Questionnaire

Name:_____ Maiden Name:_____

Address:_____
Street City State Zip

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

Date of Birth:_____ SSN:_____

Name of Employer:_____ Job type:_____

Circle Highest Education Level: Less than 9th grade 9 10 11 12 Some College Completed College

If you completed college, what type of degree do you have?_____

List the names and addresses of any medical providers you have seen in relation to your claim:

_____

_____

_____

_____

_____

_____

List the names *and Social* Security numbers for anyone you are financial responsible for who is under 21 years of age:

_____

_____

_____

_____

_____

Our office has permission to speak with_____ regarding your case_____
Name Relationship Client Initials

Name and telephone number of someone, who does not live in your household, where we can leave a message for you:

_____
Name Telephone Relationship

How did you hear about us? ☐ Friend/Family_____ ☐ Business Card/Pen

☐ Phone Book/Yellow Pages ☐ Commercial/Printed Advertisement ☐ Other_____

WHOSE *Records to be Disclosed*	Form Approved OMB No. 0960-0623
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**
   - -- **The information authorized for release may include records which may include 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 ▶	**IF** needed, second witness sign here (e.go., if signed with "X" above) **SIGN** ▶
Phone Number (or Address)	Phone Number (or Address)

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

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 SSA collects 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, 1338 Annex Building, Baltimore, MD 21235-0001.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Please read the back of the last copy before you complete 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, Shannon Fauver, 138 S. 3rd St. Louisville, KY 40202, (Name and Address)

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

- [x] Title II (RSDI)
- [x] Title XVI (SSI)
- [ ] Title IV FMSHA (Black Lung)
- [ ] 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 am appointing, 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, Shannon Fauver, 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.)

[x] I am an attorney. [ ] I am not an attorney. (Check one.)

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	
	138 S. 3rd St. Louisville, KY 40202	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date
502-569-7710	877-361-5200	

Part III (Optional) WAIVER OF FEE

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date

Part IV (Optional) ATTORNEY'S WAIVER OF DIRECT PAYMENT

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney Representative)	Date

INFORMATION FOR CLAIMANTS

What A Representative May Do

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

- o get information from your claim(s) file;
- o give us evidence or information to support your claim;
- o come with you, or for you, to any interview, conference, or hearing you have with us;
- o request a reconsideration, hearing, or Appeals Council review; and
- o help you and your witnesses prepare for a hearing and question any witnesses.

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

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

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

What Your Representative(s) May Charge

Each representative you appoint can ask for a fee. To charge you a fee for services, your representative must get our approval. (Even when someone else will pay the fee for you, for example, an insurance company, your representative usually must get our approval.) One way is to file a fee petition. The other way is to file a fee agreement with us. In either case, your representative cannot charge you more than the fee amount we approve. If he or she does, promptly report this to your Social Security office.

- o Filing A Fee Petition

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

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

What Your Representative(s) May Charge, continued

- o Filing A Fee Agreement

  If you and your representative have a written fee agreement, one of you must give it to us before we decide your claim(s). We usually will approve the agreement if you both signed it; the fee you agreed on is no more than 25 percent of past-due benefits, or $5,300 (or a higher amount we set and announced in the Federal Register), whichever is less; we approve your claim(s); and your claim results in past-due benefits. We will tell you in writing the amount of the fee your representative can charge based on the agreement.

  If we do not approve the fee agreement, we will tell you and your representative in writing. Then your representative must file a fee petition to charge and collect a fee.

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

How Much You Pay

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

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

Your representative may accept money in advance as long as he or she holds it in a trust or escrow account. If an attorney represents you and your retirement, survivors, disability insurance, or black lung claim results in past-due benefits, we usually withhold 25 percent of your past-due benefits to pay toward the fee for you.

You must pay your representative directly:

- o the rest of the fee you owe
  - if the amount of the fee is more than any amount(s) your representative held for you in a trust or escrow account and we withheld and paid your attorney for you.
- o all of the fee you owe
  - if we did not withhold past-due benefits, for example, when your representative is not an attorney or the benefits are supplemental security income; or
  - if we withheld, but later paid you the money because your attorney did not either ask for our approval until after 60 days of the date of your notice of award or tell us on time that he or she planned to ask for a fee.

