

**DISABILITY REPORT - CHILD - Form SSA-3820-BK**  
**READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM**  
**THIS IS NOT AN APPLICATION**

**IF YOU NEED HELP**

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

**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.

- Fill out as much of this form as you can before your interview appointment.
- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/ OTHER/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use Section 10, "DATE AND REMARKS," on Pages 11 and 12, and show the number of the question being answered.

**ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS**

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records
- Copies of the child's prescriptions or medicine containers
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

**YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE.** With your permission, we will do that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and medicine containers.

## The Privacy and Paperwork Reduction Acts

Sections 205(a), 223(d), and 1631 of the Social Security Act, as amended, authorizes us to collect this information. The information you provide will allow the Social Security Administration (SSA) to determine the child's potential eligibility benefit payments and to help us to decide if additional information is needed. Your response is voluntary. However, failure to provide this requested information may prevent an accurate and timely decision on any claim filed, or could result in loss of benefits.

We rarely use the information provided on this form for any purpose other than for the reasons stated above. However, we may use it for 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 an agency to assist Social Security in establishing rights to Medicare benefits 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 Department of Veterans Affairs);
- 3) To make determination 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 Medicare programs.

We may also use the information you provide in computer matching programs. Matching programs compare our 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.

Explanations about these and other reasons why information you provide us may be used or given out are available in Systems of Record Notice 60-0089 (Claims Folders Systems, SSA, Office of General Counsel, Office of Privacy and Disclosure). The Notice, information about this form, and any other information regarding our systems and programs, are available on-line at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at your 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 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at [www.socialsecurity.gov](http://www.socialsecurity.gov). Offices are also listed under U. S. Government agencies in your telephone directory or 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.*

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

### DISABILITY REPORT - CHILD

SECTION 1 -- INFORMATION ABOUT THE CHILD		
A. CHILD'S NAME <i>(First, Middle Initial, Last)</i>	B. CHILD'S SOCIAL SECURITY NUMBER	
C. YOUR NAME <i>(If agency, provide name of agency and contact person)</i>		
YOUR MAILING ADDRESS <i>(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)</i>		
CITY	STATE	ZIP CODE
YOUR EMAIL ADDRESS (Optional)		
D. YOUR DAYTIME PHONE NUMBER		
<i>(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)</i>		
_____	_____	<input type="checkbox"/> Your Number
<small>Area Code</small>	<small>Number</small>	<input type="checkbox"/> Message Number
		<input type="checkbox"/> None

E. What is your relationship to the child? \_\_\_\_\_

F. Can you speak and understand English?  YES  NO  
If "NO", what is your preferred language? \_\_\_\_\_

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

**If you cannot speak and understand English,** is there someone we may contact who speaks and understands English and will give you messages?

YES (Enter name, address, phone number, relationship)  NO  
NAME \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

\_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_  
*City State ZIP Area Code Number*  
Can you read and understand English?  YES  NO

G. Does the child live with you?  YES  NO If "NO", with whom does the child live?

NAME \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*  
\_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_  
*City State ZIP Area Code Number*

Can this person speak and understand English?  YES  NO  
If "NO", what is this person's preferred language? \_\_\_\_\_  
Can this person read and understand English?  YES  NO

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**SECTION 1 - INFORMATION ABOUT THE CHILD**

