PAPER FORMS

SSA-1696: Appointment of Representative

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number – –
Wage Earner (If Different)	Social Security Number – –

Part I

APPOINTMENT OF REPRESENTATIVE

I appoint this person, ______________________________ (Name and Address)

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

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is ______________________________ (Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) –	Fax Number (with Area Code) ( ) –	Date

Part II

ACCEPTANCE OF APPOINTMENT

I, ______________________________, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney who is participating in the direct fee payment demonstration project.

☐ I am a non-attorney . I am not participating in the direct fee payment demonstration project.

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☐ No

I have been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☐ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code) ( ) –	Fax Number (with Area Code) ( ) –	Date

Part III (Optional)

WAIVER OF FEE

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

Signature (Representative)	Date

SSA-1696: PART I - Appointment of Representative

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
John Q Public	999-99-9999
Wage Earner (If Different)	Social Security Number
	– –

Part I **APPOINTMENT OF REPRESENTATIVE**

I appoint this person, BIG JIM from BIG & BIGGER ATTORNEY's AT LAW,
(Name and Address)

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

- [x] Title II (RSDI)
- [x] Title XVI (SSI)
- [ ] Title XVIII (Medicare Coverage)
- [ ] Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

- [x] I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.
- [ ] I appoint, or I now have, more than one representative. My main representative is ______________.
(Name of Principal Representative)

Signature (Claimant)	Address	
John Q Public	1111 City Dr., Any town, USA	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date
(310) 999 -9999	( ) -	5/19/2011

SSA-1696: PART II – Acceptance of Appointment

Part II **ACCEPTANCE OF APPOINTMENT**

I, BIG JIM, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ■ I am an attorney. ☐ I am a non-attorney who is participating in the direct fee payment demonstration project.

☐ I am a non-attorney . I am not participating in the direct fee payment demonstration project.

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ■ No

I have been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ■ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative) BIG JIM	Address 9999 Attorney Row, Any town, USA	
Telephone Number (with Area Code) (213) 765-4321	Fax Number (with Area Code) ( ) -	Date 5/19/2011

SSA-1696: PART III & PART IV – Waiver of Fee, Waiver of Direct Payment

Part III (Optional) **WAIVER OF FEE**

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

Signature (Representative)	Date

Part IV (Optional) **WAIVER OF DIRECT PAYMENT**

by Attorney or Non-Attorney Eligible to Receive Direct Payment

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

Signature (Representative Waiving Direct Payment)	Date

Form **SSA-1696-U4** (06-2009) ef (06-2009)
Destroy Prior Editions

TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS
(4 Copies: File, Claimant, Representative, ODAR)

SSA- 3288: Consent for Release of Information

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

____________________ ________________ __________________
*Name *Date of Birth *Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME *ADDRESS

*I want this information released because:
There may be a charge for releasing information.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from __________ to __________
- ☐ My Medicare entitlement from __________ to __________
- ☐ Medical records from my claims folder(s) from __________ to __________
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.)

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: ____________________ *Date: __________

Relationship *(if not the individual)*: ________________ *Daytime Phone: __________

Form SSA 3288 (07-2010) EF (07-2010)

SSA- 3288: Consent for Release of Information

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

John Q Public	10/01/1970	999-99-9999
*Name	*Date of Birth	*Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME	*ADDRESS
BIG JIM	9999 Attorney Row, Any town, USA

*I want this information released because: BIG JIM and his associates will be assisting me with my Social Security claim.

There may be a charge for releasing information.

SSA- 3288: Consent for Release of Information

*Please release the following information selected from the list below:

You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☒ Current monthly Social Security benefit amount
- ☒ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from ______________ to ________________
- ☐ My Medicare entitlement from ______________ to ________________
- ☐ Medical records from my claims folder(s) from ______________ to ________________
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) ____

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: John Q Public *Date: 5/19/2011

Relationship *(if not the individual)*: ____________________ *Daytime Phone: (310)999-9999

Form **SSA-3288** (07-2010) EF (07-2010)

SSA-827: Authorization to Disclose Information to SSA

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*
NAME (First, Middle, Last)

SSN ___ - ___ - ___ | Birthday (mm/dd/yy)

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 noncommunicable disease; and tests for or records of HIV/AIDS
   - 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, insurance companies, workers' compensation programs
- 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)

SSA-827: Authorization to Disclose Information to SSA

WHOSE *Records to be Disclosed*

Form Approved
OMB No. 0960-0623

NAME *(First, Middle, Last)*
John Q Public

SSN 999-99-9999

Birthday *(mm/dd/yy)* 10/01/1970

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 noncommunicable disease; and tests for or records of HIV/AIDS
   - 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.

