DISABILITY REPORT - ADULT

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that makes the disability decision on your case will use the information you provide in this report to decide whether you are disabled. Please complete as much of the report as you can.

You may be able to apply online at: www.ssa.gov/apply.

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.

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, you may contact us at 1-800-772-1213 (TTY 1-800-325-0778). A Social Security Representative will assist you. Have the information available from the bulleted items below when you call us. If you have an appointment, please have the information available, or 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. **If you cannot speak or understand English, we will provide an interpreter free of charge.**

YOUR MEDICAL RECORDS

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS. If you have consented to us obtaining medical records from your providers, we will request your records directly from them. The information that you give us on this report tells us where to request your medical and other records.

WHAT YOU NEED TO COMPLETE THIS REPORT

- Names, addresses, and phone numbers of two people (other than your doctors) we can contact who know about your medical condition(s) and can help with your case, if needed.
- Information about any education you have completed.
- Information about all the jobs you had in the 5 years before you became unable to work.
- Any prescription or non-prescription medicines you take.
- Names, addresses, and phone numbers of any healthcare providers and information about the medical treatment you received, or testing performed.
- If you cannot remember information about your healthcare providers, the treatment you received, or the testing performed, you may be able to get that information from the telephone book, the Internet, an online medical chart, medical bills, prescriptions, or prescription medicine containers.
- If you cannot remember exact dates, provide the closest date you can remember.
- Name of organization(s) we can contact that would have medical information about your condition(s), such as Department of Veterans Affairs, social services agencies, vocational rehabilitation agencies, welfare agencies, attorneys, prisons, workers' compensation, and insurance companies who have paid you disability benefits.
- Information about any vocational rehabilitation, employment, or other support services if you are receiving Supplemental Security Income (SSI).
- **ANSWER EVERY QUESTION,** unless the report indicates otherwise: Provide as much detail as possible. 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 provide additional information. If you need more space to answer any question, use **Section 11 - Remarks**.

HOW TO SUBMIT THIS REPORT

Send or bring this completed report to your local Social Security office. If you have internet access, you can locate your nearest Social Security office by ZIP code at www.socialsecurity.gov/locator. Our 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).

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), 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 an accurate and timely decision on any claim filed.

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

- To applicants, claimants, prospective applicants or claimants, other than the data subject, and their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) 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 Systems 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 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 control number. We estimate that it will take about 80 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 regarding this burden estimate or any other aspect of this collection, including suggestions for reducing the burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate or any other aspects of this collection 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.

SECTION 1 - INFORMATION ABOUT YOU

When a question refers to "you" or "your," it refers to the person who is applying for disability benefits. **If you are completing this report for someone else**, provide information about them.

1.A. NAME (First, Middle Initial, Last, Suffix)	**1.B.** SOCIAL SECURITY NUMBER
Annette M. Farnsworth	222-22-2222

1.C. Have you used any other names on your medical or educational records? Examples include maiden name, other married names, other names, or nickname. ☒ YES ☐ NO

If YES, please list names used: Annette M. Timber

1.D. MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.

c/o Somerset Case Management, 720 W. Smith Ave.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (If not USA)
Any Town	YY	12345	

1.E. EMAIL ADDRESS

N/A

1.F. DAYTIME PHONE NUMBER(S) where we can call to speak with you or leave a message, if needed. Include area code or IDD and country code if outside the USA or Canada.

Primary: 444-444-4445 Secondary: (if available) 444-333-3333

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

SECTION 2 - CONTACTS

Is there someone we can contact who can help with your claim, if needed? Examples include a family member, friend, or neighbor.

☒ YES Please provide the names of two people **(other than your doctors)** we can contact who know about your medical condition(s) and can help you with your claim and can help us reach you if you become unavailable.

☐ NO **We recommend that you provide at least one contact, if available.** Providing the name of someone who knows you may help us to make a decision on your claim.

2.A. NAME (First, Middle Initial, Last)	**2.B.** Relationship to the Person in **1.A.**
Harriet Jones	SOAR Case Worker

2.C. MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.

Somerset Case Management, 720 W. Smith Ave.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Any Town	YY	12345	

2.D. DAYTIME PHONE NUMBER (as described in **1.F.** above)

444-444-4445

SECTION 2 - CONTACTS (continued)

2.E. Can this person speak and understand English? ☒ YES ☐ NO

If NO, what language is preferred?

2.F. NAME (First, Middle Initial, Last)	**2.G.** Relationship to the Person in **1.A.**
Max Wilson	Program Director/Case Worker Supervisor

2.H. MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.
Somerset Case Management, 720 W. Smith Ave.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Any Town	YY	12345	

2.I. DAYTIME PHONE NUMBER (as described in **1.F.** above)
444-333-3333

2.J. Can this person speak and understand English? ☒ YES ☐ NO

If NO, what language is preferred? _____

SECTION 3 - MEDICAL INFORMATION

3.A. Separately list each physical and/or mental condition that limits your ability to work. If you have cancer, please include the type and stage.

