FUNCTION REPORT - ADULT - Form SSA-3373-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213.

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.

It is important that you tell us about your activities and abilities.

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM ON PAGE 8

Privacy Act and Paperwork Reduction Act Statements

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the name claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices.

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 one hour to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not have that address, you may call Social Security at 1-800-722-1213.** 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.***

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only
Do not write In this box

Related SSN ___ - ___ - ___

Number Holder _____

SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle, Last)*

2. **SOCIAL SECURITY NUMBER**

3. **DATE** *(Month, Day, Year)*

4. YOUR DAYTIME TELEPHONE NUMBER *(if there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

Area *Phone Number*

☐ Your Number ☐ Message Number ☐ None

5. a. Where do you live? *(Check one.)*

☐ House ☐ Apartment ☐ Boarding House ☐ Nursing Home
☐ Shelter ☐ Group Home ☐ Other *(What?)*

b. With whom do you *live? (Check one.)*

☐ Alone ☐ With Family ☐ With Friends
☐ Other *(Describe relationship.)*

SECTION B - INFORMATION ABOUT DAILY ACTIVITIES

6 Describe what you do from the time you wake up until going to bed.

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? ☐ Yes ☐ No

If "YES," for whom do you care, and what do you do for them?

8. Do you take care of pets or other animals? ☐ Yes ☐ No

If "YES," what do you do for them?

9. Does anyone help you care for other people or animals? ☐ Yes ☐ No

If "YES," who helps, and what do they do to help?

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

11. Do the illnesses, injuries, or conditions affect your sleep? ☐ Yes ☐ No

If "YES," how?

12. **PERSONAL CARE** (Check here ☐ if **NO PROBLEM** with personal care.)

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress

Bathe

Care for hair

Shave

Feed self

Use the toilet

Other?

b. Do you need any special reminders to take care of personal needs and grooming? ☐ Yes ☐ No

If "YES," what type of help or reminders are needed?

c. Do you need help or reminders taking medicine? ☐ Yes ☐ No

If "YES," what kind of help do you need?

13. **MEALS**

a. Do you prepare your own meals? ☐ Yes ☐ No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses).

How often do you prepare food or meals? *(For example, daily, weekly, monthly.)*

How long does it take you?

Any changes in cooking habits since the illness, injuries, or conditions began?

b. If "No," explain why you cannot or do not prepare meals.

14. **HOUSE AND YARD WORK**

a. List household chores, both indoors and outdoors, that you are able to do. *(For example,* cleaning, laundry, household repairs, ironing, mowing, etc.)

b. How much time does it take you, and how often do you do each of these things?

c. Do you need help or encouragement doing these things? ☐ Yes ☐ No

If "YES," what help is needed?

d. If you don't do house or yard work, explain why not.

15. **GETTING AROUND**

a. How often do you go outside?

If you don't go out at all, explain why not.

b. When going out, how do you travel? *(Check all that apply.)*

☐ Walk ☐ Drive a car ☐ Ride in a car ☐ Ride a bicycle

☐ Use public transportation ☐ Other *(Explain)*

c. When going out, can you go out alone? ☐ Yes ☐ No

If "NO," explain why you can't go out alone.

d. Do you drive? ☐ Yes ☐ No

If you don't drive, explain why not.

16. **SHOPPING**

a. If you do any shopping, do you shop: *(Check all that apply.)*

☐ In stores ☐ By phone ☐ By mail ☐ By computer

b. Describe what you shop for.

c. How often do you shop and how long does it take?

17. **MONEY**

a. Are you able to:

Pay bills	☐ Yes	☐ No	Handle a savings account	☐ Yes	☐ No
Count change	☐ Yes	☐ No	Use a checkbook/money orders	☐ Yes	☐ No

Explain all "NO" answers.

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? ☐ Yes ☐ No

If "YES," explain how the ability to handle money has changed.

18. **HOBBIES AND INTERESTS**

a. What are your hobbies and interests? *(For example, reading, watching TV, sewing, playing sports, etc.)*

b. How often and how well do you do these things?

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

19. **SOCIAL ACTIVITIES**

a. Do you spend time with others? *(In person, on the phone, on the computer, etc.)* ☐ Yes ☐ No

If "YES," describe the kinds of things you do with others.

How often do you do these things?

b. List the places you go on a regular basis. *(For example, church, community center, sports events, social groups, etc.)*

Do you need to be reminded to go places? ☐ Yes ☐ No

How often do you go and how much do you take part?

Do you need someone to accompany you? ☐ Yes ☐ No

c. Do you have any problems getting along with family, friends, neighbors, or others? ☐ Yes ☐ No

If "YES," explain.

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

SECTION C - INFORMATION ABOUT ABILITIES

20. a. Check any of the following items that your illnesses, injuries, or conditions affect:

☐ Lifting	☐ Walking	☐ Stair Climbing	☐ Understanding
☐ Squatting	☐ Sitting	☐ Seeing	☐ Following Instructions
☐ Bending	☐ Kneeling	☐ Memory	☐ Using Hands
☐ Standing	☐ Talking	☐ Completing Tasks	☐ Getting Along With Others
☐ Reaching	☐ Hearing	☐ Concentration	

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift *[how many pounds]*, or you can only walk *[how far]*)

b. Are you: ☐ Right Handed? ☐ Left Handed?

c. How far can you walk before needing to stop and rest?

If you have to rest, how long before you can resume walking?

d. For how long can you pay attention?

e. Do you finish what you start? *(For example, a conversation, chores, reading, watching a movie)* ☐ Yes ☐ No

f. How well do you follow written instructions? *(For example a recipe)*

g. How well do you follow spoken instructions?

h. How well do you get along with authority figures? *(For example, police, bosses, landlords or teachers)*

i. Have you ever been fired or laid off from a job because of problems getting along with other people? ☐ Yes ☐ No

If "YES," please explain.

If "YES," please give name of employer.

j. How well do you handle stress?

k. How well do you handle changes in routine?

l. Have you noticed any unusual behavior or fears? ☐ Yes ☐ No

If "YES," please explain.

21. Do you use any of the following? *(Check all that apply.)*

☐ Crutches	☐ Cane	☐ Hearing Aid
☐ Walker	☐ Brace/Splint	☐ Glasses/Contact Lenses
☐ Wheelchair	☐ Artificial Limb	☐ Artificial Voice Box

☐ Other *(Explain)*

Which of these were prescribed by a doctor?

When was it prescribed?

When do you need to use these aids?

SECTION D - 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 didn't have anything to add), be sure to complete the fields at the bottom of this page.

Name of person completing this form *(Please print)*	Date *(month, day, year)*

Address *(Number and Street)*	email address *(optional)*

City	State	Zip Code