



## Apply Online for Disability Benefits

Applying online for disability benefits offers several advantages:

- You can start your disability claim immediately. There is no need to wait for an appointment;
- You can apply from the convenience of your own home or on any computer; and
- You avoid trips to a Social Security office, saving you time and money.

You can use the online application to apply for benefits if you:

- are age 18 or older;
- have worked and paid Social Security taxes **long enough to qualify**;
- have a medical condition that has prevented you from working or is expected to prevent you from working for at least 12 months or end in death; and
- reside in the United States or one of its territories/commonwealths.

**Please note:** If you want to apply for disability benefits for a child, go to [Applying for Disability Benefits for Children](#).


If your application has recently been denied, the [Internet Appeal](#) is a starting point to request a review of our decision about your eligibility for disability benefits.

Follow these 4 easy steps to apply online

**Step 1. Review** the [Adult Disability Checklist](#) for details about what you will need before starting the online process.

**Step 2. Fill out** the [online Disability Benefit Application](#) to provide us with information regarding eligibility for payment.

**Step 3. Fill out** the online [Adult Disability Report](#) to provide us with medical and work history.

**Step 4. Fill out, sign and mail or take** the [Authorization to Disclose Information to the Social Security Administration](#)  to your [local Social Security Office](#).

Apply Online  
For Disability  
Benefits



### More Information

[Social Security Disability Planner](#)

[Disability Benefits](#)

[Information for Representatives](#)

### More Helpful Health Care Information

Health Information from the U.S. Department of Health and Human Services

[www.healthfinder.gov](http://www.healthfinder.gov)

Prescription Drug Assistance Programs

[www.healthfinder.gov/rxdrug](http://www.healthfinder.gov/rxdrug)

Apply  
Online for  
Disability  
Benefits

? ? ?  
Frequently  
Asked  
Questions



## Welcome to the Social Security Benefit Application

Form Approved: OMB No. 0960-0618 Expires 01/31/2013

Thank you for using our online Disability application.

### Before you begin...

Before you start applying for benefits, you should read [Using this application](#) in order to understand the information and documents that may be needed.

You may also want to review:

- [Special Instructions For Blind Users](#)
- [Other Ways To Apply](#)
- [Medicare - For people Within 3 Months of Age 65 or Older](#)
- [Help With Medicare Prescription Drug Costs](#)
- [Internet Security Policy](#)
- [Website Policies & Other Important Information](#)
- [Social Security Accessibility Policy](#)

We estimate that it will take between 10 and 30 minutes to read the instructions, gather the facts, and answer the questions, but this will depend on the number of questions you need to answer. The average time is approximately 15 minutes. For more information about estimates, go to the [Paperwork Reduction Act](#) .

If you want to finish an application that you already started:

### To Start The Application Process...

**Please select one of the following. Tell us information about the person completing this application.**

- I am applying for myself.
- I am helping someone who wants to apply for benefits and is with me.
- I am helping someone who is not with me, and therefore can not sign the application at this time.

**Blind or visually impaired applicants** can use the [Internet Special Notices Option](#) page to choose how to receive notices from Social Security.

**Please select one:**

- I am not blind or visually impaired; or, I am not applying for myself.
- I have visited the Internet Special Notices Option page.

[Privacy Act Statement](#)

- I have read the **Privacy Act Statement**.



Identification    General    Other Benefits    Remarks    Review    Submit    Next Steps

Initial Information    Application Number    Additional Information

[N]ext >>

### Initial Information Section (Page 1 of 3)

## Applicant Identification

#### Applicant's Name

Please provide the name as it appears on the most recent Social Security card or [Statement](#).

<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>	<i>Suffix</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

#### Social Security Number

Example: 999-99-9999

#### Gender

Male  Female

#### Date of Birth

<i>Month</i>	<i>Day</i>	<i>Year</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

During the last 14 months, have you been unable to work because of illnesses, injuries or conditions that have lasted or are expected to last at least 12 months or can be expected to result in death? [More Info](#)

Yes  No

What date did you become unable to work?

<i>Month</i>	<i>Day</i>	<i>Year</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Are you blind?

Yes  No

[N]ext >>



Identification    General    Other Benefits    Remarks    Review    Submit    Next Steps

Initial Information    Application Number    Additional Information

<< [P]revious    [N]ext >>

### Initial Information Section (Page 2 of 3) Contact Information for Joan Public

#### U.S. Mailing Address

Street Address 1

Street Address 2

Street Address 3

Street Address 4

City

State

ZIP

Do you live at this address?