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

TO:

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR ' 164.508, the provider listed above is hereby authorized to release to FAUVER LAW OFFICE, PLLC, or any of its representatives, *all medical records, including but not limited* to: office notes, history, physical, consultation notes, discharge summaries, order and progress notes, laboratory results, nurses notes, emergency room records, operative records, in-patient records and films of x-rays, MRIs or PET scans, pharmacy and drug records, medical bills and health insurance Medicaid or Medicare records, concerning any medical treatment that I have received from you, at your institution, as well as all such records which you keep in the regular course of business are found in my medical records file. I hereby authorize release of all records regarding mental health, psychiatric (other than psychotherapy notes which must be requested by separate authorization), chemical dependency or HIV. A photo static copy hereof shall be as valid as the original. I hereby authorize a free copy of my medical records pursuant to KRS 422.317 be sent, to the extent I have not already requested my one free copy.

The purpose of this authorization and request is to permit my attorney to obtain ALL medical information pertaining to my physical or mental condition. This authorization expires three (3) years from the date of the signature. The aforementioned expiration date has not passed, as this matter is ongoing.

I hereby authorize attorneys of FAUVER LAW OFFICE, PLLC to speak to my healthcare professionals privately or to take testimony at deposition or trial as may be requested.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to FAUVER LAW OFFICE, PLLC. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Patient Signature:_____

Patient Printed Name:_____

Patient Address:_____

_____

Date of Signature:_____

Patient Date of Birth:_____

Patient Social Security Number:_____

Witness Signature:_____

Witness Printed Name:_____

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

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.

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☐ 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.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
_____	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.)

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
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☐ 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.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.**

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.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: _____

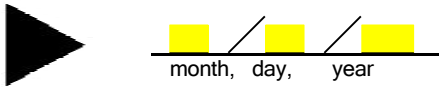
☐ NO. I stopped participating in the plan or program before completing it because:

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.

Date Report Completed	

SOCIAL SECURITY ADMINISTRATION ☐ TEL

Form Approved
OMB No. 0960-0444

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME

Do Not Write in This Space

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

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

Filing Date
(Month, Day, Year)

☐ Receipt ☐ Protective

Preferred Language:

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.	First Name, Middle Initial, Last Name	2. Sex ☐ Male ☐ Female	3. Birthdate (month, day, year)	4. Social Security Number
5.	Spouse's/Parent(s) Name(s)	6. Sex ☐ Male	7. Birthdate (month, day, year)	8. Social Security Number(s)
		☐ Female		
	Date of Marriage: (month, day, year)			

9. Other Name(s) and Social Security Number(s) you, your spouse/parents used:

(a) Your Other Name(s) (including Maiden Name)	Your Other Social Security Number(s)
(b) Spouse's/Mother's Other Name(s) (including Maiden Name)	Spouse's/Mother's Other Social Security Number(s)
(c) Father's Other Name(s)	Father's Other Social Security Number(s)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.

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

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

Name	Address	Telephone Number ( )

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

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

Name	Social Security Number
Name	Social Security Number

		You	Your Spouse, if filing
15.	(a) Have you, your child, or your parent, been subjected to battery or extreme cruelty while in the United States?	☐ YES Go to (b) ☐ NO Go to #17	☐ YES Go to (b) ☐ NO Go to #17
	(b) Have you, your child, or your parent filed a petition with the Department of Homeland Security for a change in immigration status because of being subjected to battery or extreme cruelty?	☐ YES Go to #16 ☐ NO Go to #17	☐ YES Go to #16 ☐ NO Go to #17
16.	Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	☐ YES Explain in Remarks, then Go to #17 ☐ NO Go to #17	☐ YES Explain in Remarks, then Go to #17 ☐ NO Go to #17
17.	(a) When did you first make your home in the United States?	(month, day, year)	(month, day, year)
	(b) Have you lived outside of the United States since then?	☐ YES Go to (c) ☐ NO Go to #18	☐ YES Go to (c) ☐ NO Go to #18
	(c) Give the date(s) of residence outside the United States.	(month, day, year) Date Left: _____ (month, day, year) Date Returned: _____	(month, day, year) Date Left: _____ (month, day, year) Date Returned: _____
18.	(a) Have you been outside the United States (the 50 States, District of Columbia and Northern Mariana Islands) 30 days prior to the filing date?	☐ YES Go to (b) ☐ NO Go to #19	☐ YES Go to (b) ☐ NO Go to #19
	(b) Give the date (month, day, year) you left the United States and the date you returned to the United States.	(month, day, year) Date Left: _____ (month, day, year) Date Returned: _____	(month, day, year) Date Left: _____ (month, day, year) Date Returned: _____
19.	(a) Do you have any unsatisfied felony warrants for your arrest?	You ☐ YES Go to (b) ☐ NO Go to #20	Your Spouse, if filing ☐ YES Go to (b) ☐ NO Go to #20
	(b) In which State or country was the warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
	(c) Was the warrant satisfied?	☐ YES Go to (d) ☐ NO Go to #20	☐ YES Go to (d) ☐ NO Go to #20
	(d) Date warrant satisfied:	month, day, year	month, day, year
20.	(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 #21	Your Spouse, if filing ☐ YES Go to (b) ☐ NO Go to #21
	(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 #21	☐ YES Go to (d) ☐ NO Go to #21
	(d) Date warrant satisfied:	month, day, year	month, day, year

