SOCIAL SECURITY ADMINISTRATION ☐ TEL Form Approved OMB No. 0960-0060 TOE 120/145

(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.)

(b) ☐ I became entitled, or expect to become entitled, beginning — MONTH | YEAR

(c) ☐ I became eligible, or expect to become eligible, beginning — MONTH | YEAR

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		Work Ended (If still working show "Not ended")	
	MONTH	YEAR	MONTH	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

SOCIAL SECURITY ADMINISTRATION ☐ TEL

Form Approved
OMB No 0960-0229

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)

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

Do not write in this space

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.

☐ **FS-SSA/APP** ☐ **FS-REFERRED**

Filing Date
Month, Day, Year

☐ Actual or ☐ Protective

TYPE OF CLAIM ☐ Individual with Ineligible Spouse ☐ Couple ☐ Individual ☐ Child ☐ Child with Parent(s)

PART I–BASIC ELIGIBILITY– **The questions in this section pertain to the period beginning with the first moment of the filing date month through the date this application is signed unless a question specifies a different time period.**

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

(b) Did you ever use any other names *(including maiden name)* or other Social Security numbers? → ☐ YES Go to (c) ☐ NO Go to #2

(c) Other Names and Social Security Numbers Used

2. (a) Are you married? → ☐ YES Go to (b) ☐ NO Go to #4

(b) Spouse's Name *(First, middle initial, last)* | Birth *(month, day, year)* | Social Security Number __ __ __ / __ __ / __ __ __ __

(c) Did your spouse ever use any other names *(including maiden name)* or other Social Security Numbers? → ☐ YES Go to (d) ☐ NO Go to (e)

(d) Other Names *(including maiden name)* and Social Security Numbers Used by Spouse

(e) Are you and your spouse living together? → ☐ YES If your spouse is not filing go to #3; otherwise go to #4. ☐ NO Go to (f)

(f) Date you began living apart | Address of spouse or name and address of someone who knows where the spouse is.

(g) IF YOUR SPOUSE IS NOT FILING FOR SUPPLEMENTAL SECURITY INCOME AND YOU SEPARATED SINCE THE FIRST MOMENT OF THE FILING DATE MONTH GO TO #3. IF YOUR SPOUSE IS FILING FOR SUPPLEMENTAL SECURITY INCOME, GO TO #4.

3. (a) Is your spouse the sponsor of an alien for supplemental security income? → ☐ YES Go to (b) ☐ NO Go to #4

(b) Alien's Name | Alien's Social Security Number __ __ __ / __ __ / __ __ __ __

		You	Your Spouse, if filing
4.	(a) Have you been married before? →	☐ YES Go to (b) ☐ NO Go to #5	☐ YES Go to (b) ☐ NO Go to #5

(b) Give the following information about your former spouse. If there was more than one former marriage, show the remaining information in Remarks and go to #5.

	FORMER SPOUSE'S NAME (including maiden name)	SOCIAL SECURITY NUMBER (if none or unknown, so indicate)	DATE OF MARRIAGE	DATE MARRIAGE ENDED	HOW MARRIAGE ENDED
You					
Your Spouse					

		You	Your Spouse
5.	(a) Are you blind or disabled? →	☐ YES Go to (b) ☐ NO Go to #6	☐ YES Go to (b) ☐ NO Go to #6

(b) GIVE THE FOLLOWING INFORMATION:	DATE IMPAIRMENT BEGAN	NATURE OF THE IMPAIRMENT
You		
Your Spouse		

		You	Your Spouse, if filing
6.	In what city and State or foreign country were your born? →		
7.	Are you a United States citizen by birth? →	☐ YES Go to #11 ☐ NO Go to #8	☐ YES Go to #11 ☐ NO Go to #8
8.	Are you a naturalized United States citizen? →	☐ YES Go to #11 ☐ NO Go to #9	☐ YES Go to #11 ☐ NO Go to #9
9.	(a) Are you lawfully admitted for permanent residence in the United States? →	☐ YES Go to (b) ☐ NO Go to #10	☐ YES Go to (b) ☐ NO Go to #10
	(b) Give the month, day, and year of lawful admission for permanent residence. If date is within 3 years of the filing date, go to (c); otherwise go to #11. →	DATE	DATE
	(c) Was your entry into the United States sponsored by any person or promoted by an institution or group? →	☐ YES Go to (d) ☐ NO Go to #11	☐ YES Go to (d) ☐ NO Go to #11