H. Can the child speak and understand English?  YES  NO

If "NO," what languages can the child speak? \_\_\_\_\_

If the child understands any other languages, list them here: \_\_\_\_\_

I. What is the child's height (*without shoes*)? \_\_\_\_\_

What is the child's weight (*without shoes*)? \_\_\_\_\_

J. Does the child have a **medical assistance** card? (for example Medicaid, Medi-Cal)

YES  NO

If "YES", show the **number** here: \_\_\_\_\_

**SECTION 2 - CONTACT INFORMATION**

A. Does the child have a legal guardian or custodian other than you?

YES (*Enter name, address, phone number, relationship*)  NO

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

\_\_\_\_\_  
*City State ZIP*

DAYTIME PHONE NUMBER \_\_\_\_\_

\_\_\_\_\_  
*Area Code Number*

RELATIONSHIP TO CHILD \_\_\_\_\_

Can this person **speak and understand English**?  YES  NO

If "NO", what is this person's preferred language? \_\_\_\_\_

Can this person **read and understand English**?  YES  NO

B. Is there another adult who helps care for the child and can help us get information about the child if necessary?

YES (*Enter name, address, phone number, relationship*)  NO

NAME OF CONTACT \_\_\_\_\_

ADDRESS \_\_\_\_\_

*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

\_\_\_\_\_  
*City State ZIP*

DAYTIME PHONE NUMBER \_\_\_\_\_

\_\_\_\_\_  
*Area Code Number*

RELATIONSHIP TO CHILD \_\_\_\_\_

Can this person **speak and understand English**?  YES  NO

If "NO", what is this person's preferred language? \_\_\_\_\_

Can this person **read and understand English**?  YES  NO



**SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS**

**Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.**

C. List each **DOCTOR/HMO/THERAPIST/OTHER**. Include the child's **next appointment**.

<b>1. NAME</b>		<b>DATES</b>
<b>STREET ADDRESS</b>		<b>FIRST VISIT</b>
<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>LAST VISIT</b>		
<b>PHONE</b> <small>Area Code</small> _____ <small>Number</small> _____	<b>Patient ID # (If known)</b>	<b>NEXT APPOINTMENT</b>
<b>REASONS FOR VISITS</b>		
<b>WHAT TREATMENT WAS RECEIVED?</b>		

<b>2. NAME</b>		<b>DATES</b>
<b>STREET ADDRESS</b>		<b>FIRST VISIT</b>
<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>LAST SEEN</b>		
<b>PHONE</b> <small>Area Code</small> _____ <small>Number</small> _____	<b>Patient ID # (If known)</b>	<b>NEXT APPOINTMENT</b>
<b>REASONS FOR VISITS</b>		
<b>WHAT TREATMENT WAS RECEIVED?</b>		

**SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS**

**DOCTOR/HMO/THERAPIST/OTHER**

3. <b>NAME</b>		<b>DATES</b>
<b>STREET ADDRESS</b>		<b>FIRST VISIT</b>
<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>LAST VISIT</b>		
<b>PHONE</b> <small>Area Code</small> _____ <small>Number</small> _____	<b>Patient ID # (If known)</b>	<b>NEXT APPOINTMENT</b>
<b>REASONS FOR VISITS</b>		
<b>WHAT TREATMENT WAS RECEIVED?</b>		

If you need more space, use Section 10.

D. List each **HOSPITAL/CLINIC**. Include the child's **next appointment**.

1.	<b>HOSPITAL/CLINIC</b>	<b>TYPE OF VISIT</b>	<b>DATES</b>	
<b>NAME</b>		<input type="checkbox"/> <b>INPATIENT STAYS</b> <i>(Stayed at least overnight)</i>	<b>DATE IN</b>	<b>DATE OUT</b>
<b>STREET ADDRESS</b>				
<b>CITY</b>				
<b>STATE</b> _____ <b>ZIP</b> _____		<input type="checkbox"/> <b>OUTPATIENT VISITS</b> <i>(Sent home same day)</i>	<b>DATE FIRST VISIT</b>	<b>DATE LAST VISIT</b>
<b>PHONE</b> <small>Area Code</small> _____ <small>Number</small> _____				
		<input type="checkbox"/> <b>EMERGENCY ROOM VISITS</b>	<b>DATES OF VISITS</b>	

Next appointment \_\_\_\_\_ The child's hospital/clinic number \_\_\_\_\_

Reasons for visits  
 \_\_\_\_\_  
 \_\_\_\_\_

What treatment did the child receive?  
 \_\_\_\_\_  
 \_\_\_\_\_

What doctors does the child see at this hospital/clinic on a regular basis?  
 \_\_\_\_\_  
 \_\_\_\_\_

**SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS**

**HOSPITAL/CLINIC**

2. <b>HOSPITAL/CLINIC</b>  <b>NAME</b> _____ <b>STREET ADDRESS</b> _____ <b>CITY</b> _____ <b>STATE</b> _____ <b>ZIP</b> _____ <b>PHONE</b> _____ <small>Area Code                      Number</small>	<input type="checkbox"/> <b>INPATIENT STAYS</b> <i>(Stayed at least overnight)</i>	<b>DATES</b>	
		DATE IN	DATE OUT
	<input type="checkbox"/> <b>OUTPATIENT VISITS</b> <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
	<input type="checkbox"/> <b>EMERGENCY ROOM VISITS</b>	<b>DATES OF VISITS</b>	

Next **appointment** \_\_\_\_\_ The child's hospital/clinic **number** \_\_\_\_\_

**Reasons for visits**  
\_\_\_\_\_  
\_\_\_\_\_

What **treatment** did the child receive?  
\_\_\_\_\_  
\_\_\_\_\_

What **doctors** does the child see at this hospital/clinic on a regular basis?  
\_\_\_\_\_  
\_\_\_\_\_

**If you need more space, use Section 10.**

**E. Does anyone else have medical records or information** about the child's illnesses, injuries or conditions (foster parents, social workers, counselors, tutors, school nurses, detention centers, attorneys, insurance companies, and/or Worker's Compensation), or is the child scheduled to see anyone else?

