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## 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 "N/A." 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.

Child's Full Name			Social Security N	umber	Date (mm/dd/yyyy)
Informant's Name	Relationshi	p to Ch	ild	-	l Telephone Number Area Code)
Is (was) the child cared for by a baby sitter school program? If so, please specify. If meaning the school program?					
Name		Addre	ss (Number, Stree	t, City, Sta	te, ZIP Code)
Telephone Number (including Area Code)		Dates	Attended		
2. a. Is (was) the child in school?		_ Y	′es 🗌 No		
If " <b>yes</b> ," and the school (If more th			e SSA-3820, pleas EMARKS" section		ere.
Name		Addre	ss (Number, Stree	t, City, Sta	te, ZIP Code)
Telephone Number (including Area Code)		Dates	Attended		
Grade Level Completed		Last T	eacher's Name		

2.b. Is the child in a special education program?		☐ Yes	☐ No	☐ Don't Know
c. Does the school make any special accommodations child; e.g., adaptive furniture, wheelchair ramps, extra assistance or attention?	☐ Yes	☐ No	☐ Don't Know	
If "yes" in 2.b. or 2.c., indicate type of program and/or accommodations:		Specify num in special ed		per week the child is gram:
d. Do you have a copy of the child's individual education (IEP), the report in which the teacher outlines the chi problems and lists the plans for correcting them?	☐ Yes	☐ No		
If " <b>yes</b> ," please provide a copy.				
3. Does the child receive any special counseling or tutoring	ng?			
a. In school		☐ Yes	☐ No	
b. Outside school		☐ Yes	☐ No	
If "yes," in 3.a. or 3.b., please indicate: (If	more than o	│ ne, use the "F	REMARKS" s	section.)
Type of Counseling, Tutoring				
Date Began and Ended (If completed)	Frequency	of Visits		
Counselor's or Tutor's Name Telephone		Number (inc	luding Area	Code)
Address (Number, Street, City, State, ZIP Code)				
, , , , , , , , , , , , , , , , , , ,				
4. Does the child or family have a child welfare, social ser early intervention caseworker?	rvices or	☐ Yes	☐ No	
If "yes," please provide the following information	n: (If more th	nan one, use t	he "REMAR	KS" section.)
aseworker's Name Organizati		on		
Address (Number, Street, City, State, ZIP Code)  Telephone		Number (inc	luding Area (	Code)
File or Record Number	Date First	Saw/Last Sav	v Caseworke	er

5. Has the child ever been tested or evaluated by any of the following agencies or organizations? If " <b>yes</b> ," indicate in the space provided below the agency name, address, telephone number, record number, and the type and date of test or evaluation performed (e.g., vision, hearing, speech, physical).					
a. Public/Community Health Department	☐ Yes ☐ No				
b. Child Welfare/Social Services Agency	☐ Yes ☐ No				
c. Developmental Evaluation Center	☐ Yes ☐ No				
d. Mental Health/Intellectual Disability	☐ Yes ☐ No				
e. Special Needs/Crippled Children Agency	☐ Yes ☐ No				
f. Speech and Hearing Center	☐ Yes ☐ No				
g. Women, Infants, and Children (WIC) Program	☐ Yes ☐ No				
Use the letter designation (5a, 5b, etc.) to i	identify the agency.				
If additional space is needed, use "REM	If additional space is needed, use "REMARKS" section.				

6.	Does (did) the child receive any special therapy (physical, speech and language, occupational), exercises, or any other services for his/her impairments?		Yes	□ No	
	Include information about any therapy or exercises the parent, guardian or caregiver provides the child.				
	If "yes," indicate below the therapist's name, the name of the person where the therapy program, the type(s) and frequency of treatment, when treatment where treatment was received (e.g., home, hospital, therapist's office, classical contents.	nt bega			the
	Therapist's Name	7	Telephon	ne No. (including Area C	ode)
	Address (Number, Street, City, State, ZIP Code)				
	Person Who Prescribed/Designed Therapy				
	Information about Therapy:				
_					
Therapist's Name			Telephon	ne No. (including Area C	ode)
	Address (Number, Street, City, State, ZIP Code)				
	Person Who Prescribed/Designed Therapy				
	Information about Therapy:				

Address (Number, Street, City, State, ZIP Code)

Involvement including any testing and evaluation:

			articipation. Provide name, address, of involvement. If involvement ended.
If the child takes any	y medication on an ong	going basis, please indicate the fol	lowing:
EDICATION DOSAGE FREQUENCY	PRESCRIBED BY (NAME)	REASON FOR MEDICATION	DESCRIBE ANY SIDE EFFECTS
well does the medi	ication(s) work? Please	e explain:	

11 a	If you are unable to give us information we need about the child, is there someone else who helps care for the child and, knows of the child's impairment who can help us get the information we need, and, if necessary, bring the child to a consultative examination?  Yes No
b	. If "yes," please provide the following information about this person
	Name
	Address (Number, Street, City, State, ZIP Code)
	Daytime telephone number (including Area Code)
	Relationship (e.g., relative, neighbor, family friend) to the child?
REM	IARKS:

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REMARKS (continued):					
Privacy Act Statement					

## **Collection and Use of Personal Information**

Sections 223(b), 1614, and 1631(e)(1) 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 delay the determination or continued eligibility for benefits.

We will use the information to make a decision on your claim. We may also share your information for the following purposes, called routine uses:

- 1. To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the Act:
- 2. To the appropriate State agencies (or other agencies providing services to disabled children) to identify Title XVI eligibles under the age of 16 for the consideration of rehabilitation services in accordance with section 1615 of the Act, 42 U.S.C. 1382d; and
- 3. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants.

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 Notice (SORN) 60-0089, entitled Claims Folders System; 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits; and 60-0320, entitled Electronic Disability (eDIB) Claim File. 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. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. Send only 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.