1. Schizophrenia, chronic undifferentiated type
2. _____
3. _____
4. _____
5. _____

If you need more space, go to Section 11

3.B. What is your height? 5 feet 6 inches OR _____ centimeters

3.C. What is your weight? 125 pounds OR _____ kilograms

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

☐ NO, I have never worked (Go to question **4.B.**)

☒ NO, I have stopped working (Go to question **4.C.**)

☐ YES, I am currently working (Go to question **4.F.**)

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)? (MM/DD/YYYY) _____ (Go to **Section 5**)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (MM/DD/YYYY) 09/01/2014

Why did you stop working?

☒ Because of my condition(s).

☐ Because of other reasons.

Please explain why you stopped working. Examples include laid off, early retirement, seasonal work ended, or 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? (MM/DD/YYYY) _____

SECTION 4 - WORK ACTIVITY (continued)

4.D. Did your condition(s) cause you or your employer to make changes in your work activity? Examples include job duties, hours, or rate of pay.

☒ NO (Go to **Section 5**)

☐ YES, When did the changes start? (MM/DD/YYYY) _____

4.E. Since the date in **4.D.** above, have you had earnings greater than $1,550 before tax in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ YES (Go to **Section 5**) ☐ NO (Go to **Section 5**)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you or your employer to make changes in your work activity? Examples include job duties, hours, or rate of pay.

☐ YES When did the changes start? (MM/DD/YYYY) _____

☐ NO When did your condition(s) first start bothering you? (MM/DD/YYYY) _____

4.G. Since your condition(s) first bothered you, have you had earnings greater than $1,550 before tax in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ YES ☐ NO

SECTION 5 - EDUCATION, TRAINING, AND LITERACY

5.A. Select the highest level of school completed, including homeschooling, online education, and education received in another country.

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

Date completed: 06/1978 (MM/YYYY)

Name of school: Transit High School

City: Baltimore State/Province: MD Country (if not USA): _____

5.B. Were you in special education? ☐ NO (Go to **5.C.**) ☒ YES (Complete below)

Dates from: 09/1977 (MM/YYYY) to 06/1978 (MM/YYYY)

If YES, select the last grade you were in special education.

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

Reason(s) for special education: Unknown

The school where you were last in special education:

☒ Same as **5.A.**

☐ If different from **5.A.**, complete below.

Name of school: _____

City: _____ State/Province: _____ Country (if not USA): _____

SECTION 5 - EDUCATION, TRAINING, AND LITERACY (continued)

5.C. Have you received any type of **training** (specialized job, trade, or vocational training)?

☒ NO (Go to **5.D.**) ☐ YES (Complete the table below.)

NAME OF TRAINING FACILITY	PHONE NUMBER

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

TYPE OF PROGRAM	Date Completed (or scheduled to be completed)
	MM/YYYY

5.D. What written language do you use every day in most situations (at home, work, school, in community, etc.)?

English

5.E. READING - In the language you identified in **5.D**., can you read a simple message, such as a shopping list or short and simple notes? ☒ YES ☐ NO

5.F. WRITING - In the language you identified in **5.D**., can you write a simple message, such as a shopping list or short and simple notes? ☒ YES ☐ NO

SECTION 6 - WORK HISTORY
(If you need more space, use Section 11)

6.A. Did you have a job in the 5 years before you became unable to work because of your medical conditions?

☐ NO (Go to **Section 7**) ☒ YES (Complete the table below.)

List all the jobs you had in the 5 years before you became unable to work because of your medical conditions:

- List your most recent job first
- List all job titles even if they were for the same employer
- **Do not include jobs you held less than 30 calendar days**
- Include self-employment (e.g., rideshare driver, hair stylist)
- Include work in a foreign country

	Job Title (e.g., Cashier)	**Type of Business** (e.g., Grocery Store)	**Dates Worked**		**Hours per Day**	**Days per Week**	**Rate of Pay**	
			From: MM/YYYY	To: MM/YYYY			**Amount**	**Frequency** (per) hour, day, week, month, or year
1.	Shelf Stocker	Drug store	01/2014	09/2014				
2.	Shelf Stocker	Discount store	2012	2012				
3.								
4.								
5.								

SECTION 6 - WORK HISTORY (continued)

Check the box below that applies to you.

☒ **I had more than one job.** (If you had more than one job, we may contact you for more information. **Do not** answer the questions in **Section 6.B** through **6.D**. Go to **Section 7**.)

☐ I had **only one job**. (If you had only one job, complete the questions in **6.B.** through **6.D.**)

6.B. Information about your work

6.B.1. For the job you listed in **6.A.**, describe in detail the tasks you did in a typical workday. Examples of tasks include stocking shelves, greeting customers, scheduling appointments, or maintaining records.

