You		Your Spouse	
☐ YES	☐ NO	☐ YES	☐ NO
Go to (b)	Go to #55	Go to (b)	Go to #55

(b) Give the following information; then Go to #55

Date(s) Self-Employed	Type of Business	Last Year's: Gross Income	Last Year's: Net Profit	Last Year's: Net Loss
		$	$	$
Date(s) Self-Employed	Type of Business	This Year's: Gross Income	This Year's: Net Profit	This Year's: Net Loss
		$	$	$

55.	If you or your spouse are blind or disabled, do you have any special expenses that you paid which are necessary for you to work?	**You** ☐ YES Explain in Remarks; then Go to #56 ☐ NO Go to #56	**Your Spouse** ☐ YES Explain in Remarks; then Go to #56 ☐ NO Go to #56
56.	(a) Does your spouse/parent who lives with you have to pay court-ordered support?	☐ YES Go to (b)	☐ NO Go to NOTE
	(b) Give amount and frequency of court-ordered support payment.	Amount: $	Frequency: Go to (c)
	(c) Give the following information about the person who receives these payments:	Name:	Address:

NOTE: IF YOU ARE FILING AS A CHILD AND YOU ARE EMPLOYED OR AGE 18 - 22 (WHETHER EMPLOYED OR NOT), GO TO #57; OTHERWISE, GO TO #58.

57.	(a) Have you attended school regularly since the filing date month?	☐ YES Go to (d)	☐ NO Go to (b)	
	(b) Have you been out of school for more than 4 calendar months?	☐ YES Go to (c)	☐ NO Go to (c)	
	(c) Do you plan to attend school regularly during the next 4 months?	☐ YES Explain absence in Remarks and Go to (d)	☐ NO Go to #58	
	(d) Name of School	Name of School Contact Phone Number	Dates of Attendance From / To Hours Attending or Planning to Attend	Course of Study

PART V - POTENTIAL ELIGIBILITY FOR FOOD STAMPS/MEDICAL ASSISTANCE/OTHER BENEFITS - If a California resident, Skip to #59

		You		Your Spouse, if filing	
58.	(a) Are you currently receiving food stamps?	☐ YES Go to (b)	☐ NO Go to (c)	☐ YES Go to (b)	☐ NO Go to (c)
	(b) Have you received a recertification notice within the past 30 days?	☐ YES Go to (e)	☐ NO Go to #59	☐ YES Go to (e)	☐ NO Go to #59
	(c) Have you filed for food stamps in the last 60 days?	☐ YES Go to (d)	☐ NO Go to (e)	☐ YES Go to (d)	☐ NO Go to (e)
	(d) Have you received an unfavorable decision?	☐ YES Go to (e)	☐ NO Go to #59	☐ YES Go to (e)	☐ NO Go to #59
	(e) If everyone in the household receives or is applying for SSI, Go to (f); otherwise Go to #59.				
	(f) May I take your food stamp application today?	☐ YES Go to #59	☐ NO Explain in (g)	☐ YES Go to #59	☐ NO Explain in (g)
	(g) Explanation:				

59. You may be eligible for Medicaid. However, you must help your State identify other sources that pay for medical care. Also, you must give information to help the State get medical support for any child(ren) who is your legal responsibility. This includes information to help the State determine who a child's father is. If you want Medicaid, you must agree to allow your State to seek payments from sources, such as insurance companies, that are available to pay for your medical care. This includes payments for medical care for you or any person who receives Medicaid and is your legal responsibility. The State cannot provide you Medicaid if you do not agree to this Medicaid requirement. If you need further information, you may contact your Medicaid Agency.

IN STATES WITH AUTOMATIC ASSIGNMENT OF RIGHTS LAWS, Go to (b).

	You		Your Spouse, if filing	
(a) Do you agree to assign your rights (or the rights of anyone for whom you can legally assign rights) to payments for medical support and other medical care to the State Medicaid agency?	☐ YES Go to (b)	☐ NO Go to #60	☐ YES Go to (b)	☐ NO Go to #60
(b) Do you, your spouse, parent or stepparent have any private, group, or governmental health insurance that pays the cost of your medical care? (Do not include Medicare or Medicaid.)	☐ YES Go to (c)	☐ NO Go to (c)	☐ YES Go to (c)	☐ NO Go to (c)
(c) Do you have any unpaid medical expenses for the 3 months prior to the filing date month?	☐ YES Go to #60	☐ NO Go to #60	☐ YES Go to #60	☐ NO Go to #60

60. (a) Have you ever worked under the U.S. Social Security System? ☐ YES Go to (b) ☐ NO Go to (b)

(b) Have you, your spouse, or a former spouse (or parent if you are filing as a child) ever:

	You		Your Spouse/Parent		Filed for Benefits	
	Yes	No	Yes	No	Yes	No
Worked for a railroad						
Been in military service						
Worked for the Federal Government						
Worked for a State or Local Government						
Worked for an employer with a pension plan						
Belonged to union with a pension plan						
Worked under a Social Security system or pension plan of a country other than the United States?						

(c) Explain and include dates for any "Yes" answer given in #14 or #60(a); otherwise Go to #61.

You:	Your Spouse, if filing/Your Parent, if filing as a child:

PART VI -- MISCELLANEOUS -- (Answer #61 ONLY IF YOU ARE APPLYING ON BEHALF OF SOMEONE ELSE: OTHERWISE GO TO #62.

61.	(a) Name of Person/Agency Requesting Benefits.	Relationship to Claimant	Your Social Security Number (or EIN)
	(b) If SSA determines that the claimant needs help managing benefits, do you wish to be selected representative payee?	☐ YES	☐ NO (Explain in Remarks)

PART VII -- REMARKS--(You may use this space for any explanations. Enter the item number before each explanation. If you need more space, use a signed form SSA-795.)

PART VIII -- IMPORTANT INFORMATION AND SIGNATURES

62. **IMPORTANT INFORMATION--PLEASE READ CAREFULLY**

- ▶ Failure to report any change within 10 days after the end of the month in which the change occurs could result in a penalty deduction.
- ▶ The Social Security Administration will check your statements and compare its records with records from other State and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount.
- ▶ We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you or your spouse notify us in writing that you are canceling your permission, (2) your application for SSI is denied in a final decision, (3) your eligibility for SSI terminates, or (4) we no longer consider your spouse's income and resources to be available to you. If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

63. **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 or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

Your Signature (First name, middle initial, last name) (Sign in ink.)	Date (month, day, year)
SIGN HERE ▶	Telephone Number(s) where we can contact you during the day: ( ) -

Spouse's Signature **(Sign only if applying for payments.)** (First name, middle initial, last name) (Sign in ink.)

SIGN HERE ▶

64. If you are blind or visually impaired, check the type of mail you want to receive from us.

☐ Standard notice First Class ☐ Standard notice First-Class with a follow-up phone call ☐ Standard notice & data CD by First-Class
☐ Standard notice Certified ☐ Standard & Braille notices by First-Class ☐ Standard & large print notices ☐ Standard notice & audio CD

65. WITNESS

Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing who know you, must sign below giving their full address.

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)

RECEIPT FOR YOUR CLAIM FOR SUPPLEMENTAL SECURITY INCOME

Name	Social Security Number	Date
Name	Social Security Number	Date

If you have a question or something to report call:	Social Security Office you may visit or mail your request to:
( ) -	

For general information about Social Security, visit our website at www.socialsecurity.gov on the Internet.

We will process your application for Supplemental Security Income as quickly as possible. If you have trouble getting any information or records we have asked for, please contact us and we will help you.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed. If you do not get a check or notice of determination within that time, please get in touch with us.

Privacy Act Statement/ Paperwork Reduction Act Statement
Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. We will use this information to help us determine your entitlement to benefits. Furnishing us this information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim, which may result in the loss of payments. We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. 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 an agency to assist Social Security in establishing rights to Medicare 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 and audit activities necessary to assure the integrity and improvement 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.

A complete use of routine uses for this information is available in System of Records Notices 60-0089, Claims Folder System and 60-0050, Completed Determination-Continuing Disability Determinations. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or 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 40 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING 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.**

REPORTING RESPONSIBILITIES

The amount of a Supplemental Security Income (SSI) check is based on the information told to us. You must tell Social Security every time there is a change-while we process your application AND if you start receiving SSI.

Remember, a change may make the SSI monthly payment bigger or smaller. Report changes in income of your ineligible husband/wife or child who lives with you or your sponsor or sponsor's spouse, if you are an alien. You must also report changes in the things of value that these people own. You must also report changes in income, school attendance and marital status of ineligible children who live with you.

You must tell us about any change within 10 days after the month it happens. If you do not report changes, we may have to take as much as $25, $50, or $100 out of future checks.

HOW TO REPORT

You may make your reports:

- **By telephone at the telephone number shown above or call us toll free at 1-800-772-1213 (TTY 1-800-325-0778) or**
- **In person or**
- **By mail at the address shown above.**

CHANGES TO REPORT

WHERE YOU LIVE --You must report to Social Security if:

- You move.
- You (or your spouse) leave your household for a calendar month or longer. (For example, you enter a hospital or visit a relative.)
- You are admitted to (for a calendar month or longer), or released from, a hospital or nursing home, jail, prison, or other correctional facility or other institution.
- You leave the United States for 30 consecutive days.
- You are no longer a legal resident of the United States

HOW YOU LIVE -You must report to Social Security:

- If anyone moves into or out of your household.
- If the amount of money you pay toward household expenses changes.
- Births and deaths of any people with whom you live.
- Your spouse or former spouse dies.
- Your marital status changes:
  --You get married, separated, divorced, or your marriage is annulled.
  --You begin living with someone as husband and wife.

INCOME-You must report to Social Security if you, your spouse/your parent(s):

- Start to receive money (or checks or any other type of payment) from someone or someplace.
- Have a change in the amount of money you receive.
- Begin to receive child support payments or those payments go up or down.
- Win money from gambling or a lottery.
- Start work or stop work.
- Earn more or less money. **(Keep all paystubs** and provide them to SSA when requested.)
- Become eligible for benefits other than SSI.

HELP YOU GET FROM OTHERS -You must report to Social Security if:

- The amount of help (money or food, or payment of household expenses) you receive goes up or down.
- Someone stops helping you.
- Someone starts helping you.

THINGS OF VALUE THAT YOU OWN -You must report to Social Security if:

- The value of things that you own goes over $2000 when you add them all together ($3000 if you are married and live with your spouse).
- You sell or give any thing of value away.
- You buy or are given anything of value.

YOU ARE BLIND OR DISABLED-You must report to Social Security if:

- Your condition improves or your doctor says you can return to work.
- You go to work.

IF YOU ARE THE PARENT, STEP PARENT, OR REPRESENTATIVE PAYEE FOR A CHILD UNDER 18 - A report to Social Security must be made if:

- There is a change in any income the child, his or her parent(s), step parent, or brother(s) or sister(s) receive.
- There is a change in the student status of the child's brother(s) or sister(s).
- There is a change in his or her parents' or step parents' marriage, a change in the value of anything they own, or a change in their residence.

YOU ARE UNMARRIED AND UNDER AGE 22 - A report to Social Security must be made if:

- You start or stop school
- You get married or divorced
- You start or stop working

YOUR IMMIGRATION STATUS CHANGES-

- You must report any changes to Social Security.

YOU ARE SELECTED AS A REPRESENTATIVE PAYEE -You must report to Social Security if:

- The person for whom you receive SSI checks has any changes listed above. (You may be held liable if you do not report changes that could affect the SSI recipient's payment amount, and he/she is overpaid.)
- You will no longer be able or no longer wish to act as that person's representative payee.

IF A WARRANT HAS BEEN ISSUED FOR YOUR ARREST -You must report to Social Security if:

- Your warrant is for a crime or an attempted crime that is a felony (or, in jurisdictions that do not define crimes as felonies, a crime that is punishable by death or imprisonment for a term exceeding 1 year); or
- Your warrant is for a violation of probation or parole under Federal or State law.

