Huntington's Disease Society of America

Social Security Disability Starter Kit

Created by Allison Bartlett, Esq., manager of disability programs and published 3/2021.

Welcome to the Social Security Disability Starter Kit

This starter kit has been developed with a focus on Social Security disability because it is an essential part of the HD journey for most families. This kit has been designed to provide social workers general knowledge about the Social Security disability process through webinars, resource guides, handouts, and online resources. The goal of this starter kit is to help social workers help families with general disability questions as well as Social Security disability questions and applications. There are many complexities that are a part of the disability process, including legal, financial, disability insurance, and health insurance considerations that are also touched on in this kit.

This kit is broken down into seven sections:

1. Introduction to Disability Planning

This section includes information and resources regarding the timeline for disability planning and the disability planning process. Disability planning, which includes legal and financial planning, asset protection, and disability insurance planning, is something that needs to start as soon as possible otherwise the HD individual and family may lose out on important benefits and legal and financial protections.

Disability Planning Resources

Disability Chat Webinars:

- Public & Private Disability Benefits: https://www.youtube.com/watch?v=D0h_MQ_uvmA&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=1
- Disability, Legal, and Financial Planning for Prodromal & Pre-symptomatic HD: https://www.youtube.com/watch?v=Yp2ksR-rkGI&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=8&t=2s
- Disability, Legal, and Financial Planning for Early to Mid-Stage Symptomatic HD: https://www.youtube.com/watch?v=b3i5dk939hI&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=9
- Disability, Legal, and Financial Planning for Late-Stage Symptomatic HD: https://www.youtube.com/watch?v=jrVNDpY6OI8&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=10

Online Resources

- Disability
  - Private Insurance
    - Policy Genius – provides good overview of the different types of insurance and coverage options: https://www.policygenius.com/
  - Student Loan Forgiveness - Total and Permanent Disability
    - https://studentaid.gov/manage-loans/forgiveness-cancellation/disability-discharge
    - https://disabilitydischarge.com/Application-Process
  - Working and receiving Social Security Disability
    - Ticket to Work: https://www.ssa.gov/work/

        - Work Incentives Planning and Assistance: https://www.disabilitysecrets.com/legal-advice/social-security-disability/what-wipa-program.htm
- Legal Planning
    - Advanced Directives
        - Prepare:
            - https://prepareforyourcare.org/welcome
        - 5 Wishes:
            - https://fivewishes.org/
            - https://thelastvisit.com/wp-content/uploads/2014/09/5-Wishes-Advanced-Planning-Guide1.pdf
    - Power of Attorney
        - Overview: https://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/power_of_attorney/
        - Sample documents (must confirm these abide by state laws): https://powerofattorney.com/
- Health Insurance
    - Private
        - https://www.healthcare.gov/
        - https://www.healthcare.com/
        - https://www.ehealthinsurance.com/
    - Medicare
        - https://www.medicare.gov/
        - State Health Insurance Planning and Assistance Programs (answer Medicare questions)
            - https://www.shiptacenter.org/
            - www.seniorsresourceguide.com/directories/National/SHIP/
    - Medicaid
        - State Specific financial limits: https://www.medicaidplanningassistance.org/state-specific-medicaid-eligibility/
        - https://www.medicaid.gov/state-overviews/index.html

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Financial and Legal Preparation for Prodromal/Pre-symptomatic HD

Financial Planning & Insurance: Financial planning allows you to get a comprehensive picture of your current finances, set financial goals, and help you achieve your financial goals in the future. Insurance helps you cover the cost of medical care and other benefits you may need. Financial planning and obtaining the right insurance are important whether you are single, in a relationship, or have a family because they are necessary to ensure you are able to access and pay for proper medical care and long-term care in the future.

- ☐ Make sure you are paying into a disability/retirement program:
  - Social Security disability/retirement
  - Private State disability/retirement
  - Private teacher disability/retirement
  - General private disability/retirement (TIAA, Mutual of America, etc.)
- ☐ Review and sign up for employer provided benefits if they are available:
  - Health Insurance
  - Short term disability
  - Long-term disability
  - Life Insurance
  - Legal Shield – can opt into this benefit for a year to get a will drafted then stop
- ☐ What to Look for in Employer Benefits:
  - Health Insurance:
    - Exclusions that would limit your ability to get the care you need
  - Long-term disability:
    - Exclusions pertaining to genetic conditions
    - Timeframe limitations based on when you get diagnosed (will the policy cover you if you have already been diagnosed)
    - How long you pay into the policy before you can use it
  - Life Insurance:
    - Medical record requirements
    - Family history requirements

Asset/Resource Protection: Assets/resources can be anything of value owned by individuals or organizations, and they can be categorized in different ways. Personal assets usually include cash and cash equivalents; real estate and land; personal property such as cars, boats, and jewelry; retirement and investments. Asset/resource protection is particularly important if you have a spouse or family that will need to help provide for your care when your HD progresses. It is also important if you have a spouse, family, or family member that you want to guarantee will get your assets after you die.

- ☐ Determine what asset protection options will work best for you and your family:
  - Special Needs Trust - trust is meant for a dependent who receives government benefits, such as Social Security disability benefits
  - Medicaid Asset Protection Trust - Enables someone who would otherwise be ineligible for Medicaid to become Medicaid eligible
  - Income Trust - trust that can be helpful to Medicaid applicants in states that have a set income limit for qualifying for Medicaid
  - ABLE Account - tax-advantage savings accounts for individuals with disabilities that began before age 26 and does not count towards Supplemental Security Income (SSI) or Medicaid
  - Caregiver Agreement - a contract typically between a family member who agrees to provide caregiver services for a disabled or aging relative and the person receiving care that compensates the family member for the care provided
- ☐ Speak with a specialized attorney:
  - Elder Law Attorney - should be able to cover most of the necessary legal and asset protection options
  - Estate Planning Attorney - usually only assist with wills and trusts
  - Special Needs Trust Attorney – if you need a specialized trust it is important to work with an attorney that specializes in that area (trusts are very complicated)
- ☐ Create a Will:
  - Must contain the date of execution
  - Must be signed by the individual granting the POA
  - Must be signed before a notary public and/or signed by two witnesses (state specific)
  - Needs to name the person who you want to act on your behalf as your "agent"
  - Needs to define what powers the person will have to act on your behalf

Legal Decision-Making Documents: Legal decision-making documents give someone else, a person you choose, the right or the ability to make decisions for you because you are not able to make the decision. There are many reasons you may not be able to make a decision: out of the country, unconscious, incapacitated due to Huntington's disease or another medical condition.

- ☐ Power of Attorney (POA):
  - Must contain the date of execution
  - Must be signed by the individual granting the POA
  - Must be signed before a notary public and/or signed by two witnesses (state specific)

- Needs to name the person who you want to act on your behalf as your “agent”
- Needs to define what powers the person will have to act on your behalf, like handling financial and business transactions, which includes buying or selling a house.

☐ Healthcare Power of Attorney

- Must contain the date of execution
- Must be signed by the individual granting the POA
- Must be signed before a notary public and/or signed by two witnesses (state specific)
- Needs to name the person who you want to act on your behalf as your “agent”
- Needs to define what medical decisions the “agent” will be able to make on your behalf, for instance where you can get medical treatment, what medications you can take, or if you can get surgery.

☐ Advanced Directive/Living Will

- Choose a medical decision maker
- Decide what matters most in life
- Choose what decisions your medical decision maker is able to make
- Tell Others (physicians, family) about your wishes
- Make sure to speak with your doctors and ask questions

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Disability and Legal Preparation for Early-Mid Stage symptomatic HD

Medical Care: Medical care is essential for obtaining many of the disability and legal benefits that will be needed for a symptomatic HD individual. Medical evidence provided by regular medical care is the only fact based way to provide support for all disability claims.

- ☐ Receive regular medical care:
  - See your medical providers at least once per year
    - Primary care physician
    - Neurologist
  - Be honest with your medical providers about the severity of your symptoms
- ☐ Start care with relevant specialists:
  - Neurologist
  - Psychiatrist
  - Physical or occupational therapist
- ☐ Speak with your medical providers about disability:
  - You will not be approved for disability if you do not have support from your medical providers
  - Medical providers will need to complete disability forms

Disability: There are many disability options that provide financial protection in the event you have to stop working due to HD: Temporary State Disability, Short-Term Disability, Long-Term disability, Employer Funded Disability, and Social Security Disability. It is very important to figure out what benefits you are eligible for and to follow the application instructions. All of these disability programs require proof of HD in order to be awarded benefits

- ☐ Determine what disability benefits you are eligible to receive:
  - ◯ Temporary State Disability – only for California, Hawaii, New Jersey, and New York, and Rhode Island
  - ◯ Short Term Disability – provided by employer
  - ◯ Long-Term Disability – provided by employer or private policy
  - ◯ Employer Funded Disability – provided by employer or private policy
  - ◯ Social Security Disability – federal benefit available to most Americans

☐ Short Term Disability:

- ◯ Ask Human Resources Department for a copy of the short-term disability benefits form
- ◯ Complete the form
- ◯ Ask employer to complete employer section of the form
- ◯ Get medical verification from healthcare provider
- ◯ Submit the form

☐ Long-Term Disability:

- ◯ Read copy of policy to determine:
  - Timelines you are required to meet
  - What information must be submitted to prove claim
  - What "disabled" means for your specific insurance policy
- ◯ Work with Human Resources Department or Insurance company directly to make sure claim is submitted correctly
- ◯ Submit your claim promptly
  - Most claims only give you 60 days after your HD impacts your ability to work
- ◯ Gather all necessary medical records to submit to insurance company

☐ Employer Provided Disability:

- ◯ Read copy of policy to determine:
  - Timelines you are required to meet
  - What information must be submitted to prove claim
  - What "disabled" means for your specific insurance policy
- ◯ Work with Human Resources Department or Insurance company directly to make sure claim is submitted correctly
- ◯ Submit your claim promptly
- ◯ Gather all necessary medical records to submit to insurance company

☐ Social Security Disability:

- Gather information required for claim:
  - Social Security card or number
  - Proof of Age (birthdate or birth certificate)
  - Citizenship or alien status record (birth certificate, naturalization certificate, US passport)
  - Proof of Income
  - Medical Sources
  - Work History
- Decide how to submit application:
  - Online – https://www.ssa.gov/benefits/disability/
  - Over the phone
  - In-person (not an option during COVID Pandemic)
- Complete and submit application
- Follow-up with Social Security regarding status of claim and verify that your medical records have been received
  - Find local Social Security office here: https://secure.ssa.gov/ICON/main.jsp

Health Insurance: Health insurance is essential for the continuation of medical care and for long-term care placement for HD individuals, when the time comes. Private disability insurance usually does not include health insurance and there is a 24 month waiting period for Medicare if you are approved for Social Security Disability Insurance (SSDI), so it is very important to plan for the waiting period and choose another health insurance option.

☐ Health Insurance Options:
- Insurance through spouse
- COBRA
  - Continuation of employer provided insurance at full cost
  - Often very expensive
  - Lasts for 18 months with a possible 11 month extension if approved for SSDI -> covers full Medicare waiting period
- Private insurance
  - www.Healtcare.gov
  - https://www.policygenius.com/
- Medicaid
  - Has been expanded in 39 states so many Americans can now qualify

☐ Health Care Assistance Options:
- Low-income assistance program
  - Most major hospitals and health care systems offer low-income and uninsured financial assistance
- Community health centers
  - https://www.healthcare.gov/community-health-centers/
- Speak with medical providers about financial assistance options

Legal Decision-Making Documents: Legal decision-making documents give someone else, a person you choose, the right or the ability to make decisions for you because you are not able to make the decision. There are many reasons you may not be able to make a decision: out of the country, unconscious, incapacitated due to Huntington's disease or another medical condition.

☐ Power of Attorney (POA):
- Must contain the date of execution
- Must be signed by the individual granting the POA
- Must be signed before a notary public and/or signed by two witnesses (state specific)
- Needs to name the person who you want to act on your behalf as your "agent"
- Needs to define what powers the person will have to act on your behalf, like handling financial and business transactions, which includes buying or selling a house
- https://formswift.com/power-of-attorney
- https://powerofattorney.com/

☐ Healthcare Power of Attorney
- Must contain the date of execution
- Must be signed by the individual granting the POA
- Must be signed before a notary public and/or signed by two witnesses (state specific)

- Needs to name the person who you want to act on your behalf as your “agent”
- Needs to define what medical decisions the “agent” will be able to make on your behalf, for instance where you can get medical treatment, what medications you can take, or if you can get surgery.

☐ Advanced Directive/Living Will

- Choose a medical decision maker
- Decide what matters most in life
- Choose what decisions your medical decision maker is able to make
- Tell Others (physicians, family) about your wishes
- Make sure to speak with your doctors and ask questions
- https://prepareforyourcare.org/welcome

Disability and Legal Preparation for Late-Stage symptomatic HD

Disability: There are many disability options that provide financial protection in the event you have to stop working due to HD: Temporary State Disability, Short-Term Disability, Long-Term disability, Employer Funded Disability, and Social Security Disability. It is very important to figure out what benefits you are eligible for and to follow the application instructions. All of these disability programs require proof of HD in order to be awarded benefits. **If you have reached late-stage HD and have not already applied for disability then your options will likely be limited to only Supplemental Security Income and you will need to meet the strict financial criteria and have less than $2,000 in resource as an individual or $3,000 as a married couple.**

- ☐ Social Security Disability - Supplemental Security Income:
  - Gather information required for claim:
    - Social Security card or number
    - Proof of Age (birthdate or birth certificate)
    - Citizenship or alien status record (birth certificate, naturalization certificate, US passport)
    - Proof of Income
      - Earned income
      - Spouse's income
    - Value of Assets and Resources
      - Checking and Savings accounts
      - Personal property
      - Cars
      - Life insurance policy
      - Retirement account
      - Money set aside for burial expenses (up to $1500)
    - Medical Sources
    - Work History
  - Decide how to submit application:
    - Online – https://www.ssa.gov/benefits/disability/ (not available for all SSI applications)
    - Over the phone
    - In-person (not an option during COVID Pandemic)
  - Complete and submit application

- Follow-up with Social Security regarding status of claim and verify that your medical records have been received
    - Find local Social Security office here: https://secure.ssa.gov/ICON/main.jsp

Health Insurance: Health insurance is essential for the continuation of medical care and for long-term care placement for HD individuals, when the time comes. Most health insurance does not cover long term care costs so it is necessary to plan accordingly for long term care.

☐ Health Insurance Options:

- Insurance through spouse
    - DOES NOT COVER LONG TERM CARE
- Private insurance
    - www.Healtcare.gov
    - https://www.policygenius.com/
    - DOES NOT COVER LONG TERM CARE
- Medicaid
    - Has been expanded in 39 states so many Americans can now qualify
    - States where Medicaid has not expanded will require a finding of disability to be eligible, meaning you must apply for SSI
    - Covers Long Term Care
- Medicare
    - Must be 65+ or you have been found disabled through SSDI
    - DOES NOT COVER LONG TERM CARE

☐ Health Care Assistance Options:

- Low-income assistance program
    - Most major hospitals and health care systems offer low-income and uninsured financial assistance
- Community health centers
    - https://www.healthcare.gov/community-health-centers/
- Speak with medical providers about financial assistance options

Long-Term Care: Long-Term Care (LTC) describes the medical and non-medical care that is provided over an extended period of time to people who have a chronic illness or disability. Individuals with Huntington's disease often need LTC as the disease progresses. LTC also refers to a specific kind of care, which includes nursing homes, skilled nursing facilities, and assisted living facilities. LTC is very costly and it can be very difficult to get placed into a LTC facility if the proper insurance is not in place. What needs to be done prior to placement in Long-term Care?

☐ Financial Planning:

- Assets should be moved out of HD individual's name, including house
    - Help with Medicaid eligibility
    - House can be taken by Medicaid to cover care expenses
- Divorce may be necessary to get essential benefits
- Review LTC payment options
    - Out of pocket

        - Medicaid
        - LTC insurance (not an option after HD diagnosis)
    - Possible loss of financial benefits (SSI, caregiver payments) when individual is moved to LTC
- ☐ Research care facilities
    - What care does the facility provide?
    - How will they manage your loved one?
    - What is the staffing ratio?
    - What do they know about HD?
- ☐ Acknowledge that transition to LTC may be difficult.
    - Be prepared to advocate for your loved one
    - Make sure your loved one's wishes are known
- ☐ Legal Decision-Making Documents need to be in place:
    - Durable Power of Attorney
    - Advanced directive/Living will
        - Medical decision maker/healthcare proxy
        - Outline medical wishes

Legal Decision-Making Documents: Legal decision-making documents give someone else the right or the ability to make decisions for you because you are not able to make the decision. There are many reasons you may not be able to make a decision: out of the country, unconscious, incapacitated due to Huntington's disease or another medical condition. Most legal decision-making documents require that the individual still have mental capacity – the ability to make decisions and care for themself – in order for the legal document to be effective. With HD, you need to put legal documents in place as soon as you start to show symptoms to make sure your legal wishes are followed. Many late-stage HD individuals lack mental capacity so the only available legal option is Guardianship/Conservatorship, which means they will have no say in the process.

- ☐ Power of Attorney (POA):
    - Must contain the date of execution
    - Must be signed by the individual granting the POA
    - Must be signed before a notary public and/or signed by two witnesses (state specific)
    - Needs to name the person who you want to act on your behalf as your "agent"
    - Needs to define what powers the person will have to act on your behalf, like handling financial and business transactions, which includes buying or selling a house
    - https://formswift.com/power-of-attorney
    - https://powerofattorney.com/
- ☐ Healthcare Power of Attorney
    - Must contain the date of execution
    - Must be signed by the individual granting the POA
    - Must be signed before a notary public and/or signed by two witnesses (state specific)
    - Needs to name the person who you want to act on your behalf as your "agent"
    - Needs to define what medical decisions the "agent" will be able to make on your behalf, for instance where you can get medical treatment, what medications you can take, or if you can get surgery.

☐ Advanced Directive/Living Will

- Choose a medical decision maker
- Decide what matters most in life
- Choose what decisions your medical decision maker is able to make
- Tell Others (physicians, family) about your wishes
- Make sure to speak with your doctors and ask questions
- https://prepareforyourcare.org/welcome

☐ Guardianship/Conservatorship

- Request for guardianship must be submitted to your state court
- Fill out the guardianship forms specific to your state
- A doctor will need to complete a medical form, with medical evidence, to support the need for guardianship
- The court will set a hearing to determine if guardianship is necessary
- Court will appoint an attorney to represent the family member with HD
- Judge will decide if request for guardianship is reasonable and necessary

2. Overview of Social Security Disability

This section provides general information about Social Security disability, including information about Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), eligibility criteria, work credits, the disability cycle, the denial process, and resources to start preparing for the application process. This section also includes the Wellness Journal, which was designed to help families track daily HD symptoms and limitations, doctor's appointments, medications and side effects, and other important conversations.

Disability Overview Resources

Disability Chat Webinars:

- Work Credits & How to Qualify for Disability: https://www.youtube.com/watch?v=DpmDhoDhFzw&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=2
- How Social Security Evaluates a Disability Claim and What Evidence You Need: https://www.youtube.com/watch?v=Jd0dw6uUHu0&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=3
- Debunking Disability Myths: https://www.youtube.com/watch?v=1hh-VN53hEA&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=5
- Disability Red Flags: https://www.youtube.com/watch?v=q1ERb837RhI&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=6

Online Resources

- General Social Security Resources
  - Social Security Administration (SSA): https://www.ssa.gov/
  - My Social Security: https://www.ssa.gov/myaccount/
  - Social Security Office Locator: https://secure.ssa.gov/ICON/main.jsp
  - Social Security Hearing Office Locator: https://www.ssa.gov/appeals/ho_locator.html#&vt=3
  - Social Security Disability Facts: https://www.ssa.gov/disabilityfacts/facts.html

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UNDERSTANDING DISABILITY BENEFITS

As defined by the Social Security Act

Commonly used terms and acronyms

Administrative Law Judge (ALJ)

Continuing Disability Review (CDR)

Date Last Insured (DLI)

Disability Determination Services (DDS)

Disabled Adult Child (DAC)

Social Security Administration (SSA, also "Social Security")

Social Security Disability Insurance (SSDI)

Substantial Gainful Activity (SGA)

Supplemental Security Income (SSI)

This publication was made possible by a grant from Adira Foundation.

RESOURCES

Huntington's Disease Society of America
For more resources and tips about applying for disability, please see hdsa.org.

Aunt Bertha
Search auntbertha.com by area for a list of available programs across a wide range of assistance types.

Social Security Administration
(800) 772-1213 | ssa.gov
Office locator: secure.ssa.gov/ICON/main.jsp

Legal Services Corporation
This nonprofit provides grants for legal aid to low-income U.S. residents: lsc.gov.

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Table of Contents

Social Security disability programs

The Social Security Administration (SSA) operates two programs that provide income and health insurance benefits to people who can't work because of a long-term disability. They each have complicated requirements and differences. This booklet offers a basic understanding of those differences—but a broad, simplified overview is a good place to begin:

- Social Security Disability Insurance (SSDI) was created for people who pay Social Security taxes through work.
- Supplement Security Income (SSI) is meant for people who have not worked enough or have low income, and few resources.

In both programs, eligibility guidelines require applicants to meet a strict definition of disability, as determined by federal law. We explain more about that definition in later sections.

But first, take a moment to ensure you understand the difference between the two programs.

Doing so will:

- Help you avoid wasting time and energy applying for a program you may not qualify for.
- Give you an idea of the different types of information and evidence each program will require.

Once you know which best fits your needs you can find more information on the application process and requirements beginning with the section, "How Does SSA Define Disability?"

Think of SSDI like car insurance, but for your wages.

We pay car insurance to help soften the blow of an unexpected car accident expense. When workers pay Social Security taxes, some of it is allocated to SSA as insurance to protect U.S. workers from loss of income because of a disabling condition.

Just like how people who do not pay for car insurance are not covered when they get into a car accident those who do not pay sufficient Social Security taxes will not be eligible for SSDI benefits if they have an accident or disabling condition that prevents them from working.

Think of SSI like an allowance given to people impacted by a disabling condition so they can afford their basic needs.

A comparison: Social Security Disability Insurance vs. Supplemental Security Income

As noted, SSDI and SSI are both federal programs designed to provide people that meet Social Security's definition of "disability" with monthly payments and access to government insurance benefits. Both programs require applicants to meet medical criteria as well as non-medical criteria, primarily work and resource related. As of June 2018, only 11 percent of all individuals receiving Social Security benefits qualified for both programs, so it is important to understand the differences.

The medical criteria, including how SSA evaluates the medical evidence you submit, is the same for both programs, and will be addressed in later sections.

The differences between SSDI and SSI lie in the non-medical criteria. Before we delve into the details, let's review a basic comparison of non-medical criteria for the SSI and SSDI programs.

Are there income limits for eligibility?

SSDI

Yes. SSA only considers the disability applicant's earned income (money from wages or earnings from self-employment).

- Non-blind applicants must not earn more than **$1,220 per month in 2019.**
- Blind applicants must not earn more than **$2,040 per month in 2019.**

Income from other sources, including a spouse's income, are not counted toward the limit.

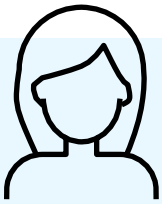
SSI

Yes. SSA considers the disability applicant's earned income.

- Non-blind applicants must not earn more than **$1,220 per month in 2019.**
- Blind applicants must not earn more than **$2,040 per month in 2019.**

SSA also considers unearned income, in-kind income (free or reduced food or shelter), and income from a spouse and other family members.

- What is counted as income for SSI is complicated. We provide some more details about the types of income counted later on but if you believe you may qualify for SSI it is best to contact SSA directly for help.



Sylvia has a chronic condition that has worsened in recent years, leading to her inability to work a full-time job. Her husband still works and receives a salary of $55,000 per year. Sylvia isn't sure she would qualify for SSDI benefits as the household's monthly income is approximately $4,583, much higher than $1,220 per month.

Sylvia has misunderstood the income limits for SSDI eligibility. The only income counted is the money that the applicant themselves is earning from wages or self-employment. Sylvia is the individual applying for SSDI benefits and her income is $0 per month, much lower than the $1,220 monthly limit so she is eligible to apply for SSDI.

Are there resource limits for eligibility?

SSDI
No, there are no resource limits.

SSI
Yes, applicants cannot have resources which exceed
- — **$2,000** for a single person.
- — **$3,000** for a couple.

Tom is no longer able to work due to a disabling condition. Six years ago he loaned a good friend $3,000 to start a business and his friend has just paid him back. Tom has no other resources.

Right now, Tom's resources are more than the allowed amount for a single person to qualify for SSI. Once Tom spends enough of the $3,000 to fall below the $2,000 resource limit he can apply for SSI benefits.

Are there age limits for eligibility?

SSDI
Yes. Individuals can apply beginning at age 18 until full retirement age (usually age 65 or older).

SSI
No, there is no age limit to apply.

If I'm approved ... Are there maximum payment amounts?

SSDI
Yes. Each year Social Security sets a maximum benefit. However the specific amount each individual approved for SSDI will receive is based on their previous earnings and how much they paid through Social Security payroll taxes while working.
- — In 2019 the maximum benefit is **$2,861 per month.**
- — In 2019 the estimated average monthly payment is **$1,234 per month.**

SSI
Yes. Each year Social Security sets a maximum benefit however the specific amount each individual approved for SSI will receive is based on how much other income they already have.
- — In 2019 the maximum benefit for a single person is **$771 per month.**
- — In 2019 the maximum benefit for a couple is **$1,157 per month.**

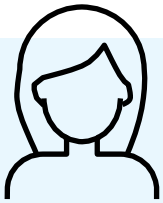
Tom recently applied for SSI. He already receives $250 per month from other income sources.

If Tom is approved for SSI the most he would be eligible to receive is $500 per month. This is because Tom is only eligible to receive the maximum benefit minus other income he is receiving ($771-$250 = $521).

Will I have to wait to start receiving payments?

SSDI
Yes. Payments begin after a five-month waiting period from the date you are deemed disabled by Social Security.

SSI
No. Payments begin the month after approval.



Sylvia was approved for Social Security disability benefits with an onset date of June 14, 2018. Sylvia will not receive her first benefit payment until she has reached the sixth full month of disability. This means the five-month waiting period begins with the first full month after the approved disability onset date.

Onset date: June 14, 2018.

Month one: July; Month two: August; Month three: September; Month four: October; Month five: November.

First benefit payment received: December 2018.

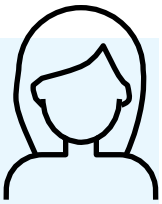
Will I become eligible for government insurance benefits?

SSDI
Yes. Individuals approved for SSDI will become eligible for Medicare insurance benefits the month they receive their 25th benefit payment.

— Because individuals approved for SSDI are also subject to a five month waiting period before payments begin the total waiting period from approval to Medicare benefits is 29 months.

SSI
Maybe. Most individuals approved for SSI will become eligible for Medicaid insurance benefits the month after they are approved.

— Medicaid rules and eligibility vary by state so enrollment may not be automatic. Read more in the section titled "Disability benefits and Medicaid coverage."



Sylvia was deemed disabled as of June 14, 2018. She received her first SSDI benefit payment in December 2018. She will not become eligible for Medicare benefits until the month she receives her 25th payment.

Month one: December 2018; Month two: January 2019; Month three: February; Month four: March etc., until month 25: December 2020.

Sylvia will become eligible for Medicare Dec. 1, 2020.

Will my family also be eligible for financial benefits?

SSDI
Maybe. In some cases children and spouses may be eligible for financial benefits once the applicant is approved.
— In 2019, the average benefit for disabled worker, spouse, and one or more children is **$2,130 per month**.

SSI
No. Benefits are only available to the applicant if approved.

If I am approved, can I receive back payment for the time between when I became disabled and when I submitted my application?

SSDI

— Yes. If Social Security decides the onset date of your disability was in the past you may be eligible to receive a lump-sum back payment.

Jamie applied for Social Security disability benefits. He alleged in his application that his disability began on March 21, 2017.

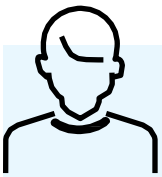
He submitted the application to Social Security in October 2017. Social Security notifies Jamie he has been approved for disability benefits in December 2017. They agree his disability began on March 21, 2017.

Jamie's five-month waiting period consists of April, May, June, July and August 2017. He is entitled to begin receiving benefits as of Sept. 1, 2017.

His lump-sum payment will total the monthly benefits he was eligible for from September to December 2017.

SSI

— No. You are only eligible for benefits from the date your application is submitted moving forward.



Tom submitted an SSI application on Feb. 17, 2018. He alleged in his application that his disability began on Dec. 20, 2017. Social Security notifies Tom that he has been approved for benefits in July 2018 and they agree his disability began on Dec. 20, 2017.

Tom will receive a lump-sum payment for the benefits he is owed from March 2018 (the first month after his application was submitted) to July 2018. Remember, there is no waiting period for SSI.

Detailed requirements: SSDI and SSI

Social Security Disability Insurance

As you now know, SSDI is designed for individuals who have worked while paying into the SSA insurance system. If you qualify, SSA provides monthly cash benefits and Medicare benefits.