6.B.2. If any of the tasks listed above involved writing or completing reports, describe the type of report you wrote or completed and how much time you spent on it per workday or workweek.

6.B.3. If any of the tasks listed above involved supervising others, describe who or what you supervised and what supervisory duties you had. Examples of supervisory duties include evaluating employee job performance, making schedules, or maintaining time records.

6.B.4. List the machines, tools, and equipment you used regularly when doing this job and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.

6.B.5. Did this job require you to interact with coworkers, the general public, or anyone else? ☐ YES ☐ NO

If YES, **describe** who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek. Examples include answering customer questions on the telephone for 5 hours per day or showing clients sale properties in person for 4 hours per day.

SECTION 6 - WORK HISTORY (continued)

6.C. Physical and environmental requirements of your work

Tell us how much time you spent doing the following physical activities in a typical workday. The total hours/minutes for standing, walking, and sitting should equal the Hours per Day reported in **6.A.** The example below shows an 8-hour workday with 2 hours standing and walking and 6 hours sitting (8 hours total).

Activity	How much of your workday? (Hours/Minutes)	Example:
Standing and walking (combined)		2 hours
Sitting		6 hours
Stooping (i.e., bending down & forward at waist)		15 minutes
Kneeling (i.e., bending legs to rest on knees)		15 minutes
Crouching (i.e., bending legs & back down & forward)		None
Crawling (i.e., moving on hands and knees)		None
Using fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt): ☐ One Hand ☐ Both Hands		2 hours (both hands)
Using hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a hammer, or water bottle): ☐ One Hand ☐ Both Hands		1 hour (both hands)
Reaching at or below the shoulder: ☐ One Arm ☐ Both Arms		1 hour (both arms)
Reaching overhead (above the shoulder): ☐ One Arm ☐ Both Arms		None
Climbing stairs or ramps		None
Climbing ladders, ropes, or scaffolds		None

If you need more space, use **Section 11**

Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.

Select the **heaviest** weight lifted:

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs.
☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

Select the weight **frequently** lifted (i.e., 1/3 to 2/3 of the workday):

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs.
☐ 50 lbs. or more ☐ Other _____

Did this job expose you to any of the following? Check all that apply.

☐ Outdoors ☐ Extreme heat (non-weather related) ☐ Extreme cold (non-weather related)
☐ Wetness ☐ Humidity ☐ Hazardous substances
☐ Moving mechanical parts ☐ High, exposed places ☐ Heavy vibrations
☐ Loud noise ☐ Other

If one or more boxes are checked, tell us about the exposure(s) and how often you were exposed.

SECTION 6 - WORK HISTORY (continued)

6.D. Explain how your medical conditions would affect your ability to do this job.

SECTION 7 - MEDICINES

7. Are you currently taking any prescription or non-prescription medicine(s)?

☐ NO (Go to **Section 8**)

☒ YES (Complete the information below. You may need to look at your medicine containers.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE DOCTOR NAME (IF KNOWN)	REASON FOR MEDICINE (IF KNOWN)
Risperdal	Dr. Marianne Sagamore	Schizophrenia
Chlortrimeton (antihistamine)	Dr. Marianne Sagamore	"to treat brain tumors"
Theragran (multivitamin)	Dr. Marianne Sagamore	"to treat brain tumors"

If you need to list more medicines, use **Section 11.**

SECTION 8 - MEDICAL TREATMENT

8.A. Have you seen or received treatment from a healthcare provider (doctor, hospital, clinic, psychiatrist, nurse practitioner, therapist, physical therapist, or other medical professional), or **do you have a future appointment scheduled**?

☐ NO (Go to **Section 9**)

☒ YES (Complete the chart(s) below)

You may find this information on medical bills, online medical chart, or the Internet.

8.A.1.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU
Holy Cross Mobile Treatment	Dr. Thomas

What medical conditions were treated or evaluated?
Psychotic Disorder NOS

PHONE NUMBER	DATE FIRST SEEN:	DATE LAST SEEN:	DATE OF NEXT APPOINTMENT: (IF KNOWN)
444-111-2222	03/2016 MM/YYYY	05/2016 MM/YYYY	MM/YYYY

ADDRESS
100 Third Street

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Any Town	YY	12345	

8.A.2.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU
Union Hospital	Dr. Marianne Sagamore

What medical conditions were treated or evaluated?
Schizophrenia, chronic undifferentiated type

PHONE NUMBER	DATE FIRST SEEN:	DATE LAST SEEN:	DATE OF NEXT APPOINTMENT: (IF KNOWN)
444-123-1000	10/2016 MM/YYYY	12/2016 MM/YYYY	MM/YYYY

ADDRESS
534 Main Street

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Any Town	YY	12345	

8.A.3.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN:	DATE LAST SEEN:	DATE OF NEXT APPOINTMENT: (IF KNOWN)
	MM/YYYY	MM/YYYY	MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

SECTION 8 - MEDICAL TREATMENT (continued)

8.A.4

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

8.A.5.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

8.A.6.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

If you need to list more facilities or healthcare providers, use **Section 11.**

SECTION 8 - MEDICAL TREATMENT (continued)

8.B. Did any of the healthcare providers listed in **8.A.** order any medical tests for you? Include tests already performed and scheduled in the future.