SOCIAL SECURITY ADMINISTRATION ☐ TEL

Form Approved
OMB No. 0960-0444

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)
(Deferred or Abbreviated)

Do Not Write in This Space

I am/We are applying for Supplemental Security Income and any federally administered state supplementation under Title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under Title XIX of the Social Security Act.

☐ DEFERRED	☐ ABAP
☐ SNAP-SSA/APP	☐ SNAP-REFERRED

Filing Date (Month, Day, Year)

☐ Receipt	☐ Protective

Preferred Language:

Written:

Spoken:

TYPE OF CLAIM ☐ Individual ☐ Individual with Ineligible Spouse ☐ Couple ☐ Child ☐ Child with Parents

PART 1 - BASIC ELIGIBILITY- Answer the questions below beginning with the first moment of the filing date month.

1. First Name, Middle Initial, Last Name	2. Sex ☐ Male ☐ Female	3. Birthdate (month, day, year)	4. Social Security Number
5. If filing as spouse or couple (a) Spouse's Name(s)	6(a). Sex ☐ Male ☐ Female	7(a). Birthdate (month, day, year)	8(a). Social Security Number(s)
If filing for child (b) Parent 1's Name(s)	6(b). Sex ☐ Male ☐ Female	7(b). Birthdate (month, day, year)	8(b). Social Security Number(s)
If filing for child (c) Parent 2's Name(s)	6(c). Sex ☐ Male ☐ Female	7(c). Birthdate (month, day, year)	8(c). Social Security Number(s)

Date of Marriage: (month, day, year)

Are you and your spouse living together? ☐ Yes ☐ No If no, date you began living apart:

9. Other Name(s) and Social Security Number(s) you or your spouse used. If filing for child benefits go to (c) and (d)

(a). Your Other Name(s) (including Name at Birth)	Social Security Number

34

(b) Spouse's Other Name(s) (including Name at Birth)	Social Security Number
(c) Parent 1's Other Name(s) (including Name at Birth)	Social Security Number
(d) Parent 2's Other Name(s) (including Name at Birth)	Social Security Number

10. Your Place of Birth (City and State or Foreign Country)

11. Spouse's Place of Birth (City and State or Foreign Country)

12. If you are filing for yourself, go to (a); if you are filing for a child, go to (e).

	You	Your Spouse, if filing
(a) Are you unable to work because of illnesses, injuries, or conditions?	☐ YES Go to (b) ☐ NO Go to #13	☐ YES Go to (b) ☐ NO Go to #13
(b) Enter the date you became unable to work.	(month, day, year) Go to (c)	(month, day, year) Go to (c)
(c) What are your illnesses, injuries, or conditions?	(Brief Description) Go to (d)	(Brief Description) Go to (d)
(d) If you were unable to work because of illnesses, injuries, or conditions before age 22, do you have a parent who is age 62 or older, unable to work because of illnesses, injuries, or conditions or deceased?	☐ YES Provide name(s) and Social Security Number (s) in Remarks. Go to #13	☐ NO Go to #13

(e) When did the child become disabled? (month, day year)

Go to (f)

(f) What are the child's disabling illnesses, injuries, or conditions?

Go to (g)

(g) Does the child have a parent or stepparent who is 62 or older, unable to work because of illnesses, injuries, or conditions, or deceased?	☐ YES Provide name(s) and Social Security Number (s) in Remarks. Go to #13	☐ NO Go to #13

13. If you (and your spouse filing for benefits) were a United States citizen at birth, go to #17; otherwise go to (a).

	You	Your Spouse, if filing
(a) Are you a naturalized United States citizen?	☐ YES Go to #17 ☐ NO Go to (b)	☐ YES Go to #17 ☐ NO Go to (b)
(b) Are you an American Indian born outside the United States?	☐ YES Go to (c) ☐ NO Go to (d)	☐ YES Go to (c) ☐ NO Go to (d)

13. (c) Check the block that shows your American Indian status.

You	Your Spouse, if filing
☐ American Indian born in Canada Go to #17	☐ American Indian born in Canada Go to #17
☐ Member of a Federally recognized Indian Tribe; Name of Tribe: Go to #17	☐ Member of a Federally recognized Indian Tribe; Name of Tribe: Go to #17
☐ Other American Indian Explain in Remarks, then Go to (d)	☐ Other American Indian Explain in Remarks, then Go to (d)

(d) Check the block below that shows your current immigration status.

You	Your Spouse, if filing
☐ **Amerasian Immigrant** Go to #14	☐ **Amerasian Immigrant** Go to #14
☐ **Lawful Permanent Resident** Go to #14	☐ **Lawful Permanent Resident** Go to #14
☐ **Refugee** Date of entry (month, day, year): Go to #16	☐ **Refugee** Date of entry (month, day, year): Go to #16
☐ **Asylee** Date status granted (month, day, year): Go to #16	☐ **Asylee** Date status granted (month, day, year): Go to #16
☐ **Conditional Entrant** Date status granted (month, day, year): Go to #16	☐ **Conditional Entrant** Date status granted (month, day, year): Go to #16
☐ **Parolee for One Year** Go to #16	☐ **Parolee for One Year** Go to #16
☐ **Cuban/Haitian Entrant** Go to #16	☐ **Cuban/Haitian Entrant** Go to #16
☐ **Deportation/Removal Withheld** Date (month, day, year): Go to #16	☐ **Deportation/Removal Withheld** Date (month, day, year): Go to #16
☐ **Other** Explain in Remarks, then Go to (e)	☐ **Other** Explain in Remarks, then Go to (e)

(e) If you have status, or have applied for status, as the spouse, child, or parent of a child of a United States citizen, or a lawfully admitted permanent resident, Go to #15; otherwise Go to #17.

36

14. (a) Date of admission:	You (month, day, year)	Your Spouse, if filing (month, day, year)
(b) Was your entry into the United States sponsored by any person or promoted by an institution or group?	☐ YES Go to (c) ☐ NO Go to (d)	☐ YES Go to (c) ☐ NO Go to (d)

(c) Give the following information about the person, institution or group:

Name	Address	Telephone Number

(d) What was your immigration status, if any, before adjustment to lawful permanent resident?	You (month, day, year) From: ____ To: ____	Your Spouse, if filing (month, day, year) From: ____ To: ____
(e) If filing as an adult, did your parents ever work in the United States before you were 18?	☐ YES Go to (f) ☐ NO Go to #16	☐ YES Go to (f) ☐ NO Go to #16

(f) Name and Social Security Number of parent(s) who worked.

Name	Social Security Number
Name	Social Security Number

15 (a) Have you, your child, or your parent, been subjected to battery or extreme cruelty while in the United States?	You ☐ YES Go to (b) ☐ NO Go to #17	Your Spouse, if filing ☐ YES Go to (b) ☐ NO Go to #17
(b) Have you, your child, or your parent filed a petition with the Department of Homeland Security for a change in immigration status because of being subjected to battery or extreme cruelty?	☐ YES Go to #16 ☐ NO Go to #17	☐ YES Go to #16 ☐ NO Go to #17
16. Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	☐ YES Explain in Remarks, then Go to #17 ☐ NO Go to #17	☐ YES Explain in Remarks, then Go to #17 ☐ NO Go to #17
17. (a) When did you first make your home in the United States?	(month, day, year)	(month, day, year)
(b) Have you lived outside of the United States since then?	☐ YES Go to (c) ☐ NO Go to #18	☐ YES Go to (c) ☐ NO Go to #18
(c) Give the date(s) of residence outside the United States.	(month, day, year) Date Left: ____ (month, day, year) Date Returned: ____	(month, day, year) Date Left: ____ (month, day, year) Date Returned: ____
18. (a) Have you been outside the United States (the 50 States, District of Columbia and Northern Mariana Islands) 30 days prior to the filing date?	☐ YES Go to (b) ☐ NO Go to #19	☐ YES Go to (b) ☐ NO Go to #19
(b) Give the date (month, day, year) you left the United States and the date you returned to the United States.	(month, day, year) Date Left: ____ (month, day, year) Date Returned: ____	(month, day, year) Date Left: ____ (month, day, year) Date Returned: ____

57

19. Claimant's Mailing Address (Number & Street, Apt. No., P.O. Box, or Rural Route)

City and State	ZIP Code	Name of County (if any) in which you live	Telephone Number

20. If you are blind or visually impaired, check the type of mail you want to receive from us

- ☐ Standard notice First-Class
- ☐ Standard notice First-Class with a follow-up phone call
- ☐ Standard notice & data CD by First-Class
- ☐ Standard notice Certified
- ☐ Standard & Braille notices by First-Class
- ☐ Standard & large print notices
- ☐ Standard notice & audio CD

	You	Your Spouse, if filing
21. (a) Do you have any felony warrants for escape from custody, flight to avoid prosecution or confinement, or flight escape?	☐ YES Go to (b) ☐ NO Go to #22	☐ YES Go to (b) ☐ NO Go to #22
(b) In which State or country was the warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
(c) Was the warrant satisfied?	☐ YES Go to (d) ☐ NO Go to #22	☐ YES Go to (d) ☐ NO Go to #22
(d) Date warrant satisfied:	(month, day, year)	(month, day, year)
22. (a) Have you violated a condition of your probation or parole under Federal or State laws?	☐ YES Go to (b) ☐ NO Go to #23	☐ YES Go to (b) ☐ NO Go to #23
(b) In which State did your violation occur?	Name of State Go to (c)	Name of State Go to (c)
(c) Date of violation:	(month, day, year)	(month, day, year)

PART 2 - LIVING ARRANGEMENT (Use "Remarks" to explain any change between the first moment of the filing date month and today.)

23. Claimant's Residence Address

City and State	ZIP Code	Name of County (if any) in which you live

24. (a) Mark the box that describes where you live.

- ☐ House, apartment, mobile home, houseboat
- ☐ Noninstitution (rest home, retirement home, foster home, or group home)
- ☐ Room in commercial establishment
- ☐ Institution (hospital, rehabilitation center, prison, or school)
- ☐ Room in private home
- ☐ Transient or homeless

(b) Date you began living there: (month, day, year)

25. Mark the box that describes with whom you live. If you live in a foster home, group home, or an institution, or if you are a transient or homeless, do not answer but explain in remarks.

- ☐ Alone
- ☐ Spouse/Parents and/or Children
- ☐ Other People

PART 3 - RESOURCES (Show resources as of the first moment of the filing date month. Use "Remarks" to explain any changes.)

26. If you own, or your name or your spouse's/parent's name(s) appear on any of the following items (either alone or with other people's name(s)), enter the total cash value of item(s) on each line.

	YES	NO	Description of Items Marked YES	Co-owned With Others Yes	Co-owned With Others No	Dollar Value You Own	Dollar Value Spouse or Parents Own
(a) Trusts						$	$
(b) Vehicles (auto, truck, camper, boat, motorcycle). How many?						$	$
(c) Property other than the home you live in (land, houses, buildings, property in foreign countries)						$	$
(d) Savings, checking accounts, stocks, bonds						$	$
(e) Cash at home, with you, or anywhere else						$	$
(f) Items held for potential value or investment (for example, coin or card collection, jewelry in safe deposit box)						$	$
(g) Insurance policies						$	$
(h) Other items that can be turned into cash						$	$

27. Are there any assets set aside to meet burial expenses for you or your spouse/parent(s)? (If "Yes" describe the item in "Remarks".)	Your Answer	☐ YES	☐ NO
	Spouse's Answer	☐ YES	☐ NO
	Mother's Answer	☐ YES	☐ NO
	Father's Answer	☐ YES	☐ NO

	You	Your Spouse
28 (a) Have you or your spouse sold, transferred title, disposed of or given away, any money or other property, including money or property in foreign countries, since the first moment of the filing date month or within the 36 months prior to the filing date month?	☐ YES ☐ NO	☐ YES ☐ NO
(b) If you co-owned any money or property with another person(s), did you or any co-owner sell, transfer, or give away any co-owned money or property within the 36 months prior to the filing date month?	☐ YES ☐ NO	☐ YES ☐ NO

IF YOU ANSWERED "YES" TO (a) OR (b), GO TO (c). IF "NO" TO BOTH, GO TO #29.

