DISABILITY REPORT- CHILD - Form SSA-3820-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

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

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 this form 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," 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 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 the "REMARKS" section on Pages 10 and 11, 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
- 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 prescription bottles.

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.

The Paperwork Reduction Act of 1995 requires us to notify you that this Information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 40 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts, and fill out the form.

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

DISABILITY REPORT - CHILD

SECTION 1 -- INFORMATION ABOUT THE CHILD

A. **CHILD'S NAME** *(First, Middle Initial, Last)*

B. **CHILD'S SOCIAL SECURITY NUMBER**

C. **YOUR NAME** *(If agency, provide name of agency and contact person)*

YOUR MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*

CITY | STATE | ZIP CODE

D. **YOUR DAYTIME PHONE NUMBER** *(If you have no phone number, give us a daytime number where we can leave a message for you)*

_____ _____ ☐ Your Number ☐ Message Number ☐ None
Area Code *Number*

E. What is **your relationship to the child**? _____

F. Can you **speak English**? ☐ YES ☐ NO

If "NO", what languages can you speak? _____

If you **cannot speak English**, give us the name of someone we may contact who speaks English and will give you messages.

NAME _____ RELATIONSHIP TO CHILD _____

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

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

Can you **read English**? ☐ YES ☐ NO

G. Does the child live with you? ☐ YES ☐ NO If "NO", with whom does the child live?

NAME _____ RELATIONSHIP TO CHILD _____

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

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

Can this person **speak English**? ☐ YES ☐ NO

If "NO", what languages can this person speak? _____

Can this person **read English**? ☐ YES ☐ NO

Disability Report - Child - Form SSA-3820-BK

SECTION 1 - INFORMATION ABOUT THE CHILD

H. Can the child speak English? ☐ YES ☐ NO

If "NO," what languages can the child speak? _____

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

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

J. Does the child have a **medical assistance** card? (for example Medicaid, Medi-Cal)

☐ YES ☐ NO

If "YES", show the **number** here: _____

SECTION 2 - CONTACT INFORMATION

Give the name of a person that we can contact (other than the child's doctors, such as legal guardian) who knows about the child's illnesses, injuries or conditions and can help you with his/her claim.

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 _____

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?**

_____

_____

_____

B. How do the child's illnesses, injuries, or conditions **limit his/her daily activities?**

_____

_____

_____

C. When did the child become disabled?

Month	*Day*	*Year*

D. Do the child's illnesses, injuries or conditions cause **pain?** ☐ 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

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

C. List **each DOCTOR/HMO/THERAPIST.** Include the child's **next appointment.**

1.

NAME		DATES
STREET ADDRESS		**FIRST** VISIT
CITY **STATE** **ZIP**		**LAST** SEEN
PHONE ___ ___ *Area Code* *Number*	**CHART/HMO #**	NEXT **APPOINTMENT**
REASONS FOR VISITS		
WHAT **TREATMENT** WAS RECEIVED?		

2.

NAME		DATES
STREET ADDRESS		**FIRST** VISIT
CITY **STATE** **ZIP**		**LAST** SEEN
PHONE ___ ___ *Area Code* *Number*	**CHART/HMO #**	NEXT **APPOINTMENT**
REASONS FOR VISITS		
WHAT **TREATMENT** WAS RECEIVED?		

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST

3.

NAME		DATES
STREET ADDRESS		FIRST VISIT
CITY STATE ZIP		LAST SEEN
PHONE ____ ____ (Area Code / Number)	CHART/HMO #	NEXT APPOINTMENT
REASONS FOR VISITS		
WHAT TREATMENT WAS RECEIVED?		

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

D. List each **HOSPITAL/CLINIC.** Include the child's **next appointment.**

1

HOSPITAL/CLINIC	TYPE OF VISIT	DATES
NAME STREET ADDRESS CITY STATE ZIP PHONE ____ ____ (Area Code / Number)	☐ INPATIENT STAYS *(Stayed at least overnight)* ☐ OUTPATIENT VISITS *(Sent home same day)* ☐ EMERGENCY ROOM VISITS	DATE IN / DATE OUT DATE FIRST VISIT / DATE LAST VISIT 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?

