SOCIAL SECURITY ONLINE

THE OFFICIAL WEBSITE OF THE U.S. SOCIAL SECURITY ADMINISTRATION

Need Larger Text?

Español | Other Languages

Search: GO

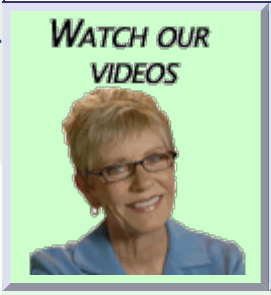
Retirement | Survivors | Disability | Supplemental Security Income (SSI) | Medicare

- What You Can Do Online
- Check the Status of Your Application
- Business Services Online
- Your Social Security Earnings Statement
- Estimate Your Retirement Benefits
- Already Receiving Benefits
- Forms and Publications
- Report Fraud, Waste or Abuse
- Find a Social Security Office
- Careers with Social Security
- Budget and Performance
- Contact Us
- Login

Watch a brief video about our website (less than two minutes)

INFORMATION IF YOU ARE:

- Applying Online for Retirement Benefits
- Applying for Disability Benefits
- Requesting a Social Security Card



Receive updates by email

QUESTIONS?

Social Security Number & Card GO

INFORMATION FOR...

-- Choose Group -- GO

OTHER USEFUL LINKS

Disability Research GO

Webinars

NEWS

- Social Security to Open New Teleservice Center in Jackson, Tennessee
- Social Security Continues to Rank as One of the "Best Places to Work in the Federal Government"
- Commissioner Astrue Receives Public Health Leadership Award
- America's Parents Vote for Change on Social Security's Most Popular Baby Names List

Press Releases More news...

Apply for Disability Benefits

To apply for disability benefits, begin by selecting the age category of the disabled person:

- Child (under age 18)
- Adult (age 18 or over)

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.

If your application is denied for:

- Medical reasons, you can complete and submit the required Appeal Request and Appeal Disability Report online.

  The disability report asks you for updated information about your medical condition and any treatment, tests or doctor visits since we made our decision.

- Non-medical reasons, you should contact your local Social Security Office to request the review. You also may call our toll-free number, 1-800-772-1213, to request an appeal. People who are deaf or hard of hearing can call our toll-free TTY number, 1-800-325-0778.

Apply for Disability Benefits - Adult (Age 18 or Over)

Updated: July 2005

To apply for disability benefits for an adult, you will need to complete **an application for Social Security Benefits** AND **an Adult Disability Report**. The report collects information about your disabling condition and how it affects your ability to work. You can complete the forms online, or you may call us to schedule an appointment and we will help you in person or by phone.

How to apply

Please follow these steps:

Step 1. Review the Adult Disability Starter Kit. This kit answers common questions about applying for benefits and includes a worksheet that will help you gather the information you need.

Step 2. Fill out the online application for Social Security Benefits. (If you've never worked, skip this step and contact us after you complete Step 3.)

Step 3. Fill out the online Adult Disability Report. At the end of the report, we will ask you to sign a form that gives your doctor permission to send us information about your disability. We need this information so we can make a decision on your claim.

NOTE: If you previously started an online application or online disability report but did not finish it, you can:

- Use your confirmation number to return to your online application.
- Use your re-entry number to return to your online disability report.

Contacting Social Security

If you don't want to do this online or need help, call us toll-free at **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

between 7 a.m. and 7 p.m.

[Top of page]

Social Security Online

Adult Disability and Work History Report

Welcome!

If you are a professional, representative or organization assisting adults age 18 or older in applying for disability benefits and are familiar with the form SSA-3368-BK Disability Report - Adult, please go to www.socialsecurity.gov/i3368pro. If you are an individual applying for yourself or for another adult or are not familiar with the SSA-3368-BK, continue reading this page.

This is a starting point to apply for disability benefits. Whether or not you have already contacted Social Security, we need you to:

- Give us information about your medical condition, medical records, and your work and education history.
- Complete a formal application for benefits.

You can apply online, apply in person or over the phone, or get more information about disability and this application process

Applying Online

Using the online Adult Disability and Work History Report gives you:

- Security and privacy for your information.
- Step by step instructions and examples to help you complete the report.
- A process to collect information that applies to you, similar to the interview process in a Social Security office.
- The ability to work at your own pace, stopping when you want and coming back to finish later.

Start the Report

Go Back to the Report I Already Started

Applying in Person or Over the Phone

If you prefer not to do this report on the Internet, you can use any of the following ways to complete a Disability Report:

- Call our toll-free number, **1-800-772-1213**. Explain that you don't want to use the online disability process but do want to set up an appointment to apply for disability benefits. 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.

- Contact your local Social Security Office and explain that you do not want to use the online disability process but would like to set up an appointment to apply for disability benefits.
- If you live outside the United States, see Service Around the World.

You can find more information on how to apply for disability benefits and the claims process.

More Information About Disability and the Application Process

Social Security's Definition of Disability
How the Disability Application Process Works
Information about Social Security's Disability Programs
Internet Security Policy
Social Security's Accessibility Policy

Adult Disability & Work History Report - PRO

Help/FAQ

Welcome!

This is the starting point for professionals, representatives, and organizations assisting adults age 18 or older in applying for disability benefits. If you are an individual applying for yourself or for another person, please go to the public version of the Adult Disability and Work History Report. If the claimant has not completed a formal application for benefits, he or she needs to do so as soon as possible to avoid losing benefits.

In this disability report, we will ask you for information about the claimant's medical sources and treatments, and work and education history. We use this information to get medical records and other information that helps us make the correct decision about the claimant's disability claim. Please give us as much information on all these areas as you can. Missing or incomplete information may delay the claim or require a contact with you or the claimant.

Important Information

Click on the link "Proper Applicant" for important information on protecting the claimant's filing date and who can file an application on the claimant's behalf.

To complete this report you will need:

- Internet access
- A personal computer with a Web browser that supports 128-bit encryption
- Adobe Reader – If you don't have Adobe Reader on your computer you can download a free copy. Use this link to get a free copy of the Adobe Reader.

Privacy Information

The Social Security Administration has access to the information you provide on this report and is authorized to keep even partially completed reports. This is for purposes of helping you complete the application process or update information. If you have decided you want to continue, you can start the report for a claimant now, or, if you are undecided, you may do so at a later time. For more information about filing online or other services provided by the Social Security Administration, please contact us.

For additional information on the Social Security

You may start a new Adult Disability and Work History Report or access a report that has not been submitted.

Start a New Report

Go Back to a Report I Already Started

Related Links

Information About this Internet Report:
How the Online Disability Report Works
Instructions for Alternative Views and Navigation
Special Instructions for Blind Users
Applying In Person or Over the Phone
Disability Report Form Guide

Disability Information:
How the Disability Application Process Works
Social Security's Definition of Disability
Information about Social Security's Disability Programs

Legal and Official Information:
Proper Applicant
Claimant's Right to Representation
Internet Security Policy
Paperwork Reduction Act

Administration’s privacy policy, see the "Privacy Policy" link in the footer below.

Adult Disability & Work History Report - PRO

The Paperwork Reduction Act Statement

This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you an average of 90 minutes to respond, but total time required will depend upon the number of questions you need to answer.

You may send comments on our estimate of the time needed to complete the Adult Disability and Work History Report-PRO to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

The OMB approval number for the Internet Adult Disability and Work History Report is 0960-0579; expiration date 2/28/2011.

Close this window to return to the report.

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Branding, Global Navigation, Claimant Summary, Function Bar

Should You Use this Report?

Not everyone will be able to use the Adult Disability and Work History Report - PRO online. You must answer all of the following questions to help determine if you should use this Internet Report. If you are helping another person fill out this report, answer all the questions as they apply to the person you are helping.

The OMB control number for this Internet Adult Disability and Work History Report is xxxx-xxx; expiration date xx/xx/xxxx.

About You/Your Organization

Which of the following best describes your organization? <Select Organization Type>

About the Claimant

Claimant's Social Security Number: (without dashes or hyphens)

Claimant's Date of Birth:

Does the claimant live in the United States or its territories or possessions? Yes No

Has the claimant previously been denied for Social Security or SSI disability benefits?
- Yes, more than 60 days ago
- Yes, less than 60 days ago
- No

Do the claimant's illnesses, injuries, or conditions (referred to as "conditions" from hereon) **keep him/her from working or seriously limit his/her ability to work?** Yes No

Will the claimant be unable to work for at least a year due to his/her condition? Yes No

Has the claimant been diagnosed with a condition that is expected to end in death? Yes No

Continue >

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Welcome Back!

Please enter the claimant's Social Security and Reentry numbers to reenter the Disability Report you already started. If you have lost the Reentry Number, you will not be able to continue with the Disability Report you already began. You may start a new online Disability Report up to 3 times. You can start a new report or contact your local Social Security office and they will help you. However, Social Security cannot access the Reentry Number.

You will be taken back to where you left off (if you didn't complete the new report process or if there is an error) or to the Main area where you will have access to all parts of the report.

Claimant's Social Security Number: (without dashes or hyphens)

Reentry Number:

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

About Your Organization

Give the name and information about the person in your organization that Social Security should contact for more information about this claim, if needed. **This page does not replace the form SSA-1696-U4 Appointment of Representative.** If you are representing the claimant, you must still give us a completed SSA-1696-U4.

Items marked with an asterisk (*) are required.

***Organization Name:**

***Contact Name:**
(Title, First, Last)
Ms.

Contact Instructions:
(300 characters maximum. About 6 lines.)
Count Characters 50 chars

***Organization Address:**
*(Street Address Line 1)
(Street Address Line 2)
*(City, State, ZIP)

***Contact Phone Number:** ( ) -
Ext: (optional)

Email Address:

Continue >

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

About Your Organization

Give the name and information about the person in your organization that Social Security should contact for more information about this claim, if needed. **This page does not replace the form SSA-1696-U4 Appointment of Representative.** If you are representing the claimant, you must still give us a completed SSA-1696-U4.

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Ms.

Contact Instructions:
(300 characters maximum. About 6 lines.)
Count Characters 50 chars

***Organization Address:**
*(Street Address Line 1)
(Street Address Line 2)
*(City, State, ZIP)

***Contact Phone Number:** ( ) -
Ext: (optional)

Email Address:

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Print the Reentry Number for this Claimant

Before going any further, we are giving you a Reentry Number. If you get disconnected, or if you decide to work on the report again later, you will need this number. It will allow you to come back to the report and continue where you left off without losing any information you already entered.

Claimant's SSN: 111-11-1111

Reentry Number: 39416753

Print or save this page so you will have a copy of the claimant's Reentry Number.