28 (c)	OWNER'S/CO-OWNER'S NAME	DESCRIPTION OF PROPERTY	DATE OF DISPOSAL
Item#1			
Item #2			
Item #3			
	NAME AND ADDRESS OF PURCHASER OR RECIPIENT	RELATIONSHIP TO OWNER	VALUE OF PROPERTY AND/ OR AMOUNT OF CASH GIFT
Item #1			$
Item #2			$
Item #3			$
	SALE PRICE OR OTHER CONSIDERATION	ARE OTHER CONSIDERATIONS OR PROCEEDS EXPECTED? EXPLAIN	DO YOU STILL OWN PART OF THE PROPERTY?
Item #1			☐ YES ☐ NO
Item #2			☐ YES ☐ NO
Item #3			☐ YES ☐ NO
	SOLD ON OPEN MARKET?	GIVEN AWAY?	TRADED FOR GOODS/ SERVICES?
Item #1	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Item #2	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Item #3	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

29. Do you give us permission to obtain any financial records from any financial institution?	You	Your Spouse, if filing
	☐ YES ☐ NO	☐ YES ☐ NO

PART 4 - INCOME (List all income received since the first moment of the filing date month or expected in the next 3 months.) Include you, your spouse/parents.

30. List cash, checks, and direct payment to bank accounts you (your spouse/parents) received or expect to receive. Include income from wages, sick pay, self-employment, interest, social security, assistance based on need, VA, gifts, pensions, and any other type of income. Give date last paid if income will stop in the next 3 months.

Person Receiving Income	Type of Income	Amount	Frequency Received	Date Last Paid	Source of Income
		$			
		$			
		$			

Also, note here if anyone pays any bills for you directly or gives you money to pay them.

31 (a) Does your spouse/parent pay court ordered child support?	☐ YES Go to (b)	☐ NO Go to #32
(b) Give the amount and frequency of payment: $		

PART 5 - SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

	You		Your Spouse, if filing	
32 (a) Are you currently receiving SNAP benefits (formerly food stamps?	☐ YES Go to (b)	☐ NO Go to (c)	☐ YES Go to (b)	☐ NO Go to (c)
(b) Have you received a recertification notice within the past 30 days?	☐ YES Go to (e)	☐ NO Go to #33	☐ YES Go to (e)	☐ NO Go to #33
(c) Have you filed for SNAP benefits in the last 60 days?	☐ YES Go to (d)	☐ NO Go to (e)	☐ YES Go to (d)	☐ NO Go to (e)
	You		Your Spouse, if filing	
(d) Have you received a favorable decision?	☐ YES Go to #33	☐ NO Go to (e)	☐ YES Go to #33	☐ NO Go to (e)
(e) May I take your SNAP application today?	☐ YES Go to #33	☐ NO Explain in (f)	☐ YES Go to #33	☐ NO Explain in (f)
(f) Explanation:				

PART 6 - MISCELLANEOUS

ANSWER #33 ONLY IF YOU ARE REQUESTING BENEFITS ON BEHALF OF SOMEONE ELSE; OTHERWISE GO TO #34.

33. Name of Person Requesting Benefits	Relationship to Claimant	Your Social Security Number

PART 7 - REMARKS - (You may use this space for any explanations. Enter the item number before each explanation. If you need more space, use a signed form SSA-795.)

PART 8 - IMPORTANT INFORMATION - PLEASE READ CAREFULLY

34. The Social Security Administration will check your statements and compare its records with records from other state and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount. We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you or your spouse notify us in writing that you are cancelling your permission, (2) your application for SSI is denied in a final decision, (3) your eligibility for SSI terminates, or (4) we no longer consider your spouse's income and resources to be available to you. If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

PART 9 - SIGNATURES

35. 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.

36. Your Signature (First name, middle initial, last name) (Write in ink.)	Date (Month, day, year)

37. Spouse's Signature (First name, middle initial, last name) (Write in ink.) (Sign only if applying for payments.)

WITNESSES

38. Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing, who know you, must sign below giving their full address.

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)

DISABILITY REPORT - CHILD - Form SSA-3820-BK
READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM THIS IS NOT AN APPLICATION

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and your interviewer will help you 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.

- Fill out as much of this form as you can before your interview appointment. Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or " none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/ OTHER/ HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail ahead of time, if you were told to do so.
- 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 questions or want to tell us more about an answer, please use Section 10, "DATE AND REMARKS," on Pages 11 and 12, and show the number of the question being answered.

ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records
- Copies of the child's prescriptions or medicine containers
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and medicine containers.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 1631(e)(1), and 223(d)(5)(A) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may affect the decision on the claim.

We will use the information to make a decision regarding if a child is eligible for benefit payments. We may also share your information for the following purposes, called routine uses:

1. To Federal, State, or local agencies that conduct business with the Social Security Administration (SSA) and the release of records is determined to be relevant and necessary; and disclosure is compatible to the reason why the records were collected;

2. To third party contacts when additional information about the child is needed or verification of eligibility for benefits; and

3. To workers who are performing work for SSA as authorized by law and who technically do not have the status of Federal employees; and other Federal agencies for assisting SSA in the efficient administration of its programs.

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 Notice (SORN) 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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 90 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

DISABILITY REPORT - CHILD

SECTION 1 - INFORMATION ABOUT THE CHILD

A. **CHILD'S NAME** *(First, Middle Initial, Last)*

B. **CHILD'S SOCIAL SECURITY NUMBER**

C. **YOUR NAME** *(If agency, provide name of agency and contact person)*

YOUR MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*

CITY | **STATE** | **ZIP CODE**

YOUR EMAIL ADDRESS (Optional)

D. **YOUR DAYTIME PHONE NUMBER** *(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)*

Area Code *Number*

☐ Your Number ☐ Message Number ☐ None

E. What is **your relationship to the child**?

F. Can you **speak and understand English**? ☐ YES ☐ NO

If "NO", what is your preferred language?

NOTE: If you cannot speak and understand English, we will provide you an interpreter, free of charge. **If you cannot speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages?

☐ YES (Enter name, address, phone number, relationship) ☐ NO

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ DAYTIME PHONE _____

City *State* *ZIP* *Area Code* *Number*

Can you **read and understand English**? ☐ YES ☐ NO

G. Does the child live with you? ☐ YES ☐ NO If "NO", with whom does the child live?

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ DAYTIME PHONE _____

City *State* *ZIP* *Area Code* *Number*

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

46

Disability Report - Child - Form SSA-3820-BK

SECTION 1 - INFORMATION ABOUT THE CHILD

H. Can the child speak and understand English? ☐ YES ☐ NO

If "NO," what languages can the child speak? _____

If the child understands any other languages, list them here: _____

I. What is the child's height *(without shoes)*? _____

What is the child's weight *(without shoes)*? _____

J. Does the child have a **medical assistance** card? (for example Medicaid, Medi-Cal) ☐ YES ☐ NO

If "YES", show the **number** here: _____

SECTION 2 - CONTACT INFORMATION

A. Does the child have a legal guardian or custodian other than you?

☐ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____
Area Code *Number*

RELATIONSHIP TO CHILD _____

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

B. Is there another adult who helps care for the child and can help us get information about the child if necessary?

☐ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME OF CONTACT _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____
Area Code *Number*

RELATIONSHIP TO CHILD _____

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

SECTION 3 - THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER

A. What are the child's disabling **illnesses, injuries, or conditions**?

B. When did the child become disabled? _____
Month Day Year

C. Do the child's illnesses, injuries or conditions cause **pain** or other symptoms? ☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

☐ YES ☐ NO

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each DOCTOR/HMO/THERAPIST/OTHER**. Include the child's **next appointment**.

1. **NAME**

DATES

STREET ADDRESS

FIRST VISIT

CITY | **STATE** | **ZIP** | **LAST VISIT**

PHONE

Area Code *Number*

Patient ID # (If known)

NEXT APPOINTMENT

REASONS FOR VISITS

WHAT **TREATMENT** WAS RECEIVED?

2. **NAME**

DATES

STREET ADDRESS

FIRST VISIT

CITY | **STATE** | **ZIP** | **LAST VISIT**

PHONE

Area Code *Number*

Patient ID # (If known)

NEXT APPOINTMENT

REASONS FOR VISITS

WHAT **TREATMENT** WAS RECEIVED?

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3. **NAME**			**DATES**
STREET ADDRESS			**FIRST VISIT**
CITY	**STATE**	**ZIP**	**LAST VISIT**
PHONE *Area Code* *Number*	**Patient ID #** (If known)		**NEXT APPOINTMENT**

REASONS FOR VISITS

WHAT **TREATMENT** WAS RECEIVED?

If you need more space, use Section 10.

D. List each **HOSPITAL/CLINIC.** Include the child's **next appointment.**

1. HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
NAME	☐ **INPATIENT STAYS** *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS	☐ **OUTPATIENT VISITS** *(Sent home same day)*		
CITY	☐ **EMERGENCY ROOM VISITS**	**DATE FIRST VISIT**	**DATE LAST VISIT**
STATE **ZIP**		**DATES OF VISITS**	
PHONE *Area Code* *Number*			

Next **appointment**	The child's hospital/clinic **number**

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
NAME	☐ **INPATIENT STAYS** *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS	☐ **OUTPATIENT VISITS** *(Sent home same day)*		
CITY	☐ **EMERGENCY ROOM VISITS**	**DATE FIRST VISIT**	**DATE LAST VISIT**
STATE **ZIP**			
PHONE *Area Code* *Number*		**DATES OF VISITS**	

Next **appointment**

The child's hospital/clinic **number**

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

If you need more space, use Section 10.

E. Does **anyone else have medical records or information** about the child's illnesses, injuries or conditions (foster parents, social workers, counselors, tutors, school nurses, detention centers, attorneys, insurance companies, and/or Worker's Compensation), or is the child scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME			**DATES**
ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE *Area Code* *Number*			NEXT APPOINTMENT

CLAIM NUMBER *(If any)*

REASONS FOR VISITS

If you need more space, use Section 10.

SECTION 5 - MEDICATIONS

Does the child currently take any **medications** for illnesses, injuries or conditions? ☐ YES ☐ NO

If "YES", tell us the following: *(Look at the child's medicine containers, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

If you need more space, use Section 10.

SECTION 6 - TESTS

Has the child had, or will he/she have, any **medical tests** for illnesses, injuries or conditions?

☐ YES ☐ NO If "YES", tell us the following (give approximate dates, if necessary).

KIND OF TEST	WHEN WAS/WILL TESTS BE DONE? *(Month, day, year)*	WHERE DONE *(Name of Facility)*	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY - Name of body part			
SPEECH/LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY - Name of body part			
MRI/CAT SCAN - Name of body part _____			

If the child has had other tests, list them in Section 10.

SECTION 7 - ADDITIONAL INFORMATION

A. Has the child been **tested or examined** by any of the following?

Headstart (Title V)	☐ YES	☐ NO
Public or Community Health Department	☐ YES	☐ NO
Child Welfare or Social Service Agency or WIC	☐ YES	☐ NO
Early Intervention Services	☐ YES	☐ NO
Program for Children with Special Health Care Needs	☐ YES	☐ NO
Mental Health/Mental Retardation Center	☐ YES	☐ NO

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work?

☐ YES ☐ NO

If you answered "YES" to any of the above in A. or B., please complete C. below:

C. 1. NAME OF AGENCY

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

TYPE OF TEST	WHEN DONE
TYPE OF TEST	WHEN DONE

FILE OR RECORD NUMBER

2. NAME OF AGENCY

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

TYPE OF TEST	WHEN DONE
TYPE OF TEST	WHEN DONE

FILE OR RECORD NUMBER

If there are any other agencies, show them in Section 10.

SECTION 8 - EDUCATION

A. Is the child currently enrolled in any school? ☐ YES, grade: _____ ☐ NO, too young

☐ NO, other reason (complete B)

B. Other reason the child is not enrolled in school:

_____

_____

_____

_____

_____

_____

_____

_____

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Has the child been tested for behavioral or learning problems? ☐ YES ☐ NO

If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech/language therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH/LANGUAGE THERAPIST _____

SECTION 8 - EDUCATION

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *County* *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems? ☐ YES ☐ NO
If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Was the child in special education? ☐ YES ☐ NO
If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech/language therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH/LANGUAGE THERAPIST _____

If there are other schools, show them in Section 10.

