Disability Report - Child - SSA-3820-BK

Read All Of This Information Before You Begin Completing This Form

This Is Not An Application

If You Need Help

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

How To Complete This Form

- Fill out as much of this form as you can before your interview appointment. Print or write clearly.
- If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or " none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/ OTHER/ 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 ahead of time, if you were told to do so.
- 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 Section 10, "DATE AND REMARKS," on Pages 13 and 14, and show the number of the question being answered.

About The Child's Medical And Other Records

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records
- Copies of the child's prescriptions or medicine containers
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

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 from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and medicine containers.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223, and 1631 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 prevent us from making an accurate and timely decision on the claim.

We will use the information to determine child applicant eligibility for benefit payments. We may also share your information for the following purposes, called routine uses:

- To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his/her affairs or his/her eligibility for or entitlement to benefits under the Social Security program; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

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, as published in the Federal Register (FR) on April 1, 2003 at 68 FR 15784; and 60-0320, entitled Electronic Disability (eDIB) Claim File, as published in the FR on December 22, 2003 at 68 FR 71210. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy/.

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 90 minutes to read the instructions, gather the facts, and answer the questions. Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

Disability Report - Child

Section 1 - Information About the Child

A. Child's Name *(First, Middle Initial, Last)*	B. Child's Social Security Number
Annie M. Farnsworth	111-11-1111

C. Your Name *(If agency, provide name of agency and contact person)*
Harriett Jones (SOAR Case Manager)

Your Mailing Address *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*
Some Town Family Shelter, 123 Some Street

City	State	ZIP Code
Some Town	YY	12345

Your Email Address (Optional) hjones@stfs.org

D. Your Daytime Phone Number
444 (*Area Code*) 444-4444 (*Number*)
(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)
☐ Your Number ☐ Message Number ☐ None

E. What is your relationship to the child? SOAR Case Manager

F. Can you speak and understand English? ☒ Yes ☐ No If "No," what is your preferred language? _____

NOTE: If you cannot speak and understand English, we will provide you an interpreter, free of charge. **If you cannot speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages?

☐ Yes *(Enter name, address, phone number, relationship)* ☐ No

Name: _____ Relationship to Child: _____

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

City _____ State ____ ZIP ____ Daytime Phone ____ (*Area Code*) ____ (*Number*)

Can you **read and understand English**? ☒ Yes ☐ No

G. Does the child live with you? ☐ Yes ☒ No If "No," with whom does the child live?

Name: Annette M. Farnsworth Relationship to Child: mother

Address: Some Town Family Shelter, 123 Some Street
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

Some Town (City) YY (State) 12345 (ZIP) Daytime Phone 444 (*Area Code*) 444-4444 (*Number*)

Can this person **speak and understand English**? ☒ Yes ☐ No

If "No," what is this person's preferred language? _____

Can this person **read and understand English**? ☒ Yes ☐ No

Section 1 - Information About the Child

H. Can the child speak and understand English? ☒ Yes ☐ No

If "No," what languages can the child speak?

If the child understands any other languages, list them here:

I. What is the child's height *(without shoes)*? 3'0

What is the child's weight *(without shoes)*? 49

J. Does the child have a **medical assistance** card? ☒ Yes ☐ No

If "Yes," show the **number** here: 123456

Section 2 - Contact Information

A. Does the child have a legal guardian or custodian other than you?

☒ Yes *(Enter name, address, phone number, relationship)* ☐ No

Name: Annette M. Farnsworth

Address: Some Town Family Shelter, 123 Some Street

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

Some Town	yy	12345
City	State	ZIP

Daytime Phone Number 444 444-4444

Area Code *Number*

Relationship to Child: mother

Can this person **speak and understand English**? ☒ Yes ☐ No

If "No," what is this person's preferred language?

Can this person **read and understand English**? ☒ Yes ☐ No

B. Is there another adult who helps care for the child and can help us get information about the child if necessary?

☐ Yes *(Enter name, address, phone number, relationship)* ☒ No

Name of Contact:

Address:

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

City	State	ZIP

Daytime Phone Number:

Area Code *Number*

Relationship to Child:

Can this person **speak and understand English**? ☐ Yes ☐ No

If "No," what is this person's preferred language?

Can this person **read and understand English**? ☐ Yes ☐ No

Section 3 - The Child's Illnesses, Injuries or Conditions and How They Affect Him/Her

A. What are the child's disabling **illnesses, injuries, or conditions?**

Uncontrolled seizure disorder, attention deficit hyperactivity disorder, oppositional defiant disorder,fetal alcohol syndrome, cognitive and intellectual disability

B. When do you estimate the child became disabled?
(Use Section 10 - Date and Remarks to provide additional information) 01/01/2017 *MM/DD/YYYY*

C. Do the child's illnesses, injuries or conditions cause **pain** or other symptoms? ☒ Yes ☐ No

Section 4 - Information About the Child's Medical Records

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

☒ Yes ☐ No

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

☒ Yes ☐ No

Section 4 - Information About the Child's Medical Records

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each Doctor/HMO/Therapist/Other**. If you cannot remember the exact dates, try to give us approximate dates. Examples: 12-20-19, Dec. 2019, last winter. Include the child's **next appointment**.

