North Carolina
Coalition to End Homelessness
NC SOAR: SSI/SSDI Access, Outreach and Recovery
soar@ncceh.org www.ncceh.org 919.755.4393

NC SOAR Outcome Reporting Form

SOAR Caseworker Information

Name	
Agency	
Phone	
Email	
County	
Certified SOAR Worker	☐yes ☐no

Applicant Information

First Two Letters of First Name	
First Two Letters of Last Name	
Date of Birth	/ /
Gender	☐ male ☐female
Veteran?	☐yes ☐no

SSI and SSDI Application Information

Level of Application	☐Initial Application ☐Reconsideration ☐Administrative Law Judge Hearing
Is this an update to a previously submitted outcome?	☐yes ☐no
Protective Filing Date	/ /
Length of time homeless (as of Protective Filing Date)	years or months
Did you file an SSI and SSDI application?	☐yes ☐no
If no application was filed, why?	
Was the application given the SSA "Homeless Flag?"	☐yes ☐no
If no, why not?	
Did you become the 1696 Representative?	☐yes ☐no
Date Disability report and application for SSI/SSDI completed	/ /
Date medical records and/or medical summary report submitted to DDS	/ /

Return form via email to: soar@ncceh.org or via fax to 1-888-742-3465

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Determination Information

Date of Determination (If Presumptive Disability Decision was made, please use that date here.)	/ /
Outcome of Determination	☐Approved ☐Denied
Was the case reassigned to a SOAR DDS Examiner? (If you are unsure, please contact NCCEH.)	☐yes ☐no
SSI Approved?	☐yes ☐no
SSI Benefit Amount Awarded? (monthly)	$
SSDI Approved?	☐yes ☐no
SSDI Benefit Amount Awarded? (monthly)	$
Amount of Back Pay Awarded?	$
Medicaid Approved?	☐yes ☐no
Medicare Approved?	☐yes ☐no
Rep. Payee Needed?	☐yes ☐no
Rep. Payee Provided?	☐yes ☐no
Consultative Exam Required?	☐yes ☐no
Date Housed	/ /
Further Comments:	

Revised: January 2012

Getting Started: Organizing and Completing an Initial SOAR Application[1]

Is this your first SOAR application? If so, don't worry. The biggest and first step has already taken place-- you are SOAR trained. Schedule a minimum of one hour a day to work on your SOAR application and keep that commitment. Stick to the timelines outlined below. It is important that you complete the SOAR application in stages so that you aren't overwhelmed by it. While waiting on medical documentation, use your scheduled SOAR time to complete the i3368 PRO and to continue to work on the medical summary report. The timelines allow you to complete each stage of the application process and to focus your energy and brain power on completing the medical summary report during the latter weeks so that you easily meet the 60 days allowed.

Documents needed to complete the process

- SOAR Consent to Release Information form (from SOAR Process)
- Worksheet #4 (Substance Use Worksheet) from Module VII of *Participant Guide*
- Worksheet #6 (Applicant Assessment Worksheet) from Module X of *Participant Guide*
- Worksheet #7 (Functional Information Worksheet) from Module XI of *Participant Guide*
- SSA form 3368 (Adult Disability Report) from Module 4 of the *Participant Guide*
- SSA form 1696 (Appointment of Representative, revised 5/08) download from SSA website
- SSA 827 forms from Module 4 of *Participant Guide*; after completing the i3368 PRO online application, the computer program will instruct you to print a specific number of SSA forms 827 needed.
- SSA form 8000 (Application for SSI)

TIMELINE FOR COMPLETING AN INITIAL SOAR APPLICATION
Day One ▪ Complete and have applicant sign SOAR Consent to Release Information form. This allows you to obtain the SSA status of the applicant. ▪ Fax SOAR Consent to Release Information form to designated SSA location to the attention of SSA SOAR contact. If the person is eligible to apply, this fax secures a protective filing date for the applicant. The SSA SOAR contact should fax back to you the front page of the SOAR Consent to Release Information within 48 hours.
Day Two or Three ▪ Contact the SSA office if the SSA SOAR contact has not faxed back the details of applicant's involvement with SSA to you within 72 hours. ▪ When SSA faxes its response to you, it includes past history with SSA and gives you the information you need to proceed with the appropriate SOAR process. ▪ If the client does not have a pending case or active appeal, proceed with an initial application as follows… ▪ Have applicant sign SSA-827 Authorization to Disclose Information to the SSA and agency Release of Information forms; have applicant sign releases equal to number of hospitals, clinics and doctor's offices he/she remembers being treated. Mail both a SSA and agency release to each treatment source within the first 24 to 48 hours of initiating SOAR application effort..

[1] Developed by US Public Heath Service, Commander Eddie Frazier, Michigan SOAR Team, Yvonne M. Perret, and Deborah Dennis, National SOAR Technical Assistance Team

- After applicant identifies a primary provider (psychiatrist/medical doctor), contact the provider and let the staff there know you are working with the applicant on applying for SSI/SSDI benefits. Ask for their input and let them know that you'll be requesting the physician/psychiatrist/s signature on a summary of how the applicant's illness and symptoms affect his/her ability to work.
- Complete the first two pages of Worksheet #6, through Personal History. **This will allow you to complete the introduction of your applicant's medical summary report.**
- Go to the computer; bookmark i3368 PRO online from SSA website.
- While on the computer, also bookmark ISBA (Social Security Disability) online from SSA website.
- While on the computer, download the medical summary report template from the SOAR website (www.prainc.com/soar, link to trainings) to create a medical summary template. This is how you should organize your information in the applicant's medical summary report. Start your rough draft of applicant's medical summary. On the first day of this initial application work, you will input information for the introduction and begin the section on Personal History. Completing the Introduction and starting the Personal History will take only 20-30 minutes. Beginning the medical summary report immediately gives you 60 days to complete it instead of the 7-14 days attempted by many case managers
- Getting things organized and setup initially will take about 2.5 hours. Putting your SOAR application in the recommended order will also allow you to work on different aspects of the application as you move forward rather than trying to complete this all at once, feeling pressured by other responsibilities to meet the deadline.

Week 1-2

- Complete and have applicant sign SSA form 1696 Appointment of Representative form
- Meet with applicant 1-2 times per week to work on worksheets #4, #6 and #7. Enter information in the appropriate sections on the medical summary report as you collect the information. These worksheets should be completed by the end of week two. This will give you six weeks to work on the medical summary report. Most of the information used in the medical summary is transferred from worksheets #4, 6 and 7. Include in the medical summary report direct quotes from the applicant and your observations of how the applicant's illness/symptoms interfere with his/her ability to work.
- Meet with applicant 1-2 times per week to complete paper 3368 application. Begin transferring information to i3368 PRO online application as soon as possible. Complete the 3368 paper application by the end of week two. The i3368 PRO online application has 7 sections. Schedule enough time to complete each section. When starting the i3368 PRO, complete information and obtain a reentry number for the applicant so you can use that number to re-enter each time you add information to this form. Print the reentry page and place it in the applicant's folder. The reentry number and the applicant's social security number allow you to work on the i3368 PRO when your schedule allows. After working on the i3368 PRO online application, save it. Do not submit it to SSA until you are prepared to turn in the completed SOAR application package.
- Continue to work with applicant's primary provider for additional information and to obtain commitment for a co-signature on the medical summary.
- Continue collection of medical records. As you identify additional sources for medical information, send an agency release and a SSA 827 to those providers to collect additional information. Work with treatment sources to identify ways to collect information quickly, e.g., pick up at their department, fax, etc.

