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 for Online Adult Disability Application

The information below will help you gather the information you may need to create a *my* Social Security account and complete the online Disability application. We recommend you print this page to use while gathering your information.

Create a *my* Social Security Account

You are required to login to your existing *my* Social Security account, or attempt to create one. To create an account, we will ask you a series of identity questions for verification. You may want to have certain items on hand to be prepared for additional security questions, such as, but not limited to: **mobile phone (for the purpose of receiving texts and emails), credit card, W-2, and tax forms.**

File for Benefits Online – The Information You Need

Date and Place of Birth - If you were born outside the United States or its territories:
- Name of your birth country at the time of your birth (it may have a different name now)
- Permanent Resident Card number (if you are not a U.S citizen)

Marriage and Divorce
- Name of current spouse, name of prior spouse (if the marriage lasted more than 10 years or ended in death)
- Spouse(s) date of birth and SSN (optional)
- Beginning and ending dates of marriage(s), place of marriage(s) (city, state or country, if married outside the U.S.)

Names and Dates of Birth of Children Who:
- Became disabled prior to age 22, or
- Are under age 18 and are unmarried, or
- Are aged 18 to 19 and still attending secondary school full time

U.S. Military Service
- Type of duty and branch, service period dates

Employer Details for Current Year and Prior 2 Years (not self-employment)
- View your Social Security Statement online at ***www.socialsecurity.gov/myaccount***
- Employer name, employment start and end dates, total earnings (wages, tips, etc.)

Self-Employment Details for Current Year and Prior 2 Years
- View your Social Security Statement online at ***www.socialsecurity.gov/myaccount***
- Business type and total net income

Direct Deposit - Domestic bank (USA)
- Account type and number
- Bank routing number

Direct Deposit - International bank (non-USA)
- International Direct Deposit (IDD) bank country
- Bank name, bank code, and currency
- Account type and number, branch/transit number

Alternate Contact
- Name, address and phone number of someone we can contact who knows about your medical condition(s) and can help you with your claim

List of your Medical Conditions

Information About Doctors, Healthcare Professionals, Hospitals and Clinics
- Names, addresses, phone numbers, patient ID numbers, and dates of examinations and treatments
- Names and dates of medical tests you have had and who sent you for them
- Names of medications (prescriptions and non-prescriptions), reason for medication and who prescribed them

Information About Other Medical Records
- Vocational rehabilitation services, workers compensation, public welfare, prison/ jail, an attorney, or another place

Job History
- Date your medical condition began to affect your ability to work

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.

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.

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

Section 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 decision on the named claimant's claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate and timely decision on the named claimant's claim.

We rarely use the information you supply for any purpose other than to make decisions regarding claims. 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 and improvement of 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 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 list of routine uses for this information is available in Systems of Records Notice entitled, Claims Folders Systems, 60-0089. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.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 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. 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.***

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?

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 $1,090 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 $1,090 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.

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

Date completed: ____________

Name of School

City	State/Province	Country (If not USA)
Phone	Fax	

5.B. Did you receive special education such as through an Individualized Education Program (IEP) or equivalent. ☐ Yes ☐ No (Go to 5.C.)

Check the last grade you received special education

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

Dates from: ____________ to ____________

School where you last received special education: ____________

☐ Same as 5.A. If different from school information in 5.A., complete below:

Name of School

City	State/Province	Country (If not USA)
Phone	Fax	

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

☐ Yes ☐ No

If "Yes", what type? Date completed:

5.D. Can you read and write a simple message in any language (Examples: shopping list, short and simple notes)?

☐ Yes ☐ No

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 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.							

SECTION 6 - JOB HISTORY (continued)

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 questions below.

☐ I had **more than one job** in the last 15 years before I became unable to work. Do **not** answer the questions on this page; go to Section 7 on page 5. (We may contact you for more information.)

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 11.

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 11.

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 11.

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 11.

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.

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☐ 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 11.

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.

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☐ 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 11.

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 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)

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.