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

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

- ☐ House, Apartment, Mobile Home, Houseboat
- ☐ Room in commercial establishment
- ☐ Room in private home
- ☐ Noninstitution (rest home, retirement home or group home)
- ☐ Institution (hospital, rehabilitation center, prison or school)
- ☐ Transient

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

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

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

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

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

	YES	NO	Description of Items Marked YES	Co-owned With Others Yes	Co-owned With Others No	Dollar Value You Own	Dollar Value Spouse or Parents Own
a. Vehicles (cars, trucks, boats, motorcycles). How many?						$	$
b. Insurance policies						$	$
c. Cash at home, with you, or anywhere else						$	$
d. Savings, checking accounts, stocks, bonds						$	$
e. Trust(s)						$	$
f. Property other than the home you live in						$	$
g. Life estates or property you inherited						$	$
h. Other items that can be turned into cash						$	$

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

25.	(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	**Your Spouse** ☐ YES ☐ NO
	(b) If you co-owned any money or property with another person(s), did you or any co-owner sell, transfer, or give away any co-owned money or property within the 36 months prior to the filing date month?	**You** ☐ YES ☐ NO	**Your Spouse** ☐ YES ☐ NO

IF YOU ANSWERED "YES" TO (a) OR (b), GO TO (c). IF "NO" TO BOTH, GO TO #26.

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

	NAME AND ADDRESS OF PURCHASER OR RECIPIENT	RELATIONSHIP TO OWNER	VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT
Item #1			$
Item #2			$
Item #3			$

	SALE PRICE OR OTHER CONSIDERATION	ARE OTHER CONSIDERATIONS OR PROCEEDS EXPECTED? EXPLAIN	DO YOU STILL OWN PART OF THE PROPERTY?
Item #1			☐ YES ☐ NO
Item #2			☐ YES ☐ NO
Item #3			☐ YES ☐ NO

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

PART IV - INCOME (List all income received since the first moment of the filing date month or expected in the next 3 months.)

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

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

27. (a) Does your spouse/parent pay court ordered child support? ☐ YES Go to (b) ☐ NO Go to #28

(b) Give the amount and frequency of payment:

$ _____

PART V - FOOD STAMPS

		You		Your Spouse, if filing	
28.	(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 #29	☐ YES Go to (e)	☐ NO Go to #29
	(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 a favorable decision?	☐ YES Go to #29	☐ NO Go to (e)	☐ YES Go to #29	☐ NO Go to (e)
	(e) May I take your food stamp application today?	☐ YES Go to #29	☐ NO Explain in (f)	☐ YES Go to #29	☐ NO Explain in (f)

(f) Explanation:

PART VI- MISCELLANEOUS

ANSWER #29 ONLY IF YOU ARE REQUESTING BENEFITS ON BEHALF OF SOMEONE ELSE; OTHERWISE GO TO #30.

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

PART VII - REMARKS - Use this space for any explanations.

PART VIII -- IMPORTANT INFORMATION -- PLEASE READ CAREFULLY

30. 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.

PART IX - SIGNATURES

31. **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 false information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

32. Your Signature (First name, middle initial, last name) (Write in ink.)

SIGN HERE ▶

Date (Month, day, year)

Telephone Number(s) where we can contact you during the day:

( ) -

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

SIGN HERE ▶

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

City and State	ZIP Code	Enter name of county (if any) in which you live

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

City and State	ZIP Code	Enter name of county (if any) in which you live

36. 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

WITNESSES

37. 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)

GPO U.S. GOVERNMENT PRINTING OFFICE: 2009—349-144/80115

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 write to:
( ) -	

Your application for Supplemental Security Income will be processed as quickly as possible. You should hear from us within ____days. If you do not hear from us within that time, please get in touch with us in person, by mail, or call us at the telephone number shown at the top of this page.