Yes     No

Daytime telephone number

Telephone Number

Type

Home

What is the best time to call?

9 a.m. to Noon     Noon to 5 p.m.     Anytime between 9 a.m. and 5 p.m.

Email Address

We will send an acknowledgement to this address

Please confirm your email address

#### Language Preferences

Language preferred for speaking

English

Language preferred for reading

English

<< [P]revious    [N]ext >>



Identification    General    Other Benefits    Remarks    Review    Submit    Next Steps

Initial Information    Application Number    Additional Information

<< [P]revious    [N]ext >>

### Initial Information Section (Page 3 of 3) Birth and Citizenship Information for Joan Public

Were you born in the United States or a U.S. Territory or Commonwealth?

[More Info](#)

Yes     No

Place of Birth [More Info](#)

City

State, Territory, or Commonwealth

Are you a U.S. citizen? [More Info](#)

Yes     No

Type of citizenship [More Info](#)

<< [P]revious    [N]ext >>



Identification	General	Other Benefits	Remarks	Review	Submit	Next Steps
Initial Information	Application Number	Additional Information	Application Number	Go	<< [P]revious [N]ext >>	

## Application Number Section (Page 1 of 1) Application Number for Joan Public

You have successfully started **your** Disability application. We are providing you with an Application Number. The number can be used to restart an incomplete application.

**Your Application Number: 31152722**

**Please print this page (with your browser's printer) or write down your Application Number.** You may need it to complete your online application or to check the status of your claim.

If you are unable to complete your online application for any reason, use the "Sign Off (finish this later)" option at the bottom left corner of each page. We will save all the information you provided prior to the page where you use the "Sign Off (finish this later)" option.

After waiting at least five minutes, you will be able to continue this application again by selecting "Continue Application" from the *Welcome* page. You will need to enter **your** Social Security number and this Application Number to continue your application.

If you lose this number and have not completed the application, you can start a new application and we will give you a new Application Number. The old number will be disabled. Social Security employees will not ask for, or be able to access **your** Application Number.

We may use 04/08/2010 as the official date of this application. In order to use 04/08/2010, we must receive the signed application by **10/09/2010 or you may lose Social Security benefits.** If this date falls on the weekend or is a Federal holiday, we must receive the signed application by the following business day.

Supplemental Security Income or SSI is a federal program that provides monthly payments to people who have limited income and assets and who are age 65 or older, or blind or have a disability. For more information about the SSI program, please read the pamphlet, [Supplemental Security Income](#).

If you intend to file an SSI application you need to file your application with us by **06/07/2010 or you may lose SSI benefits.** If this date falls on the weekend or is a Federal holiday, we must receive the signed application by the following business day. Call us at 1-800-772-1213 (TTY 1-800-325-0778) to arrange an appointment to file for SSI. You **cannot** apply for SSI over the Internet.

If you need assistance, please call us at 1-800-772-1213 (TTY 1-800-325-0778) for more information.

[S]ign Off (finish this later)	<< [P]revious	[N]ext >>
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- Identification
- General
- Other Benefits
- Remarks
- Review
- Submit
- Next Steps

Benefit Information

Benefit Information

<< [P]revious    [N]ext >>

## Benefit Information Section

### Benefit Information for Joan Public

### Supplemental Security Income (SSI)

The SSI program pays benefits to people age 65 and older or blind or disabled adults under 65 who have limited income and resources. [More Info](#)

**Have you recently applied for Supplemental Security Income?**

Yes  No

**Do you intend to apply for Supplemental Security Income?**

Yes  No

### Previous Application for Medicare, Social Security Benefits, or Supplemental Security Income (SSI)

**Have you previously applied for Medicare, Social Security Benefits, or Supplemental Security Income (SSI) benefits?**

Yes  No

**Which type(s) of benefits?**

Please select all that apply.

- Medicare benefits
- Social Security benefits
- Supplemental Security Income benefits

**Did you previously file on your own Social Security number?**

Yes  No

**Please provide the Social Security number and name of the person on whose record you previously applied.**

For example, please provide a parent's name and Social Security number if an application for child's benefits was filed.