E. Is the child attending Daycare/Preschool? ☐ YES ☐ NO

If "YES", complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *County* *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

55

SECTION 9 - WORK HISTORY

A. Has the child ever worked (including sheltered work)? ☐ YES ☐ NO

If "YES", complete the following:

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

NAME OF SUPERVISOR _____

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

SECTION 10 - DATE AND REMARKS

Please give the date you filled out this disability report.

_____

Date (MM/DD/YYYY)

Use this section for any additional information about your child.

SECTION 10 - REMARKS

Social Security Administration

Form Approved
OMB No. 0960-0499

QUESTIONNAIRE FOR CHILDREN CLAIMING SSI BENEFITS

Please print, type, or write clearly and answer all items to the best of your ability. If you need help completing any part of this form, we will help you. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. If you do not know the answer, enter "unknown." If the question does not apply, enter "N/A." If you need more space to answer any of the questions, please use "REMARKS" and enter the number of the question next to your answer.

Child's Full Name	Social Security Number	Date (month, day, year)

Informant's Name	Relationship to Child	Daytime Telephone Number (including Area Code)

1. Is (was) the child cared for by a baby sitter? Does (did) the child attend any type of preschool, daycare and/or after school program? If so, please specify. If more than one of the above, use the "REMARKS" section.

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	Dates Attended

2. a. Is (was) the child in school?	☐ Yes ☐ No

If "***yes***," and the school was not listed in Item 12A of the SSA-3820-F6, please show it here.
(If more than one, use the "REMARKS" section.)

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	Dates Attended
Grade Level Completed	Last Teacher's Name

58

2.b. Is the child in a special education program?	☐ Yes ☐ No ☐ Don't Know
c. Does the school make any special accommodations for the child; e.g., adaptive furniture, wheelchair ramps, extra assistance or attention?	☐ Yes ☐ No ☐ Don't Know
If **"yes"** in 2.b. or 2.c., indicate type of program and/or accommodations:	Specify number of hours per week the child is in special education program:
d. Do you have a copy of the child's individual education plan (IEP), the report in which the teacher outlines the child's problems and lists the plans for correcting them? If "***yes***," please provide a copy.	☐ Yes ☐ No
3. Does the child receive any special counseling or tutoring?	
a. In school	☐ Yes ☐ No
b. Outside school	☐ Yes ☐ No

If "***yes***," in 3.a. or 3.b., please indicate: *(If more than one, use the "REMARKS" section.)*

Type of Counseling, Tutoring	
Date Began and Ended (If completed)	Frequency of Visits
Counselor's or Tutor's Name	Telephone Number (including Area Code)
Address (Number, Street, City, State, ZIP Code)	

4. Does the child or family have a child welfare, social services or early intervention caseworker?	☐ Yes ☐ No

If "***yes***," please provide the following information: *(If more than one, use the "REMARKS" section.)*

Caseworker's Name	Organization
Address (Number, Street, City, State, ZIP Code)	Telephone Number (including Area Code)
File or Record Number	Date First Saw/Last Saw Caseworker

5. Has the child ever been tested or evaluated by any of the following agencies or organizations? If "*yes*," indicate in the space provided below the agency name, address, telephone number, record number, and the type and date of test or evaluation performed *(e.g., vision, hearing, speech, physical)*.

a. Public/Community Health Department	☐ Yes	☐ No
b. Child Welfare/Social Services Agency	☐ Yes	☐ No
c. Developmental Evaluation Center	☐ Yes	☐ No
d. Mental Health/Intellectual Disability	☐ Yes	☐ No
e. Special Needs/Crippled Children Agency	☐ Yes	☐ No
f. Speech and Hearing Center	☐ Yes	☐ No
g. Women, Infants and Children (WIC) Program	☐ Yes	☐ No

Use the letter designation *(5a, 5b, etc.)* to identify the agency.

If additional space is needed, use "REMARKS" section.

60

6. Does (did) the child receive any special therapy (physical, speech and language, occupational), exercises, or any other services for his/her impairments?

Include information about any therapy or exercises the parent, guardian or caregiver provides the child.

☐ Yes ☐ No

If **"yes,"** indicate below the therapist's name, the name of the person who PRESCRIBED AND/OR DESIGNED the therapy program, the type(s) and frequency of treatment, when treatment began and ended (if completed), and where treatment was received *(e.g., home, hospital, therapist's office, clinic.)*

Therapist's Name

Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

Therapist's Name

Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

lol

7. Does (did) the child receive vocational rehabilitation services? If "*yes*," describe services received below the rehabilitation counselor's information. Include dates and record number.	☐ Yes ☐ No
Rehabilitation Counselor's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Services received:

(If additional space is needed, use "REMARKS" section.)

NOTE: PROVIDING INFORMATION ABOUT THE CHILD'S INVOLVEMENT WITH THE COURT SYSTEM IS OPTIONAL

8. Has the child ever been involved with the court system other than in custody proceedings? If "*yes*," please explain involvement, including testing and evaluation.	☐ Yes ☐ No

Youth Development Center's Name

Address (Number, Street, City, State, ZIP Code)

Probation or Parole Officer's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Involvement including any testing and evaluation:

62

9. Does (did) the child participate in any community or school activities, such as choir, Special Olympics, Boy's/Girl's Club, Scouts, or sports? ☐ Yes ☐ No

If "yes," describe involvement, amount of time spent in activity, and level of participation. Provide name, address, and telephone number of individual who supervises the activity. Include dates of involvement. If involvement ended, explain why.

10. If the child takes any medication on an ongoing basis, please indicate the following:

MEDICATION DOSAGE/ FREQUENCY	PRESCRIBED BY (NAME)	REASON FOR MEDICATION	DESCRIBE ANY SIDE EFFECTS

How well does the medication(s) work? Please explain:

63

11 a. If you are unable to give us information we need about the child, is there someone else who helps care for the child and, knows of the child's impairment who can help us get the information we need, and, if necessary, bring the child to a consultative examination?

☐ Yes ☐ No

b. If "yes," please provide the following information about this person

Name

Address (Number, Street, City, State, ZIP Code)

Daytime telephone number (including Area Code)

Relationship *(e.g., relative, neighbor, family friend)* to the child?

REMARKS:

REMARKS (continued):

Privacy Act Statement
Questionnaire for Children Claiming SSI Benefits

Sections 223 and 1632 of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a decision on your claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than for the reasons explained above. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs);

2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System (60-0089); Supplemental Security Income Record and Special Veterans Benefits (60-0103); and Electronic Disability (eDIB) Claim File (60-0320). Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 30 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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.***

QUESTIONNAIRE FOR CHILDREN CLAIMING SSI BENEFITS

Please print, type, or write clearly and answer all items to the best of your ability. If you need help completing any part of this form, we will help you. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. If you do not know the answer, enter "unknown." If the question does not apply, enter "N/A." If you need more space to answer any of the questions, please use "REMARKS" and enter the number of the question next to your answer.

Child's Full Name	Social Security Number	Date (month, day, year)

Informant's Name	Relationship to Child	Daytime Telephone Number (including Area Code)

1. Is (was) the child cared for by a baby sitter? Does (did) the child attend any type of preschool, daycare and/or after school program? If so, please specify. If more than one of the above, use the "REMARKS" section.

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	**Dates Attended**

2. a. Is (was) the child in school? ☐ Yes ☐ No

If "***yes***," and the school was not listed in Item 12A of the SSA-3820-F6, please show it here.
(If more than one, use the "REMARKS" section.)

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	**Dates Attended**
Grade Level Completed	**Last Teacher's Name**

lelo

2.b. Is the child in a special education program?	☐ Yes ☐ No ☐ Don't Know
c. Does the school make any special accommodations for the child; e.g., adaptive furniture, wheelchair ramps, extra assistance or attention?	☐ Yes ☐ No ☐ Don't Know
If **"yes"** in 2.b. or 2.c., indicate type of program and/or accommodations:	Specify number of hours per week the child is in special education program:
d. Do you have a copy of the child's individual education plan (IEP), the report in which the teacher outlines the child's problems and lists the plans for correcting them? If "***yes***," please provide a copy.	☐ Yes ☐ No
3. Does the child receive any special counseling or tutoring?	
a. In school	☐ Yes ☐ No
b. Outside school	☐ Yes ☐ No

If "***yes***," in 3.a. or 3.b., please indicate: *(If more than one, use the "REMARKS" section.)*

Type of Counseling, Tutoring	
Date Began and Ended (If completed)	Frequency of Visits
Counselor's or Tutor's Name	Telephone Number (including Area Code)
Address (Number, Street, City, State, ZIP Code)	

4. Does the child or family have a child welfare, social services or early intervention caseworker?	☐ Yes ☐ No

If "***yes***," please provide the following information: *(If more than one, use the "REMARKS" section.)*

Caseworker's Name	Organization
Address (Number, Street, City, State, ZIP Code)	Telephone Number (including Area Code)
File or Record Number	Date First Saw/Last Saw Caseworker

67

5. Has the child ever been tested or evaluated by any of the following agencies or organizations? If "**yes**," indicate in the space provided below the agency name, address, telephone number, record number, and the type and date of test or evaluation performed *(e.g., vision, hearing, speech, physical).*

a. Public/Community Health Department	☐ Yes	☐ No
b. Child Welfare/Social Services Agency	☐ Yes	☐ No
c. Developmental Evaluation Center	☐ Yes	☐ No
d. Mental Health/Intellectual Disability	☐ Yes	☐ No
e. Special Needs/Crippled Children Agency	☐ Yes	☐ No
f. Speech and Hearing Center	☐ Yes	☐ No
g. Women, Infants and Children (WIC) Program	☐ Yes	☐ No

Use the letter designation *(5a, 5b, etc.)* to identify the agency.

If additional space is needed, use "REMARKS" section.

68

6. Does (did) the child receive any special therapy (physical, speech and language, occupational), exercises, or any other services for his/her impairments?	☐ Yes ☐ No
Include information about any therapy or exercises the parent, guardian or caregiver provides the child.	

If **"yes,"** indicate below the therapist's name, the name of the person who PRESCRIBED AND/OR DESIGNED the therapy program, the type(s) and frequency of treatment, when treatment began and ended (if completed), and where treatment was received *(e.g., home, hospital, therapist's office, clinic.)*

Therapist's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

Therapist's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

7. Does (did) the child receive vocational rehabilitation services? If "*yes*," describe services received below the rehabilitation counselor's information. Include dates and record number.	☐ Yes ☐ No
Rehabilitation Counselor's Name	Telephone No. (including Area Code)
Address (Number, Street, City, State, ZIP Code)	

Services received:

(If additional space is needed, use "REMARKS" section.)

NOTE: PROVIDING INFORMATION ABOUT THE CHILD'S INVOLVEMENT WITH THE COURT SYSTEM IS OPTIONAL

8. Has the child ever been involved with the court system other than in custody proceedings? If "*yes*," please explain involvement, including testing and evaluation.	☐ Yes ☐ No
Youth Development Center's Name	
Address (Number, Street, City, State, ZIP Code)	
Probation or Parole Officer's Name	Telephone No. (including Area Code)
Address (Number, Street, City, State, ZIP Code)	

Involvement including any testing and evaluation:

70

9. Does (did) the child participate in any community or school activities, such as choir, Special Olympics, Boy's/Girl's Club, Scouts, or sports? ☐ Yes ☐ No

If "yes," describe involvement, amount of time spent in activity, and level of participation. Provide name, address, and telephone number of individual who supervises the activity. Include dates of involvement. If involvement ended, explain why.

10. If the child takes any medication on an ongoing basis, please indicate the following:

MEDICATION DOSAGE/ FREQUENCY	PRESCRIBED BY (NAME)	REASON FOR MEDICATION	DESCRIBE ANY SIDE EFFECTS

How well does the medication(s) work? Please explain:

71

11 a. If you are unable to give us information we need about the child, is there someone else who helps care for the child and, knows of the child's impairment who can help us get the information we need, and, if necessary, bring the child to a consultative examination?

