DISABILITY REPORT

☐ **Adult Disability** ☐ **Child Disability**

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

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

HOW TO COMPLETE THIS FORM

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

- Fill out as much of this form as you can before your interview appointment.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 7, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/ CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend, a family member, or the FSMSSA Branch Offices.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or, mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your," or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Page 11, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. If you need the records back, tell us and we will photocopy them and return them to you.

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE FSMSSA

Please sign the enclosed authorization form so that this office will be able to request your medical records on your behalf.

WHAT DO WE MEAN BY "DISABILITY"?

"Disability" under the Social Security Act is based on your inability to engage in any substantial gainful employment by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. For purposes of this claim, we want you to understand that "disability" means that 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 your disability is expected to last (or has lasted) for at least a year or 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.

As defined by recent amendments of the Social Security Act, the Disability Insurance Benefit is entitled to as follow:

(1) Every person who:
   a. Is both fully and currently insured.
   b. Is disabled and has been disabled for at least three full calendar months; and
   c. Has filed a complete application with the Social Security Administrator for disability insurance shall be entitled to a disability insurance benefit, subject to the earnings test as defined in this subtitle.

(2) Disability insurance benefits shall be paid for each month, beginning with the first month of the waiting period and ending with the month preceding the month in which the disabled individual dies or recovers from his disability.

(3) Notwithstanding the provisions of subsections (1) and (2) above, retroactive payments shall not be made for more than the twenty-four (24) months immediately preceding the month in which the disability application is "received" by the Administration."

The Social Security Administration is authorized to collect the information on this form to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration to facilitate statistical research and such activities necessary to assure the integrity and improvements of the Social Security Programs.

I fully understand the terms and conditions set forth in the above declarations.

_____ _____

Signature of Claimant Date

SOCIAL SECURITY ADMINISTRATION

DISABILITY REPORT

For FSMSSA Use Only
Do not write in this box.

Related SSN _____

Number Holder _____

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME

B. SOCIAL SECURITY NUMBER

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

_____ _____ Your Number ☐ Message Number ☐ None ☐
Area Code *Number*

D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries or conditions and can help you with your claim.

NAME _____ RELATIONSHIP _____

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

_____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Phone Number*

E. What is your height without shoes? _____ *feet* _____ *inches*

F. What is your weight without shoes? _____ *pounds*

H. Can you speak English? YES ☐ NO ☐ If "NO," what languages can you speak? _____

If you cannot speak English, is there someone we may contact who speaks English and will give you messages? *(If this is the same person as in "D" above, show "SAME" here.)*

NAME _____ RELATIONSHIP _____

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

_____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Phone Number*

I. Can you read English? YES ☐ NO ☐

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

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries or conditions** that limit your ability to work? _____

_____

_____

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

_____

_____

_____

C. Do your illnesses, injuries or conditions cause you **pain**? YES ☐ NO ☐

D. When did your illnesses, injuries, or conditions **first bother you?**

Month	*Day*	*Year*

E. When did you become **unable to work** because of your illnesses, injuries or conditions?

Month	*Day*	*Year*

F. Have you **ever worked**? YES ☐ NO ☐

G. Did you **work at any time** after the date your illnesses, injuries or conditions first bothered you? YES ☐ NO ☐

H. If "YES," did your illnesses, injuries or conditions cause you to: *(Check all that apply.)*

☐ **work fewer hours?** *(Explain below.)*
☐ **change your job duties?** *(Explain below.)*
☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below.)*

_____

_____

_____

_____

I. Are you **working now**? YES ☐ NO ☐

If "NO," when did **you stop working**?

Month	*Day*	*Year*

J. Why did you **stop working**? _____

_____

_____

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

Pain Questionnaire

If your illnesses, injuries or conditions cause you pain, please answer the questions listed below.

Where is the location of the pain?

_____

_____

What causes the pain?

_____

_____

How is it relieved?

_____

_____

Does it affect your ability to
- ☐ stand?
- ☐ walk?
- ☐ sit?
- ☐ other? (specify: _____)

Were you provided by your doctor any form of medication to remedy the pain?

☐ Yes ☐ No

If yes, what sort of medication have you been provided with?

_____

_____

Does the medication help?

☐ Yes ☐ No

Please describe in your own words, the difficulties and discomforts that this pain causes you.

_____

_____

_____

_____

_____

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List the **jobs** that you have had in the **last 15 years that you worked**.

JOB TITLE *(Example, Cook)*	**TYPE OF BUSINESS** *(Example, Restaurant)*	**DATES WORKED** *(month & year)*		**HOURS PER DAY**	**DAYS PER WEEK**	**RATE OF PAY** *(Per hour, day, week, month or year)*
		FROM	TO			
						$ /
						$ /
						$ /
						$ /
						$ /
						$ /
						$ /

B. Describe the **job above** that you did the **longest**. (What did you do all day in this job?)

_____

_____

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 ☐
Did you supervise other people?	YES ☐	NO ☐
If "YES," was this your main duty?	YES ☐	NO ☐

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

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

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

_____

_____

F. Check **heaviest** weight lifted:

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

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

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

SECTION 4 - EDUCATION/TRAINING INFORMATION

A. Circle the highest grade of **school** completed.

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

Approximate **date** completed: _____

B. Did you attend **special education** classes? YES ☐ NO ☐ If "YES,"

NAME OF SCHOOL _____

ADDRESS _____

_____

City *State* *ZIP*

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you ever completed any of **special job training, trade or vocational school**? YES ☐ NO ☐

If "YES," what type? _____

Approximate date completed: _____

SECTION 5 - VOCATIONAL REHABILITATION INFORMATION

A. Have you received services from **Vocational Rehabilitation** or any other organization to help you get back to work?
YES ☐ NO ☐ If "YES,"

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

_____

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

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____

Were you provided with rehabilitation services that could help you get back to work? YES ☐ NO ☐

SECTION 6 - INFORMATION ABOUT YOUR ACTIVITIES

1. Has your doctor told you to cut back or limit your activities in any way? ☐ Yes ☐ No
   If "yes", give the name of the doctor below and tell what he or she told you about cutting back or limiting your activities.