If you lose or forget the claimant's Reentry Number, you will have to begin this Adult Disability and Work History Report over again, and you will lose all the information you already entered. You can start a newDisability Report only 3 times. Social Security can help you start the process over again, but we cannot look up the Reentry Number for you.

To Come Back to This Report Later:
Go to this web site: http://www.socialsecurity.gov/disabilityreportpro
Type in the claimant's Social Security Number and Reentry Number shown above

Time Limit
We need a formal application for disability benefits from the claimant before we can process this claim. This Adult Disability and Work History Report is NOT a formal application, but it is a required part of the the claims process. The claimant may lose benefits if we do not receive the application by:

- 6 months from the date you first started a report for the claimant for Social Security (SSA) disability benefits, or
- 60 days from the date you first started a report for the claimant for Supplemental Security Income (SSI) disability benefits.

Since this Report applies to both types of applications, we cannot tell at this time which deadline applies to the claimant. Therefore, to fully protect all possible benefits, we recommend that he/she submit a formal application no later than 60 days from the date you started a report for the first time.

To print this page, please use the Print button at the top of your browser.

Continue >

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Branding, Global Navigation, Claimant Summary, Function Bar

Sign Out

If you want to, you can stop for now. Later, you can come back to where you left off and continue working on this report. You can also review the parts you already completed and add or change information.

To Come Back to This Report Later:
Go to this web site: www.socialsecurity.gov/disabilityreportpro
Type in the claimant's Social Security Number and Reentry Number shown below

Claimant's SSN: 111-11-1111

Reentry Number: 39416753

Print or save this page so you will have a copy of the claimant's Reentry Number.

If you lose or forget the claimant's Reentry Number, you will have to begin this Adult Disability and Work History Report over again, and you will lose all the information you already entered. You can start a new Disability Report only 3 times. Social Security can help you start the process over again, but we cannot look up the Reentry Number for you.

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We need a formal application for disability benefits from the claimant before we can process this claim. This Adult Disability and Work History Report is NOT a formal application, but it is a required part of the the claims process. The claimant may lose benefits if we do not receive the application by:

- 6 months from the date you started a report for the claimant for the first time for Social Security (SSA) disability benefits, or
- 60 days from the date you started a report for the claimant for the first time for Supplemental Security Income (SSI) disability benefits.

Since this Report applies to both types of applications, we cannot tell at this time which deadline applies to the claimant. Therefore, to fully protect all possible benefits, we recommend that he/she submit a formal application no later than 60 days from the date you started a report for the first time.

To print this page, please use the Print button at the top of your browser.

Continue Working on this Report

Start a New Report

Exit

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

About the Claimant: General Information

Items marked with an asterisk (*) are required.

Claimant's Contact Details

***Claimant's Name:**
(First, Middle Initial, Last, Suffix)

***Claimant's Address:**

*(Street Address Line 1)

(Street Address Line 2)

*(City, State, ZIP)

***Daytime Phone Number:** ( ) - Ext: (optional)

- **Claimant's phone number**
- **Claimant's message number**

Email Address:

Someone Else We Can Contact

***Is there someone else we can contact who knows about the claimant's condition and can help with his/her claim?** Yes No

Claimant's English-Speaking Ability

Can the claimant:

***Speak and understand English?** Yes No, he/she speaks the following languages:

***Read and understand English?** Yes No

***Write more than his/her name in English?** Yes No

***If the claimant cannot speak and understand English, is there someone we may contact who speaks English and will give the claimant messages?** Yes No

Other Information

***Are there other name(s) that the claimant may have used on his/her medical records?** Yes No

If the claimant has a Medicaid card or medical assistance card issued by a state government, please provide us with the number.

***What is the claimant's height without shoes?** Feet: Inches:

***What is the claimant's weight without shoes?** lbs

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

About the Claimant: General Information

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(Street Address Line 2)

*(City, State, ZIP)

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< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

About John Doe: Medical, Work, and Education History

Items marked with an asterisk (*) are required.

About the Claimant's Condition

***List all of the conditions that limit the claimant's ability to work.**
(If there are more than one, list each on a separate line.)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

***When did the claimant's conditions first start to bother him/her?**
(whether he/she knew what the problem was at the time)

Examples: June 11, 2003; October 2000; Summer 1999

***Do any of the conditions listed cause the claimant pain or other symptoms?** (•) Yes ( ) No

***Did the claimant go to a doctor, hospital, clinic or anyone else for mental or emotional problems that limits his/her daily activities?** (•) Yes ( ) No

Claimant's Work History

***Has the claimant ever worked?**

- (•) Yes, but stopped because of his/her condition
- ( ) Yes, but stopped because of other reasons (not due to his/her condition)
- ( ) Yes, but stopped due to his/her condition and other reasons
- ( ) Yes, currently working
- ( ) No, has never worked

Claimant's Education and Special Job Training

***How many years of school has the claimant completed?**

Approximate date completed: (optional)

***Has the claimant completed any type of special job training, trade or vocational school?** (•) Yes ( ) No

***Has the claimant attended special education classes or received other education services beyond what is done in a regular classroom?** (•) Yes ( ) No

***Has the claimant received vocational rehabilitation services or participated in the Ticket Program?** (•) Yes ( ) No

< Previous | Continue >

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

About John Doe: Medical, Work, and Education History

Items marked with an asterisk (*) are required.

About the Claimant's Condition

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(whether he/she knew what the problem was at the time)

Examples: June 11, 2003; October 2000; Summer 1999

***Do any of the conditions listed cause the claimant pain or other symptoms?** (•) Yes ( ) No

***Did the claimant go to a doctor, hospital, clinic or anyone else for mental or emotional problems that limits his/her daily activities?** (•) Yes ( ) No

Claimant's Work History

***Has the claimant ever worked?**

Change the Answer

- ( ) Yes, but stopped because of his/her condition
- ( ) Yes, but stopped because of other reasons (not due to his/her condition)
- (•) Yes, but stopped due to his/her condition and other reasons
- ( ) Yes, currently working
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Approximate date completed: (optional)

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***Has the claimant received vocational rehabilitation services or participated in the Ticket Program?** (•) Yes ( ) No

< Previous | Continue >

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Important: Describe John Doe's Conditions

Items marked with an asterisk (*) are required.

***Describe each of the claimant's listed conditions that limit his/her ability to work.**

(500 characters maximum. About 10 lines.)

Count Characters 278 chars

***Explain how the claimant's conditions limit his/her ability to do basic work activities such as sitting, lifting and carrying things, standing, walking, concentrating, or remembering instructions.**

(500 characters maximum. About 10 lines.)

Count Characters 50 chars

***Explain how the following limit the claimant's ability to work or do his/her daily activities:**

- **Pain**
- **Fatigue**
- **Feeling depressed**
- **Any other symptoms**

(500 characters maximum. About 10 lines.)

Count Characters 0 chars

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Important: Date Claimant Became Unable to Work

Items marked with an asterisk (*) are required.

***When does the claimant say his/her condition became severe enough to keep him/her from working (even though he/she has never worked)?**

Encourage the claimant to select the closest date he/she can remember.

☐ **At birth**

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Important: Date Claimant Became Unable to Work

Items marked with an asterisk (*) are required.

***When did the claimant's condition first interfere with his/her ability to work?**

Encourage the claimant to select the closest date he/she can remember.

***Has the claimant's condition caused him/her to do any of these things?**

- (•) **Yes** ( ) **No**

If the claimant said "Yes", then tell us if the claimant's condition caused him/her to make any changes. Please select all that apply.

- [ ] **Change job duties or found new ways to do the job**
- [ ] **Change to a different employer**
- [ ] **Work fewer hours**
- [ ] **Take sick days or misses scheduled work time**
- [ ] **Stop working for a period of time**
- [ ] **Get extra help from employer, co-workers, or other employees**
- [ ] **Make other changes to the work not listed above**

***Explain in detail each type of change that was selected above.** *(if applicable)*

(1000 characters maximum. About 20 lines.)

Count Characters 50 chars

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Important: Date Claimant Became Unable to Work

Items marked with an asterisk (*) are required.

***When did the claimant become unable to work because of his/her condition?**

Encourage the claimant to select the closest date he/she can remember.

***When did the claimant most recently stop working?**

Encourage the claimant to select the closest date he/she can remember.

***Please explain why the claimant stopped working.**

(900 characters maximum. About 20 lines.)

Count Characters 50 chars

***Did the claimant work at any time after the condition first bothered him/her?**

(•) Yes ( ) No

If the claimant said "Yes", then tell us if the claimant's condition caused him/her to make any changes. Please select all that apply.

- [ ] **Change job duties or find new ways to do the job**
- [ ] **Change to a different employer**
- [ ] **Work fewer hours**
- [ ] **Take sick days or missed scheduled work time**
- [ ] **Stop working for a period of time**
- [ ] **Get extra help from employer, co-workers, or other employees**
- [ ] **Make other changes to the work not listed above**
- [ ] **Did not make other changes to his/her work**

***Explain in detail each type of change that was selected above.** *(if applicable)*

(1000 characters maximum. About 20 lines.)

Count Characters 50 chars

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Important: Date Claimant Became Unable to Work

Items marked with an asterisk (*) are required.

***When did the claimant become unable to work because of his/her condition?**

Encourage the claimant to select the closest date he/she can remember.

***When did the claimant most recently stop working?**

Encourage the claimant to select the closest date he/she can remember.

***Did the claimant work at any time after the condition first bothered him/her?**

- (•) **Yes** ( ) **No**

If the claimant said "Yes", then tell us if the claimant's condition caused him/her to make any changes. Please select all that apply.

- [ ] **Change job duties or find new ways to do the job**
- [ ] **Change to a different employer**
- [ ] **Work fewer hours**
- [ ] **Take sick days or missed scheduled work time**
- [ ] **Stop working for a period of time**
- [ ] **Get extra help from employer, co-workers, or other employees**
- [ ] **Make other changes to the work not listed above**
- [ ] **Did not make other changes to his/her work**

***Explain in detail each type of change that was selected above.**

(1000 characters maximum or 20 lines)

Count Characters 50 chars

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | Medical Tests | Jobs | Other Records

About John Doe: General Information

Edit **[Claimant's Name]** **[Street Address Line 1], [City, State, ZIP]**
Height: **x ft x inches** Weight: **xxx lbs**
You said the claimant: Speaks and understands English.
Reads and understands English.
Is able to write more than his/her name in English.

Edit The claimant does not have other names on his/her medical records other than **[Claimant's Name]**.

Edit There is no contact who knows about the claimant's condition and can help with his/her claim.

Edit There is no contact who speaks English and will give the claimant messages.

About John Doe: Medical, Work, and Education History

Claimant's Condition

Edit The following conditions first started to bother the claimant on **[first bothered date]:**
[Display first 100 characters of the condition listing]

Edit The claimant's condition does not cause pain or other symptoms.