☐ Yes ☐ No

b. If "yes," please provide the following information about this person

Name

Address (Number, Street, City, State, ZIP Code)

Daytime telephone number (including Area Code)

Relationship *(e.g., relative, neighbor, family friend)* to the child?

REMARKS:

72

REMARKS (continued):

Privacy Act Statement
Questionnaire for Children Claiming SSI Benefits

Sections 223 and 1632 of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a decision on your claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than for the reasons explained above. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs);

2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System (60-0089); Supplemental Security Income Record and Special Veterans Benefits (60-0103); and Electronic Disability (eDIB) Claim File (60-0320). Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 30 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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.***

93

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0540

PAIN REPORT - CHILD

SECTION 1 - IDENTIFYING INFORMATION

1. A. Print NAME OF CHILD:

FIRST	MIDDLE	LAST

B. CHILD'S SOCIAL SECURITY NUMBER:

— —

C. YOUR NAME (if you represent an agency, provide agency name):

DAYTIME TELEPHONE NUMBER *(including Area Code)*:

( ) —

MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*:

CITY	STATE	ZIP CODE

PAIN DESCRIPTION

Please answer the questions on the following pages concerning the pain related to the child's illnesses or injuries. Answer the questions the best you can based on what the child has told you and what you have observed. If he or she has pain in more than one part of his or her body (for example, chest pain and ear pain), please describe each one separately. Use Section 2 for the first pain, Section 3 for the second pain, and so on. If he or she has pain in more than three parts of the body, use Section 5, REMARKS, to describe the other pains.

74

SECTION 2 - FIRST PAIN

2. A. Where does the child have the pain? *For example, chest, ear, etc.*

B. When the child is in pain, what does he or she do? *For example, cries constantly, pulls at the ear, etc.*

C. How often does he or she have the pain?

_____ per
Number of times

☐ Minute ☐ Day ☐ Month OR ☐ Continuously

☐ Hour ☐ Week ☐ Year

D. How long does the pain generally last? *Try to answer in terms of length of time he or she has pain without stopping; for example, 30 minutes, 2 hours, all day, etc.*

E. Based on what you have seen, tell us how bad the child's pain seems to be. *Be specific; describe in your own words any ways that the pain appears to stop the child from doing things other children his or her age can do. If the child has not always had pain, explain how the pain has changed the way(s) that he or she can do things.*

F. What appears to cause the pain or make it worse?

2. G. What appears to relieve the pain or make it better?

H. If the child takes any medicine(s) (prescription or non-prescription) for this pain, please complete the following:

Name of Medicine? *(for example, CODEINE)*	Date The Child Began Taking It *(for example, 12/06/1991)*	Dosage *(for example, 1-2 pills)*	How Often Taken? *(for example, every 4 HOURS)*	Relieves the pain?
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never

I. Does the medication cause any side effects? ☐ YES ☐ NO
If "yes," please explain:

Ne

SECTION 3 - SECOND PAIN

3. A. Where does the child have the pain? *For example, chest, ear, etc.*

B. When the child is in pain, what does he or she do? *For example, cries constantly, pulls at the ear, etc.*

C. How often does he or she have the pain?

_____ per
Number of times

☐ Minute ☐ Day ☐ Month OR ☐ Continuously

☐ Hour ☐ Week ☐ Year

D. How long does the pain generally last? *Try to answer in terms of length of time he or she has pain without stopping; for example, 30 minutes, 2 hours, all day, etc.*

E. Based on what you have seen, tell us how bad the child's pain seems to be. *Be specific; describe in your own words any ways that the pain appears to stop the child from doing things other children his or her age can do. If the child has not always had pain, explain how the pain has changed the way(s) that he or she can do things.*

F. What appears to cause the pain or make it worse?

77

3. G. What appears to relieve the pain or make it better?

H. If the child takes any medicine(s) (prescription or non-prescription) for this pain, please complete the following:

Name of Medicine? *(for example, CODEINE)*	Date The Child Began Taking It *(for example, 12/06/1991)*	Dosage *(for example, 1-2 pills)*	How Often Taken? *(for example, every 4 HOURS)*	Relieves the pain?
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never

I. Does the medication cause any side effects? ☐ YES ☐ NO
If "yes," please explain:

78

SECTION 4 - THIRD PAIN

4. A. Where does the child have the pain? *For example, chest, ear, etc.*

B. When the child is in pain, what does he or she do? *For example, cries constantly, pulls at the ear, etc.*

C. How often does he or she have the pain?

_____ per
Number of times

☐ Minute ☐ Day ☐ Month OR ☐ Continuously

☐ Hour ☐ Week ☐ Year

D. How long does the pain generally last? *Try to answer in terms of length of time he or she has pain without stopping; for example, 30 minutes, 2 hours, all day, etc.*

E. Based on what you have seen, tell us how bad the child's pain seems to be. *Be specific; describe in your own words any ways that the pain appears to stop the child from doing things other children his or her age can do. If the child has not always had pain, explain how the pain has changed the way(s) that he or she can do things.*

F. What appears to cause the pain or make it worse?

4. G. What appears to relieve the pain or make it better?

H. If the child takes any medicine(s) (prescription or non-prescription) for this pain, please complete the following:

Name of Medicine? *(for example, CODEINE)*	Date The Child Began Taking it *(for example, 12/06/1991)*	Dosage *(for example, 1-2 pills)*	How Often Taken? *(for example, every 4 HOURS)*	Relieves the pain?
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never

I. Does the medication cause any side effects? ☐ YES ☐ NO
If "yes," please explain:

8D

SECTION 5 - REMARKS

Function Report - Child Birth to 1st Birthday

Filling Out The Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

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

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Privacy Act Statement

Sections 1614 and 1631(e)(1), of the Social Security Act, as amended, and 20 CFR 416.924(a), authorize us to collect this information. We will use the information you provide on behalf of the child to determine his or her eligibility for Supplemental Security Income (SSI) payments based on disability.

Furnishing us the information is voluntary. However, failing to provide all or part of the requested information may prevent our making an accurate and timely decision on the claim.

We rarely use the information you supply for any purpose other than to make a decision regarding the child's eligibility for SSI payments. However, we may use it for the administration and integrity of our programs. We may also disclose the information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to our benefits and coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and 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, and investigatory activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

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. We use the information from these programs to establish or verify a person's eligibility for federally funded and administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of this information is available in our Privacy Act System of Records Notice 60-0089, entitled, Claims Folders Systems. Additional information about this and other system of records notices and our programs is available on-line at www.socialsecurity.gov or at your 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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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.***

FUNCTION REPORT - CHILD
BIRTH TO 1st BIRTHDAY

SECTION 1 - IDENTIFYING INFORMATION

1. A. Print **NAME OF CHILD:**

FIRST _____

MIDDLE _____

LAST _____

B. Child's **SOCIAL SECURITY NUMBER:**

_____

C. Child's **DATE OF BIRTH:**

_____
Month/Day/Year

D. **PERSON COMPLETING FORM**

NAME: _____

RELATIONSHIP TO CHILD: _____

DATE FORM COMPLETED: _____
Month/Day/Year

DAYTIME TELEPHONE NUMBER *(including Area Code)*:

_____

MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*:

CITY	STATE	ZIP CODE

SECTION 2 - FUNCTION DETAILS

2. A. Does the child have problems seeing?

☐ YES (Continue) →

☐ NO (Go to 2.B.)

If "**yes**," please mark every statement below that is generally true about the child:

☐ Child uses glasses or contact lenses. If the child has problems seeing even with glasses or contact lenses, please explain:

☐ Child cannot be fitted for glasses or contact lenses. Explain:

☐ Child has other seeing problems. If so, please describe:

B. Does the child have problems hearing?

☐ YES (Continue) →

☐ NO (Go to 2.C.)

If "**yes**," please mark every statement below that is generally true about the child:

☐ Child uses hearing aid(s). If the child has problems hearing even with a hearing aid(s) OR has trouble using a hearing aid, please explain:

☐ Child cannot be fitted for hearing aid(s). Explain:

☐ Child has other hearing problems. If so, please describe:

2. C. Are the child's activities or abilities limited?

- ☐ YES (Continue) →
- ☐ NO (Go to 2.D.)
- ☐ NOT SURE (Continue) →

If "**yes**," or "**not sure**," please tell us what the child does by marking "yes" or "no" for each of the following:

- ☐ **Yes** ☐ **No** Makes various cooing sounds, such as "aaah" and "oooh"
- ☐ **Yes** ☐ **No** Makes various babbling sounds, such as "babababa" or "mamamama"
- ☐ **Yes** ☐ **No** Says simple words other than "mama" and "dada"

Child generally

- ☐ **Yes** ☐ **No** Stops crying when picked up and held
- ☐ **Yes** ☐ **No** Watches face of person talking to him or her
- ☐ **Yes** ☐ **No** Pats, "talks to" or otherwise responds to himself or herself in mirror
- ☐ **Yes** ☐ **No** Plays games, such as "peek-a-boo"
- ☐ **Yes** ☐ **No** Understands simple statements like "come here" or "sit down"
- ☐ **Yes** ☐ **No** Points to something he or she wants that is out of reach, such as a toy or food
- ☐ **Yes** ☐ **No** Understands names of favorite toys or other things, such as a bottle
- ☐ **Yes** ☐ **No** Turns head in direction of familiar noises or voices
- ☐ **Yes** ☐ **No** Turns head when his or her name is called
- ☐ **Yes** ☐ **No** Smiles at faces he or she knows
- ☐ **Yes** ☐ **No** Quiets or stops crying when sees parent or other person he or she knows
- ☐ **Yes** ☐ **No** Cuddles in arms when held by parent or caregiver
- ☐ **Yes** ☐ **No** Reaches out to be picked up

86

2.	C. (Continued)	**Child can** ☐ Yes ☐ No Roll from stomach to back ☐ Yes ☐ No Roll from back to stomach ☐ Yes ☐ No Get to a sitting position without help ☐ Yes ☐ No Rock back and forth on hands and knees ☐ Yes ☐ No Crawl or creep ☐ Yes ☐ No Pull self up to a standing position ☐ Yes ☐ No Reach for toys, or other objects ☐ Yes ☐ No Stand up without holding on to someone or something ☐ Yes ☐ No Walk holding on to someone or something ☐ Yes ☐ No Eat foods, such as cereal, cookie, by self ☐ Yes ☐ No Move toy or other object from hand-to-hand ☐ Yes ☐ No Hold small objects between fingers ☐ Yes ☐ No Throw ball or other object

D. If necessary, please explain any of the items in Question 2.C. In addition, please tell us anything else about the child that you think we should know:

Function Report - Child Age 1 to 3rd Birthday

Filling Out The Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

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

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

The Privacy And Paperwork Reduction Acts

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. If you want to learn more about this, contact any 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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING 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 Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

SECTION 2 - FUNCTION DETAILS

2. A. Does the child have problems seeing?

☐ YES (Continue) →

☐ NO. (Go to 2.B.)

If "**yes**," please mark every statement below that is generally true about the child:

☐ Child uses glasses or contact lenses. If the child has problems seeing even with glasses or contact lenses, please explain:

_____

_____

_____

_____

☐ Child cannot be fitted for glasses or contact lenses. Explain:

_____

_____

_____

☐ Child has other seeing problems. If so, please describe:

_____

_____

_____

B. Does the child have problems hearing?

☐ YES (Continue) →

☐ No (Go to 2.C.)

If "**yes**," please mark every statement below that is generally true about the child:

☐ Child uses hearing aid(s). If the child has problems hearing even with a hearing aid(s) OR has trouble using a hearing aid, please explain:

_____

_____

_____

☐ Child cannot be fitted for hearing aid(s).

☐ Child has other hearing problems. If so, please describe:

_____

_____

_____

☐ Child uses American Sign Language.

☐ Child reads lips.

92

2. C. Is the child totally unable to talk?

☐ YES (Go to 2.D.)

☐ NO (Continue) →

Does the child have problems talking (for example, saying simple words)?

☐ Yes (answer questions below)

☐ No (continue to question 2.D.)