Other things to know about SSDI:

- Monthly payment amounts are based on earning history.
- If approved, you will begin receiving monthly cash benefits after five full months from the date of SSA's award notice.
- Those without enough work history to qualify for SSDI may be eligible for SSI.
- Anyone who applies for SSDI can indicate that they also want to be screened for SSI benefits.

Nonmedical requirements

Before Social Security will look at the medical evidence in your claim, you must show that you qualify for SSDI benefits by demonstrating you have worked:

1. Long enough.
2. Recently enough.
3. While paying Social Security taxes (federal payroll tax).
   — Not all jobs pay into Social Security. For example, many teachers pay into a private pension and must contact the private provider to apply for disability.

Social Security quantifies your work with "work credits." You can earn up to four credits each year. You earn them based on your total yearly wages or self-employment income. The amount needed for one credit varies from year to year. In 2019, you earn one credit for each $1,360 of wages or self-employment income. If Tom earns $5,440 in the year 2019, he will earn all four credits for 2019.

The number of work credits you need to qualify for SSDI depends on the age you stopped working as the result of disability. Generally you need 40 credits, 20 of which were earned in the last 10 years ending with the year your disability stopped you from working. Younger workers may qualify with fewer credits.

If your work credits aren't recent enough, you can still qualify for SSDI if your disability began prior to the last time you were insured by Social Security and you can prove that.

IMPORTANT: Your "insured status" affects whether you are eligible for benefits. If at all possible, apply for benefits while your Social Security coverage is in effect. SSA keeps track of whether you are still covered and refers to the date when you will or did lose coverage as your date last insured (DLI). You can request your DLI by calling SSA.

Supplemental Security Income

SSI is a federal financial assistance program that provides monthly payments to those who:

- Are disabled but never worked.
- Do not have enough work credits to qualify for SSDI.
- Or, have low enough SSDI earnings that they also qualify for SSI benefits.

Other things to know about SSDI:

- With little or no income, you could receive up to the federal benefit amount, which generally changes yearly. The SSI benefit amount and state supplemental payment amounts vary based on your income, living arrangements, and other factors. In 2019 the maximum monthly SSI benefit is $771 for an individual and $1,157 for a couple.
- Some states supplement the federal SSI benefit with additional payments.
- If you also qualify for SSDI, SSI payments may be available during the usual five-month waiting period before SSDI case benefits begin.
- SSI benefits begin the month after the application is filed regardless of when the disability started.

Nonmedical requirements

While work history in not an eligibility requirement for SSI, you must:

- Be disabled at any age as determined by SSA, blind, or at least 65 years of age with financial need.
- Meet citizenship requirements.
- Meet the financial requirements for SSI.

Applicants for SSI must meet strict household income and resources criteria. SSI generally requires recipients to have:

1. Financial resources that do not exceed $2,000 for one person and $3,000 for a couple.
2. Income below a certain limit, determined annually.

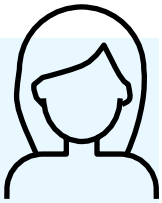
What resources are counted for eligibility?

- Cash and bank accounts (checking, savings, CDs, etc.).
- The value of land and buildings, other than the home in which you reside.
- Personal property valued above $2,000 such as jewelry, household goods, etc.
- Stocks, bonds or other investments.
- Vehicles, other than the one you or someone in your household use for transportation.

What resources are exempt?

SSA does not count the following when considering the value of your resources:

- The home you live in.
- Equipment required due to your physical condition.
- Household goods and property worth less than $2,000.
- One wedding ring and one engagement ring.
- Burial space for you and your family.
- Burial funds for you and your spouse, each valued at $1,500 or less.
- Life insurance policies with a combined face value of $1,500 or less. However, you and your spouse may not have life insurance policies totaling more than $1,500.
- Retroactive SSI or SSDI checks for up to nine months after you receive them.
- One vehicle—if you or someone in your household use it for transportation.
- Property set up in a trust according to certain states' laws, as long as the SSI beneficiary has no direct access to the trust fund.



Gina applies for SSI and SSDI in May 2016 because of a disability that began in January 2016. After a long wait, she is approved for benefits in June 2018. After the five-month waiting period passes, Gina is eligible for past due benefits from June 2016 to June 2018 for both SSI and SSDI. This payment is exempt as a resource for SSI eligibility for up to nine months. If Gina does not spend the back pay within nine months, she may lose her SSI eligibility but she will continue to receive SSDI.

What income is counted?

If your income is over the allowable limit, you cannot collect SSI. This limit is adjusted annually according to the cost of living. You will need to contact Social Security to determine if you are eligible for SSI.

SSI counts several kinds of income:

- Earned income: money received for wages or earnings from self-employment.
- Unearned income: money received from other sources, such as SSDI benefits, unemployment insurance, workers' compensation, interest income, and cash from friends or relatives.
- In-kind support and maintenance: SSA defines this as food or shelter that somebody else provides for you. SSA will not count in-kind support and maintenance if one of the following is true. You:
  - Live alone and pay your own food and shelter.
  - Live only with your spouse and minor children, and nobody outside the household pays for your food or shelter.
  - Live with other people and pay your share of the food and shelter expenses.
- Deemed income: If you live with a spouse, parent or sponsor, then SSA will consider a portion of this person's income to compute your potential SSI benefit amount.

Hopefully by now you have a pretty good idea of which program(s) is best for you. Next, you can learn more about the process SSA uses to determine if you fit their definition of disability as well as the process you will embark on.

How does the SSA define disability?

The five-step disability determination process:

Social Security uses a step-by-step process to determine disability for both SSDI and SSI by establishing the following:

1. Are you working above "Substantial Gainful Activity"?

If you are working and your earnings average more than a certain limit, SSA will not consider you disabled. SSA refers to this threshold as the Substantial Gainful Activity (SGA) limit.

Qualifying substantial work involves performing significant physical or mental activities, or a combination of both. Work activity is gainful if the work is:

- Performed for pay or profit.
- Of a nature generally performed for pay or profit.
- Or, intended for profit whether or not a profit is realized.

SGA is calculated as gross earnings, meaning it is your income before taxes. Federal regulations specify a higher SGA amount for blind individuals. See the table of SGA limits to the right.

Year	Blind	Non-blind
2019	$2,040	$1,220
2018	$1,970	$1,180
2017	$1,950	$1,170
2016	$1,820	$1,130

You can continue working while applying for disability if you are not earning more than the SGA limit. If you are not earning above the applicable earnings limit, **SSA goes to Step 2**.

2. Is your condition "severe"?

You must demonstrate your condition is severe enough to interfere with basic work-related activities for SSA to consider your claim. Your condition must also have lasted or be expected to last 12 months or longer. If you can prove this, **SSA goes to Step 3**.

3. Does your condition meet or equal one of the Listing of Impairments?

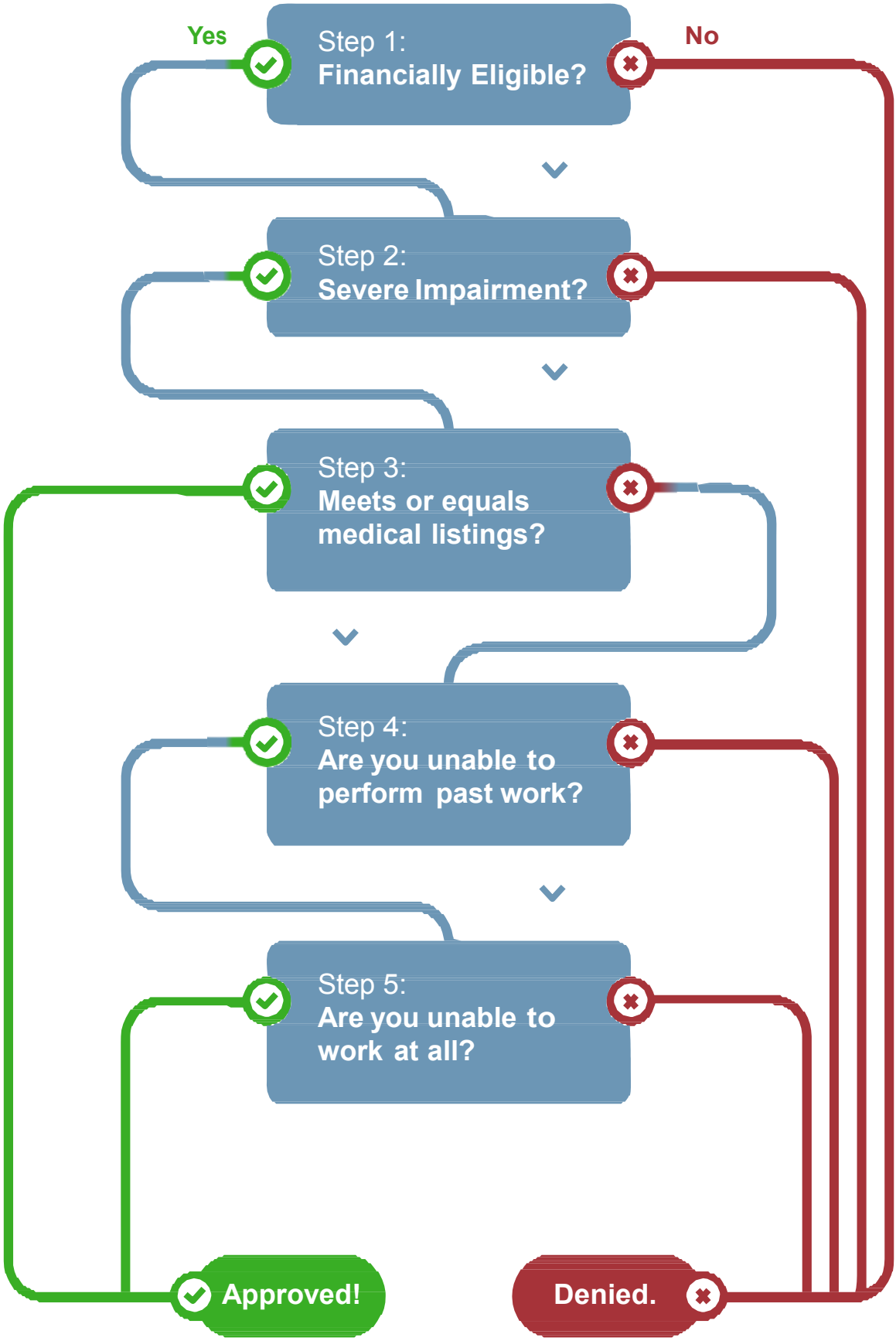
SSA maintains a list of impairments considered severe enough to prevent you from working. The list can be found on SSA's website. If your condition meets or equals the criteria in the listing you will be found disabled. If not, **SSA goes to Step 4**.

4. Can you do your past relevant work?

If your condition is severe but SSA examiners do not find you meet or equal a listing, they must then determine if it interferes with your ability to perform your past relevant work (work done within the last 15 years). If they find it does not interfere with your ability to perform your past relevant work, you are deemed not disabled. If they find it does interfere with your ability to perform your past relevant work, **SSA goes to Step 5**.

5. Can you do any other type of work?

If you are unable to perform your past relevant work, SSA will analyze your ability to adjust to other work or your ability to engage in SGA. SSA considers medical conditions, age, education, past work experience and any transferable skills you may have. If you cannot engage in SGA your claim will be approved. If SSA deems you are able to engage in SGA your claim will be denied.


Yes
Step 1:
Financially Eligible?
No
Step 2:
Severe Impairment?
Step 3:
Meets or equals
medical listings?
Step 4:
Are you unable to
perform past work?
Step 5:
Are you unable to
work at all?
Approved!
Denied.

The application timeline

Once an initial disability application has been submitted, the average wait time for a decision is about six months. In certain circumstances, a disability application could be expedited based on Compassionate Allowance (CAL) or if your condition meets certain criteria.

If your initial disability application is denied, you do have the option to appeal the decision.

The appeals process

Level One – Reconsideration

The reconsideration process occurs when an appeal is made on the initial denial. The Disability Determination Services (DDS) for each state reviews the previously considered information, along with any new information that becomes available. You must file your request for reconsideration within 60 days of receipt of the initial denial. The average time for a decision at reconsideration is four months.

Ten states were part of a prototype program that tested a disability process without the reconsideration stage. The 10 prototype states will begin reinstating the reconsideration process in 2019 and 2020.

The first group of states—California (Los Angeles North and West), Colorado, Louisiana, New Hampshire and New York—reinstated the reconsideration process on Jan. 1, 2019, meaning any initial denial received on or after Jan. 1, 2019 will now go to reconsideration. Previously these appeals proceeded directly to the administrative law judge (ALJ) hearing level.

The remaining states will reinstate reconsideration to their process on the following timeline:

- Pennsylvania will require reconsideration for initial denials issued on or after April 1, 2019.
- Alabama and Michigan will require reconsideration for initial denials issued on or after Oct. 1, 2019.
- Missouri will require reconsideration for initial denials issued on or after Jan. 1, 2020.
- Alaska will require reconsideration for initial denials issued on or after March 1, 2020.

Level Two – Hearing

If you disagree with the reconsideration decision, you may ask for a hearing. An ALJ will conduct a formal hearing where you will have a chance to personally present your claim. The ALJ takes a fresh look at all of the evidence and issues an independent decision based on the merits of the claim.

Currently, hearings are scheduled 18-24 months from the date requested and a decision following the hearing can take an additional two to four months.

While multiple denials and the disability process can be discouraging, the ALJ hearing can be your best chance for approval. It is your opportunity to tell your story about how your disability impacts you. The judge will have the opportunity to review your entire case file, listen to your story, and ask you questions. Approval rates at Hearing:

- Without a lawyer: 46.1 percent.
- With a lawyer: approximately 60 percent.

Level Three — Appeals Council

Appeals Council review most often occurs when the claimant appeals an unfavorable decision by the ALJ. The Appeals Council may take no action on the claim, affirm the ALJ's decision, reverse the ALJ's decision, or remand the case back to the ALJ with specific instruction on how to proceed.

Level Four — Federal Court

If you disagree with the Appeals Council's decision, or if the Appeals Council decides not to review your claim, you may file a lawsuit in a federal court. You may request an appeal all the way up to the United States Supreme Court, which the court decides whether to hear or not hear.

Continuing disability review

SSA will periodically review whether your disability has improved. The length of time before your case is reviewed depends on the severity of your condition and likelihood for improvement:

- The standard length for review is every three years.
- Conditions that are expected to improve will be reviewed every six to 18 months.
- Conditions not expected to improve will be reviewed every five to seven years.

If SSA determines that you are no longer disabled because your condition has improved, your benefits will stop. You can appeal this decision and you can elect to continue receiving benefits while your case is reviewed. You must submit the request to continue benefit payments within 10 days of the notice that your benefits will be stopped; there are no exceptions to this rule.

Social Security also reviews your income, resources, and living arrangement to ensure that nonmedical requirements are met. This periodic review is called a redetermination. If SSA finds that you no longer meet the non-medical requirements, you may be required to pay back any overpayment.

During a review, Social Security will look to confirm that you are still receiving medical treatment for your disabling condition(s).

Tips for applying for disability

Proof from doctors

Medical evidence

According to SSA, your doctor visits, tests, diagnosis and treatment are evidence that your medical condition's severity keeps you from working. Your medical records should support your symptoms. It is important to be honest with your doctors about the types and severity of symptoms you experience, otherwise your medical evidence will not be a true reflection of your day-to-day life living with your disability and this in turn could affect the outcome of your disability application.

Keep good records

Without records you are unlikely to remember the date of every doctor visit, lab test, medicine taken and therapy received. Try to obtain business cards of every doctor you see, save your medication lists, and keep notes of your good days and bad days and other medical events. We also recommend maintaining a diary to keep track of this information.

Evidence from you

Symptoms vs. diagnosis

SSA does not expect you to be an expert on medical conditions. SSA would rather learn about your impairment from your doctors and medical records. What SSA wants to receive from you are details about your symptoms and how your symptoms impact your day-to-day life. For example: How severe is your fatigue, shortness of breath, cognitive impairment, etc.? Is it constant or intermittent? What aggravates your symptoms? What reduces them? No one knows your symptoms better than you. Do your best to explain them in great detail without exaggerating or minimizing.

Do not omit or gloss over any lesser conditions just because you have one severe condition and several minor ones. Again, maintaining a Wellness Journal will help you keep track of these important details and may be very compelling in the SSA's decision.

Physical restrictions

What changes have you made to your life? What limitations/restrictions do you have? What can't you do? Sit for lengthy periods? Stand and walk? Lift and carry? Bend, twist, kneel and stoop? Manipulate objects with your hands? SSA will focus on your limitations rather than your diagnosis. Be specific in your descriptions. For example, say: "I am unable to sit for more than 30 minutes at a time," or "I can wash dishes, but I have to take breaks and sit on a stool while washing the dishes."

Effect of symptoms and restrictions

How does your medical condition affect your daily activities? Tell SSA about the impact on your personal care (hygiene, dressing, bathing), errands and housework (driving, shopping, cleaning), and social functioning (hobbies, sports, interaction with friends and family).

IMPORTANT: Be as honest and accurate as possible with the information you provide to Social Security. Conflicting information or discrepancies, even provided unintentionally, may have a detrimental effect on the validity of your claim.

Children and disability benefits

Disabled child's benefits — SSI only

A disabled child is only eligible for SSI benefits. A child under the age of 18 can qualify for SSI benefits if he or she meets Social Security's definition of disability for children, and his or her income and resources, along with his or her parent's income and resources, fall within the eligibility limits. The income and resource guidelines are adjusted according to the number of parents and other children living in the household.

Once a child turns 18, only his or her income and resources are included for SSI eligibility purposes, even if he or she continues living at home. Note that any person found eligible for SSI benefits under the rules for children will automatically be subject to a review to confirm eligibility under the rules for adults after turning 18.

Criteria

Social Security evaluates a child's condition under a special set of rules for determining disability in children.

If a child's condition is not listed in the children's listing of impairments or is not as medically serious as a listed condition, Social Security can still consider a child with severe limitations disabled. Evaluators will look at all the child's activities, such as playing and attending school, and compare functioning with other children the same age who do not have disabilities.

Important factors in this decision can include the side effects of medications and treatments required by the child's condition and how much help the child needs to function in daily activities compared to other children.

Auxiliary child benefits

Children under age 18, whether disabled or not, may be eligible to draw benefits on a parent's Social Security earnings records if the parent is receiving SSDI benefits. The program does not apply if a parent is only receiving SSI benefits. Children may also be able to receive benefits if their parent is receiving retirement benefits from Social Security, or the parent is deceased and has met the insured status requirements.

Disabled adult children's benefits

A disabled adult child may only be eligible for benefits if an insured parent receives disability or retirement benefits, or if the parent is deceased.

If the child is age 18 or older, unmarried (although marriage to another disabled adult child beneficiary is allowable), and the disability began prior to the age of 22, he or she may also be eligible for benefits.

This benefit may continue for the child's lifetime, as long as the child remains disabled, unmarried, does not engage in substantial gainful activity resulting in benefits stopping, and does not become entitled to a higher benefit amount on another Social Security program. Disabled adult child benefits will result in Medicare eligibility after being entitled to cash benefits for 24 months.

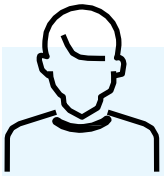
After approval: Benefits and work

Benefits, work and SSDI

Benefits and Medicare

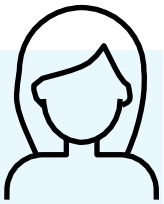
If SSA determines you "disabled" and awards you SSDI benefits (see page 9 for details), your Medicare enrollment will not begin until after you receive 24 qualifying benefit payments. This means you wait a total of 29 months from when SSA determines your disbility began until Medicare coverage begins: the five-month benefit waiting period, plus 24 months of benefit payments.

While every person has the same waiting period for Medicare, it impacts each person differently based on how long SSA takes to review your case. If you are approved at the initial application level, you will likely have to wait 24 months for your Medicare to start. If you are approved at the hearing level, after waiting three years for a favorable decision, your Medicare will start immediately.



Jaime's disability began in March 2017 and he was approved for benefits in December 2017. After the five-month waiting period and the 24 months of benefits payments, his Medicare coverage will begin in September 2019.

Once eligible, SSA automatically enrolls you in Medicare A and B, unless you affirmatively opt out. In addition, all Medicare beneficiaries have the option to purchase additional coverage to pay a portion of their medication costs (Part D plan or Medicare Advantage plan with prescription coverage) or supplement costs left behind by Medicare A and B (Medicare Supplemental plan, also known as Medigap). Carefully review all your options (or seek expert help in choosing coverage) once you become eligible for Medicare—many people need more coverage than A and B alone.



Gina's disability began in January 2016, but SSA does not approve her for benefits until June 2018. Gina is eligible for Medicare immediately because the time it took SSA to make a decision included the 29-month waiting period.

We recommend you sign up for medical or drug coverage when you first become eligible for Medicare. If you wait too long to sign up you may be subject to higher premiums (called a late enrollment penalty) or experience a lapse in coverage while you wait for the next open enrollment period.

If you use Medicare and have limited income and resources, you may qualify for a government assistance program. The Low-Income Subsidy (also called "Extra Help") helps with prescription drug costs. And Medicare Savings Programs help with medical costs, if eligible. You have to apply in person or over the phone at your local SSA office. Find out more at ssa.gov, by calling SSA at 800-772-1213, or by locating your local office number.

How will returning to work affect my benefits?

SSA created special rules to make it possible for you to work and still receive monthly SSDI or SSI payments until you can work on a regular basis. In 2019, you can make up to $880 per month* and continue to receive your disability payments. If you go back to work and earn more than $880 in a month, you could continue to receive your disability benefits if you meet the criteria for the

*Amount updated annually.

Trial Work Period or the Extended Period of Eligibility. You can find more information about these specialty work periods here.

If you are able to go back to work and you do not qualify for the specialty work periods, you will stop receiving disability benefits. But, if you cannot continue working because of your medical condition, you can request expedited reinstatement of your benefits.

Expedited reinstatement allows you to request that your disability benefits start again without having to complete a new application as long as you stopped receiving benefits because of earnings from work. You must make this request within five years of when your benefits stopped. SSA pays provisional benefits for up to six months while they determine if you are still eligible to receive disability benefits under their rules. You can only request expedited reinstatement once.

Work incentives include:

- Continued cash benefits for a time while you work.
- Continued Medicare or Medicaid while you work.
- Help with education, training and rehabilitation to start a new line of work.

Benefits, work and SSI

Disability benefits and Medicaid coverage

Everyone who receives SSI benefits should qualify for Medicaid. Most states automatically enroll you when you are found disabled and awarded SSI benefits (if you don't already have it). But in some states (Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, Utah, and the Northern Mariana Islands), enrollment is not automatic, so you have to file a separate Medicaid application. A few additional states (Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia) have their own Medicaid eligibility criteria that are completely separate from SSI and also require a separate application.

How will returning to work affect my benefits?

SSI payment amounts correlate to how much other income you have. When other income increases, SSI payments typically decrease. If you earn more than the SSI limit, the payments will stop. However, payments will automatically start again for any month that income drops below the SGA limit.

While the rules are different under SSDI and SSI, it is important to let SSA know promptly when you start or stop working.

Notes

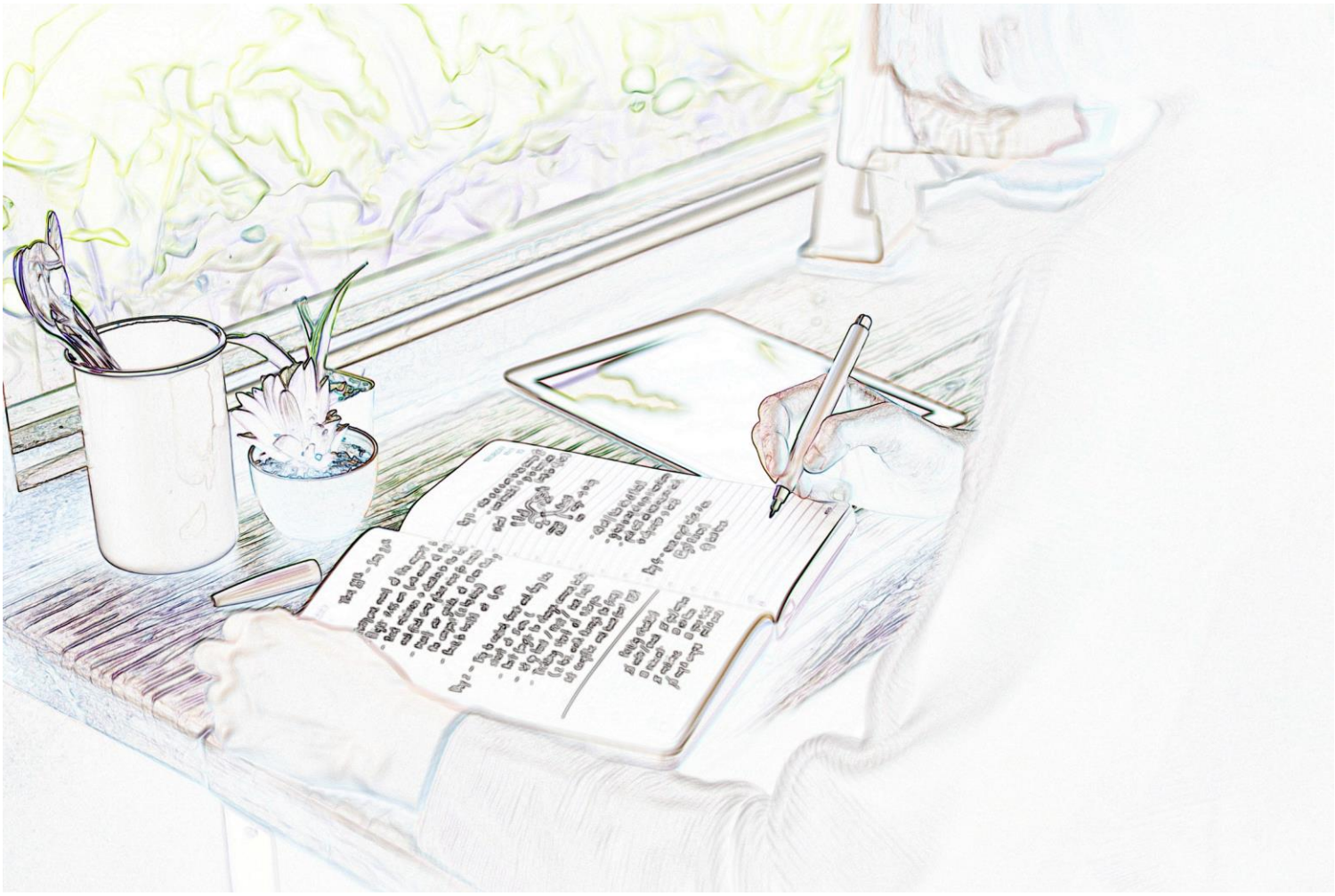
Notes

Notes

Notes

Huntington's Disease Society of America

Wellness Journal



A Useful Tool for the Social Security Disability Application Process

Welcome to your wellness journal, a place to document specific details about your diagnoses, symptoms and treatments. These pages will inform your Social Security disability case—while also helping you and your doctors better understand your condition.

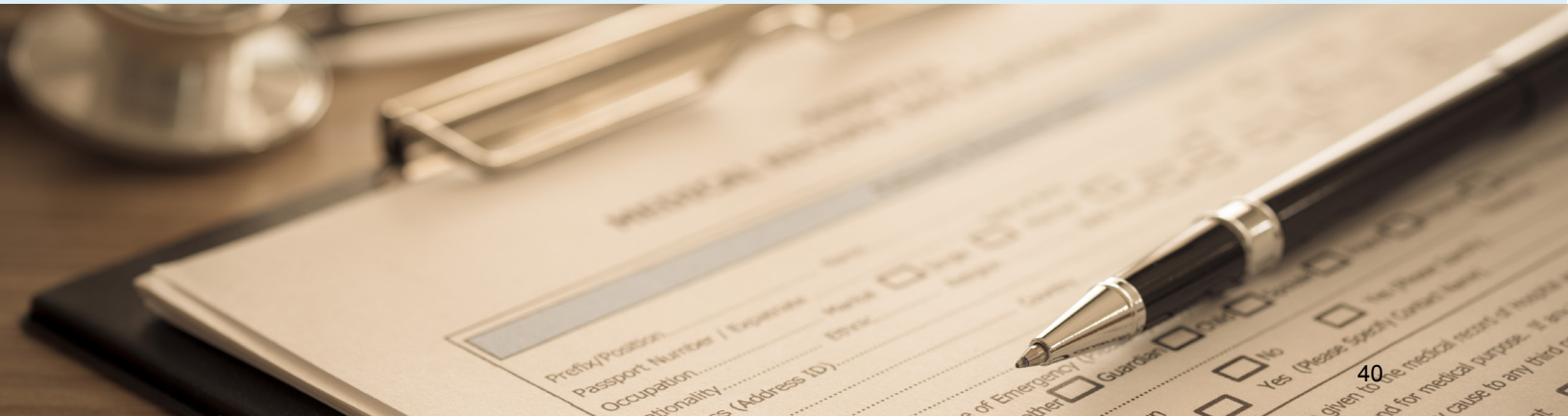
No one remembers all of the details of every appointment or conversation. Keeping records that can be referred back to at a later time is vital. Remember, doctors will not record information in your medical records if you do not honestly share symptoms and limitations with them and other treatment professionals.

Sharing and discussing the details you record here with your doctors and other treating providers is important to the disability application process. Social Security examiners and judges do not know you personally and when weighing your case must rely on information included in your medical records and, if necessary, your testimony.