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

Name	Address	Telephone No. *(Include Area Code)* (___) -

(e) GO TO #11

		You	Your Spouse, if filing
10.	(a) Is the Immigration and Naturalization Service (INS) aware of your presence in the United States? →	☐ YES Go to (b) ☐ NO Go to #11	☐ YES Go to (b) ☐ NO Go to #11
	(b) Through what date will INS allow you to remain in the United States? (If indefinitely, so indicate) →	DATE *(month, day, year)*	DATE *(month, day, year)*
11.	(a) When did you first make your home in the United States? →	DATE *(month, day, year)*	DATE *(month, day, year)*
	(b) Have you lived outside the United States since then? →	☐ YES Go to (c) ☐ NO Go to #12	☐ YES Go to (c) ☐ NO Go to #12
	(c) Give dates of residence outside the United States. *(Month, day, year)* →	FROM: TO:	FROM: TO:
12.	(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 #13	☐ YES Go to (b) ☐ NO Go to #13
	(b) Give the date *(Month, day, year)* you left the United States and the date you returned to the United States. →	Date Left Date Returned	Date Left Date Returned

PART II–LIVING ARRANGEMENTS–The questions in this section pertain to the signature date.

13. Check the applicable block to show where you live now:

☐ House ☐ Apartment ☐ Room (private home) ☐ Room (commercial establishment) ☐ Mobile Home ☐ Foster Home ☐ Transient ☐ Other (Specify) _____

INSTITUTIONS

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

IF YOU ARE LIVING IN A FOSTER HOME, AN INSTITUTION, OR ARE A TRANSIENT, EXPLAIN IN REMARKS AND GO TO #21.

14. Do you live alone or with your spouse only? → ☐ YES Go to #16 ☐ NO Go to #15

15. (a) Give the following information about everyone who lives with you (or with you and your spouse):

NAME	RELATIONSHIP TO YOU OR SPOUSE	SEX M	SEX F	DATE OF BIRTH (Month, day, year)	BLIND OR DISABLED YES	BLIND OR DISABLED NO	IF UNDER AGE 22 MARRIED YES	IF UNDER AGE 22 MARRIED NO	IF UNDER AGE 22 STUDENT YES	IF UNDER AGE 22 STUDENT NO

(b) Do all the persons listed in 15(a) receive assistance or income based on need? → ☐ YES Go to (c) ☐ NO Go to (c)

(c) Does anyone listed in 15(a) who is not married and under age 18 OR between ages 18-21, not married, and a student receive income? → ☐ YES Go to (d) ☐ NO Go to #16

(d) CHILD RECEIVING INCOME	SOURCE & TYPE	MONTHLY AMOUNT
		$
		$
		$

16. (a) Do you (or does anyone who lives with you) own or rent the place where you live? → ☐ YES Go to #17 ☐ NO Go to (b)

(b) Name and address of person who owns or rents the place where you live:

Telephone number, if known *(Include Area Code)*
(_ _ _) -

(c) GO TO #20

17. (a) Are you (or your living with spouse) buying or do you own the place where you live? → ☐ YES Go to (c) ☐ NO If you are a child living with parent(s) go to (b); otherwise go to # 18.

(b) Are your parent(s) buying or do they own the place where you live? → ☐ YES Go to (c) ☐ NO Go to #18

(c) What is the amount and frequency of the mortgage payment? → Amount $ | Frequency of Payment

(d) GO TO #20

18.	(a) Do you (or your living with spouse) have rental liability for the place where you live? →	☐ YES Go to (d)	☐ NO If you are a child living with parent(s) go to (b); otherwise go to (c).
	(b) Do your parent(s) have rental liability? →	☐ YES Go to (d)	☐ NO Go to (c)
	(c) Does anyone who lives with you have rental liability for the place where you live? →	☐ YES Give name of person with rental liability in Remarks and go to #19.	☐ NO Give name of person with home ownership in Remarks and go to #20
	(d) What is the amount and frequency of the rent payment? →	Amount $	Frequency of payment
19.	(a) Are you (or anyone who lives with you) the parent or child of the landlord or the landlord's spouse? →	☐ YES Go to (b)	☐ NO Go to #20