If "**yes**," please mark <u>every</u> statement below that is <u>generally</u> true about the child:

☐ Says simple words like "he," "bottle," "doggy"

☐ Uses two-word phrases, such as "mommy go" or "push toy"

☐ Uses short sentences of 4 or more words, such as "Can I go out?"

☐ Has a vocabulary of at least 50 words

For each of the two statements below, mark the block that best describes the child, and then describe any other speech problems:

The child's speech can be understood by people who know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

The child's speech can be understood by people who don't know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

If the child has other problems talking, please explain:

2. D. Does the child have difficulty understanding and learning?

☐ YES (Continue) →

☐ NO (Go to 2.E.)

☐ NOT SURE (Continue) →

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for the following:

☐ **Yes**	☐ **No**	Waves "bye-bye"
☐ **Yes**	☐ **No**	Plays pat-a-cake
☐ **Yes**	☐ **No**	Uses one or more words (can be made-up words) to ask for toys, food, or people
☐ **Yes**	☐ **No**	Follows most simple, one-step directions, such as "come here" or "give it to me"
☐ **Yes**	☐ **No**	Knows and can point to parts of face or body such as eye or hand when asked
☐ **Yes**	☐ **No**	Plays "pretend" with dolls or stuffed animals
☐ **Yes**	☐ **No**	Uses own name or "I" or "me" to refer to self
☐ **Yes**	☐ **No**	Listens at least 5 minutes to stories being read
☐ **Yes**	☐ **No**	Follows two-step directions, such as "find your shoe and bring it to me"

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to understand and learn:

94

2. E. Are the child's physical abilities limited?

☐ YES (Continue) →

☐ NO (Go to 2.F.)

☐ NOT SURE (Continue) →

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following. Check "yes" if it is something the child used to do but doesn't do any more just because he or she is older. For example, if the child used to stand with help, and can now stand without help, check "yes" for both.

☐ **Yes**	☐ **No**	Crawl
☐ **Yes**	☐ **No**	Stand with help
☐ **Yes**	☐ **No**	Stand without help
☐ **Yes**	☐ **No**	Walk holding on to someone or something
☐ **Yes**	☐ **No**	Walk without holding on
☐ **Yes**	☐ **No**	Climb onto furniture
☐ **Yes**	☐ **No**	Throw a ball or other object
☐ **Yes**	☐ **No**	Dance or jump up and down
☐ **Yes**	☐ **No**	Walk up and down steps by self
☐ **Yes**	☐ **No**	Run, but may fall down sometimes
☐ **Yes**	☐ **No**	Run without falling
☐ **Yes**	☐ **No**	Stack small blocks 2 high
☐ **Yes**	☐ **No**	Stack small blocks 4 high
☐ **Yes**	☐ **No**	Stack small blocks 6 high
☐ **Yes**	☐ **No**	Push and pull small toys
☐ **Yes**	☐ **No**	Scribble with a crayon or pencil
☐ **Yes**	☐ **No**	Hold crayon or pencil with thumb and fingers, not fist

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's physical abilities:

2. F. Does the child's impairment(s) affect his or her behavior with other people?

☐ YES (Continue) →

☐ NO (Go to 2.G.)

☐ NOT SURE (Continue) →

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ **Yes**	☐ **No**	Is affectionate towards parents
☐ **Yes**	☐ **No**	Says "no" a lot
☐ **Yes**	☐ **No**	Plays next to other children but not with them
☐ **Yes**	☐ **No**	Plays "catch" or other simple games with other children

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's behavior around other people:

_____

_____

_____

G. Is the child's ability to help take care of his or her personal needs limited?

☐ YES (Continue) →

☐ NO (Go to 2.H.)

☐ NOT SURE (Continue) →

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ **Yes**	☐ **No**	Cooperates in getting dressed
☐ **Yes**	☐ **No**	Cooperates in brushing teeth
☐ **Yes**	☐ **No**	Drinks from a cup or glass without help
☐ **Yes**	☐ **No**	Feeds self with spoon
☐ **Yes**	☐ **No**	Can undress by self

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to take care of his or her personal needs:

_____

_____

_____

H. Please tell us anything else about the child that you think we should know.

_____

_____

_____

_____

_____

SECTION 3 - REMARKS

Filling Out The Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

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

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- When we ask for certain numbers, such as dates and telephone numbers, we provide blocks to fill in. In these places, please print only one number in each block. For numbers under 10, put a zero in the first block for the month and/or day, as appropriate. Make entries like this:

Month	Day	Year
0 5	2 7	9 4

- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Continued on the Reverse ——→

The Privacy And Paperwork Reduction Acts

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 General Accounting 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. If you want to learn more about this, contact any 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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND 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.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Function Report Child Age 3 to 6th Birthday

Filling out the Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

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

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Continued on the Reverse

100

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(e)(1), of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on behalf of the minor child to determine his or her benefit eligibility.

Furnishing us the information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on the claim.

We rarely use the information for any purpose other than for making a decision regarding entitlements to benefits. However, we may use it for the administration and integrity of our programs. We may also disclose the information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to our benefits and coverage;

2. To comply with Federal laws requiring the release of information from our records (e.g. to the Government Accountability Office and 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, and investigatory activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

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. We use the information from these programs to establish or verify a person's eligibility for federally funded and administered benefit programs and for repayment of incorrect payment's or delinquent debts under these programs.

A complete list of routine uses of this information is available in our Privacy Act System of Records Notices entitled, Claims Folders Systems, 60-0089. Additional information about this and other system of records notices and our programs are available on-line at www.socialsecurity.gov or at your 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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING 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 Boulevard, Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

FUNCTION REPORT - CHILD AGE 3 TO 6th BIRTHDAY

SECTION 1 - IDENTIFYING INFORMATION

1. A. Print **NAME OF CHILD:**

FIRST	MIDDLE	LAST

B. Child's **SOCIAL SECURITY NUMBER:**

C. Child's **DATE OF BIRTH:**

Month/Day/Year

D. **PERSON COMPLETING FORM**

NAME:

RELATIONSHIP TO CHILD:

DATE FORM COMPLETED:

Month/Day/Year

DAYTIME TELEPHONE NUMBER *(including Area Code)* :

MAILING ADDRESS (Number and Street, Apt. No. (if any), P.O. Box, or Rural Route):

CITY	STATE	ZIP CODE

SECTION 2 - FUNCTION DETAILS

2. A. Does the child have problems seeing?

☐ YES (Continue)

☐ NO (Go to 2.B.)

If "**yes**," please mark every statement below that is generally true about the child:

☐ Child uses glasses or contact lenses. If the child has problems seeing even with glasses or contact lenses, please explain:

_____

_____

_____

_____

☐ Child cannot be fitted for glasses or contact lenses. Explain:

_____

_____

_____

_____

☐ Child has other seeing problems. If so, please describe:

_____

_____

_____

_____

B. Does the child have problems hearing?

☐ YES (Continue)

☐ NO (Go to 2.C.)

If " **yes**," please mark every statement below that is generally true about the child:

☐ Child uses hearing aid(s). If the child has problems hearing even with a hearing aid(s) OR has trouble using a hearing aid, please explain:

_____

_____

_____

_____

☐ Child cannot be fitted for hearing aid(s).

_____

_____

☐ Child has other hearing problems. If so, please describe:

_____

_____

_____

☐ Child uses American Sign Language.

☐ Child reads lips.

2. C. Is the child totally unable to talk?

☐ YES (Go to 2.D.)

☐ NO (Continue)

Does the child have problems talking clearly?

☐ Yes (answer questions below)

☐ No (continue to question 2.D.)

If "yes," please mark the block that best describes the child in each of the two statements below, and then describe any other speech problems:

Speech can be understood by people who know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

Speech can be understood by people who don't know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

If the child has other problems talking, please explain:

2. D. Is the child's ability to communicate limited?

☐ YES (Continue)

☐ NO (Go to 2.E.)

☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ Yes	☐ No	Asks a lot of what, why, and where questions
☐ Yes	☐ No	Uses complete sentences of more than 4 words most of the time
☐ Yes	☐ No	Talks about what he or she is doing
☐ Yes	☐ No	Takes part in conversations with other children
☐ Yes	☐ No	Asks for what he or she wants
☐ Yes	☐ No	Tells about things and activities that happened in the past
☐ Yes	☐ No	Can tell a made up or familiar short story
☐ Yes	☐ No	Can answer questions about a short read-aloud children's story or TV story like "Little Red Ridinghood"
☐ Yes	☐ No	Can deliver simple messages such as telephone messages

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to communicate:

2. E. Does the child's impairment(s) limit his or her progress in understanding and using what he or she has learned?

☐ YES (Continue)

☐ NO (Go to 2.F.)

☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ Yes	☐ No	Recite numbers to 3
☐ Yes	☐ No	Count three objects (like blocks, cars or dolls)
☐ Yes	☐ No	Recite numbers to 10
☐ Yes	☐ No	Identify most colors, such as purple, and shapes, such as a star
☐ Yes	☐ No	Knows his or her age
☐ Yes	☐ No	Asks what words mean
☐ Yes	☐ No	Knows his or her birthday
☐ Yes	☐ No	Knows his or her telephone number
☐ Yes	☐ No	Can define common words
☐ Yes	☐ No	Can read capital letters of the alphabet
☐ Yes	☐ No	Understands a joke

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's progress in understanding and using what he or she has learned:

2. F. Are the child's physical abilities limited?

☐ YES (Continue)

☐ NO (Go to 2.G.)

☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ Yes	☐ No	Catch a large ball, like a beach ball
☐ Yes	☐ No	Ride a big wheel, tricycle, or bike with training wheels
☐ Yes	☐ No	Wind up a toy
☐ Yes	☐ No	Print at least some letters
☐ Yes	☐ No	Copy first name
☐ Yes	☐ No	Use scissors fairly well

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's physical abilities:

_____

_____

_____

_____

G. Does the child's impairment(s) affect his or her behavior with other people?

☐ YES (Continue)

☐ NO (Go to 2.H.)

☐ NOT SURE (Continue)

If " **yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ Yes	☐ No	Enjoys being with other children the same age
☐ Yes	☐ No	Shows affection towards other children
☐ Yes	☐ No	Is affectionate towards parents
☐ Yes	☐ No	Shares toys
☐ Yes	☐ No	Takes turns
☐ Yes	☐ No	Plays "pretend" with other children
☐ Yes	☐ No	Plays games like tag, hide-and-seek
☐ Yes	☐ No	Plays board games (like checkers or Candyland)

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's behavior around other people:

_____

_____

_____

_____

2. H. Does the child's impairment(s) affect his or her habits and ability to take care of personal needs?

☐ YES (Continue)

☐ NO (Go to 2.I.)

☐ NOT SURE (Continue)

If " **yes** ," or " **not sure** ," please tell us what the child does or can do by checking "yes" or "no" for each of the following. Check "yes" if it is something the child used to do but doesn't do any more just because he or she is older. For example, if the child used to dress with help but now dresses without help, check "yes" for both.

☐ Yes	☐ No	Usually controls bowels and bladder during the day
☐ Yes	☐ No	Eats using a fork and spoon by self
☐ Yes	☐ No	Dresses self with help
☐ Yes	☐ No	Dresses self without help (except tying shoes)
☐ Yes	☐ No	Washes or bathes without help
☐ Yes	☐ No	Brushes teeth with help
☐ Yes	☐ No	Brushes teeth without help
☐ Yes	☐ No	Puts toys away

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's habits and ability to take care of personal needs:

I. Is the child's ability to pay attention and stick with a task limited?

☐ YES (Continue)

☐ NO (Go to 2.J.)

☐ NOT SURE (Continue)

If " **yes**," or " **not sure**," how long can the child pay attention to TV, music, reading aloud or games?

☐ 15 minutes ☐ 30 minutes

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to pay attention and stick with a task:

2. J. Please tell us anything else about the child that you think we should know.

SECTION 3 - REMARKS

Function Report Child Age 3 to 6th Birthday

Filling out the Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

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

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Continued on the Reverse

110

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(e)(1), of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on behalf of the minor child to determine his or her benefit eligibility.

Furnishing us the information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on the claim.