We may need more information before we can decide whether or not you are eligible for SSI payments. If we need more information, we will contact you. In the meantime, if you move or change your mailing address, you (or someone for you) should report the change to the office shown at the top of this page.

You (or someone for you) must let us know if your immigration status changes.

Also, you (or someone for you) must let us know if you are admitted to a hospital or other medical facility. You could lose some SSI payments if you do not let us know right away.

Always give your Social Security Number when writing or telephoning about your claim. If you have any questions about your claim, we will be glad to help you.

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 Veteran's 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 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. These 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 18-19 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 1-800-325-1213).** *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.**

(Do not write in this space)

APPLICATION FOR DISABILITY INSURANCE BENEFITS

I apply for a period of disability and/or all insurance benefits for which I am eligible under title II and part A of title XVIII of the Social Security Act, as presently amended.

PART I—INFORMATION ABOUT THE DISABLED WORKER

1. (a) PRINT your name → FIRST NAME, MIDDLE INITIAL, LAST NAME

   (b) Enter your name at birth if different from item (a) →

   (c) Check (√) whether you are → ☐ Male ☐ Female

2. Enter your Social Security Number → ___ ___ ___ / ___ ___ / ___ ___ ___ ___

3. (a) Enter your date of birth → MONTH, DAY, YEAR

   (b) Enter name of State or foreign country where you were born. →

If you have already presented, or if you are now presenting, a public or religious record of your birth established before you were age 5, go on to item 4.

(c) Was a public record of your birth made before you were age 5? ☐ Yes ☐ No ☐ Unknown

(d) Was a religious record of your birth made before you were age 5? ☐ Yes ☐ No ☐ Unknown

4. (a) What are the illnesses, injuries, or conditions that limit your ability to work? (Give a brief description.)

   (b) Are your illnesses, injuries or conditions related to your work in anyway? → ☐ Yes ☐ No

5. (a) When did you become unable to work because of your illnesses, injuries or conditions? → MONTH, DAY, YEAR

   (b) Are you still unable to work? → ☐ Yes ☐ No

   (c) If you are no longer unable to work because of your illnesses, injuries or conditions, enter the date you became able to work. → MONTH, DAY, YEAR

6. (a) Have you (or has someone on your behalf) ever filed an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare? → ☐ Yes (if "Yes," answer (b) and (c).) ☐ No ☐ Unknown (If "No," or "Unknown" go on to item 7.)

   (b) Enter name of person on whose Social Security record you filed other application. →

   (c) Enter Social Security Number of person named in (b). *If unknown, check this block.* ☐ → ___ ___ ___ / ___ ___ / ___ ___ ___ ___

7. (a) Were you in the active military or naval service (including Reserve or national Guard active duty or active duty for training) after September 7, 1939 and before 1968? → ☐ Yes (if "Yes," answer (b) and (c).) ☐ No (If "No, " go on to item 8.)

   (b) Enter dates of service → FROM: (month, year) TO: (month, year)

   (c) Have you <u>ever</u> been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (include Veterans Administration benefits <u>only</u> if you waived military retirement pay) → ☐ Yes ☐ No

8. (a) Have you filed (or do your intend to file) for any other public disability benefits? (Include workers' compensation and Black Lung benefits) → ☐ Yes (If "Yes," answer (b).) ☐ No (If "No," go on to item 9.)

(b) The other public disability benefit(s) you have filed (or intend to file) for is (Check as many as apply):

☐ Veterans Administration Benefits ☐ Welfare

☐ Supplemental Security Income ☐ Other (If "Other," complete a Workers' Compensation/Public Disability Benefit Questionnaire)

9. (a) Do you have social security credits (for example, based on work or residence) under another country's Social Security System? (If "Yes," answer (b).) (If "No," go on to item 10.) → ☐ Yes ☐ No

(b) List the country(ies): →

10. (a) Are you entitled to, or do you expect to become entitled to, a pension or annuity based on your work after 1956 not covered by Social Security? ☐ Yes (If "Yes," answer (b) and (c).) ☐ No (If "No," go on to item 11.)

	MONTH	YEAR
(b) ☐ I became entitled, or expect to become entitled, beginning		
(c) ☐ I became eligible, or expect to become eligible, beginning		

I agree to notify the Social Security Administration if I become entitled to a pension or annuity based on my employment after 1956 not covered by Social Security, or if such pension of annuity stops.