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC	TYPE OF VISIT	DATES
NAME **STREET ADDRESS** **CITY** **STATE** ZIP **PHONE** Area Code Number	☐ **INPATIENT** STAYS *(Stayed at least overnight)* ☐ **OUTPATIENT** VISITS *(Sent home same day)* ☐ **EMERGENCY ROOM** VISITS	DATE IN / DATE OUT DATE FIRST VISIT / DATE LAST VISIT 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 Remarks, Section 10.

E. Does **anyone else have medical records or information** about the child's illnesses, injuries or conditions (Workers' Compensation, insurance companies, counselors, detention centers, attorneys, and/or tutors), or is the child scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME	DATES
ADDRESS	**FIRST** VISIT
CITY **STATE** **ZIP**	**LAST** SEEN
PHONE Area Code Number	NEXT APPOINTMENT

CLAIM NUMBER *(If any)* _____

REASONS FOR VISITS _____

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

SECTION 5 - MEDICATIONS

Does the child currently take any **medications** for the illnesses, injuries or conditions?

☐ YES ☐ NO If "YES", tell us the following: *(Look at the child's medicine bottles, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

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

SECTION 6 - TESTS

Has the child had, or will he/she have, any **medical tests** for the illnesses, injuries or conditions? ☐ YES ☐ NO If "YES", tell us the following (give approximate dates, if necessary).

KIND OF TEST	WHEN DONE, OR WHEN IT WILL BE DONE *(Month, day, year)*	WHERE DONE *(Name of Facility)*	WHO SENT THE CHILD FOR THIS TEST?
BIOPSY--Name of body part			
X-RAY--Name of body part			
MRI/CAT SCAN - Name of body part			

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

SECTION 8 - EDUCATION

A. What is the child's **current grade** in school or the **highest grade** completed?

B. Is the child currently attending school *(other than summer school)*? ☐ YES ☐ NO

If "NO", explain why the child is not attending 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 _____

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 _____

Has the child been tested for behavioral or learning problems? ☐ YES ☐ NO

If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? ☐ YES ☐ NO

If "YES", and the teacher's name is different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech therapy? ☐ YES ☐ NO

If "YES", and the therapist's name is different from above, give:

NAME OF SPEECH THERAPIST _____

SECTION 7 - ADDITIONAL INFORMATION

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

1.	Headstart (Title V)	☐ YES	☐ NO
2.	Public or Community Health Department	☐ YES	☐ NO
3.	Child Welfare or Social Service Agency	☐ YES	☐ NO
4.	Women, Infant and Children (WIC) Program	☐ YES	☐ NO
5.	Program for Children with Special Health Care Needs	☐ YES	☐ NO
6.	Mental Health/Mental Retardation Center	☐ YES	☐ NO
7.	Vocational Rehabilitation	☐ YES	☐ NO

If you answered "YES" to any of the above, complete B below.

If "NO," to 7 above, and the child is over age 15, do you want the child to be referred to Vocational Rehabilitation? ☐ YES ☐ NO

B. 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 there are any other agencies, show them in Remarks, Section 10.

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 the teacher's name is different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech therapy? ☐ YES ☐ NO

If "YES", and the therapist's name is different from above, give:

NAME OF SPEECH THERAPIST _____

If there are other schools, show them in Remarks, 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 work)? ☐ 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 *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 - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

_____

_____

_____

_____

_____

_____

_____

_____

SECTION 10 - REMARKS

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of **claimant** or person filing on claimant's behalf *(parent, guardian)*	**Date** *(Month, day, year)*

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

1. Signature of **Witness**	2. Signature of **Witness**
Address *(Number and street, city, state, and ZIP code)*	**Address** *(Number and street, city, state, and ZIP code)*

*U.S. Government Printing Office: 2000 — 461-206/20024