Weeks 3-4

- Begin and complete SSA-8000 SSI Application (a clean document with applicant's signature)
- Obtain any needed supportive documentation for SSI Application, e.g., bank statements, any documentation of resources, etc.

- Continue to work on i3368 PRO if not complete. Use your word processing program to check spelling for narrative comment sections of i3368 PRO. Be sure to meet the timeline for this section of the application. Complete transfer of information from paper 3368 to i3368 PRO online application by end of week four.
- Continue to collect and follow up on medical records that are needed.
- Work on and make entries in the medical summary report as you receive information.
- Have applicant sign additional 827s for treatment sources that have not yet sent in information so DDS can follow up on these.
- Complete ISBA (SSDI online application) after completing i3368 PRO online application. Most of the information needed for the ISBA in contained within the SSI application as well as the i3368 PRO. The ISBA online application takes about 20 – 30 minutes to complete. As with the i3368 PRO, save information entered and do not submit until you are ready to turn in completed SOAR application package. The ISBA online application should be completed by the week four.
- Completing i3368 PRO, the ISBA, and requesting medical information early in the application process allows you to have four weeks or more to focus primarily on completing the medical summary.

Weeks 5-8 (as needed)

- Continue to work on items not completed during the first four weeks
- Continue to work on and revise medical summary. Incorporate medical information that speaks to applicant's functional impairments and severity of symptoms. Use direct quotes from applicant as often as possible. Have a co-worker review medical summary for clarity and grammar.
- Contact SSA SOAR Contact and establish date you will turn in completed Initial SOAR Application, giving directly to SOAR contact. Begin attempts at contact with SSA SOAR contact at least 1-2 weeks before 60-day deadline. This will allow for potential time out-of-office or illness for you or SSA SOAR contact. SOAR Application must be complete and delivered to SSA SOAR contact *on or before 60-day deadline, if at all possible before the 60-day deadline.*
- Immediately before the appointment with SSA to turn in the packet, submit the ISBA SSDI on-line application and the i3368PRO on-line.

REMINDER: A Complete Initial SOAR Application Package consists of…

1. SOAR Checklist is used as a cover sheet for complete package
2. A medical summary report signed by the SOAR provider and physician or psychologist (allowing this document to be included as medical evidence).
3. Copies of all medical records in chronological order.
4. A clean and complete SSA-8000 signed and dated by applicant. The SSA 8000 information will be transferred into the online application by SSA after receipt of completed Initial SOAR Application Packet
5. Submit i3368 PRO and ISBA (SSDI application) on-line 24-48 hours before turning in completed package to SSA.

NC SOAR (SSI/SSDI Outreach, Access and Recovery)
Consent for Release of Information

Sign this form only if you want the Social Security Administration to give information or records about you to _____(service provider).

TO: Social Security Administration fax_____ Local SSA Office_____
Customer's Name_____
Date of Birth_____ Social Security Number_____

THIS SECTION TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION

____No Record ____Supplemental Security Income ____Social Security Disability Income

____Terminated Record _____ SSI Date Terminated _____
MMDDYY

Current Claim Status

____ SSI Claim Pending:
Initial Claim Date Filed _____
Reconsideration Date Filed _____
Hearing Level Date Filed _____

____ SSDI Claim Pending:
Initial Claim Date Filed _____
Reconsideration Date Filed _____
Hearing Level Date Filed _____

____ SSI Claim Denied:
Initial Claim Date Denied _____
Reconsideration Date Denied _____
Hearing Level Date Denied _____

____ SSDI Claim Denied:
Initial Claim Date Denied _____
Reconsideration Date Denied _____
Hearing Level Date Denied _____

(Circle One)
SSI Denial Reason: Medical Non-Medical Other SSDI Denial Reason: Medical Non-Medical Other

Other (if circled above, please explain):_____

Allowance

____ SSI: Eligibility date _____ _____ SSDI: Eligibility date _____

SSA Claims information was provided by: _____
(SSA Staff)
Date of Response _____

Telephone Number: _____ SSA Field Office Code: _____

Service Provider _____

Customer's Name _____

Date of Birth _____ Social Security Number_____

I authorize SSA to release the dates and status of my Social Security Disability Insurance and/or Supplemental Security Income application(s), to:

_____ _____

(Service Provider) **(fax #)**

This consent for release of information is in effect from _____ to _____ (not to exceed 1 year).
(MMDDYY) (MMDDYY)

I want this information released because I am pursuing entitlement to Social Security disability programs.

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information that I provided on this form and that 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.

Signature: _____ Relationship: _____

(Below, show signatures, names, and addresses of two people if signed by mark.)

Date: _____

Witness #1

_____
(Print Name)

_____
(Signature)

_____
(Address)

_____
(City, State, and Zip code)

Witness #2

_____
(Print Name)

_____
(Signature)

_____
(Address)

_____
(City, State, and Zip code)

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(a) and 1631(d) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on this form to verify your appointment of an individual as your representative and his or her acceptance of the appointment.

Completion of this form is voluntary; however, if you want to use this form to appoint someone to act on your behalf in matters before the Social Security Administration (SSA), then you and that individual must complete the appropriate sections of this form.

We rarely use the information you supply for any purpose other than to verify your appointment of an individual as your representative and his or her acceptance of the appointment. 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 right 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 or 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 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 list of routine uses for this information is available in our System of Records Notice entitled "Appointed Representative File" (60-0325). The notice, additional information regarding this form, routine uses of information, and our programs and systems are available on-line at www.socialsecurity.gov or at your local Social Security office.

With your permission, your representative may designate an associate or other party to request and receive information from your claim file on your representative's behalf.

For more information about this privacy statement and how information you provide to us may be used or disclosed to others please contact any Social Security office.

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 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 XVIII (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 main representative.