Edit The claimants has not gone to a doctor, hospital, clinic or anyone else for mental or emotional problems that limit his/her daily activities.

Description of Condition

Edit Conditions that limit the claimant's ability to work:
[Display first 100 characters of text area]

Conditions that limit the claimant's basic work activities:
[Display first 100 characters of text area]

Pain, fatigue, feeling depressed and any other symptoms that limit the claimant's ability to work or do daily activities in the following manner:
[Display first 100 characters of text area]

Work History

Edit The claimant has never worked.

Edit The claimant became unable to work because of his/her condition on **mm/dd/yyyy.**

Education and Special Job Training

Edit Years of school completed: **[level completed 6.0]**, Approximate date completed: ***no date entered***.

Edit The claimant did not attend special education classes or received other education services.

Edit The claimant did not complete any special job training, trade or vocational school.

Edit The claimant did not receive vocational rehabilitation services or participated in a Ticket Program.

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | Medical Tests | Jobs | Other Records

About John Doe: General Information

Edit **[Claimant's Name]** **[Street Address Line 1], [City, State, ZIP]**
Height: **x ft x inches** Weight: **xxx lbs**
You said the claimant: Speaks and understands English.
Reads and understands English.
Is able to write more than his/her name in English.

Edit The claimant has other names on his/her medical records other than **[Claimant's Name].**
[otherFirstName Other MiddleInitial otherLastName, otherSuffix]
[otherFirstName Other MiddleInitial otherLastName, otherSuffix]
[otherFirstName Other MiddleInitial otherLastName, otherSuffix]
[otherFirstName Other MiddleInitial otherLastName, otherSuffix]

Edit There is a person who knows about the claimant's condition and can help with his/her claim.
[Contact Name] **[Street Address Line 1], [City, State, ZIP]**

Edit There is a person who speaks English and will give the claimant messages.
[Contact Name] **[Street Address Line 1], [City, State, ZIP]**

About John Doe: Medical, Work, and Education History

Claimant's Condition

Edit The following conditions first started to bother the claimant on **[first bothered date]:**
[Display first 100 characters of the condition listing]

Edit The claimant's condition causes pain or other symptoms.

Edit The claimant went to a doctor, hospital, clinic or anyone else for mental or emotional problems that limit his/her daily activities.

Description of Condition

Edit Conditions that limit the claimant's ability to work:
[Display first 100 characters of text area]

Conditions that limit the claimant's basic work activities:
[Display first 100 characters of text area]

Pain, fatigue, feeling depressed and any other symptoms that limit the claimant's ability to work or do daily activities in the following manner:
[Display first 100 characters of text area]

Work History

Edit The claimant stopped work because of his/her condition.

Edit The claimant became unable to work because of his/her condition on: **[alleged onset]**.

The claimant most recently stopped working on: **[date stopped work]**.

The claimant stopped working because:
[Display first 100 characters of text area]

The claimant worked after the condition first bothered him/her and this caused him/her to:

- Change job duties or find new ways to do the job
- Work fewer hours
- Take sick days or miss scheduled work time

Explanation for changes:
[Display first 100 characters of text area]

Education and Special Job Training

Edit Years of school completed: **[level completed 6.0]**, Approximate date completed: **[completion date 6.0]**.

Edit The claimant attended special education classes or received other education services.
School Information: **[School Name]** **[Street Address Line 1], [City, State, ZIP]**

Edit The claimant completed special job training, trade or vocational school.
Program Information: **[Display first 100 characters of 'Type of Program' text area]**

Edit The claimant received vocational rehabilitation services or participated in a Ticket Program at the following place.
[Agency Name] **[Street Address Line 1], [City, State, ZIP]**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Someone Else We Can Contact About Claimant's Conditions

Jump to: Go

You said that there is someone else we can contact who knows about the claimant's conditions and can help with his/her claim. If this is not true, please **Change the Answer**.

Items marked with an asterisk (*) are required.

***Contact Person's Name:**
(First, Middle Initial, Lastm Suffix)

***Relationship to Claimant:**

If other, please indicate:

***Contact's Address:**

- **Same as John Doe's address**
- **Same as <Organization>'s address**
- **Other address** (provide below)

(Street Address Line 1)
(Street Address Line 2)
(City, State, ZIP)

***Daytime Phone Number:**

- **Same as John Doe's phone number**
- **Same as <Organization>'s phone number**
- **Other phone number** (provide below)

( ) - Ext: (optional)

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Someone We Can Contact Who Speaks and Understands English

Jump to: Go

You said that there is someone else who speaks and understands English and can deliver messages to the claimant. If this is not true, please **Change the Answer**.
Items marked with an asterisk (*) are required.

***Contact Person's Name:**
(First, Middle Initial, Last, Suffix)

***Relationship to Claimant:**

If other, please indicate:

***Contact's Address:**

- **Same as John Doe's address**
- **Same as <Organization>'s address**
- **Other address** (provide below)

(Street Address Line 1)
(Street Address Line 2)
(City, State, ZIP)

***Daytime Phone Number:**

- **Same as John Doe's phone number**
- **Same as <Organization>'s phone number**
- **Other phone number** (provide below)

( ) - Ext: (optional)

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Other Names Used on Medical Records

Jump to: Go

You indicated that the claimant's medical records may be listed under another name (maiden name, previous married name(s), nickname, etc.). If this is not true, please **Change the Answer.**

Items marked with an asterisk (*) are required.

***Claimant's Other Names (First, Middle Initial, Last)**

Provide at least one.

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Special Education Classes

Jump to: Go

You said the claimant attended special education classes or received other education services, if this is not true, please **Change the Answer**.

Name of School:

Address:

(Street Address Line 1)

(Street Address Line 2)

(Street Address Line 3)

(City, State, ZIP)

Phone Number: ( ) - Ext: (optional)

Dates Attended **From:** **To:**

Type of Program:

Tell us what kind of services the claimant received, how often, and where he/she received these services.

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

The claimant had special education classes at more than one school

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Special Job Training, Trade or Vocational School

Jump to: Go

The claimant completed special job training, trade or vocational school, if this is not true, please **Change the Answer**.

Type of Program:

Tell us what kind of services the claimant received, how often, and where the claimant received these services.

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

Approximate Date Completed:

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Provide Vocational Rehabilitation Agency Details

Jump to: Go

The claimant received vocational rehabilitation services or participated in a Ticket Program at the following place, if this is not true, please **Change the Answer**.

Items marked with an asterisk (*) are required.

***Organization Name:**

Counselor's Name:
(First, Last)

***Address:**

*(Street Address Line 1)

(Street Address Line 2)

(Street Address Line 3)

*(City, State, ZIP)

***Phone Number:** ( ) - Ext: (optional)

Appointment Dates

When did the claimant first go?

When did the claimant last go?

Types of Services or Tests Performed:

(1000 character maximum. About 20 lines of typing)

Count Characters 50 chars

The claimant had vocational rehabilitation services at another agency

< Previous **Continue >**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | **Doctors** | Hospitals | Medications | Medical Tests | Jobs | Other Records

Doctors (up to 15)

***Has the claimant gone to a doctor for his/her condition (s)?**

(•) Yes ( ) No

If you answer "yes" and later need to change this to "no", you must first delete all doctor information that you may have entered.

- Include physicians, psychologists, optometrists, nurse practioners, therapists, chiropractors, acupuncturists, etc.
- You can prompt the claimant to check current medicine containers for doctors' names.
- Do not include staff doctors at the hospital.
- To edit doctor details, select the doctor's name below.

! You must provide details for at least one doctor.

Add a Doctor

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | **Doctors** | Hospitals | Medications | Medical Tests | Jobs | Other Records

Doctors (up to 15)

***Has the claimant gone to a doctor for his/her condition (s)?**

(•) Yes ( ) No

If you answer "yes" and later need to change this to "no", you must first delete all doctor information that you may have entered.

- Include physicians, psychologists, optometrists, nurse practioners, therapists, chiropractors, acupuncturists, etc.
- You can prompt the claimant to check current medicine containers for doctors' names.
- Do not include staff doctors at the hospital.
- To edit doctor details, select the doctor's name below.

Dr. Jane Doe
Dr. Jane Doe
Dr. Jane Doe
Dr. Jane Doe
Dr. Jane Doe
Dr. Jane Doe

Add a Doctor

Adult Disability & Work History Report - PRO

Sign Off | Edit Organization Profile | Help/FAQ

test claimant **xxx-xx-1111**

Alleged Onset: **03/25/2003** Work Status: **Never worked**

Condition(s): qqqqqqqqqq.

Provide Doctor Details

Jump to: Go

You can search for a medical provider by selecting the "Search Medical Providers" button. Once you have searched for and selected the appropriate provider, the information will be added to your report and you will be able to continue the report process.

Search Medical Providers

Items marked with an asterisk (*) are required.

* **Doctor's Name:** Dr.

(Title, First, Last)

HMO/Clinic/Office Name:

* **Address:**

Please provide complete address. Do NOT use punctuation marks.

* **(Street Address 1)**

(Street Address 2)

(Street Address 3)

* **(City, State, ZIP)**

* **Phone Number:** ( ) -

Ext: (optional)

Why does the claimant see this doctor?

(1000 characters maximum. About 20 lines. If you need more space, continue in the Remarks section at the end of this report.)

Count Characters You have entered 0 characters

What treatment(s) did the claimant receive?

(1000 characters maximum. About 20 lines. If you need more space, continue in the Remarks section at the end of this report.)

Count Characters You have entered 0 characters

Visit Dates:

First Visit:

Last Visit:

Next Appointment: (if not scheduled, enter "None")

Medical Records #

Unknown

Delete this Doctor | Done

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Adult Disability & Work History Report - PRO

Medical Provider Search Results

Search results based on the following search criteria:

State: MD
Phone Number: 410
Doctor's Last Name: Doe
Doctor's First Name: Doe

To select a medical provider click on the "Select" button. The information about the selected medical provider will automatically be added to the Medical Provider Details page.

	Name	Organization	Address	Phone Number
Select	Johnaaaaaaaaaaa Doeaaaaaaaaaaaaaaaaa		111 Market Place, Suite 1070 Baltimore, MD, 21212	410-555-1212
Select	Jane Doe		111 Market Place, Suite 1070, Baltimore, MD, 21212	410-555-1213
Select	John Doe	Johns HopkinsJohns HopkinsJohns HopkinsJohns Hopkinsaaaaa	17 Johns Hopkins Plaza, Room 1717, Baltimore, MD, 21212	410-110-0101
Select	John Doe		111 Market Place, Suite 1070, Baltimore, MD, 21212	410-555-1212

You have reached the maximum number of displayable search results.