We rarely use the information for any purpose other than for making a decision regarding entitlements to benefits. However, we may use it for the administration and integrity of our programs. We may also disclose the information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to our benefits and coverage;

2. To comply with Federal laws requiring the release of information from our records (e.g. to the Government Accountability Office and 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, and investigatory activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

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. We use the information from these programs to establish or verify a person's eligibility for federally funded and administered benefit programs and for repayment of incorrect payment's or delinquent debts under these programs.

A complete list of routine uses of this information is available in our Privacy Act System of Records Notices entitled, Claims Folders Systems, 60-0089. Additional information about this and other system of records notices and our programs are available on-line at www.socialsecurity.gov or at your 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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING 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 Boulevard, Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

111

FUNCTION REPORT - CHILD AGE 3 TO 6th BIRTHDAY

SECTION 1 - IDENTIFYING INFORMATION

1. A. Print **NAME OF CHILD:**

FIRST	**MIDDLE**	**LAST**

B. Child's **SOCIAL SECURITY NUMBER:**

C. Child's **DATE OF BIRTH:**
Month/Day/Year

D. **PERSON COMPLETING FORM**

NAME:

RELATIONSHIP TO CHILD:

DATE FORM COMPLETED:
Month/Day/Year

DAYTIME TELEPHONE NUMBER *(including Area Code)* :

MAILING ADDRESS (Number and Street, Apt. No. (if any), P.O. Box, or Rural Route):

CITY	STATE	ZIP CODE

SECTION 2 - FUNCTION DETAILS

2. A. Does the child have problems seeing?

☐ YES (Continue)

☐ NO (Go to 2.B.)

If **"yes,"** please mark every statement below that is generally true about the child:

☐ Child uses glasses or contact lenses. If the child has problems seeing even with glasses or contact lenses, please explain:

_____

_____

_____

_____

☐ Child cannot be fitted for glasses or contact lenses. Explain:

_____

_____

_____

_____

☐ Child has other seeing problems. If so, please describe:

_____

_____

_____

_____

B. Does the child have problems hearing?

☐ YES (Continue)

☐ NO (Go to 2.C.)

If " **yes**," please mark every statement below that is generally true about the child:

☐ Child uses hearing aid(s). If the child has problems hearing even with a hearing aid(s) OR has trouble using a hearing aid, please explain:

_____

_____

_____

_____

☐ Child cannot be fitted for hearing aid(s).

_____

_____

☐ Child has other hearing problems. If so, please describe:

_____

_____

_____

☐ Child uses American Sign Language.

☐ Child reads lips.

113

2. C. Is the child totally unable to talk?

☐ YES (Go to 2.D.)

☐ NO (Continue)

Does the child have problems talking clearly?

☐ Yes (answer questions below)

☐ No (continue to question 2.D.)

If "yes," please mark the block that best describes the child in each of the two statements below, and then describe any other speech problems:

Speech can be understood by people who know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

Speech can be understood by people who don't know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

If the child has other problems talking, please explain:

2. D. Is the child's ability to communicate limited?

☐ YES (Continue)

☐ NO (Go to 2.E.)

☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ Yes	☐ No	Asks a lot of what, why, and where questions
☐ Yes	☐ No	Uses complete sentences of more than 4 words most of the time
☐ Yes	☐ No	Talks about what he or she is doing
☐ Yes	☐ No	Takes part in conversations with other children
☐ Yes	☐ No	Asks for what he or she wants
☐ Yes	☐ No	Tells about things and activities that happened in the past
☐ Yes	☐ No	Can tell a made up or familiar short story
☐ Yes	☐ No	Can answer questions about a short read-aloud children's story or TV story like "Little Red Ridinghood"
☐ Yes	☐ No	Can deliver simple messages such as telephone messages

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to communicate:

2. E. Does the child's impairment(s) limit his or her progress in understanding and using what he or she has learned?

☐ YES (Continue)

☐ NO (Go to 2.F.)

☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ Yes	☐ No	Recite numbers to 3
☐ Yes	☐ No	Count three objects (like blocks, cars or dolls)
☐ Yes	☐ No	Recite numbers to 10
☐ Yes	☐ No	Identify most colors, such as purple, and shapes, such as a star
☐ Yes	☐ No	Knows his or her age
☐ Yes	☐ No	Asks what words mean
☐ Yes	☐ No	Knows his or her birthday
☐ Yes	☐ No	Knows his or her telephone number
☐ Yes	☐ No	Can define common words
☐ Yes	☐ No	Can read capital letters of the alphabet
☐ Yes	☐ No	Understands a joke

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's progress in understanding and using what he or she has learned:

2. F. Are the child's physical abilities limited?

☐ YES (Continue)

☐ NO (Go to 2.G.)

☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ Yes	☐ No	Catch a large ball, like a beach ball
☐ Yes	☐ No	Ride a big wheel, tricycle, or bike with training wheels
☐ Yes	☐ No	Wind up a toy
☐ Yes	☐ No	Print at least some letters
☐ Yes	☐ No	Copy first name
☐ Yes	☐ No	Use scissors fairly well

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's physical abilities:

_____

_____

_____

_____

G. Does the child's impairment(s) affect his or her behavior with other people?

☐ YES (Continue)

☐ NO (Go to 2.H.)

☐ NOT SURE (Continue)

If " **yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ Yes	☐ No	Enjoys being with other children the same age
☐ Yes	☐ No	Shows affection towards other children
☐ Yes	☐ No	Is affectionate towards parents
☐ Yes	☐ No	Shares toys
☐ Yes	☐ No	Takes turns
☐ Yes	☐ No	Plays "pretend" with other children
☐ Yes	☐ No	Plays games like tag, hide-and-seek
☐ Yes	☐ No	Plays board games (like checkers or Candyland)

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's behavior around other people:

_____

_____

_____

_____

2. H. Does the child's impairment(s) affect his or her habits and ability to take care of personal needs?

☐ YES (Continue)

☐ NO (Go to 2.I.)

☐ NOT SURE (Continue)

If " **yes** ," or " **not sure** ," please tell us what the child does or can do by checking "yes" or "no" for each of the following. Check "yes" if it is something the child used to do but doesn't do any more just because he or she is older. For example, if the child used to dress with help but now dresses without help, check "yes" for both.

☐ Yes	☐ No	Usually controls bowels and bladder during the day
☐ Yes	☐ No	Eats using a fork and spoon by self
☐ Yes	☐ No	Dresses self with help
☐ Yes	☐ No	Dresses self without help (except tying shoes)
☐ Yes	☐ No	Washes or bathes without help
☐ Yes	☐ No	Brushes teeth with help
☐ Yes	☐ No	Brushes teeth without help
☐ Yes	☐ No	Puts toys away

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's habits and ability to take care of personal needs:

_____

_____

_____

_____

I. Is the child's ability to pay attention and stick with a task limited?

☐ YES (Continue)

☐ NO (Go to 2.J.)

☐ NOT SURE (Continue)

If " **yes**," or " **not sure**," how long can the child pay attention to TV, music, reading aloud or games?

☐ 15 minutes ☐ 30 minutes

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to pay attention and stick with a task:

_____

_____

_____

_____

_____

_____

_____

_____

2. J. Please tell us anything else about the child that you think we should know.

SECTION 3 - REMARKS

Function Report - Child Age 6 to 12th Birthday

Filling Out The Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

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

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Continued on the Reverse

120

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(e)(1), of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on behalf of the minor child to determine his or her benefit eligibility.

Furnishing us the information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on the claim.

We rarely use the information for any purpose other than for making a decision regarding entitlements to benefits. However, we may use it for the administration and integrity of our programs. We may also disclose the information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to our benefits and coverage;

2. To comply with Federal laws requiring the release of information from our records (e.g. to the Government Accountability Office and 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, and investigatory activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

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. We use the information from these programs to establish or verify a person's eligibility for federally funded and administered benefit programs and for repayment of incorrect payment's or delinquent debts under these programs.

A complete list of routine uses of this information is available in our Privacy Act System of Records Notices entitled, Claims Folders Systems, 60-0089. Additional information about this and other system of records notices and our programs are available on-line at www.socialsecurity.gov or at your 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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND 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, 1338 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

FUNCTION REPORT - CHILD AGE 6 TO 12th BIRTHDAY

SECTION 1 - IDENTIFYING INFORMATION

1. A. Print **NAME OF CHILD:**

FIRST	MIDDLE	LAST

B. Child's **SOCIAL SECURITY NUMBER:**

C. Child's **DATE OF BIRTH:**

Month/Day/Year

D. **PERSON COMPLETING FORM**

NAME:

RELATIONSHIP TO CHILD:

DATE FORM COMPLETED:

Month/Day/Year

DAYTIME TELEPHONE NUMBER *(including Area Code)*:

MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*:

CITY	STATE	ZIP CODE

122

SECTION 2 - FUNCTION DETAILS

2. A. Does the child have problems seeing?

☐ YES (Continue)

☐ NO (Go to 2.B.)

If **"yes,"** please mark every statement below that is generally true about the child:

☐ Child uses glasses or contact lenses. If the child has problems seeing even with glasses or contact lenses, please explain:

_____

_____

_____

☐ Child cannot be fitted for glasses or contact lenses. Explain:

_____

_____

_____

_____

☐ Child has other seeing problems. If so, please describe:

_____

_____

_____

_____

B. Does the child have problems hearing?

☐ YES (Continue)

☐ NO (Go to 2.C.)

If **"yes,"** please mark every statement below that is generally true about the child:

☐ Child uses hearing aid(s). If the child has problems hearing even with a hearing aid(s) OR has trouble using a hearing aid, please explain:

_____

_____

_____

_____

☐ Child cannot be fitted for hearing aid(s).

☐ Child has other hearing problems. If so, please describe:

_____

_____

_____

_____

☐ Child uses American Sign Language.

☐ Child reads lips.

2. C. Is the child totally unable to talk?

☐ YES (Go to 2.D.)

☐ NO (Continue)

Does the child have problems talking clearly?

☐ Yes (answer questions below)

☐ No (continue to question 2.D.)

If "**yes**," please mark the block that best describes the child in each of the two statements below, and then describe any other speech problems:

Speech can be understood by people who know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

Speech can be understood by people who don't know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

If the child has other problems talking, please explain:

2. D. Is the child 's ability to communicate limited?

- ☐ YES (Continue)
- ☐ NO (Go to 2.E.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by marking "yes" or "no" for each of the following:

- ☐ **Yes** ☐ **No** Deliver telephone messages
- ☐ **Yes** ☐ **No** Repeat stories he or she has heard
- ☐ **Yes** ☐ **No** Tell jokes or riddles accurately
- ☐ **Yes** ☐ **No** Explain why he or she did something
- ☐ **Yes** ☐ **No** Uses sentences with "because," "what if," or "should have been"
- ☐ **Yes** ☐ **No** Talks with family
- ☐ **Yes** ☐ **No** Talks with friends

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to communicate:

2. E. Is the child's ability to progress in learning limited?

- ☐ YES (Continue)
- ☐ NO (Go to 2.F.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

☐ **Yes**	☐ **No**	Read capital letters of alphabet
☐ **Yes**	☐ **No**	Read capital letters and small letters
☐ **Yes**	☐ **No**	Read simple words
☐ **Yes**	☐ **No**	Read and understands simple sentences
☐ **Yes**	☐ **No**	Read and understands stories in books or magazines
☐ **Yes**	☐ **No**	Print some letters
☐ **Yes**	☐ **No**	Print name
☐ **Yes**	☐ **No**	Write in longhand (script)
☐ **Yes**	☐ **No**	Spell most 3-4 letter words
☐ **Yes**	☐ **No**	Write a simple story with 6-7 sentences
☐ **Yes**	☐ **No**	Add and subtract numbers over 10
☐ **Yes**	☐ **No**	Knows days of the week and months of the year
☐ **Yes**	☐ **No**	Understands money - can make correct change
☐ **Yes**	☐ **No**	Tells time

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to progress in learning:

2. F. Are the child's physical abilities limited?

- ☐ YES (Continue)
- ☐ NO (Go to 2.G.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

- ☐ **Yes** ☐ **No** Walk
- ☐ **Yes** ☐ **No** Run
- ☐ **Yes** ☐ **No** Throw a ball
- ☐ **Yes** ☐ **No** Ride a bike
- ☐ **Yes** ☐ **No** Jump rope
- ☐ **Yes** ☐ **No** Use roller skates or roller blades
- ☐ **Yes** ☐ **No** Swim
- ☐ **Yes** ☐ **No** Use scissors
- ☐ **Yes** ☐ **No** Work video game controls
- ☐ **Yes** ☐ **No** Dress/undress dolls or action figures

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's physical abilities:

2. G. Does the child's impairment(s) affect his or her behavior with other people?

- ☐ YES (Continue)
- ☐ NO (Go to 2.H.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

- ☐ **Yes** ☐ **No** Has friends his or her own age
- ☐ **Yes** ☐ **No** Can make new friends
- ☐ **Yes** ☐ **No** Generally gets along with you or other adults
- ☐ **Yes** ☐ **No** Generally gets along with school teachers
- ☐ **Yes** ☐ **No** Plays team sports (for example, baseball, basketball, soccer)

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's behavior with other people:

2. H. Does the child's impairment(s) affect his or her ability to help himself or herself and cooperate with others in taking care of personal needs?