11. (a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year? ☐ Yes (If "Yes," skip to item 12.) ☐ No (If "No," answer (b).)

(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.

12. Enter below the names and addresses of all the persons, companies, or Government agencies for whom you have worked this year and last year. IF NONE, WRITE "NONE" BELOW AND GO ON TO ITEM 14.

NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer)	Work Began MONTH	Work Began YEAR	Work Ended (If still working show "Not ended") MONTH	Work Ended (If still working show "Not ended") YEAR
(If you need more space, use "Remarks" space on page 4.)				

13. May the Social Security Administration or the State agency reviewing your case ask your employers for information needed to process your claim? → ☐ Yes ☐ No

14. THIS ITEM MUST BE COMPLETED, EVEN IF YOU WERE AN EMPLOYEE.

(a) Were you self-employed this year and last year? (If "Yes," answer (b).) (If "No," go on to item 15.) → ☐ Yes ☐ No

(b) Check the year or years in which you were self-employed	In what kind of trade or business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from your trade or business $400 or more? (Check "Yes" or "No")
☐ This Year		
☐ Last Year		☐ Yes ☐ No
☐ Year before last		☐ Yes ☐ No

15. (a) How much were your total earnings last year? (Count both wages and self-employment income. If none, write "None.") → Amount $ _____

(b) How much have you earned so far this year? (If none, write "None.") → Amount $ _____

	(c) Did you receive any money from an employer(s) on or after the date in item 5(a) when you became unable to work because of your illnesses, injuries, or conditions? (If "Yes", give the amounts and explain in "Remarks" on page 4.) →	☐ Yes ☐ No Amount $ _____
	(d) Do you expect to receive any additional money from an employer such as sick pay, vacation pay, other special pay? (If "Yes," please give amounts and explain in "Remarks" on page 4.) →	☐ Yes ☐ No Amount $ _____

PART II—INFORMATION ABOUT THE DISABLED WORKER AND SPOUSE

16.	Have you ever been married? → (If "Yes," answer item 17.) (If "No," go on to item 18.)	☐ Yes ☐ No

17. (a) Give the following information about your current marriage. If not currently married, show your last marriage below.

To whom married		When (Month, day, year)	Where (Name of City and State)
Your current or last marriage	How marriage ended (If still in effect, write "Not ended.")	When (Month, day, year)	Where (Name of City and State)
	Marriage performed by ☐ Clergyman or public official ☐ Other (Explain in Remarks)	Spouse's date of birth (or age)	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) ___ ___ ___ / ___ ___ / ___ ___ ___ ___		

(b) Give the following information about each of your previous marriages. **(If none, write "NONE.")**

To whom married		When (Month, day, year)	Where (Name of City and State)
Your previous marriage	How marriage ended	When (Month, day, year)	Where (Name of City and State)
	Marriage performed by ☐ Clergyman or public official ☐ Other (Explain in Remarks)	Spouse's date of birth (or age)	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) ___ ___ ___ / ___ ___ / ___ ___ ___ ___		

(Use a separate statement for information about any other marriages.)

18.	Have you or your spouse worked in the railroad industry for 7 years or more? →	☐ Yes ☐ No

PART III—INFORMATION ABOUT THE DEPENDENTS OF THE DISABLED WORKER

19. If your claim for disability benefits is approved, your children (including natural children, adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) may be eligible for benefits based on your earnings record.

List below: FULL NAME OF ALL such children who are now or were in the past 12 months UNMARRIED and:

- UNDER AGE 18
- AGE 18 TO 19 AND ATTENDING SECONDARY SCHOOL
- DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)

(IF THERE ARE NO SUCH CHILDREN, WRITE "NONE" BELOW AND GO ON TO ITEM 20.)

20.	Do you have a dependent parent who was receiving at least one-half support from you when you became unable to work because of your disability? (if "Yes," enter name and address in "Remarks" on page 4.)	☐ Yes ☐ No

IMPORTANT INFORMATION ABOUT DISABILITY INSURANCE BENEFITS — PLEASE READ CAREFULLY

I. SUBMITTING MEDICAL EVIDENCE: I understand that as a claimant for disability benefits, I am responsible for providing medical evidence showing the nature and extent of my disability. I may be asked either to submit the evidence myself or to assist the Social Security Administration in obtaining the evidence. If such evidence is not sufficient to arrive at a determination, I may be requested by the State Disability Determination Service to have an independent examination at the expense of the Social Security Administration.

