

6. Do (did) you make management decisions after your illness or injury? YES NO
 (If "yes," describe the kinds of decisions made, the time spent making them and any changes that have taken place).

7. A. If you began your business after you were injured or became ill, did you receive any special assistance from an agency or other source in setting up your business? YES NO
 B. Does this assistance continue or have additional special services been supplied? YES NO
 (If "yes," please describe)

8. A. What is the value of any normal business expense which you do (did) not pay including that which is furnished or paid for by another person or organization (such as free space or utilities)? Why were such items supplied to you for free and by whom were they furnished?
 B. Describe any special expenses related to your illness or injury that you paid which are necessary for you to work (for example, attendant care, medical devices, equipment, prostheses, or similar items or services).

DESCRIBE ANY ADDITIONAL HELP YOU NEED (NEEDED) IN PERFORMING YOUR USUAL DUTIES BECAUSE OF YOUR ILLNESS OR INJURY.

A. Number of assistants	B. Time they devoted to helping you	C. What do (did) they do?
D. Are/were assistants (check one) <input type="checkbox"/> PAID <input type="checkbox"/> UNPAID	E. If paid, how much?	
F. Is (are) assistant(s) related to you? (check one) <input type="checkbox"/> YES <input type="checkbox"/> NO	G. If yes, what is the relationship?	
H. Why was the additional help needed?		

9.

Use this section for additional space to answer any previous questions and to give any additional information you think will be helpful. Please refer to the previous questions by number, such as 4A or 4B or 5.

10.

If more space is needed, use an extra sheet.

Check the appropriate block below:

11. I am **not** receiving Social Security disability benefits and/or Supplemental Security Income (SSI).
 I **am** receiving Social Security disability benefits and/or Supplemental Security Income (SSI), and I understand that the information provided above may result in my benefits being stopped. I have been given the opportunity to submit any evidence I wanted and to make any statements concerning my claim.

PLEASE READ THE FOLLOWING STATEMENT, THEN SIGN, DATE AND PROVIDE ADDRESS AND TELEPHONE NUMBER.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, 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 information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of claimant/beneficiary or representative

Date

Mailing address (Number and Street, Apt. no., P.O. Box, or Rural Route.)

Telephone (Include area code)

City

State

County

ZIP Code

SSA USE ONLY

A. Contact made: (check one) IN PERSON BY MAIL BY TELEPHONE

B. Completed by: (check one) CLAIMANT SSA REPRESENTATIVE OTHER

12. C. If "Other" show

Name:	Address (include ZIP code)
Phone Number (include area code)	Relationship

13. Interviewer/reviewer check list ("Yes" answers should be developed in accordance with DI 13010ff. Rationalize "Yes" or "No" answers below except when it is necessary to complete the SSA-831-U3 and SSA-833-U3). Check all that apply:

A. Unpaid business expenses (Rent, utilities, etc.) Yes No

B. Impairment-related work expenses Yes No

C. Unpaid help, or business sponsored by an agency Yes No

D. Unsuccessful work attempt (CDI - no medical issue - DO jurisdiction for a final determination) Yes No

E. Unsuccessful work attempt (DO recommendation only - DDS jurisdiction for a final determination.) Yes No

F. Substantial gainful activity Yes No

Note: If work continues and is determined to be substantial gainful activity and no medical issue exists, prepare the appropriate final determination (SSA-831-U3 or SSA-833-U3) rationalizing the work issue. Keep in mind that preparation of the SSA-831-U3 or the SSA-833-U3 would not be appropriate if there is a possibility of a closed period of disability, a trial work period or an unsuccessful work attempt.

Rationale:

14. Remarks

15. Signature of SSA interviewer or reviewer	Title	DO code	Date
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Work Activity Report (Self-Employed Person), Form, SSA-820-F4
Privacy Act Statement
Collection and Use of Personal Information

Sections 223 and 1632 of the Social Security Act as amended [42 U.S.C. 423 and 1383a], authorize us to collect this information. The information you provide will allow us to determine your eligibility for benefits. Your response is voluntary. However, your failure to provide all or part of the requested information could prevent us from making an accurate and timely decision on your claim and could result in the loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. 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, General Services Administration, National Archives Records Administration, 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 agencies 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.

A complete list of routine uses for this information is available in our System of Records Notice entitled, Earnings Recording and Self-Employment Income System, 60-0059. The notice, additional information regarding this form, and information regarding our system and programs, are available on-line at www.socialsecurity.gov or at any 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 15 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. 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.