

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Educational Disabilities, if any:

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

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

<input type="checkbox"/> Regular Education, no special instruction <input type="checkbox"/> Special Ed. Instruction: Hours/week: _____ <input type="checkbox"/> Inclusion - Sp. instr. in regular class _____ <input type="checkbox"/> Resource Room _____ <input type="checkbox"/> Self-contained, regular school _____ <input type="checkbox"/> Self-contained, special school _____ <input type="checkbox"/> Special school, non-public _____ <input type="checkbox"/> Residential _____	<table style="width: 100%;"> <tr> <th style="text-align: left;">Therapies, etc:</th> <th style="text-align: left;">Hours/week:</th> </tr> <tr> <td><input type="checkbox"/> Occupational Therapy</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Physical Therapy</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Speech - Language Therapy</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Counselling (please specify)</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other (please specify)</td> <td>_____</td> </tr> </table>	Therapies, etc:	Hours/week:	<input type="checkbox"/> Occupational Therapy	_____	<input type="checkbox"/> Physical Therapy	_____	<input type="checkbox"/> Speech - Language Therapy	_____	<input type="checkbox"/> Counselling (please specify)	_____	<input type="checkbox"/> Other (please specify)	_____
Therapies, etc:	Hours/week:												
<input type="checkbox"/> Occupational Therapy	_____												
<input type="checkbox"/> Physical Therapy	_____												
<input type="checkbox"/> Speech - Language Therapy	_____												
<input type="checkbox"/> Counselling (please specify)	_____												
<input type="checkbox"/> Other (please specify)	_____												

PLEASE PROVIDE YOUR NAME AND TITLE ON NEXT PAGE

SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting

**Privacy Act Statement
Request for Administrative Information**

Collection and Use of Personal Information

Sections 1614 and 1633 of the Social Security Act, as amended, and 20 CFR 416.924a(a), authorize us to collect this information. We will use the information you provide to make a decision on the named claimant's claim.

The information you furnish on this form is voluntary. However, failure to provide the requested information could prevent us from making an accurate and timely decision on the named claimant's claim.

We rarely use the information you supply for any other purpose than to make a decision on a claimant's disability. 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 an 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 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 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.

Explanations about these and other reasons why information you provide us may be used or given out are available in Systems of Records Notice 60-0089 (Claims Folder Systems). The Notice, additional information about this form, and any other information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at your local Social Security office.

SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

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, answer the questions, and collect school records. If you have questions about how to complete the form, contact the Requesting Office; see page 1, upper left corner, for the name, address, and phone number of the Requesting Office. If you need the address or phone number of the Requesting Office, you can get it by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778). **SEND THE COMPLETED FORM TO THE REQUESTING OFFICE.** *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.*