DISABILITY REPORT - CHILD - Form SSA-3820-BK

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, complete as much of it as you can, and your interviewer will help you finish it.

HOW TO COMPLETE THIS FORM

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

- Fill out as much of this form as you can before your interview appointment.
- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or " none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/ OTHER/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 ahead of time, if you were told to do so.
- 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 Section 10, "DATE AND REMARKS," on Pages 11 and 12, and show the number of the question being answered.

ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records
- Copies of the child's prescriptions or medicine containers
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

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 from whom to request 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 medicine containers.

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 Government Accountability 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 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

NOTE: This is the only portion of the SSI application process that can currently be done online. If you submit this online, please provide the Social Security Liaison with the Confirmation # for tracking purposes. (Print at least two copies - one for your file, and one to turn in as a cover sheet for the supporting documents with all the other paperwork.)

DISABILITY REPORT - CHILD

SECTION 1 -- INFORMATION ABOUT THE CHILD

A. **CHILD'S NAME** *(First, Middle Initial, Last)*

B. **CHILD'S SOCIAL SECURITY NUMBER**

C. **YOUR NAME** *(If agency, provide name of agency and contact person)*

Child & Family Connections - Schella Lapomarel or Sol Gonzalez.

YOUR MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*

4100 Okeechobee Blvd.

CITY	STATE	ZIP CODE
West Palm Beach	FL	33409

YOUR EMAIL ADDRESS (Optional) slapomorel@cfcpbc.org or sgonzalez@cfcpbc.org

D. **YOUR DAYTIME PHONE NUMBER**

Schella Lapomorel (561) 352-2451
Sol Gonzalez (561) 352-2465

(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)

Your Number [X] Message Number [ ] None

E. What is **your relationship to the child**? Rep Payee

F. Can you **speak and understand English**? [X] YES [ ] NO

If "NO", what is your preferred language? _____

NOTE: If you cannot speak and understand English, we will provide you 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 (Enter name, address, phone number, relationship) [ ] NO

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____

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

_____ DAYTIME PHONE _____ _____

City *State* *ZIP* *Area Code* *Number*

Can you **read and understand English**? [ ] YES [ ] NO

G. Does the child live with you? [ ] YES [X] NO If "NO", with whom does the child live?

NAME _____ RELATIONSHIP TO CHILD Foster Parent or Group Home

ADDRESS _____

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

_____ DAYTIME PHONE _____ _____

City *State* *ZIP* *Area Code* *Number*

Can this person **speak and understand English**? [ ] YES [ ] NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? [ ] YES [ ] NO

Disability Report - Child - Form SSA-3820-BK

SECTION 1 - INFORMATION ABOUT THE CHILD

H. Can the child speak and understand English? ☐ YES ☐ NO

If "NO," what languages can the child speak? _____

If the child understands any other languages, list them here: _____

I. What is the child's height *(without shoes)*? _____

What is the child's weight *(without shoes)*? _____

J. Does the child have a **medical assistance** card? (for example Medicaid, Medi-Cal)

☒ YES ☐ NO

If "YES", show the **number** here: _____

SECTION 2 - CONTACT INFORMATION

A. Does the child have a legal guardian or custodian other than you?

☒ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME Department of Children & Families / Child & Family Connections

ADDRESS 4100 Okeechobee Blvd.

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

West Palm Beach, FL 33409

ZIP

DAYTIME PHONE NUMBER Schella Lapomarel (561) 352-2451
Sol Gonzalez (561) 352-2465

RELATIONSHIP TO CHILD Rep Payee

Can this person **speak and understand English**? ☒ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

B. Is there another adult who helps care for the child and can help us get information about the child if necessary?

☒ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME OF CONTACT Case Manager's Name

ADDRESS 4100 Okeechobee Blvd.

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

West Palm Beach, FL 33409

City *State* *ZIP*

DAYTIME PHONE NUMBER Case Manager's Cell #

Area Code *Number*

RELATIONSHIP TO CHILD Dependency Case Manager

Can this person **speak and understand English**? ☒ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

SECTION 3 - THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER

A. What are the child's disabling **illnesses, injuries, or conditions**?

Give details and examples using common everyday language, not medical or clinical terminology.
Explain the interaction between the physical and emotional, and side effects of medication.
Give specific examples of how their condition affects (limits) their daily life
Include exposure to traumatic events.

B. When did the child become disabled?

Month	*Day*	*Year*

The date here must coincide with the 8000 application. DOB may be used if unknown.

C. Do the child's illnesses, injuries or conditions cause **pain** or other symptoms? ☐ YES ☐ NO

Usually Yes - think of side effects.

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

☐ YES ☐ NO

Think of the date as 6 months to 2 years prior to applying for SSI.

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

☐ YES ☐ NO

Usually yes

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each DOCTOR/HMO/THERAPIST/OTHER**. Include the child's **next appointment**.

1.

