SOCIAL SECURITY ADMINISTRATION

DISABILITY REPORT - FIELD OFFICE

IDENTIFYING INFORMATION

1. NAME OF PERSON ON WHOSE SOCIAL SECURITY RECORD THIS CLAIM IS BEING FILED

HIS OR HER SOCIAL SECURITY NUMBER

NAME OF CLAIMANT *(if different from above)*

SSN *(if different from above)*

☐ Male ☐ Female DOB ____________

2. CLAIMANT'S ALLEGED ONSET DATE (AOD) ____________

3. RECOMMENDED ONSET DATE *(if different from above)* *(check type of claim(s) and enter recommended onset)*

☐ SSI ____________

☐ DIB/Freeze ____________ ☐ DWB ____________ ☐ CDB ____________ ☐ OTHER ____________

4. REASON FOR RECOMMENDED ONSET DATE

☐ SSI Application Date ☐ Controlling Date

☐ SSI Alien ☐ Statutorily Blind

☐ Date Last Insured ☐ Work Before/After AOD

☐ Date First Insured ☐ UWA ☐ SGA ☐ Not SGA ☐ 820/821 In File

☐ Other (explain in item 5)

5. EXPLANATION FOR RECOMMENDED ONSET DATE, WHEN APPLICABLE: ____________

☐ 820/821 Pending Date Requested ____________

MISCELLANEOUS INFORMATION

6. Protective filing date ____________

Date last insured (DIB/Freeze case) ____________

Beginning of Prescribed Period (DWB) ____________

End of Prescribed Period ____________

Controlling date ____________

Closed period case ☐ Yes ☐ No

PRIOR FILING INFORMATION - Use Remarks, if additional space is needed.

7. Prior filing(s) ☐ Yes ☐ No

If yes, and you are not sending the prior folder(s) to the DDS, enter the following;

Type of prior claim(s) ____________

SSN(s) of prior claim(s) ____________

Date of last decision ____________ Level of last decision ____ ☐ Allowance ☐ Denial

Date of prior termination (if applicable) ____________

Location of prior folder ______

Prior folder requested ☐ Yes ____________ (date requested) ☐ No

8. CHECK ANY OF THE FOLLOWING FO PD/PB CRITERIA THAT APPLY IN AN SSI CLAIM PER DI 11055.230ff.

☐ 1. Amputation of two limbs.

☐ 2. Amputation of a leg at the hip.

☐ 3. Allegation of total deafness.

☐ 4. Allegation of total blindness.

☐ 5. Allegation of bed confinement or immobility without a wheel chair, walker, or crutches, due to a longstanding condition -- excluding recent accident and recent surgery.

☐ 6. Allegation of a stroke (cerebral vascular accident) more than 3 months in the past and continued marked difficulty in walking or using a hand or arm.

☐ 7. Allegation of cerebral palsy, muscular dystrophy, or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of hands or arms.

☐ 8. Allegation of diabetes with amputation of a foot.

☐ 9. Allegation of Down Syndrome.

☐ 10. Allegation of severe mental deficiency made by another individual filing on behalf of a claimant who is at least 7 years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school because of mental deficiency or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities.

Note: "Mental deficiency" means mental retardation. This PD category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine daily activities (e.g., fastening a seat belt) grossly exceeds age-appropriate dependence as a result of mental retardation.

☐ 11. A child is age 6 months or younger and the birth certificate or other evidence (e.g. hospital admission summary) shows a weight below 1200 grams (2 pounds 10 ounces) at birth.

☐ 12. Human immunodeficiency virus (HIV) infection (See DI 11055.241)

☐ 13. A child is age 6 months or younger and available evidence (e.g., the hospital admission summary) shows a gestational age at birth on the table below with the corresponding birth weight indicated:

Gestational Age (in weeks)	Weight at Birth	
37-40	Less than 2000 grams	(4 pounds, 6 ounces)
36	1875 grams or less	(4 pounds, 2 ounces)
35	1700 grams or less	(3 pounds, 12 ounces)
34	1500 grams or less	(3 pounds, 5 ounces)
33	1325 grams or less	(2 pounds, 15 ounces)

☐ 14. A physician or knowledgeable hospice official confirms an individual is receiving hospice services because of terminal cancer. (See DI E11010.001ff. for terminal illness procedures.)

☐ 15. Allegation ofspinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held assistive devices for more than two weeks following the injury, with confirmation of such status from an appropriate medical professional.

9. OBSERVATIONS/PERCEPTIONS

How was the interview conducted?

☐ Teleclaim with claimant (Complete 1-8 and 15 below) ☐ Face-to-face with claimant (Complete 1-15 below) ☐ No contact with claimant (Go to Page 4)

If the claimant had difficulty with the following, check the "yes" block and explain in "observations" or check "no" or "not observed/perceived." (Explain any "no" answers that you think would assist the DDS in making a decision.)

1. Hearing	☐ Yes	☐ No	☐ Not observed/perceived
2. Reading	☐ Yes	☐ No	☐ Not observed/perceived
3. Breathing	☐ Yes	☐ No	☐ Not observed/perceived
4. Understanding	☐ Yes	☐ No	☐ Not observed/perceived
5. Coherency	☐ Yes	☐ No	☐ Not observed/perceived
6. Concentrating	☐ Yes	☐ No	☐ Not observed/perceived
7. Talking	☐ Yes	☐ No	☐ Not observed/perceived
8. Answering	☐ Yes	☐ No	☐ Not observed/perceived
9. Sitting	☐ Yes	☐ No	☐ Not observed/perceived
10. Standing	☐ Yes	☐ No	☐ Not observed/perceived
11. Walking	☐ Yes	☐ No	☐ Not observed/perceived
12. Seeing	☐ Yes	☐ No	☐ Not observed/perceived
13. Using hand(s)	☐ Yes	☐ No	☐ Not observed/perceived
14. Writing	☐ Yes	☐ No	☐ Not observed/perceived

15. Other (specify) ______________________________

OBSERVATIONS: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

10. Development initiated by FO

A. Medical

Source	Date Requested	Tickle/Diary Date	Evidence to be Forwarded by Source to		Capability Development Requested
			DDS	FO	

B. Other

Source	Date Requested	Tickle/Diary Date	Evidence to be Forwarded by Source to	
			DDS	FO

C. Forms to be completed by applicant and sent to the DDS.

☐ SSA-3370 ☐ SSA-3371 ☐ SSA-3369 ☐ Other ______________

11. If medical evidence was brought in to the FO by the claimant, check here ☐

12. Is DDS capability deveopment needed? ☐ Yes ☐ No

REMARKS ______________________________

NAME OF INTERVIEWER (Print)

Area Code Phone Number

NAME OF PERSON COMPLETING FORM (Print) *(if different from inverviewer)*

DATE