Having a detailed log of all your experiences leading up to and during your disability application allows both you and Social Security to see a timeline of the symptoms and difficulties you are facing. Your medical records and testimony tell a story, the story of your disabling condition and how it affects you—you want that story to be as accurate as possible.

As you begin using this wellness journal, you might find reviewing the sample journal entries beginning on page 12 useful.

This publication was made possible by a grant from Adira Foundation.



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MEDICATIONS	**DATE:**
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	

MEDICATIONS	**DATE:**
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	

DAILY EXPERIENCES			
Activites of Daily Living (ADLs): ADLs are tasks people need to do everyday for healthy living.			
Symptoms:			Date: Good Day Bad Day
ADL (bathing, dressing, toileting, eating, etc.)	**Y/N**	**_____ Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**_____ Mins**	**Adjustments?**

Symptoms:			Date: Good Day Bad Day
ADL	**Y/N**	**_____ Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**_____ Mins**	**Adjustments?**

DAILY EXPERIENCES			
Activites of Daily Living (ADLs): ADLs are tasks people need to do everyday for healthy living.			
Symptoms:			Date: ¯ Good Day Bad Day
ADL (bathing, dressing, toileting, eating, etc.)	**Y/N**	**_____ Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**_____ Mins**	**Adjustments?**

Symptoms:			Date: Good Day Bad Day
ADL	**Y/N**	**_____ Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**_____ Mins**	**Adjustments?**

DOCTOR APPOINTMENTS	**DATE:**
Doctor:	Time:

Test	Reason	Follow Up?
		Yes, Date:_____ No
		Yes, Date:_____ No
		Yes, Date:_____ No
		Yes, Date:_____ No

Therapy changes (medication, dosage, titration, start/stop)

My To-Do List	Referrals

Questions:	Answers:
_____	1. _____
_____	2. _____
_____	3. _____
_____	4. _____

DOCTOR APPOINTMENTS	**DATE:**
Doctor:	Time:

Test	Reason	Follow Up?
		Yes, Date:_____ No
		Yes, Date:_____ No
		Yes, Date:_____ No
		Yes, Date:_____ No

Therapy changes (medication, dosage, titration, start/stop)

My To-Do List	Referrals

Questions:	Answers:
_____	1. _____
_____	2. _____
_____	3. _____
_____	4. _____

IMPORTANT CONVERSATIONS	**DATE:**
Organization:	Time:
Spoke to: (name, dept., time) 1.	Follow up? Yes Date: No Time:
2.	4.
3.	5.
They contacted me. I contacted them. Reason:	
My next steps: _____ _____ _____	Resources to contact: (name, contact info) 1. _____ 2. _____ 3. _____
Organization:	Time:
Spoke to: (name, dept., time) 1.	Follow up? Yes Date: No Time:
2.	4.
3.	5.
They contacted me. I contacted them. Reason:	
My next steps: _____ _____ _____	Resources to contact: (name, contact info) 1. _____ 2. _____ 3. _____

IMPORTANT CONVERSATIONS	**DATE:**
Organization:	Time:
Spoke to: (name, dept., time) 1.	Follow up? Yes Date: No Time:
2.	4.
3.	5.
They contacted me. I contacted them. Reason:	
My next steps: _____ _____ _____	Resources to contact: (name, contact info) 1. _____ 2. _____ 3. _____
Organization:	Time:
Spoke to: (name, dept., time) 1.	Follow up? Yes Date: No Time:
2.	4.
3.	5.
They contacted me. I contacted them. Reason:	
My next steps: _____ _____ _____	Resources to contact: (name, contact info) 1. _____ 2. _____ 3. _____

APPENDIX A – MEDICATIONS (SAMPLE)	DATE: 3/12/18
Name of medication: Naproxen sodium	
Prescribing doctor: Dr. Arrigoni	Reason taking: High Blood Pressure
Started: 3/12/18	If stopped, date:
Dose/timing/titration:	
Side effects: High blood pressure, Nausea, Dizziness, Headaches	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	

APPENDIX B – DAILY EXPERIENCES (Sample)

Activites of Daily Living (ADLs): ADLs are tasks people need to do everyday for healthy living.

Symptoms: **Severe pain in hands and joints. Shortness of breath. Anxiety**	Date: **5/19/18** ❑ Good Day ☒ Bad Day

ADL (bathing, dressing, toileting, eating, etc.)	**Y/N**	**_____ Mins**	**Adjustments?**
Shower and dress	Y	35	Skipped conditioner Used a shower chair
Made lunch for myself	Y	15	Used pre-prepared food in microwave
Other ADLs (other things you do daily)	**Y/N**	**_____ Mins**	**Adjustments?**
Retrieved Mail	Y	10	Used slip-on shoes because too painful to bend
Made lunch for myself	Y	15	Used pre-prepared food in microwave
Laundry	N		Too painful to carry heavy laundry basket up or down stairs and painful to bend for washer door. Daughter did for me.
Pay Electric Bill	N		Too painful to grasp pen to write

Symptoms:	Date: ❑ Good Day ❑ Bad Day

ADL	**Y/N**	**_____ Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**_____ Mins**	**Adjustments?**

APPENDIX C – DOCTOR APPTS (Sample)

DATE: 7/29/18

Doctor: Dr. Menchuck

Time: 8:00am

Test	Reason	Follow Up?
Chest X-Ray	Checking lungs for blockage/infection	❑ Yes, Date:_____ ☒ No
Echocardiogram	Checking heart valves and vessels	☒ Yes, Date: 11/3/18 ❑ No
Pulmonary Function Test	Checking on how my lungs are working, like how much air they can hold	☒ Yes, Date: 8/27/18 ❑ No
		❑ Yes, Date:_____ ❑ No

Therapy changes (medication, dosage, titration, start/stop)

Prednisone	New prescription, short supply
ProAir	New prescription

My To-Do List

- ☒ Pick up new prescription, short supply
- ❑ Confirm cost and update spending plan to include new prescriptions
- ❑

Referrals

Questions:

- ❑ Is the generic medicine of ProAir the same? The pharmacist mentioned it and said it is less expensive under my insurance
- ❑ How long will I need to stay on these medicines?
- ❑
- ❑

Answers:

1.
2.
3.
4.

APPENDIX D IMPORTANT CONVERSATIONS (Sample)	**DATE:** 10/19/18
Organization: MetLife	Time: 2:20pm
Spoke to: (name, dept., time) 1. Janice, Disability, 2:20pm	Follow up? ☒ Yes ☐ No Date: 10/22/18 Time: 9:00 am
2.	4.
3.	5.
☒ They contacted me. ☐ I contacted them. Reason: Not able to start sending long term disability payments. Missing a form from Dr. Arrigoni. Said I need to apply for Social Security disability.	
My next steps: ☐ Call Dr. Arrigoni's office on Tuesday to ask about the form ☐ Give the fax number and make sure form is sent 'attention' to Janice ☐ Call Caring Voice to see if I can get help with the disability application	Resources to contact: (name, contact info) 1. MetLife, Janice - 800-555-9485 2. 3. Caring Voice, 888-267-1440 (SSDI Help, Free)
Organization:	Time:
Spoke to: (name, dept., time) 1.	Follow up? ☐ Yes ☐ No Date: Time:
2.	4.
3.	5.
☐ They contacted me. ☐ I contacted them. Reason:	
My next steps: ☐ _____ ☐ _____ ☐ _____	Resources to contact: (name, contact info) 1. _____ 2. _____ 3. _____

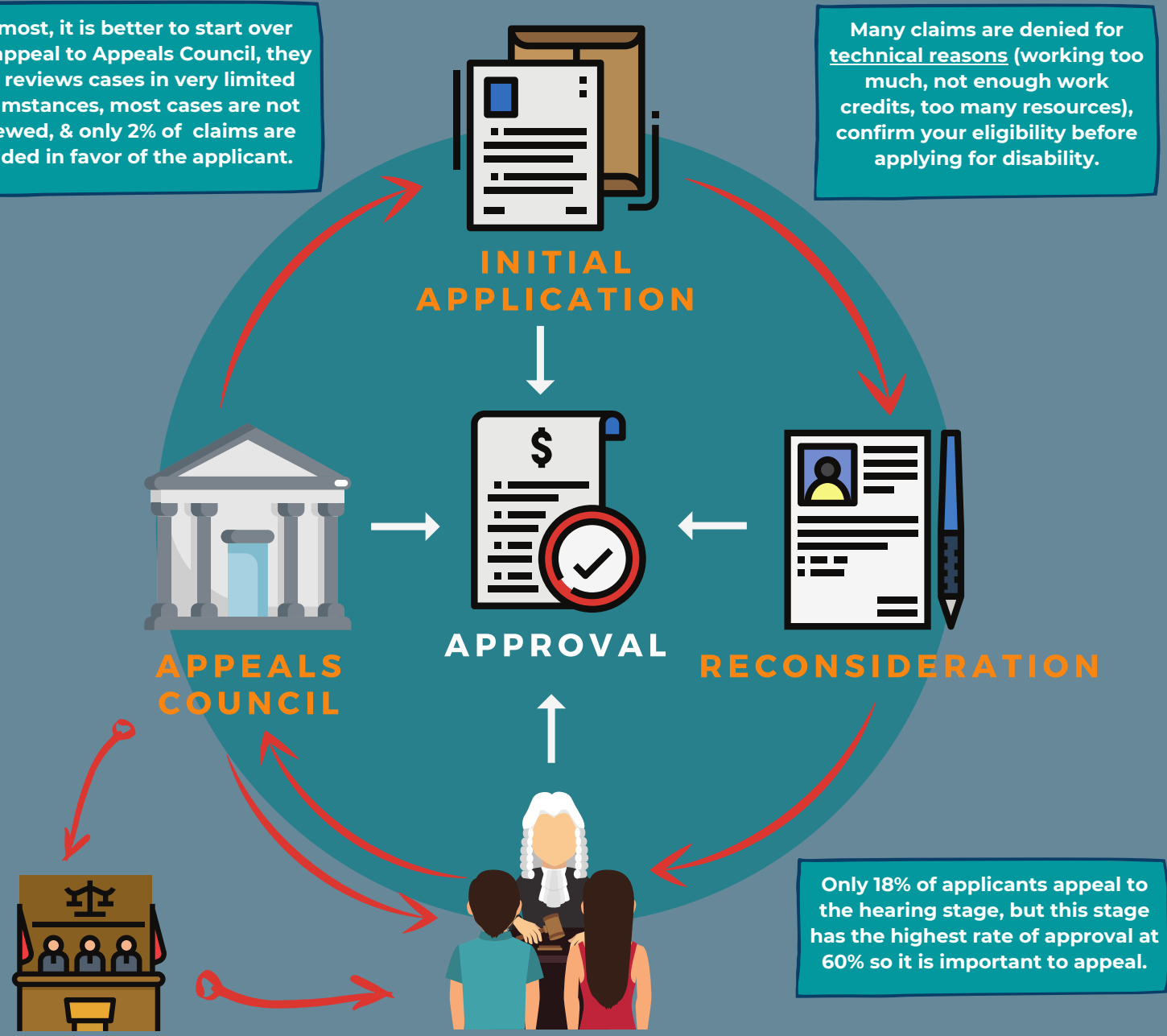
This material is intended for support, informational and educational purposes only and in no way should be taken as the practice of medicine, either health care advice or services. Use of any names, organizations or products in sample forms and materials are for example purposes only and do not reflect an endorsement by or affiliation with Huntington's Disease Society of America or Adira Foundation. You should consult with, and rely only on the advice of, your physician or health care professional.

SOCIAL SECURITY DISABILITY PROCESS

More than 2 million Americans apply for Social Security disability every year. If you are no longer able to work because of a disabling condition, like Huntington's disease, it is important to apply for disability as soon as possible.

For most, it is better to start over than appeal to Appeals Council, they only reviews cases in very limited circumstances, most cases are not reviewed, & only 2% of claims are decided in favor of the applicant.

Many claims are denied for technical reasons (working too much, not enough work credits, too many resources), confirm your eligibility before applying for disability.

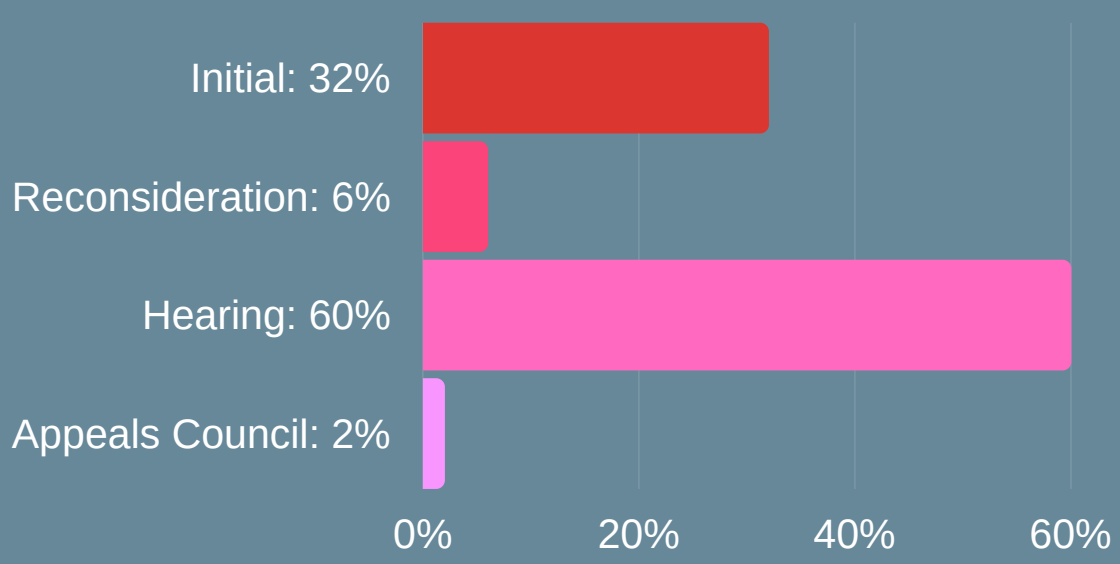


Only 18% of applicants appeal to the hearing stage, but this stage has the highest rate of approval at 60% so it is important to appeal.

Less than 1% of cases appeal to Federal Court, a decision can take years, and cases are sent back to the Administrative hearing for a final decision.

DISABILITY FACTS & FIGURES

- HD is a compassionate allowance condition
- Average monthly benefit is $1200
- Disability claim processing time:
  - Initial: 6 months
  - Reconsideration: 3-4 Months
  - Hearing: 12-24 Months
  - Appeals Council: 12-16 Months
- Approval Rates:



Huntington's Disease Society of America

STAGES OF THE SOCIAL SECURITY DISABILITY DENIAL PROCESS

INITIAL APPLICATION

SSA REVIEWS PAPER APPLICATION
6 MONTHS FOR A DECISION

DISABILITY DENIAL

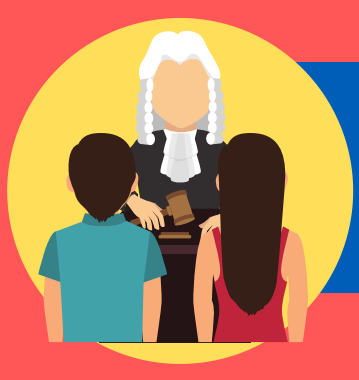
60 DAYS TO APPEAL

RECONSIDERATION APPEAL

SSA REVIEWS APPLICATION FOR ERRORS
3-4 MONTHS FOR A DECISION

DISABILITY DENIAL

60 DAYS TO APPEAL

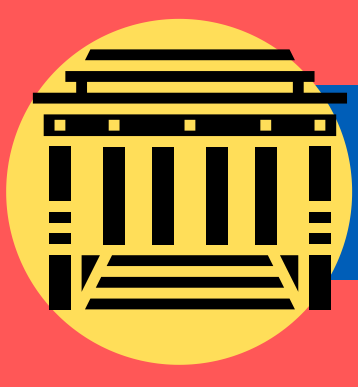


ADMINISTRATIVE LAW HEARING APPEAL

JUDGE HEARS CASE IN PERSON
18-24 MONTHS FOR HEARING

DISABILITY DENIAL

60 DAYS TO APPEAL



APPEALS COUNCIL

COUNCIL REVIEWS JUDGE'S DECISION
12-18 MONTHS FOR DECISION

3. Social Security Publications

This section includes Social Security publications that cover common disability questions, including: earning work credits, disability benefits for non-citizens, receiving disability while living abroad, survivor benefits, and representative payees. The How You Earn (Work) Credits publication is a very important tool for the HD community since lapsed and expired work credits is a common reason for disability denial, and for most HD individuals if their credits have expire they are not going to be able to get Social Security Disability Insurance (SSDI). This is a trend we hope to change through the spread of awareness about work credits.

The publications have not been directly included within this document but links to the publications have been provided because some are 20-40 pages in length.

Social Security Publications

1. How You Earn Credits…… https://www.ssa.gov/pubs/EN-05-10072.pdf
2. How Workers' Compensation Affect Your Benefits… https://www.ssa.gov/pubs/EN-05-10018.pdf
3. Benefits for Children with Disabilities…… https://www.ssa.gov/pubs/EN-05-10026.pdf
4. SSI for Noncitizens…… https://www.ssa.gov/pubs/EN-05-11051.pdf
5. Payments While Outside the United States…… https://www.ssa.gov/pubs/EN-05-10137.pdf
6. Survivors Benefits…… https://www.ssa.gov/pubs/EN-05-10084.pdf
7. A Guide for Representative Payees…… https://www.ssa.gov/pubs/EN-05-10076.pdf

4. Social Security Disability Application Process

This section provides resources and information to help families complete the Social Security disability application. Information in this section includes Social Security's rules for how to find an adult disabled with Huntington's disease, what information is needed for the application, compassionate allowance, how to choose the right disability start date, and how to talk about HD with Social Security. The resources in this section have been specifically designed for HD families to answer common Social Security disability questions. It is essential for social workers, clinic staff, and families to understand the criteria set forth in Social Security Listings 11.17 for Adult Onset Huntington's disease and 12.02 for Neurocognitive disorders in order to give HD individuals the best chance of being approved for Social Security disability.

Social Security Application Resources

Disability Chat Webinars

- Preparing to File a Disability Application and Collecting Medical Records: https://www.youtube.com/watch?v=AumSShWKu3Q&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=4

Online Resources

- Social Security Disability
  - Social Security Starter Kit: https://www.ssa.gov/disability/disability_starter_kits_adult_eng.htm
  - Compassionate Allowance: https://www.ssa.gov/compassionateallowances/

    - Huntington's disease Listing 11.17: https://www.ssa.gov/disability/professionals/bluebook/11.00-Neurological-Adult.htm#11_17
    - Neurocognitive disorders Listing 12.02: https://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm#12_02
    - Online Application: https://www.ssa.gov/benefits/disability/
- Social Security Disability Appeal
    - Online Appeal Application: https://secure.ssa.gov/iApplsRe/start
    - Your Right to Appeal: https://www.ssa.gov/pubs/EN-05-10058.pdf
    - The Appeals Process: https://www.ssa.gov/pubs/EN-05-10041.pdf
- Social Security Approval
    - Social Security Representative Payee: https://www.ssa.gov/payee/
    - What You Need to Know When You Get SSDI: https://www.ssa.gov/pubs/EN-05-10153.pdf
    - What You Need to Know When You Get SSI: https://www.ssa.gov/pubs/EN-05-11011.pdf
    - Reviewing Your Disability: https://www.ssa.gov/pubs/EN-05-10068.pdf

Application Tips for Applying for Social Security Disability Insurance (SSDI) Benefits

1. Make sure you are working below Substantial Gainful Activity (SGA):
   a. 2019: $1,220 per month gross (before taxes)

2. Get your Date Last Insured (DLI)
   a. DLI lets you know how long you have to apply for SSDI and if you are still eligible for benefits
      i. Future date = you are still eligible for benefits
      ii. Past date = seek additional guidance
   b. How to get DLI:
      i. Call your local Social Security Field Office; **Find your local office's phone number and address here:** www.ssa.gov/locator
      ii. Create a *my* Social Security account at https://www.ssa.gov/myaccount/

3. Do not wait to apply – If you think you may be eligible for SSDI, contact the Social Security Administration (SSA) right away!

4. You can complete an application online at https://secure.ssa.gov/iClaim/dib or call your local SSA Field Office (FO) to set up an appointment.
   a. If you make an appointment to apply and you file an application within 60 days of the call, SSA may use the date of your call as your application filing date.

5. Alleging Disability:
   a. **Choosing your onset date** – the date needs to reflect both when you stopped working and when you have medical evidence of your diagnosis.
      i. Examples: Date of first right heart catheterization; Date of initial diagnosis; Date of genetic test result
   b. Combination of Impairments:
      i. Include all of your diagnosis on the application because Social Security is required to evaluate all of your conditions and how they impact you
   c. Listing's to Allege based on your diagnosis can be found at: https://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm
      i. There may not be a specific Listing for your diagnosis so it is okay to choice a Listing that is closely related to your diagnosis - Example: Narcolepsy *equals* Listing 11.02 Epilepsy
      ii. **Possible Listings**:
         1. 11.17 Huntington's disease
            - 11.17A HD with physical symptoms
            - 11.17B HD with cognitive decline
         2. 12.02 Neurocognitive decline
         3. 12.04 Depression
         4. 12.06 Anxiety

6. Requesting Medical Records
    a. Make a list of any medical providers your have seen since you became disabled – not just providers for the specific condition, all providers
    b. Contact your providers to get information on how to request records
        i. Some might be able to send you records directly
        ii. Some will require you to send a request to a third party processor (Ciox, Iron Mountain)
        iii. Some allow you to access your records through online charts/portals
    c. Keep a track of dates when you sent request
        i. Keep copies of your requests
        ii. Follow up on a weekly basis, make sure to keep record of those calls and request turnaround times

7. SSA requires (originals):
    a. Social security card or number
    b. Proof of age (ex: birth certificate)
    c. Citizenship or alien status record (ex: birth certificate, naturalization certificate, U.S. passport, etc.)
    d. Proof of Income
        i. Earned income: payroll stubs, tax return from previous year
        ii. Unearned income: award letters, bank statements, court orders, receipts show how much you receive, how often, and the source of payment
    e. Medical Sources
        i. Medical records, if you have them
            1. It is always better to provide copies of your medical records directly to SSA;
        ii. Medical letters from your doctors;
        iii. Names, addresses, and phone numbers of doctors, and the dates you were treated;
        iv. Names of all medications that you take
    f. Work History:
        i. Job titles;
        ii. Type of business;
        iii. Names of employers;
        iv. Dates worked;
        v. Hours worked per day/week;
        vi. Days worked per week;
        vii. Rate of pay;
        viii. Description of job duties;
        ix. Accommodations provided by employers

8. While awaiting a determination:
    a. See your doctor regularly
    b. Follow-up with Social Security on the status of your case
        i. Local Field Office
        ii. Disability Determination Services
    c. Complete any forms sent to you from SSA in a timely manner and be as detailed and accurate as possible.

*The material enclosed is provided for informational purposes only and does not constitute legal advice. We provide this information as a public service. Transmission of the information is not intended to create, and the receipt does not constitute, an attorney-client relationship between sender and receiver. For additional information, please see www.ssa.gov/benefits/disability.

Evaluating Huntington's Disease under Social Security Regulations

Social Security has medical criteria, called the Listing of Impairments, to determine disability for a number of different conditions, including Huntington's Disease. Understanding these criteria can help create a stronger disability application. The complete Listing of Impairments can be found at https://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm

11.00 – Neurological Disorders*

Listing 11.17: Neurodegenerative disorders of the central nervous system**, such as Huntington 's disease**, Friedreich's ataxia, and spinocerebellar degeneration , characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or
2. Interacting with others (see 11.00G3b(ii)); or
3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or
4. Adapting or managing oneself (see 11.00G3b(iv)).

Understanding the Listing

Physical functioning.

- Examples of this criterion include specific motor abilities, such as independently initiating, sustaining, and completing the following activities: standing up from a seated position, balancing while standing or walking, or using both your upper extremities for fine and gross movements (see 11.00D).
- Physical functioning may also include functions of the body that support motor abilities, such as the abilities to see, breathe, and swallow (see 11.00E and 11.00F). Examples of when your limitation in seeing, breathing, or swallowing may, on its own, rise to a "marked" limitation include: prolonged and uncorrectable double vision causing difficulty with balance; prolonged difficulty breathing requiring the use of a prescribed assistive breathing device, such as a portable continuous positive airway pressure machine; or repeated instances, occurring at least weekly, of aspiration without causing aspiration pneumonia.
- Alternatively, you may have a combination of limitations due to your neurological disorder that together rise to a "marked" limitation in physical functioning. We may also find that you have a "marked" limitation in this area if, for example, your symptoms, such as pain or fatigue (see 11.00T), as documented in your medical record, and caused by your neurological disorder or its

treatment, seriously limit your ability to independently initiate, sustain, and complete these work-related motor functions, or the other physical functions or physiological processes that support those motor functions.

- We may also find you seriously limited in an area if, while you retain some ability to perform the function, you are unable to do so consistently and on a sustained basis. The limitation in your physical functioning must last or be expected to last at least 12 months. These examples illustrate the nature of physical functioning. We do not require documentation of all of the examples.

Mental functioning.

1. Understanding, remembering, or applying information. This area of mental functioning refers to the abilities to learn, recall, and use information to perform work activities. Examples include: understanding and learning terms, instructions, procedures; following one- or two-step oral instructions to carry out a task; describing work activity to someone else; asking and answering questions and providing explanations; recognizing a mistake and correcting it; identifying and solving problems; sequencing multi-step activities; and using reason and judgment to make work-related decisions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

2. Interacting with others. This area of mental functioning refers to the abilities to relate to and work with supervisors, co-workers, and the public. Examples include: cooperating with others; asking for help when needed; handling conflicts with others; stating your own point of view; initiating or sustaining conversation; understanding and responding to social cues (physical, verbal, emotional); responding to requests, suggestions, criticism, correction, and challenges; and keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

3. Concentrating, persisting, or maintaining pace. This area of mental functioning refers to the abilities to focus attention on work activities and to stay on-task at a sustained rate. Examples include: initiating and performing a task that you understand and know how to do; working at an appropriate and consistent pace; completing tasks in a timely manner; ignoring or avoiding distractions while working; changing activities or work settings without being disruptive; working close to or with others without interrupting or distracting them; sustaining an ordinary routine and regular attendance at work; and working a full day without needing more than the allotted number or length of rest periods during the day. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

4. Adapting or managing oneself. This area of mental functioning refers to the abilities to regulate emotions, control behavior, and maintain well-being in a work setting. Examples include: responding to demands; adapting to changes; managing your psychologically based symptoms; distinguishing between acceptable and unacceptable work performance; setting realistic goals; making plans for yourself independently of others; maintaining personal hygiene and attire appropriate to a work setting; and being aware of normal hazards and taking appropriate precautions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

Huntington's Disease Society of America

COMPASSIONATE ALLOWANCE INFORMATION

DI 23022.923 Adult Onset Huntington Disease

Compassionate Allowance is a way to quickly identify diseases and other medical conditions that, by definition, meet Social Security's standards for disability benefits. The CAL initiative helps Social Security reduce waiting time to reach a disability determination for individuals with the most serious disabilities.

When completing a disability application for HD, always request compassionate allowance: ***Please flag my claim for CAL processing per DI 23022.923 because I have Huntington's Disease.***

ADULT ONSET HUNTINGTON DISEASE	
ALTERNATE NAMES	Huntington's chorea; Huntington's Disease
DESCRIPTION	**Huntington disease (HD)** is a hereditary neurodegenerative disorder that is characterized by progressively worsening motor, cognitive, behavioral, and psychiatric symptoms. HD is caused by a mutation of the Huntington gene called a "CAG repeat expansion". The mutation results in gradual neuronal degeneration in the basal ganglia of the brain, and progresses to involve other regions of the brain responsible for coordination of movements, thoughts, and emotions. Neuronal degeneration causes diffuse and severe brain atrophy that is comparable to late stage Alzheimer disease. Clinical presentation of HD may include changes in personality, behavior, cognition, speech, and coordination. Physical changes include random uncoordinated extremity movements (chorea), rigidity, leg stiffness, clumsiness, slowness of movement, tremors and muscle spasms. As the disease progresses, concentration on cognitive tasks becomes increasingly difficult, and an individual may have difficulty swallowing and feeding himself. Family history of HD is usually but not always positive.
DIAGNOSTIC TESTING, PHYSICAL FINDINGS, AND ICD-9-CM CODING	The diagnosis of HD is made by clinical history documenting changes in motor, behavioral and cognitive function; family history of HD; abnormal neurologic exam findings; abnormal neuropsychological test results; and HD gene test with abnormal results (40 or more CAG repeats). Brain imaging is optional, but if performed may show atrophy of the caudate nucleus or diffuse brain atrophy. ICD-9 code: 333.4

ONSET AND PROGRESSION	The average onset age is around 40, plus or minus 10 years; however, onset has been documented as young as age 5 (see Juvenile HD) and as old as age 90. Death usually occurs at about 15 to 20 years after onset of symptoms, and is due to complications of the disease.
TREATMENT	There is no cure or treatment to stop, slow or reverse the progression of HD. Claimant's medical source(s) may prescribe medications to manage symptoms. A psychiatrist or behavior management specialist may address behavior disorders. A speech language pathologist may evaluate communication and swallowing problems. A nutritionist may be consulted to address nutritional needs as the disease progresses. Assistive devices such as wheelchairs, helmets, and communication boards may be used for safety, and to improve quality of life.

