FUNCTION REPORT – ADULT – THIRD PARTY -- Form SSA-3380-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 call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the decision on the claim of the person applying for or receiving disability benefits. You can help that person by completing as much of the form as you can.

It is important that you tell us about the person's activities and abilities and about any changes in his or her activities or abilities since the person's illnesses, injuries, or conditions and any related symptoms first bothered him or her.

- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please indicate "don't know," or "none," "not observed," or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to consider any symptoms related to the person's illnesses, injuries, or conditions, such as pain, fatigue, shortness of breath, weakness, or nervousness, when answering questions about how the person's illnesses, injuries, or conditions affect his or her activities or abilities.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section, beginning on Page 13 or attach a blank sheet of paper, and show the number of the question being answered. If you do attach a blank sheet of paper, please put the name of the person applying for disability benefits at the top of the sheet so that we can make sure we keep the sheet with his or her claim file.

REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM AND THE DATE THE FORM WAS COMPLETED ON PAGE 14.

The Privacy Act

The Social Security Administration is authorized to collect the information on this form under sections 205(a) and (b), 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 person's claim or case. 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 person's claim or case. Although the information you furnish is almost never used for any purpose other than making a determination about the person's disability or continuing 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 Government Accountability 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.

The 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 you about 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not have that address, you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 6401 Security, Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

AFTER COMPLETING THIS FORM, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

OMB No. 0960-0635

SOCIAL SECURITY ADMINSTRATION

FUNCTION REPORT – ADULT-THIRD PARTY

SECTION A – GENERAL INFORMATION

1. NAME OF PERSON APPLYING FOR OR RECEIVING DISABILITY BENEFITS
(First, Middle Initial, Last)

_____

If you are not able to answer a question about the person applying for or receiving disability benefits, please check "Not Observed" or "Don't Know," as appropriate and move to the next question.

2. a. Does the person live in a: (Check where the person lives **NOW**)
Don't Know □ (If you answered "Don't Know," go to question 3.)

1. House? □
2. Apartment? □
3. Boarding House? □
4. Nursing Home? □
5. Shelter? □
6. Group Home? □
7. Other? □

If you checked "**Other**," please **DESCRIBE** where the person lives.

_____

b: Does the person live (Check the person's **CURRENT** living arrangement)

1. Alone? □
2. With Family? □
3. With Friends? □
4. Other? □

If you checked "**Other**," please **DESCRIBE** the person's living arrangement

_____

_____

c. Has there been any change in where the person lives or his or her living arrangements because of his or her illnesses, injuries, or conditions? YES □ NO □
Don't Know □
If "NO" or "Don't Know", go to **Section B.**
If "YES," please **DESCRIBE** what has changed._____

_____

d. What is the reason for the change? Don't Know □

_____

_____

_____

SECTION B – INFORMATION ABOUT THE PERSON'S ABILITIES

3. a. Does the person's illnesses, injuries, or conditions affect his or her ability to:

1. Lift? YES □ NO □ Don't Know □ **8.** Kneel? YES □ NO □ Don't Know □

2. Carry? YES □ NO □ Don't Know □ **9.** Crawl? YES □ NO □ Don't Know □

3. Stand? YES □ NO □ Don't Know □ **10.** Reach? YES □ NO □ Don't Know □

4. Walk? YES □ NO □ Don't Know □ **11.** Use Hands? YES □ NO □ Don't Know □

5. Sit? YES □ NO □ Don't Know □ **12.** See? YES □ NO □ Don't Know □

6. Climb Stairs? YES □ NO □ Don't Know □ **13.** Hear? YES □ NO □ Don't Know □

7. Bend? YES □ NO □ Don't Know □ **14.** Talk? YES □ NO □ Don't Know □

b. If you checked "YES" for an activity, please **LIST** the number of the activity and **EXPLAIN HOW** and **WHY** you believe the illnesses, injuries, or conditions affect the person's ability to do that activity. For example, before the person was able to lift a gallon of milk with one hand, but now she seems to need both hands because her grip strength seems to have deteriorated; before the person was able to walk 2 miles, but now he can only walk 100 feet because he says he gets tired; the person used to wear shoes that laced, but now she only wears slip-on shoes because she says her fingers are too stiff to tie laces. Please be as **SPECIFIC** as you can. _____

_____

_____

_____

_____

_____

c. For each of the activities below, please check the box that best describes what you have observed the person can do.

