FUNCTION REPORT – ADULT – Form SSA 3373-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 disability decision on your disability claim. You can help them by completing as much of the form as you can.

It is important that you tell us about your activities and abilities.

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK**. If you do not know the answer or the answer is "none" or the answer is "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 more space is needed 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

Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. 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. We generally use the information you supply for the purpose of making decisions regarding claims. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (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); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State and local level; and (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at any local 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 61 minutes to read the instructions, gather the facts, and answer the questions.
SEND OR BRING 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.

Form Approved
OMB No. 0960-0681

SOCIAL SECURITY ADMINISTRATION

FUNCTION REPORT – ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only
Do not write in this box

Related SSN _____-____-_____

Number Holder _____

SECTION A – GENERAL INFORMATION

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

2. **SOCIAL SECURITY NUMBER**
- -

3. **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*

4. a. Where do you live? *(Check one.)*

☐ House ☐ Apartment ☐ Boarding House ☐ Nursing Home

☐ Shelter ☐ Group Home ☐ Other *(What?)* _____

b. With whom do you live? *(Check one.)*

☐ Alone ☐ With Family ☐ With Friends

☐ Other *(Describe relationship.)* _____

SECTION B – INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

5. How do your illnesses, injuries, or other conditions limit your ability to work? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SECTION C – INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

_____

_____

_____

_____

_____

_____

_____

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? ☐ Yes ☐ No

If "YES," for whom do you care, and what do you do for them? _____

_____

8. Do you take care of pets or other animals? ☐ Yes ☐ No

If "YES," what do you do for them? _____

_____

9. Does anyone help you care for other people or animals? ☐ Yes ☐ No

If "YES," who helps, and what do they do to help? _____

_____

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

_____

11. Do the illnesses, injuries, or conditions affect your sleep? ☐ Yes ☐ No

If "YES," how? _____

_____

12. **PERSONAL CARE** (Check here ☐ if **NO PROBLEM** with personal care.)

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress_____

Bathe_____

Care for hair_____

Shave_____

Feed self_____

Use the toilet_____

Other_____

b. Do you 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. Do you need help or reminders taking medicine? ☐ Yes ☐ No

If "YES," what kind of help do you need? _____

_____

13. **MEALS**

a. Do you prepare your own meals? ☐ Yes ☐ No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses) _____

_____

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

_____

How long does it take you? _____

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

_____

b. If "No," explain why you cannot or do not prepare meals. _____

_____

14. **HOUSE AND YARD WORK**

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.) _____

_____

b. How much time does it take you, and how often do you do each of these things?

_____

c. Do you need help or encouragement doing these things? ☐ Yes ☐ No

If "Yes," what help is needed? _____

d. If you do not do house or yard work, explain why not. _____

_____

15. **GETTING AROUND**

a. How often do you go outside? _____

If you don't go out at all, explain why not. _____

_____

b. When going out, how do you 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 you go out alone? ☐ Yes ☐ No

If "NO," explain why you can't go out alone? _____

_____

d. Do you drive? ☐ Yes ☐ No

If you don't drive, explain why not. _____

_____

16. **SHOPPING**

a. If you do any shopping, do you shop: *(Check all that apply.)*

☐ In stores ☐ By phone ☐ By mail ☐ By computer

b. Describe what you shop for. _____

_____

c. How often do you shop and how long does it take? _____

_____

17. **MONEY**

a. Are you 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 your 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. _____

_____

18. **HOBBIES AND INTERESTS**

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

_____

b. How often and how well do you do these things? _____

_____

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

_____

_____

19. **SOCIAL ACTIVITIES**

a. Do you spend time with others? *(In person, on the phone, on the computer, etc.)*? ☐ Yes ☐ No

If "YES," describe the kinds of things you do with others. _____

_____

How often do you do these things? _____

b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.). _____

_____

Do you need to be reminded to go places? ☐ Yes ☐ No

How often and how much do you take part? _____

_____

Do you need someone to accompany you? ☐ Yes ☐ No

c. Do you 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 D – INFORMATION ABOUT ABILITIES

20. a. Check any of the following items that your illnesses, injuries, or conditions affect:

☐ Lifting	☐ Walking	☐ Stair Climbing	☐ Understanding
☐ Squatting	☐ Sitting	☐ Seeing	☐ Following Instructions
☐ Bending	☐ Kneeling	☐ Memory	☐ Using Hands
☐ Standing	☐ Talking	☐ Completing Tasks	☐ Getting Along with Others
☐ Reaching	☐ Hearing	☐ Concentration	

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

_____

_____

_____

b. Are you: ☐ Right Handed? ☐ Left Handed?

c. How far can you walk before needing to stop and rest? _____

If you have to rest, how long before you can resume walking?_____

_____

d. For how long can you pay attention? _____

e. Do you finish what you start? *(For example, a conversation, chores, reading, watching a movie)* ☐ Yes ☐ No

f. How well do you follow written instructions? (For example, a recipe) _____

_____

g. How well do you follow spoken instructions? _____

_____

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers) _____

_____

i. Have you 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 the name of the employer_____

j. How well do you handle stress? _____

_____

k. How well do you handle changes in routine? _____ _____

_____

l. Have you noticed any unusual behavior or fears? ☐ Yes ☐ No

If "YES," please explain. _____

_____

21. Do you use any of the following? *(Check all that apply.)*

☐ Crutches	☐ Cane	☐ Hearing Aid
☐ Walker	☐ Brace/Splint	☐ Glasses/Contact Lenses
☐ Wheelchair	☐ Artificial Limb	☐ Artificial Voice Box

☐ Other *(Explain)* _____

Which of these were prescribed by a doctor? _____

_____

When was it prescribed? _____

_____

When do you use these aids? _____

_____

22. Do you currently take any medicines for your illnesses, injuries, or conditions? ☐ Yes ☐ No

If "YES," do any of your medicines cause side effects? ☐ Yes ☐ No

If "YES," please explain. *(Do not list all of the medicines that you take. List only the medicines that cause side effects.)*

Name of Medicine	Side Effects You Have

SECTION E – 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 didn't have anything to add), be sure to complete the fields at the bottom of this page.

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

Address (Number and Street)	Email address (optional)

City	State	Zip Code
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