SUGGESTED PROGRAMMATIC ASSESSMENT*

Suggested MER for evaluation:

- Claimant's medical source(s) records documenting progression of motor, cognitive, and psychiatric symptoms and signs; family history of HD; and abnormal neurological exam findings consistent with HD.
- Laboratory testing showing a CAG repeat in the HD gene (40 or more CAG repeats).
- Brain imaging may provide supporting evidence.
- Psychological or psychiatric reports including neurocognitive testing.

Suggested Listings for Evaluation:

DETERMINATION	LISTING	REMARKS
Meets Listing	11.17 or 12.02	Listing level neurological and/or cognitive findings must be documented; **diagnosis of HD or laboratory testing results alone do not meet listing severity.**

* Adjudicators may, at their discretion, use the Medical Evidence of Record or Listings suggested to evaluate the claim. However, the decision to allow or deny the claim rests with the adjudicator.

To Link to this section - Use this URL: http://policy.ssa.gov/poms.nsf/lnx/0423022923

Huntington's Disease Society of America

Social Security Disability:
How to Choose your Disability Onset Date

What is the disability onset date?

The disability onset date is the date that your disability became severe enough that you could no longer work.

Why do I need to choose an onset date?

Everyone who submits a Social Security Disability Insurance (SSDI) application or Supplemental Security Income (SSI) application has to choose an onset date.

Social Security does not use the phrase "onset date" but asks: What is the date you became disabled?

Why is the onset date important?

The onset date is incredibly important because that is the date Social Security uses to determine if you were actually disabled. All of the medical records, work history, and supplemental evidence you submit with your claim have to support your chosen onset date. Choosing the wrong onset date could have very negative consequences for your application and could result in a denial.

How do I choose my disability on-set date?

Your disability onset date should reflect when you stop working AND when you have medical evidence to support your claim.

Social Security will tell you that your onset date is when you stop working, but this is not accurate. If you have no medical proof of the symptoms and limitations you experience from your Adult Onset Huntington's Disease (HD), you WILL NOT be found disabled.

What kind of medical evidence will support my claim?

You need medical evidence that includes symptoms and limitations related to Adult Onset Huntington's disease, which can be physical, cognitive, or behavioral. Medical evidence can come from any kind of medical provider – neurologist, psychiatrist, physical therapist, primary care physician, nurse practitioner, psychologist – as long as the evidence includes HD related symptoms. You do not need a gene test to apply for Social Security disability.

Elizabeth:

Elizabeth has a history of HD in her family and she tested positive for the HD gene in 2015. Elizabeth was not symptomatic at the time of her gene test results so she continued working as an accountant and she started treatment with a neurologist at an HDSA Center of Excellence in 2015. Elizabeth continued to see her neurologist at least once a year while she continued working. In 2019, Elizabeth began to have trouble working, she was not able to get to work on time, she struggled with deadlines and multi-tasking, she began making errors at work, and she started having difficulty working with others. In 2020, Elizabeth and her neurologist decided it was time for Elizabeth to stop working due to her HD symptoms and apply for disability. Elizabeth stopped working on March 27, 2020 and has started a Social Security disability application. **What should Elizabeth choose as her onset date?** _____

Elizabeth should choose March 28, 2020 as her onset date because it reflects both when she stopped working and when she has supporting medical evidence. Elizabeth has been getting specialized care for her HD for 5 years so she can choose the date she stopped working as her on-set date.

Tom:

Tom has a history of HD in his family, but he decided that he did not want to get genetic testing and he has not been getting medical care of any kind. Tom stopped working in October 2016 because he was no longer able to keep a job, no matter how hard he tried. Tom finally went to a neurology appointment on July 29, 2019, and was clinically diagnosed with stage II HD based on his family history and presentation of symptoms. He had a follow-up appointment on January 15, 2020. The neurologist recommended that Tom apply for disability due to the symptoms and limitations he was experiencing from HD. **Tom has started a Social Security disability application, what date should he choose as his onset date?** _____

Tom should choose July 29, 2019 as his onset date because it reflects the existence of supporting medical evidence and it is after he has stopped working due to his HD symptoms and limitations. If Tom chose October 2016 for his onset date he would get denied because he does not have *any* medical evidence at that time.

Choose your Disability Onset Date

Date you stopped working: _____

Date you first started getting medical care for HD: _____

Disability Onset date = the later of the two dates

Your Disability Onset Date:_____

Describing HD in a Social Security Disability Application

Huntington's disease is a rare condition that is not well-known or understood, especially by Social Security. It is important to include information about what Huntington's disease is and how it impacts a person when submitting a Social Security Disability application. When working with Social Security it is best to provide as much information as possible.

The samples provided below will help you describe HD to Social Security and complete your disability application.

Describing HD:

Huntington's disease is like Alzheimer's and Parkinson's disease combined.

Sample HD Background information:

Huntington's disease is a progressive genetic disorder that breaks down the nerve cells in a person's brain, causing their mental and physical abilities to deteriorate. HD is known as a quintessential family disease because it is inherited in an autosomal dominant fashion, meaning that every person with HD has a parent that is affected by the disease, and every child has a 50% chance of inheriting the defective gene from that parent. All individuals who have inherited the faulty gene will become symptomatic during their life, typically between the ages of 30 and 50 (during prime working age). Symptoms such as involuntary movement and twitching (chorea), personality changes, impaired mental capacity, mood swings, slurred speech, and impaired gait and balance worsen over a 10 to 25 year period, before HD patients succumb to the disease or a related complication like pneumonia or heart failure. Persons at-risk for HD can obtain a genetic test that will conclude if they carry the genetic marker for the disease, but many individuals choose not to receive genetic testing due to the devastating prognosis. There is currently no cure or treatment to halt the progression of HD. The disease remains a fatal diagnosis for the 30,000 symptomatic Americans, and the 200,000 more that are genetically at-risk for developing symptoms.

Sample Remarks Section (to be used as a guide):

Please note my earnings from 2017 are an estimate. I should be deemed disabled per Adult Listing 11.17 for Huntington's disease (HD). HD is a neurocognitive degenerative disorder that impacts my ability to walk, talk, and reason. My symptoms of chorea, involuntary movements, trouble walking, weight loss, sadness, depression, lack of motivation, difficulty sleeping, memory loss, and intellectual decline prevent me from maintaining substantial gainful activity (only include the symptoms you actually experience). Please flag my claim for CAL processing per DI 23022.923 as HD is a terminal illness.*

*Please note this is a sample and should not be input into a disability application without relevant changes. All of the information included in a disability claim needs to reflect **YOUR** personal symptoms, limitations, and circumstances.

Huntington's Disease

Questions to Help Determine Symptoms and Limitations

Cognitive Symptoms

1. When did you start experiencing symptoms of HD (even if you did not know they were HD related)?
2. What are your main symptoms of HD?
3. Do you have difficulty learning new things?
4. Are you able to read?
    a. What kinds of things do you read?
    b. How often do you read?
    c. Do you think you would be able to read an entire novel, like a 200 page book?
    d. Would you be able to listen to a book on tape?
5. Do you have problems with memory?
    a. What is worse, short term or long term?
    b. What kinds of problems have you experienced with your memory?
    c. If you had multiple appointments in a given week would you be able to keep track of where you needed to be and when?
    d. How do you keep track of places you need to be and things you need to do?
    e. Does someone specific remind you, do you use a calendar?
    f. What kinds of things do you need to be reminded to do?
6. How long can you concentrate at one time?
    a. 30 minutes? 60 minutes? 2 hours?
7. Do you have trouble with motivation?
8. Do you have difficulty following instructions?
9. Are you able to finish what you started?
    a. If you started a puzzle, would you be able to finish it?
10. Have you shown any signs of change in personality or mood?
    a. Example?
    b. Did you change from an outgoing person to a quiet person?
    c. Do you any trouble with impulsivity?
11. Are you able to go out by yourself?
12. Would you be able to work at a job with people?
13. Anywhere you go on a regular basis?

Physical Symptoms

1. When did you first start experiencing involuntary movements/chorea?
2. In what parts of your body do you experience chorea?
3. Describe your chorea/involuntary movements.
4. How is your balance and coordination?
    a. Do you have any difficulties with stairs?
    b. Do you have any difficulty walking?
    c. Do you trip or fall? How often?
    d. Are there specific things that trigger a fall?
    e. Do you use an assistive device?
    f. Has a doctor recommended an assistive device?
5. Does anything make it better? Worse?
6. Are you taking medication for your chorea?
7. Does the chorea in your hands and arms give you difficulty?
    a. Do you drop things?
    b. How often do you drop things?
    c. What kinds of things do you drop?
    d. Do you have trouble holding a knife and fork?
8. How long have you had trouble using your hands?
    a. Are you able to tie tennis shoes?
    b. Are you able to shave?
    c. Are you able to write? Is your handwriting legible?
    d. Do you think you would be able to write someone a letter?
9. Have you ever injured yourself because of your chorea?
    a. Example?
10. Has your chorea impacted your ability to work?
11. Do you have any issues with choking?
    a. Is there any food that you choke on or have difficulty eating?

Activities of Daily Living

1. Do you need help with personal care?
2. What help do you need with personal care?
    a. Do you have trouble getting dressed?
    b. Do you need to sit down to put on pants?
    c. Do you need help with buttons or zippers?
    d. Do you need a shower stool or shower bar?
3. What chores are you able to complete now, without assistance?
    a. Do you need help or reminders when completing chores?
    b. Do you need to take breaks when completing chores?
    c. Do you forget steps when completing chores?
    d. How many chores can you complete in a day?
4. Are you able to cook for yourself?
    a. What do you cook for yourself?
    b. Do you prepare meals from scratch or do you prepare frozen/pre-made meals?
    c. Any snacks you prepare for yourself?
    d. Do you use the microwave?
    e. Do you use the stove or oven?
    f. Could you follow a recipe from start to finish?
5. Have your hobbies changed because of your HD?
    a. What has changed?
    b. What are your hobbies now?
6. Do you have good days and bad days?
    a. Describe a good day.
    b. Describe a bad day.
    c. How many bad days do you have a month?

What You Should Know Before You Apply for Social Security Disability Benefits

We sent you this disability starter kit because you requested an appointment to file for disability benefits. The enclosed letter has the date, time, and location of your appointment.

The following are answers to questions most people ask about when applying for disability benefits. Knowing the answers to these questions will help you understand the process.

★ What can I expect during the appointment?

A Social Security representative will interview you and complete an application for disability benefits and an Adult Disability Report. The interview will take place either in your local Social Security office or by telephone. It will take at least 1 hour.

★ What can I do to speed up the process?

You can cut your interview time in half by starting the process online. You can complete online, BOTH the **application for benefits** and the **disability report** by going to:

www.socialsecurity.gov/applyfordisability.

You still need to **keep your scheduled appointment** with the local Social Security office, so a representative can review your information.

If you cannot do business with us online, you can complete the enclosed Medical and Job Worksheet and have it ready for your appointment.

You can also speed things up by bringing to your office appointment the information listed on the enclosed checklist. If you have an appointment by telephone, the representative may ask you to provide any required checklist items.

★ How does Social Security decide if I am disabled?

By law, Social Security has a very strict definition of disability. To be found disabled:

- You must be unable to do any substantial work because of your medical condition(s); **and**
- Your medical condition(s) must have lasted, or be expected to last, at least 1 year, or be expected to result in your death.

★ My doctor says I am disabled. Is that enough to qualify me for disability benefits?

No. You cannot get disability benefits solely because your doctor says you are disabled.

(over)

★ I am getting disability payments from my job or another agency. Can I automatically get Social Security disability benefits?

No. Social Security disability laws are different from most other programs. For example, Social Security does not pay benefits for partial disability.

★ How long does it take to make a decision?

Generally, it takes about 3 to 5 months to get a decision. However, the exact time depends on how long it takes to get your medical records and any other evidence needed to make a decision.

★ How does Social Security make the decision?

We send your application to a state agency that makes disability decisions. The state has medical and vocational experts who will contact your doctors and other places where you received treatment to get your medical records.

The state agency may send you forms to complete or ask you to have an examination or medical test. If the state does request an examination, **make sure you keep the appointment.** You will not have to pay for any examination or test you are sent for, by the state agency.

★ If Social Security decides that I am disabled, what types of benefits can I receive?

Social Security pays disability benefits under two programs:

- Social Security Disability Insurance (SSDI) for insured workers, their disabled surviving spouses, and children (disabled before age 22) of disabled, retired, or deceased workers.
- Supplemental Security Income (SSI) for people with little or no income and resources.

★ Will my personal information be kept safe?

Yes. Social Security protects the privacy of each individual we serve. As a Federal agency, we are required by the Privacy Act of 1974 (5 U.S.C. 522a) to protect the information we get from you.

★ What if I am more comfortable speaking in a language other than English?

You are encouraged to bring a friend or relative to translate for you. We provide free interpreter services to help you conduct your Social Security business. However, we need advanced notice to make arrangements with the translator.

★ Where can I get more information?

You can visit our website at ***www.socialsecurity.gov***, ask the interviewer during your appointment, or call us toll-free at **1-800-772-1213** (for the deaf or hard of hearing, call TTY 1-800-325-0778).

Checklist – Adult Disability Interview

We encourage you to begin the application process online.

Visit ***www.socialsecurity.gov/applyfordisability*** to get started!

Use this **Checklist** to get ready for your appointment or when filing online. We need your personal and income information to complete the interview to determine if you are eligible for disability benefits. Keep your appointment even if you do not have all of the information. We will help you get any missing information.

☑ **Check off the applicable items below as you get them together for your interview.**

- ☐ **Medical records already in your possession.** (We will help you get the rest of your medical records. Please bring whatever medical records you have to the interview).
- ☐ Workers' compensation information, including the settlement agreement, date of injury, claim number, and proof of other disability awarded payment amounts.
- ☐ Names and dates of birth of your minor children and your spouse.
- ☐ Dates of marriages and divorces.
- ☐ Checking or savings account number, including the bank's 9-digit routing number, if you want Direct Deposit for your benefit checks.
- ☐ Name, address, and phone number of a person we can contact if we are unable to get in touch with you.
- ☐ If a medical release Form SSA-827 (Authorization to Disclose Information to the Social Security Administration) was included with this package, please **complete** (sign and date with witness signature) **and** return it as directed.
- ☐ If unable to file online, **complete** the "Medical and Job Worksheet – Adult" and **bring** to your interview.

Bring the Checklist items and information to your appointment or have them with you if your appointment is by telephone.

Do not delay filing your application, even if you do not have all of the information.

MEDICAL AND JOB WORKSHEET - ADULT

Please do **not** mail this worksheet to your local office.
Did you know that you can start the application process online?
Visit ***www.socialsecurity.gov/applyfordisability*** for more information!
Complete this worksheet to get ready for the appointment or when filing online. This worksheet is not the application for Social Security disability benefits. You should bring this worksheet to your appointment or have it with you if your appointment is by telephone.

A. Medical Conditions

List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

CONDITIONS	
1.	
2.	
3.	
4.	
5.	

B. If you are not working, when did you stop working?

C. Height without shoes:_____feet_____inches **Weight without shoes:**_____pounds

D. Medical Sources

Please list any doctors, hospitals, clinics, therapists, or emergency rooms you have visited because of your conditions.

NAME	ADDRESS	PHONE NUMBER (with area code)	DATE FIRST SEEN OR ADMISSION DATE	DATE LAST SEEN OR DISCHARGE DATE

E. Medicines

Please list any medicines you take and why you take them. If prescribed, please provide the doctor's name.

NAME OF MEDICINE	WHY YOU TAKE IT	PRESCRIBED BY

F. Medical Tests

Please list any medical tests you had or are going to have in the future.

NAME OF TEST	PROVIDER WHO SENT YOU	DATE(S)

G. Job History

List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

JOB TITLE (*e.g., cook*)	TYPE OF BUSINESS (*e.g., restaurant*)	DATES WORKED		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY	
		FROM Mo/Yr	TO Mo/Yr			Amount	Frequency

Bring this worksheet to your appointment or have it with you if your appointment is by telephone. Do not delay filing your application, even if you do not have all of the information. We will help you get any missing information.

5. Social Security Forms

This section includes Social Security disability forms that are commonly used/received during the Social Security application process, including paper copies of the disability application, which consists of the Application for Disability Insurance Benefits AND the Adult Disability Report. I DO NOT recommend submitting a paper application; the forms have been included in this section to serve as a resource for the types of questions that Social Security will ask. The paper application forms are not the most effective method to apply for disability, are confusing, and do not provide enough space for all of the information needed in the application.

The Appointment of Representative form allows a friend or family member to represent the HD individual in their disability claim, giving Social Security the legal authority to speak to the representative, send them important documentation, and be actively involved in the disability process. Without the Appointment of Representative form, no one has legal rights to information or updates about the disability claim other than the HD individual who has applied for disability, which can be an issue if the HD individual is fairly progressed. The Work Activity Report – Self-Employment and Work Activity Report is sent out to anyone who is working while applying for disability. Social Security sends the Adult Function Report to EVERYONE when their claim is sent to Disability Determination Services, sometimes an Adult Function Report – Third Party is sent to a friend or family member. Lastly, the Work History Report is generally sent to anyone over the age of 40.

Social Security Forms

Disability Chat Webinars

- Completing Disability Forms: https://www.youtube.com/watch?v=-ZJpk7iTGOI&list=PLLQmMRDsNEY1R6kYm2Q7xKuBJYb1pEjz0&index=8

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

Part 1 - Claimant's Appointment of Representation

I appoint this individual, _____

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) ☐ Title VIII (SVB)

This individual 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 principal representative is:

Name of Principal Representative

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

Part 2 - Representative's 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 3 satisfies this requirement.)

Check one: ☐ I am an attorney ☐ I am a non-attorney eligible for direct payment under SSA law.
☒ I am a non-attorney not eligible for direct payment.

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

I am now or have previously 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 3 - Fee Arrangement

(Select an option, sign and date this section.)

☐ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits - I do not qualify for or do not request direct payment. (*SSA must authorize the fee unless a regulatory exception applies.*)

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** - By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). (*SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.*)

☒ **I am waiving fees from any source** - I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

File Copy

APPLICATION FOR DISABILITY INSURANCE BENEFITS

(Do not write in this space)

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.

1.	**PRINT your name**	FIRST NAME, MIDDLE INITIAL, LAST NAME
2.	Enter your Social Security Number	
3.	Check (X) whether you are	☐ Female ☐ Male

Answer question 4 if English is not your preferred language. Otherwise, go to item 5.

4.	Enter the language you prefer to: speak	write
5.	(a) Enter your date of birth	
	(b) Enter name of city and state or foreign country where you were born.	
	(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
6.	(a) Are you a U.S. citizen?	☐ Yes (If "Yes," go to item 7) ☐ No (If "No," answer (b))
	(b) Are you an alien lawfully present in the U.S.?	☐ Yes (If "Yes," answer (c)) ☐ No (If "No," go to item 7)
	(c) When were you lawfully admitted to the U.S.?	
7.	(a) Enter your name at birth if different from item (1)	
	(b) Have you used any other names?	☐ Yes (If "Yes," answer (c)) ☐ No (If "No," go to item 8)
	(c) Other name(s) used.	
8.	(a) Have you used any other Social Security number(s)?	☐ Yes (If "Yes," answer (b)) ☐ No (If "No" go to item 9)
	(b) Enter Social Security number(s) used.	
9.	When do you believe your condition(s) became severe enough to keep you from working (even if you have never worked)?	
10.	(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 to item 11)
	(b) Enter name of person on whose Social Security record you filed the other application.	
	(c) Enter Social Security Number of person named in (b). *If unknown, check this block.* ☐ Unknown	

11.	(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 to item 12)
	(b) Enter dates of service	FROM: (Month, Year)	TO: (Month, Year)
	(c) Have you ever been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (Include Veteran's Administration benefits only if you waived military retirement pay.)	☐ Yes	☐ No
12.	Did you or your spouse (or prior spouse) work in the railroad industry for 5 years or more?	☐ Yes	☐ No
13.	(a) Do you have Social Security credits (for example, based on work or residence) under another country's Social Security System?	☐ Yes (If "Yes," answer (b))	☐ No (If "No," go to item 14)
	(b) List the country(ies):		
14.	(a) Are you entitled to, or do you expect to be entitled to, a pension or annuity (or a lump sum in place of 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 to item 15)
	(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 PROMPTLY NOTIFY the Social Security Administration if I become entitled to a pension or annuity based on my employment not covered by Social Security, or if such pension or annuity stops.		
15.	(a) Have you ever been married?	☐ Yes (If "Yes," answer (b))	☐ No (If "No," go to item 16)

(b) Give the following information about your current marriage. If not currently married, write "None." _____ (If "None," go on to item 15(c))

Spouse's name (including maiden name)	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)	Spouse's Social Security Number (If none or unknown, so indicate)

(c) Enter information about any other marriage if you:

- Had a marriage that lasted at least 10 years; or
- Had a marriage that ended due to the death of your spouse, regardless of duration; or
- Were divorced, remarried the same individual within the year immediately following the year of the divorce, and the combined period of marriage totaled 10 years or more. If none, write "None." _____ Go on to item 15 (d) if you have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22) and you are divorced from the child's other parent who is now deceased and the marriage lasted less than 10 years.

Spouse's name (including maiden name)		When (Month, day, year)	Where (Name of City and State)
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)	Date of spouse's death	Spouse's Social Security Number (If none or unknown, so indicate)

15. (d) Enter information about any marriage if you:

- Have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22); and
- Were married for less than 10 years to the child's mother or father, who is now deceased; and
- The marriage ended in divorce

If none, write "None." _____

Spouse's name (including maiden name)		When (Month, day, year)	Where (Name of City and State)
Date of divorce (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)	Date of spouse's death	Spouse's Social Security Number (If none or unknown, so indicate)

Use the "REMARKS" space on page 5 for marriage continuation or explanation.

16. If your claim for disability benefits is approved, your children (including 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 ELEMENTARY OR SECONDARY SCHOOL FULL-TIME
- DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)

17. (a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year? ☐ Yes (If "Yes," go to item 18) ☐ 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.

18. 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 TO ITEM 19.

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".)

19. Complete item 19 even if you were an employee.

(a) Were you self-employed this year or last year? ☐ Yes ☐ No
(If "Yes," answer (b)) (If "No," go to item 20)

(b) Check the year (or years) you were self-employed	In what type of trade/business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from the trade or business $400 or more? (Check "Yes" or "No")
☐ This year		
☐ Last year		☐ Yes ☐ No

20. (a) How much were your total earnings last year? Count both wage and self-employment income. (If none, write "None.") _____ Amount $ _____

(b) How much have you earned so far this year? (If none, write "None.") _____ Amount $ _____

21. (a) Are you still unable to work because of your illnesses, injuries, or conditions? ☐ Yes ☐ No
(If "Yes," go to item 22) (If "No," answer (b))

(b) Enter the date you became able to work. MONTH, DAY, YEAR

22. Are your illnesses, injuries, or conditions related to your work in any way? ☐ Yes ☐ No

23. Are you blind or do you have low vision even with glasses or contacts? ☐ Yes ☐ No

24. (a) Have you filed, or do you intend to file, for any other public disability benefits (including workers' compensation, Black Lung benefits and SSI)? ☐ Yes ☐ No
(If "Yes," answer (b)) (If "No," to item 25)

(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)

25. (a) Did you receive any money from an employer(s) on or after the date in item 9 when you became unable to work because of your illnesses, injuries, or conditions? If "Yes", give the amounts and explain in "Remarks". ☐ Yes ☐ No
Amount $ _____

(b) 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". ☐ Yes ☐ No
Amount $ _____

26. Do you, or did you, have a child under age 3 (your own or your spouse's) living with you in one or more calendar years when you had no earnings? ☐ Yes ☐ No

27. 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 the parent's name and address and Social Security number, if known, in "Remarks". ☐ Yes ☐ No

28. If you were unable to work before age 22 because of an illness, injury or condition, do you have a parent (including adoptive or stepparent) or grandparent who is receiving social security retirement or disability benefits or who is deceased? If yes, enter the name(s) and Social Security number, if known, in "Remarks" (if unknown, check "Unknown"). ☐ Yes ☐ No ☐ Unknown

REMARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

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. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF APPLICANT	Date (Month, Day, Year)
Signature (First name, middle initial, last name) (Write in ink)	Telephone Number(s) at which you may be contacted during the day. (Include the area code)

DIRECT DEPOSIT PAYMENT INFORMATION (FINANCIAL INSTITUTION)

Routing Transit Number	Account Number	☐ Checking ☐ Savings	☐ Enroll in Direct Express ☐ 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.

Privacy Act Statement
Collection and Use of Information

Sections 202, 205, and 223 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision concerning your or a dependent's eligibility to benefit payments.

We will use the information you provide to help us determine your or a dependent's eligibility for benefit payments. We may also share the information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations.

2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0059, entitled Earnings Recording and Self-Employment Income System and 60-0089, entitled Claims Folders System. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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.***

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.
- Your citizenship or immigration status changes.
- 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 a jail, prison, penal institution or correctional facility for more than 30 continuous days for conviction of a crime, or you are confined for more than 30 continuous days to a public institution by a court order in connection with a crime.
- You become entitled to a pension, an annuity, or a lump sum payment based on your employment 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.
- You have an unsatisfied warrant for more than 30 continuous days for your arrest for a crime or attempted crime that is a felony of flight to avoid prosecution or confinement, escape from custody and flight-escape. In most jurisdictions that do not classify crimes as felonies, this applies to a crime that is punishable by death or imprisonment for a term exceeding one year (regardless of the actual sentence imposed).
- You have an unsatisfied warrant for more than 30 continuous days for a violation of probation or parole under Federal or State law.
- Change of Marital Status - Marriage, divorce, annulment of marriage.
- If you become the parent of a child (including an adopted child) after you have filed your claim, let us know about the child so we can decide if the child is eligible for benefits. Failure to report the existence of these children may result in the loss of possible benefits to the child(ren).
- You return to work (as an employee or self-employed) regardless of amount of earnings.
- Your condition improves.
- You are under age 65 and 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 online, by telephone, mail, or in person, whichever you prefer. If you are awarded benefits, and one or more of the above change(s) occur, you should report by:

- Visiting the section "my Social Security" at our web site at www.socialsecurity.gov;
- Calling us TOLL FREE at 1-800-772-1213;
- If you are deaf or hearing impaired, calling us TOLL FREE at TTY 1-800-325-0778; or
- Calling, visiting or writing your local Social Security office at the phone number and address shown on your claim receipt.

For general information about Social Security, visit our web site at www.socialsecurity.gov.

DISABILITY REPORT - ADULT

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The information you give us on this report will be used by the office that makes the disability decision on your disability claim. Completing this report accurately and completely will help us expedite your claim. Please complete as much of the report as you can.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. Please do **not** ask your healthcare provider to complete this report. If you cannot complete the report, a Social Security Representative will assist you. If you have an appointment, please have the completed report ready when we contact you. If we ask you to do so, please mail the completed report to us ahead of time.

Note: If you are assisting someone else with this report, please answer the questions as if that person were completing the report.

HOW TO COMPLETE THIS REPORT

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your healthcare providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION,** unless the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- 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 question, please use Section 11 - Remarks on the last page to finish your answer. Write the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any of your medical records, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and the completed report with 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 request your records. The information that you give us on this report tells us where to request your medical and other records.

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 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 is expected 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.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), and 1631 of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information to determine eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs; and

- To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act Systems of Records Notice (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 90 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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 regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS

DISABILITY REPORT ADULT	**For SSA Use Only- Do not write in this box.** **Related SSN Number Holder**

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle Initial, Last)	**1.B.** Social Security Number

1.C. Mailing Address (Street or PO Box) Include apartment number or unit (if applicable).

City	State/Province	ZIP/Postal Code	Country (If not USA)

1.D. Email Address

1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA Phone number _____

☐ Check this box if you do not have a phone or a number where we can leave a message.

1.F. Alternate Phone Number - another number where we may reach you, if any.
Alternate phone number _____

1.G. Can you speak and understand English? ☐ Yes ☐ No

If no, what language do you prefer?

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

1.H. Can you read and understand English? ☐ Yes ☐ No

1.I. Can you write more than your name in English? ☐ Yes ☐ No

1.J. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname. ☐ Yes ☐ No

If yes, please list them here:

SECTION 2 - CONTACTS

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim.

2.A. Name (First, Middle Initial, Last)	**2.B.** Relationship to you

2.C. Daytime Phone Number (as described in **1.E.** above)

2.D. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

2.E. Can this person speak and understand English? ☐ Yes ☐ No

If no, what language is preferred?

SECTION 2 - CONTACTS (continued)

2.F. Who is completing this report?