1. Walk for 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ hours before having to rest.
Not Observed □

2. Stand for 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ hours before having to rest.
Not Observed □

3. Sit for 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ hours before having to change position.
Not Observed □

4. Bend Frequently □ Occasionally □ Never □

5. Lift 10 □ 20 □ 30 □ 40 □ 50 □ pounds frequently

6. Lift 10 □ 20 □ 30 □ 40 □ 50 □ pounds occasionally

7. Can reach his or her arms out and up Frequently □ Occasionally □ Never □

d. Does the person **USE**:

1. Crutches?	YES ☐	NO ☐ Don't Know ☐
2. Cane?	YES ☐	NO ☐ Don't Know ☐
3. Walker?	YES ☐	NO ☐ Don't Know ☐
4. Brace/Splint?	YES ☐	NO ☐ Don't Know ☐
5. Wheelchair?	YES ☐	NO ☐ Don't Know ☐
6. Glasses/Contact Lenses?	YES ☐	NO ☐ Don't Know ☐
7. Hearing Aid?	YES ☐	NO ☐ Don't Know ☐
8. Artificial Arm or Leg?	YES ☐	NO ☐ Don't Know ☐
9. Artificial Voice Box?	YES ☐	NO ☐ Don't Know ☐
10. Other Assistive Device?	YES ☐	NO ☐ Don't Know ☐

If you checked "YES" to **10.**, please **DESCRIBE** the device.

_____

_____

_____

e. If you checked "NO" or "Don't Know" for **d.1.-d.10.**, go to **g.**
If you checked "YES" for any assistive device, **LIST** each type of assistive device he or she uses, **DESCRIBE** when he or she uses it, and **TELL** if it does or does not help the person in his or her daily activities.

_____

_____

_____

_____

f. If the assistive device(s) was prescribed, **TELL** who prescribed it and the **DATE** it was prescribed or check here if you don't know and go to **g.** Don't Know ☐ _____

_____

_____

g. Have the person's illnesses, injuries, or conditions affected his or her ability to:

1. Pay attention?	YES ☐ NO ☐ Don't Know ☐
2. Understand	YES ☐ NO ☐ Don't Know ☐
3. Finish something he or she starts?	YES ☐ NO ☐ Don't Know ☐
4. Read a newspaper, magazine, or book?	YES ☐ NO ☐ Don't Know ☐
5. Watch a movie?	YES ☐ NO ☐ Don't Know ☐
6. Follow written instructions?	YES ☐ NO ☐ Don't Know ☐
7. Follow spoken instructions?	YES ☐ NO ☐ Don't Know ☐
8. Handle changes in his or her routine?	YES ☐ NO ☐ Don't Know ☐
9. Handle stress?	YES ☐ NO ☐ Don't Know ☐

h. If you checked "YES" for any activity in **g.**, please **LIST** the activity and **EXPLAIN WHAT** has changed because of the person's illnesses, injuries, or conditions._____

4. MEDICATION, TREATMENT, OR OTHER METHOD

a. Does the person take any prescription or non-prescription medications for his or her illnesses, injuries, conditions, or symptoms? YES □ NO □ Don't Know □

If "NO" or "Don't Know," go to **b.**

If "YES," please answer **1.**, **2.**, and **3.**

1. Does the person take the medications in the dosages and at the frequency instructed?

YES □ NO □

If "NO," please **EXPLAIN** why not and at **WHAT** dosage and frequency he or she takes the medication.

2. Does the person need help or reminders to take his or her medications? YES □ NO □

If "NO," go to **3.**

If "YES," what help or reminders does he or she need? Please **DESCRIBE.**

3. Has the medication affected the person's ability to do things (for example, after taking a medication he or she can bend more easily; or the medication makes him or her sleepy)?

YES □ NO □

If "NO," go to **b.**

If "YES," please **EXPLAIN what you know about** the effect the medication the person takes for his or her illnesses, injuries, or conditions has on his or her ability to do things.

b. Is there any treatment, other than medication, (for example, acupuncture or physical therapy) or other method (for example, she lies flat on her back or changes position) that the person uses now or that he or she has used in the past for his or her illnesses, injuries, conditions or symptoms?

