DISABILITY REPORT - ADULT - Form SSA-3368-BK

PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

THIS IS NOT AN APPLICATION

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. However, if you have access to the Internet, you may access the Disability Report Form Guide at http://www.socialsecurity.gov/disability/3368/index.htm.

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.

- Please 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 4, 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 or family member.
- 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 Pages 9 and 10, 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. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means 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 if 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.

The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) 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 named 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. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT: This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *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.

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.)*

_______ *Area Code* _______________ *Number* ☐ Your Number ☐ Message Number ☐ None

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)

____
City *State* *ZIP*

DAYTIME PHONE _______ *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)

____
City *State* *ZIP*

DAYTIME PHONE _______ *Area Code* _______________ *Number*

I. Can you **read and understand 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** 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			
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? ____________

____

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**