NAME EPSDT may be used here		DATES
STREET ADDRESS		**FIRST VISIT**
CITY **STATE** **ZIP**		**LAST VISIT**
PHONE _____ _____ *Area Code* *Number*	**Patient ID #** (If known)	**NEXT APPOINTMENT**
REASONS FOR VISITS		
WHAT **TREATMENT** WAS RECEIVED?		

2.

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

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3.

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

If you need more space, use Section 10.

D. List each **HOSPITAL/CLINIC.** Include the child's **next appointment.**

1.

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

ER visits don't count since their purpose is to stabilize rather than treat the patient.

Next **appointment** _____ The child's hospital/clinic **number** _____

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2.

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

Next **appointment** _____ The child's hospital/clinic **number** _____

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

If you need more space, use Section 10.

E. Does **anyone else have medical records or information** about the child's illnesses, injuries or conditions (Workers' Compensation, insurance companies, counselors, detention centers, attorneys, and/or tutors), or is the child scheduled to see anyone else?

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

Schools, Insurance Companies, and sometimes Attorneys will have info on a child's medical condition. CFC Clinical Dept. may also have information.

NAME	**DATES**
ADDRESS	**1ST** VISIT
CITY **STATE** **ZIP**	**LAST** SEEN
PHONE Area Code ____ Number ____	NEXT APPOINTMENT

CLAIM NUMBER *(If any)* _____

REASONS FOR VISITS _____

If you need more space, use Section 10.

SECTION 5 - MEDICATIONS

Does the child currently take any **medications** for illnesses, injuries or conditions? ☐ YES ☐ NO

If "YES", tell us the following: *(Look at the child's medicine containers, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

Be sure to list all medicines and side effects. Sometimes there may be an adverse interaction between two medications.
If medications are unknown, it's ok to say "see medical records"

If you need more space, use Section 10.

SECTION 6 - TESTS

Has the child had, or will he/she have, any **medical tests** for illnesses, injuries or conditions? ☐ YES ☐ NO If "YES", tell us the following (give approximate dates, if necessary).

KIND OF TEST	WHEN WAS/WILL TESTS BE DONE? *(Month, day, year)*	WHERE DONE *(Name of Facility)*	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part			
SPEECH/LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part			
MRI/CAT SCAN - Name of body part			

List all that are known. Use another sheet if necessary. Ok to say "See Medical Records"

If the child has had other tests, list them in Section 10.

SECTION 7 - ADDITIONAL INFORMATION

A. Has the child been **tested or examined** by any of the following?

Headstart (Title V)	☐ YES	☐ NO
Public or Community Health Department	☐ YES Often	☐ NO
Child Welfare or Social Service Agency	☐ YES	☐ NO
Women, Infant and Children (WIC) Program	☐ YES Often	☐ NO
Program for Children with Special Health Care Needs	☐ YES	☐ NO
Mental Health/Mental Retardation Center	☐ YES	☐ NO

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work?

☐ YES ☒ NO Unlikely unless older teen & SIL / IL

If you answered "YES" to any of the above in A. or B., please complete C. below:

C. 1. NAME OF AGENCY contact info of the healtcare provider who did the test

ADDRESS _____

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

_____

City *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

2. NAME OF AGENCY _____

ADDRESS _____

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

_____

City *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

If there are any other agencies, show them in Section 10.

SECTION 8 - EDUCATION

A. What is the child's **current grade** in school or the **highest grade** completed?

B. Is the child currently attending school *(other than summer school)*? ☐ YES ☐ NO

If "NO", explain why the child is not attending school.

List the name and school currently attending. If over summer, use "highest grade completed" and the school they were at most recently. Homeschooling and GED count.

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

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

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Has the child been tested for behavioral or learning problems? ☐ YES ☐ NO
If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

IQ, Speech, Hearing, Vision, Behavior, etc.

Is the child in special education? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH THERAPIST _____

SECTION 8 - EDUCATION

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

If child has been in lots of different schools for short periods of time, it's helpful to list the others on a separate sheet of paper.

NAME OF SCHOOL _____

ADDRESS _____

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

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems? ☐ YES ☐ NO

If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Was the child in special education? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH THERAPIST _____

If there are other schools, show them in Section 10.

Often

E. Is the child attending Daycare/Preschool? ☐ YES ☐ NO

If "YES", complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____

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

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

SECTION 9 - WORK HISTORY

A. Has the child ever worked (including sheltered ☐ YES ☐ NO

If "YES", complete the following:

Almost never, but may apply to older teens and SIL / IL

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____

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

_____ _____ _____

City *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

NAME OF SUPERVISOR _____

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

SECTION 10 - DATE AND REMARKS

Please give the date you filled out this disability report.

Date (MM/DD/YYYY) / /

Use this section for any additional information about your child.

It's better to include something here that will help the application be approved. Again, day-to-day examples in layman's terms are preferred. There's plenty of space here - tell about a recent situation that illustrates the child's problems. Or explain the trauma they experienced in the past and how it affects them now. Finally, use the phrase "Case manager completed to the best of ability based on the information available at the time" and sign it.

SECTION 10 - REMARKS