- ☐ The person who is applying for disability. (Go to Section 3 - Medical Conditions)
- ☐ The person listed in **2.A.** (Go to Section 3 - Medical Conditions)
- ☐ Someone else (Complete the rest of Section 2 below)

2.G. Name (First, Middle Initial, Last)

2.H. Relationship to Person Applying

2.I. Daytime Phone Number

2.J. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

SECTION 3 - MEDICAL CONDITIONS

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1. _____
2. _____
3. _____
4. _____
5. _____

If you need more space, go to Section 11- Remarks on the last page

3.B. What is your height without shoes? _____ feet _____ inches OR _____ centimeters (if outside USA)

3.C. What is your weight without shoes? _____ pounds OR _____ kilograms (if outside USA)

3.D. Do your conditions cause you pain or other symptoms? ☐ Yes ☐ No

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

- ☐ No, I have never worked (Go to question **4.B.** below)
- ☐ No, I have stopped working (Go to question **4.C.** below)
- ☐ Yes, I am currently working (Go to question **4.F.** on page 5)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your conditions(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year) _____ (Go to Section 5 on page 5)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year) _____

Why did you stop working?

- ☐ Because of my condition(s).
- ☐ Because of other reasons. Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed). _____

Even though you stopped working for other reasons, when do you believe your conditions(s) became severe enough to keep you from working? (month/day/year) _____

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours, or rate of pay)

- ☐ No (Go to Section 5 - Education and Training on page 5)
- ☐ Yes, When did you make changes? (month/day/year) _____

SECTION 4 - WORK ACTIVITY (continued)

4.E. Since the date in 4.D. above, have you had gross earnings greater than $1,180 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No (Go to Section 5) ☐ Yes (Go to Section 5)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

☐ No When did your condition(s) first start bothering you? (month/day/year) _____

☐ Yes When did you make changes? (month/day/year)

4.G. Since your condition(s) first bothered you, have you had gross earnings greater than $1,180 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No ☐ Yes

SECTION 5 - EDUCATION AND TRAINING

5.A. Check the highest grade of school completed. (Select 12, if you have education equivalent to high school from another country.)

														College:			
0	1	2	3	4	5	6	7	8	9	10	11	12	GED	1	2	3	4 or more
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Date completed: ____ / ____
MM YYYY

Name of school: _____

City: _____ State/Province: _____ Country (if not USA) _____

5.B. Did you receive special education, such as through an Individualized Education Plan (IEP) or equivalent education?

☐ Yes ☐ No (Go to **5.C.**)

Dates from: ____ / ____ to ____ / ____
MM YYYY MM YYYY

Check the last grade you received special education.

Pre K	K	1	2	3	4	5	6	7	8	9	10	11	12
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Reason(s) for IEP or equivalent education: _____

The school where you last received special education:

☐ Same as **5.A.**

☐ If different from **5.A.**, complete below.

Name of school: _____

City: _____ State/Province: _____ Country (if not USA) _____

SECTION 5 - EDUCATION AND TRAINING (continued)

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

☐ Yes ☐ No

If "Yes," what type? _____ Date completed: ____ / ____
MM YYYY

5.D. What written language do you use every day in most situations (at home, work, school, in community, etc.)?

5.E. In the language you identified in **5.D**., can you **read** a simple message, such as a shopping list or short and simple notes? ☐ Yes ☐ No

5.F. In the language you identified in **5.D**., can you **write** a simple message, such as a shopping list or short and simple notes? ☐ Yes ☐ No

If you need to list other educations or training use Section 11 - Remarks on the last page.

SECTION 6 - JOB HISTORY

6.A. List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

☐ Check here and go to Section 7 - Medicines on page 8 if you did not work at all in the 15 years before you became unable to work.

Job Title	Type of Business	Dates Worked		Hours Per Day	Days Per Week	Rate of Pay	
		From MM/YY	To MM/YY			Amount	Frequency
1.							
2.							
3.							
4.							
5.							

Check the box below that applies to you.

☐ I had **only one job** in the last 15 years before I became unable to work. Answer the question below.

☐ I had **more than one job** in the last 15 years before I became unable to work. Do not answer the question on this page; go to Section 7 - Medicines on page 8. (We may contact you for more information.)

SECTION 6 - JOB HISTORY (continued)

Do not complete this page if you had **more than one job** in the last 15 years before you became unable to work.

6.B. Describe this job. What did you do all day?

(If you need more space, use Section 11 - Remarks on the last page.)

6.C. 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 any duties like this? ☐ Yes ☐ No

6.D. In this job, how many hours each day did you do each of the tasks listed:

Task	Hours	Task	Hours	Task	Hours
Walk		Stoop *(Bend down & forward at waist.)*		Handle large objects	
Stand		Kneel *(Bend legs to rest on knees.)*		Write, type, or handle small objects	
Sit		Crouch *(Bend legs & back down & forward.)*		Reach	
Climb		Crawl *(Move on hands & knees.)*			

6.E. Lifting and carrying (*Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job*.)

6.F. Check heaviest weight lifted:

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

6.G. 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

6.H. Did you supervise other people in this job? ☐ Yes (Complete items below) ☐ No (if No, go to **6.I.**)

How many people did you supervise?

Did you hire and fire employees? ☐ Yes ☐ No

What part of your time did you spend supervising people? _____

6.I. Were you a lead worker? ☐ Yes ☐ No

SECTION 7 - MEDICINES

7. Are you taking any medicines (prescription or non-prescription)?

☐ Yes, (Give the information requested below. You may need to look at your medicine containers.)

☐ No, (Go to Section 8 - Medical Treatment)

Name of Medicine	If prescribed, give name of doctor	Reason for medicine

If you need to list other medicines, go to Section 11 - Remarks on the last page.

SECTION 8 - MEDICAL TREATMENT

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled**?

8.A. For any **physical** condition(s)? ☐ Yes ☐ No

8.B. For any **mental** condition(s) **(including emotional or learning problems)**? ☐ Yes ☐ No

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 14.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office	Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic, or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests the provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ Check this box if no test by this provider or at this facility.

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 14.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.D. Name of Facility or Office	Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic, or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests the provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ Check this box if no test by this provider or at this facility.

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 14.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.E. Name of Facility or Office	Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic, or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests the provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ Check this box if no test by this provider or at this facility.

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 14.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.F. Name of Facility or Office	Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic, or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests the provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ Check this box if no test by this provider or at this facility.

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 14.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.G. Name of Facility or Office	Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic, or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests the provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ Check this box if no test by this provider or at this facility.

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 14.

SECTION 9 - OTHER MEDICAL INFORMATION

9. Does **anyone else** have medical information about your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

☐ Yes (Please complete the information below)

☐ No (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11 - Remarks on the last page.)

Name of Organization	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Name of Contact Person	Claim or ID number (if any)

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.

SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

10.A. Have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- Any Individualized Education Program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ Yes (Complete the following information) ☐ No (Go to Section 11 - Remarks)

10.B. Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

10.C. When did you start participating in the plan or program?

SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES (continued)

10.D. Are you still participating in the plan or program?

☐ Yes, I am scheduled to complete the plan or program on: _____

☐ **No,** I completed the plan or program on: _____

☐ **No,** I stopped participating in the plan or program before completing it because:

10.E. List the types of service, tests, or evaluations that you received (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluation, or classes.

If you need to list another plan or program use Section 11 - Remarks and give the same detailed information as above.

SECTION 11 - REMARKS

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

Date Report Completed (MM/DD/YYYY)

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
DATE STAMP

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.

Filing Date (month, day, year)

☐ **Receipt** ☐ **Protective**

☐ **FS-SSA/APP** ☐ **FS-REFERRED**

Preferred Language
Written: **Spoken:**

TYPE OF CLAIM ☐ Individual ☐ Individual with Ineligible Spouse ☐ Couple ☐ Child ☐ Child with Parents

PART I--BASIC ELIGIBILITY-- Answer the questions below beginning with the first moment of the filing date month.

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

(b) Did you ever use any other names (including maiden name) or any other Social Security Numbers? ☐ YES Go to (c) ☐ NO Go to (d)

(c) Other Name(s) | Other Social Security Number(s) used

(d) If you are also filing for Social Security Benefits, go to #2; otherwise complete the following:

Mother's Maiden Name: Father's Name: Go to #2

2. Applicant's Mailing Address (Number & Street, Apt. No. P.O. Box, Rural Route)

City and State | ZIP Code | County

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

City and State | ZIP Code | County

4. **DIRECT DEPOSIT PAYMENT ADDRESS (FINANCIAL INSTITUTION)**

Routing Transit Number | Account Number | ☐ Checking ☐ Savings | ☐ Enroll in Direct Express ☐ Direct Deposit Refused

5.	(a) Are you married?	☐ YES Go to (b)	☐ NO Go to #6
	(b) Date of marriage: (month, day, year)		
	(c) Spouse's Name (First, middle initial, last)	Birthdate (month, day, year)	Social Security Number
	(d) Did your spouse ever use any other names (including maiden name) or Social Security Numbers?	☐ YES Go to (e)	☐ NO Go to (f)
	(e) Other Name(s)	Other Social Security Number(s) Used	
	(f) Are you and your spouse living together?	☐ YES Go to #6	☐ NO Go to (g)
	(g) Date you began living apart : (month, day, year)		
	(h) Address of spouse or name of someone who knows where spouse is. (Complete only if spouse is age 65, blind or disabled.)		

6.	(a) Have you had any other marriages? If never married, check this box ☐	**You** ☐ YES Go to (b) ☐ NO Go to #7	**Your Spouse, if filing** ☐ YES Go to (b) ☐ NO Go to #7

(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 #4.

	YOU	**YOUR SPOUSE**
FORMER SPOUSE'S NAME (including maiden name)		
BIRTHDATE (month, day, year)		
SOCIAL SECURITY NUMBER		
DATE OF MARRIAGE (month, day, year)		
DATE MARRIAGE ENDED (month, day, year)		
HOW MARRIAGE ENDED		

7.	If you are filing for yourself, go to (a); if you are filing for a child, go to (e).		
	(a) Are you unable to work because of illnesses, injuries or conditions?	**You** ☐ YES Go to (b) ☐ NO Go to #8	**Your Spouse** ☐ YES Go to (b) ☐ NO Go to #7
	(b) Enter the date you became unable to work.	(month, day, year)	(month, day, year)
	(c) What are your illnesses, injuries or conditions?		
	You Go to (d)	**Your Spouse** Go to (d)	

7. (d) If you were unable to work because of illnesses, injuries, or conditions before you were age 22, do you have a parent who is age 62 or older, unable to work because of illnesses, injuries or conditions, or deceased?

☐ YES Parent's Name: _____

Social Security Number: _____

Address: _____

_____

☐ NO Go to #8

(e) When did the child become disabled? (month, day, year) Go to (f)

(f) What are the child's disabling illnesses, injuries or conditions? Go to (g)

(g) Does the child have a parent(s) who is age 62 or older, unable to work because of illness, injuries, or conditions, or deceased?

☐ YES Parent's Name: _____

Social Security Number: _____

Address: _____

_____

☐ NO Go to #8

8.

Birthplace	City	State	Country (if other than the U.S.)
You			
Your Spouse, if filing			

Go to #9

		You		Your Spouse, if filing	
9.	Are you a United States citizen by birth?	☐ YES Go to #15	☐ NO Go to #10	☐ YES Go to #15	☐ NO Go to #10
10.	Are you a naturalized United States citizen?	☐ YES Go to #15	☐ NO Go to #11	☐ YES Go to #15	☐ NO Go to #11
11.	(a) Are you an American Indian born outside the United States?	☐ YES Go to (b)	☐ NO Go to (c)	☐ YES Go to (b)	☐ NO Go to (c)

(b) Check the block that shows your American Indian status.

You	Your Spouse, if filing
☐ American Indian born in Canada Go to #15	☐ American Indian born in Canada Go to #15
☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #15	☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #15
☐ Other American Indian Explain in Remarks, then Go to (c)	☐ Other American Indian Explain in Remarks, then Go to (c)

11. (c) Check the block below that shows your current immigration status

You	Your Spouse, if filing
☐ Amerasian Immigrant — Go to #12	☐ Amerasian Immigrant — Go to #12
☐ Lawful Permanent Resident — Go to #12	☐ Lawful Permanent Resident — Go to #12
☐ Refugee Date of entry: — Go to #14	☐ Refugee Date of entry: — Go to #14
☐ Asylee Date status granted: — Go to #14	☐ Asylee Date status granted: — Go to #14
☐ Conditional Entrant Date status granted: — Go to #14	☐ Conditional Entrant Date status granted: — Go to #14
☐ Parolee for One Year — Go to #14	☐ Parolee for One Year — Go to #14
☐ Cuban/Haitian Entrant — Go to #14	☐ Cuban/Haitian Entrant — Go to #14
☐ Deportation/Removal Withheld Date: — Go to #14	☐ Deportation/Removal Withheld Date: — Go to #14
☐ Other Explain in Remarks, then Go to (d)	☐ Other Explain in Remarks, then Go to (d)

(d) If you have status, or have applied for status as the spouse, child, or parent of a child of a US citizen, or lawfully admitted permanent resident alien, Go to #13; otherwise Go to #15.

12. If you are lawfully admitted for permanent residence:

	You (month, day, year)	**Your Spouse** (month, day, year)
(a) Date of Admission		
(b) Was your entry into the United States sponsored by any person or promoted by an institution or group?	☐ YES Go to (c) ☐ NO Go to (d)	☐ YES Go to (c) ☐ NO Go to (d)

(c) Give the following information about the person, institution, or group, then Go to (d):

Name	Address	Telephone Number
		( ) -

(d) What was your immigration status, if any, before adjustment to lawful permanent resident?	**You**	**Your Spouse, if filing**
	Status:	Status:
	(month, day, year) From: To:	(month, day, year) From: To: Go to (e)
(e) If filing as an adult, did your parents ever work in the United States before you were age 18?	☐ YES Go to (f) ☐ NO Go to #14	☐ YES Go to (f) ☐ NO Go to #14

(f) Name and Social Security Number of parent(s) who worked.

Name	Social Security Number
Name	Social Security Number

		You	Your Spouse, if filing
13.	(a) Have you, your child or your parent, been subjected to battery or extreme cruelty while in the United States?	☐ YES Go to (b) ☐ NO Go to #15	☐ YES Go to (b) ☐ NO Go to #15
	(b) Have you, your child, or your parent filed a petition with the Department of Homeland Security for a change in immigration status because of being subjected to battery or extreme cruelty?	☐ YES Go to #14 ☐ NO Go to #15	☐ YES Go to #14 ☐ NO Go to #15
14.	Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	☐ YES Explain in #60(b), then Go to #15 ☐ NO Go to #15	☐ YES Explain in #60(b), then Go to #15 ☐ NO Go to #15
15.	(a) When did you first make your home in the United States?	(month, day, year)	(month, day, year)
	(b) Have you lived outside of the United States since then?	☐ YES Go to (c) ☐ NO Go to #16	☐ YES Go to (c) ☐ NO Go to #16
	(c) Give the dates of residence outside the United States.	(month, day, year) From: To:	(month, day, year) From: To:
16.	(a) Have you been outside the United States (the 50 states, District of Columbia and Northern Mariana Islands) 30 consecutive days prior to the filing date?	☐ YES Go to (b) ☐ NO Go to #17	☐ YES Go to (b) ☐ NO Go to #17
	(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:

IF YOU ARE FILING ON BEHALF OF YOUR CHILD, GO TO #17.
IF YOU ARE MARRIED AND YOUR SPOUSE IS NOT FILING FOR SUPPLEMENTAL SECURITY INCOME AND YOU LIVED TOGETHER AT ANY TIME SINCE THE FIRST MOMENT OF THE FILING DATE MONTH, GO TO #17; OTHERWISE GO TO #18.

17.	(a) Is your spouse/parent the sponsor of an alien who is eligible for supplemental security income?	☐ YES Go to (b) ☐ No Go to #18
	(b) Eligible Alien's Name	Eligible Alien's Social Security Number Go to #18

		You	Your Spouse, if filing
18.	(a) Do you have any unsatisfied felony warrants for your arrest?	☐ YES Go to (b) ☐ NO Go to #19	☐ YES Go to (b) ☐ NO Go to #19
	(b) In which state or country was this warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
	(c) Was the warrant satisfied?	☐ YES Go to (d) ☐ NO Go to #19	☐ YES Go to (d) ☐ NO Go to #19
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)
19.	(a) Do you have any unsatisfied Federal or State warrants for violating the conditions of probation or parole?	☐ YES Go to (b) ☐ NO Go to #20	☐ YES Go to (b) ☐ NO Go to #20

19.			
	(b) In which state or country was the warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
	(c) Was the warrant satisfied?	☐ YES ☐ NO Go to (d) Go to #20	☐ YES ☐ NO Go to (d) Go to #20
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)

PART II - LIVING ARRANGEMENTS - The questions in this section refer to the signature date.

20. Check the block which best describes your present living situation:

☐ Household	Since (month, day, year) Go to #25
☐ Non-Institutional Care	Since (month, day, year) Go to #23
☐ Institution	Since (month, day, year) Go to #21
☐ Transient or homeless	Since (month, day, year) Go to #38

INSTITUTION

21. Check the block that identifies the type of institution where you currently reside, then Go to #22:

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

22. Give the following information about the INSTITUTION:

(a) Name of institution:

(b) Date of admission:

(c) Date you expect to be released from this institution:

Go to #38

NON-INSTITUTIONAL CARE

23. Check the block that best describes your current residence, then Go to #24:

☐ Foster Home ☐ Group Home ☐ Other (Specify)

24. Give the following information about your Noninstitutional Care:

(a) Name of facility where you live:

24.	(b) Name of placing agency	Address	Telephone Number
			( ) -

(c) Does this agency pay for your room and board?

☐ YES Go to #38 ☐ NO If NO, who pays?

Go to #38

HOUSEHOLD ARRANGEMENTS

25. Check the block that describes your current residence, then Go to #26:

☐ House	☐ Mobile Home
☐ Apartment	☐ Houseboat
☐ Room (private home)	☐ Other (Specify)
☐ Room (commercial establishment)	

26. Do you live alone or only with your spouse? ☐ YES Go to #28 ☐ NO Go to #27

27. (a) Give the following information about everyone who lives with you:

Name	Relationship	Public Assistance		Sex		Birthdate mm/dd/yy	Blind or Disabled		If Under 22				Social Security Number
									Married		Student		
		YES	NO	M	F		YES	NO	YES	NO	YES	NO	

If anyone listed is under age 22 and not married, Go to (b); otherwise, Go to #28.

27. (b) Does anyone listed in 27(a) who is under age 18, OR between ages 18-22 and a student, receive income? ☐ YES Go to (c) ☐ NO Go to #28

(c) Child Receiving Income	Source and Type	Monthly Amount
		$
		$
		$
		$
		$
		$

28. (a) Do you (or does anyone who lives with you) own or rent the place where you live? ☐ YES Go to #29 ☐ No Go to (b)

(b) Name of person who owns or rents the place where you live	Address	Telephone Number
		( ) -

(c) If you live alone or only with your spouse, and do not own or rent, Go to #38; otherwise, Go to #32.

29. (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 your parent(s) Go to (b); otherwise Go to #30

(b) Are your parent(s) buying or do they own the place where you live? ☐ YES Go to (c) ☐ NO Go to #30

(c) What is the amount and frequency of the mortgage payment?

Amount: $ Frequency of Payment:

Go to (d)

(d) If you are a child living only with your parents, or only with your parents and their other children who are subject to deeming, or with others in a public assistance household, or living alone or with your spouse, Go to #38; otherwise Go to #32.

30. (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 your parent(s) Go to (b); otherwise Go to (c)

(b) Does your parent(s) have rental liability? ☐ YES Go to (d) ☐ NO Go to (c)

30. (c) Does anyone who lives with you have rental liability for the place where you live?

☐ YES Give name of person with rental liability: _____ Go to #31

☐ NO Give name of person with home ownership: _____ Go to #32

(d) What is the amount and frequency of the rent payment?

Amount: $ Frequency of Payment:

Go to #31

31. (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 (c)

(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):

(c) If you are a child living only with your parents, or only with your parents and their other children who are subject to deeming, or with others in a public assistance household, or living alone or with your spouse, Go to #38.

32. (a) Does anyone living with you contribute to the household expenses? (NOTE: See list of household expenses in #37) ☐ YES Go to (b) ☐ NO Go to #33

(b) Amount others contribute: $

Go to #33

33. (a) Do you eat all your meals out? ☐ YES Go to #34 ☐ NO Go to (b)

(b) Do you buy all your food separately from other household members: ☐ YES Go to #34 ☐ NO Go to #34

34. Do you contribute to household expenses?

☐ YES Average Monthly Amount: $ _____ Go to #35

☐ NO Go to #35

35. (a) Do you have a loan agreement with anyone to repay the value of your share of the household expenses? ☐ YES Go to (b) ☐ NO Go to #35(d)

(b) Give the name, address and telephone number of the person with whom you have a loan agreement :

(c) Will the amount of this loan cover your share of the household expenses? ☐ YES Go to #38 ☐ NO Go to (d)

(d) **If you contribute** toward household expenses and you answered "NO" to both 33(a) & (b), Go To #36. If you answered "YES" to either 33(a) or 33(b), Go to #37.

If you do not contribute toward household expenses, go to #38.

36. (a) Is part or all of the amount in #34 just for food?

☐ YES Give Amount: $ _____ Go to (b) ☐ NO Go to (b)

(b) Is part or all of the amount in #34 just for shelter?

☐ YES Give Amount: $ _____ Go to #37 ☐ NO Go to #37

37. What is the average monthly amount of the following household expenses:
(Show average over the past 12 months unless you have been residing at your present address less than 12 months. If so, show average for the months you have resided at your present address.)

CASH EXPENSES	AVERAGE MONTHLY AMOUNT
Food (complete only if #33(a) & (b) are answered NO)	$
Mortgage or Rent	$
Property Insurance (if required by mortgage lender)	$
Real Property Taxes	$
Electricity	$
Heating Fuel	$
Gas	$
Sewer	$
Garbage Removal	$
Water	$
TOTAL	$ Go to #38

38. (a) Does anyone who does NOT LIVE with you pay for, or provide you or your household (if applicable), any of your food or shelter items?

☐ YES Name of Provider (Person or Agency) _____

List of Items _____

Monthly Value: $ _____

☐ NO Go to (b)

(b) Does anyone who does NOT LIVE with you give you, or your household (if applicable), money to pay for any of your or your household's food or shelter items?

☐ YES Name of Provider (Person or Agency) _____

List of Items _____

Monthly Value: $ _____

☐ NO Go to #39

39. (a) Has the information given in #20-38 been the same since the first moment of the filing date month?	☐ YES Go to (b)	☐ NO Explain in Remarks, then Go to (b)
(b) Do you expect any of this information to change?	☐ YES Explain in Remarks, then Go to #40	☐ NO Go to #40

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

		You		Your Spouse	
40.	(a) Do you own, or does your name appear (alone or with any other person's name) on the title of any vehicles (auto, truck, motorcycle, camper, boat, etc.)?	☐ YES Go to (b)	☐ NO Go to #41	☐ YES Go to (b)	☐ NO Go to #41

40.

(b) Owner's Name	Description (Year, Make & Model)	Used For	Current Market Value	Amount Owed
			$	$
			$	$
			$	$
			$	$

41. (a) Do you own or are you buying any life insurance policies?

You		Your Spouse	
☐ YES	☐ NO	☐ YES	☐ NO
Go to (b)	Go to #42	Go to (b)	Go to #42

(b) Owner's Name		Name of Insured	Name & Address of Insurance Company	Policy Number
Policy (#1)				
Policy (#2)				
Policy (#3)				

	Face Value	Cash Surrender Value	Date of Purchase	Dividends		Accumulations	
				YES	NO	YES	NO
Policy (#1)	$	$					
Policy (#2)	$	$					
Policy (#3)	$	$					

(c) Loans Against Policy? ☐ YES ☐ NO

Policy Number: _____

Amount: $_____ Go to #42

42.

(a) Do you (either alone or jointly with any other person) own any:	You		Your Spouse	
	YES	NO	YES	NO
Life estates or ownership interest in an unprobated estate?				
Items acquired or held for their value as an investment?	☐	☐	☐	☐

42. (b) Give the following information for any "Yes" answer in #42(a); otherwise, Go to #43.

Owner's Name	Name of Item	Value	Amount Owed	Give Name & Address of Bank or Other Organization
		$	$	
		$	$	
		$	$	
		$	$	

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

	You		**Your Spouse**	
	YES	NO	YES	NO
Cash at home, with you, or anywhere else				
Financial Institution Accounts				
Checking				
Savings				
Credit Union				
Christmas Club				
Time Deposits/Certificates of Deposit				
Individual Indian Money Account				
Other (Including IRAs and Keough Accounts)				

(b) If all the items in #43(a) are answered "NO", Go to #44. For any "YES" answer, give the following information:

Owner's/Trustee's Name	Name of Item	Value	Name & Address of Bank or Other Organization	Identifying Number
		$		
		$		
		$		

44.	(a) Do you give us permission to obtain any financial records from any financial institution?	You		Your Spouse, if filing	
		☐ YES Go to (b)	☐ NO Go to (b)	☐ YES Go to (b)	☐ NO Go to (b)

(b) Do you own or does your name appear on any of the following items:	You		Your Spouse	
	YES	NO	YES	NO
Stocks or Mutual Funds				
Bonds (Including U.S. Savings Bonds)				
Promissory Notes				
Trusts				
Other items that can be turned into cash				

(c) If all the items in #44(b) are answered "NO", Go to #45. For any "YES" answer, give the following information:

Owner's/Trustee's Name	Name of Item	Value	Name & Address of Bank or Other Organization	Identifying Number
		$		
		$		
		$		
		$		

45.	(a) Do you own, or does your name appear (alone or with any other person's name) on any land, houses, buildings, real property, property in foreign country, equipment, mineral rights, items in a safe deposit box, assets set aside for emergencies or heirs, or any other property of any kind that has not been shown anywhere else on the application	You		Your Spouse	
		☐ YES Go to (b)	☐ NO Go to #46	☐ YES Go to (b)	☐ NO Go to #46

(b) Describe the property (including size, location, and how it is used. If the property is not used now, when was it last used? Do you plan to use the property in the future?

Item #1

Item #2

45.

Owner's Name	Estimated Current Market Value	Tax Assessed Value	Mortgage	Owed on Item
	$	$	$	$
	$	$	$	$
	$	$	$	$

46. (a) Have you or your spouse acquired any assets since the first moment of the filing date month? ☐ YES Go to (b) ☐ NO Go to (c)

(b) Explain:

(c) Has there been any increase or decrease in the value of you or your spouse's resources since the first moment of the filing date month? ☐ YES Go to (d) ☐ NO Go to #47

(d) Explain:

47. (a) Have you or your spouse sold, transferred title, disposed of or given away, any money or other property, (including money or property in foreign countries), since the first moment of the filing date month or within the 36 months prior to the filing date month?

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

(b) If you co-owned any money or property with another person(s), did you or any co-owner sell, transfer, or give away any co-owned money or property within the 36 months prior to the filing date month?

	☐ YES ☐ NO	☐ YES ☐ NO

IF YOU ANSWERED "YES" TO (a) OR (b), GO TO (c). IF "NO" TO BOTH, GO TO #48.

(c)	OWNER'S/CO-OWNERS NAME	DESCRIPTION OF PROPERTY	DATE OF DISPOSAL
ITEM #1			
ITEM #2			
ITEM #3			

	NAME AND ADDRESS OF PURCHASER OR RECIPIENT	RELATIONSHIP TO OWNER	VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT
ITEM #1			$

47.

ITEM #2			$
ITEM #3			$

	SALES PRICE OR OTHER CONSIDERATION	ARE OTHER CONSIDERATION OR PROCEEDS EXPECTED? EXPLAIN.	DO YOU STILL OWN PART OF THE PROPERTY?
ITEM #1			
ITEM #2			
ITEM #3			

	SOLD ON OPEN MARKET?	GIVEN AWAY?	TRADED FOR GOODS/SERVICES?
ITEM #1	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ITEM #2	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ITEM #3	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

48. (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 items mentioned in #41 and #43-47.