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 II Acceptance of Appointment

Each individual you appoint in Part I should also complete Part II. 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 III 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. 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 "Attorneys and Appointed Representatives" 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 "Attorneys and Appointed Representatives" 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. and 416.1500 et. seq.
- Social Security Rulings 83-27 and 82-39
- 26 U.S.C. §§ 6041 and 6045(f)

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

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

Part I **APPOINTMENT OF REPRESENTATIVE**

I appoint this person, _____
(Name and Address)

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 Coverage) ☐ Title VIII (SVB)

This person 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 main representative is _____
(Name of Principal Representative)

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

Part II **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 III 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 III **FEE ARRANGEMENT**

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

☐ **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.)*

☐ **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, 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.)*

☐ **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

Worksheet 1

SSI & SSDI Non-Medical Documentation Checklist

(if not applicable, write N/A)

Name_____

DOB_____ SSN_____

Application date_____

SSI

All applicants:

_____ Photo ID

_____ If own/rent, copy of mortgage/rent agreement

_____ If he or she doesn't rent: name, address of person(s) providing in-kind help

_____ List of dependents

_____ Ownership of vehicle(s)

_____ Copy of life insurance policy

_____ Most recent bank account statement, including any joint bank accounts

_____ Copy of certificates of deposit

_____ Copy of stock/mutual fund certificates

_____ Copy of bonds held in own name

_____ Copy of any land/houses, etc., proof of ownership

_____ Copy of burial contracts

_____ Copy of any other household income: pay stubs, other benefits, child support

Immigrants:

_____ Proof of sponsorship — original

_____ Proof of citizenship or alien status — original

_____ Birth certificate (may be required)

SSDI

All applicants:

_____ Birth certificate

_____ Copy of any current pay stubs

_____ List of dependents

_____ Proof of Worker's Compensation or State Disability Insurance Benefits (benefits letter or check stubs)

Immigrants:

_____ Proof of sponsorship — original

_____ Proof of citizenship or alien status — original

Worksheet 2

SSI Income/Resource Worksheet

(if the income/resource does not apply, write N/A)

Name_____

DOB_____ SSN_____

Application date_____

Income

Type	Date Submitted
Earned	
Wage stubs	
Tax return	
Unearned	
Benefit letters	
Court orders	
Alimony/child support receipts	
Bank statements (interest)	
Dividends/royalties	
Rental/lease income	

Resources

Type	Date Submitted
Vehicles owned*	
Houses owned**	
Other property owned	
Life insurance policies	
Bank statements	
Investment statements	
Savings statements	
Burial expense set-aside	
Cemetery lot, crypt, etc.	

* One car or truck is fully excluded from resources if used for daily activities.
** A house that a person owns is excluded if the individual lives in it.

Worksheet 3

Applicant Tracking Worksheet

(use additional sheets, if necessary)

Name_____ DOB_____ SSN_____

Phone_____ Address_____

Third Party Contact (N/A if no one)_____

Third Party Phone _____ Third Party Address _____

Area of town where person stays_____

Food kitchens/shelters/etc._____

Other staff/programs involved_____

Program/Staff person_____

Protected filing date_____

Application date_____

☐ By Phone ☐ In Person

SSA Claims Representative

Name _____ Phone _____

Office address _____

Medical evidence submitted with application? ☐ Yes ☐ No

Medical records sent for:

Source _____

Date(s) requested_____ Date received_____ Date sent to SSA/DDS _____

Source _____

Date(s) requested_____ Date received_____ Date sent to SSA/DDS _____

Source _____

Date(s) requested_____ Date received_____ Date sent to SSA/DDS _____

DDS Disability Examiner

Name _____ Phone _____

Dates of follow-up contact with DDS examiner_____

Consultative examination appointment? ☐ Yes ☐ No If yes, Date_____

Decision ☐ Approved ☐ Denied Date _____

Reconsideration filed (N/A if person is approved)_____

MEDICAL AND JOB WORKSHEET - ADULT

This worksheet can help you to prepare for your interview or to complete the Disability Report on the Internet. It lists some of the information we will ask you. You may want to write down some of this information in the space provided so you will have it at the interview. We will not collect this worksheet.

A. When did you become unable to work? (Month/Day/Year) _____

B. What **medical condition(s), illness(es) or injury(ies)** limits your ability to work? _____

_____

C. We will ask you about your medical treatment. What **doctor/HMO/therapist or other person treated your condition(s), illness(es) or injury(ies)** or whom do you expect to treat you in the future? What **month and year** were you there, or expect to go there next?

Name, Address, Phone, and Patient ID Number(s)	**Date(s)**

D. What **hospitals, clinics, or emergency rooms** have you been to, or expect to go to? What **month and year** were you there, or expect to go there next?

Name, Address, Phone and Hospital/Clinic Number(s)	**Date(s)**

OVER

E. What **medications** do you take and **why** do you take them? **If they are prescribed,** we will ask the **doctor's name who prescribed them**. You can bring your prescription bottles with you.

Name of Medication and Why You Take It	Doctor's Name

F. What **medical tests** have you had or are going to have? We will ask the **name of the place** where you were tested, the **date of the test**, and the **name of the person who sent you** for the test(s).

Name of Test	Place Where Tested	Person Who Sent You	Date(s)

G. What is your **medical assistance number**? _____

H. What **kind of work** have you done in the 15 years before you became disabled? We will ask you for the information below.

	Job Title (e.g., Cook)	**Type of Business** (e.g., Restaurant)	**Dates Worked** (month & year) **From:**	**To:**	**Hours Per Day**	**Days Per Week**	**Rate of Pay** (Per hour, week, year)
1.							$
2.							$
3.							$
4.							$
5.							$

Keep your appointment. Do not delay filing even if you do not have all of the information. We will help you get any missing information.

Worksheet 5
Medical Evidence Worksheet

Name_____

DOB_____ **SSN**_____

ADMISSION NOTE

Source_____ Date(s) requested_____ Date received_____

PSYCHOSOCIAL EVALUATION

Source_____ Date(s) requested_____ Date received_____

PSYCHOLOGICAL TESTING

Source_____ Date(s) requested_____ Date received_____

OCCUPATIONAL THERAPY EVALUATION

Source_____ Date(s) requested_____ Date received_____

NEUROLOGICAL ASSESSMENT

Source_____ Date(s) requested_____ Date received_____

PHYSICAL EXAM

Source_____ Date(s) requested_____ Date received_____

LABORATORY RESULTS

Source_____ Date(s) requested_____ Date received_____

EEG/CT SCAN RESULTS

Source_____ Date(s) requested_____ Date received_____

PSYCHIATRIC EVALUATIONS

Source_____ Date(s) requested_____ Date received_____

PROGRESS NOTES THAT DESCRIBE FUNCTIONAL PROBLEMS AND CURRENT SYMPTOMS

Source_____ Date(s) requested_____ Date received_____

DISCHARGE SUMMARY

Source_____ Date(s) requested_____ Date received_____

Authorization for Release of Information

PATIENT'S/CLIENT'S NAME: _____ BIRTH DATE ___/___/___
LAST FIRST M. I. Mo. Day Year

The undersigned hereby authorizes and requests

_____
HOSPITAL, AGENT, OR TREATMENT PROGRAM

to provide

_____
NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE

the following information: (please specify)

Discharge summary, admission information, psychosocial evaluation, psychosocial testing report, progress notes, and other relevant information: _____

_____

_____

Dates of Hospitalization: ALL DATES

Dates of Services Provided: ALL DATES

The disclosure is to be used for the following purposes: For obtaining Social Security disability benefits.