SSA-827: Authorization to Disclose Information to SSA

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, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY **SSA/DDS** (<u>as needed</u>) 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.**

SSA-827: Authorization to Disclose Information to SSA

PLEASE SIGN USING BLUE OR BLACK INK ONLY		IF not signed by subject of disclosure, specify basis for authority to sign		
INDIVIDUAL authorizing disclosure SIGN ▶ John Q Public		☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)		
		(Parent/guardian/personal representative sign here if two signatures required by State law) ▶		
Date Signed 5/19/2011	Street Address 1111 City Dr.			
Phone Number (with area code) (310) 999 -9999	City Any town		State	ZIP 90000

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.

Form **SSA-827** (4-2009) ef (04-2009) Use 2-2003 and Later Editions Until Supply is Exhausted

SSA-3369: Work History Report

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0578

WORK HISTORY REPORT

For SSA Use Only
Do not write in this box.

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 Phone Number

☐ Your Number ☐ Message Number ☐ None

SECTION 2 - INFORMATION ABOUT YOUR WORK

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

Job Title	Type of Business	Dates Worked	
		From	To
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Work History Report - Form SSA-3369-BK

SSA-3369: Work History Report

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0578

WORK HISTORY REPORT

For SSA Use Only
Do not write in this box.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last)	**B. SOCIAL SECURITY NUMBER**
John Q Public	999-99-9999

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.)*

(310) 999 - 9999
Area Code *Phone Number*

■ Your Number ☐ Message Number ☐ None

Work History Repo

SSA-3369: Work History Report

SECTION 2 - INFORMATION ABOUT YOUR WORK

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

Job Title	Type of Business	Dates Worked	
		From	To
1. Short Order Cook	Fast Food	2/1995	12/2004
2. Cashier	Grocery Store	3/2005	9/2010
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Form SSA-3369-BK (04-2011) ef (04-2011) Destroy Prior Editions

PAGE 1

ort - Form SSA-3369-BK

SSA-3369: Work History Report – Job #1

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1	Short Order Cook		
Rate of Pay $ 7.00	Per *(Check One)* ■ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day 6	Days per week 5

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

I made pizzas, hamburgers, french fries, and many other fast food items on a daily basis.

In this job, did you:

	YES	NO
Use machines, tools, or equipment?	■	☐
Use technical knowledge or skills?	☐	■
Do any writing, complete reports, or perform duties like this?	☐	■

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

Walk?	1	Kneel? *(Bend legs to rest on knees)*	½ hr
Stand?	3	Crouch? *(Bend legs & back down & forward)*	½ hr
Sit?	½ hr	Crawl? *(Move on hands & knees)*	0
Climb?	0	Handle, grab, or grasp big objects?	0
Stoop? *(Bend down and forward at waist)*	½ hr	Reach?	0
		Write, type, or handle small objects?	0

SSA-3369: Work History Report – Job #1

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

I carried multiple boxes of food, from the food truck to the freezers. The distance was about 40 feet. Primarily, I carried small food orders from the cooking station to the food counter.

Check the **heaviest** weight lifted:

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

Check weight you **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 ______

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ■ NO (Skip to the last question on this page.)

How many people did you supervise? ________

What part of your time was spent supervising people? ________

Did you hire and fire employees? ☐ YES ■ NO

Were you a lead worker? ■ YES ☐ NO

SSA-3369: Work History Report – Job #2

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1 Cashier		
Rate of Pay $ 11.25 — Per *(Check One)*: ■ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day 7	Days per week 5

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

My primary duties were to handle monetary transactions, while scanning, bagging, and accommodating grocery carts.

In this job, did you:

	YES	NO
Use machines, tools, or equipment?	■	☐
Use technical knowledge or skills?	☐	■
Do any writing, complete reports, or perform duties like this?	■	☐

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

Activity	Hours
Walk?	1
Stand?	4
Sit?	½ hr
Climb?	0
Stoop? *(Bend down and forward at waist)*	½ hr
Kneel? *(Bend legs to rest on knees)*	½ hr
Crouch? *(Bend legs & back down & forward)*	½ hr
Crawl? *(Move on hands & knees)*	0
Handle, grab, or grasp big objects?	0
Reach?	0
Write, type, or handle small objects?	0

SSA-3369: Work History Report – Job #2

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

I carried multiple bags of groceries from the check-out counter to the customers shopping cart. I did not carry these items farther than 10 feet.