Cancel

Refine Search | New Search

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Adult Disability & Work History Report - PRO

Medical Provider Search Results

Search results based on the following search criteria:

State:	MD
Phone Number:	410
Doctor's Last Name:	Doe
Doctor's First Name:	Doe

No medical providers found for the search criteria you selected!

Cancel | Refine Search | New Search

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | **Hospitals** | Medications | Medical Tests | Jobs | Other Records

Hospitals (up to 12)

***Has the claimant gone to a hospital for his/her condition (s)?**

(•) Yes ( ) No

If you answer "yes" and later need to change this to "no", you must first delete all hospital information that you may have entered.

- Include places other than doctors' offices where the claimant went for treatments, tests, surgery, or emergency room visits.
- To edit hospital details, select the hospital name below.

! You must provide details for at least one hospital.

Add a Hospital

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | **Hospitals** | Medications | Medical Tests | Jobs | Other Records

Hospitals (up to 12)

***Has the claimant gone to a hospital for his/her condition (s)?**

(•) Yes ( ) No

If you answer "yes" and later need to change this to "no", you must first delete all hospital information that you may have entered.

- Include places other than doctors' offices where the claimant went for treatments, tests, surgery, or emergency room visits.
- To edit hospital details, select the hospital name below.

Johns Hopkins Hospital
Johns Hopkins Hospital
Union Memorial
Union Memorial
Johns Hopkins Hospital
Johns Hopkins Hospital

Add a Hospital

Adult Disability & Work History Report - PRO

Sign Off | Edit Organization Profile | Help/FAQ

gsdfdsds dsfsdfsd **xxx-xx-2121**

Alleged Onset: **06/27/1988** Work Status: **Never worked**

Condition(s): erterter.

Provide Hospital/Clinic Details

You can search for a medical provider by selecting the "Search Medical Providers" button. Once you have searched for and selected the appropriate provider, the information will be added to your report and you will be able to continue the report process.

Search Medical Providers

Items marked with an asterisk (*) are required.

***Hospital/Clinic Name:**

***Address:**

Please provide complete address. Do NOT use punctuation marks.

***(Street Address 1)**

(Street Address 2)

(Street Address 3)

***(City, State, ZIP)**

***Phone Number:** ( ) -
Ext: (optional)

Hospital/Clinic #:
Unknown

***Did the claimant have any inpatient stays at this hospital or clinic?**

We will only collect details for up to 3 stays.

- Had no inpatient stays
- Had 1 inpatient stay
- Had 2 inpatient stays
- Had 3 inpatient stays
- Had more than 3 inpatient stays at this hospital/clinic

***Did the claimant have any outpatient visits at this hospital or clinic?**

- Had no outpatient visits
- Had outpatient visits

***Did the claimant have any emergency room visits at this hospital or clinic?**

We will only collect details for up to 2 visits.

- Had no emergency room visits
- Had 1 emergency room visit
- Had 2 emergency room visits
- Had more than 2 emergency room visits at this hospital/clinic

What doctors did the claimant see on a regular basis in this hospital or clinic?

List the first and last name of each doctor, if possible. Provide as much information as you can.
Example: Dr. Jas Linder, Dr. Brenda Battle, Dr. Taylor, and Dr. Degler
Your answer can be no more than 1000 characters, which is about 20 lines of typing. If you need more space, continue in the Remarks section at the end of this report.

Count Characters You have entered 0 characters

Next Appointment: (if not scheduled, enter "None")

Delete this Hospital/Clinic

Continue

Back to Hospital/Clinic Tab

Branding, Global Navigation, Claimant Summary, Function Bar

Provide Hospital Details

Jump to: Go

Items marked with an asterisk (*) are required.

***Hospital/Clinic Name:**

***Address:**

*(Street Address Line 1)

(Street Address Line 2)

(Street Address Line 3)

*(City, State, ZIP)

***Phone Number:** ( ) - Ext: (optional)

Hospital/Clinic #:

Unknown

***Did the claimant have any inpatient stays at this hospital or clinic?**

We will only collect details for up to 3 stays.

Edit Inpatient Stay 1
Edit Inpatient Stay 2
Edit Inpatient Stay 3

Had 3 inpatient stays

Has more than 3 inpatient stays at this hospital

***Did the claimant have any outpatient visits at this hospital or clinic?**

Edit Outpatient visit details

Had outpatient visits

***Did the claimant have any emergency room visits at this hospital or clinic?**

We will only collect details for up to 2 visits.

Edit Emergency Room Visit 1
Edit Emergency Room Visit 2

Had 2 emergency room visits

Has more than 2 emergency room visits at this hospital

Next Appointment: (if not scheduled, enter "None")

If you want to delete this hospital, you must first delete the inpatient, outpatient or emergency room pages for this hospital that follow this page.

Continue >

Back to Hospital Tab

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

<HospitalName>: Inpatient Stay x of x

Jump to: Go

When was the claimant admitted?

When was the claimant released?

Why was the claimant admitted to the hospital/ clinic?
(160 characters max. About 4 lines.)

Count Characters 50 chars

What treatment did the claimant receive?
(160 characters max. About 4 lines.)

Count Characters 50 chars

If the claimant saw the same doctor regularly during this inpatient stay, please give us the doctor's name.

Other: (Title, First Name, Last Name)

Dr.

Delete this Visit

< Previous **Continue >**

Back to Hospital Details

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

<HospitalName>: Outpatient Visits

Jump to: Go

First outpatient visit:

Most recent outpatient visit:

Why did the claimant go for outpatient visits?
(1000 characters max. About 20 lines.)

Count Characters 50 chars

What treatments did the claimant receive?
(160 characters max. About 4 lines.)

Count Characters 50 chars

If the claimant saw the same doctor regularly during those visits, please give us the doctor's name.

Other: (Title, First Name, Last Name)

Dr.

Delete this Visit

< Previous **Continue >**

Back to Hospital Details

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

<HospitalName>: ER Visit x of x

Jump to: Go

When did this visit to the emergency room take place?

Why did the claimant go to the emergency room?
(160 characters max. About 4 lines.)

Count Characters 50 chars

What treatments did the claimant receive?
(160 characters max. About 4 lines.)

Count Characters 50 chars

Delete this Visit

< Previous **Continue >**

Back to Hospital Details

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | **Medications** | Medical Tests | Jobs | Other Records

Medications

***Does the claimant currently take any prescription or over-the-counter medicines for his/her condition (s)?**

(•) Yes ( ) No

If you answer "yes" and later need to change this to "no", you must first delete all medication information that you may have entered.

- List all prescription and non-prescription (over-the-counter) medicines that the claimant currently takes for his/her condition.
- If possible, encourage the claimant to provide the exact name listed on his/her medicine container.
- To edit medicine details, select the medicine name below.

Prescription Medicines (up to 20 medicines)

! You must provide details for at least one medicine.

[Add Prescription Medicine]

Over-the-Counter Medicines (up to 10 medicines)

! You must provide details for at least one medicine.

[Add Over-the-Counter Medicine]

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | **Medications** | Medical Tests | Jobs | Other Records

Medications

***Does the claimant currently take any prescription or over-the-counter medicines for his/her condition (s)?**

(•) Yes ( ) No

If you answer "yes" and later need to change this to "no", you must first delete all medication information that you may have entered.

- List all prescription and non-prescription (over-the-counter) medicines that the claimant currently takes for his/her condition.
- If possible, encourage the claimant to provide the exact name listed on his/her medicine container.
- To edit medicine details, select the medicine name below.

Prescription Medicines (up to 20 medicines)

Midrin
Benzphetamine
Taxol
Fexofenadine
Wellbutrin
Chlorpromazine

[Add Prescription Medicine]

Over-the-Counter Medicines (up to 10 medicines)

Advil
St. Johns Wort
Ephedra
Prilosec OTC
Claritin
Stress B Complex

[Add Over-the-Counter Medicine]

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Provide Prescription Medicine Details

Jump to: [ ] Go

Items marked with an asterisk (*) are required.

***Prescription Medicine Name:**

Who prescribed this medicine?

Other: (Title, First Name, Last Name)

Dr.

Reason for medicine:

(400 character maximum. About 8 lines.)

Count Characters 50 chars

Side effects experienced:

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

Delete this Medicine

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Provide Over-the-Counter Medicine Details

Jump to: Go

Items marked with an asterisk (*) are required.

***Over-the-Counter Medicine Name:**

Which doctor, if any, told the claimant to take this medication?

Other: (Title, First Name, Last Name)

Dr.

Reason for medicine:

(400 character maximum. About 8 lines.)

Count Characters 50 chars

Side effects experienced:

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

Delete this Medicine

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Provide Prescription Medicine Details

Jump to: [▾] Go

Items marked with an asterisk (*) are required.

***Prescription Medicine Name:** [ ]

Who prescribed this medicine? **You must first tell us the claimant had doctors before you can answer this question.**

Reason for medicine:

(400 character maximum. About 8 lines.)

[ ]

Count Characters 50 chars

Side effects experienced:

(1000 character maximum. About 20 lines.)

[ ]

Count Characters 50 chars

Delete this Medicine

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | **Medical Tests** | Jobs | Other Records

Medical Tests (up to 18 tests)

***Has the claimant had or scheduled any medical tests for his/her condition(s)?**

(•) **Yes** ( ) **No**

If you answer "yes" and later need to change this to "no", you must first delete all medical test information that you may have entered.

- List all tests that the claimant has had or expects to have.
- Include a specific test only once, we will let you select how many times the test was performed.
- To edit test details, select the test name below.

***!** You must provide details for at least one medical test.*

<Select Test Type> ▼ **Add Test**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | **Medical Tests** | Jobs | Other Records

Medical Tests (up to 18 tests)

***Has the claimant had or scheduled any medical tests for his/her condition(s)?**

(•) **Yes** ( ) **No**

If you answer "yes" and later need to change this to "no", you must first delete all medical test information that you may have entered.

- List all tests that the claimant has had or expects to have.
- Include a specific test only once, we will let you select how many times the test was performed.
- To edit test details, select the test name below.

Blood Test
Biopsy
EEG (Brain Wave Test)
EMG entire body
MRI/CT Scan
Psychological evaluation

<Select Test Type> ▼ **Add Test**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | **Medical Tests** | Jobs | Other Records

Medical Tests (up to 18 tests)

***Has the claimant had or scheduled any medical tests for his/her condition(s)?**

(•) **Yes** ( ) **No**

If you answer "yes" and later need to change this to "no", you must first delete all medical test information that you may have entered.

- List all tests that the claimant has had or expects to have.
- Include a specific test only once, we will let you select how many times the test was performed.
- To edit test details, select the test name below.