II. RELEASE OF INFORMATION: I authorize any physician, hospital, agency or other organization to disclose to the Social Security Administration, or to the State Agency that may review my claim or continuing disability, any medical record or other information about my disability.

I also authorize the Social Security Administration to release medical information from my records, only as necessary to process my claim, as follows:

- Copies of medical information may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- Results of any such independent examination may be provided to my personal physician.
- Information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
- The State Vocational Rehabilitation Agency may review any evidence necessary for determining my eligibility for rehabilitative services.

THIS MUST BE ANSWERED ➧ 21. DO YOU UNDERSTAND AND AGREE WITH THE AUTHORIZATIONS GIVEN ABOVE?

☐ Yes ☐ No (If "No," explain why in "Remarks.")

22. Check if applicable:

( ) I am not submitting evidence of ( ) my ( ) the deceased's earnings that are not yet on ( ) my ( ) his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in benefits will be paid with full retroactivity.

REMARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

III. REPORTING RESPONSIBILITIES: I agree to promptly notify Social Security if:

- My MEDICAL CONDITION IMPROVES so that I would be able to work, even though I have not yet returned to work.
- I GO TO WORK whether as an employee or a self-employed person.
- I apply for or begin to receive a workers' compensation (including black lung benefits) or another public disability benefit, or the amount that I am receiving changes or stops, or I receive a lump-sum settlement.
- I am confined to jail, prison, a penal institution or correctional facility for conviction or a crime or I am confined to a public institution by court order in connection with a crime.

The above events may affect my eligibility or disability benefits as provided in the Social Security Act, as amended.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

SIGNATURE OF APPLICANT	Date (Month, day, year)
Signature (First name, middle initial, last name) (Write in ink)	
SIGN HERE ➧	Telephone Number(s) at which you may be contacted during the day. (include the area code)

FOR OFFICIAL USE ONLY	Direct Deposit Payment Address *(Financial Institution)*			
	Routing Transit Number	C/S	Depositor Account Number	☐ No Account ☐ Direct Deposit Refused

Applicant's Mailing Address *(Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks, " if different.)*

City and State	ZIP Code	County (if *any)* in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in Signature block.

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)*

FOR YOUR INFORMATION

An agency in your State that works with us in administering the Social Security disability program is responsible for making the disability decision on your claim. In some cases, it is necessary for them to get additional information about your condition or to arrange for you to have a medical examination at Government expense.

Collection and Use of Information From Your Application-Privacy Act Notice/Paperwork Act Notice

The Social Security Administration is authorized to collect the information on this form under sections 202(b), 202(c), 205(a), and 1872 of the Social Security Act, as amended (42 U.S.C. 402(b), 402(c), 405(a), and 1395(ii). While it is VOLUNTARY, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage. Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of the Social Security programs or for the administration of programs requiring coordination with the Social Security Administration, information may be disclosed to another person or to another governmental agency as follows: 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 General Accounting Office and the Veterans Administration); and 3. to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

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

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT NOTICE AND TIME IT TAKES STATEMENT:

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 20 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

PERSON TO CONTACT ABOUT YOUR CLAIM	SSA OFFICE	DATE CLAIM RECEIVED
TELEPHONE NUMBER (INCLUDE AREA CODE)		

Your application for Social Security disability benefits has been received and will be processed as quickly as possible.

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.

In the meantime, if you change your address, or if there is some other change that may affect your claim, you - or someone for you - should report the change. The changes to be reported are listed below.

Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	SOCIAL SECURITY CLAIM NUMBER

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAID

- You change your mailing address for checks or residence. To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.
- You go outside the U.S.A. for 30 consecutive days or longer.
- Any beneficiary dies or becomes unable to handle benefits.
- Custody Change-Report if a person for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.
- You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.
- You become entitled to a pension or annuity based on your employment after 1956 not covered by Social Security, or if such pension or annuity stops.
- Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.
- Change of Marital Status—Marriage, divorce, annulment of marriage.
- You return to work (as an employee or self-employed) regardless of amount of earnings.
- Your condition improves.
- If you apply for or begin to receive workers' compensation (including black lung benefits) or another public disability benefit, or the amount of your present workers' compensation or public disability benefit changes or stops, or you receive a lump-sum settlement.

HOW TO REPORT

You can make your reports by telephone, mail, or in person, whichever you prefer.

If you are awarded benefits, and one or more of the above changes occur, the change(s) should be reported by calling:

_____

(Telephone Number—Include Area Code)

*U.S. Government Printing Office: 1999 -- 454-993/80719