YES □ NO □

If "NO," go to **Section C.**

If "YES," please answer **1.**, **2.**, **3.**, and **4**:

1. For each treatment or other method the person uses or has used, **LIST** the **TYPE** and the **DATE** he or she started the treatment or other method and the **DATE** treatment ended. If he or she is still taking the treatment or using the other method, show "ongoing."

_____

_____

_____

_____

2. Was the treatment or other method recommended by a doctor or other health care professional who treated or examined the person ? YES □ NO □

If "NO," go to **3.**

If "YES," please **LIST** the treatment or other method, the **NAME** of the doctor or other health care professional who recommended it, and **HOW OFTEN** the person takes the treatment or uses the other method.

_____

_____

_____

3. Does the person need help or reminders to follow his or her treatments or other methods?

YES □ NO □

If "NO," go to **4.**

If "YES," what kind of help or reminders does the person need? Please **DESCRIBE.**

_____

_____

_____

4. Have the treatments or other methods the person uses or has used affected his or her ability to do things (for example, he says changing positions relieves pain in his back; the treatments leave him tired)?

YES □ NO □

If "NO," go to **Section C.**

If "YES," please **EXPLAIN** the effect the treatments or other methods the person uses for illnesses, injuries, or conditions have on his or her ability to do things. Please be **SPECIFIC.**

_____

_____

_____

SECTION C – INFORMATION ABOUT THE PERSON'S DAILY ACTIVITIES

5. PERSONAL CARE

a. Do the person's illnesses, injuries, or conditions affect his or her ability to:

1. Dress? YES □ NO □ Don't Know □
2. Shower or bathe? YES □ NO □ Don't Know □
3. Care for his or her hair? YES □ NO □ Don't Know □
4. Care for his or her teeth? YES □ NO □ Don't Know □

5. Shave? YES □ NO □ Don't Know □

6. Feed himself or herself? YES □ NO □ Don't Know □

7. Use a toilet? YES □ NO □ Don't Know □

8. Do some other personal care activity? YES □ NO □ Don't Know □

b. For each item that you checked "YES," **LIST** the number of the item and **DESCRIBE** how the person's illnesses, injuries, or conditions affects that activity (for example, it takes more time for him to dress, he or she has a simpler hair style, he or she changed to an electric razor).

_____

_____

_____

_____

_____

_____

_____

c. Does the person need help or reminders to care for his or her personal needs? YES □ NO □

If "NO," go to question **7.**

If "YES," what kind of help or reminders does he or she need?

_____

_____

_____

6. Does the person's illnesses, injuries, or conditions affect his or her sleep? YES □ NO □

If "NO," go to question **7.**

If "YES," please **EXPLAIN.**

_____

_____

_____

7. Does the person take care of:

a. Another person (for example, a spouse, child, grandchild, parent, or friend)?

YES □ NO □ Don't Know □

b. A pet or other animal? YES □ NO □ Don't Know □

c. If you answered "NO" or "Don't Know ," to **a.** and **b.**, go to question **8.**

If you answered "YES" to **a.** or **b**:

1. Who or what does the person take care of?

_____

_____

2. What does he or she do for them?

_____

_____

3. Does someone help the person to take care of the other person, pet or other animal?

YES □ NO □

If "NO," go to question **8.**

If "YES," please answer **a.** and **b.**

a. Who helps the person?

_____

_____

b. How do they help the person?

_____

_____

_____

8. Has there been any change in what the person can do because of his or her illnesses, injuries, or conditions?

YES □ NO □ Don't Know □

If "NO," go to question **9.**

If "YES," please **EXPLAIN.**

_____

_____

9. GETTING AROUND

a. Does the person go outside his or her home alone? YES □ NO □ Don't Know □

If "YES" or "Don't Know," go to **b.**

If "NO," please **EXPLAIN** why he or she does not go out alone.

_____

_____

_____

_____

b. When the person goes outside his or her home, does he or she (Check **ALL** that apply)

1. Walk? □

2. Drive himself or herself? □

3. Go as a passenger in a car, truck, or other private vehicle? □

4. Use public transportation? □

5. Ride a bicycle? □

6. Other? □

If you checked "Other' please **DESCRIBE.** _____

_____

_____

c. If you checked **b.2.**, please **TELL** how **OFTEN** the person drives and how **FAR** he or she can drive comfortably.

d. Even if the person does not drive himself or herself when he or she goes outside his or her home, is the person **able** to drive?