☒ NO (Go to **Section 9**)

☐ YES (Select tests from the chart below)

TEST	NAME OF HEALTHCARE PROVIDER OR FACILITY	DATE OF TEST (MM/YYYY)
Blood test (not HIV)		
Breathing test		
Cardiac catheterization		
EEG (brain wave test)		
EKG (heart test)		
Hearing test		
HIV test		
Speech/language test		
Treadmill (exercise test)		
Vision test		
Psychological/IQ test		
Biopsy (list body part):		
MRI/CT scan (list body part):		
X-ray (list body part):		
Other - please specify:		

If you need to list more tests, use **Section 11.**

SECTION 9 - OTHER MEDICAL INFORMATION

9. Does anyone else (other than your healthcare providers) have your medical information? Examples include Department of Veterans Affairs, social service agencies, vocational rehabilitation agencies, welfare agencies, attorneys, prisons, workers' compensation, and insurance companies who have paid you disability benefits.

☒ NO (Go to **Section 10** if you are receiving Supplemental Security Income (SSI) and have been asked to complete this report; if not, go to **Section 11**.)

☐ YES (Complete the information below)

NAME OF ORGANIZATION	PHONE NUMBER

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

NAME OF CONTACT PERSON	CLAIM 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**

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.

SECTION 10 - SUPPORT SERVICES

Provide information about your participation in support services, if applicable. Examples of support services can include:

- An Individualized Education Program (IEP) through a school (if a student aged 18-21)
- An individual work plan with an employment network under the Ticket to Work Program
- A Plan to Achieve Self-Support (PASS)
- An individualized plan for employment with a vocational rehabilitation agency or any other organization

10.A. Have you participated or are you participating in any support services mentioned above or any other vocational rehabilitation, employment services, or other support services to help you to go to work?

☐ YES (Complete the information below) ☐ NO (Go to **Section 11**)

10.B. FACILITY OR ORGANIZATION NAME	PHONE NUMBER

COUNSELOR, INSTRUCTOR, OR JOB COACH NAME

ADDRESS (Street or PO Box) Include Suite, Building, etc.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

SECTION 10 - SUPPORT SERVICES (continued)

10.C. Are you still participating in the plan or program? (Select answer below)

☐ YES Date began: _____ MM/YYYY Expected completion date: _____ MM/YYYY

☐ NO Date began: _____ MM/YYYY Date stopped: _____ MM/YYYY

Reason stopped: _____

10.D. What types of services, tests, or evaluation were provided?

Select all that apply:

☐ Vision test ☐ Psychological/IQ test ☐ Work classes ☐ Hearing test ☐ Work evaluation

☐ Other - Please explain: _____

If you need to list another plan or program, use **Section 11**

SECTION 11 - REMARKS

Please provide 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 provide the requested information, please use this space to provide the additional information requested in those sections. Be sure to include the section and question number to which you are referring.

This is a SOAR claim. Ms. Farnsworth is experiencing homelessness, but can be contacted through her case manager, Harriet Jones, who completed this form.

Ms. Farnsworth's dates of employment are estimated to the best of her ability. She was unable to remember the months in which she worked.

Ms. Farnsworth reports that she has been treated at Freedom Hospital and Taylor Evans for "psychiatry and dentistry," however, these providers have no record of treatment for her.

Ms. Farnsworth also reports that she has received treatment for brain tumors, cysts, dwarfism of the blood, leukemia, and partial deafness. She also reports that she had cerebral palsy and polio at birth. These conditions have not been verified by treatment providers.

SECTION 11 - Remarks (continued)

SECTION 12 - WHO IS COMPLETING THIS REPORT

Date Report Completed (MM/DD/YYYY) 01/17/2017

Who is completing this report?

- ☐ The person listed in **1.A.**
- ☒ The person listed in **2.A.**
- ☐ The person listed in **2.F.**
- ☐ Someone else (Complete the information below)

NAME (First, Middle Initial, Last)	Relationship to the Person in **1.A.**

MAILING ADDRESS (Street or PO Box) Include the apartment number, if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

DAYTIME PHONE NUMBER where we may reach you or leave a message, if needed. Include the area code or IDD and country code if outside the USA or Canada.