**YES** (If "YES," complete information below.)

**NO**

<b>NAME</b>	<b>DATES</b>
<b>ADDRESS</b>	<b>FIRST VISIT</b>
<b>CITY</b> _____ <b>STATE</b> _____ <b>ZIP</b> _____	<b>LAST SEEN</b>
<b>PHONE</b> _____ <small>Area Code                      Number</small>	<b>NEXT APPOINTMENT</b>
<b>CLAIM NUMBER (If any)</b> _____	
<b>REASONS FOR VISITS</b> _____	

**If you need more space, use Section 10.**



**SECTION 5 - MEDICATIONS**

Does the child currently take any **medications** for illnesses, injuries or conditions?  YES  
 If "YES", tell us the following: *(Look at the child's medicine containers, if necessary.)*  NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

**If you need more space, use Section 10.**

**SECTION 6 - TESTS**

Has the child had, or will he/she have, any **medical tests** for illnesses, injuries or conditions?  YES  NO If "YES", tell us the following (give approximate dates, if necessary).

KIND OF TEST	WHEN WAS/WILL TESTS BE DONE? <i>(Month, day, year)</i>	WHERE DONE <i>(Name of Facility)</i>	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part			
SPEECH/LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part			
MRI/CAT SCAN - Name of body part			

**If the child has had other tests, list them in Section 10.**

**SECTION 7 - ADDITIONAL INFORMATION**

A. Has the child been **tested or examined** by any of the following?

- |  |                          |     |                          |    |
|--|--------------------------|-----|--------------------------|----|
| Headstart (Title V)                                    | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Public or Community Health Department                  | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Child Welfare or Social Service Agency or WIC          | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Early Intervention Services                            | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Program for Children with Special Health<br>Care Needs | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Mental Health/Mental Retardation Center                | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work?

- YES       NO

If you answered "YES" to any of the above in A. or B., please complete C. below:

C. 1. NAME OF AGENCY \_\_\_\_\_

ADDRESS \_\_\_\_\_

*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

\_\_\_\_\_  
*City State ZIP*

PHONE NUMBER \_\_\_\_\_

*Area Code Number*

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

FILE OR RECORD NUMBER \_\_\_\_\_

2. NAME OF AGENCY \_\_\_\_\_

ADDRESS \_\_\_\_\_

*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

\_\_\_\_\_  
*City State ZIP*

PHONE NUMBER \_\_\_\_\_

*Area Code Number*

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

FILE OR RECORD NUMBER \_\_\_\_\_

**If there are any other agencies, show them in Section 10.**



**SECTION 8 - EDUCATION**

D. List the names of all other schools attended in the last 12 months and give dates attended.

NAME OF SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_

*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

*City*

*County*

*State*

*ZIP*

PHONE NUMBER \_\_\_\_\_

*Area Code*

*Number*

DATES ATTENDED \_\_\_\_\_

TEACHER'S NAME \_\_\_\_\_

Was the child tested for behavioral or learning problems?

YES

NO

If "YES", complete the following:

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

Was the child in special education?

YES

NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER \_\_\_\_\_

Was the child in speech therapy?

YES

NO

If "YES", and different from above, give:

NAME OF SPEECH THERAPIST \_\_\_\_\_

**If there are other schools, show them in Section 10.**

E. Is the child attending Daycare/Preschool?

YES

NO

If "YES", complete the following:

NAME OF DAYCARE/  
PRESCHOOL/CAREGIVER  
R \_\_\_\_\_

ADDRESS \_\_\_\_\_

*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

*City*

*County*

*State*

*ZIP*

PHONE NUMBER \_\_\_\_\_

*Area Code*

*Number*

DATES ATTENDED \_\_\_\_\_

TEACHER'S/CAREGIVER'S NAME \_\_\_\_\_

**SECTION 9 - WORK HISTORY**

A. Has the child ever worked (including sheltered  YES  NO

If "YES", complete the following:

DATES WORKED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_  
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

\_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *ZIP*

PHONE NUMBER \_\_\_\_\_  
*Area Code* \_\_\_\_\_ *Number*

NAME OF SUPERVISOR \_\_\_\_\_

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 10 - DATE AND REMARKS**

Please give the date you filled out this disability report.

Date (MM/DD/YYYY)  /  /

Use this section for any additional information about your child.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

