

DISABILITY REPORT-ADULT-Form SSA-3368-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it.

HOW TO COMPLETE THIS FORM

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

- Fill out as much of this form as you can before your interview appointment.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is “none” or “does not apply,” please write: “don’t know,” or “none,” or “does not apply.”
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or, mail it ahead of time, if you were told to do so.
- When a question refers to “you,” “your,” or the “Disabled Person,” it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the “REMARKS” section on Pages 9 and 10, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to the office with your completed forms or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do

that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, you may be able to get this information from the telephone book or from medical bills, prescriptions and prescription bottles.

WHAT WE MEAN BY “DISABILITY”

“Disability” under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that “disability” means that you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and your disability is expected to last (or has lasted) for at least a year or to result in death. So when we ask, “when did you become unable to work,” we are asking when you became disabled as defined by the Social Security Act.

The Privacy and Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631 (e)(l) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant’s claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the name claimant’s claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant’s disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veteran Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 30 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.

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

**DISABILITY REPORT
ADULT**

For SSA Use Only
Do not write in this box.

Related SSN _____
Number Holder _____

SECTION 1 — INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** (First, Middle Initial, Last)

B. **SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)

_____ Your Number Message Number None
Area Code Number

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME _____ RELATIONSHIP _____

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

_____ DAYTIME PHONE _____
City State ZIP Area Code Phone Number

E. What is your **height** without shoes?
_____ feet _____ inches

F. What is your **weight** without shoes?
_____ pounds

G. Do you have a **medical assistance card**? (For example, Medicaid or Medi-Cal) YES NO
If "YES," show the **number** here: _____

H. Can you **speak English**? YES NO If "NO," what languages can you speak? _____

If you cannot speak English, is there someone we may contact who speaks English and will give you messages? (if this is the same person as in "D" above, show "SAME" here.)

NAME _____ RELATIONSHIP _____

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

_____ DAYTIME PHONE _____
City State ZIP Area Code Phone Number

I. Can you **read English**? YES NO

J. Can you **write more than your name in English**? YES NO

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries or conditions** that limit your ability to work? _____

How do your illnesses, injuries or conditions limit your ability to work? _____

C. Do your illnesses, injuries or conditions cause **you pain**? YES NO

D. When did your illnesses, injuries or conditions **first bother you**?

<i>Month</i>	<i>Day</i>	<i>Year</i>
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E. When did you become **unable to work** because of your illnesses, injuries or conditions?

<i>Month</i>	<i>Day</i>	<i>Year</i>
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F. Have **you ever worked**? YES NO (If "NO," go to Section 4.)

G. Did **you work at any time** after the date your illnesses, injuries or conditions first bothered you? YES NO

H. If "YES," did your illnesses, injuries or conditions cause you to: (Check *all that* apply,)

work fewer hours? (Explain below.)

change your job duties? (Explain below.)

make any job-related changes such as your attendance, help needed, or employers? (Explain below.)

I. Are **you working now**? YES NO

If "NO," when did **you stop working**?

<i>Month</i>	<i>Day</i>	<i>Year</i>
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Why did you **stop working**? _____

SECTION 3 – INFORMATION ABOUT YOUR WORK

A. List all the **jobs** that **you** have had in the **last 15 years** that you worked.

JOB TITLE <i>(Example, Cook)</i>	TYPE OF BUSINESS <i>(Example, Restaurant)</i>	DATES WORKED <i>(month & year)</i>		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY <i>(Per hour, day week, month or year)</i>
		FROM	TO			
						\$ /
						\$ /
						\$ /
						\$ /
						\$ /
						\$ /
						\$ /

B. Describe the **job above** that you did the **longest**. (What did you do all day in this job?)

- C. In **this job**, did you:
- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| Use machines, tools or equipment? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Use technical knowledge or skills? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Do any writing, complete reports, or perform any duties like this? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Did you supervise other people? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| If "YES," was this your main duty? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

- D. In **this job**, how many total hours each day did you:
- | | |
|--|---|
| Walk? _____ | Kneel? <i>(Bend legs to rest on knees.)</i> _____ |
| Stand? _____ | Crouch? <i>(Bend legs and back down & forward.)</i> _____ |
| Sit? _____ | Crawl? <i>(Move on hands & knees.)</i> _____ |
| Climb? _____ | Handle, grab or grasp big objects? _____ |
| Stoop? <i>(Bend down and forward at waist.)</i> _____ | Write, type or handle small objects? _____ |

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

- F. Check **heaviest** weight lifted:
- Less than 10 lbs.
 10 lbs.
 20 lbs.
 50 lbs.
 100 lbs. or more
 Other _____

- 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 _____

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST

NAME		DATES	
STREET ADDRESS		FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN
PHONE		CHART/HMO #	NEXT APPOINTMENT
<small>Area Code</small>	<small>Phone Number</small>		

REASONS FOR VISITS _____

WHAT TREATMENT WAS RECEIVED? _____

If you need more space, use Remarks, Section 9

E. List each HOSPITAL/CLINIC. Include your next appointment.

HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
NAME	<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT
STREET ADDRESS	<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
CITY	<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	
STATE			
ZIP			
PHONE			
<small>Area Code</small>	<small>Phone Number</small>		

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

SECTION 5 – MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions?

YES NO

If "YES," please tell us the following: (Look at your medicine bottles, if necessary.)

NAME OF MEDICINE	PRESCRIBED BY <i>(Name of Doctor)</i>	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9

SECTION 6 – TESTS

Have you had, or will you have, any **medical tests** for your illnesses, injuries or conditions?

Y E S NO If "YES," please tell us the following: (Give approximate *dates*, if necessary.)

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? <i>(Month, day, year)</i>	WHERE DONE? <i>(Name of Facility)</i>	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHERETIZATION			
BIOPSY Name of body part _____			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you have had any other tests, list them in Remarks, Section 9.

SECTION 7 – EDUCATION/TRAINING INFORMATION

A. Circle the highest grade of **school** completed.

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

Approximate **date** completed: _____

B. Did you attend **special education** classes? YES NO If "YES,"

NAME OF SCHOOL _____

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

_____ City State ZIP

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school**? YES NO

If "YES," what type? _____

Approximate date completed: _____

SECTION 8 – VOCATIONAL REHABILITATION INFORMATION

A. Have you received services from **Vocational Rehabilitation** or any other organization to help you get back to work? YES NO If "YES,"

NAME OF _____

NAME OF COUSELOR _____

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

_____ City State ZIP

DAYTIME PHONE _____
Area Code Number

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

B. Would you like to receive rehabilitation services that could help you get back to work? YES NO