1.

Name			Dates
Dr. Betty Brain, Neurologist			
Street Address			First Visit
Some Town Neurology, 333 Some Street			1/1/16
City	State	ZIP	Last Visit
Some Town	YY	12345	10/1/18
Phone 333 (Area Code) 333-3333 (Number)	Patient ID # (if known)		Next Appointment
	MCO 123456		5/1/19

Reasons for visits

Epilepsy

What treatment was received?

EEG testing, MRI, medication, neurological evaluations

2.

Name			Dates
Dr. Peter Pediatrician			
Street Address			First Visit
555 Some Street			1/7/14
City	State	ZIP	Last Visit
Some Town	YY	12345	10/1/18
Phone 777 (Area Code) 777-7777 (Number)	Patient ID # (if known)		Next Appointment
	MCO 123456		None

Reasons for visits

General medical conditions

What treatment was received?

Medications, lab work, annual physical

Section 4 - Information About the Child's Medical Records

Doctor/HMO/Therapist/Other

3. Name			Dates
Street Address			First Visit
City	State	ZIP	Last Visit
Phone *Area Code* *Number*	Patient ID # (if known)		Next Appointment
Reasons for visits			
What treatment was received?			

If you need more space, use Section 10.

D. List each **Hospital/Clinic**. If you cannot remember the exact dates, try to give us approximate dates. Examples: 12-20-19, Dec. 2019, last winter. Include the child's **next appointment**.

1. Hospital/Clinic		Type of Visit	Dates	
Name Some Town Hospital		☒ **Inpatient Stays** *(Stayed at least overnight)*	Date In 4/1/15	Date Out 4/4/15
Street Address 444 Some Street		☐ **Outpatient Visits** *(Sent home same day)*	9/3/16	9/4/16
City Some Town		☒ **Emergency Room Visits**	Date First Visit 9/1/15	Date Last Visit 4/1/18
State YY	ZIP 12345		Dates of Visits	
Phone 888 *Area Code*	888-8888 *Number*		10/4/15,1/4/1	7/4/16;9/3/17
Next appointment None		The child's hospital/clinic number MCO 123456		
Reasons for visits Grand mal seizures due to epilepsy				
What treatment did the child receive? EEGs, labwork, medications				
What doctors does the child see at this hospital/clinic on a regular basis? Dr. Betty Brain, and attending pediatric neurologist				

Section 4 - Information About the Child's Medical Records

Hospital/Clinic

2. Hospital/Clinic

Name	Type of Visit	Dates	
	☐ **Inpatient Stays** *(Stayed at least overnight)*	Date In	Date Out
Street Address	☐ **Outpatient Visits** *(Sent home same day)*		
City	☐ **Emergency Room Visits**	Date First Visit	Date Last Visit
State / ZIP			
Phone *Area Code* *Number*		Dates of Visits	

Next **appointment**

The child's hospital/clinic number

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

If you need more space, use Section 10.

E. Does **anyone else have medical records or information** about the child's illnesses, injuries or conditions (foster parents, social workers, counselors, tutors, school nurses, detention centers, attorneys, insurance companies, and/or Worker's Compensation), or is the child scheduled to see anyone else? If you cannot remember the exact dates, try to give us approximate dates. Examples: 12-20-19, Dec. 2019, last winter.

☒ Yes (If "Yes," complete information below.) ☐ No

Name			Dates
Dr. Sara Stanle			
Address Some Town Elementary School			First Visit 9/1/17
City Some Town	State YY	ZIP 12345	Last Seen 10/20/18
Phone 555 (*Area Code*) 555-5555 (*Number*)			Next Appointment 10/25/18

Claim Number *(if any)*

Reasons for Visits

Counseling for ADHD,oppositional defiance disorder,IQ testing and other educational assessments and behavioral health testing (mental status exam, psychological eval)

If you need more space, use Section 10.

Section 5 - Medications

Does the child currently take any **medications** for illnesses, injuries or conditions? ☒ Yes ☐ No

If "Yes," tell us the following: *(Look at the child's medicine containers, if necessary)*

Name of Medicine	If Prescribed, Give Name of Doctor	Reason for Medicine	Side Effects The Child Has
Tegretol	Dr. Betty Brain	epilepsy	nausea, dizziness, drowsiness
Depakote	Dr. Betty Brain	epilepsy	nausea, dizziness, drowsiness
Adderall ER	Dr. Peter Pediatrician	ADHD, ODD	drowsiness

If you need more space, use Section 10.