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

20. (a) Does anyone who does NOT live with you provide your household with all or part of the food and shelter (including payment of the bills for food, rent, or home mortgage payments, property insurance required by the mortgage holder, real property taxes, heating fuel, gas, electricity, garbage removal, water, or sewerage) or give the household money for these items? → ☐ YES Go to (b) ☐ NO Go to (c)

(b) ITEM	CONTRIBUTOR'S NAME AND ADDRESS (TELEPHONE NUMBER AND AREA CODE IF KNOWN)	MONTHLY AMOUNT	MONTHS RECEIVED
		$	
		$	
		$	
		$	

(c) GO TO (d) IF YOU (OR YOUR LIVING WITH SPOUSE) OWN OR RENT AND LIVE WITH OTHERS (OTHER THAN SPOUSE ONLY) BUT YOU DO NOT LIVE IN A PUBLIC ASSISTANCE HOUSEHOLD; OTHERWISE, GO TO #21.

	(d) Does anyone living with you give you (or your living with spouse) money for or help pay for all or part of your food, rent or home mortgage payments, property insurance required by the mortgage holder, real property taxes, heating fuel, gas, electricity, garbage removal, water, or sewer bills? →	☐ YES Go to #21 ☐ NO Go to #21
21.	(a) Has the information given in items #13 through #20 been the same since the first moment of the filing date month? →	☐ YES Go to (b) ☐ NO Explain in Remarks and go to (b).
	(b) Do you expect this information to change? →	☐ YES Explain in Remarks and go to #22. ☐ NO Go to #22

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

		YOU	Your Spouse
22.	(a) Do you own or does your name appear on the title of any vehicles; e.g., cars, trucks, boats, motorcycles, etc.? →	☐ YES Go to (b) ☐ NO Go to #23	☐ YES Go to (b) ☐ NO Go to #23

(b) OWNER'S NAME	DESCRIPTION (YEAR MAKE& MODEL)	USED FOR	EQUIPPED FOR HANDICAPPED? YES	EQUIPPED FOR HANDICAPPED? NO	CURRENT MARKET VALUE	AMOUNT OWED
					$	$
					$	$
					$	$

23. (a) Do you own or are you buying any life insurance policies? → | You: ☐ YES Go to (b) ☐ NO Go to #24 | Your Spouse: ☐ YES Go to (b) ☐ NO Go to #24

(b) Give the following Information on each policy:

OWNER'S NAME	NAME OF INSURED	NAME AND ADDRESS OF INSURANCE COMPANY
Policy (#1)		
Policy (#2)		
Policy (#3)		

POLICY NUMBER	FACE VALUE	CASH SURRENDER VALUE	DATE PURCHASED	LOANS AGAINST YES	LOANS AGAINST NO
Policy (#1)	$	$		$	
Policy (#2)	$	$		$	
Policy (#3)	$	$		$	

24. (a) Do you (either alone or jointly with any other person) own any:

	You YES	You NO	Your Spouse YES	Your Spouse NO
Life estates or ownership interest in an unprobated estate? →				
Household or personal Items worth more than $500 each? →				

(b) Give the following Information for any "Yes" answer in 24(a); otherwise go to #25

OWNER'S NAME	NAME OF ITEM	VALUE	AMOUNT OWED ON ITEM	WHERE APPROPRIATE, GIVE NAME AND ADDRESS OF BANK OR OTHER ORGANIZATION
		$	$	
		$	$	

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

	You YES	You NO	Your Spouse YES	Your Spouse NO
Cash at home, with you, or anywhere else →				
Checking Accounts →				
Savings Accounts →				
Credit Union Accounts →				
Christmas Club Accounts →				
Certificates of Deposit →				
Notes →				
Stocks or Mutual Funds →				
Bonds →				
Other items that can be turned Into cash →				

(b) Give the following information for any "Yes" answer in 25(a), otherwise go to #26