YES □ NO □

1. If "YES," please **EXPLAIN.**_____

2. If "NO," please **EXPLAIN** why he or she cannot drive (for example, he or she never learned how to drive).

e. Has there been any change in how the person travels to places outside his or her home (for example, to a doctor, shopping, visiting) because of his or her illnesses, injuries, or conditions? YES □ NO □

If "NO," go to question **10**

If "YES," please **DESCRIBE** the change._____

10. MONEY

a. Is the person able to:

1. Use money by himself or herself ? YES □ NO □ Don't Know □

2. Count change? YES □ NO □ Don't Know □

3. Handle a savings account? YES □ NO □ Don't Know □

4. Use checks or money orders? YES □ NO □ Don't Know □

If he or she is able to do all of the listed activities, go to **b.**

For any item that you checked "NO," please **EXPLAIN** why the person is not able to do the activity. _____

b. Have you observed any change in the person's ability to manage his or her money or pay bills because of his or her illnesses, injuries, or conditions? YES □ NO □

If "NO," go to question **11.**

If "YES," please **DESCRIBE** the change._____

11-. MEALS

a. Does the person prepare his or her own meals? YES □ NO □ Don't Know □

If "YES" or "Don't Know," go to **b.**

If "NO," please **EXPLAIN** why he or she does not prepare his or her meals.

_____

_____

_____

_____

b. What meals does the person usually prepare? (Check **ALL** that apply)

1. Breakfast □ **2.** Lunch □ **3.** Dinner □

c. Normally does he or she (Check the answer that is **MOST OFTEN** true)

1. Order take-out food? □

2. Make simple meals, needing little preparation (dry cereal and milk, sandwiches, canned soup)? □

3. Use ingredients requiring peeling or slicing vegetables, frying, baking or roasting meat, or following a recipe? □

d. Have you observed any change in the way he or she prepares meals (for example, the type of meals, the time spend preparing meals, how often meals are prepared) because of his or her illnesses, injuries, or conditions? YES □ NO □

If "NO," go to question **12.**

If "YES," pleases **DESCRIBE** the changes. _____

_____

_____

_____

12. HOUSE AND YARD WORK

a. Does the person do any house or yard work (for example, wash dishes, laundry, ironing, dusting, vacuuming, household repairs, home improvement projects, mow a lawn, gardening)?

YES □ NO □ Don't Know □ (Go to question **13.**)

If "NO," please **EXPLAIN** why not. _____

_____

_____

If "YES," **LIST** the household or yard work that he or she does._____

_____

_____

_____

b. Have you observed any change in the **way** he or she does the house or yard work listed in **12.a.** or in the **time** it takes him or her to do the work because of his or her illnesses, injuries, or conditions? YES □ NO □

If "NO," go to **c.**

If "YES," please **LIST** any house or yard work he or she does in which there has been a change and **DESCRIBE** the change. Please be **SPECIFIC**.

_____

_____

_____

_____

_____

c. Does the person need help, reminders, or encouragement to do any of the house or yard work he or she does? YES □ NO □

If "NO," go to question **13.**

If "YES," **LIST** each activity for which he or she needs help, reminders, or encouragement, **DESCRIBE** why the person needs the help, reminders, or encouragement, and **LIST** who provides the help, reminders, or encouragement._____

_____

_____

_____

_____

13. SHOPPING

a. Does the person do any shopping for himself or herself or others?YES □ NO□ Don't Know □

If "NO," go to **d.** If "Don't Know," go to question **14.**

If "YES," does the person shop: (Check "YES" for **ALL** that apply)

1. In the stores? YES □ NO □ **3.** By mail (catalogue)? YES □ NO □

2. By phone? YES □ NO □ **4.** By computer? YES □ NO □

b. Does the person shop for:

1. Groceries? YES □ NO □

If "NO," go to **2.**

If "YES," **HOW OFTEN** does the person shop for groceries ?