Blood Test
Biopsy
EEG (Brain Wave Test)
EMG entire body
MRI/CT Scan
Psychological evaluation

<Select Test Type> ▾ [Add Test]

☐ The claimant has more "Other Tests" than those listed. List any additional "Other Tests" in the Remarks section of this report.

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Provide Details About <Medical Test>

Jump to: Go

Items marked with an asterisk (*) are required.

***Test Name:**	**<Predefined Test Name>** **Part of body covered by test:**
Most recent date test was done or is expected to be done:	
Where was or where will this test be done?	**Unknown**
Who sent you or will send you for this test?	**Unknown** **Other: (Title, First Name, Last Name)** Ms.
How many times has this test been done?	

Delete this Test

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Provide Details About <Medical Test>

Jump to: [▼] Go

Items marked with an asterisk (*) are required.

***Test Name:**	**<Predefined Test Name>** **Part of body covered by test:** [ ]
Most recent date test was done or is expected to be done:	[ ]
Where was or where will this test be done?	[▼] ☐ **Unknown**
Who sent you or will send you for this test?	**You must first tell us the claimant had doctors before you can answer this question.**
How many times has this test been done?	[▼]

Delete this Test

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Provide Test Details

Jump to: Go

Items marked with an asterisk (*) are required.

***Test Name:**	**<Predefined Test Name>**
Most recent date test was done or is expected to be done:	
Where was or where will this test be done?	**Unknown**
Who sent you or will send you for this test?	**Unknown** **Other: (Title, First Name, Last Name)** Ms.
How many times has this test been done?	

Delete this Test

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Provide Test Details

Jump to: Go

Items marked with an asterisk (*) are required.

***Test Name:**	**Part of body covered by test:**
Most recent date test was done or is expected to be done:	
Where was or where will this test be done?	**Unknown**
Who sent you or will send you for this test?	**Unknown** **Other: (Title, First Name, Last Name)** Ms.
How many times has this test been done?	

Delete this Test

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | Medical Tests | **Jobs** | Other Records

Jobs

The claimant has never worked. If this is not true, please **Change the Answer**.

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | Medical Tests | **Jobs** | Other Records

John Doe's Jobs (up to 18 jobs)

The claimant has worked, but stopped due to his/her condition. If this is not true, please **Change the Answer**.

- List all the jobs the claimant had in the 15 years before he/she became unable to work because of his/her condition(s).
- Start with the most recent job and go backward to the earliest job.
- To edit job details, select the job title below.

! *You must provide details for at least one job.*

Add a Job

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | Medical Tests | **Jobs** | Other Records

John Doe's Jobs (up to 18 jobs)

The claimant has worked, but stopped due to his/her condition. If this is not true, please **Change the Answer**.

- List all the jobs the claimant had in the 15 years before he/she became unable to work because of his/her condition(s).
- Start with the most recent job and go backward to the earliest job.
- To edit job details, select the job title below.

Chiropractor, June 1982 to December '95

Add a Job

Longest Job

Select Longest Job The following is the claimant's longest job: Chiropractor, June 1982 to December '95

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | Medical Tests | **Jobs** | Other Records

John Doe's Jobs (up to 18 jobs)

The claimant has worked, but stopped due to his/her condition. If this is not true, please **Change the Answer**.

- List all the jobs the claimant had in the 15 years before he/she became unable to work because of his/her condition(s).
- Start with the most recent job and go backward to the earliest job.
- To edit job details, select the job title below.

Physical Therapist, October 1999 to June 2002

Chiropractor, June 1982 to December '95

Physical Therapist, October 1999 to June 2002

Chiropractor, June 1982 to June '95

Physical Therapist, October 1999 to June 2002

Chiropractor, June 1982 to December '95

Add a Job

John Doe's Longest Job and Work-Related Comments

Select Longest Job The following is the claimant's longest job: Chiropractor, June 1982 to December '95

Add Work Comments [Display first 100 characters of comments...]

Branding, Global Navigation, Claimant Summary, Function Bar

Information about the Claimant's Job

Jump to: [ ] Go

Items marked with an asterisk (*) are required.

Job Details

*Occupation/Job Title: [ ]

*Type of Business: [ ]

*Dates Worked: From: [ ] To: [ ]

Hours Worked: Average Hours per Day: [ ] Average Days per Week: [ ]

Pay Rate: $ [ ] . [ ] per [ ]

Job Skills and Work

Did the claimant:

Serve as a lead worker? (•) Yes ( ) No

Use machines, tools or equipment? (•) Yes ( ) No

Use technical knowledge or skills? (•) Yes ( ) No

Do any writing, complete reports, or perform any duties like this? (•) Yes ( ) No

Describe the claimant's duties.
- What were his/her main responsibilities?
- What did he/she do during a normal workday?
- Include specific tools and skills that were used

(1000 character maximum. About 20 lines of typing)

[Count Characters] 50 chars

[ ]

Supervisory Activities

Did the claimant supervise other people? (•) Yes ( ) No

If the claimant said "Yes", then provide us with details of the claimant's supervisory activities.

Number of people supervised: (•) Yes ( ) No

Responsible for hiring/firing? [ ]

Time spent supervising: [Almost all day (about 2/3 of the work day)]

Physical Activities

During a normal workday on this job, how much time does the claimant spend on each of these activities:

Walking [ ]

Standing [ ]

Sitting [ ]

Climbing [ ]

Kneeling [ ] (Bending legs and resting on knees)

Crawling [ ] (Moving on hands and knees)

Stooping [ ] (Bending legs and back, down and forward)

Crouching [ ] (Bending legs and back, down and forward)

Using fingers [ ] (Writing, typing, or handling small objects)

Using hands [ ] (Handling, grabbing, or grasping big objects)

Reaching [ ] (Extending hands and arms in any direction)

Please describe how the claimant lifted and carried things on the job.
- What did he/she lift?
- How far did he/she carry it?
- How often did he/she do this?

[Count Characters] 50 chars

[ ]

How heavy were the items the claimant frequently lifted(1/3 to 2/3 of the work day) on this job?
- (•) Less than 10 lbs. (Gallon of milk = 8 lbs.)
- ( ) 10 lbs.
- ( ) 25 lbs.
- ( ) 50 lbs. or more
- ( ) Other: [ ]

What was the heaviest weight the claimant lifted on this job?
- (•) Less than 10 lbs. (Gallon of milk = 8 lbs.)
- ( ) 10 lbs.
- ( ) 20 lbs.
- ( ) 50 lbs.
- ( ) 100 lbs or more
- ( ) Other: [ ]

[Delete this Job] [Done]

Footer

JB003 Select Longest Job - Not Selected

Branding, Global Navigation, Claimant Summary, Function Bar

Select Longest Job Jump to: Go

Items marked with an asterisk (*) are required.

***Select the one job the claimant did for the longest period of time.** <Select longest job>

Done

i3368 PRO Footer

JB003 Select Longest Job - Job Selected

Branding, Global Navigation, Claimant Summary, Function Bar

Select Longest Job Jump to: Go

Items marked with an asterisk (*) are required.

***Select the one job the claimant did for the longest period of time.** Physical Therapist (October 1999 to Summer 2002)

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Work-Related Comments

Jump to: Go

Do you have any additional comments or information about the claimant's work that you think we should know about when reviewing his/her case?

If so, please enter them here. If the claimant had more jobs than you listed earlier, please include them here also.

(2000 character maximum. About 40 lines of typing.)

Count Characters **50 chars**

Done

Branding, Global Navigation, Claimant Summary, Function Bar

Change Work Status

***Has the claimant ever worked?**

- (•) **Yes, but stopped because of his/her condition**
- ( ) **Yes, but stopped because of other reasons (not due to his/her condition)**
- ( ) **Yes, but stopped due to his/her condition and other reasons**
- ( ) **Yes, currently working**
- ( ) **No, has never worked**

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | Medical Tests | Jobs | **Other Records**

Other Medical Records (up to 6 different places)

***Does the claimant have other places that might have medical records or condition information?**

(•) **Yes** ( ) **No**

If you answer "yes" and later need to change this to "no", you must first delete all medical test information that you may have entered.

- If the claimant has relevant medical records in other places, list them here.
- Do not repeat any places that you have already told us about.
- We will collect details for only one organization type.
- To edit organization details, select the organization or agency name below.

***!** You must provide details for at least one place.*

<Select a Place> [▼] **Add Place**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Claimant's Info | Doctors | Hospitals | Medications | Medical Tests | Jobs | **Other Records**

Other Medical Records (up to 6 different places)

***Does the claimant have other places that might have medical records or condition information?**

(•) **Yes** ( ) **No**

If you answer "yes" and later need to change this to "no", you must first delete all medical test information that you may have entered.

- If the claimant has relevant medical records in other places, list them here.
- Do not repeat any places that you have already told us about.
- We will collect details for only one organization type.
- To edit organization details, select the organization or agency name below.

ABC Legal Services
Maryland Welfare Agency
Leavenworth
ABC Legal Services
Maryland Welfare Agency
Leavenworth

<Select a Place> [Add Place]

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Medical Records at a Workers' Compensation Office

Jump to: Go

Items marked with an asterisk (*) are required.

*Workers' Compensation Office:

Contact Name:
(First, Last)

*Address:

*(Street Address Line 1)

(Street Address Line 2)

(Street Address Line 3)

*(City, State, ZIP)

*Phone Number: ( ) - Ext:

Claim Number:

Application Dates

Date Claimant Applied:

Date of Most Recent Decision:

Next Scheduled Appointment: (if not scheduled, enter "None")

Reason for Claim:

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

The claimant has medical records at another Workers Compensation office.

Delete this Place

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Medical Records at a Welfare Agency

Jump to: Go

Items marked with an asterisk (*) are required.

***Name of Welfare Agency:**

Name of Social Worker:
(First, Last)

***Address:**

*(Street Address Line 1)

(Street Address Line 2)

(Street Address Line 3)

*(City, State, ZIP)

***Phone Number:** ( ) - Ext:

Case Number:

Appointment Dates

When did the claimant first go?

When did the claimant last go?

Next Scheduled Appointment: (if not scheduled, enter "None")

Reason for Visits or Services:

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

The claimant has medical records at another welfare agency.

Delete this Place

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Medical Records at a Prison/Jail

Jump to: Go

Items marked with an asterisk (*) are required.

*Name of Prison or Jail:

Contact Name:
(First, Last)

*Address:

*(Street Address Line 1)

(Street Address Line 2)

(Street Address Line 3)

*(City, State, ZIP)

*Phone Number: ( ) - Ext:

Inmate Number:

Dates of Visits to Prison Doctor

First Visit:

Last Visit:

Next Scheduled Appointment: (if not scheduled, enter "None")

Reason for Medical Visits:

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

The claimant has medical records at another prison/jail.