You	Your Spouse
☐ YES ☐ NO	☐ YES ☐ NO
Go to (b) Go to #49	Go to (b) Go to #49

(b) DESCRIPTION (Where appropriate, give name & 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 #49 ☐ NO Explain in (c)
Item 1	☐ YES ☐ NO	☐ YES Go to #49 ☐ NO Explain in (c)

(c) EXPLANATION

49.	(a) Do you own any cemetery lots, crypts, caskets, vaults, urns, mausoleums, or other repositories for burial or any headstones or markers?	You ☐ YES Go to (b) ☐ NO Go to #50	Your Spouse ☐ YES Go to (b) ☐ NO Go to #50

(b) Owner's Name	Description	For Whose Burial	Relationship to You or Your Spouse	Current Market Value
				$
				$
				$ Go to #50

PART IV -- INCOME

50. (a) Since the first moment of the filing date month, have you (or your spouse) received or do you (or your spouse) expect to receive income in the next 14 months from any of the following sources?	You		Your Spouse	
	YES	NO	YES	NO
State or Local Assistance Based on Need				
Refugee Cash Assistance				
Temporary Assistance for Needy Families				
General Assistance from the Bureau of Indian Affairs				
Disaster Relief				
Veteran Benefits Based on Need (Paid Directly or Indirectly as a Dependent)				
Veteran Payments Not Based on Need (Paid Directly or Indirectly as a Dependent)				
Other Income Based on Need				
Social Security				
Black Lung				
Railroad Retirement Board Benefits				
Office of Personnel Management (Civil Service)				
Pension (Foreign Military, State, Local, Private, Union, Retirement or Disability)				
Military Special Pay or Allowance				
Unemployment Compensation				

50.					
	Workers' Compensation				
	State Disability				
	Insurance or Annuity Payments				
	Dividends/Royalties				
	Rental/Lease Income Not from a Trade or Business				
	Alimony				
	Child Support				
	Other Bureau of Indian Affairs Income				
	Gambling/Lottery Winnings				
	Other Income or Support				

(b) Give the following information for any block checked YES in #50(a); otherwise, Go to #51

Person Receiving Income	Type of Income	Amount Received	Frequency of Payment	Date Expected or Received	Source (Name, Address of Person, Bank, Organization, or Company)	Identifying Number
		$				
		$				
		$				

IF YOU EVER RECEIVED SSI BEFORE, GO TO #51; OTHERWISE GO TO #52

		You		Your Spouse	
51.	Are any overpayments being collected from benefits you receive from the Social Security Administration, Railroad Retirement Board, Office of Personnel Management, Veterans' Affairs, Military Pensions, Military Special Pay Allowances, Black Lung, Workers' Compensation, or State Disability or Unemployment Benefits?	☐ YES Explain in Remarks, then Go to #52	☐ NO Go to #52	☐ YES Explain in Remarks, then Go to #52	☐ NO Go to #52
52.	Since the first moment of the filing date month, have you received or do you expect to receive any meals or other gifts which are not cash?	☐ YES Explain in Remarks, then Go to #53	☐ NO Go to #53	☐ YES Explain in Remarks, then Go to #53	☐ NO Go to #53
53.	(a) Have you (or your spouse) received wages or sick pay since the first moment of the filing date month through the current month?	☐ YES Go to (b)	☐ NO Go to (e)	☐ YES Go to (b)	☐ NO Go to (e)

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

You	Your Spouse
Go to (c)	Go to (c)

53. (c)

	Date last worked (month, day, year)	Date last paid (month, day, year)	Date next paid (month, day, year)
You			
Your Spouse			

(d) Total monthly wages received (before any deductions)	Your Amount $	Your Spouse's Amount $
(e) Do you (or your spouse) expect to receive any wages in the next 14 months?	**You** ☐ YES Go to (f) ☐ NO Go to #54	**Your Spouse** ☐ YES Go to (f) ☐ NO Go to #54

(f) Name and address of employer if different from #53(b) (include telephone number, if known)

You	Your Spouse

(g) 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	$				
Your Spouse	$				

(h) Do you expect any change in wage information provided in #53(g)	**You** ☐ YES Go to (i) ☐ NO Go to #54	**Your Spouse** ☐ YES Go to (i) ☐ NO Go to #54

(i) Explain Change:

You	**Your Spouse**

54. (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?

You ☐ YES Go to (b) ☐ NO Go to #55

Your Spouse ☐ YES Go to (b) ☐ NO Go to #55

(b) Give the following information; then Go to #55

Date(s) Self-Employed	Type of Business	**Last Year's:** Gross Income $	**Last Year's:** Net Profit $	**Last Year's:** Net Loss $
Date(s) Self-Employed	Type of Business	**This Year's:** Gross Income $	**This Year's:** Net Profit $	**This Year's:** Net Loss $

		You	Your Spouse
55.	If you or your spouse are blind or disabled, do you have any special expenses that you paid which are necessary for you to work?	☐ YES Explain in Remarks; then Go to #56 ☐ NO Go to #56	☐ YES Explain in Remarks; then Go to #56 ☐ NO Go to #56
56.	(a) Does your spouse/parent who lives with you have to pay court-ordered support?	☐ YES Go to (b)	☐ NO Go to NOTE
	(b) Give amount and frequency of court-ordered support payment.	Amount: $	Frequency: Go to (c)
	(c) Give the following information about the person who receives these payments:	Name:	Address:

NOTE: IF YOU ARE FILING AS A CHILD AND YOU ARE EMPLOYED OR AGE 18 - 22 (WHETHER EMPLOYED OR NOT), GO TO #57; OTHERWISE, GO TO #58.

57.	(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 #58	
	(d) Name of School	Name of School Contact	Dates of Attendance From / To	Course of Study
		Phone Number	Hours Attending or Planning to Attend	

PART V - POTENTIAL ELIGIBILITY FOR FOOD STAMPS/MEDICAL ASSISTANCE/OTHER BENEFITS - If a California resident, Skip to #59

		You		Your Spouse, if filing	
58.	(a) Are you currently receiving food stamps?	☐ YES Go to (b)	☐ NO Go to (c)	☐ YES Go to (b)	☐ NO Go to (c)
	(b) Have you received a recertification notice within the past 30 days?	☐ YES Go to (e)	☐ NO Go to #59	☐ YES Go to (e)	☐ NO Go to #59
	(c) Have you filed for food stamps in the last 60 days?	☐ YES Go to (d)	☐ NO Go to (e)	☐ YES Go to (d)	☐ NO Go to (e)
	(d) Have you received an unfavorable decision?	☐ YES Go to (e)	☐ NO Go to #59	☐ YES Go to (e)	☐ NO Go to #59
	(e) If everyone in the household receives or is applying for SSI, Go to (f); otherwise Go to #59.				
	(f) May I take your food stamp application today?	☐ YES Go to #59	☐ NO Explain in (g)	☐ YES Go to #59	☐ NO Explain in (g)
	(g) Explanation:				

59. You may be eligible for Medicaid. However, you must help your State identify other sources that pay for medical care. Also, you must give information to help the State get medical support for any child(ren) who is your legal responsibility. This includes information to help the State determine who a child's father is. If you want Medicaid, you must agree to allow your State to seek payments from sources, such as insurance companies, that are available to pay for your medical care. This includes payments for medical care for you or any person who receives Medicaid and is your legal responsibility. The State cannot provide you Medicaid if you do not agree to this Medicaid requirement. If you need further information, you may contact your Medicaid Agency.

IN STATES WITH AUTOMATIC ASSIGNMENT OF RIGHTS LAWS, Go to (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 #60	☐ YES Go to (b)	☐ NO Go to #60
(b) Do you, your spouse, parent or stepparent have any private, group, or governmental health insurance that pays the cost of your medical care? (Do not include Medicare or Medicaid.)	☐ YES Go to (c)	☐ NO Go to (c)	☐ YES Go to (c)	☐ NO Go to (c)
(c) Do you have any unpaid medical expenses for the 3 months prior to the filing date month?	☐ YES Go to #60	☐ NO Go to #60	☐ YES Go to #60	☐ NO Go to #60

60. (a) Have you ever worked under the U.S. Social Security System? ☐ YES Go to (b) ☐ NO Go to (b)

(b) Have you, your spouse, or a former spouse (or parent if you are filing as a child) ever:	You		Your Spouse/Parent		Filed for Benefits	
	Yes	No	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 with a pension plan						
Belonged to union with a pension plan						
Worked under a Social Security system or pension plan of a country other than the United States?						

(c) Explain and include dates for any "Yes" answer given in #14 or #60(a); otherwise Go to #61.

You:	Your Spouse, if filing/Your Parent, if filing as a child:

PART VI -- MISCELLANEOUS -- (Answer #61 ONLY IF YOU ARE APPLYING ON BEHALF OF SOMEONE ELSE: OTHERWISE GO TO #62.

61.	(a) Name of Person/Agency Requesting Benefits.	Relationship to Claimant	Your Social Security Number (or EIN)

(b) If SSA determines that the claimant needs help managing benefits, do you wish to be selected representative payee?	☐ YES	☐ NO (Explain in Remarks)

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.)

PART VIII -- IMPORTANT INFORMATION AND SIGNATURES

62. **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.
- ▶ We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you or your spouse notify us in writing that you are canceling your permission, (2) your application for SSI is denied in a final decision, (3) your eligibility for SSI terminates, or (4) we no longer consider your spouse's income and resources to be available to you. If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

63. **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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

Your Signature (First name, middle initial, last name) (Sign in ink.)	Date (month, day, year)
SIGN HERE ▶	Telephone Number(s) where we can contact you during the day: ( ) -

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

SIGN HERE ▶

64. If you are blind or visually impaired, check the type of mail you want to receive from us.

☐ Standard notice First Class ☐ Standard notice First-Class with a follow-up phone call ☐ Standard notice & data CD by First-Class
☐ Standard notice Certified ☐ Standard & Braille notices by First-Class ☐ Standard & large print notices ☐ Standard notice & audio CD

65. WITNESS

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 address.

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)

RECEIPT FOR YOUR CLAIM FOR SUPPLEMENTAL SECURITY INCOME

Name	Social Security Number	Date
Name	Social Security Number	Date

If you have a question or something to report call:	Social Security Office you may visit or mail your request to:
( ) -	

For general information about Social Security, visit our website at www.socialsecurity.gov on the Internet.

We will process your application for Supplemental Security Income 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 notice of determination within that time, please get in touch with us.

Privacy Act Statement/ Paperwork Reduction Act Statement
Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. We will use this information to help us determine your entitlement to benefits. Furnishing us this information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim, which may result in the loss of payments. We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Medicare 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);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State and local level; and,
4. To facilitate statistical research and audit activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete use of routine uses for this information is available in System of Records Notices 60-0089, Claims Folder System and 60-0050, Completed Determination-Continuing Disability Determinations. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or any local Social Security office.

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 40 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.**

REPORTING RESPONSIBILITIES

The amount of a Supplemental Security Income (SSI) 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 SSI.

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

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 may make your reports:

- **By telephone at the telephone number shown above or call us toll free at 1-800-772-1213 (TTY 1-800-325-0778) or**
- **In person or**
- **By mail at the address shown above.**

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 are admitted to (for a calendar month or longer), or released from, a hospital or nursing home, jail, prison, or other correctional facility or other institution.
- You leave the United States for 30 consecutive days.
- You are no longer a legal resident of the United States

☐ **HOW YOU LIVE -You must report to Social Security:**

- If anyone moves into or out of your household.
- If the amount of money you pay toward household expenses changes.
- Births and deaths of any people with whom you live.
- Your spouse or former spouse dies.
- Your marital status changes:
  --You get married, separated, divorced, or your marriage is annulled.
  --You begin living with someone as husband and wife.

☐ **INCOME-You must report to Social Security if you, your spouse/your parent(s):**

- Start to receive money (or checks or any other type of payment) from someone or someplace.
- Have a change in the amount of money you receive.
- Begin to receive child support payments or those payments go up or down.
- Win money from gambling or a lottery.
- Start work or stop work.
- Earn more or less money. (**Keep all paystubs** and provide them to SSA when requested.)
- Become eligible for benefits other than SSI.

☐ **HELP YOU GET FROM OTHERS -You must report to Social Security if:**

- The amount of help (money or food, 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 things that you own goes over $2000 when you add them all together ($3000 if you are married and live with your spouse).
- You sell or give any thing 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.

☐ **IF YOU ARE THE PARENT, STEP PARENT, OR REPRESENTATIVE PAYEE FOR A CHILD UNDER 18 - A report to Social Security must be made if:**

- There is a change in any income the child, his or her parent(s), step parent, or brother(s) or sister(s) receive.
- There is a change in the student status of the child's brother(s) or sister(s).
- There is a change in his or her parents' or step parents' marriage, a change in the value of anything they own, or a change in their residence.

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

- You start or stop school
- You get married or divorced
- You start or stop working

☐ **YOUR IMMIGRATION STATUS CHANGES-**

- You must report any changes 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 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.

☐ **IF A WARRANT HAS BEEN ISSUED FOR YOUR ARREST -You must report to Social Security if:**

- Your warrant is for a crime or an attempted crime that is a felony (or, in jurisdictions that do not define crimes as felonies, a crime that is punishable by death or imprisonment for a term exceeding 1 year); or
- Your warrant is for a violation of probation or parole under Federal or State law.

Social Security Administration
Retirement, Survivors, and Disability Insurance
Important Information

FO Address:

Date:

BNC#:

We are writing to you because we need to know more about your work. Please tell us about your work since . We will use this information to decide if you can receive or continue to receive disability benefits.

What You Need To Do

Please complete and return the completed form **within 15 days** to the address shown above. It is important to fill out the form carefully and completely. Remember to sign and date the form. If you do not return this form, we will make our determination based on the evidence we have in our records.

Some Information To Help You Complete This Form

Our records show the following self-employment income for you. This list may not be complete. It may not show your work for this year or last year. You should add any additional work information as you complete the form.

Self-Employment	Year	Yearly Income

For More Information

Please read the enclosed pamphlet, “Working While Disabled ... How We Can Help.” It will tell you more about why we need to know about your work, and will explain our rules about working. This pamphlet is also available online at www.ssa.gov/pubs/10095.html.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit http://oig.ssa.gov/report or call the Inspector General's Fraud Hotline at **1-800-269-0271** (TTY **1-866-501-2101**).

If You Have Questions

If you have any questions, or need help completing the form:

- Visit our website at www.socialsecurity.gov to find general information about Social Security.
- Call us toll-free at 1-800-772-1213, or call your local office at . You may also call your Social Security contact, , at . We can answer most questions over the phone.
- Write or visit any Social Security office. If you plan to visit an office, you may call ahead to make an appointment. The office that serves your area is located at:

- If you are deaf or hard of hearing, our toll-free TTY number is 1-800-325-0778.
- If you live outside the United States, please contact any Social Security office or the nearest United States Embassy or consulate. If you live in the Philippines, you may contact the Veterans Administration Regional Office, Social Security Division, 1131 Roxas Boulevard, Manila. You may also write to the Social Security Administration, P.O. Box 17775, Baltimore, Maryland, 21235-7775, USA.

Please have this letter with you if you call or visit an office. If you write, please include a copy of this letter. It will help us answer your questions.

Social Security Administration

Enclosures:
SSA Pub No. 05-10095
Pre-addressed Envelope

Work Activity Report - Self-Employment

Identification - To Be Completed by SSA

Name of Claimant or Beneficiary	BNC#	☐ Blind ☐ Not Blind
Claim Number(s) & BIC		

Please use this form to describe your work activity since **(Insert alleged onset date, date of entitlement, or last determination date, as appropriate)**	**DATE**

Information - To Be Completed By Person Applying For Or Receiving Benefits

Please answer each of the questions on this form with as many details as you can. This information will help us decide if you should get or keep getting disability benefits.

If you need more room for your answers, go to the Remarks section at the end of the form.

1. Have you had any self-employment income **since the DATE shown above in the Identification section**? (check one)

☐ **NO.** If you did not work but income was reported for you**, go to Question 2.**

☐ **YES. Go to Question 3.**

2. If you did not work but income was reported for you, complete the information below. When you are finished, **go to Question 9**.

Payment For	Name and Address of Payer	Amount or Estimate of Value	Date Worked (MM/YYYY-MM/YYYY)
Example: Income after business stopped	ABC Company 123 Any Street Your Town, MD 54321	$100 per day, week, month, or year	01/2000 - 02/2000
		$_____ per_____	
		$_____ per_____	

3. Please tell us about your work **since the DATE shown in the Identification section.**

Type of Self-Employment or Name of Business	Area Code and Telephone Number	Area Code and Fax Number

Mailing address	City	State	ZIP

What is the primary product or service?

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working	Average Number of Hours Worked per Month

Type of ownership arrangement? (Check one)

☐ Sole Owner ☐ Limited Liability Company (LLC) ☐ Other (Please explain)

☐ Corporation ☐ Partnership ☐ Independent Contractor

☐ Farm Landlord ☐ Farm Tenant

Claim #:

4. In the space below, show each month you worked in your business, the net earnings, and if you worked 45 hours or more.

Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?	Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No

If you need more room for your answers, **go to the Remarks section.**

5. Please attach all of your self-employment tax returns (including Schedule C & SE or 1099) **since the DATE shown in the Identification section.**

☐ I have **ENCLOSED** my Tax Returns. **Go to Question 6.**

☐ **I DO NOT have Tax Returns.** For any years that you DO NOT have tax returns, use the chart below to tell us about your total annual gross and net self-employment income.

Year (YYYY)	Gross	Net	Year (YYYY)	Gross	Net
	$	$		$	$
	$	$		$	$

6. Has anyone besides yourself had **management responsibilities** for this business (i.e., a partner, employee, relative, or helper) **since the DATE shown in the Identification section**?

☐ **NO. Go to Question 7.**

☐ **YES.** Complete the questions below.

- How many hours per month (on average) does or did the other person(s) spend on management duties ________ Hours per month
- How many hours per month (on average) do or did you spend on management duties? ________ Hours per month
- Please tell us what duties you and the other person performed below.

____

____

____

____

____

____

____

____

Claim #:

7. Since the DATE shown in the Identification section did you make any changes in your work activity due to your physical and/or mental condition(s)?

☐ **NO. Go to Question 8.**

☐ **YES.** Please describe your changes below (Check all that apply below).

Type of change	Date (MM/DD/YYYY)	Please Explain
☐ Stopped Working		
☐ Reduced my work hours		My hours reduced from _____ per _____ to _____ per _____ because
☐ Changed to lighter or easier work		
☐ Other changes		

8. Has any person or organization **contributed to or paid for** any business expenses or provided any **free help, items, or services** related to your business **since the DATE shown in the Identification section** (For example: rent, supplies, inventory, purchase, repair of equipment, or an employee or helper that works for you for free)?

☐ **NO. Go to Question 9.**

☐ **YES.** Describe the expenses paid or items or services provided, their value of the contribution, and who provided them below.

Claim #:

9. Do or did you spend any of your own money for items or services **related to your physical and/or mental condition(s)** that you needed in order to work and for which you did not get reimbursed? (For example: medicines or co-pays, medical devices or procedures, Braille equipment, special telephone or equipment, service animal, attendant care, modifications to a car used for work, or other special transportation.) We may ask you for proof of payment.

☐ **NO. Go to the next section.**

☐ **YES.** Tell us what you paid below. Do not show any expenses that have been or will be paid by an insurance company, other organization, or other person.

Describe Item or Service	Cost	Date Paid (MM/YYYY-MM/YYYY)
Example: Money spent for medicines	$100 per day, week, month, or year	01/2009 - 02/2009
	$_____ per_____	
	$_____ per_____	
	$_____ per_____	
	$_____ per_____	

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

Claim #:

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition(s) or my work.

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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of Claimant, Beneficiary or Representative	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

If this statement is signed with a mark (e.g. X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

2. Signature of Witness	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(d) and 1633 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information to make a determination of eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To employers or former employers, including State Social Security administrators, for correcting and reconstructing State employee earnings records and for Social Security purposes; and

2. To Federal, State, or local agencies for the purpose of validating Social Security numbers used in administering cash or non-cash income maintenance programs or health maintenance programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0059, entitled Earnings Recording and Self-Employment Income System and 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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 (OMB) control number. The OMB control number for this collection is 0960-0598. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.*

Social Security Administration
Retirement, Survivors, and Disability Insurance
Important Information

FO Address

Date:

BNC#:

We are writing to you because we need to know more about your work. Please tell us about your work since . We will use this information to decide if you can receive or continue to receive disability benefits.

What You Need To Do

Please complete and return the completed form **within 15 days** to the address shown above. It is important to fill out the form carefully and completely. Remember to sign and date the form. If you do not return this form, we may contact your employer or make our determination based on the evidence we have in our records.

Some Information To Help You Complete This Form

Our records show these employers and yearly earnings for you. This list may not be complete. It may not show your work for this year or last year. You should add any additional work information as you complete the form.

Employer Name	Year	Earnings

For More Information

Please read the enclosed pamphlet, “Working While Disabled: How We Can Help.” It will tell you more about why we need to know about your work, and will explain our rules about working. This pamphlet is also available at www.ssa.gov/pubs/10095.html online.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit https://oig.ssa.gov/report or call the Inspector General's Fraud Hotline at **1-800-269-0271** (TTY **1-866-501-2101**).

If You Have Questions

If you have any questions, or need help completing the form:

- Visit our website at www.ssa.gov to find general information about Social Security.
- Call us toll-free at 1-800-772-1213, or call your local office at . You may also call your Social Security contact, at . We can answer most questions over the phone.
- Write or visit any Social Security office. If you plan to visit an office, you may call ahead to make an appointment. The office that serves your area is located at:

- If you are deaf or hard of hearing, our toll-free TTY number is 1-800-325-0778.
- If you are outside the United States or its territories:
  - If you are in Canada, visit www.ssa.gov/foreign/canada.htm to find the office that services your area.
  - Contact your nearest Federal Benefits Unit (FBU). Visit www.ssa.gov/foreign/foreign.htm for a list of FBU's.
  - Write to the Social Security Administration at:
    P.O. Box 17769
    Baltimore, Maryland, 21235-7769
    USA

Please have this letter with you if you call or visit an office. If you write, please include a copy of this letter. It will help us answer your questions.

Social Security Administration

Enclosures:
SSA Pub No. 05-10095
Pre-addressed Envelope

Work Activity Report - Employee

Identification - To Be Completed by SSA

Name of Claimant or Beneficiary	BNC#	☐ Blind ☐ Not Blind

Please use this form to describe your work activity since (Insert alleged onset date, date of entitlement, or last determination date, as appropriate)	Date

Information - To Be Completed By Person Applying For Or Receiving Benefits

Please answer each of the questions on this form with as many details as you can. This information will help us decide if you should get or keep getting disability benefits.

If you need more room for your answers, go to the Remarks section at the end of the form.

1. Have you had any employment income or wages since the DATE shown above in the Identification section? (check one)

☐ **NO. If you did not work but income was reported for you, go to Question 2.**

☐ **YES. Go to Question 3.**

2. If you did not work, other types of income may have been reported for you. Please complete the information below. We may ask you for proof of this income. When you are finished, **go to Question 7**.

Type of Payment	Name and Address of Payer	Amount	Date Worked (MM/YYYY-MM/YYYY)
☒ Example	ABC Company 123 Any Street Your Town, MD 54321	$100.00 per day, week, month, or year	01/2000 - 02/2000
☐ Back Pay		$ _____ per _____	
☐ Vacation Pay		$ _____ per _____	
☐ Holiday Pay		$ _____ per _____	
☐ Bonus or Commission		$ _____ per _____	
☐ Royalties		$ _____ per _____	
☐ Sick Pay		$ _____ per _____	
☐ Disability Pay		$ _____ per _____	
☐ Insurance Payment		$ _____ per _____	
☐ Workers Comp		$ _____ per _____	
☐ Other (Please explain) _____		$ _____ per _____	

BNC#: _____

3A. Please tell us about your work **since the DATE shown in the Identification section, beginning with your most recent employer**. If you are not sure about this, ask your employer(s) to help you. Use the additional space provided in the Remarks section if you need more room for your answer.

Current or Most Recent Employer's Name	Supervisor's Name	Supervisor's Telephone No. *(include area code)*
Mailing Address	City	State / ZIP Code
Job Title and Type of Work		
Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working	Rate of Pay $ _____ per _____ / Hours Worked per Week (on average)

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	$		$		$
	$		$		$
	$		$		$
	$		$		$

3B. If you do not have any more employers, **go to Question 4.**

Previous Employer's Name	Supervisor's Name	Supervisor's Telephone No. *(include area code)*
Mailing Address	City	State / ZIP Code
Job Title and Type of Work		
Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working	Rate of Pay $ _____ per _____ / Hours Worked per Week (on average)

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	$		$		$
	$		$		$
	$		$		$
	$		$		$

BNC#: _____

3C. If you do not have any more employers, **go to Question 4.**

Previous Employer's Name	Supervisor's Name	Supervisor's Telephone No. *(include area code)*

Mailing Address	City	State	ZIP Code

Job Title and Type of Work

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working	Rate of Pay $ _____ per _____	Hours Worked per Week (on average)

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	$		$		$
	$		$		$
	$		$		$
	$		$		$

If you have more employers, go to Additional Employment Information.

4. Do or did you get any other payment(s) or benefit(s) from an employer **in addition to the regular pay** shown in Question 3?

☐ **NO. Go to Question 5.**

☐ **YES. Please check all that apply below.**

☐ Sick Pay ☐ Disability Pay ☐ Vacation Pay ☐ Tips ☐ Bonus

☐ Transportation ☐ Car or Vehicle ☐ Childcare ☐ Meals ☐ Room or Rent

☐ Other (Please explain): _____

Type of Payment	Employer Name	Amount or Estimate of Value	Date Received (MM/YYYY-MM/YYYY)
Example: *Sick Pay*	*ABC Company*	*$100.00 per day, week, month, or year*	*01/2000 - 02/2000*
		$ _____ per _____	
		$ _____ per _____	
		$ _____ per _____	

BNC#: _____

5. For any job(s) that you told us about in Question 3, have you worked under any special conditions listed below?

Yes	Special Condition	Employer Name	Date (MM/YYYY to MM/YYYY)	Please Describe
☐	Had extra help, extra supervision or a job coach			
☐	Worked irregular or fewer hours than other workers			
☐	Given special equipment because of my condition			
☐	Took more rest periods than other workers			
☐	Given special transportation to and from work			
☐	Had fewer or easier duties than other workers			
☐	Allowed to produce less work than other workers			
☐	Hired through special training or therapy program			
☐	Given work that was suited to my condition			
☐	Given special help getting ready for work			
☐	Other (explain)			
☐	Other (explain)			
☐	None of the above apply. **Go to Question 6A.**			

BNC#: _____

6A. For any job that you told us about in Question 3, did you make any of the changes below since the **DATE shown in the Identification section** (Check all that apply).

Yes	Special Condition	Employer Name	Date (MM/DD/YYYY)	Reasons for Changes in Work Activity
☐	Stopped working			☐ My physical and/or mental condition(s) ☐ Special conditions that allowed me to work were removed ☐ Other reasons (please explain in 6B)
☐	Reduced my work hours			☐ My physical and/or mental condition(s) ☐ Special conditions that allowed me to work were removed ☐ Other reasons (please explain in 6B)
☐	Reduced my earnings			☐ My physical and/or mental condition(s) ☐ Special conditions that allowed me to work were removed ☐ Other reasons (please explain in 6B)
☐	Changed to a lighter or easier type of work			☐ My physical and/or mental condition(s) ☐ Special conditions that allowed me to work were removed ☐ Other reasons (please explain in 6B)
☐	**No**, I did not make any changes since the date shown in the Identification section. **Go to Question 7.**			

6B. Use this space to provide any additional information about your work changes.

BNC#: _____

7. Do or did you spend any of your own money for items or services **related to your physical and/or mental condition(s)** that you needed in order to work and for which you did not get reimbursed? (For example; medicines or co-pays, medical devices or procedures, Braille equipment, special telephone or equipment, service animal, attendant care, modifications to a car used for work, or other special transportation.) We may ask you for proof of payment.

☐ **NO.** I did not spend any of my own money for items or services related to my physical and/or mental condition.

☐ **YES.** Please tell us what you paid below. Do not show any expenses that have been or will be paid by an insurance company, other organization, or other person.

Describe Item or Service	Cost	Date Paid (MM/YYYY-MM/YYYY)
Example: Service animal	*$100.00 per day, week, month, or year*	*01/2000 - 02/2000*
	$ _____ per _____	
	$ _____ per _____	
	$ _____ per _____	
	$ _____ per _____	

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

BNC#: _____

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition or my work.

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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of Claimant, Beneficiary or Representative	Date	Area Code and Telephone Number

Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)	City	State	ZIP Code

If this statement is signed with a mark (e.g., X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	Date	Area Code and Telephone Number

Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)	City	State	ZIP Code

2. Signature of Witness	Date	Area Code and Telephone Number

Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)	City	State	ZIP Code

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(d) and 1633 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed or could result in an overpayment of benefits.

We will use the information to make a determination of eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To employers or former employers for correcting or reconstructing earnings records and for Social Security tax purposes only; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0059, entitled Earnings Recording and Self-Employment Income System, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819, 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210, and 60-0330, entitled eWork, as published in the FR on September 15, 2003, at 68 FR 54037. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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 (OMB) control number. The OMB control number for this collection is 0960-0059. We estimate that it will take about 40 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to*****:** *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.*

BNC#: _____

ADDITIONAL EMPLOYMENT INFORMATION
(Continuation from Page 5)

Employer's Name	Supervisor's Name	Supervisor's Telephone No. *(include area code)*

Mailing Address	City	State	ZIP Code

Job Title and Type of Work

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working	Rate of Pay $ _____ per _____	Hours Worked per Week (on average)

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	$		$		$
	$		$		$
	$		$		$
	$		$		$

Employer's Name	Supervisor's Name	Supervisor's Telephone No. *(include area code)*

Mailing Address	City	State	ZIP Code

Job Title and Type of Work

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working	Rate of Pay $ _____ per _____	Hours Worked per Week (on average)

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	$		$		$
	$		$		$
	$		$		$
	$		$		$

BNC#: _____

ADDITIONAL EMPLOYMENT INFORMATION
(Continuation from Page 5)

Employer's Name	Supervisor's Name	Supervisor's Telephone No. *(include area code)*

Mailing Address	City	State	ZIP Code

Job Title and Type of Work

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working	Rate of Pay $ _____ per _____	Hours Worked per Week (on average)

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	$		$		$
	$		$		$
	$		$		$
	$		$		$

Employer's Name	Supervisor's Name	Supervisor's Telephone No. *(include area code)*

Mailing Address	City	State	ZIP Code

Job Title and Type of Work

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working	Rate of Pay $ _____ per _____	Hours Worked per Week (on average)

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	$		$		$
	$		$		$
	$		$		$
	$		$		$

FUNCTION REPORT - ADULT

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 10, and show the number of the question being answered.

Function Report - Adult - Form SSA-3373-BK

REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM ON PAGE 10

Privacy Act Statements
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information you provide to make a determination of eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs; and

- To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all our SORNs, is available on our website at https://ssa.gov/privacy.