OWNER'S NAME	NAME OF ITEM	VALUE	NAME AND ADDRESS OF BANK OR OTHER ORGANIZATION APPROPRIATE	IDENTIFYING NUMBER
		$		
		$		
		$		
		$		

26. (a) Do you have any land, houses, buildings, real property, property in foreign countries, equipment, business, mineral rights or other money or property of any kind (including belongings held in safe deposit boxes) that have not been shown elsewhere on the application? (Include assets set aside for an emergency or to provide for your heirs.) →

You	Your Spouse
☐ YES Go to (b) ☐ NO Go to #27	☐ YES Go to (b) ☐ NO Go to #27

(b) Give the following information:

DESCRIPTION OF PROPERTY (If real property, include type and size of structure, acreage or lot size, location.)	HOW IS IT USED? (If not used now, when was it last used and what is next planned use.)
Item 1	Item 1
Item 2	Item 2

OWNER'S NAME	ESTIMATED CURRENT MARKET VALUE	TAX ASSESSED VALUE	AMOUNT OF MORTGAGE PAYMENT	AMOUNT OWED ON ITEM
Item 1	$	$	$	$
Item 2	$	$	$	$

27. (a) Have you sold, transferred title, disposed of or given away any money or other property, including property or money in foreign countries, since the first moment of the filing date month or within the 30 months prior to the filing date month?

You	Your Spouse, If filing
☐ YES (Go to (b)) ☐ NO Go to #28	☐ YES Go to (b) ☐ NO Go to #28

(b) Give the following information:

OWNER'S NAME	DATE OF DISPOSAL	DESCRIPTION OF PROPERTY
Item 1		
Item 2		

IF THE DATE OF DISPOSAL IS BEFORE 7/1/88 AND LESS THAN 24 MONTHS PRIOR TO THE MONTH OF FILING OR IF THE DATE OF DISPOSAL IS AFTER 6/30/88, GO TO 27(c); OTHERWISE GO TO #28.

(c) Give the following about the information in 27(b):

NAME AND ADDRESS OF PURCHASER OR RECIPIENT	RELATIONSHIP TO OWNER	SOLD ON OPEN MARKET YES	SOLD ON OPEN MARKET NO
Item 1			
Item 2			

VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT	SALES PRICE OR OTHER AGREEMENT	ARE ADDITIONAL CONSIDERATIONS OR PROCEEDS EXPECTED? EXPLAIN	DO YOU STILL OWN PART OF THE PROPERTY YES	DO YOU STILL OWN PART OF THE PROPERTY NO
Item 1 $				
Item 2 $				

28. (a) Have you acquired any resource since the first moment of the filing date month? →

You	Your Spouse
☐ YES Go to (b) ☐ NO Go to (c)	☐ YES Go to (b) ☐ NO Go to (c)

(b) Explain any "Yes" answer given in 28(a)

You	Your Spouse

(c) Has there been any increase or decrease in the value of your resources since the first moment of the filing date month? →

You	Your Spouse
☐ YES Go to (d) ☐ NO Go to #29	☐ YES Go to (d) ☐ NO Go to #29

(d) Explain any "Yes" answer given in 28(c)

You	Your Spouse

29. (a) Do you have any assets set aside for burial expenses such as burial contracts, trusts, agreements, or anything else you intend for your burial expenses? Include any assets mentioned in items #22 through #26 and item #28. →

You	Your Spouse
☐ YES Go to (b) ☐ NO Go to #30	☐ YES Go to (b) ☐ NO Go to #30

(b)

DESCRIPTION (Where appropriate, give name and address of organization and account/policy number)	VALUE	WHEN SET ASIDE *(Month, Day, Year)*	OWNER'S NAME
Item 1	$		
Item 2	$		

FOR WHOSE BURIAL	IS ITEM IRREVOCABLE?	WILL INTEREST EARNED OR APPRECIATION IN VALUE REMAIN IN THE BURIAL FUND?
Item 1	☐ YES ☐ NO	☐ YES Go to #30 ☐ NO Explain In (c)
Item 2	☐ YES ☐ NO	☐ YES Go to #30 ☐ NO Explain In (c)

(c) Explanation:

Item 1

Item 2

30. (a) Do you own any cemetery lots, crypts, caskets, vaults, urns, mausoleums or other repositories for burial or any headstones or markers? →

You	Your Spouse
☐ YES Go to (b) ☐ NO Go to #31	☐ YES Go to (b) ☐ NO Go to #31

(b)

OWNER'S NAME	DESCRIPTION	FOR WHOSE BURIAL	RELATIONSHIP TO YOU OR SPOUSE	CURRENT MARKET VALUE (if applicable)
				$
				$

PART IV—INCOME—The questions in this section specify time period.