	<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>	<i>Suffix</i>
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

*Social Security Number*

<< [P]revious    [N]ext >>



Identification ✓	General ✓	Other Benefits	Remarks	Review	Submit	Next Steps
Benefit Information ✓	Disability Questions	Ability To Work				Go

<< [P]revious      [N]ext >>

### Disability Questions Section (Page 1 of 4) Ability To Work for Joan Public

Please list the illnesses, injuries or conditions that limit ability to work. [More Info](#)

Include mental or emotional conditions.

Are these illnesses, injuries or conditions related to work in any way?

Yes    No

Are you now able to work?

Yes    No

What is the date you became able to work

Month      Year  
     

[S]ign Off (finish this later)

<< [P]revious      [N]ext >>





Identification  General  Other Benefits  Remarks  Review  Submit  Next Steps

Benefit Information  Disability Questions  Dependents  Go

<< [P]revious [N]ext >>

## Disability Questions Section (Page 3 of 4) Dependents for Joan Public

### Parents

Do you have a parent who receives one-half support from you?

Yes  No

#### First Parent's Name

First Name  Middle Name  Last Name  Suffix

#### First Parent's Address

Street Address 1

City  State  ZIP

Do you have another parent who receives one-half support from you?

Yes  No

[S]ign Off (finish this later) << [P]revious [N]ext >>



Identification ✓ General ✓ Other Benefits ✓ Remarks ✓ Review Submit Next Steps

Overall Summary Overall Summary Go

<< [P]revious [N]ext >>

## Overall Summary Section (Page 1 of 1) Overall Summary for Joan Public

This page shows all the questions and answers you've provided. If you need to make changes, select the "Edit" button to return to that part of the application. To return to the Overall Summary, please select the Review tab or the "Return to Summary" button.

### Identification Tab

#### Initial Information Section

✓ **Applicant Identification Page**

Applicant Name: **Joan Q Public**  
Social Security Number: **743990366**  
Gender: **Female**  
Date of Birth: **July 03, 1948**

During the last 14 months, unable to work because of illnesses, injuries or conditions that have lasted or are expected to last at least 12 months or can be expected to result in death:  
**Yes**  
Unable to work as of: **February 24, 1995**  
Blind: **No**

✓ **Contact Information Page**

**Mailing Address**  
Mailing Address: **234 First St, Silver Spring, MD, 20901**  
Reside at this address: **Yes**

**Phone and email**  
Daytime telephone number: **301 555 7890**  
Type of phone: **Home**  
Best time to call: **Noon to 5 p.m.**  
Email address:

**Language preferences**  
Preferred language for speaking: **English**  
Preferred language for reading: **English**



Identification ✓	General ✓	Other Benefits ✓	Remarks ✓	Review ✓	Submit	Next Steps	
Send this application						Send this application	Go

<< [P]revious	Sign Now
---------------	----------

## Send this application Section (Page 1 of 1) Send this application for Joan Public

*To return to the Overall Summary, please use the "Return to Summary" button.*

Congratulations, you're just about ready to complete your application for disability benefits.

Please read and accept the following statement to finish the application. If you are helping someone to complete the application, then that person needs to read and accept the statements.

I understand and agree that my application will be signed electronically by selecting "**Sign Now**" below. I also understand that my electronic signature means that I intend to file for benefits and have provided the Social Security Administration with accurate information. I declare under penalty of perjury that I have examined all the information on this application and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this electronic application, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

When you select "**Sign Now**", you will be sending your completed information electronically to the Social Security Administration. You will no longer be able to change your information.

[S]ign Off (finish this later)
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<< [P]revious	Sign Now
---------------	----------



Identification

General

Other Benefits

Remarks

Review

Submit

Next Steps

Receipt

What's Next?

[N]ext >>

## Receipt Section (Page 1 of 1)

### Evidence and Receipt for Joan Public

Your benefit application was received on July 20, 2010 at 8:48:49 am.

Print this page. It provides instructions on what you need to do now.

We cannot complete processing of your claim until we have received and verified all documents.

#### Documents You Need to Submit to Social Security.

We will need, and can accept, uncertified photocopies of the following:

- Any [medical evidence](#) already in your possession regarding your disability.
- Award letters, pay stubs, settlement agreements or other proof of temporary or permanent [workers' compensation](#) -type benefits you received.

