

FORM SSA-3881-BK (QUESTIONNAIRE FOR CHILDREN CLAIMING SSI BENEFITS)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

Form Approved
OMB No. 0960-0499

QUESTIONNAIRE FOR CHILDREN CLAIMING SSI BENEFITS

Please print, type, or write clearly and answer all items to the best of your ability. If you need help completing any part of this form, we will help you. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. If you do not know the answer, enter "unknown." If the question does not apply, enter "WA." If you need more space to answer any of the questions, please use 'REMARKS' and enter the number of the question next to your answer.

PAPERWORK/PRIVACY ACT NOTICE

The information requested on this form is authorized by Section 223 and Section 1632 of the Social Security Act. The information provided will be used in making a decision on your claim. While completion of this form is voluntary, failure to provide all or part of the requested information could prevent an accurate and timely decision on your claim and could result in the loss of benefits. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal law requiring the exchange of information between Social Security and another agency.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

These and other reasons why information about you may be used or given out are explained in the *Federal Register*. If you want to learn more about this, contact any Social Security Office.

Child's Full Name	Social Security Number _____/_____/_____
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Informant's Name	Relationship to Child	Telephone Number at which you may be contacted during the day (____)____-____ area code
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1. **Is** (was) the child cared for by a baby sitter? Does (did) **the child** attend any type of preschool, **daycare** and/or **afterschool** program? If so, **please** specify. If more than one of the above, use the "REMARKS" section.


Name	Address (Number, Street , City, State, Zip Code)
Telephone Number (- - e) - - - w - - - area code	Dates Attended

2. a. **Is** (was) the **child** in **school**? → Yes No

If "yes," and the school was not listed in Item 12A of the SSA-3820-F6, please show it here. (If more than one, use the "REMARKS" section.)

Name	Address (Number, Street , City, State, Zip Code)
Telephone Number (____) - - - - area code	Dates Attended
Grade(s)	Last Teacher's Name

2.	b. Is the child in a special education program? →	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	c. Does the school make any special accommodations for the child; e.g., adaptive furniture, wheelchair ramps, extra assistance or attention? →	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	If "yes" in 2.b. or 2.c., indicate type of program and/or accommodation:	Specify number of hours per week the child is in special education program:
	d. Do you have a copy of the child's individual education plan (IEP), the report in which the teacher outlines the child's problems and lists the plans for correcting them? → If "yes," please provide a copy.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Does the child receive any special counseling or tutoring?	
	a. In school →	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Outside school →	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If "yes," in 3.a. or 3.b., please indicate: (If more than one, use the "REMARKS" section.)	
	Type of Counseling, Tutoring	
	Date Began and Ended (If completed)	Frequency of Visits
	Counselor's or Tutor's Name	Telephone Number (- - -) - - - - - <small>area code</small>
	Address (Number and Street, City, State and Zip Code)	
4.	Does the child of family have a child welfare, social services of early intervention caseworker? →	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If "yes," please provide the following information: (If more than one, use the "REMARKS" section..)	
	Caseworker's Name	Organization
	Address (Number and Street, City, State and Zip Code)	Telephone Number (- D -) - - D - - - - <small>area code</small>
	File or Record Number	Date First Saw/Last Saw Caseworker

<p>6. Does (did) the child receive any special therapy (physical, speech and language, occupational), exercises, or any other services for his/her impairments? </p> <p>Include information about any therapy or exercises the parent, guardian or caregiver provides the child.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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If **"yes,"** indicate below the therapist's name, **the** name of the person who **PRESCRIBED AND/OR DESIGNED** the therapy **program**, the type(s) and frequency of treatment, when treatment began and **ended (if completed)**, and *where treatment was received (e.g., home, hospital, therapist's office, chic.)*

Therapist's Name	Telephone Number (____) - ____ - ____ area code
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Address (Number and Street, City, State and Zip Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

Therapist's Name	Telephone Number (- v -) - B - - - - - area code
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Address (Number and Street, City, State and Zip Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

7.	Does (did) the child receive vocational rehabilitation services? →	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes," describe services received below the rehabilitation counselor's information. Include dates and record number.		
Rehabilitation Counselor's Name		Telephone Number (- - -) - - - - w - - - - area code
Address (Number and Street, City , State and Zip Code)		
Services received:		
(If additional space is needed, use 'REMARKS' section.)		

8.	NOTE: PROVIDING INFORMATION ABOUT THE CHILD'S INVOLVEMENT WITH THE COURT SYSTEM IS OPTIONAL.	
Has the child ever been involved with the court system other than in custody proceedings? →		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes," please explain involvement , including testing and evaluation:		
Youth Development Center's Name		
Address (Number and Street, City , State and Zip Code)		
Probation or Parole Officer's Name		Telephone Number (- - -) - - - - - area code
Address (Number and Street, City , State and Zip Code)		
Involvement:		

9. Does (did) the child participate in any community or school activities, such as choir, **Special** Olympics, **Boy's/Girl's** Club, **Scouts**, or sports? Yes No

If "yes," describe involvement, amount of **time** spent in activity, and level of participation. **Provide** name, **address**, and **telephone number** of individual who **supervises** the activity. **Include** dates of **involvement**. If involvement ended, explain **why**.


10. If the child takes any medication on an ongoing basis, please indicate the following:

MEDICATION DOSAGE/FREQUENCY	PRESCRIBED BY (NAME)	REASON FOR MEDICATION	DESCRIBE ANY SIDE EFFECTS

How well does the medication(s) work? *Please explain:*

REMARKS (continued):

I AUTHORIZE ANY PERSON, AGENCY, OR ORGANIZATION TO DISCLOSE TO THE SOCIAL SECURITY ADMINISTRATION OR TO THE STATE AGENCY THAT MAY REVIEW MY CLAIM OR CONTINUING DISABILITY, ANY MEDICAL RECORDS OR OTHER INFORMATION ABOUT MY DISABILITY.

Signature of claimant or person filing on claimant's behalf  SIGN HERE	Date (Month, Day, Year)
Address (Number and Street)	Telephone Number (____) ____-____ <small>area code</small>

City, State, Zip Code

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 the 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)

TIME IT TAKES TO COMPLETE THIS FORM

We estimate that it will take you about 20 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on how long it takes to complete this form or on any other aspect of this form, write to the Social Security Administration. **ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235, and to the Office of Management and Budget, Paperwork Reduction Project (0960-0499), Washington, D.C. 20503. DO NOT SEND COMPLETED FORMS OR INFORMATION CONCERNING YOUR CLAIM TO THESE OFFICES.**