_____

This consent will expire one (1) year from the date hereof unless otherwise stipulated.

I understand that the information may/will include treatment for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency virus (HIV), including acquired immunodeficiency syndrome (AIDS) or tests for HIV or AIDS.

I understand that I may revoke my consent to release information from my records, but not retroactive to release of information already made in good faith.

Signed _____ Date _____

_____ Date _____
Signature of Parent, Relative, or Legal Guardian, where applicable

Witness _____ Date _____

ANY INDIVIDUAL OR AGENCY RECEIVING THIS INFORMATION IS PROHIBITED FROM MAKING FURTHER DISCLOSURE OF THIS INFORMATION.

IF THIS INFORMATION CONCERNS A PERSON ADMITTED FOR TREATMENT OF ALCOHOL OR DRUG ABUSE, THE CONFIDENTIALITY OF THIS INFORMATION IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATION (42 CFR PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION, IF HELD BY OTHER PARTY, IS NOT SUFFICIENT FOR THIS PURPOSE.

Sample Medical Records Request Letter

Re:
DOB:
SSN:

Dear :

Our program serves homeless adults and helps them obtain income, services, and other resources. Part of this effort is to help individuals apply for Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI), two disability income programs operated by the Social Security Administration (SSA). In addition to providing needed income support for beneficiaries, both programs provide medical insurance (Medicaid or Medicare), which could reimburse your facility for future care you provide this individual as well as possibly cover some retroactive bills.

To be eligible for disability benefits, individuals must make sure that their medical records are provided to the State agency that Social Security contracts with to make disability determinations, called Disability Determination Services (DDS). Without this medical information, eligibility for desperately needed benefits is unlikely.

You have provided medical services to the above referenced person. I have enclosed two releases of information (one for SSA and one for our provider agency) signed by the above individual. If you would please send me your medical information as soon as possible, I will ensure that this information is sent on to the DDS for review.

For you to have a sense of what is needed from your records, I also have enclosed with this letter a list of medical information that can be extraordinarily helpful. Your cooperation is critical for the success of this application and for the recovery of this person.

If you have any questions, please do not hesitate to contact me at . I thank you in advance for your swift response to this request.

Sincerely,

Medical Information for SSI/SSDI

- Admission notes
- Physical examination reports
- Laboratory test results and reports
- Other diagnostic evaluations such as x-rays, CT scans, MRI results, etc.
- Psychiatric evaluations
- Psychosocial history reports (usually from social workers)
- Psychological testing results and reports
- Occupational therapy reports
- Neurological evaluations
- Neuropsychological testing reports
- Any additional evaluation reports
- Progress notes for duration of each treatment episode
- Discharge summaries

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last)*

SSN ___ ___ | Birthday *(mm/dd/yy)*

SSA USE ONLY NUMBER HOLDER (If other than above)

NAME

SSN ___ ___

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

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

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

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

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

FROM WHOM

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

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

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

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

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

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

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

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

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

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(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 ▶

Phone Number (or Address)

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

SIGN ▶

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.

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

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

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

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

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

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

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

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

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

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

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

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

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

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** 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.

Worksheet 4
Substance Use Worksheet

Name_____

DOB_____ SSN_____

General History

(Detailed information is listed on Worksheet 6, the Applicant Assessment form. Information on brain damage and past abuse is taken from that assessment.)

Brain damage history (due to head injury, illness, or substance use)? ☐ Yes ☐ No

History of physical abuse? ☐ Yes ☐ No

History of sexual abuse? ☐ Yes ☐ No

Diagnosis of serious and persistent mental illness? ☐ Yes ☐ No

List diagnoses: Axis I: (clinical disorders)

_____

_____

_____

Axis II: (personality disorders, mental retardation)

_____

_____

_____

Axis III: (physical health problems)

_____

_____

_____

Substance Use History

What do you drink now? About how much? What other drugs do you use, about how much, and (usually) how often? *(Obtain clarification if the person says something like "'a little," or "alot," or "not much.")*

Do you recall how old you were when you first started drinking (or using other drugs)?

What was going on in your life then? How was your life going?

What do you think made you decide to drink and/or use other drugs?

When you drank or used drugs, how did you feel? What was the effect of your use on your life?

What happened since that time? How would you describe your life since you've been using? What do you think affected how much you drank alcohol or used other drugs?

What is your substance of choice now (if you could use any alcohol or other drug that you wanted, what would it be)? Why do you prefer this drug? How does it make you feel? What does it do?

How old were you when you drank/used drugs the most? What was going on at that time?

Have you ever tried to limit your substance use? If yes, what happened?

Have you ever experienced blackouts (when you didn't remember what happened), shaking, or seizures when you were using alcohol or other drugs? How often? Were you treated for anything when this happened?

Have you ever been in any treatment for your substance use? If yes, what kind of treatment? What was that like for you? Was it helpful? In what way?

Do you feel your substance use is a problem? Can you tell me why?

If you tried to stop drinking or using drugs now, what do you think would happen? How do you think you would do? How would you feel?

Future Steps

Further evaluation needed? ☐ Yes ☐ No

If yes, what type of evaluation?

Appointment dates for needed evaluation(s)			
Place	Address	Phone Number	Type of Evaluation

Interviewer _____ **Date** _____

Worksheet–4

Worksheet 6
Applicant Assessment Worksheet

Name_____

DOB_____ SSN_____

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Physical Description

Height_____ Weight_____

Clothing, hygiene, grooming

Glasses? ☐ Yes ☐ No

Speech problems?

Abnormal mouth movements?

Hand/leg tremors?

Slowness/quickness in movement?

Agitation?

Attitude/Behavior?

Personal History

(Place of birth, siblings, parent(s)/guardian/person who raised individual, anyone else who lived with the family, description of childhood and growing up, discipline)

Educational History

(Last year completed, any difficulties in school (learning or social), any repeated grades, favorite/least favorite subjects)

Employment History
(Thorough, chronological history of employment dates, employers, types of work/tasks completed, job atmosphere, relationships with co-workers, reasons for/circumstances of leaving each position)

Military Service History
(Was the individual ever in the military? Which service? How long? Where stationed? What did he or she do? What was the outcome: honorable/dishonorable discharge? If dishonorable, why?)

Marital/Intimate Relationships
(Current relationships, past relationships, children, outcomes)

Legal History

(Current legal status, history of past arrests, charges, outcomes)

Homelessness History/Prior Living Situations/Current Living Situation

Physical Health

(Current and past health problems, treatment, medications, surgery, accidents, brain damage/injury)

Surgery

Hospitalization

Head Injury

Other Accidents/Injuries

Substance Use/Abuse

(See Substance Use Worksheet, Worksheet 4, in Module VII)

Psychiatric History

(Initial symptoms, ongoing symptoms, inpatient treatment, outpatient treatment, day hospital/day programs, emergency room visits, past and current treatment)

Current Symptoms/Difficulties

Orientation

Ask the person the place, year, month, date, day of the week.