Delete this Place

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Medical Records at Insurance Company

Jump to: Go

Items marked with an asterisk (*) are required.

*Insurance Company Name:

Contact Name:
(First, Last)

*Address:
*(Street Address Line 1)
(Street Address Line 2)
(Street Address Line 3)
*(City, State, ZIP)

*Phone Number: ( ) - Ext:

Identification/Patient Number:

Dates of Contact
First Contact:
Most Recent Contact:
Next Scheduled Appointment: (if not scheduled, enter "None")

Reason for Visits or Services:

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

The claimant has medical records at another insurance company.

Delete this Place

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Medical Records with Attorney or Law Firm

Jump to: Go

Items marked with an asterisk (*) are required.

*Name of Law Firm:

Name of Attorney/Lawyer:
(First, Last)

*Address:

*(Street Address Line 1)

(Street Address Line 2)

(Street Address Line 3)

*(City, State, ZIP)

*Phone Number: ( ) - Ext:

Case Number:

Visits to Attorney/Law Firm

When did the claimant first go?

When did the claimant last go?

Next Scheduled Appointment: (if not scheduled, enter "None")

Reason for Visits or Services:

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

The claimant has medical records with another attorney/law firm.

Delete this Place

Done

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Medical Records at Another Place

Jump to: Go

Items marked with an asterisk (*) are required.

*Name of Place:

Contact Name:
(First, Last)

*Address:
*(Street Address Line 1)
(Street Address Line 2)
(Street Address Line 3)
*(City, State, ZIP)

*Phone Number: ( ) - Ext:

Case Number:

Dates of Visits

When did the claimant first go?

When did the claimant last go?

Next Scheduled Appointment: (if not scheduled, enter "None")

Reason for Visits:

(1000 character maximum. About 20 lines.)

Count Characters 50 chars

The claimant has medical records at other places.

Delete this Place

Done

Footer

Adult Disability & Work History Report - PRO

Search Medical Provider

For a quick search enter only the physician's or facility's phone number. Also, refine your search results by using multiple search fields.

Items marked with an asterisk (*) are required.

Search Tips

* **State:**	MD	
Phone Number: (Example: 111-111-1111)	Begins with	
Doctor's First Name:	Begins with	
Doctor's Last Name:	Begins with	
HMO/Hospital/Clinic/Office Name:	Begins with	
Street Address 1:	Contains	
City:	Begins with	
Zip:	Begins with	

Cancel Clear Search

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Adult Disability & Work History Report - PRO

Medical Provider Search Results

Search results based on the following search criteria:

State: MD
Phone Number: 410
Doctor's Last Name: Doe
Doctor's First Name: Doe

To select a medical provider click on the "Select" button. The information about the selected medical provider will automatically be added to the Medical Provider Details page.

	Name	Organization	Address	Phone Number
Select	Johnaaaaaaaaaa Doeaaaaaaaaaaaaaaaa		111 Market Place, Suite 1070 Baltimore, MD, 21212	410-555-1212
Select	Jane Doe		111 Market Place, Suite 1070, Baltimore, MD, 21212	410-555-1213
Select	John Doe	Johns HopkinsJohns HopkinsJohns HopkinsJohns Hopkinsaaaaa	17 Johns Hopkins Plaza, Room 1717, Baltimore, MD, 21212	410-110-0101
Select	John Doe		111 Market Place, Suite 1070, Baltimore, MD, 21212	410-555-1212

Cancel | Refine Search | New Search

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Adult Disability & Work History Report - PRO

Medical Provider Search Is Currently Unavailable

The Medical Provider Search is currently unavailable.

You may continue with the Adult Disability and Work History Report by adding the medical provider information manually, or try accessing the report at a later time.

Continue

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Branding, Global Navigation, Claimant Summary, Function Bar

Review and Send: Report Submission Checkpoint

You are ready to send 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 or the claimant, if we need any more information. If the claimant wants to make changes after sending this report, he/she or an authorized representative can contact Social Security.

! = ***Please check these screens*** ✓ = ***You have viewed these screens, no problems***

1) Review, Print, Save, Confirm Information

- ! **Fix Errors/Confirm Information**
- **Add Remarks**
- **Print/Save for Your Records**
- **Print XX Medical Release Forms** (SSA-827)
- ! **Print Cover Sheet**

2) Ready to Submit?

You must resolve all errors and print the Cover Sheet before you can submit this report.

Important: After you send this report, you will not be able to come back to it online.

Back to Claimant's Info | **Send Now**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Review and Send: Report Submission Checkpoint

You are ready to send 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 or the claimant, if we need any more information. If the claimant wants to make changes after sending this report, he/she or an authorized representative can contact Social Security.

! = ***Please check these screens*** ✓ = ***You have viewed these screens, no problems***

1) Review, Print, Save, Confirm Information

- ✓ **Confirm Information**
- ✓ **Add Remarks**
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- ✓ **Print XX Medical Release Forms** (SSA-827)
- ✓ **Print Cover Sheet**

2) Ready to Submit?

You must resolve all errors and print the Cover Sheet before you can submit this report.

Important: After you send this report, you will not be able to come back to it online.

Back to Claimant's Info | **Send Now**

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Fix Errors and Confirm Information

Back

! Errors: Before you can submit this form to Social Security, you must correct the following errors and/or omissions.

- Edit *You must provide details for at least one doctor.*
- Edit *You must provide details for at least one hospital.*
- Edit *You must provide details for at least one medication.*
- Edit *You must provide details for at least one medical test.*
- Edit *You must provide details for at least one place.*
- Edit *You must provide details for at least one job.*

Claimant's Info

- Edit About John Doe: General Information (claimant's contact info, English-speaking ability, height, weight, etc.)
- Edit About John Doe: Medical, Work, and Education History (condition listing, date condition first bothered, treatments received, etc.)
- Edit Describe John Doe's Conditions (detailed condition description)
- Edit Date Claimant Became Unable to Work (work history info)
- Edit Other Names Used on Medical Records
- Edit English-speaking Contact
- Edit Someone Else We Can Contact About Claimant's Conditions
- Edit Special Education Class Details
- Edit Special Job Training, Trade or Vocational School Details
- Edit Vocational Rehabilitation or Ticket-to-Work Program Details

Doctors

No details entered.

Hospitals

No details entered.

Medication

No details entered.

Medical Tests

No details entered.

Other Places with Medical Records

No details entered.

Jobs

No details entered.

Back

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Fix Errors and Confirm Information

Back to Checkpoint | Next Step >

! Errors: Before you can submit this form to Social Security, you must correct the following errors and/or omissions.

Edit *You did not select the longest job.*

Claimant's Info

- Edit About John Doe: General Information (claimant's contact info, English-speaking ability, height, weight, etc.)
- Edit About John Doe: Medical, Work, and Education History (condition listing, date condition first bothered, treatments received, etc.)
- Edit Describe John Doe's Conditions (detailed condition description)
- Edit Date Claimant Became Unable to Work (work history info)
- Edit Other Names Used on Medical Records
- Edit English-speaking Contact
- Edit Someone Else We Can Contact About Claimant's Conditions
- Edit Special Education Class Details
- Edit Special Job Training, Trade or Vocational School Details
- Edit Vocational Rehabilitation or Ticket-to-Work Program Details

Doctors

- Edit Dr. John Doe
- Edit Dr. John Again
- Edit Dr. Jane Doe
- Edit Dr. Jane Again
- Edit Dr. Jane Gain

Hospitals

- Edit Johns Hopkins Hospital
- Edit Johns Hopkins Again
- Edit Union Memorial
- Edit Union Memorial Again

Medication

- Edit Prozac
- Edit Stronger Prozac
- Edit Stress B Complex
- Edit Lithium

Medical Tests

- Edit Finger Test
- Edit Toe Test
- Edit Biopsy
- Edit Enter Details

Other Places with Medical Records

- Edit ABC Legal Services
- Edit Maryland Welfare Agency
- Edit Leavenworth Prison
- Edit Acme Insurance Co.

Jobs

- Edit Backseat Driver
- Edit Armchair Commando
- Edit Mondaymorning Quarterback
- Edit Dream Job

Back to Checkpoint | Next Step >

Branding, Global Navigation, Claimant Summary, Function Bar

Confirm Information

Back to Checkpoint | Next Step >

Claimant's Info

- Edit About John Doe: General Information (claimant's contact info, English-speaking ability, height, weight, etc.)
- Edit About John Doe: Medical, Work, and Education History (condition listing, date condition first bothered, treatments received, etc.)
- Edit Describe John Doe's Conditions (detailed condition description)
- Edit Date Claimant Became Unable to Work (work history info)
- Edit Other Names Used on Medical Records
- Edit English-speaking Contact
- Edit Someone Else We Can Contact About Claimant's Conditions
- Edit Special Education Class Details
- Edit Special Job Training, Trade or Vocational School Details
- Edit Vocational Rehabilitation or Ticket-to-Work Program Details

Doctors

- Edit Dr. John Doe
- Edit Dr. John Again
- Edit Dr. Jane Doe
- Edit Dr. Jane Again
- Edit Dr. Jane Gain

Hospitals

- Edit Johns Hopkins Hospital
- Edit Johns Hopkins Again
- Edit Union Memorial
- Edit Union Memorial Again

Medication

- Edit Prozac
- Edit Stronger Prozac
- Edit Stress B Complex
- Edit Lithium

Medical Tests

- Edit Finger Test
- Edit Toe Test
- Edit Biopsy
- Edit Enter Details

Other Places with Medical Records

- Edit ABC Legal Services
- Edit Maryland Welfare Agency
- Edit Leavenworth Prison
- Edit Acme Insurance Co.

Jobs

- Edit Backseat Driver
- Edit Armchair Commando
- Edit Mondaymorning Quarterback
- Edit Dream Job
- Edit The following is the claimant's longest job: Chiropractor, June 1982 to December '95

Back to Checkpoint | Next Step >

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Fix Errors and Confirm Information

Back to Checkpoint | Next Step >

! Errors: Before you can submit this form to Social Security, you must correct the following errors and/or omissions.

- Edit *You must provide details for at least one doctor.*
- Edit *You must provide details for at least one hospital.*
- Edit *You must provide details for at least one medication.*
- Edit *You must provide details for at least one medical test.*
- Edit *You must provide details for at least one place.*
- Edit *You must provide details for at least one job.*

Claimant's Info

- Edit About John Doe: General Information (claimant's contact info, English-speaking ability, height, weight, etc.)
- Edit About John Doe: Medical, Work, and Education History (condition listing, date condition first bothered, treatments received, etc.)
- Edit Describe John Doe's Conditions (detailed condition description)
- Edit Date Claimant Became Unable to Work (work history info)
- Edit Other Names Used on Medical Records
- Edit English-speaking Contact
- Edit Someone Else We Can Contact About Claimant's Conditions
- Edit Special Education Class Details
- Edit Special Job Training, Trade or Vocational School Details
- Edit Vocational Rehabilitation or Ticket-to-Work Program Details

Doctors

No details entered.