**Do not delay mailing or bringing in your documents, even if you do not have all the documents we need. We will help you get any other documents you need.**

You can mail or take your documents to any Social Security Office.

If you submit any documents to us, we must have your Social Security number so that we can match them with your claim. Please write your Social Security number on a separate sheet of paper and include it with your documents. **Do not write anything on your original documents.**

**We will return all documents and photocopies to you unless you specifically tell us otherwise.**

**Caution: Do not mail** foreign records or any Department of Homeland Security (DHS) documents to us - especially those you are required to keep with you at all times. These documents are extremely difficult, time-consuming and expensive to replace if lost; and some cannot be replaced. Instead, **bring them to your Social Security office** where they will be examined and returned to you.



- Identification
- General
- Other Benefits
- Remarks
- Review
- Submit
- Next Steps


- Receipt
- What's Next?

- << [P]revious
- Continue to Adult Disability Report

## What's Next? Section (Page 1 of 1) What's Next for Joan Public

Thank you for completing one of the three steps in the Disability Application Process.

Print this page. It provides instructions on what you need to do now.



**To finish the Disability Application Process, click on the "Continue to Adult Disability Report" button to complete the following two steps:**

1. Complete the Adult Disability Report (SSA-3368), and
2. Sign and send the Medical Release Form, Authorization to Disclose Information to the Social Security Administration (SSA-827)

### Check the Status of your Application

The Confirmation Number for this claim is: **31152722**

Please guard this number carefully. It's the key to your application information. Social Security employees will **never** ask for your Confirmation Number.

Please wait at least 5 business days from today before you check your application status. Just go to the Social Security Claims page at <http://www.socialsecurity.gov>, select "**Check the Status of Your Application**" and enter your Confirmation Number.

### To contact Social Security

- Call our toll-free number, 1-800-772-1213. If you are deaf or hard of hearing call our toll-free "TTY" number, 1-800-325-0778. Representatives are available at this number Monday through Friday from 7 a.m. to 7 p.m.
- Contact your local Social Security office at the address below or the office of your choice by using our [Office Locator](#):

SOCIAL SECURITY  
10230 NEW HAMPSHIRE AV  
SUITE 304  
SILVER SPRING, MD 20903



## Welcome to the Social Security Adult Disability Report

Form Approved: OMB No. 0960-0579 Expires 11/30/2012

Thank you for completing part of your online application for Social Security benefits. If you are applying for disability benefits, we will need additional information about your personal, medical, work, and education history. To protect your privacy, we will ask you to repeat some information you already entered in the form that you already completed.

### Before you begin...

Before you start this report, you should read [How this Report Works](#) in order to understand the information and documents that may be needed.

You may also want to review the following related links:

#### Information About This Internet Report

- [Special Instructions For Blind Users](#)
- [How to Move Around in this Report](#)
- [How the Application Process Works](#)

#### Disability Information

- [Social Security's Definition of Disability](#)
- [How We Make a Disability Decision](#)
- [Information about Social Security's Disability Programs](#)
- [Other Ways To Complete The Disability Report](#)

#### Legal and Official Information

- [Internet Security Policy](#)
- [Website Policies & Other Important Information](#)
- [Social Security Accessibility Policy](#)

We estimate that it will take approximately 90 minutes to read the instructions, gather the facts, and answer the questions, but this will depend on the number of questions you need to answer. For more information about estimates, go to the [Paperwork Reduction Act](#) .

### To Start The Report...

If you want to start a new Disability Report, first refer to the instructions under [How this Report Works](#)

- I have read the [Privacy Act Statement](#)

Start Report



Joan Public xxx-xx-0103

## Personal Information

Please tell us about yourself.

### Gender

Female  Male

## Contact Information

### Address

Street Address 1

Street Address 2

Street Address 3

Street Address 4

City

State

ZIP

### Daytime Phone Number

Phone Number

Extension

Is there another number where we may reach you?

Yes  No

Phone Number

Extension

### Email Address

Enter your email address.

Please confirm the email address.