- ☐ YES (Continue)
- ☐ NO (Go to 2.I.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

- ☐ **Yes** ☐ **No** Uses zipper by self
- ☐ **Yes** ☐ **No** Buttons clothes by self
- ☐ **Yes** ☐ **No** Ties shoelaces
- ☐ **Yes** ☐ **No** Takes a bath or shower without help
- ☐ **Yes** ☐ **No** Brushes teeth
- ☐ **Yes** ☐ **No** Combs or brushes hair
- ☐ **Yes** ☐ **No** Washes hair by self
- ☐ **Yes** ☐ **No** Chooses clothes by self
- ☐ **Yes** ☐ **No** Eats by self using a knife, fork, and spoon
- ☐ **Yes** ☐ **No** Picks up and puts away toys
- ☐ **Yes** ☐ **No** Hangs up clothes
- ☐ **Yes** ☐ **No** Helps around the house (for example, washes or dries dishes, makes bed(s), sweeps/vacuums floor, rakes or mows yard, helps with laundry)
- ☐ **Yes** ☐ **No** Does what he or she is told most of the time
- ☐ **Yes** ☐ **No** Obeys safety rules; for instance, looks for cars before crossing street
- ☐ **Yes** ☐ **No** Gets to school on time
- ☐ **Yes** ☐ **No** Accepts criticism or correction

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to help him or herself and cooperate with others in caring for personal needs:

2. I. Is the child's ability to pay attention and stick with a task limited?

- ☐ YES (Continue)
- ☐ NO (Go to 2.J.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

- ☐ **Yes** ☐ **No** Keeps busy on his/her own
- ☐ **Yes** ☐ **No** Finishes things he or she starts
- ☐ **Yes** ☐ **No** Works on arts and crafts projects (draws, paints, knits, does woodwork)
- ☐ **Yes** ☐ **No** Completes homework
- ☐ **Yes** ☐ **No** Completes chores most of the time

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to pay attention and stick with a task:

J. Please tell us anything else about the child that you think we should know.

SECTION 3 - REMARKS

Function Report Child Age 12 to 18th Birthday

Filling Out The Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

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

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Continued on the Reverse

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(e)(1), of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on behalf of the minor child to determine his or her benefit eligibility.

Furnishing us the information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on the claim.

We rarely use the information for any purpose other than for making a decision regarding entitlements to benefits. However, we may use it for the administration and integrity of our programs. We may also disclose the information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to our benefits and coverage;

2. To comply with Federal laws requiring the release of information from our records (e.g. to the Government Accountability Office and 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, and investigatory activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

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. We use the information from these programs to establish or verify a person's eligibility for federally funded and administered benefit programs and for repayment of incorrect payment's or delinquent debts under these programs.

A complete list of routine uses of this information is available in our Privacy Act System of Records Notices entitled, Claims Folders Systems, 60-0089. Additional information about this and other system of records notices and our programs are available on-line at www.socialsecurity.gov or at your 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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND 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, 1338 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

FUNCTION REPORT - CHILD AGE 12 TO 18th BIRTHDAY

SECTION 1 - IDENTIFYING INFORMATION

1. A. Print **NAME OF CHILD:**

FIRST	MIDDLE	LAST

B. Child's **SOCIAL SECURITY NUMBER:**

C. Child's **DATE OF BIRTH:**

Month/Day/Year

D. **PERSON COMPLETING FORM**

NAME:

RELATIONSHIP TO CHILD:

DATE FORM COMPLETED:

Month/Day/Year

DAYTIME TELEPHONE NUMBER *(including Area Code)*:

MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*:

CITY	STATE	ZIP CODE

SECTION 2 - FUNCTION DETAILS

2. A. Does the child have problems seeing?

☐ YES (Continue)

☐ NO (Go to 2.B.)

If **"yes,"** please mark <u>every</u> statement below that is <u>generally</u> true about the child:

☐ Child uses glasses or contact lenses. If the child has problems seeing even with glasses or contact lenses, please explain:

_____

_____

_____

☐ Child cannot be fitted for glasses or contact lenses. Explain:

_____

_____

_____

_____

☐ Child has other seeing problems. If so, please describe:

_____

_____

_____

_____

B. Does the child have problems hearing?

☐ YES (Continue)

☐ NO (Go to 2.C.)

If "**yes**," please mark <u>every</u> statement below that is <u>generally</u> true about the child:

☐ Child uses hearing aid(s). If the child has problems hearing even with a hearing aid(s) OR has trouble using a hearing aid, please explain:

_____

_____

_____

_____

☐ Child cannot be fitted for hearing aid(s).

☐ Child has other hearing problems. If so, please describe:

_____

_____

_____

_____

☐ Child uses American Sign Language.

☐ Child reads lips.

2. C. Is the child totally unable to talk?

☐ YES (Go to 2.D.)

☐ NO (Continue)

Does the child have problems talking clearly?

☐ Yes (answer questions below)

☐ No (Continue to 2.D.)

If "**yes,**" please mark the block that best describes the child in each of the two statements below, and then describe any other speech problems:

Speech can be understood by people who know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

Speech can be understood by people who don't know the child well:

☐ Most of the time, or

☐ Some of the time, or

☐ Hardly ever.

If the child has other problems talking, please explain:

2. D. Are the child's daily activities limited?

- ☐ YES (Continue)
- ☐ NO (Go to 2.E.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please mark every statement below that is true about the child:

- ☐ Goes to school full-time
- ☐ Goes to school part-time
- ☐ Works part-time
- ☐ Works full-time
- ☐ Other. Describe:

_____

_____

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's daily activities:

_____

_____

_____

E. Is the child's ability to communicate limited?

- ☐ YES (Continue)
- ☐ NO (Go to 2.F.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "**yes**" or "**no**" for each of the following:

- ☐ **Yes** ☐ **No** Answer the telephone and make telephone calls
- ☐ **Yes** ☐ **No** Deliver phone messages
- ☐ **Yes** ☐ **No** Repeat stories he or she has heard
- ☐ **Yes** ☐ **No** Tell jokes or riddles accurately
- ☐ **Yes** ☐ **No** Explain why he or she did something
- ☐ **Yes** ☐ **No** Uses sentences with "because," "what if," or "should have been"
- ☐ **Yes** ☐ **No** Ask for what he or she needs
- ☐ **Yes** ☐ **No** Talks with family
- ☐ **Yes** ☐ **No** Talks with friends

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to communicate:

_____

_____

_____

_____

2. F. Is there any limitation in the child's progress in understanding and using what he or she has learned?

- ☐ YES (Continue)
- ☐ NO (Go to 2.G.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "**yes**" or "**no**" for each of the following:

- ☐ **Yes** ☐ **No** Read and understand sentences in comics and cartoons
- ☐ **Yes** ☐ **No** Read and understand stories in books, magazines, or newspapers
- ☐ **Yes** ☐ **No** Spell words of more than 4 letters
- ☐ **Yes** ☐ **No** Tell time
- ☐ **Yes** ☐ **No** Add and subtract numbers over 10
- ☐ **Yes** ☐ **No** Multiply and divide numbers over 10
- ☐ **Yes** ☐ **No** Understands money - can make correct change
- ☐ **Yes** ☐ **No** Understand, carry out, and remember simple instructions

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's progress in understanding and using what he or she has learned:

_____

_____

_____

G. Are the child's physical abilities limited?

- ☐ YES (Continue)
- ☐ NO (Go to 2.H.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "**yes**" or "**no**" for each of the following:

☐ **Yes**	☐ **No**	Walk	☐ **Yes**	☐ **No**	Ride a bike
☐ **Yes**	☐ **No**	Run	☐ **Yes**	☐ **No**	Throw a ball
☐ **Yes**	☐ **No**	Dance	☐ **Yes**	☐ **No**	Jump rope
☐ **Yes**	☐ **No**	Swim	☐ **Yes**	☐ **No**	Play sports
☐ **Yes**	☐ **No**	Drive a car	☐ **Yes**	☐ **No**	Work video games controls

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's physical abilities:

_____

_____

_____

2. H. Does the child's impairment(s) affect his or her social activities or behavior with other people?

- ☐ YES (Continue)
- ☐ NO (Go to 2.I.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "**yes**" or "**no**" for each of the following:

- ☐ **Yes** ☐ **No** Has friends his or her own age
- ☐ **Yes** ☐ **No** Can make new friends
- ☐ **Yes** ☐ **No** Generally gets along with you or other adults
- ☐ **Yes** ☐ **No** Generally gets along all right with brothers and sisters
- ☐ **Yes** ☐ **No** Generally gets along with school teachers
- ☐ **Yes** ☐ **No** Plays team sports (for example, baseball, basketball, soccer)

If necessary, please explain, In addition, please tell us anything else you think we should know about the child's behavior around other people:

2. I. Is the child's ability to take care of his or her personal needs and safety limited?

- ☐ YES (Continue)
- ☐ NO (Go to 2.J.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "**yes**" or "**no**" for each of the following:

☐ **Yes**	☐ **No**	Takes care of personal hygiene (keep clean, brush teeth, comb hair, etc.)
☐ **Yes**	☐ **No**	Washes and puts away his or her clothes
☐ **Yes**	☐ **No**	Helps around the house (for example, washes or dries dishes, makes bed(s), sweeps/vacuums floor, rakes or mows yard, helps with laundry)
☐ **Yes**	☐ **No**	Can cook a meal for self
☐ **Yes**	☐ **No**	Gets to school on time
☐ **Yes**	☐ **No**	Studies and does homework
☐ **Yes**	☐ **No**	Takes needed medication
☐ **Yes**	☐ **No**	Can use public transportation by himself/ herself
☐ **Yes**	☐ **No**	Accepts criticism or correction
☐ **Yes**	☐ **No**	Keeps out of trouble
☐ **Yes**	☐ **No**	Obeys rules
☐ **Yes**	☐ **No**	Avoids accidents
☐ **Yes**	☐ **No**	Asks for help when needed

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to take care of his or her personal needs and safety:

2. J. Is the child's ability to pay attention and stick with a task limited?

- ☐ YES (Continue)
- ☐ NO (Go to 2.K.)
- ☐ NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "**yes**" or "**no**" for each of the following:

- ☐ **Yes** ☐ **No** Works on arts and crafts projects (draws, paints, knits, does woodwork)
- ☐ **Yes** ☐ **No** Keeps busy on his or her own
- ☐ **Yes** ☐ **No** Finishes things he or she starts
- ☐ **Yes** ☐ **No** Completes homework
- ☐ **Yes** ☐ **No** Completes homework on time
- ☐ **Yes** ☐ **No** Completes chores most of the time

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to pay attention and stick with a task:

K. Please tell us anything else about the child that you think we should know.

SECTION 3 - REMARKS

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*	
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 noncommunicable disease; and tests for or records of HIV/AIDS
   - 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, insurance companies, workers' compensation programs
- 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.

143

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.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. 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, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, 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 and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

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. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any 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 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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.*