31. (a) Since the first moment of the filing date month, have you received or do you expect to receive income in the next 14 months from any of the following sources?

	YOU		YOUR SPOUSE	
	YES	NO	YES	NO
FEDERAL BENEFITS: Social Security				
Railroad Retirement				
Veterans Administration (Based on need/not based on need)				
Office of Personnel Management (Civil Service)				
Military Pension, Special Pay, or Allowance				
Black Lung				
Bureau of Indian Affairs				
Earned Income Tax Credits				
STATE/LOCAL BENEFITS: Unemployment Compensation				
Workers' Compensation				
State Disability				
State or Local Pension				
Aid to Families with Dependent Children				
State or Local Assistance Based on Need				
PRIVATE BENEFITS: Employer or Union Pension				
Insurance or Annuity Payments				
MISCELLANEOUS: Interest (bank accounts, stocks, CD's, etc.)				
Rental/Lease Income				
Dividends/Royalties				
Alimony				
Child Support				
OTHER INCOME NOT PREVIOUSLY MENTIONED				

(b) Give the following information for any "Yes" answer in 31 (a), otherwise go to #32.

PERSON RECEIVING	TYPE OF INCOME	AMOUNT	FREQUENCY	DATES EXPECTED OR RECEIVED	SOURCE (Name/Address of Person, Bank, Company, or Organization)	IDENTIFYING NUMBER
You		$		From: / To:		
You		$		From: / To:		
You		$		From: / To:		
Your Spouse		$		From: / To:		
Your Spouse		$		From: / To:		
Your Spouse		$		From: / To:		

		You	Your Spouse
32.	Since the first moment of the filing date month, have you received or do you expect to receive any clothing, meals, or other gifts which are not cash? →	☐ YES Explain in Remarks and go to #33 ☐ NO Go to #33	☐ YES Explain in Remarks and go to #33 ☐ NO Go to #33
33.	(a) Have you received wages since the first moment of the filing date month through the current month? →	☐ YES Go to (b) ☐ NO Go to (d)	☐ YES Go to (b) ☐ NO Go to (d)

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

You	Your Spouse

(c) Total wages received (before any deductions) for each month:

You	Month(s)							
	Amounts							
Your Spouse	Month(s)							
	Amounts							

	You	Your Spouse
(d) Do you expect to receive any wages in the next 14 months? →	☐ YES Go to (e) ☐ NO Go to #34	☐ YES Go to (e) ☐ NO Go to #34

(e) Name and address of employer if different from 33(b) *(include telephone number and area code, if known)*

You	Your Spouse

(f) Give the following information.

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

	You	Your Spouse
(g) Do you expect any change in wage information provided in 33(f)? →	☐ YES Go to (h) ☐ NO Go to (34)	☐ YES Go to (h) ☐ NO Go to (34)

(h) Explain change:

You	Your Spouse

		You	Your Spouse
34.	(a) Have you been self-employed at any time since the beginning of the taxable year in which the filing date month occurs or do you expect to be self-employed in the current taxable year?	☐ YES Go to (b) ☐ NO Go to (35)	☐ YES Go to (b) ☐ NO Go to (35)

(b) Give the following information:

	TYPE OF BUSINESS	LAST YEAR'S: GROSS INCOME	LAST YEAR'S: NET INCOME	LAST YEAR'S: NET LOSS	THIS YEAR'S: GROSS INCOME	THIS YEAR'S: NET INCOME	THIS YEAR'S: NET LOSS	DATES OF SELF-EMPLOYMENT
You		$	$		$	$		
		$	$		$	$		
Your Spouse		$	$		$	$		
		$	$		$	$		

IF YOU OR YOUR SPOUSE ARE DISABLED AND RECEIVE WAGES OR EXPECT TO RECEIVE WAGES OR ARE SELF-EMPLOYED OR EXPECT TO BE SELF-EMPLOYED, ANSWER #35: OTHERWISE, GO TO #36.