**(Continue Onto Next Page)**

**Have you used any other names on medical or educational records?**

Examples: Maiden name, other married name, or nickname

Yes  No

**List any other names you have used on medical or educational records.**

1.	<i>First Name</i> <input type="text"/>	<i>Middle Name</i> <input type="text"/>	<i>Last Name</i> <input type="text"/>	<i>Suffix</i> <input type="text" value="Select"/>
2.	<i>First Name</i> <input type="text"/>	<i>Middle Name</i> <input type="text"/>	<i>Last Name</i> <input type="text"/>	<i>Suffix</i> <input type="text" value="Select"/>
3.	<i>First Name</i> <input type="text"/>	<i>Middle Name</i> <input type="text"/>	<i>Last Name</i> <input type="text"/>	<i>Suffix</i> <input type="text" value="Select"/>

**Preferred Language**

**Can you speak and understand English?**

If you cannot speak and understand English, we will provide an interpreter free of charge.

Yes  No

**I prefer this language:**

**Can you read and understand English?**

Yes  No

**Can you write more than your name in English?**

Yes  No





Joan Public xxx-xx-0103

Overview	Identification	Medical	Work/Education	Remarks	Review	Submit
Report Completer	Personal Information	Reentry Number	Other Contact			

<< [P]revious    [N]ext >>

## You May Continue

You have successfully started your Disability Report. We are providing you with a Reentry Number. If you cannot complete this report in a single session, use this number to come back and finish later.

Print or save this page for your records. Note: If you choose to save this page, save it as a file and not as a bookmark. [More Info](#)

[Print this page...](#)

Your Reentry Number is: **D49514239**

The Reentry web site is:  
[www.socialsecurity.gov/adultdisabilityreport](http://www.socialsecurity.gov/adultdisabilityreport)

**Print or save this page, or write down the number and web site, so you will have what you need to return to your report at a later time.**

If you are unable to complete your online report for any reason, use the "Sign Off (finish later)" option at the bottom left corner of each page. We will save all the information you provided.

### To Come Back to This Report Later

1. Wait at least 5 minutes.
2. Go to this web site: [www.socialsecurity.gov/adultdisabilityreport](http://www.socialsecurity.gov/adultdisabilityreport).
3. Select the "Go back to the Report I Already Started" button.
4. Type in your Social Security Number and Reentry Number shown above.

**If you lose your Reentry Number before you submit the report, you will not be able to go back to this report and finish.** You can start a new report and we will give you a new Reentry Number, but all of the information you previously entered will be lost. Social Security employees will not be able to access your Reentry Number.

Joan Public xxx-xx-0103

Overview  Identification  **Medical** Work/Education Remarks Review Submit  
Conditions  **Doctors** Hospitals/Clinics Tests Medicines Other Records

<< [P]revious [N]ext >>

## Doctors and Other Healthcare Professionals

If you do not have any more **doctors/healthcare professionals** to enter, click the **Next** button.

- If you were an inpatient or outpatient at a hospital or clinic, do not list staff doctors. We will ask about them later.
- Include only the people who have treated you for the conditions related to your disability.
- Give each person's first and last name if possible.

### Summary of Doctors and Other Healthcare Professionals

		Doctors/Healthcare Professionals	City	Phone

Add Doctor/Healthcare Professional

[S]ign Off (finish later)

<< [P]revious [N]ext >>



Joan Public xxx-xx-0103

Done with this Doctor

## Doctors and Other Healthcare Professionals

### Doctor/Healthcare Professional Details

Remove this Doctor

Name of Doctor/Healthcare Professional: [More Info](#)

<i>Prefix</i>	<i>First Name</i>	<i>Last Name</i>	<i>Suffix</i>
<input type="text" value="Dr."/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Office Name or Clinic, if applicable:

Doctor/Healthcare Professional's Address:

If you don't have the full street address, give us as much as you can.  
Example: "On Main St next to the Courthouse"

Country

Street Address 1

Street Address 2

Street Address 3

Street Address 4

City

State

ZIP

Doctor/Healthcare Professional's Phone Number:

United States of America  International

Include area code.

U.S. Phone Number

Extension

Patient ID Number, if known:

## Treatment Dates with this Doctor/Healthcare Professional

Please give us the closest date(s) you can remember.

**First visit:**

**Last visit:**

**Next visit:**

Leave blank if no appointment scheduled.

## Tests Ordered by this Doctor/Healthcare Professional [More Info](#)

**Has this doctor/healthcare professional ordered any tests for you?**

This includes any medical tests you have had or will have.

Yes  No

**Details about Test 1:**

*Kind of Test*

*Date of Test*

This doctor/healthcare professional ordered this test for me more than once.

