

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 (TTY 1-800-325-0778).

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to make a decision on the disabled person's claim. You can help by completing as much of the form as you can. When a question refers to the "disabled person," it refers to the person who is applying for or receiving disability benefits.

It is important that you tell us what you know about the disabled person's activities and abilities.

DO NOT ASK THE DISABLED PERSON TO GIVE YOU ANSWERS

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- 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, use the "REMARKS" section on Page 8, and show the number of the question being answered.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

Privacy Act and Paperwork Reduction Act Statements

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 1631(d)(1) 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 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.

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 30 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 (TTY 1-800-325-0778).** *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.*

**PLEASE REMOVE THIS SHEET BEFORE RETURNING
THE COMPLETED FORM.**

FUNCTION REPORT - ADULT -THIRD PARTY

How the disabled person's illnesses, injuries, or conditions limit his/her activities

SECTION A - GENERAL INFORMATION

1. NAME OF DISABLED PERSON *(First, Middle, Last)*

2. YOUR NAME <i>(Person completing the form)</i>	3. RELATIONSHIP <i>(To disabled person)</i>	4. DATE <i>(Month, Day, Year)</i>
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5. YOUR DAYTIME TELEPHONE NUMBER *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

() - _____ Your Number Message Number None
Area Code Phone Number

6. a. How long have you known the disabled person? _____

b. How much time do you spend with the disabled person and what do you do together?

7. a. Where does the disabled person live? *(Check one.)*

House Apartment Boarding House Nursing Home
 Shelter Group Home Other *(What?)* _____

b. With whom does he/she live? *(Check one.)*

Alone With Family With Friends
 Other *(Describe relationship.)* _____

SECTION B - INFORMATION ABOUT DAILY ACTIVITIES

8. Describe what the disabled person does from the time he/she wakes up until going to bed.

9. Does this person take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? Yes No
If "YES," for whom does he/she care, and what does he/she do for them? _____

10. Does he/she take care of pets or other animals? Yes No
If "YES," what does he/she do for them? _____

11. Does anyone help this person care for other people or animals? Yes No
If "YES," who helps, and what do they do to help? _____

12. What was the disabled person able to do before his/her illnesses, injuries, or conditions that he/she can't do now?

13. Do the illnesses, injuries, or conditions affect his/her sleep? Yes No
If "YES," how? _____

14. **PERSONAL CARE** (Check here if **NO PROBLEM** with personal care.)
a. Explain how the illnesses, injuries, or conditions affect this person's ability to:
Dress _____
Bathe _____
Care for hair _____
Shave _____
Feed self _____
Use the toilet _____
Other? _____

b. Does he/she need any special reminders to take care of personal needs and grooming? Yes No

If "YES," what type of help or reminders are needed? _____

c. Does he/she need help or reminders taking medicine? Yes No

If "YES," what kind of help does he/she need? _____

15. MEALS

a. Does the disabled person prepare his/her own meals? Yes No

If "Yes," what kind of food is prepared? (For example, sandwiches, frozen dinners, or complete meals with several courses). _____

How often does he/she prepare food or meals? (For example, daily, weekly, monthly.)

How long does it take him/her? _____

Any changes in cooking habits since the illness, injuries, or conditions began?

b. If "No," explain why he/she cannot or does not prepare meals. _____

16. HOUSE AND YARD WORK

a. List household chores, both indoors and outdoors, that the disabled person is able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.)

b. How much time do chores take, and how often does he/she do each of these things?

c. Does he/she need help or encouragement doing these things? Yes No

If "YES," what help is needed? _____

d. If the disabled person doesn't do house or yard work, explain why not. _____

17. GETTING AROUND

a. How often does this person go outside? _____

If he/she doesn't go out at all, explain why not. _____

b. When going out, how does he/she travel? (Check all that apply.)

- Walk Drive a car Ride in a car Ride a bicycle
 Use public transportation Other (Explain) _____

c. When going out, can he/she go out alone? Yes No

If "NO," explain why he/she can't go out alone. _____

d. Does the disabled person drive? Yes No

If he/she doesn't drive, explain why not. _____

18. SHOPPING

a. If the disabled person does any shopping, does he/she shop: (Check all that apply.)

- In stores By phone By mail By computer

b. Describe what he/she shops for. _____

c. How often does he/she shop and how long does it take? _____

19. MONEY

a. Is he/she able to:

- Pay bills Yes No Handle a savings account Yes No
Count change Yes No Use a checkbook/money orders Yes No

Explain all "NO" answers. _____

b. Has the disabled person's ability to handle money changed since the illnesses, injuries, or conditions began?

Yes No

If "YES," explain how the ability to handle money has changed. _____

20. HOBBIES AND INTERESTS

a. What are his/her hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.) _____

b. How often and how well does he/she do these things? _____

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

21. SOCIAL ACTIVITIES

a. Does the disabled person spend time with others? (*In person, on the phone, on the computer, etc.*)

Yes No

If "YES," describe the kinds of things he/she does with others. _____

How often does he/she do these things? _____

b. List the places he/she goes on a regular basis. (For example, church, community center, sports events, social groups, etc.) _____

Does he/she need to be reminded to go places?

Yes No

How often does he/she go and how much does he/she take part? _____

Does he/she need someone to accompany him/her?

Yes No

c. Does this person have any problems getting along with family, friends, neighbors, or others?

Yes No

If "YES," explain. _____

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

SECTION C - INFORMATION ABOUT ABILITIES

22. a. Check any of the following items the disabled person's illnesses, injuries, or conditions affect:

- | | | | |
|------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Walking | <input type="checkbox"/> Stair Climbing | <input type="checkbox"/> Understanding |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Seeing | <input type="checkbox"/> Following Instructions |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Memory | <input type="checkbox"/> Using Hands |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Talking | <input type="checkbox"/> Completing Tasks | <input type="checkbox"/> Getting Along With Others |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Hearing | <input type="checkbox"/> Concentration | |

Please explain how his/her illnesses, injuries, or conditions affect each of the items you checked. (For example, he/she can only lift [how many pounds], or he/she can only walk [how far])

b. Is the disabled person: Right Handed? Left Handed?

c. How far can he/she walk before needing to stop and rest? _____

If he/she has to rest, how long before he/she can resume walking? _____

d. For how long can the disabled person pay attention? _____

e. Does the disabled person finish what he/she starts? (For example, a conversation, chores, reading, watching a movie) Yes No

f. How well does the disabled person follow written instructions? (For example, a recipe)

g. How well does the disabled person follow spoken instructions? _____

h. How well does the disabled person get along with authority figures? (For example, police, bosses, landlords or teachers) _____

i. Has he/she ever been fired or laid off from a job because of problems getting along with other people? Yes No

If "YES," please explain. _____

If "YES," please give name of employer. _____

j. How well does the disabled person handle stress? _____

k. How well does he/she handle changes in routine? _____

l. Have you noticed any unusual behavior or fears in the disabled person? Yes No

If "YES," please explain. _____

23. Does the disabled person use any of the following? (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Brace/Splint | <input type="checkbox"/> Glasses/Contact Lenses |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Artificial Limb | <input type="checkbox"/> Artificial Voice Box |
| <input type="checkbox"/> Other (Explain) _____ | | |

Which of these were prescribed by a doctor? _____

When was it prescribed? _____

When does this person need to use these aids? _____