35.	Do you have any special expenses related to your illness or injury that you paid which are necessary for you to work? →	**You** ☐ YES Describe in Remarks and go to #36 ☐ NO Go to #36	**Your Spouse** ☐ YES Describe in Remarks and go to #36 ☐ NO Go to #36

IF YOU ARE FILING AS A CHILD, AND YOU ARE EMPLOYED OR AGE 18-22 (WHETHER EMPLOYED OR NOT), GO TO #36; OTHERWISE, GO TO #37.

36.	(a) Have you attended school regularly since the filing date month? →	☐ YES Go to (d)	☐ NO Go to (b)
	(b) Have you been out of school for more than 4 calendar months? →	☐ YES Go to (c)	☐ NO Go to (c)
	(c) Do you plan to attend school regularly during the next 4 months? →	☐ YES Explain absence in Remarks and go to (d)	☐ NO Go to #37

(d) Give the following information:

NAME AND ADDRESS OF SCHOOL	NAME OF PERSON AT SCHOOL WE MAY CONTACT	DATES OF ATTENDANCE	COURSE OF STUDY
	NAME PHONE *(include area code)* (_ _ _) -	FROM TO HOURS ATTENDING OR PLANNING TO ATTEND:	

PART V— POTENTIAL ELIGIBILITY FOR OTHER BENEFITS/FOOD STAMPS/MEDICAL ASSISTANCE

37.	(a) Have you or a former spouse (or if you are filing as a child, have you or your parents) ever:	**YOU**		**YOUR SPOUSE**	
		YES	NO	YES	NO
	Worked for a railroad?				
	Been in military service?				
	Worked for the Federal government?				
	Worked for a State or local government?				
	Worked for an employer or belonged to a union with a pension plan?				
	Done work that was covered under the Social Security system or pension plan of a country other than the United States?				

(b) Explain and include dates (if appropriate) for any "Yes" answer given in 37(a); otherwise go to #38.

YOU	**YOUR SPOUSE**

		You	Your Spouse if filing
38.	(a) Are you currently receiving food stamps or has a food stamp application been filed for you within the past 60 days on which there has not been a decision? →	☐ YES Go to # 39 ☐ NO Go to (b)	☐ YES Go to #39 ☐ NO Go to (b)
	(b) Do you wish to apply for food stamps? →	☐ YES ☐ NO	☐ YES ☐ NO

39. **Where this application is an application for Title XIX under the Social Security Act, I/we understand that If I/we refuse to assign my/our rights to medical support and payments for medical care from any individual or private, group, or government health insurance, or refuse to cooperate in giving information regarding any health insurance I/we may have, that the Social Security Administration cannot determine whether I am/we are eligible for Medicaid and that I/we must then apply for Medicaid at the Medicaid agency. I/we also understand that as a condition to become eligible for Medicaid, I/we must cooperate with the Medicaid agency in establishing paternity and in obtaining medical support and payments from third party payers.**

IN STATES WITH AUTOMATIC ASSIGNMENT OF RIGHTS LAWS, GO TO 39(b).

	You	Your Spouse if filing
(a) Do you agree to assign your rights (or the rights of anyone for whom you can legally assign rights) to payments for medical support and other medical care to the State Medicaid agency? →	☐ YES Go to (b) ☐ NO Go to #40	☐ YES Go to (b) ☐ NO Go to #40
(b) Do you, your spouse, parent or step-parent have any private, group, or government health insurance that pays the cost of your medical care? (Do not include Medicare or Medicaid) →	☐ YES ☐ NO	☐ YES ☐ NO
(c) Do you have any unpaid medical expenses for the 3 months prior to the filing date month? →	☐ YES ☐ NO	☐ YES ☐ NO

PART VI—MISCELLANEOUS

ANSWER #40 ONLY IF YOU ARE REQUESTING BENEFITS ON BEHALF OF SOMEONE ELSE; OTHERWISE, GO TO #41.

40.