Check the **heaviest** weight lifted:

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

Check weight you **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 ______

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ■ NO (Skip to the last question on this page.)

How many people did you supervise? ________

What part of your time was spent supervising people? ________

Did you hire and fire employees? ☐ YES ■ NO

Were you a lead worker? ☐ YES ■ NO

SSA-3369: Work History Report

SECTION 3 - REMARKS

Use this section to add any information you did not have space for in other parts of the form. Show the page number of the part you are continuing.

BE SURE TO COMPLETE THE BOTTOM OF THIS PAGE.

Name of person completing this form if other than the disabled *person (Please print)* BIG JIM		**Date** 5/19/2011
Address *(Number and Street)* 9999 Attorney Row		**Email address** *(optional)*
City Any town, USA	**State**	**ZIP Code** -

SSA-3367-F4: Disability Report – Field Office Form

SOCIAL SECURITY ADMINISTRATION

DISABILITY REPORT - FIELD OFFICE

IDENTIFYING INFORMATION

1. NAME OF PERSON ON WHOSE SOCIAL SECURITY RECORD THIS CLAIM IS BEING FILED

HIS OR HER SOCIAL SECURITY NUMBER – –

NAME OF CLAIMANT (if different from above)

SSN *(if different from above)* – –

☐ Male ☐ Female DOB ____________

2. CLAIMANT'S ALLEGED ONSET DATE (AOD) ____________

3. POTENTIAL ONSET DATE *(if different from above)* *(check type of claim(s) and enter potential onset)*

☐ SSI ____________

☐ DIB/Freeze ____________ ☐ DWB ____________ ☐ CDE ____________ ☐ OTHER ____________

4. REASON FOR POTENTIAL ONSET DATE

☐ SSI Application Date ☐ Controlling Date

☐ SSI Alien ☐ Statutorily Blind

☐ Date Last Insured ☐ Work Before/After AOD

☐ Date First Insured ☐ UWA ☐ SGA ☐ Not SGA ☐ 820/821 In File

☐ Other (explain in item 5)

5. EXPLANATION FOR POTENTIAL ONSET DATE, WHEN APPLICABLE:

☐ 820/821 Pending Date Requested ____________

MISCELLANEOUS INFORMATION

6. Protective filing date ____________ Date last insured (DIB/Freeze case) ____________

Beginning of Prescribed Period (DWB) ____________ End of Prescribed Period

Controlling date ____________

Closed period case ☐ Yes ☐ No

PRIOR FILING INFORMATION - Use Remarks, if additional space is needed.

7. Prior filing(s) ☐ Yes ☐ No

If yes, and you are not sending the prior folder(s) to the DDS, enter the following:

Type of prior claim(s) ____________

SSN(s) of prior claim(s) - - - - - -

Date of last decision ____________ Level of last decision ____ ☐ Allowance ☐ Denial

Date of prior termination (if applicable) ____________

Location of prior folder ____

Prior folder requested ☐ Yes ____________ (date requested) ☐ No

Disability Report - Field Office Form SSA-3367

SSA-3367-F4: Disability Report – Field Office Form

SOCIAL SECURITY ADMINISTRATION

DISABILITY REPORT - FIELD OFFICE

IDENTIFYING INFORMATION

1. NAME OF PERSON ON WHOSE SOCIAL SECURITY RECORD THIS CLAIM IS BEING FILED John Q Public	HIS OR HER SOCIAL SECURITY NUMBER 999-99-9999
NAME OF CLAIMANT (if different from above) ☒ Male ☐ Female DOB 10/01/1970	SSN *(if different from above)* – –

2. CLAIMANT'S ALLEGED ONSET DATE (AOD) ________

3. POTENTIAL ONSET DATE *(if different from above)* *(check type of claim(s) and enter potential onset)* ☐ SSI ________

☐ DIB/Freeze ________ ☐ DWB ________ ☐ CDB ________ ☐ OTHER ________

4. REASON FOR POTENTIAL ONSET DATE

☐ SSI Application Date ☐ Controlling Date
☐ SSI Alien ☐ Statutorily Blind
☐ Date Last Insured ☐ Work Before/After AOD
☐ Date First Insured ☐ UWA ☐ SGA ☐ Not SGA ☐ 820/821 In File
☐ Other (explain in item 5)