Hospitals

No details entered.

Medication

No details entered.

Medical Tests

No details entered.

Other Places with Medical Records

No details entered.

Jobs

No details entered.

Back to Checkpoint | Next Step >

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Confirm Information

Back to Checkpoint | Next Step >

Claimant's Info

- Edit About John Doe: General Information (claimant's contact info, English-speaking ability, height, weight, etc.)
- Edit About John Doe: Medical, Work, and Education History (condition listing, date condition first bothered, treatments received, etc.)
- Edit Describe John Doe's Conditions (detailed condition description)
- Edit Date Claimant Became Unable to Work (work history info)

Doctors

- Edit The claimant did not go to any doctors for his/her condition.

Hospitals

- Edit The claimant did not go to any hospitals for his/her condition.

Medication

- Edit The claimant does not take any medications for his/her condition.

Medical Tests

- Edit The claimant does not have or has not scheduled any medical tests for his/her condition.

Other Places with Medical Records

- Edit The claimant does not have medical records at other places.

Jobs

- Edit They claimant has never worked.

Back to Checkpoint | Next Step >

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Fix Errors and Confirm Information

Back to Checkpoint | Next Step >

! Errors: Before you can submit this form to Social Security, you must correct the following errors and/or omissions.

- Edit *You did not tell us if the claimant went to a doctor.*
- Edit *You did not tell us if the claimant went to a hospital.*
- Edit *You did not tell us if the claimant takes any prescription or over-the-counter medications.*
- Edit *You did not tell us if the claimant had or has scheduled any medical tests.*
- Edit *You did not tell us if the claimant has medical records at other places.*
- Edit *You must provide details for at least one job.*

Claimant's Info

- Edit About John Doe: General Information (claimant's contact info, English-speaking ability, height, weight, etc.)
- Edit About John Doe: Medical, Work, and Education History (condition listing, date condition first bothered, treatments received, etc.)
- Edit Describe John Doe's Conditions (detailed condition description)
- Edit Date Claimant Became Unable to Work (work history info)
- Edit Other Names Used on Medical Records
- Edit English-speaking Contact
- Edit Someone Else We Can Contact About Claimant's Conditions
- Edit Vocational Rehabilitation or Ticket-to-Work Program Details

Doctors

No details entered.

Hospitals

No details entered.

Medication

No details entered.

Medical Tests

No details entered.

Other Places with Medical Records

No details entered.

Jobs

No details entered.

Back to Checkpoint | Next Step >

Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Additional Remarks About this Case

Does the claimant have any additional comments or information we should know when reviewing this case?

If so, please enter them here. If you checked a box anywhere on this report to show that the claimant had more information than the space allowed (for example, "The claimant has more doctors than listed"), you may give us that information here.

(3000 character maximum. About 60 lines of typing.)

Count Characters

50 chars

Back to Checkpoint

Next Step >

Footer

Adult Disability and Work History Report - PRO

Print or Save a Copy of this Report for Your Records

Before you submit this report to Social Secuity, you can print or save it for your files. Once you send it, you will not be able to access it online. For instructions on how to print, save, or view the saved file, please refere to the Print/Save/View Guide.

(3368) Section 1 – Information About the Disabled Person

A. Name: **Robert Woskolski**

B. Social Security Number: **999-30-8805**

C. Daytime Telephone Number (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.): **706-724-4235 Your Number**

D. Give the name of a friend or a relative that we can contact (other than your doctors) who knows about your illnesses, injuries or conditions and can help you with your claim.

Name: **April F. Woskolski**
Relationship: **Husband or wife**
Address: **5230 Hereford Farm Road**
Evanston, GA 30809
Daytime Phone: **706-965-5555**

E. What is your height without shoes? **6' 0"**

F. What is your weight without shoes? **195 lbs**

G. Do you have a medical assistance card? **No**
If "yes", show the number here:

H. Can you speak and understand English? **Yes**
If "no", what languages can you speak?

If you cannot speak English, give us the name of someone we may contact who speaks English and will give you messages. (If this is the same person as in "D" above show "SAME" here.)

I. Can you read and understand English? **Yes**

J. Can you write more than your name in English? **Yes**

(3368) Section 2 – Your Illnesses, Injuries or Conditions and How They Affect You

A. What are the illnesses, injuries or conditions that limit your ability to work?
stroke, paralysis of right arm/hand, speech problem, diabetes.

B. How do your illnesses, injuries or conditions limit your ability to work?
He only has the use of his left hand (he is right-handed). He gets depressed because he cannot use his right hand. He cannot respond to questions asked and cannot ask questions if he doesn't understand. He knows the answers but he is not always able to say it aloud. His stroke has affected his ability to read and to do mathematical problems. He cannot remember how to type on a computer. He cannot lift or carry anything that requires two hands. The doctors tell him that his concentration is severely affected, limiting him to remembering one or two instructions at a single time. He can't answer the telephone because he can't respond to conversations. His balance is affected by the weakness in his right leg, which tires easily if he walks too much. He has trouble telling time sometimes. When he speaks, he says different words than what he is thinking. He has bad headaches all day long. He has become depressed because of his limitations and on many days has trouble getting out of bed and getting dressed by himself.

C. Do your illnesses, injuries or conditions cause you pain? **Yes**

D. When did your illnesses, injuries or conditions first bother you? **04/07/2001**

E. When did you become unable to work because of your illnesses, injuries or conditions? **04/24/2002**

F. Have you ever worked? **Yes**

G. Did you work at any time after the date your illnesses, injuries or conditions first bothered you? **Yes**

H. If "Yes", did your illnesses, injuries or conditions cause you to:
Work fewer hours? **Yes**
Change your job duties? **No**
Make any job-related changes such as your attendance, help needed, or employers? **Yes**
Explain: **Got extra help from employer, co-workers, or other employees. Robert started feeling sick and very weak about two weeks prior to going into the hospital. He was unable to complete his office duties and had to ask other employees for help finishing required reports. He had to ask for help from co-workers because he felt weak and couldn't lift things. He went home early several days because he was so tired and his head ached.**

I. Are you working now? **No**
If "No", when did you stop working? **05/07/2002**

J. Why did you stop working? **Because of his/her condition**.

(3368) Section 3 – Information About Your Work

A. List the kinds of jobs you have had in the past 15 years that you worked

B. *=Longest Job Held

Longest Job held	Job title	Type of Business	Dates Worked (From-To)	Hours Per Day	Days Per Week	Rate of Pay/Per
*	Office manager	Veterinary hospital	1987-5/24/2002	9	6	$36/hour

C. Describe the job above that you did the longest. (What did you do all day in this job?)
Robert managed the office staff and vet technicians. He made the surgery schedules and oversaw all preparations for surgery. He did blood tests, took x-rays, administered shots, and gave medications. He did work schedules and payroll reports, as well as projected sales reports and projected payroll reports for the home office. He was required to take managerial seminars and continuing education each year.

D. In this job, did you:
Use machines, tools, or equipment? **Yes**
Use technical knowledge or skills? **Yes**
Do any writing, complete reports, or perform any duties like this? **Yes**

E. In this job, how many total hours each day did you:
Walk? **5**
Stand? **1**
Sit? **3**
Climb? **0**
Stoop? **1**
Kneel? **1**
Crouch? **0**
Crawl? **0**
Handle, grab or grasp big objects? **5**
Reach? **4**
Write, type or handle small objects? **6**

F. Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.):
He carried animals to the e-ray table and the exam table for the doctors. He handled packages coming into the building containing medicine.

G. Heaviest weight you lifted: **100 lbs. or more**

H. Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday): **50 lbs. or more**

I. Did you supervise other people in this job? **Yes**
How many people did you supervise? **15**
How much of your time was spent supervising people? **almost all**
Did you hire and fire employees? **Yes**

J. Were you a lead worker? **Yes**

(3368) Section 4 – Information About Your Medical Records

A. Have you been seen by a doctor or anyone else for the illnesses, injuries or conditions that limit your ability to work? **Yes**
Have you gone to a hospital/clinic or anyone else for the illnesses, injuries or conditions that limit your ability to work? **Yes**

B. Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work? **No**

C. List other names you used on your medical records:

Tell us who may have medical records or other information about your illnesses, injuries or conditions

D. List each Doctor/HMO/ Therapist. Include your next appointment:

Name:	**Dr. Richard Liston**			
Address:	**Center for Primary Care** **4343 N. Belair Road** **Evans GA 30908**		Date First Visit:	**03/13/2002**
			Date Last Seen:	**01/12/2004**
Phone:	**706-555-7563**	Chart/HMO#:	Next Appointment:	**05/10/2004**
Reasons for Visits: **He started seeing Dr. Liston after a mini-stroke in March 2002. Dr. Liston started Robert on Plavix to keep him from having another stroke. In May, he became ill and was diagnosed with pneumonia. He stayed home from work for a week and continued to worsen. On May 14, he went to the emergency room because he couldn't breathe. The doctors drained 2 liters of blood-tinged fluid from his lungs. He was told he needed surgery, but that he first had to stop taking the Plavix so that he wouldn't bleed too much. After ten days, he had the surgery and then had a stroke. At that time, Dr. Liston turned him over to a specialist.**				
What treatment was received? **Physical examinations, lung x-rays, blood tests, CT scans for cancer and stroke.**				

Name:	**Dr. Melissa Scott**			
Address:	**Acute Care Specialists** **36 Gray Court** **Augusta GA 30909**		Date First Visit:	**05/14/2002**
			Date Last Seen:	**03/31/2004**
Phone:	**706-555-6199**	Chart/HMO#:	Next Appointment:	**none**
Reasons for Visits: **This doctor followed Robert through 3 weeks in intensive care in Doctor's Hospital and then for outpatient treatment at Select Specialty Hospital. While in intensive care, he developed respiratory failure, causing him to be put on a ventilator. Eventually, he had to have a tracheotomy. This doctor monitored all his medications while he was hospitalized. He developed several infections, requiring numerous regimens of IV antibiotics. He developed blood clots in his right arm that caused my arm to stiffen and not respond to therapy.**				
What treatment was received? **IV antibiotics, x-rays, CT scans, physical therapy and counseling, treatments to help circulation in his legs**				