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 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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 regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***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.

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle Initial, Last)*	2. **SOCIAL SECURITY NUMBER**

3. **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.)*

_____ _____ ☐ Your Number ☐ Message Number ☐ None

Area Code *Phone Number*

4. 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 YOUR ILLNESSES, INJURIES, OR CONDITIONS

5. How do your illnesses, injuries, or conditions limit your ability to work?

SECTION C - 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?

If "YES," who helps, and what do they do to help? ☐ Yes ☐ No

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. How do you spend time with others? *(Check all that apply.)*

☐ In person ☐ On the phone ☐ Email ☐ Texting ☐ Mail

☐ Video Chat (for example Skype or Facetime) ☐ Other *(Explain)*

b. Describe the kinds of things you do with others.

How often do you do these things?

c. 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

If "YES", explain.

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

If "YES," explain.

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

SECTION D - 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?

22. Do you currently take any medicines for your illnesses, injuries, or conditions? ☐ Yes ☐ No

If "YES, "do any of your medicines cause side effects? ☐ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE	SIDE EFFECTS YOU HAVE

SECTION E - 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 *(MM/DD/YYYY)*
Address (Number and Street)	Email address (optional)
City	State / ZIP Code

FUNCTION REPORT - ADULT - THIRD PARTY Form SSA-3380-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 (TTY 1-800-325-0778).

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to make a decision on the disabled person's claim. You can help by completing as much of the form as you can. When a question refers to the "disabled person," it refers to the person who is applying for or receiving disability benefits.

It is important that you tell us what you know about the disabled person's activities and abilities.

DO NOT ASK THE DISABLED PERSON TO GIVE YOU ANSWERS

- 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 you need more space to answer any questions, use the "REMARKS" section on Page 10, and show the number of the question being answered.

Function Report - Adult - Third Party Form SSA-3380-BK

REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM ON PAGE 10

Privacy Act and Paperwork Reduction Act Statements

Sections 205(a), 223(d), and 1631 of the Social Security Act (Act), as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information you provide to make a determination of eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs; and

- To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all of our SORNs, is available on our website at https://www.ssa.gov/privacy.

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 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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 regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to*: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***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 - THIRD PARTY

How the disabled person's illnesses, injuries, or conditions limit his/her activities

For SSA Use Only
Do not write in this box.

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION A - GENERAL INFORMATION

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

2. **YOUR NAME** *(Person completing the form)*	3. **RELATIONSHIP** *(To disabled person)*	4. **DATE** *(MM/DD/YYYY)*

5. **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.)*

_____ - _____ ☐ Your Number ☐ Message Number ☐ None
Area Code Phone Number

6. a. How long have you known the disabled person? _____
b. How much time do you spend with the disabled person and what do you do together?

7. a. Where does the disabled person live? *(Check one.)*

☐ House ☐ Apartment ☐ Boarding House ☐ Nursing Home

☐ Shelter ☐ Group Home ☐ Other (What?) _____

b. With whom does he/she live? *(Check one.)*

☐ Alone ☐ With Family ☐ With Friends

☐ Other (describe relationship) _____

SECTION B - INFORMATION ABOUT ILLNESSES, INJURIES, OR CONDITIONS

8. How does this person's illnesses, injuries, or conditions limit his/her ability to work?

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

9. Describe what the disabled person does from the time he/she wakes up until going to bed.

10. Does this person take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? ☐ Yes ☐ No

If "YES," for whom does he/she care, and what does he/she do for them?

11. Does he/she take care of pets or other animals? ☐ Yes ☐ No

If "YES," what does he/she do for them?

12. Does anyone help this person care for other people or animals? ☐ Yes ☐ No

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

13. What was the disabled person able to do before his/her illnesses, injuries, or conditions that he/she can't do now?

14. Do the illnesses, injuries, or conditions affect his/her sleep? ☐ Yes ☐ No

If "YES," how?

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

a. Explain how the illnesses, injuries, or conditions affect this person's ability to:

Dress

Bathe

Care for hair

Shave

Feed self

Use the toilet

Other

b. Does he/she 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. Does he/she need help or reminders taking medicine? ☐ Yes ☐ No

If "YES," what kind of help does he/she need?

16. **MEALS**

a. Does the disabled person prepare his/her own meals? ☐ Yes ☐ No

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

How often does he/she prepare food or meals? (For example, daily, weekly, monthly.)

How long does it take him/her?

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

b. If "No," explain why he/she cannot or does not prepare meals.

17. **HOUSE AND YARD WORK**

a . List household chores, both indoors and outdoors, that the disabled person is able to do .
(For example, cleaning, laundry, household repairs, ironing, mowing, etc.)

b. How much time do chores take, and how often does he/she do each of these things?

c. Does he/she need help or encouragement doing these things? ☐ Yes ☐ No

If "YES," what help is needed?

d. If the disabled person doesn't do house or yard work, explain why not.

18. **GETTING AROUND**

a. How often does this person go outside?

If he/she doesn't go out at all, explain why not.

b. When going out, how does he/she 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 he/she go out alone? ☐ Yes ☐ No

If "NO," explain why he/she can't go out alone.

d. Does the disabled person drive? ☐ Yes ☐ No

If he/she doesn't drive, explain why not.

19. **SHOPPING**

a. If the disabled person does any shopping, does he/she shop: *(Check all that apply.)*

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

b. Describe what he/she shops for.

c. How often does he/she shop and how long does it take?

20. **MONEY**

a. Is he/she 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 the disabled person's 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.

21. **HOBBIES AND INTERESTS**

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

b. How often and how well does he/she do these things?

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

22. **SOCIAL ACTIVITIES**

a. How does the disabled person spend time with others? *(Check all that apply.)*

☐ In person ☐ On the phone ☐ Email ☐ Texting ☐ Mail

☐ Video Chat (for example Skype or Facetime) ☐ Other *(Explain)* _____

b. Describe the kinds of things he/she does with others.

How often does he/she do these things?

c. List the places he/she goes on a regular basis. (For example, church, community center, sports events, social groups, etc.)

Does he/she need to be reminded to go places? ☐ Yes ☐ No

How often does he/she go and how much does he/she take part?

Does he/she need someone to accompany him/her? ☐ Yes ☐ No

d. Does this person have any problems getting along with family, friends, neighbors, or others? ☐ Yes ☐ No

If "YES," explain.

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

SECTION D - INFORMATION ABOUT ABILITIES

23. a. Check any of the following items the disabled person's 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 his/her illnesses, injuries, or conditions affect each of the items you checked. (For example, he/she can only lift [how many pounds], or he/she can only walk [how far])

b. Is the disabled person: ☐ Right Handed? ☐ Left Handed?

c. How far can he/she walk before needing to stop and rest?

If he/she has to rest, how long before he/she can resume walking?

d. For how long can the disabled person pay attention?

e. Does the disabled person finish what he/she starts? *(* For example, a conversation, chores, reading, watching a movie.) ☐ Yes ☐ No

f. How well does the disabled person follow written instructions? (For example, a recipe.)

g. How well does the disabled person follow spoken instructions?

h. How well does the disabled person get along with authority figures? (For example, police, bosses, landlords or teachers.)

i. Has he/she 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 does the disabled person handle stress?

k. How well does he/she handle changes in routine?

l. Have you noticed any unusual behavior or fears in the disabled person? ☐ Yes ☐ No

If "YES," please explain.

24. Does the disabled person 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 does this person need to use these aids?

25. Does the disabled person currently take any medicines for his/her illnesses, injuries, or conditions? ☐ Yes ☐ No

If " YES," do any of the medicines cause side effects? ☐ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that the disabled person takes. List only the medicines that cause side effects for the disabled person.)

NAME OF MEDICINE	SIDE EFFECTS PERSON HAS

SECTION E - 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 *(MM/DD/YYYY)*
Address (Number and Street)	Email address (optional)
City	State / ZIP Code

WORK HISTORY REPORT- Form SSA-3369-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. Then call the phone number provided on the letter sent with the form or the phone number of the person who asked you to complete the form for help to 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.

- Print or type.
- A reference to "you," "your," or "the Disabled Person," or "claimant" means the person who is applying for disability benefits. If you are filling out the form for someone else, provide information about him or her.
- **ANSWER ALL OF THE QUESTIONS FOR EACH JOB YOU DESCRIBE.** 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."
- 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.

WHY THIS INFORMATION IS IMPORTANT

The information we ask for on this form will help us understand how your illnesses, injuries, or conditions might affect your ability to do work for which you are qualified. The information tells us about the kinds of work you did, including the types of skills you needed and the physical and mental requirements of each job. In Section 2, be sure to give us all of the different jobs you did in the 15 years before you became unable to work because of your illnesses, injuries, or conditions. There is a separate page to describe each different job.

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

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a determination of eligibility for Social Security benefits.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0089, entitled, Claims Folders Systems; and, 60-0090, entitled, Master Beneficiary Record. Additional information about these and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 1 hour to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE STATE AGENCY THAT REQUESTED IT. If you have questions about how to complete the form, contact the State Agency that requested it. If you need the address or phone number for your State Agency, you can get it by calling 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.***

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

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.)*

( ) – ☐ Your Number ☐ Message Number ☐ None

Area Code *Phone Number*

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.				
10.				

Work History Report - Form SSA-3369-BK

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

JOB TITLE NO. 1

Rate of Pay	Per *(Check One)*					Hours per day	Days Per Week
$ _____	☐ Hour	☐ Day	☐ Week	☐ Month	☐ Year		

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

_____

_____

_____

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

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
Reach? _____
Write, type, or handle small objects? _____

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

_____

_____

_____

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

Give us more information about Job No. 2 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 2

Rate of Pay	Per *(Check One)*					Hours per day	Days per week
$ _____	☐ Hour	☐ Day	☐ Week	☐ Month	☐ Year		

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

_____

_____

_____

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

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

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

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

_____

_____

_____

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

Give us more information about Job No. 3 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 3

Rate of Pay	Per *(Check One)*					Hours per day	Days per week
$ _____	☐ Hour	☐ Day	☐ Week	☐ Month	☐ Year		

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

_____

_____

_____

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

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
Reach? _____
Write, type, or handle small objects? _____

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

_____

_____

_____

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

Give us more information about Job No. 4 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 4

Rate of Pay	Per *(Check One)*					Hours per day	Days per week
$ _____	☐ Hour	☐ Day	☐ Week	☐ Month	☐ Year		

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

_____

_____

_____

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

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

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

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

_____

_____

_____

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

Give us more information about Job No. 5 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 5

Rate of Pay	Per *(Check One)*					Hours per day	Days per week
$ _____	☐ Hour	☐ Day	☐ Week	☐ Month	☐ Year		

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

_____

_____

_____

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

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
Reach? _____
Write, type, or handle small objects? _____

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

_____

_____

_____

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

Give us more information about Job No. 6 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 6

Rate of Pay	Per *(Check One)*					Hours per day	Days per week
$ _____	☐ Hour	☐ Day	☐ Week	☐ Month	☐ Year		

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

_____

_____

_____

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

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
Reach? _____
Write, type, or handle small objects? _____

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

_____

_____

_____

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

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)*	**Date** *(Month, day, year)*	
Address *(Number and Street)*	**Email address** *(optional)*	
City	**State**	**ZIP Code**

6. Medical Support Resources

This section includes resources for physicians and clinic staff to provide supporting evidence for a Social Security disability claim, including sample medical letters, official Social Security medical evaluation forms, and a medical source statement created specifically for HD patients. Treating physician records and medical opinion are vital in a Social Security disability claim. An HD patient cannot get approved for any kind of Social Security disability without clinical evidence of HD and supporting medical documentation.

Additionally, a medical letter that provides no details about an HD patient's symptomology and limitations regarding activities of daily living and ability to work, essentially a letter that states "my patient is disabled because I said so," will not be accepted by Social Security and could discredit all of the medical evidence provided by the HD clinic. Only Social Security has the legal authority to determine who is disabled and the person who suffers is the HD patient.

Medical Support Resources

March 22, 2021

To Whom It May Concern:

This is regarding my patient Ms./Mr. XX OOO (DOB: xx-xx-xxxx). I am (Job title) at the University/ Hospital/Medical Center, where my primary role is to evaluate and treat people with a hereditary central nervous system condition called Huntington Disease (HD). Ms./Mr. OOO has been diagnosed with HD, which was confirmed by genetic testing showing a CAG repeat of xx. Her/His clinical symptoms are consistent with this diagnosis.

Background on Huntington Disease: HD is a terminal inherited neurological condition that affects the brain and its functioning. Like other individuals with HD, Ms./Mr. OOO is currently experiencing symptoms in three main areas of functioning: behavior and emotions; cognition and intelligence; and motor skills. As HD is a permanent condition that progresses over time and has no cure, Ms./Mr. OOO's symptoms will continue to worsen over time.

Behavioral and emotional symptoms can include problems with depression, anxiety, anger, and frustration. People may have difficulty controlling emotions and may also show sleep disturbances and personality changes.

Cognitive changes may often appear as difficulty in concentration and focus. Typically, the short-term memory is affected and, as the disease progresses, it frequently becomes impaired. As the disease progresses, it may become difficult for people to perform tasks and cope with problems.

Motor skills can also be impaired in individuals with HD. Involuntary movements are characteristic of this disease and may involve muscles in the arms, legs, and face. Speech and swallowing may also be affected, making these activities difficult.

Findings for Ms. OOO: Ms./Mr. OOO has been followed in our HD Center of Excellence at _____ since the beginning of YYYY. Her/His evaluations include [neuropsychiatric testing, Montreal Cognitive Assessment, neurological examination, and psychiatric evaluations.

Ms. OOO exhibits [behavioral/cognitive/motor – choose all that apply] symptoms. Per Listing 11.17 for Neurodegenerative disease, such as Huntington's disease, s/he has demonstrated: [**bold** the relevant impairments]

A. Disorganization of motor function in two extremities, resulting in an extreme limitation in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; OR
B. Marked limitation in physical functioning, and in one of the following:
    1. Understanding, remembering, or applying information; or
    2. Interacting with others; or
    3. Concentrating, persisting, or maintaining pace; or
    4. Adapting or managing oneself.

Ms./Mr. OOO's neuropsychiatric evaluation determined that s/he has [dementia/cognitive dysfunction/cognitive decline/memory loss] secondary to HD. Per Listing 12.02 for Neurocognitive disorders, s/he has demonstrated significant cognitive impairment or changes, most notably in: [at least one of the following - **bold** the relevant impairments]

1. Complex Attention
2. Executive function;
3. Learning and memory;
4. Language;
5. Perceptual-motor; or
6. Social cognition.

These cognitive changes result in an extreme limitation [one of the following] OR marked limitation: [at least two of the following]:

1. Understanding, remembering, or applying information.
2. Interacting with others.
3. Concentrating, persisting, or maintaining pace.
4. Adapting and managing oneself.

Example (this information should be patient specific and should not be copied and pasted from this section):
She is currently experiencing cognitive changes and psychiatric manifestations of HD which impair her short-term and intermediate memory. Due to this impairment, she has marked limitations interacting with others and maintaining pace at work. Specifically, she is unable to remember and follow instructions that are provided by coworkers. She has a delay in her response to requests, and an inability to keep up with required tasks. When speaking on the phone, she can no longer stay on script and is providing incorrect information to customers [specific details are good].

Ms./Mr. OOO's psychiatric evaluation determined that s/he has a history of a chronic organic mental disorder which has been present for [at least 2 years] and has caused significant limitation in basic work activities. This includes: [must meet both requirements]

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of the mental disorder; AND
2. Marginal adjustment, that is, patient has minimal capacity to adapt to changes in his/her environment or to demands that are not already part of his/her daily life.

Example (this information should be patient specific and should not be copied and pasted from this section):
Ms. OOO's psychiatric evaluation determined that she has a history of a chronic organic mental disorder which has been present for 2 years and has caused significant limitation in basic work activities. This includes an Adjustment Disorder with depression and anxiety which causes Ms. OOO to decompensate following even minimal changes in her environment. She also has emotional lability and mood disorder which causes repeated episodes of anger outbursts towards others. This significantly limits her social functioning and has caused problems with her ability to work with others, demonstrating marked limitations interacting with others. These symptoms are secondary to her diagnosis of HD, and have resulted in the loss of jobs in the past because she is unable to work successfully with others.

According to her neurological evaluation, Ms./Mr. OOO also has motor signs which are consistent with her/his diagnosis of HD. These include extreme/marked limitations in physical functioning in the form of [paresis/paralysis/ tremor/involuntary movements/ataxia/or sensory disturbances] which occur [singly/in combination with__] and affect [# of extremities/trunk/head] resulting in sustained disturbance of [gross and dexterous movements/gait and station] despite treatment.

Example (this information should be patient specific and should not be copied and pasted from this section):
According to her neurological evaluation, Ms. OOO also has motor signs which are consistent with her diagnosis of HD. These include marked limitations in physical functioning in the form of chorea (abnormal movements) that occurs in combination with loss of coordination, is widespread, and affects all four extremities. This results in sustained disturbance of gross motor movements along with abnormal gait despite treatment. Due to these motor abnormalities, she has a wide-based, uncoordinated gait and is at risk for falls and injury.

In my medical opinion, Ms./Mr. OOO is unable to perform responsibilities required of any job on a regular basis due to the disability in both her psychological and cognitive function caused by the HD. Her/his short-term memory impairment would affect her/his ability to learn new tasks, resulting in marked limitations understanding and applying information, and her/his other neuropsychiatric symptoms would affect her/his ability to be an effective coworker, resulting in marked limitations interacting with others. In addition, the activities and stress involved in the workplace will irreversibly exacerbate the symptoms that Ms./Mr. OOO is already experiencing due to the HD. Her/His symptoms have, unfortunately, become more severe over time, and will continue to progress, causing increasing problems with poor memory, judgment, speech, swallowing, coordination, and involuntary movements.

Please feel free to contact me at (X) with any questions or concerns.

Sincerely,

[redacted]

November 14, 2016

Patient: [redacted]
Date of Birth: [redacted]
Date of Visit: [redacted]

To Social Security Disability Determination: [redacted]

This letter is to provide additional medical support for the disability determination of [redacted], who has Huntington's Disease.

[redacted] was first seen at my office on [redacted] after being seen by [redacted] in Dayton, OH with symptoms that were confirmed to be HD. [redacted] diagnosis was made by a complete neurological exam and by a blood test which provided genetic confirmation. [redacted] is adopted thus no positive family history is available.

HD is an inherited neuropsychiatric disorder that is progressive and terminates in the death of the affected individual. Recovery or remission never occurs. The diagnosis of HD is based upon clinical symptoms (which can first appear at any age throughout the individual's lifetime), a positive family history and the genetic test results. Treatment is ineffective in terms of halting the progression of the disease and medical care focuses solely on symptom management.

Incapacitation occurs relatively early in the course of this debilitating disease with progression to total disability and dependency for all activities of daily living. There are three characteristic clinical features in HD: 1)loss of ability to control bodily movements 2)loss of the ability to think and act quickly, to learn new material, to prioritize and multitask and to remember and 3) mood state changes including anxiety, apathy, depression and aggression among others. HD is unpredictable and the symptoms are often inconsistent.

[redacted] has presented with the above mentioned symptoms present in varying degrees of severity throughout the past year. [redacted] has always been employed in low paying positions such as a cashier. [redacted] difficulties with fine motor coordination, combined with uncontrolled movements, are now making it challenging for [redacted] to manage the cash register without dropping money or pushing incorrect keys. [redacted] frustration level is such that [redacted] becomes quickly flustered thus increasing [redacted] motor in-coordination. [redacted] cannot work under pressure and cannot be relied upon to self-correct. When given a task such as stocking shelves [redacted] is unable to do so due to poor balance and coordination. [redacted] anxiety increases as [redacted] performance on even simple tasks decreases adding to [redacted] stress and depression. Due to the anxiety, [redacted] finds it impossible to work more than on a part-time basis thus limiting the income [redacted] can receive from the low paying job [redacted] currently has.

[redacted] is not a candidate for any substantial, gainful or self-supporting employment. Like all patients with HD [redacted] cognitive and neurological impairments make

[redacted]

learning new tasks challenging if not impossible at this point. Upon administration of the MOCA, (Montreal Cognitive Assessment) [redacted] total score was [redacted] out of a possible 30 points. [redacted] cognitive decline along with chorea and anxiety are all factors in [redacted] need for disability. Huntington's Disease is among the conditions that are a part of Social Security Administrations Compassionate Allowance conditions needing assistance in as short a time as possible.

In summary it is my belief that [redacted] is totally and permanently disabled due to [redacted] progressive and incurable diagnosis of HD.

Sincerely,

[redacted]

[redacted]

Form Approved
OMB No. 0960-0662

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME OF INDIVIDUAL

SOCIAL SECURITY NUMBER

\- -

To determine this individual's ability to do **work-related activities on a regular and continuous basis**, please give us your opinions for each activity shown below:

The following terms are defined as:

- **REGULAR AND CONTINUOUS BASIS** means 8 hours a day, for 5 days a week, or an equivalent work schedule.
- **OCCASIONALLY** means very little to one-third of the time.
- **FREQUENTLY** means from one-third to two-thirds of the time.
- **CONTINUOUSLY** means more than two-thirds of the time.

Age and body habitus of the individual should not be considered in the assessment of limitations. It is important that you relate particular medical or clinical findings to any assessed limitations in capacity: The usefulness of your assessment depends on the extent to which you do this.

I. LIFTING/CARRYING

Check the boxes representing the amount the individual can lift and how often it can be lifted.

Lift	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:				
B. 11 to 20 lbs:				
C. 21 to 50 lbs:				
D. 51 to 100 lbs:				

Check the boxes representing the amount the individual can carry and how often it can be carried.

Carry	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:				
B. 11 to 20 lbs:				
C. 21 to 50 lbs:				
D. 51 to 100 lbs:				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

II. SITTING/STANDING/WALKING

Please check how many hours the individual can (if less than one hour, how many minutes):

At One Time without Interruption

	Minutes	Hours
A. Sit	_____	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8
B. Stand	_____	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8
C. Walk	_____	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Total in an 8 hour work day

	Minutes	Hours
A. Sit	_____	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8
B. Stand	_____	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8
C. Walk	_____	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If the total time for sitting, standing and walking does not equal or exceed 8 hours, what activity is the individual performing for the rest of the 8 hours?

Does the individual require the use of a cane to ambulate? ☐ **Yes** ☐ **No**

If the answer is "yes" please answer the following:

- How far can the individual ambulate without the use of a cane? _____
- Is the use of a cane medically necessary? ☐ **Yes** ☐ **No**
- With a cane, can the individual use his/her free hand to carry small objects? ☐ **Yes** ☐ **No**

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

III. USE OF HANDS

Indicate how often the individual can perform the following activites:

ACTIVITY	Right Hand					Left Hand			
	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)		Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
REACHING (Overhead)									
REACHING (All Other)									
HANDLING									
FINGERING									
FEELING									
PUSH/PULL									

Which is the individual's dominant hand? ☐ Right Hand ☐ Left Hand

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support this assessment.

IV. USE OF FEET

Indicate how often the individual can perform the following activities:

ACTIVITY	Right Foot					Left Foot			
	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)		Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Operation of Foot Controls									

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

V. POSTURAL ACTIVITIES

How often can the individual perform the following activities:

ACTIVITY	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Climb stairs and ramps				
Climb ladders or scaffolds				
Balance				
Stoop				
Kneel				
Crouch				
Crawl				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

VI. DO ANY OF THE IMPAIRMENTS AFFECT THE CLAIMANT'S HEARING OR VISION?

☐ **No** ☐ **Yes** ☐ **Not Evaluated**

If "yes" please complete the following questions (where appropriate)

1. If a **hearing impairment** is present,

   a. Does the individual retain the ability to hear and understand simple oral instructions and to communicate simple information? ☐ Yes ☐ No

   b. Can the individual use a telephone to communicate? ☐ Yes ☐ No

2. If a **visual impairment** is present,

   a. Is the individual able to avoid ordinary hazards in the workplace, such as boxes on the floor, doors ajar, or approaching people or vehicles? ☐ Yes ☐ No

   b. Is the individual able to read very small print? ☐ Yes ☐ No

   c. Is the individual able to read ordinary newspaper or book print? ☐ Yes ☐ No

   d. Is the individual able to view a computer screen? ☐ Yes ☐ No

   e. Is the individual able to determine differences in shape and color of small objects such as screws, nuts or bolts? ☐ Yes ☐ No

   Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

VII. ENVIRONMENTAL LIMITATIONS

How often can the individual tolerate exposure to the following conditions:

Condition	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Unprotected Heights				
Moving Mechanical Parts				
Operating a motor vehicle				
Humidity and wetness				
Dust, odors, fumes and pulmonary irritants				
Extreme cold				
Extreme heat				
Vibrations				
Other: (Identify)				

Condition	Quiet (Library)	Moderate (Office)	Loud (Heavy Traffic)	Very Loud (Jackhammer)
Noise				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

VIII. PLEASE PLACE A CHECK IN APPROPRIATE BOXES BASED SOLELY ON THE CLAIMANT'S PHYSICAL IMPAIRMENTS

ACTIVITY	YES	NO
Can the individual perform activities like shopping?		
Can the individual travel without a companion for assistance?		
Can the individual ambulate without using a wheelchair, walker, or 2 canes or 2 crutches?		
Can the individual walk a block at a reasonable pace on rough or uneven surfaces?		
Can the individual use standard public transportation?		
Can the individual climb a few steps at a reasonable pace with the use of a single hand rail?		
Can the individual prepare a simple meal & feed himself/herself?		
Can the individual care for their personal hygiene?		
Can the individual sort, handle, or use paper/files?		

Please identify the medical findings that support this assessment and why the findings support the assessment (unless a narrative report is attached).

IX. STATE ANY OTHER WORK-RELATED ACTIVITIES, WHICH ARE AFFECTED BY ANY IMPAIRMENTS, AND INDICATE HOW THE ACTIVITIES ARE AFFECTED. WHAT ARE THE MEDICAL FINDINGS THAT SUPPORT THIS ASSESSMENT?

X. THE LIMITATIONS ABOVE ARE ASSUMED TO BE YOUR OPINION REGARDING CURRENT LIMITATIONS ONLY.

HOWEVER, IF YOU HAVE SUFFICIENT INFORMATION TO FORM AN OPINION WITHIN A REASONABLE DEGREE OF MEDICAL PROBABILITY AS TO PAST LIMITATIONS, ON WHAT DATE WERE THE LIMITATIONS YOU FOUND ABOVE FIRST PRESENT? _____

XI. HAVE THE LIMITATIONS YOU FOUND ABOVE LASTED OR WILL THEY LAST FOR 12 CONSECUTIVE MONTHS? ☐ **Yes** ☐ **No**

_____ _____

SIGNATURE DATE

_____

Print Name, Title and Medical Specialty (Legibly Please)

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a)(3)(H)(I) and 1631(d)(1) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to complete processing of the named patient's claim.

The information you furnish on this form is voluntary. However, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim.

We rarely use the information you supply for any purpose other than for determining eligibility for benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

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 Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state and local level; and

4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.ssa.gov or at your local Social Security office.

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 15 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 underU. 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.***

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0662

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (MENTAL)

==========

NAME OF INDIVIDUAL **SOCIAL SECURITY NUMBER**

INSTRUCTIONS:

Please assist us in determining this individual's ability to do work-related activities on a sustained basis. "Sustained basis" means the ability to perform work-related activities eight hours a day for five days a week, or an equivalent work schedule. (SSR 96-8p). Please give us your professional opinion of what the individual can still do despite his/her impairment(s). The opinion should be based on your findings with respect to medical history, clinical and laboratory findings, diagnosis, prescribed treatment and response, and prognosis.

For each activity shown below, respond to the questions about the individual's ability to perform the activity. When doing so, use the following definitions for the rating terms:

- None - Absent or minimal limitations. If limitations are present they are transient and/or expected reactions to psychological stresses.
- Mild - There is a slight limitation in this area, but the individual can generally function well.
- Moderate - There is more than a slight limitation in this area but the individual is still able to function satisfactorily.
- Marked - There is serious limitation in this area. There is a substantial loss in the ability to effectively function.
- Extreme - There is major limitation in this area. There is no useful ability to function in this area.

IT IS VERY IMPORTANT TO DESCRIBE THE FACTORS THAT SUPPORT YOUR ASSESSMENT. WE ARE REQUIRED TO CONSIDER THE EXTENT TO WHICH YOUR ASSESSMENT IS SUPPORTED.

---

(1) Is ability to understand, remember, and carry out instructions affected by the impairment? ☐ No ☐ Yes
If "no," go to question #2. If "yes," please check the appropriate block to describe the individual's restriction for the following work-related mental activities.

	None	Mild	Moderate	Marked	Extreme
Understand and remember simple instructions.	☐	☐	☐	☐	☐
Carry out simple instructions.	☐	☐	☐	☐	☐
The ability to make judgments on simple work-related decisions.	☐	☐	☐	☐	☐
Understand and remember complex instructions.	☐	☐	☐	☐	☐
Carry out complex instructions.	☐	☐	☐	☐	☐
The ability to make judgments on complex work-related decisions.	☐	☐	☐	☐	☐

Identify the factors (e.g., the particular medical signs, laboratory findings, or other factors described above) that support your assessment.