5. EXPLANATION FOR POTENTIAL ONSET DATE, WHEN APPLICABLE:

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Disability Report - F

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MISCELLANEOUS INFORMATION

6. Protective filing date ____________ Date last insured (DIB/Freeze case) ____________

Beginning of Prescribed Period (DWB) ____________ End of Prescribed Period

Controlling date ____________

Closed period case ☐ Yes ☐ No

PRIOR FILING INFORMATION - Use Remarks, if additional space is needed.

7. Prior filing(s) ☐ Yes ☐ No

If yes, and you are not sending the prior folder(s) to the DDS, enter the following:

Type of prior claim(s) ____________

SSN(s) of prior claim(s) – – – – – – ____________

Date of last decision ____________ Level of last decision ____ ☐ Allowance ☐ Denial

Date of prior termination (if applicable) ____________

Location of prior folder ____

Prior folder requested ☐ Yes ____________ (date requested) ☐ No

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8. CHECK ANY OF THE FOLLOWING FO PD/PB CRITERIA THAT APPLY IN AN SSI CLAIM PER DI 11055.230ff.

1. Obsolete - Reserved for future use.

☐ 2. Amputation of a leg at the hip.

☐ 3. Allegation of total deafness; that is, no sound perception in either ear.

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☐ 4. Allegation of total blindness; that is, no light perception in either eye.

☐ 5. Allegation of bed confinement and immobility without a wheelchair, walker, or crutches, due to a longstanding condition, excluding recent accident and recent surgery.

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

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

Pages 2 & 3 list all of the possible presumptive benefits.

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9. OBSERVATIONS/PERCEPTIONS

How was the interview conducted?

☐ Teleclaim with claimant (Complete 1-8 and 15 below)	■ Face-to-face with claimant (Complete 1-15 below)	☐ No contact with claimant (Go to Page 5)

If the claimant had difficulty with the following, check the "yes" block and explain in "observations" or check "no" or "not observed/perceived." (Explain any "no" answers that you think would assist the DDS in making a decision.)

1. Hearing	☐ Yes	☐ No	■ Not observed/perceived
2. Reading	☐ Yes	■ No	☐ Not observed/perceived
3. Breathing	☐ Yes	☐ No	■ Not observed/perceived
4. Understanding	■ Yes	☐ No	☐ Not observed/perceived
5. Coherency	■ Yes	☐ No	☐ Not observed/perceived
6. Concentrating	■ Yes	☐ No	☐ Not observed/perceived
7. Talking	☐ Yes	☐ No	■ Not observed/perceived
8. Answering	☐ Yes	■ No	☐ Not observed/perceived
9. Sitting	☐ Yes	■ No	☐ Not observed/perceived

Page 4 is a critical part of the disability process, and _is_ necessary for 3rd parties to complete.

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10. Standing	☐ Yes	■ No	☐ Not observed/perceived
11. Walking	☐ Yes	■ No	☐ Not observed/perceived
12. Seeing	☐ Yes	☐ No	■ Not observed/perceived
13. Using hand(s)	☐ Yes	■ No	☐ Not observed/perceived
14. Writing	☐ Yes	■ No	☐ Not observed/perceived

15. Other (specify)

OBSERVATIONS: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

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10. Development initiated by FO

A. Medical

Source	Date Requested	Tickle/Diary Date	Evidence to be Forwarded by Source to		Capability Development Requested
			DDS	FO	
			☐	☐	
			☐	☐	

B. Other

Source	Date Requested	Tickle/Diary Date	Evidence to be Forwarded by Source to	
			DDS	FO
			☐	☐
			☐	☐

C. Forms to be completed by applicant and sent to the DDS.

☐ SSA-3371 ☐ SSA-3369 ☐ Other ____________

11. If medical evidence was brought in to the FO by the claimant, check here ☐

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NAME OF INTERVIEWER (Print)

BIG JIM from BIG & BIGGER ATTORNEY's AT LAW

(213) 765 -4321

Area Code | Phone Number

NAME OF PERSON COMPLETING FORM (Print) (if different from interviewer)

DATE 5/19/2011