

DISABILITY REPORT - ADULT - Form SSA-3368-BK

PLEASE 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, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the Internet, you may access the Disability Report Form Guide at <http://www.socialsecurity.gov/disability/3368/index.htm>.

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.

- Please 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 4, 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 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 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 Pages 9 and 10, 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. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to 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 do that for you. The information we ask for on this form tells us to whom we should send a request for 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 prescription bottles.

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 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 if 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.

The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security 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 named 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 as follows: (1) to enable a third party or 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 General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the 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 give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT: 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 YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.*

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

**DISABILITY REPORT
ADULT**

For SSA Use Only

Do not write in this box.

Related SSN _____

Number Holder _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. NAME *(First, Middle Initial, Last)*

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* *Number*

E. What is your height without shoes?
_____ feet _____ inches

F. What is your weight without shoes?
_____ pounds

G. Do you have a medical assistance card? (For Example, Medicaid or Medi-Cal) If "YES," show the number here: _____
 YES NO

H. 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 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 NO *(If "YES," and that person is the same as in "D" above show "SAME" here. If not, complete the following information.)*

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

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

I. Can you read and understand English? YES NO **J. Can you write more than your name in English?** YES NO

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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
or **other symptoms**?

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 *(If "NO," go to Section 4.)*

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 3 - INFORMATION ABOUT YOUR WORK

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries or conditions.

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. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

D. 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 duties like this? YES NO

E. In **this job**, how many total hours each day did you:

- Walk? _____ Stoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____
- Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____
- Sit? _____ Crouch? *(Bend legs & back down & forward.)* _____ Write, type or handle small objects? _____
- Climb? _____ Crawl? *(Move on hands & knees.)* _____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

G. Check **heaviest** weight lifted:

- Less than 10 lbs 10 lbs 20 lbs 50 lbs 100 lbs. or more Other _____

H. 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 _____

I. Did you supervise other people in this job? YES (Complete items below.) NO (If NO, go to J.)

- How many people did you supervise? _____
- What part of your time was spent supervising people? _____
- Did you hire and fire employees? YES NO

J. Were you a lead worker? YES NO

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

- A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? YES NO
- B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? YES NO

If you answered "NO" to both of these questions, go to Section 5.

- C. List **other names** you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

- D. List each **DOCTOR/HMO/THERAPIST/OTHER**. Include your next appointment.

1. NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE <small>Area Code Phone Number</small>	PATIENT ID # (If known)		NEXT APPOINTMENT
REASONS FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

2. NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE <small>Area Code Phone Number</small>	PATIENT ID # (If known)		NEXT APPOINTMENT
REASONS FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3. NAME			DATES	
STREET ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN	
PHONE <small>Area Code Phone Number</small>		PATIENT ID # (If known)	NEXT APPOINTMENT	
REASONS FOR VISITS _____				
WHAT TREATMENT WAS RECEIVED? _____				

If you need more space, use Remarks, Section 9.

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					
CITY		<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT		DATE LAST VISIT
STATE	ZIP				
PHONE <small>Area Code Phone Number</small>		<input type="checkbox"/> EMERGENCY ROOM VISITS	DATE OF VISITS		

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 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP			
PHONE			<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
<small>Area Code Phone Number</small>					
			<input type="checkbox"/> EMERGENCY ROOM VISITS	DATE OF VISITS	

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? _____

If you need more space, use Remarks, Section 9.

F. Does anyone else have medical records or information about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

YES *(If "YES," complete information below.)*

NO

NAME			DATES	
STREET ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN	
PHONE			NEXT APPOINTMENT	
<small>Area Code Phone Number</small>				
CLAIM NUMBER (if any) _____				
REASONS FOR VISITS _____				

If you need more space, use Remarks, Section 9.

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? YES
 If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for 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? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
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 _____			

If you have had other tests, list them in Remarks, Section 9.

SECTION 7-EDUCATION/TRAINING INFORMATION

A. Check the highest grade of **school** completed.

Grade school:

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 "NO," go to part C)

NAME OF SCHOOL _____

ADDRESS _____

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

City State Zip

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

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

YES NO If "YES," what type? _____

Approximate date completed: _____

**SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT,
or OTHER SUPPORT SERVICES INFORMATION**

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services to help you go to work?

YES (Complete the information below) NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

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

City State Zip

DAYTIME PHONE NUMBER _____

Area Code Number

DATES SEEN _____ TO _____

TYPE OF SERVICES OR _____

TESTS PERFORMED (IQ, vision, physicals, hearing, workshops, etc.)