---

(2) Is ability to interact appropriately with supervision, co-workers, and the public, as well as respond to changes in the routine work setting, affected by impairments? ☐ No ☐ Yes
If "no," go to question #3. If "yes," please check the appropriate block to describe the individual's restriction for the following work-related mental activities.

	None	**Mild**	**Moderate**	**Marked**	**Extreme**
Interact appropriately with the public.	☐	☐	☐	☐	☐
Interact appropriately with supervisor(s).	☐	☐	☐	☐	☐
Interact appropriately with co-workers.	☐	☐	☐	☐	☐
Respond appropriately to usual work situations and to changes in a routine work setting.	☐	☐	☐	☐	☐

Identify the factors (e.g., the particular medical signs, laboratory findings, or other factors described above) that support your assessment.

(3) Are any other capabilities affected by the impairment? ☐ **No** ☐ **Yes**
If "yes," please identify the capability and describe how it is affected.

Identify the factors (e.g., the particular medical signs, laboratory findings, or other factors described above) that support your assessment.

(4) The limitations above are assumed to be your opinion regarding current limitations only.

However, if you have sufficient information to form an opinion within a reasonable degree of medical or psychological probability as to past limitations, on what date were the limitations you found above first present?_____

(5) If the claimant's impairment(s) include alcohol and/or substance abuse, do these impairments contribute to any of the claimant's limitations as set forth above? If so, please identify and explain what changes you would make to your answers if the claimant was totally abstinent from alcohol and/or substance use/abuse.

(6) Can the individual manage benefits in his/her own best interest? ☐ **No** ☐ **Yes**

Signature **Date**

Print Name, Title and Medical Specialty (Legibly Please)

Huntington's Disease Society of America

Medical Source Statement Instructions

Please complete the enclosed Medical Source Statement and answer all questions to the best of your ability. This form asks about a patient's ability to do activities in a competitive work environment and the patient's limitations if required to perform work activities 40 hours per week, 50 weeks a year.

The enclosed form was created specifically for individuals suffering from Huntington's disease to capture all of the relevant symptoms and limitations that could impact their ability to work and their activities of daily living. The form was created to reflect Social Security specific criteria for Huntington's Disease, as outlined in Listing 11.17[1], along with Social Security's criteria for mental and physical residual functional capacity.[2]

The Social Security Administration (SSA) views the opinion of a treating physician as **extremely valuable** in a disability claim. It does not expect you to order a functional capacity evaluation. Instead, SSA expects that you will provide an opinion based on your understanding of your patient's symptoms and knowledge of your patient's impairments. Estimates are acceptable. Thank you for your assistance.

[1] https://www.ssa.gov/disability/professionals/bluebook/11.00-Neurological-Adult.htm; https://hdsa.org/wp-content/uploads/2019/07/Listing-11.17.pdf

[2] https://secure.ssa.gov/poms.nsf/lnx/0424510000.

Huntington's Disease Society of America

HUNTINGTON'S DISEASE MEDICAL SOURCE STATEMENT

Name: _____ DOB: _____ SSN: _____

Dear Dr. _____

As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination before the Social Security Administration. Completion of this form can provide crucial evidence as part of the disability process.

Your medical specialty: _____

1. Please state the diagnosis of the problem that causes the patient's limitations and restrictions, as well as the objective, clinical, or other specific findings that support your diagnosis and opinion:

   _____

   _____

2. Frequency and length of contact: _____

3. Have the patient's impairments lasted, or can they be expected to last at least twelve months?

   ☐ Yes ☐ No

4. Prognosis: _____

5. Identify all of the patient's ***symptoms and signs***:

Involuntary movements (chorea)	☐ Yes ☐ No	Changes in sleep patterns	☐ Yes ☐ No
Trouble walking	☐ Yes ☐ No	Sadness	☐ Yes ☐ No
Clumsiness, imbalance	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Unsteadiness	☐ Yes ☐ No	Lack of motivation	☐ Yes ☐ No
Trouble holding objects	☐ Yes ☐ No	Difficult to get along with	☐ Yes ☐ No
Speech difficulty	☐ Yes ☐ No	Sexual problems	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No
Difficulty with bladder control	☐ Yes ☐ No	Memory loss	☐ Yes ☐ No
Difficulty with bowel control	☐ Yes ☐ No	Intellectual decline	☐ Yes ☐ No
Delusions or hallucinations	☐ Yes ☐ No	Suspiciousness, paranoia	☐ Yes ☐ No
Difficulty swallowing	☐ Yes ☐ No	Choking	☐ Yes ☐ No

6. List any other symptoms, signs, and clinical findings: _____

   _____

7. How severe are the symptoms suffered by the patient?

   ☐ Extreme ☐ Severe ☐ Moderately Severe ☐ Moderate ☐ Mild

8. Does the patient demonstrate a loss of specific cognitive abilities or affective changes and the medically-documented persistence of any of the following?

Disorientation to time and place	☐ Yes	☐ No	Memory impairment:		
Perceptual or thinking disturbances	☐ Yes	☐ No	Short term	☐ Yes	☐ No
Change in personality	☐ Yes	☐ No	Intermediate	☐ Yes	☐ No
Disturbance in mood	☐ Yes	☐ No	Long term	☐ Yes	☐ No
Emotional lability	☐ Yes	☐ No	Impulse Control Impairment	☐ Yes	☐ No

9. Rate your patient's mental limitations as a result of the neurological impairment using the following scale:

Mild means the ability to function independently, appropriately, effectively, and on a sustained basis, is slightly limited

Moderate means the ability to function independently, appropriately, effectively, and on a sustained basis, is fair.

Marked means the ability to function independently, appropriately, effectively, and on a sustained basis, is seriously limited.

Extreme means not able to function independently, appropriately, effectively, and on a sustained basis, but it does not mean a total loss of ability to function.

RATE THE DEGREE OF LIMITATION	None	Mild	Moderate	Marked	Extreme
Understanding information:					
Remembering information:					
Applying information:					
Interacting with others:					
Concentrating:					
Persisting:					
Maintaining pace:					
Adapting in the workplace:					
Managing oneself in the workplace:					

10. Is the patient limited in their ability to interact in any of the following ways in a work setting?
    - With the public ☐ Yes ☐ No
    - With supervisors ☐ Yes ☐ No
    - With coworkers ☐ Yes ☐ No

11. Does a minimal increase in mental demands or change in the environment cause the patient to decompensate?

    ☐ Yes ☐ No

12. Does the patient have a current history of one or more years' inability to function outside a highly-supportive living arrangement, with an indication of continued need for such an arrangement?

☐ Yes ☐ No

13. Does the patient have disorganization of motor function in two extremities resulting in an extreme limitation in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities? ☐ Yes ☐ No

If yes, please describe the degree of interference with locomotion and/or interference with the use of fingers, hands, and arms: _____
_____
_____

a. Does the patient need to use an assistive device to stand up from a seated position?

☐ Yes ☐ No

b. Does the patient need to use an assistive device to walk? ☐ Yes ☐ No

If yes, what type of assistive device is used?

☐ cane(s) ☐ crutches motorized scooter
walker wheelchair assistance of another person

14. Rate the degree to which you patient is physically limited:

◯ None ◯ Mild ◯ Moderate ◯ Marked ◯ Extreme

15. As a result of the patient's impairments, estimate the patient's functional limitations if the patient were placed in a ***competitive work environment:***

a. How many city blocks can the patient walk without rest or severe pain? _____

b. Please circle the hours and/or minutes that the patient can sit, stand, or walk ***at one time***

Sit: Minutes Hours

Stand: _____ Minutes Hours

Walk: _____ Minutes Hours

16. Please indicate how long **in total,** the patient can sit and stand/walk ***during an eight-hour working day*** (with normal breaks):

Sit	**Stand/walk**	
		less than 2 hours
		about 2 hours
		about 4 hours
		at least 6 hours

17. Does the patient need a job that permits shifting positions ***at will*** from sitting, standing or walking?

☐ Yes ☐ No

18. Will the patient sometimes need to take unscheduled breaks during a working day?

☐ Yes ☐ No

If yes, 1) How ***often*** do you think this will happen? _____

2) How ***long*** (on average) will the patient have to rest before returning to work? _____

3) What symptoms cause a need for breaks?

Muscle weakness	Pain/paresthesias, numbness
Chronic fatigue	Adverse effects of medication
Other: _____	

19. How many pounds can the patient lift and carry in a competitive work environment?

	Never	Rarely (up to 3 hours)	Occasionally (3 to 6 hours)	Frequently (over 6 hours)
10 lbs.				
11 to 20 lbs.				
21 to 50 lbs.				
51 to 100 lbs.				

20. How often can the patient perform the following activities?

	Never	Rarely (up to 3 hours)	Occasionally (3 to 6 hours)	Frequently (over 6 hours)
Reaching (overhead)				
Reaching (all other)				
Push/Pull				
Climb stairs and ramps				
Climb ladders or scaffolds				
Balance				
Stoop (bend)				
Kneel				
Crouch/Squat				
Crawl				
Twist				
List other activities: _____				

21. If the patient has significant limitations with reaching, handling or fingering: What symptoms cause limitations of use of the upper extremities?

Pain/ paresthesias	Incoordination	Chorea
Muscle weakness	Spasticity	Fatigue
Tremor	Other: _____	

Please indicate the percentage of time during an eight-hour working day that the patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn <u>Twist Objects</u>	**FINGERS: Fine <u>Manipulations</u>**	**ARMS: Reaching <u>In Front of Body</u>**	**ARMS: Reaching <u>Overhead</u>**
Right:	**%**	**%**	**%**	**%**
Left:	**%**	**%**	**%**	**%**

22. How much is the patient likely to be **"*off task*"**? That is, what percentage of a typical workday would the patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks?

0% 5% 10% 15% 20% 25% or more

23. Do emotional factors contribute to the severity of the patient's symptoms and functional limitations?

☐ Yes ☐ No

24. Are the patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No

If yes, assuming the patient were trying to work full-time, please estimate, on the average, how many days per month the patient is likely to be absent from work as a result of the impairments or treatment:

Never
About one day per month
About two days per month
About three days per month
About four days per month
More than four days per month

25. Would the patient's disability or impairment prevent him or her from traveling alone? ☐ Yes ☐ No
Why? _____

26. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, difficulty speaking, need to avoid temperature extremes, wetness, humidity, noises, dust, fumes, gases or hazards, etc.) that would affect the patient's ability to work at a regular job on a sustained basis.

_____

_____ _____
Signature Date

_____
Name, Title and Medical Specialty

7. Support Letters

This section includes sample letters from friends, family, and employers. Well written support letters can change the outcome of a disability case because they offer insight into the day-to-day life of the HD individual. Medical records do not always include a lot of details about activities of daily living, but support letters can fill in the gaps.

Support Letters

Huntington's Disease Society of America

Information to include in a support letter to Social Security

Provide specific examples (including dates) of how HD has impacted the person's life from the time of symptom onset to the present. Examples of possible topics that you could include in the letter are as follows:

1. HD person's ability to perform daily tasks and follow basic instructions.
    a. Does (s)he remember to take their medication?
    b. Does (s)he have any responsibility around the house (or need reminders to do things)?
    c. Does (s)he leave the house/require supervision?
2. HD person's ability to perform personal care tasks for themselves (cooking, bathing, and dressing).
3. Changes in mood, behavior, or physical condition.
4. What was (s)he able to do before their disease that they cannot do now?
    - Consider things like house/yard work, hobbies, driving, shopping, and social activities

A sample letter is attached to give you an idea of what to put in the letter. **You should address your letter to the Social Security Administration and date and sign it.**

6-5-17

Dear Social Security Administration,

I met [redacted] when we were thirteen years old and have been best friends and brothers since that first day. We are huge nerds and martial artists. Growing up [redacted] has always had a mind that was a steel trap and he could remember the most remote details of which ever book series that we were reading. He is a true warrior at heart and takes his martial arts very seriously. He trained and honed his body to be like the masters of the old days.

When we found out that he has Huntington's on Feb. of 2012 things started to take a turn for the worst.

MEMORY

As I said before [redacted] had a mind that was a steel trap and as sharp as a sword when we were younger. Now he has to call me and ask me questions about books and movies that he just read or watched. One of the more scary incidents that I have seen is when we went and saw the movie Thor: Dark World when it came out in the theaters. This movie hit theaters on November 8th of 2013. We had taken our children to see the movie on a Saturday. [redacted] called me the following Sunday to tell me about the movie and how awesome it was. I had to remind him that I was there with him and that I sat next to him for the movie.

For the martial arts [redacted] taught he had to know forms that are called kata like the back of his hand. Brandon knows upwards of fifty different kata. These kata are a series of movements to build muscle memory for all the different techniques you would learn. He used to be able to run them backwards. He now has to watch videos online just to remember even the most basic kata.

Around April of 2015 [redacted] got a job working with me for a utility tree trimming company. He had the hardest time just to remember the most basic tasks of each day. Each morning when the truck would get to the job site it was always the same routine of wheel chocks, cone off the truck, and to put out work signs. [redacted] would always have to be reminded what to do and what to set out. He also would forget where things were on the truck even though everything that is on the truck has a predetermined place.

Muscle Failure

[redacted] has always been a very fit and active man. He would normally spend six days a week working out whether it was weight lifting or martial arts training. He always took great pride in how strong he was for some one of his size. In the last year there has been a very noticeable decline in the way that his muscles are working. I have seen him when he was lifting weights slowly have to use lighter and lighter weights. It seems as if his body is working independently of his mind. Like there are two people in his body trying to run the show. I have also seen the same thing when we are practicing martial arts together. He would want to throw a technique but instead of what he wanted to do it would be a

different technique. This also happened when he was working with me. I would watch as he was climbing a tree to trim it and I could see what he was attempting to do but his body just wouldn't let him. He would have to stand there and really focus just to get the correct movement to finish his task.

Mood

Growing up [redacted] was always happy and joking around. In the last three years that has changed drastically. He has a broad range of mood swings. Things that are small and insignificant will now send him into a blind rage. He will randomly just get sad and melancholy which will then be followed with regret and anger just because of the way he was feeling. We were at the gym on 6-1-17 and a younger kid asked him a question and [redacted] just got very angry and snapped at the kid for bothering him. Brandon after a little while went over and apologized for his actions. [redacted] cannot control these actions and when an episode happens he will get so down on himself that he will just stay at his apartment for a few days to try and calm himself down over it.

In conclusion, I've watched a man that was proud, giving, and loving turn into someone that cannot control his body or mind. Please reconsider [redacted] for getting aid and the help that he needs. Please help my brother.

[redacted]

December 30, [redacted]

To Whom It May Concern,

We are the parents of [redacted]

Before Adult Onset Huntington's Disease symptoms appeared in [redacted], she was focused and goal oriented, achieved her Master's Degree in Speech Language Pathology, and was a dedicated Speech Language Pathologist in clinical and school settings. [redacted] was vibrant and outgoing and made friends easily. She went on mission work trips to Mexico, Peru, and Africa, and enjoyed trying new things like painting, guitar, dancing. She was athletic, competing in ski racing, soccer, and mini-triathlons. She enjoyed recreational activities; mountain biking, water skiing, and hiking.

We began to notice changes in [redacted] behavior in the latter months of 2016. She was withdrawn, sad, and disconnected. We also noticed that she was clumsy, uncoordinated, and had fallen down our stairs a couple of times while visiting during the Christmas holiday.

While driving down to visit [redacted] and her family in June of 2017, [redacted] told us on the phone that she had quit her job with the [redacted] County School District, which concerned us greatly, believing that this was a move that was totally out of character and irrational; she was the primary financial support for the family, and without her income they would not be able to make ends meet. Visiting with [redacted] and her family on that trip, we found her more withdrawn than over the holidays, and our concerns grew. It was at this time that we reached out to a genetic counselor, and then a social worker with Huntington's Disease Society of America. [redacted] birth father had been diagnosed with Huntington's Disease and committed suicide, and we were concerned that [redacted] was exhibiting signs that could be consistent with that disease. These conversations led to [redacted] being examined first in [redacted], and eventually diagnosed with Adult Onset Huntington's Disease at [redacted] University in [redacted].

Since [redacted]'s diagnosis, we spent more time traveling to visit and help take care of [redacted] and her family. I [redacted] have had to quit my job in order to help care for [redacted] and her children. Family financial support has allowed them to pay their bills, but we realize that this support cannot be sustained. [redacted] is unable to take care of her 3 children while her husband, [redacted], is working. Before moving to [redacted], the 2 older children would have to go to daycare so [redacted] could focus on the youngest child.

[redacted] continues to decline; physically, mentally, and emotionally.

- ✧ Her slurring of speech has increased and is constant
- ✧ [redacted]'s ability to process incoming information is slow. When speaking with her you have to pause and wait for her to think about what you said, wait for her to gather her thoughts, and then she responds slowly and with slurred speech
- ✧ She frequently has choking episodes while eating
- ✧ Her coordination has noticeably declined, she has fallen on stairs and on flat ground when out for a walk, she's unable to perform movements like jogging or jumping jacks

- ✧ She exhibits increased chorea, and involuntary movements are constant
- ✧ With [redacted]'s unsteady gait, uncontrolled movements, and her slurred speech, she has a drunken appearance
- ✧ She is unable to maintain focus and exhibits poor decision making
- ✧ [redacted] has lost strength, and has trouble grasping and holding onto items
- ✧ Her dexterity has declined; she has difficulty with tasks such as cutting paper, cutting vegetables, her handwriting is barely legible
- ✧ [redacted] has difficulty planning and preparing meals.
- ✧ She has difficulty driving, and has had 5 minor accidents in the past few years
- ✧ Emotionally, [redacted] cannot deviate from plans without becoming upset
- ✧ She is sad, withdrawn, and disconnected.
- ✧ [redacted] has facial twitches and a glazed or distant look in her eyes.

Because of what we see as [redacted]'s current condition, her extended family has helped them move to [redacted], where we can be regularly involved and care for her and her family. We are also aware that Huntington's Disease is a progressive disease, and she will continue to decline in all the areas that she has already exhibited difficulties. We do not believe that she is capable of any kind of work, and have worked hard to bring her and her family to [redacted], as we also do not believe that she is capable of caring for her family without additional assistance.

[redacted]'s Adult Onset Huntington's Disease diagnosis has devastated her immediate and extended family. As her parents we are saddened that [redacted] can no longer perform her job as a speech language pathologist and don't believe that she is not capable of keeping up with the demands of any type of job. We are also saddened that [redacted] cannot be the mom that she so desperately wanted to be. She has trouble preparing their meals, bathing the children, reading stories to them, setting and following routines, and recognizing her children's emotions. [redacted]'s diagnosis rules our daily life. It is constantly on our mind and part of our daily routine by helping care for the kids, preparing meals, shopping, house work, getting [redacted] to her appointments, providing [redacted] and her family with a place to live, providing guidance on finances, child rearing, planning for the future, and how to care for [redacted] and her family.

Sincerely,

[redacted]

Date

Dear Social Security Administration,

I believe that XXXX and I met at a biker club reunion when we were kids.

In **1995**, we got married.

We took a vacation in the spring of **2000** with my parents and sister in the Dominican Republic at an all-inclusive resort. She was miserable the whole week, never smiled, never wanted to do anything and complained about everything. My mother sat with XXXX by the pool and tried to talk with her. XXXX burst out crying for no reason. I did not know what to do. I asked XXXX why she was like this. All she said was she did not feel comfortable and wanted to go home. This is not a normal reaction to a vacation. When we got home XXXX was still not herself.

In **2004**, I was lucky and got a job in West Virginia but rented a house in Virginia. XXXX was not happy about the move and said the rental house was too small. We had regular arguments about the house, the area and the lack of friends. XXXX continued to hoard. She had a better excuse now – We can't throw anything out, it's all in boxes and we can't go through them now because we don't have the space to open things up. XXXX was getting harder to talk to and it was becoming more difficult to reason with her.

During the year **2005** XXXX was acting opposite of her nature. She would be sad, distracted, apathetic, forgetful, and unable to follow directions. In **2005**, I got a call at work that there had been a fire at my house. I rushed home and found the kids across the street, no fire trucks in front of the house but XXXX was standing outside the house crying. I asked what happened and she said she left plastic bowls in the oven and turned it on and forgot about it until the smoke started pouring out of the oven and set off the smoke detectors when she was upstairs with the kids. She got the kids out of the house and across the street to her friend's house to call the fire department. They arrived and found the source of the smoke.

In **2006**, we invited a work friend and his wife over for dinner. I bought frozen beef stew or stroganoff for dinner. XXXX's only job was to stir the pot and keep the meal from sticking and burning. About an hour before dinner we started smelling a strange smell and started to investigate. We ended up in the kitchen and there was smoke coming out of the pot on the stove. XXXX thought she turned the heat down but did not and she did not stir the pot. There was burned food on the bottom of the pot and smoke pouring out. I took the burned pot of food threw it into the back yard. We were never able to sand out all the burn. This was a simple job that XXXX once could have done. She lost her sense of time and forgot something simple.

In **2007**, she fell down the stairs two different times but did not hurt herself enough to need a hospital. XXXX continued to hoard and house cleaning was almost non-existent except for when I did it. XXXX just did the dishes poorly. Life went on but XXXX did not seem like she was very much aware of the events around her. Her world seemed to shrink. I talked to XXXX about starting up her hobbies so she would have something to do and somewhere to go and someone to talk with. She said there was no sense in that because she no longer cared about them. She had lots of temper tantrums and some screaming as her ability to speak convincingly decreased.

In **2010** we found out from her Uncle that her Mother tested positive for HD. XXXX started going to a psychologist before we found out about her Mother's test results. XXXX liked to go to the psychologist to talk. I gave XXXX instruction lists of things to do to keep her busy at home. Her apathy took over and she did very little and started sleeping a lot during the day. She also started making humming noises and humph sounds when I was around.

XXXX and I went to Dr. XXXX for an evaluation in February **2013**. I was amazed at how poorly XXXX did in the testing. I had no idea how bad she really was until I watched her try to follow directions from the Doctor. This is when I first actually fully realized how bad XXXX really was and how much damage the HD had caused. The Doctor found her to be completely disabled and unable to function in normal work environments. We started out with the same dose of XXXX and added XXXXX for her depression. She feels a little less negative, has a little less apathy and is no longer talking about divorce. We have requested Dr. XXXX to double the amount of XXXXX to improve her control.

I hope this letter has shown how XXXX went from being an outgoing, active, intelligent, capable hard working and fun loving lady to a reduced function introvert that sleeps most of the time (continuous muscle contractions are tiring) and seldom ventures far from home.

Please help us by using this and other non-medical evidence to award XXXX the SSA disability status she deserves, due to her 20 to 25 year downhill slide caused by her genetically-inherited Huntington's disease.

Thank you,

{INK SIGNATURE}

XXXX XXXXX – XXXX's Husband

November 11, 2013

March 20, 2018

RE: [redacted]

Employment Dates: 6/25/2012-07/28/2017

To Whom It May Concern:

[redacted] was hired as a Staff Accountant at the Company's headquarters location in Hoffman Estates, Illinois on Monday, June 25, 2012.

At the time of hire, [redacted] diagnosis had begun to limit his daily activities and he was unable to work full-time hours on a sustained basis. It was for this reason that the CEO of our [redacted] made a decision to hire [redacted]. The intent of hiring [redacted] was to allow him to continue to be employed as his condition progressed in a protective environment that could accommodate the flexibility he may need.

During the initial employment period beginning June 25, 2012 through approximately June 2015, [redacted] was able to perform assigned basic accounting duties satisfactorily although not always on a full-time schedule. During the first half of the year of 2015 [redacted] began to demonstrate a pattern of frequently being off task, difficulty concentrating, and became error prone. For this reason, it became necessary to limit the work assigned to [redacted] and to assign a team member to check the work he performed for accuracy.

In July of 2015, a determination was made that [redacted] could not perform basic accounting entries (calculate an entry on his own) without error. A decision was made to limit the work assigned to [redacted] to include only those tasks involving fixed assets. All of the other work [redacted] previously performed was assigned to other team members.

The fixed asset tasks assigned to [redacted] involved tracking the inventory and depreciation of fixed assets. This is considered an entry level task, which an inexperienced accounting clerk can typically perform without error. Further to this, the assigned fixed asset tasks assigned to [redacted] would typically take an entry level accounting clerk approximately twenty hours per week to complete.

The fixed asset tasks began to take [redacted] approximately forty hours per week to perform. [redacted] began to demonstrate difficulty concentrating and was frequently off task. Additionally, [redacted] continued to make errors.

The efforts to limit the assigned tasks of [redacted] did not improve his work performance or accuracy. For this reason, beginning in July of 2015, all of [redacted] work product was verified for accuracy by an Accounting Manager. If errors were identified, they were corrected by the Accounting Manager before the entry was finalized.

[redacted] symptoms began to consistently interfere with his work performance and attendance. [redacted] it was agreed that the accounting team would continue to accommodate [redacted] by allowing him to continue to work in a limited capacity with direct over sight of his work.

In February of 2016, a determination was made that [redacted] could not perform the tasks assigned involving fixed assets. Methods were put in place that required [redacted] l to only submit an entry, rather than evaluate and or calculate it himself. However, upon audit of his work, it was found that [redacted] l consistently failed to perform the task(s). Specifically, he did not submit the entry when required or pursuant to the schedule of tasks. Additionally, [redacted] l became non responsive. An effort was made to limit the amount of emails received by [redacted]. As a result of these efforts, [redacted] received less than ten emails per day. In some cases the email was a request for a fixed asset number. [redacted] consistently did not respond to these requests. [redacted] demonstrated a continued decline in ability to process basic requests to look up a number or return an email.

As a direct result, all duties outside of recurring entries related to the close of the Month were removed from [redacted] l. He was assigned tasks that involved him simply 'pushing a button' by submitting an entry made by a co-worker on his behalf. An example of this was an amortization performed by another accountant, but assigned to [redacted] to submit. These minimal tasks involved approximately eight hours of work per month. Oversight continued. There continued to be a demonstrated pattern of [redacted] failing to submit the assigned entry.

At this crossroad, the symptoms of [redacted] diagnosis were evident in the workplace. He was spatially disoriented. This included becoming confused about tasks previously well-known to him during the years he has been an accountant and since his employment begun with our Company. He demonstrated memory impairment and would forget an instruction or to return a call or to answer when asked. There were changes to [redacted] personality. He was not even tempered. He had low-frustration levels. He was withdrawn from others. Perhaps because of his apparent physical and cognitive deterioration. He seemed discouraged and embarrassed to come outside his office. At times, he would randomly walk throughout the office and yell out by way of verbalizing but without words.

Additional accommodations were made including having a co-worker check all of [redacted] work, verifying every entry [redacted] was assigned to submit, and actual oversight of his well-being while [redacted] was in the office. Both [redacted] performance and attendance were not addressed with [redacted]. It was understood that the Company would continue to accommodate [redacted] decline in function until such time as [redacted] determined he could no longer perform any work.

In March of 2017, [redacted] demonstrated increased symptoms and was commonly confused or overwhelmed with the task of submitting an entry.

[redacted] developed distinct symptoms of constant tongue/mouth movements, rhythmic twitching of fingers and hands, and a pronounced listing and twitching as he walked.

At his point, [redacted] could not submit an entry without someone virtually checking and correcting his work at all times. The task assigned to [redacted] of submitting an entry made by another co-worker was reduced to a total of five journal entries at month end. This task involved approximately two hours of work per month. The balance of [redacted] time was spent in his office, provided to him for privacy. [redacted] routinely used the internet, took a nap, coordinated and attended medical appointments, and otherwise used working hours for personal tasks.

Further to this, [redacted] had developed an all-consuming obsession about food and the bathroom. Specifically, he was observed spending an entire day arranging snack food items on the surface of his desk, and would be routinely observed going to and from the bathroom carrying a shopping bag filled with his own personal supply of napkins, toilet paper, and paper towels.

In July of 2017, it was determined that [redacted] was unable to perform any work tasks and that his disturbance in mood could not be accommodated in the office. His symptoms interfered with his ability to function. Staff members had been more than willing to pitch in to facilitate the accommodations that had been made for [redacted] thus far. However, over time, it became impossible for us to keep providing this amount of support, and sadly, a decision had to be made to end his employment.

Sincerely,

[redacted]
Vice President, Human Resources

Huntington's Disease Society of America

What to Do When You or Families Have Disability Questions

The Social Security disability process can be complicated and overwhelming, but Allison Bartlett, Esq. is here to answer questions and provide assistance through this process. She can help families navigate the disability process by providing resources, she can help determine what information families and social workers need to gather for disability claims, she can offer guidance on how to Social Security complete forms, and she can answer questions on a variety of disability related issues. Allison cannot complete applications on behalf of families or represent families at a hearing.

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HDSA meets all Standards of Excellence of the Better Business Bureau Wise Giving Alliance, National Health Council and the American Institute of Philanthropy

Federal employee? Support HDSA through the Combined Federal Campaign Designate #0526

Before starting the disability process, families should review HDSA's disability page for tips, general information, and resource guides about applying for disability with HD: https://hdsa.org/find-help/healthcare-and-future-planning/disability-benefits-and-hd/disability-support/

When to contact Allison Bartlett* with questions:

- Stopping work and when to apply for disability
- What questions to ask employer/HR department
- Issues with work credits or lag earnings
- Subsidies (substantial accommodations while working)
- How to approach an application with limited medical evidence
- Completing the disability application or disability forms
- Disability denials and appeals
- Administrative Law Judge hearing, what to expect and how to prepare

Contact Information:

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