(a) Name of Person Requesting Benefits	Relationship to Claimant	Your Social Security Number
		_ _ _ / _ _ / _ _ _ _

(b) Do you wish to be selected as the claimant's representative payee? →	☐ YES	If you are applying on behalf of a child go to (c); otherwise go to #41.	☐ NO	Explain in Remarks and go to #41.
(c) Are you the natural or adoptive parent with custody? →	☐ YES	Go to (d)	☐ NO	Go to (d)
(d) Have you ever been convicted of a felony? →	☐ YES	Explain in Remarks and go to (e)	☐ NO	Go to (e)
(e) Are you serving, or have you ever served, as representative payee for anyone receiving a Social Security or Supplemental Security Income benefit? →	☐ YES	Enter SSN's in Remarks and go to (f)	☐ NO	Go to (f)
(f) Does the claimant have a legal representative or a legal guardian appointed by a court? →	☐ YES	If you are NOT the legal rep/guardian, go to (g); otherwise go to (h).	☐ NO	Go to #41

(g) Give the following information about the legal representative or legal guardian:

Name	Address	Telephone Number *(Include area code, if known)*
		(_ _ _) -

(h) Explain what led the court to appoint a legal representative or a legal guardian.

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

IMPORTANT INFORMATION—PLEASE READ CAREFULLY

- Failure to report any change within 10 days after the end of the month in which the change occurs could result in a penalty deduction.
- The Social Security Administration will check your statements and compare its records with records from other State and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount.
- If you are disabled or blind, you must accept any appropriate vocational rehabilitation services offered to you by the State agency to which we refer you.

PART VIII–SIGNATURES

I/We understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under Federal law, State law, or both. Everything on this application is the truth as best I/we know It.

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

SIGN HERE

Date *(Month, day, year)*

Telephone number(s) at which you may be contacted during the day

(_____) –
AREA CODE

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

SIGN HERE

43. **FOR OFFICIAL USE ONLY**

DIRECT DEPOSIT PAYMENT ADDRESS *(FINANCIAL INSTITUTION)*

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

44. Applicant's Mailing Address *(Number and Street, Apt. No., P. 0. Box or Rural Route)*

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

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

City and State	ZIP Code	Enter name of county *(if any)* In which the claimant lives

WITNESSES

46. 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 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)*

*U.S. Government Printing Office: 1998 — 433-332/80051

RECEIPT FOR YOUR CLAIM FOR SUPPLEMENTAL SECURITY INCOME

NAME	SOCIAL SECURITY NUMBER	DATE
	_ _ _ / _ _ / _ _ _ _	
NAME	SOCIAL SECURITY NUMBER	
	_ _ _ / _ _ / _ _ _ _	
Telephone Number *(include area code)* to call if you have a question or something to report. (__ __ __) -	Social Security Office you may come in person or mail your request to:	

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

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

PAPERWORK/PRIVACY ACT NOTICE

The Social Security Administration is authorized to collect the information on your application form under Section 1631 (e) of the Social Security Act, as amended (42 U.S.C. 1383(e)). Your response to this request is voluntary; however, as explained below, 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 payments not authorized by the Social Security Act.

The information on your application is needed to enable Social Security to determine if you are eligible for Supplemental Security Income payments. Failure to provide all or part of the information could prevent an accurate and timely decision on your claim, and could result in the loss of some payments. Although the information you furnish on the application is rarely used for any other purpose than stated in the foregoing, there is a possibility that 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 Supplemental Security Income payments and (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Department of Veterans Affairs.).

Computer Matching 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.

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.

Time It Takes To Complete This Form: We estimate that it will take you about 34 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. If you have comments or suggestions on this estimate, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001. **Send only comments relating to our "time it takes" estimate to the office listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed under Social Security Administration in the U.S. Government section of your telephone directory.**

REPORTING RESPONSIBILITIES

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

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

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

HOW TO REPORT

You can make your reports by telephone at the telephone number shown above or you may report In person or by mail at the address shown above. See reverse side of this page for "Changes to Report."

CHANGES TO REPORT

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

- You move.
- You (or your spouse) leave your household for a calendar month or longer. For example, you enter a hospital or visit a relative.
- You leave the United States for 30 days or more.
- You are released from a hospital, nursing home, etc.
- You are no longer a legal resident of the United States.