Section 6 - Tests

Has the child had, or will the child have, any **medical tests** for illnesses, injuries, or conditions?

☒ Yes ☐ No If "Yes," tell us the following *(give approximate dates, if necessary)*

Kind of Test	When Was/Will Tests Be Done *(Month, Day, Year)*	Where Done *(Name of Facility)*	Who Sent The Child For This Test
EKG (Heart Test)			
Treadmill (Exercise Test)			
Cardiac Catheterization			
Biopsy - Name of body part			
Speech/Language	09/01/2017	Some Town School	School Social Worker
Hearing Test			
Vision Test			
IQ Testing			
EEG (Brain Wave Test)	Multiple 9/14-10/1/18	Pediatric Neurology Office	Dr. Betty Brain
HIV Test			
Blood Test (Not HIV)			
Breathing Test			
X-Ray - Name of body part			
MRI/CAT Scan - Name of body part	09/14/2018	Pediatric Neurology Office	Dr. Betty Brain

If the child has had other tests, list them in Section 10.

Section 7 - Additional Information

A. Has the child been **tested or examined** by any of the following?

Headstart (Title V)	☒ Yes	☐ No
Public or Community Health Department	☐ Yes	☒ No
Child Welfare or Social Service Agency or WIC	☐ Yes	☒ No
Early Intervention Services	☒ Yes	☐ No
Program for Children with Special Health Care Needs	☐ Yes	☒ No
Mental Health/Developmental Disabilities Center	☐ Yes	☒ No

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work?

☐ Yes ☒ No

If you answered "Yes" to any of the above A. or B., please complete C. below:

C. 1. Name of Agency _____

Address _____

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

_____ _____ _____

City State ZIP

Phone Number _____ _____

Area Code *Number*

Type of Test _____ When Done _____

Type of Test _____ When Done _____

File or Record Number _____

2. Name of Agency _____

Address _____

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

_____ _____ _____

City State ZIP

Phone Number _____ _____

Area Code *Number*

Type of Test _____ When Done _____

Type of Test _____ When Done _____

File or Record Number _____

If the child has had other tests, list them in Section 10.

Section 8 - Education

A. Is this child currently enrolled in any school? ☒ Yes, grade: 1st ☐ No (too young)

☐ No, other reason (complete B)

B. Other reason the child is not enrolled in school:

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

Name of School: Some Town Elementary School

Address: 123 Some Street

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

Some Town	Some	YY	12345
City	County	State	ZIP

Phone Number: 555 (*Area Code*) 555-5555 (*Number*)

Dates Attended: 9/1/17-Present

Teacher's Name: Dr. Nancy Nice

Has the child been tested for behavioral or learning problems? ☒ Yes ☐ No

If "Yes", complete the following:

Type of Test: Psychological Evaluation When Done: 09/01/2016

Type of Test: WIS III When Done: 05/01/2018

Is the child in special education? ☒ Yes ☐ No

If "Yes", and different from above, give:

Name of Special Education Teacher: Nancy Nice

Is the child in speech/language therapy? ☐ Yes ☒ No

If "Yes", and different from above, give:

Name of Speech/Language Therapist

Section 8 - Education

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

Name of School _____

Address _____

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

_____

City County State ZIP

Phone Number _____ _____
Area Code *Number*

Dates Attended _____

Teacher's Name _____

Was the child tested for behavioral or learning problems? ☐ Yes ☐ No
If "Yes", complete the following:

Type of Test _____ When Done _____

Type of Test _____ When Done _____

Was the child in special education? ☐ Yes ☐ No
If "Yes", and different from above, give:

Name of Special Education Teacher _____

Was the child in speech/language therapy? ☐ Yes ☐ No
If "Yes", and different from above, give:

Name of Speech/Language Therapist _____

If the child has had other tests, list them in Section 10.

E. Is the child attending Daycare/Preschool? ☐ Yes ☐ No
If "Yes", complete the following:

Name of Daycare/Preschool/Caregiver _____

Address _____

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

_____

City County State ZIP

Phone Number _____ _____
Area Code *Number*

Dates Attended _____

Teacher's/Caregiver's Name _____

Section 9 - Work History

A. Has the child ever worked (including sheltered employment, which refers to employment provided for individuals with disabilities in a protected environment under an institutional program)? ☐ Yes ☒ No

If "Yes", complete the following:

Dates Worked _____

Name of Employer _____

Address _____

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

_____

City County State ZIP

Phone Number _____ _____

Area Code *Number*

Name of Supervisor _____

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

Section 10 - Date and Remarks

Please give the date you filled out this disability report.

10/01/2018

Date (MM/DD/YYYY)

Use this section for any additional information about your child.

This is a SOAR-assisted claim. Please contact me, Harriet Jones, at (444)444-4444.

Section 10 - Date and Remarks