_____

_____

_____

2. Clothing (for himself or herself or others)? YES □ NO □

If "NO," go to **3.**

If "YES," **HOW OFTEN** does he or she shop for clothing?

_____

_____

_____

_____

3. Other shopping? YES □ NO □

If "NO," go to **d.**

IF "YES," **DESCRIBE** what the person shops for and **HOW OFTEN** he or she does this type of shopping.

_____

_____

_____

_____

c. Has there been any change in the way the person shops (for example, he or she now shop more by phone), or in your shopping habits (for example, does he or she shop less often) because of his or her illnesses, injuries, or conditions? YES □ NO □

If "NO," go to question **14.**

If "YES," please **DESCRIBE** the change Please be **SPECIFIC.** _____

_____

_____

_____

_____

d. If the person **does not** shop for himself or herself or others, is this a change? YES □ NO □

If "NO," go to question **14.**

If "YES," please **DESCRIBE** the change. Please be **SPECIFIC.** _____

_____

_____

_____

14. SOCIAL ACTIVITIES

a. Does the person do things with other people (in person, on the phone, on the computer)?

YES □ NO □ Don't Know □

If "NO," go to **c.** If "Don't Know," go to question **15.**

If "YES," please **DESCRIBE** the kinds of things he or she does with other people.

_____

_____

_____

b. How often does the person do each of the things you described in **a.**?

_____

_____

_____

c. Are there things the person does outside the home or places he or she goes on a regular basis (religious services, community center, sports events, social groups, visit with family or friends, etc.)?

YES □ NO □

If "NO," go to **e.**

If "YES," for each thing he or she does or place he or she goes, **TELL** how often he or she does the activity or goes to the place and what he or she does there (for example, weekly Sunday morning church service, monthly community meeting-treasurer, watch weekly little league games during season).

_____

_____

d. Has there been any change in the person's social activities because of his or her illnesses, injuries, or conditions? YES □ NO □

If "YES," **DESCRIBE** the change. Please be **SPECIFIC.**

_____

_____

_____

_____

e. Does the person get along with others (family, friends, neighbors, etc.)?

YES □ NO □

If "YES," go to **f.**

If "NO" please **EXPLAIN** why not. Please be **SPECIFIC.**

_____

_____

_____

_____

f. Does the person get along with authority figures (for example, police, a boss, landlord, or teacher)? YES □ NO □

If "YES," go to **g.**

If "NO," please **EXPLAIN** in what way he or she does not get along with authority figures._____

_____

_____

_____

_____

g. Has the person ever quit, been fired, or been laid off from a job because of his or her injuries, illnesses, or conditions? YES □ NO □

If "NO," go to question **15.**

If "YES," please **EXPLAIN** what happened._____

_____

_____

_____

15. HOBBIES AND INTERESTS

a. Does the person have any hobbies or interests (for example, reading, watching TV, sewing, playing or watching sports, bingo, playing cards, fishing, hunting, camping, gardening, computer)? YES □ NO □ Don't Know □

If you checked "NO" or "Don't Know ," go to question **16.**

If "YES," please **LIST** each hobby or interest and **HOW OFTEN** he or she does it.

_____

_____

_____

_____

b. Has there been any change in his or her ability to do any of the hobbies or interests you listed **or** the time he or she spends on them because of his or her illnesses, injuries, or conditions?

YES □ NO □

If "NO," go to **Section D.**

If "YES," please **DESCRIBE** the change. Pleases be **SPECIFIC.**

_____

_____

16. UNUSUAL BEHAVIOR, FEARS, OR CHANGES IN BEHAVIOR

Have you noticed any unusual behavior, fears, or changes in behavior in the person?

YES □ NO □ Don't Know □

If "NO" or "Don't Know," go to **Section D.**

If "YES," please describe the unusual behavior or fears._____

_____

_____

If you have observed any changes in the person's behavior, please describe the changes._____

_____

_____

_____

SECTION D- -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 complete the information requested on the bottom of page 14.**

_____

_____

_____

Name of person completing this form (Please Print) Date (month, day, year)

Your relationship to the person applying for or receiving disability benefits (for example, spouse, neighbor, friend)_____ How often do you see this person? _____
How long have you known this person?_____

Your Address (Number and Street) email address (optional)

City State Zip Code

Your daytime telephone number (Area code and number)