

DISABILITY REPORT

Adult Disability

Child Disability

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 7, 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, a family member, or the FSMSSA Branch Offices.
- 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 Page 11, 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 our office with your completed forms or bring them with you to your interview. If you need the records back, tell us and we will photocopy them and return them to you.

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE FSMSSA

Please sign the attached authorization form at the end of the application so that this office will be able to request your medical records on your behalf.

WHAT WE MEAN BY “DISABILITY”

“Disability” under the Social Security Act is based on your inability to engage in any substantial gainful employment by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 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.

Section 803A of the Social Security Act reads as follows:

“Section 803A. Disability benefits.

- (1) Every person who:
 - a. Is fully insured;
 - b. Is disabled and has been disabled for at least three full calendar months; and
 - c. Has filed a complete application with the Social Security Administrator for disability insurance shall be entitled to a disability insurance benefit, subject to the earnings test as defined in this subtitle.
- (2) Disability insurance benefits shall be paid for each month, beginning with the first month of the waiting period and ending with the month preceding the month in which the disabled individual dies or recovers from his disability.
- (3) Notwithstanding the provisions of subsections (1) and (2) above, retroactive payments shall not be made for more than the twenty-four (24) months immediately preceding the month in which the disabled individual has submitted an application.”

The Social Security Administration is authorized to collect the information on this form 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 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 to facilitate statistical research and such activities necessary to assure the integrity and improvements of the Social Security Programs.

I fully understand the terms and conditions set forth in the above declarations.

Signature of Claimant

Date

DISABILITY REPORT

For FSMSSA Use Only
Do not write in this box.

Related SSN _____

Number Holder _____

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME

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.)*

Area Code _____
Number Your Number Message Number None

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)

City *State* *ZIP* DAYTIME PHONE _____
Area Code *Phone Number*

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

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)

City *State* *ZIP* DAYTIME PHONE _____
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? _____

B. 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

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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J. Why did you **stop working**? _____

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

Pain Questionnaire

If your illnesses, injuries or conditions cause you pain, please answer the questions listed below.

Where is the location of the pain?

What causes the pain?

How is it relieved?

Does it affect your ability to

- stand?
- walk?
- sit?
- other? (specify: _____)

Were you provided by your doctor any form of medication to remedy the pain?

Yes No

If yes, what sort of medication have you been provided with?

Does the medication help?

Yes No

Please describe in your own words, the difficulties and discomforts that this pain causes you.

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List 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 or rest on knees.)</i> _____ |
| Stand? _____ | Crouch? <i>(Bend legs & 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 20 lbs 50 lbs 100 lbs or more Other _____

SECTION 4 - 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 _____

City *State* *ZIP*

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

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

If "YES," what type? _____

Approximate date completed: _____

SECTION 5 - 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 ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

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

DAYTIME PHONE NUMBER _____
Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____

Were you provided with rehabilitation services that could help you get back to work? YES NO

SECTION 6 - INFORMATION ABOUT YOUR ACTIVITIES

1. Has your doctor told you to cut back or limit your activities in any way? Yes No

If "yes", give the name of the doctor below and tell what he or she told you about cutting back or limiting your activities.

2. Describe your daily activities in the following areas and state what and how much you do of each and how often you do it:

■ **Household maintenance** (including cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

■ **Recreational activities and hobbies** (fishing, farming, musical instruments, sewing, etc.):

■ **Social Contacts** (visits with friends, relatives, neighbors):

■ **Other** (drive car, motorcycle, etc.)

SECTION 7 - INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/THERAPIST

3.

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

WHAT TREATMENT WAS RECEIVED? _____		

If you need more space, use Remarks, Section 10.

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

1.