Psychomotor Activity

Does the individual have difficulty sitting still? Does he or she seem agitated? Is the person noticeably slow in activity? Describe.

Mood

How do you sleep at night? If you don't sleep well, what happens?

Have you noticed a changed (increase or decrease) in appetite? If the individual doesn't eat, is it because of access to food or appetite changes?

Rate the individual's mood most of the time from very sad (1) to very happy (10).

Does your mood change a lot? Do you have thoughts of hurting yourself or hurting others?

Obsessions/Compulsions

Do you notice that there are certain things you must do the exact same way each time you do them? For example, organizing your clothes or washing your hands?

Do you worry about the same thing(s) over and over?

Do you have things you are afraid of? Do you think about those things happening a lot?

Manic/Bipolar Symptoms

Do you ever feel that your thoughts are moving too quickly? Too slowly?

Have you ever experienced a spending spree that you can't afford?

Do you ever stay up for long periods of time with no sleep and feel very energetic and productive?

Have you ever felt very powerful or in a high-level position even though other people might not have seen you that way?

Psychotic Symptoms

Sometimes people notice that they hear voices or noises that other people say they don't hear. Does this happen to you? What do you notice?

Sometimes people also see things that other people say they don't see. Does this ever happen to you? What do you see?

Do you sometimes feel that you aren't yourself? Or that you are another person?

Other Symptoms/Information

Do you feel, in general, that other people want to hurt you or that they want to help you? Why?

Do you ever notice yourself feeling very nervous with shaking hands, racing heart, sweaty palms, and a general unsettled feeling? When does this happen?

When someone makes you very angry, what do you do? How do you handle that?

Final Comments/Observations

Interviewer _____ **Date** _____

Worksheet–6

Worksheet 7

Functional Information Worksheet

(use additional sheets, if necessary)

Name_____

DOB_____ SSN_____

Daily Activities/Typical Day

What time do you get up in the morning?

How do you spend your days?

How many meals do you usually have in a day? What times? What do you eat? If you don't eat regularly, how come?

How do you spend your evenings?

What time do you usually go to bed? How do you sleep?

Does your routine change on the weekend? If so, how does it change?

Functional Area I — Activities of Daily Living (ADLs)

What do you know how to cook? When was the last time you were able to cook? What are your favorite foods to prepare?

If you needed to shop for food to last a few days, would you need assistance or is that something you can tackle yourself? Do you usually have someone go with you to shop? Who? What assistance does he or she provide?

Are you able to use the telephone? When was the last time you were able to make a call?

If you needed a phone number and didn't have it, how would you get it? *(Question relates to the use of a phone book or information, i.e., 411)*

When you have your own place to live, what kind of housekeeping things do you do on a regular basis? What kind of chores do you find difficult to do? *If the person lives with someone else:* How are the chores split up? Do you need reminders to do chores?

About how often are you able to bathe or shower? Is this what's been your usual routine? Do you need any assistance doing this? *If the person doesn't bathe regularly:* What keeps you from bathing or showering?

Are you able to do your own laundry? How often do you usually do it? *If not:* How come? Who does your laundry?

Have you ever been to the post office? What services did you use there?

Budgeting is something we all struggle with. How are you at budgeting? Are you able to set up a budget and stick with it — or might that be something you could use assistance with? *If this applies:* When you have income, what usually happens to your spending habits? Do you, like some of us do, spend right away or are you able to make it last?

How do you usually get to places? Walk? Drive? Use public transportation? How does that work for you?

If this applies: When were you able to have your own place to live? What happened that you don't live there anymore? How did things go when you were there?

Are there any sort of other regular things that you think most people do every day that you find are difficult? Why?

Functional Area II — Social Functioning

If applicable: Do you maintain contact with your family? If not, why?

How often do you go somewhere outside? Do you usually go by yourself or with other people? Do you prefer to be alone or with other people? Why?

How often do you visit other people? Who do you usually visit? How often do other people come to see you?

Do you notice that you had friendships before that you don't have now? Do you have thoughts about that?

Who do you see on a regular basis? How do you and _____ get along?

What do you do if someone makes you really angry? How do you respond? What do you do?

Do you feel like you avoid being around other people? If yes, why?

Are you in any groups? Do you like being in groups?

What kind of person would you say you get along best with? Who gives you the most difficulty?

If applicable: When you worked before, how did you get along with your boss? Your co-workers?

Functional Area III — Concentration, Persistence, and Pace *(has to do with ability to complete tasks in a timely manner)*

Have you noticed any changes in your ability to concentrate? If so, what have you noticed?

Ask the person to complete serial 7s (i.e., Subtract 7 from 100, then subtract 7 from that total ... until the person reaches 65). If the person can't do 7s, ask him or her to try serial 3s. Note what happens.

Do you notice any changes in your memory? What do you notice? When do you notice this? Can you give me a specific example?

Would you describe yourself as someone who is easily distracted or do you find you can stay focused on a task if you need to?

Ask the person to follow a three-step instruction: Take this paper, fold it in half, and please return it to me.

What do you enjoy doing? What do you have an opportunity to do? When did you last do this? Are there any changes in what you enjoy now and what you used to enjoy?

Do you like to watch TV? If yes, what do you watch? Would you be able to watch an hour-long show and tell me about it shortly after you saw it?

Do not ask this if you know the person is unable to read. What do you usually read? Do you do this often? Could you tell me what you just read if I asked you soon after?

Functional Area IV — Repeated Episodes of Decompensation *(each of extended duration)*

Ask this series of questions only if the person has had experience in work or work-like settings.

Over the last year, have you found yourself doing well for a while and then having a tough time that seemed to last? Please tell me what happened?

When these experiences recurred, what seemed to happen before and after—to make things harder and to make things get better?

Please tell me, if you can, what you feel you might do to try to prevent things from getting hard again?

How often do you feel these tough times seemed to happen? Is there anything different about this year from previous years or is this about what typically happens with you?

The section below is for the case manager only. This information can be used to ensure that the Functional Assessment is complete. It should not be included in the Medical Summary Report. These ratings are up to the DDS to determine and not the case manager. This grid is a worksheet only and should not be sent to the DDS.

Overall Estimated Rating of Degree of Functional Impairment

ADLs—

☐ None ☐ Slight ☐ Moderate ☐ Marked† ☐ Extreme

Reason for Ranking—

Social Functioning—

☐ None ☐ Slight ☐ Moderate ☐ Marked† ☐ Extreme

Reason for Ranking—

Concentration, Persistence, and Pace—

☐ Never ☐ Seldom ☐ Often ☐ Frequent† ☐ Constant

Reason for Ranking—

Repeated Episodes of Decompensation—

☐ Never ☐ Once or Twice ☐ Repeated (3+)† in last year ☐ Continual

Reason for Ranking—

†*To qualify for benefits alleging marked functional impairment in two or more areas, a person would generally need to evidence a degree of impairment shown by the asterisk.*

Interviewer _____ **Date** _____ Worksheet–7

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.	(a) Are you married?	☐ YES Go to (b)	☐ NO Go to #3	
	(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 #3	☐ NO Go to (g)	
	(g) Date you began living apart : (month, day, year)			

2. (h) Address of spouse or name of someone who knows where spouse is. (Complete only if spouse is age 65, blind or disabled.)