2. Describe your daily activities in the following areas and state what and how much you do of each and how often you do it:

■ **Household maintenance** (including cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

■ **Recreational activities and hobbies** (fishing, farming, musical instruments, sewing, etc.):

■ **Social Contacts** (visits with friends, relatives, neighbors):

■ **Other** (drive car, motorcycle, etc.)

SECTION 7 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? YES ☐ NO ☐

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? YES ☐ NO ☐

If you answered "NO" to both of these questions, go to Section 8.

C. List **other names** you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/THERAPIST.** Include your **next appointment**.

1.

NAME	**DATES**
STREET ADDRESS	**FIRST** VISIT
CITY **STATE** **ZIP**	**LAST** SEEN
PHONE _____ _____ **CHART #** *Area Code* *Phone Number*	NEXT **APPOINTMENT**
REASONS FOR VISITS _____	
WHAT **TREATMENT** WAS RECEIVED? _____	

2.

NAME	**DATES**
STREET ADDRESS	**FIRST** VISIT
CITY **STATE** **ZIP**	**LAST** SEEN
PHONE _____ _____ **CHART #** *Area Code* *Phone Number*	NEXT **APPOINTMENT**
REASONS FOR VISITS _____	
WHAT **TREATMENT** WAS RECEIVED? _____	

SECTION 7 - INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/THERAPIST

3.

NAME	DATES
STREET ADDRESS	FIRST VISIT
CITY STATE ZIP	LAST SEEN
PHONE _____ _____ CHART # (Area Code / Phone Number)	NEXT APPOINTMENT
REASONS FOR VISITS _____	
WHAT TREATMENT WAS RECEIVED? _____	

If you need more space, use Remarks, Section 10.

E. List each HOSPITAL/CLINIC. Include your **next appointment.**

1.

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

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment did you receive?** _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

SECTION 7 - INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

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

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

_____

What **treatment did you receive?** _____

_____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

_____

NAME	**DATES**
STREET ADDRESS	**FIRST** VISIT
CITY **STATE** **ZIP**	**LAST** SEEN
PHONE _____ _____ **CHART/HMO #** *Area Code* *Phone Number*	NEXT **APPOINTMENT**
CLAIM NUMBER *(If any)*	
REASONS FOR VISITS?	

If you need more space, use Remarks, Section 10.

SECTION 8 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? YES ☐ NO ☐
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)*

NAME OF MEDICINE	PRESCRIBED BY *(Name of Doctor)*	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 10.

SECTION 9 - TESTS

Have you had, or will you have, any **medical tests** for your illnesses, injuries, or conditions?
YES ☐ NO ☐ If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? *(Month, day, year)*	WHERE DONE? *(Name of Facility)*	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY Name of body part _____			
HEARING TEST			
VISION TEST			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY Name of body part _____			
MRI/CT SCAN Name of body part _____			
Other (Specify)			

If you have had other tests, list them in Remarks, Section 10.

SECTION 10 - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the bottom of the page and complete the signature block.

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

Signature of **claimant** or person filing on claimant's behalf ***(Parent, guardian)***	**Date** ***(Month, day, year)***

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

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 FSMSSA USE ONLY -- DO NOT WRITE ON THIS PAGE

SECTION 11 - BRANCH OFFICE OBSERVATIONS

Check any of the following categories which apply to this case:

A. ☐ Amputation of two limbs

B. ☐ Amputation of a leg at the hip

C. ☐ Allegation of total deafness

D. ☐ Allegation of total blindness

E. ☐ Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, allegedly due to a longstanding condition - exclude recent accident and recent surgery.

F. ☐ Allegation or stroke (cerebral vascular accident)more than 3 months in the past and continued marked difficulty in walking or using a hand or arm.

G. ☐ Allegation of cerebral palsy, muscular dystrophy or muscular atrophy and marked difficulty in walking (e.g., use of braces), speaking or coordination of the hands or arms.

H. ☐ Allegation of diabetes with amputation of a foot.

I. ☐ Allegation of Down Syndrome.

J. ☐ An applicant filing on behalf of another individual alleges severe mental deficiency for claimant who is at least 7 years of age. The applicant alleges that the individual attends (or attended) a special school, or special classes in school, because of his mental deficiency, or is unable to attend any school (or if beyond school age was unable to attend), and requires care and supervision of routine daily activities.

K. ☐ Human immunodeficiency virus (HIV) infection.

Check each item to indicate if any difficulty was observed:

Reading	☐ Yes	☐ No	Using Hands	☐ Yes	☐ No
Writing	☐ Yes	☐ No	Breathing	☐ Yes	☐ No
Answering	☐ Yes	☐ No	Seeing	☐ Yes	☐ No
Hearing	☐ Yes	☐ No	Walking	☐ Yes	☐ No
Sitting	☐ Yes	☐ No			
Understanding	☐ Yes	☐ No	Other (Specify): _____		

If any of the above items were checked “yes”, describe the exact difficulty involved:

Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above, etc.):

NAME OF FSMSS BRANCH STAFF INTERVIEWER (Print)

Signature

DATE