HOW YOU LIVE – You must report to Social Security if:

- Someone moves into or out of your household.
- The amount of money you pay toward household expenses changes.
- Births and deaths of any people with whom you live.
- Your marital status changes:
  - You get married, separated, divorced, or your marriage Is annulled.
  - You separate from your spouse or start living together again after a separation.
  - You begin living with someone as husband and wife.

INCOME – You must report to Social Security if:

- The amount of money (or checks or any other type of payment) you receive from someone or someplace goes up or down or you start to receive money (or checks or any other type of payment).
- You start work or stop work.
- Your earnings go up or down.

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

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

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

- The value of your resources goes over $2,000 when you add them all together ($3,000 if you are married and live with your spouse).
- You sell or give any things of value away.
- You buy or are given anything of value.

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

- Your condition improves or your doctor says you can return to work.
- You go to work.
- You stop going to or refuse any vocational rehabilitation services.
- You stop going to or refuse treatment for drug addiction or alcoholism.

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

- If you are under age 18 and live with your parent(s), ask your parent(s) to report if they have a change in income, a change In their marriage, a change in the value of anything they own, or either has a change in residence.
- You start or stop school.
- You get married.

YOUR IMMIGRATION AND NATURALIZATION SERVICE (INS) STATUS CHANGES – You must report any change to Social Security.

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

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

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 _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** *(First, Middle Initial, Last)*

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

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

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

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

G. Do you have a **medical assistance card**? (For Example, Medicaid or Medi-Cal) If "YES," show the **number** here: ☐ YES ☐ NO _____

H. Can you **speak and understand English**? ☐ YES ☐ NO If "**NO**," what is your preferred language? _____

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

If you cannot **speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO *(If "YES," and that person is the same as in "D" above show "SAME" here. If not, complete the following information.)*

NAME _____ **RELATIONSHIP** _____

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

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

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

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

Disability Report-Adult-Form SSA-3368-BK

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** or **other symptoms**? ☐ 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 *(If "NO," go to Section 4.)*

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 3 - INFORMATION ABOUT YOUR WORK

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries or conditions.

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. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

_____

_____

D. 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 duties like this? ☐ YES ☐ NO

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

Walk? _____ Stoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____

Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____

Sit? _____ Crouch? *(Bend legs & back down & forward.)* _____ Write, type or handle small objects? _____

Climb? _____ Crawl? *(Move on hands & knees.)* _____

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

_____

_____

G. Check **heaviest** weight lifted:

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

H. 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 _____

I. Did you supervise other people in this job? ☐ YES (Complete items below.) ☐ NO (If NO, go to J.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

SECTION 4 - 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 5.

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/HMO/THERAPIST/OTHER.** Include your **next appointment.**

1.

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

2.

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

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

If you need more space, use Remarks, Section 9.

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					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE Area Code Phone Number			☐ **EMERGENCY ROOM** VISITS	DATE OF VISITS	

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 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

2.

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

_____

If you need more space, use Remarks, Section 9.

F. Does **anyone else have medical records or information** about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

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

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

If you need more space, use Remarks, Section 9.

SECTION 5 - MEDICATIONS

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

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for 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			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
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 _____			

If you have had other tests, list them in Remarks, Section 9.

SECTION 7-EDUCATION/TRAINING INFORMATION

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

Grade school: 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 "NO," go to part C)*

NAME OF SCHOOL _____

ADDRESS _____

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

_____

City *State* *Zip*

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school?**

☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

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

_____

City *State* *Zip*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____

(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 9 - REMARKS

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

SECTION 9 - REMARKS

Name of person completing this form (*Please Print)*	**Date Form Completed** *(Month, day, year)*
Address *(Number and street)*	**e-mail address** *(optional)*
City **State**	**Zip Code**

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last)*

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

SSA USE ONLY NUMBER HOLDER (If other than above)

NAME

SSN _ _

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

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

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

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

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

FROM WHOM

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

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

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

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

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

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

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

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

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

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

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP -

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

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

SIGN ▶

Phone Number (or Address)	Phone Number (or Address)

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