3. (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 #4	☐ YES Go to (b) ☐ NO Go to #4

(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		

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

	You	Your Spouse
(a) Are you unable to work because of illnesses, injuries or conditions?	☐ YES Go to (b) ☐ NO Go to #5	☐ YES Go to (b) ☐ NO Go to #5
(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)

(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 #5

(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)

4. (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 #5

5.

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

Go to #6

		You		Your Spouse, if filing	
6.	Are you a United States citizen by birth?	☐ YES Go to #12	☐ NO Go to #7	☐ YES Go to #12	☐ NO Go to #7
7.	Are you a naturalized United States citizen?	☐ YES Go to #12	☐ NO Go to #8	☐ YES Go to #12	☐ NO Go to #8
8.	(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 #12	☐ American Indian born in Canada Go to #12
☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #12	☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #12
☐ Other American Indian Explain in Remarks, then Go to (c)	☐ Other American Indian Explain in Remarks, then Go to (c)

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

You	Your Spouse, if filing
☐ Amerasian Immigrant Go to #9	☐ Amerasian Immigrant Go to #9
☐ Lawful Permanent Resident Go to #9	☐ Lawful Permanent Resident Go to #9
☐ Refugee Date of entry: Go to #11	☐ Refugee Date of entry: Go to #11
☐ Asylee Date status granted: Go to #11	☐ Asylee Date status granted: Go to #11
☐ Conditional Entrant Date status granted: Go to #11	☐ Conditional Entrant Date status granted: Go to #11
☐ Parolee for One Year Go to #11	☐ Parolee for One Year Go to #11
☐ Cuban/Haitian Entrant Go to #11	☐ Cuban/Haitian Entrant Go to #11
☐ Deportation/Removal Withheld Date: Go to #11	☐ Deportation/Removal Withheld Date: Go to #11
☐ Other Explain in Remarks, then Go to (d)	☐ Other Explain in Remarks, then Go to (d)

8.	**(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 #10; otherwise Go to #12.**		
9.	If you are lawfully admitted for permanent residence:		
	(a) Date of Admission	**You** (month, day, year)	**Your Spouse** (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, then Go to (d):		
	Name / Address / Telephone Number		
			( ) -
	(d) What was your immigration status, if any, before adjustment to lawful permanent resident?	**You** Status: (month, day, year) From: To:	**Your Spouse, if filing** Status: (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 #11	☐ YES Go to (f) ☐ NO Go to #11
	(f) Name and Social Security Number of parent(s) who worked.		
	Name	Social Security Number	
	Name	Social Security Number	
10.	(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 #12	**Your Spouse, if filing** ☐ YES Go to (b) ☐ NO Go to #12
	(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 #11 ☐ NO Go to #12	☐ YES Go to #11 ☐ NO Go to #12
11.	Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	☐ YES Explain in #57(b), then Go to #12 ☐ NO Go to #12	☐ YES Explain in #57(b), then Go to #12 ☐ NO Go to #12
12.	(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 #13	☐ YES Go to (c) ☐ NO Go to #13
	(c) Give the dates of residence outside the United States.	(month, day, year) From: To:	(month, day, year) From: To:
13.	(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 #14	☐ YES Go to (b) ☐ NO Go to #14

13.	(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 #14.
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 #14; OTHERWISE GO TO #15.

14.	(a) Is your spouse/parent the sponsor of an alien who is eligible for supplemental security income?	☐ YES Go to (b)	☐ No Go to #15
	(b) Eligible Alien's Name	Eligible Alien's Social Security Number Go to #15	
15.	(a) Do you have any unsatisfied felony warrants for your arrest?	**You** ☐ YES Go to (b) ☐ NO Go to #16	**Your Spouse, if filing** ☐ YES Go to (b) ☐ NO Go to #16
	(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 #16	☐ YES Go to (d) ☐ NO Go to #16
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)
16.	(a) Do you have any unsatisfied Federal or State warrants for violating the conditions of probation or parole?	**You** ☐ YES Go to (b) ☐ NO Go to #17	**Your Spouse, if filing** ☐ YES Go to (b) ☐ NO Go to #17
	(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 #17	☐ YES Go to (d) ☐ NO Go to #17
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)

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

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

☐	Household	Since (month, day, year) Go to #22
☐	Non-Institutional Care	Since (month, day, year) Go to #20
☐	Institution	Since (month, day, year) Go to #18
☐	Transient	Since (month, day, year) Go to #35

INSTITUTION

18. Check the block that identifies the type of institution where you currently reside, then Go to #19:

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

19. 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 #35

NON-INSTITUTIONAL CARE

20. Check the block that best describes your current residence, then Go to #21:

☐ Foster Home ☐ Group Home ☐ Other (Specify)

21. Give the following information about your Noninstitutional Care:

(a) Name of facility where you live:

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

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

☐ YES Go to #35 ☐ NO If NO, who pays?

Go to #35

HOUSEHOLD ARRANGEMENTS

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

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

23. Do you live alone or only with your spouse? ☐ YES Go to #25 ☐ NO Go to #24

24. (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 #25.

(b) Does anyone listed in 24(a) who is under age 18, OR between ages 18-22 and a student, receive income? ☐ YES Go to (c) ☐ NO Go to #25

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

25. (a) Do you (or does anyone who lives with you) own or rent the place where you live? ☐ YES Go to #26 ☐ No Go to (b)

25.	(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 #35; otherwise, Go to #29.

26.			
	(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 #27
	(b) Are your parent(s) buying or do they own the place where you live?	☐ YES Go to (c)	☐ NO Go to #27

(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 #35; otherwise Go to #29.

27.			
	(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)

(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 #28

☐ NO Give name of person with home ownership:

Go to #29

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

Amount: $ Frequency of Payment:

Go to #28

28.				
	(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 #35.

29.			
	(a) Does anyone living with you contribute to the household expenses? (NOTE: See list of household expenses in #34)	☐ YES Go to (b)	☐ NO Go to #30

(b) Amount others contribute: $

Go to #30

30.	(a) Do you eat all your meals out?	☐ YES Go to #31	☐ NO Go to (b)
	(b) Do you buy all your food separately from other household members:	☐ YES Go to #31	☐ NO Go to #31

31. Do you contribute to household expenses?

☐ YES Average Monthly Amount: $ _____ Go to #32

☐ NO Go to #32

32.	(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 #32(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 #35	☐ NO Go to (d)

(d) **If you contribute** toward household expenses and you answered "NO" to both 30(a) & (b), Go To #33. If you answered "YES" to either 30(a) or 30(b), Go to #34.
If you do not contribute toward household expenses, go to #35.

33. (a) Is part or all of the amount in #31 just for food?

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

(b) Is part or all of the amount in #31 just for shelter?

