SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0646

REQUESTING OFFICE NAME AND ADDRESS	ATTACH LABEL OR TYPE IN CLAIMANT NAME

REQUEST FOR ADMINISTRATIVE INFORMATION
Please ask the person(s) most familiar with the child's records to complete this form.
Continue any answers as needed on next page.

Name of School

1. **Has there been any recent evaluation or testing of this child? If yes, kind(s) of test/evaluation:**	**Date(s):**

Please send us copies of all comprehensive evaluations, triennial assessments, psychological or speech/language testing, current Individualized Education Programs, teacher/therapist progress reports, and all other records that can help us evaluate the child's functioning.

2. **Has the child been referred for assessment team evaluation or special class placement or services? If yes, to whom?**	**Date(s):**

3. **Current Instructional Levels**	**Standardized Assessment Instrument**	**Score/Percentile Rank**	**Date(s):**
Reading Level:			
Math Level:			
Written Language Level:			

4. **Grade(s) repeated, if any:**

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

5. **Educational Disabilities, if any:**

- ☐ Mental Retardation/Mentally Impaired/Intellectually Limited
- ☐ Hearing Impairment/Deafness
- ☐ Speech or Language Impairment
- ☐ Visual Impairment/Blindness
- ☐ Emotional Disturbance/Behavior Disorder
- ☐ Orthopedic Impairment
- ☐ Autism
- ☐ Traumatic Brain Injury
- ☐ Other Health Impairment (please specify) _____
- ☐ Specific Learning Disability (please specify) _____
- ☐ Developmental Delay (please specify) _____
- ☐ Multiple Disabilities (please specify)

6. **Placement and Related Services (Check all that apply):**

- ☐ Regular Education, no special instruction
- ☐ Special Ed. Instruction: **Hours/week:**
  - ☐ Inclusion - Sp. instr. in regular class _____
  - ☐ Resource Room _____
  - ☐ Self-contained, regular school _____
  - ☐ Self-contained, special school _____
  - ☐ Special school, non-public _____
  - ☐ Residential _____

Therapies, etc: **Hours/week:**

- ☐ Occupational Therapy _____
- ☐ Physical Therapy _____
- ☐ Speech - Language Therapy _____
- ☐ Counselling (please specify) _____
- ☐ Other (please specify) _____

PLEASE PROVIDE YOUR NAME AND TITLE ON NEXT PAGE

ADDITIONAL COMMENTS Use this section for continuation of any answers from page 1, and for any additional information about this child's records that may help us obtain the information we need to evaluate the child's functioning.

Name/Title	Date	Phone ( ) –
Name/Title (If more than one person helped complete this form)	Date	Phone ( ) –

THANK YOU

The Privacy and Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 1614 and 1633 of the Social Security Act. Social Security needs this information to make a decision on the named claimant's claim. This form is authorized under CFR 416.924a (a). 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 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 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 15 minutes to read the instructions, gather the facts, and answer the questions. SEND THE COMPLETED FORM TO THE STATE AGENCY THAT REQUESTED IT. If you have questions about how to complete the form, contact the State Agency that requested it. If you need the address or phone number for your State Agency, you can get it by calling Social Security at 1-800-772-1213. *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***