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 STATE ZIP	<input type="checkbox"/>	EMERGENCY ROOM VISITS	DATES OF VISITS	
PHONE				
<small>Area Code 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 7 - INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

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	STATE	<input type="checkbox"/>	EMERGENCY ROOM VISITS	DATES OF VISITS	
ZIP					
PHONE					

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? _____

NAME	DATES	
STREET ADDRESS	FIRST VISIT	
CITY	STATE	ZIP
LAST SEEN	NEXT APPOINTMENT	
PHONE	CHART/HMO #	

CLAIM NUMBER (If any) _____

REASONS FOR VISITS? _____

If you need more space, use Remarks, Section 10.

SECTION 8 - 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 10.

SECTION 9 - TESTS

Have you had, or will you have, any **medical tests** for your illnesses, injuries, or conditions?
 YES 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 CATHETERIZATION			
BIOPSY Name of body part _____			
HEARING TEST			
VISION TEST			
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 _____			
Other (Specify)			

If you have had other tests, list them in Remarks, Section 10.

FOR FSMSSA USE ONLY -- DO NOT WRITE ON THIS PAGE

SECTION 11 - BRANCH OFFICE OBSERVATIONS

Check any of the following categories which apply to this case:

- A. Amputation of two limbs
- B. Amputation of a leg at the hip
- C. Allegation of total deafness
- D. Allegation of total blindness
- E. Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, allegedly due to a longstanding condition - exclude recent accident and recent surgery.
- F. Allegation of stroke (cerebral vascular accident) more than 3 months in the past and continued marked difficulty in walking or using a hand or arm.
- G. Allegation of cerebral palsy, muscular dystrophy or muscular atrophy and marked difficulty in walking (e.g., use of braces), speaking or coordination of the hands or arms.
- H. Allegation of diabetes with amputation of a foot.
- I. Allegation of Down Syndrome.
- J. An applicant filing on behalf of another individual alleges severe mental deficiency for claimant who is at least 7 years of age. The applicant alleges that the individual attends (or attended) a special school, or special classes in school, because of his mental deficiency, or is unable to attend any school (or if beyond school age was unable to attend), and requires care and supervision of routine daily activities.
- K. Human immunodeficiency virus (HIV) infection.

Check each item to indicate if any difficulty was observed:

- | | | | | | |
|---------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| Reading | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Using Hands | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Writing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Answering | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seeing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Walking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sitting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Understanding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other (Specify): _____ | | |

If any of the above items were checked "yes", describe the exact difficulty involved:

Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above, etc.):

RESIDENTS OF THE FSM

I further authorize, by my signature below, a private photocopy company as approved by the FSM Social Security Administration to photocopy all medical records needed as evidence in determining my eligibility for social security benefits. I also understand that I have a right to receive a copy of this authorization upon request. Copy request and received.

Yes No

TO BE COMPLETED BY FSMSSA NUMBER HOLDER

SOCIAL SECURITY NUMBER

EMPLOYEE/CLAIMANT/BENEFICIARY (If other than number holder)

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE FSM SOCIAL SECURITY ADMINISTRATION (FSMSSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE - PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE (Include Zip Code)	RELATIONSHIP TO DISABLED PERSON
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INFORMATION ABOUT DISABLED PERSON - PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS (If known) AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE (Include Zip Code)	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER (If known and different than SSN) (Clinic/Patient No.)
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APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE (e.g. dates of hospital admission, treatment, discharge, etc.)

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

I hereby authorize the above-named source to release or disclose to the FSM Social Security administration or state agency the following information for the period(s) identified above:

- 1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV;
- 2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
- 3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
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STREET ADDRESS	TELEPHONE NUMBER (Area Code)
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CITY	STATE	ZIP CODE
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The signature and address of a person who either knows the person signing this form or is satisfied as to the person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS
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CITY	STATE	ZIP CODE
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**Explanation of Form on Reverse, Authorization for Source to Release Information to the
FSM Social Security Administration**

We are requesting you to authorize the release of information about your impairment to us. Sources usually require this authorization before releasing information to us. Also, the law requires this authorization for release of information about certain conditions.

You can provide this authorization by signing form on reverse.