☐ YES Give Amount: $_____ Go to #34 ☐ NO Go to #34

34. 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 #30(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 #35

35. (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 #36

36.	(a) Has the information given in #17-35 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 #37	☐ NO Go to #37

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

		You		Your Spouse	
37.	(a) Do you own or does your name appear on, either alone or with other people, the title of any vehicles (auto, truck, motorcycle, camper, boat, etc.)?	☐ YES Go to (b)	☐ NO Go to #38	☐ YES Go to (b)	☐ NO Go to #38

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

		You		Your Spouse	
38.	(a) Do you own or are you buying any life insurance policies?	☐ YES Go to (b)	☐ NO Go to #39	☐ YES Go to (b)	☐ NO Go to #39

38. (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 #39

39. (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?				

(b) Give the following information for any "Yes" answer in #39(a); otherwise, Go to #40.

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

40. (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 #40(a) are answered "NO", Go to #41. 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
		$		
		$		
		$		

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

41. (c) If all the items in #41(b) are answered "NO", Go to #42. 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
		$		
		$		
		$		
		$		

42. (a) Do you have any land, houses, buildings, real property, property in a foreign country, equipment, mineral rights, items in a safe deposit box, assets set aside for emergencies or for your heirs, or any other property of any kind that has not been shown anywhere else on the application?

You		Your Spouse	
☐ YES	☐ NO	☐ YES	☐ NO
Go to (b)	Go to #43	Go to (b)	Go to #43

(b) Describe the property (including size, location, and how it is used. If not used now, when was it last used and what is next planned use.)

Item #1

Item #2

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

43.	(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 #44
	(d) Explain:	

44.	(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?	**You** ☐ YES ☐ NO Go to (b)	**Your Spouse** ☐ 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 #45.

(c)	OWNER'S/CO-OWNERS NAME	DESCRIPTION OF PROPERTY	DATE OF DISPOSAL
ITEM #1			
ITEM #2			
ITEM #3			

	NAME AND ADDRESS OR PURCHASER OR RECIPIENT	RELATIONSHIP TO OWNER	VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT
ITEM #1			$
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

45.	(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 #38 and #40-44.	You ☐ YES ☐ NO Go to (b) Go to #46	Your Spouse ☐ YES ☐ NO Go to (b) Go to #46

(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 #46 ☐ NO Explain in (c)
Item 1	☐ YES ☐ NO	☐ YES Go to #46 ☐ NO Explain in (c)

(c) EXPLANATION

46.	(a) Do you own any cemetery lots, crypts, caskets, vaults, urns, mausoleums, or other repositories for burial or any headstones or markers?	You ☐ YES ☐ NO Go to (b) Go to #47	Your Spouse ☐ YES ☐ NO Go to (b) Go to #47

(b) Owner's Name	Description	For Whose Burial	Relationship to You or Your Spouse	Current Market Value
				$
				$
				$ Go to #47

PART IV -- INCOME

47. (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 (Military, State, Local, Private, Union, Retirement or Disability)				
Military Special Pay or Allowance				
Unemployment Compensation				
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				

47. (b) Give the following information for any block checked YES in #47(a); otherwise, Go to #48

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 #48; OTHERWISE GO TO #49

		You	Your Spouse
48.	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 ☐ NO Explain in Remarks, then Go to #49 — Go to #49	☐ YES ☐ NO Explain in Remarks, then Go to #49 — Go to #49
49.	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 ☐ NO Explain in Remarks, then Go to #50 — Go to #50	☐ YES ☐ NO Explain in Remarks, then Go to #50 — Go to #50
50.	(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 ☐ NO Go to (b) — Go to (e)	☐ YES ☐ NO Go to (b) — 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)

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

	Your Amount	Your Spouse's Amount
(d) Total monthly wages received (before any deductions)	$	$

	You	Your Spouse
(e) Do you (or your spouse) expect to receive any wages in the next 14 months?	☐ YES ☐ NO Go to (f) — Go to #51	☐ YES ☐ NO Go to (f) — Go to #51

(f) Name and address of employer if different from #50(b) (include telephone number, if known)

You	Your Spouse

50. (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 #50(g)	You	Your Spouse
	☐ YES Go to (i) ☐ NO Go to #51	☐ YES Go to (i) ☐ NO Go to #51

(i) Explain Change:

You	Your Spouse

51. (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 Go to (b) ☐ NO Go to #52	☐ YES Go to (b) ☐ NO Go to #52

(b) Give the following information; then Go to #52

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**
		$	$	$

52. 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	Your Spouse
☐ 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) 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 #54; OTHERWISE, GO TO #55.

54.	(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 #55

Name of School	Name of School Contact	Dates of Attendance From	To	Course of Study
	Phone Number	Hours Attending or Planning to Attend		

PART V - POTENTIAL ELIGIBILITY FOR FOOD STAMPS/MEDICAL ASSISTANCE/OTHER BENEFITS - If a California resident, Skip to #56

		You		Your Spouse, if filing	
55.	(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 #56	☐ YES Go to (e)	☐ NO Go to #56
	(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 #56	☐ YES Go to (e)	☐ NO Go to #56
	(e) If everyone in the household receives or is applying for SSI, Go to (f); otherwise Go to #56.				
	(f) May I take your food stamp application today?	☐ YES Go to #56	☐ NO Explain in (g)	☐ YES Go to #56	☐ NO Explain in (g)
	(g) Explanation:				

56.	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).				
	(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?	You ☐ YES Go to (b)	☐ NO Go to #57	Your Spouse, if filing ☐ YES Go to (b)	☐ NO Go to #57
	(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 #57	☐ NO Go to #57	☐ YES Go to #57	☐ NO Go to #57

57.	(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 #11 or #57(a); otherwise Go to #58.						
	You:	Your Spouse, if filing/Your Parent, if filing as a child:					

PART VI -- MISCELLANEOUS -- (Answer #58 ONLY IF YOU ARE APPLYING ON BEHALF OF SOMEONE ELSE: OTHERWISE GO TO #59.

58.	(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

59. **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.

60. **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 ▶

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

City and State	ZIP Code	County

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

City and State	ZIP Code	County

63. **FOR OFFICIAL USE ONLY**

DIRECT DEPOSIT PAYMENT ADDRESS (FINANCIAL INSTITUTION)

Routing Transit Number	C/S Number	Depositor Account	☐ No Account
			☐ Direct Deposit Refused

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

☐ Certified ☐ Regular ☐ Regular with a Follow-up phone call

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
Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. The information you provide will be used to enable the Social Security Administration to determine if you are eligible for Supplemental Security Income (SSI) payments.

The information you furnish on this form is voluntary. However, failure to provide the requested information may keep us from making an accurate and timely decision on your claim, which in turn may result in loss of some payments.

We rarely use the information you supply for any purpose other than for determining eligibility for SSI. 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 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 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 (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

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.