**Details about Test 2:**

*Kind of Test*

*Describe Other*

*Enter Body Part*

*Date of Test*

This doctor/healthcare professional ordered this test for me more than once.

You may enter more tests later on the "Tests" tab.

## Medicines Recommended or Prescribed by this Doctor/Healthcare Professional

**Has this doctor/healthcare professional recommended or prescribed any medicines for you?**

Yes  No

List any medicines you are taking and the reasons you are taking them.  
List only one medicine at a time. Look at the medicine container if necessary.

**(Continue Onto Next Page)**

Medicine 1:

Reason 1:

Medicine 2:

Reason 2:

Medicine 3:

Reason 3:

You may enter more medicines later on the "Medicines" tab.

## Medical conditions treated by this Doctor/Healthcare Professional

**What medical conditions were treated or evaluated by this doctor/healthcare professional?**

Examples: back injury, arthritis, diabetes, depression, blind.

Characters remaining: 1000

Check Spelling

## Treatment from this Doctor/Healthcare Professional

**What treatment did you receive from this doctor/healthcare professional?**

You DO NOT need to repeat any information that you have already told us about medicines and tests.

Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling.

**(Continue Onto Next Page)**

Empty text box for input.

Characters remaining: 1000

Check Spelling

[S]ign Off (finish later)

Done with this Doctor



Joan Public xxx-xx-0103

- Overview
  - Identification
  - Medical
  - Work/Education
  - Remarks
  - Review
  - Submit
- Conditions
  - Doctors
  - Hospitals/Clinics
  - Tests
  - Medicines**
  - Other Records

## Medicines

If you do not have any more **medicines** to enter, click the **Next** button.

**Summary of Medicines**

		Name of Medicine	Reason	Prescribed/Recommended by



Joan Public xxx-xx-0103

- Overview ✓
- Identification ✓
- Medical
- Work/Education
- Remarks
- Review
- Submit
- Conditions ✓
- Doctors ✓
- Hospitals/Clinics ✓
- Tests ✓
- Medicines
- Other Records

Done with this Medicine

## Medicines

### Medicine Details

Remove this Medicine

**List the name of the medicine.**

List only one medicine at a time. Look at the medicine container if necessary.

**What is the reason you are taking this medicine?**

**Who recommended or prescribed this medicine?**

If the doctor's name is not in the list, select "Other Medical Professional."

Add Doctor/Healthcare Professional

[S]ign Off (finish later)

Done with this Medicine





Joan Public xxx-xx-0103

Overview ✓ Identification ✓ Medical ✓ Work/Education ✓ Remarks ✓ Review ✓ Submit

Printing Instructions Submit Receipt Next Steps

[R]eturn to review << [P]revious [N]ext >>

## Printing Instructions

**Do you have a working printer right now?**  
 Yes  No

## Working Printer Directions

Please print or save this page for your records. Note: If you choose to save this page, save it as a file and not as a bookmark. [More Info](#)

[Print this page...](#)

Your claim for disability benefits is very important to us. Help us start work on the claim as soon as possible by taking all the following steps. Even though this is an online report, there is still paperwork involved. (The Medical Release form requires [Adobe Reader](#) to open and print it.)

### What You Need To Do Next:

1. Print the [Cover Sheet](#).
2. Print, sign, and date the [Medical Release Form](#).
3. **Select the Next button to electronically submit this Disability Report**
4. Mail or bring the Cover Sheet and signed and dated Medical Release Form to the local Social Security office listed below. DO NOT take these forms to your doctor.

### Your local Social Security office:

SOCIAL SECURITY ADMINISTRATION  
5 PARK CENTER CT  
SUITE 100  
OWINGS MILLS, MD 21117  
(866) 681-1412

If you already have copies of your medical records, you can send or bring them to us with the Cover Sheet and Medical Release form. However, we do not recommend that you delay submission of this report by requesting medical records yourself. We can do this for you.

### If you have printing problems:

Please try again. If you still are unable to print, continue on. Contact Social Security at the address and phone number listed above to tell us that you could not print the medical release form.

[S]ign Off (finish later)

<< [P]revious [N]ext >>



## Cover Sheet

 [Print this page...](#)

I have completed the Adult Disability Report online.