Complete lists of routine uses for this information are available in System of Records Notice 60-0103, Supplemental Security Income Record and Special Veterans Benefits, and also in System of Records Notice 60-0089, Claims Folder Systems. The Notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.ssa.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 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 UNDER AGE 18 AND YOU ARE LIVING WITH YOUR PARENTS-A report to Social Security must be made if:**

- Your parents have a change in income, a change in their marriage, a change in the value of anything they own, or either has a change in 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.

DISABILITY REPORT - ADULT
SSA-3368-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

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

IF YOU NEED HELP

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

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

HOW TO COMPLETE THIS REPORT

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

YOUR MEDICAL RECORDS

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

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

WHAT WE MEAN BY "DISABILITY"

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

The Privacy Act

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

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

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

The Paperwork Reduction Act

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions.

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

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

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT

For SSA Use Only - Do not write in this box.

Related SSN _____

Number Holder _____

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle Initial, Last)

1.B. Social Security Number

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

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

1.D. Email Address

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

Phone number _____

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

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

Alternate phone number _____

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

If no, what language do you prefer? _____

If you cannot speak and understand English, we will provide an interpreter, free of charge.

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

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

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

If yes, please list them here:

SECTION 2 - CONTACTS

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

2.A. Name (First, Middle Initial, Last)

2.B. Relationship to you

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

_____

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

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

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

If no, what language is preferred? _____

SECTION 2 - CONTACTS (continued)

2.F. Who is completing this report?

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

2.G. Name (First, Middle Initial, Last)	**2.H.** Relationship to Person Applying

2.I. Daytime Phone Number _____

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

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

SECTION 3 - MEDICAL CONDITIONS

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

1.
2.
3.
4.
5.

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

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

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

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

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

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

IF YOU HAVE NEVER WORKED:

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

IF YOU HAVE STOPPED WORKING:

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

Why did you stop working?

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

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

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

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

SECTION 4 - WORK ACTIVITY (continued)

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

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

IF YOU ARE CURRENTLY WORKING:

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

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

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

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

☐ NO ☐ YES

SECTION 5 - EDUCATION AND TRAINING

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

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

Date completed: _____

5.B. Did you attend special education classes? ☐ YES ☐ NO (Go to 5.C.)

Name of School _____

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

Dates attended special education classes: from _____ to _____

5.C. Have you completed any type of specialized job training, trade, or vocational school? ☐ YES ☐ NO

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

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

SECTION 6 - JOB HISTORY

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

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

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

SECTION 6 - JOB HISTORY (continued)

Check the box below that applies to you.

☐ I had **only one job** in the last 15 years before I became unable to work. Answer the questions below.

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

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

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

_____

_____

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

6.C. In this job, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform any duties like this? ☐ YES ☐ NO

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

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

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

_____

_____

_____

_____

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

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

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

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

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

How many people did you supervise? _____

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

Did you hire and fire employees? ☐ YES ☐ NO

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

SECTION 7 - MEDICINES

7. Are you taking any medicines (prescription or non-prescription)?

☐ YES (Give the information requested below. You may need to look at your medicine containers.)

☐ NO (Go to Section 8 - Medical Treatment.)

Name of Medicine	If prescribed, give name of doctor	Reason for medicine

If you need to list other medicines, go to Section 11 - Remarks on the last page.

SECTION 8 - MEDICAL TREATMENT

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled?**

8.A. For any **physical** condition(s)?

☐ YES ☐ NO

8.B. For any **mental** condition(s) **(including emotional or learning problems)?**

☐ YES ☐ NO

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

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

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

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

Phone Number	Patient ID# (if known)

Mailing Address

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

Dates of Treatment

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

What medical conditions were treated or evaluated?

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

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

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

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

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

SECTION 8 - MEDICAL TREATMENT (continued)

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

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

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Phone Number	Patient ID# (if known)

Mailing Address

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

Dates of Treatment

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

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☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

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

SECTION 8 - MEDICAL TREATMENT (continued)

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

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

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

Phone Number	Patient ID# (if known)

Mailing Address

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

Dates of Treatment

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

What medical conditions were treated or evaluated?

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

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

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

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☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

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

SECTION 8 - MEDICAL TREATMENT (continued)

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

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

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

Phone Number	Patient ID# (if known)

Mailing Address

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

Dates of Treatment

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

What medical conditions were treated or evaluated?

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

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

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

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☐ Biopsy (list body part) _____		☐ X-Ray (list body part) _____	
☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

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

SECTION 8 - MEDICAL TREATMENT (continued)

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

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

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

Phone Number	Patient ID# (if known)

Mailing Address

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

Dates of Treatment

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

What medical conditions were treated or evaluated?

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

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

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

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

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

SECTION 9 - OTHER MEDICAL INFORMATION

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

☐ YES (Please complete the information below.)

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

Name of Organization	Phone Number

Mailing Address

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

Name of Contact Person	Claim or ID number (if any)

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

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

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

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

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

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

10.B. Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Mailing Address

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

10.C. When did you start participating in the plan or program? _____

SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES (continued)

10.D. Are you still participating in the plan or program?

☐ YES, I am scheduled to complete the plan or program on: _____

☐ NO. I completed the plan or program on: _____

☐ NO. I stopped participating in the plan or program before completing it because:

_____

_____

_____

10.E. List the types of services, tests, or evaluations that you received (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluations, or classes).

_____

_____

_____

If you need to list another plan or program use Section 11 - Remarks and give the same detailed information as above.

SECTION 11 - REMARKS

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

_____

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Date Report Completed	▶	___/___/___ month, day, year

SOCIAL SECURITY ADMINISTRATION | TOE 250 | Form Approved OMB No.0960-0024

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

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).** ***Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.***

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Including Area Code)
( ) –

DATE

Privacy Act Statement

Sections 205(a) and 205(j), of the Social Security Act, as amended, authorize us to collect this information. The information is needed to make a determination regarding whether or not the named individual should be paid benefits directly or whether benefits should be paid to a representative payee. The information you furnish on this form is voluntary. However, failure to provide all or part of the information could prevent an accurate and timely decision on the proper payee for benefit receipt purposes.

We rarely use the information you supply for any purpose other than for making a determination on a claim. 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: (1) to enable a third party or an 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 Department of Veteran Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

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

A complete list of routine uses for this information is available in Systems of Record Notices 60-0089 and 60-0222. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
– –

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER – –	PATIENT'S DATE OF BIRTH	

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. Please Note: This determination affects how benefits are paid and has no bearing on disability determinations; SSA will NOT pay for this information. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER – –	PATIENT'S DATE OF BIRTH	

1. Date you last examined the patient _____

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

   By capable we mean that the patient:

   - Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
   - Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes	☐ No	☐ Unsure
If "Yes", please omit question 3, but be sure to sign and date the form.	If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.	If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

   ☐ Yes ☐ No

   If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)	TITLE
ADDRESS (Number and street, City, State, and ZIP Code)	TELEPHONE NUMBER *(Include Area Code)* ( ) –

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.

SIGNATURE OF PHYSICIAN/ MEDICAL OFFICER	DATE