I understand that the full Adult Disability Report that I completed over the Internet and sent to SSA electronically will be used in making a decision on claim for disability benefits.

**Joan Public's address is:**

Line 1  
BALTIMORE, MD 21244

**Joan Public's phone number is:**

123-332-1331

**Name and address of someone else SSA can contact who knows about Joan Public's condition:**

Jessica Biehl  
Line1  
Concord, MD 21228

I have attached the following items:  
(Check all that apply.)

- Medical Release SSA-827 Form
- Copies of Medical Records You Already Have
- Other (Please list below.)

**Name of person completing this disability report:** Joan Public

**Mail or bring to:**

SOCIAL SECURITY ADMINISTRATION  
5 PARK CENTER CT  
SUITE 100  
OWINGS MILLS, MD 21117



Joan Public xxx-xx-0103

Overview ✓ Identification ✓ Medical ✓ Work/Education ✓ Remarks ✓ Review ✓ Submit

Printing Instructions ✓ Submit Receipt Next Steps

<< [P]revious Submit

## Submit Report

You are ready to submit this report electronically to Social Security. If you were not able to complete all parts of the report, don't worry. We will contact you if we need any more information.

**IMPORTANT:** You will NOT be able to come back to this report online after you press the Submit button.

If you want to make changes after submitting the online Disability Report, you can contact the Social Security office.

If you are ready to submit this report, use the Submit button.

[S]ign Off (finish later)

<< [P]revious Submit



## Sign Off (finish later)

Print or save this page for your records. Note: If you choose to save this page, save it as a file and not as a bookmark. [More Info](#)

 [Print this page](#)

### To Come Back to This Report Later:

1. Go to this web site: "<http://www.socialsecurity.gov/adulthooddisabilityreport>".
2. Select "Go Back to Report I Already Started".
3. Type in your Social Security Number and Rentry Number.

### Not Coming Back?

If you do not plan to complete this report online, but you want to apply for disability benefits:

1. Be sure to save or print your Reentry Number and
2. Contact Social Security to make an appointment. Please tell them you started this disability report online.

### Your Reentry Number is D49514239.

You can use your Reentry Number to come back to this Disability Report as many times as you like. **If you lose or forget your Reentry Number, you will not be able to come back to this Disability Report and you will lose all the information you already entered.** To protect your privacy, Social Security does not have access to your Reentry Number.

### Protect All Possible Benefits

Benefits may be lost if a complete application is not filed within:

- 60 days after the date you first start a report for Supplemental Security Income (SSI) disability benefits, or
- 6 months after the date a proper applicant first starts a report for Social Security Disability Insurance (SSDI) benefits. You must meet specific requirements in order to file an application for someone else.

We need a signed formal application for disability benefits before we can process a disability claim. This Disability Report is NOT a formal application, but it is a required part of the claims process. When you complete this report, we will give you instructions on completing the formal application (if you have not already done this).

To contact Social Security:

- Call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free "TTY" number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.
- Visit [a local Social Security Office](#).

Yes, sign off


Cancel, return to report

# Disability Benefits Checklist for Adults Applying on the Internet

Last reviewed or modified Friday Jan 22, 2010



OVW001-CHECKLIST

This checklist will help you gather the information you may need to complete the *Internet Disability Benefits Application* and the *Disability Report*. [Please print this page to use while you gather your materials.](#) 

## DISABILITY APPLICATION

- Military Service discharge information (Form DD 214) for all periods of active duty.
- W-2 Form (or your IRS 1040 and Schedules C and SE if self-employed) from last year.
- Social Security Number(s) for your spouse and minor children.
- Checking or savings account number and bank routing number, if you want Direct Deposit for your benefit checks.

## DISABILITY REPORT

- Name, address and phone number of someone we can contact who knows about your medical conditions and can help with your claim.
- Names, addresses, phone numbers, patient ID numbers, and dates of treatment for all doctors, hospitals, and clinics.  
**NOTE:** You may want to refer to any Medical Records you have.
- Names of medicines you are taking and who prescribed them.  
**NOTE:** You may want to have your medicine bottles available.
- Names and dates of medical tests you have had and who sent you for them.
- Types of jobs and dates you worked for your last 5 jobs.
- Information about any insurance or workers' compensation claims you filed, such as claim number and name, address and phone number of insurance company.

**We may contact you for additional information after  
you submit your application and report.**

[Close this window](#)