Name:	**Dr. Pam Waters**			
Address:	**Walton Rehabilitation Clinic** **1355 Independence Dr** **Augusta GA 30901**		Date First Visit:	**07/10/2002**
			Date Last Seen:	**02/14/2004**
Phone:	**706-555-7746**	Chart/HMO#:	Next Appointment:	**05/07/2004**
Reasons for Visits: **To monitor his physical therapy and all medications required. He also needed anti-anxiety medication.**				
What treatment was received? **physical therapy, counseling, medications**				

E. List each Hospital/Clinic. Include your next appointment:

Name:	**Doctors Hospital of Augusta**		
Address:	**3666 Sean Road** **Augusta GA 30909**		
Phone:	**706-651-3232**		
Inpatient Date In 1:	**05/14/2002**	Inpatient Date Out 1:	**06/13/2002**
Inpatient Date In 2:		Inpatient Date Out 2:	
Inpatient Date In 3:		Inpatient Date Out 3:	
Outpatient Date First Visit:		Outpatient Date Last Visit	
Emergency Room Dates of Visits	**5/14/2002**		
Next Appointment:			
Your Hospital/Clinic Number:			
Reasons for Visits: **He couldn't breathe and his chest was hurting.**			
What treatment did you receive? **lung surgery, critical care nursing, blood transfusion, antibiotic therapy**			
What doctors do you see at this hospital/clinic on a regular basis? **Dr. Melissa Scott, Dr. Beth Jeffries**			

Name:	**Select Specialty Hospital**		
Address:	**3600 Sean Road** **4th floor** **Augusta GA 30909**		
Phone:	**706-651-0000**		
Inpatient Date In 1:		Inpatient Date Out 1:	
Inpatient Date In 2:		Inpatient Date Out 2:	
Inpatient Date In 3:		Inpatient Date Out 3:	
Outpatient Date First Visit:	**06/13/2002**	Outpatient Date Last Visit	**07/10/2002**
Emergency Room Dates of Visits			
Next Appointment:			
Your Hospital/Clinic Number:			
Reasons for Visits: **To receive needed outpatient therapy to recover after hospital stay**			
What treatment did you receive? **Physical and speech therapy**			
What doctors do you see at this hospital/clinic on a regular basis? **Dr. Melissa Scott, Dr. Alan Taylor**			

F. Does anyone else have medical records or information about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else? **Yes**

Organization:	**ETC Law Firm**		
Contact Name:	**Mr. Attorney Attorney**		
Address:	**6266 Independence Dr** **Augusta GA 30901**	Date First Visit:	**07/10/2002**
		Date Last Seen:	**02/14/2004**
Phone:	**706-555-7746**	Next Appointment:	**05/07/2004**
Claim Number:	**00000000000**		
Reasons for Visits: **Wanted to sue the restaurant because my breathing got worse after I worked there.**			

(3368) Section 5 – Medications

Do you currently take any medications for your illnesses, injuries or conditions? **Yes**

If "Yes", please tell us the following: (Look at your medicine bottles, if necessary.)

Name of Medicine	Prescribed By (Name of Doctor)	Reason For Medicine	Side Effects You Have
1. Aspirin	Dr. Pam Waters	To help keep blood thin	None
2. Acidphex	Dr. Richard Liston	Helps prevent too much stomach acid, to keep from having indigestion	None
3. Plavix	Dr. Melissa Scott	Helps keep platelets from sticking together causing clots that could cause more strokes	None
4. Glucotrol	Dr. Pam Waters	Controls diabetes	None
5. Zocor	Dr. Richard Liston	Controls cholesterol	None

(3368) Section 6 – Tests

Have you had, or will you have any medical tests for your illnesses, injuries or conditions? **Yes**

If "Yes". Please tell us the following: (Give approximate dates, if necessary.)

Kind of Test	When done, or When Will It Be done? (Month, day, year)	Where done	Who Sent You For Test
1. EKG	05/30/2002	Doctors Hospital of Augusta	Dr. Melissa Scott
2. Biopsy Bone marrow, hip	07/29/2002	Walton Rehabilitation Clinic	Dr. Pam Waters
3. Blood test	01/12/2004	Dr. Liston's office	Dr. Richard Liston
4. X-ray Chest	03/21/2004	Doctors Hospital of Augusta	Dr. Melissa Scott
5. MRI/CT Scan Head	08/17/2003	Doctors Hospital of Augusta	Dr. Melissa Scott

(3368) Section 7 – Education/Training Information

A. Highest grade of school completed: **12**
Approximate date completed: **1973**

B. Did you attend special education classes? **No**

C. Have you completed any type of special job training, trade or vocational school? **Yes**

If "Yes", what type? **Veterinary assistant program**

Approximate date completed: **June 1975**

(3368) Section 8 – Information About Your Vocational Rehabilitation

A. Have you received services from Vocational Rehabilitation or any other organization to help you get back to work?
Yes

Organization:	**State VR**		
Contact Name:	**Ms. Any One**		
Address:	**6200 Independence Dr** **Augusta GA 30901**		
Phone:	**706-555-7746**		
Dates Seen:	**07/10/2002**	To:	**02/14/2004**
Types of Services or Tests Performed: **Took an aptitute test to see what other jobs he could perform.**			

(3368) Section 9 – Remarks

Had these tests more than once: EKG, biopsy, blood test (not HIV), x-ray, MRI/CT scan.

My e-mail address is rjwos@aol.com

Back to Checkpoint | Next Step >

(800) 772-1213 or TTY (800)325-0778 , 7am-7pm

Branding, Global Navigation, Claimant Summary, Function Bar

Print Medical Release Forms

The law requires us to obtain signed medical release forms from the claimant so that we may get medical records from each of his/her doctors or hospitals. Send the medical releases along with the Cover Sheet and any other attachments.

Print XX copies.

SSA-827 Medical Release Form (pdf)

Note: If you need assistance on how to complete the medical release form, we have provided some instructions.

When you select the link, the form will launch in a new browser window. You should close the window after you have printed the form in order to return to this Adult Disability and Work History Report. This form is in Portable Document Format (PDF) and requires Adobe Acrobat Reader to open and print it. If you don't have Adobe Acrobat Reader on your computer you can dowload it at http://access.adobe.com.

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Footer

Branding, Global Navigation, Claimant Summary, Function Bar

Print Cover Sheet

You **must** print and send this page to the following Social Security office with the SSA-827s, any medical evidence the claimant has given you, and any other documents on behalf of the claimant.

Mail To: **Social Security Office**
6401 Security Blvd.
Baltimore, MD 21235-0001

Organization

3rd Party Organization
Ms. Contact Person
11155 Claimant's Info St.
Wayne, PA 22255
(212) 555-1212

Claimant

My organization is assisting the following claimant in completing his/her Adult Disability and Work History Report.

John Doe
xxx-xx-xxxx
111 Claimant's Info St.
Nowhere, NW 22222
(222) 555-1212 (message number)

Attachments

The following items are attached:

_____ **SSA-827 Medical Release Form** (Please attach at least XX signed and dated copies)
Number Attached: _____

_____ **Medical Evidence**

Other: _____

Alerts and Comments

_____ **TERI** (Potential terminally ill claimant)

Additional Comments:

Back to Checkpoint

Branding, Global Navigation, Claimant Summary, Function Bar

Thank You - Successful Submission!

We have received your submission of the Online Adult Disability and Work History Report for the following claimant:

Claimant's Name: **John Doe**

Claimant's SSN: **111-11-1111**

Important--Next Steps:

Remember to send the following items to the claimant's local Social Security office at the address below.

- Cover sheet
- Signed and dated medical release forms
- Copies of any claimant's medical evidence you may have

Claimant's Local Social Security Office:

SOCIAL SECURITY ADMINISTRATION
110 West Road
Suite 500 Corp Center
Towson, MD 21204
(410) 825-3336

What to expect:

It takes about 120 days to process an application for disability benefits, but every case is different. The claim may take more or less time to process.
While we are processing your application, we may need to do the following:

- Contact you or the claimant for more information or to set up an interview
- Send you or the claimant additional forms to fill out
- Ask the claimant to see a doctor for a special exam if we need more medical evidence (we will pay for this) relating to his/her condition

Contact Social Security if the claimant:

- Goes to a new doctor
- Has a new medical test done
- Has a change in his/her condition
- Returns to work
- Changes his/her address or phone number

Time Limit:

We need a formal application for disability benefits from the claimant before we can process this claim. This Adult Disability and Work History Report is NOT a formal application, but it is a required part of the the claims process. The claimant may lose benefits if we do not receive the application by:

- 6 months from the date you started a report for the claimant for the first time for Social Security (SSA) disability benefits, or
- 60 days from the date you started a report for the claimant for the first time for Supplemental Security Income (SSI) disability benefits.

Since this Report applies to both types of applications, we cannot tell at this time which deadline applies to the claimant. Therefore, to fully protect all possible benefits, we recommend that he/she submit a formal application no later than 60 days from the date you started a report for the first time.

Start a New Report

Exit

Header

This Report is Only for Professionals, Representatives and Organizations

This Adult Disability and Work History Report - PRO is only for use by professionals, representatives and organizations assisting disabled adults age 18 or older. There is a different online Adult Disability and Work History Report for you to use if you are an individual completing this report for yourself or for someone else.

If you are not sure which report to complete, or for further assistance:

- 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 your local Social Security office.

Go to the Adult Disability and Work History Report | Back

Header

Warning: System Will Shut Down

This Internet Disability Report is scheduled to shut down for the day within two hours.

The Disability Report is available during the following hours (Eastern Time):

Monday through Friday: 5:00 AM - 1:00 AM
Saturday: 5:00 AM - 11:00 PM
Sunday: 8:00 AM - 10:00 PM
Holidays: 5:00 AM - 11:00 PM

If you choose to start the report now and the system shuts down before you finish it, you will lose only the information on the page you are working on at the time of the shutdown.

You may want to consider starting the report at another time to avoid losing any information. If you decide to start this report later, you should write down this web site so that you can return to it: http:www.socialsecurity.gov/disabilityreportpro

Select the Exit button to leave this report. You will be taken to the Social Security home page.

Exit | Continue with Report

Header

Print/Save/View Guide

To print this report:
Choose the Print button on your browser button bar or Choose Print from the File menu. Make sure the correct printer is selected and choose OK.

To save this report:
Choose Save As from the File menu. We recommend that you save as an HTML file. Provide a file name and location, if needed, and choose OK.

To view the saved page:
Open your browser. Choose Open from the File menu. Click Browse and locate the file name and location you used. (When you reopen this HTML file, none of the buttons or links on the page will work.

Close this window to return to the report.

Header

Proper Applicant
The disability application process requires the completion of this report and a separate application for benefits. This report is not the application for benefits. Although you may complete this report for the claimant, we can only accept an application filed by the claimant or one of the specific individuals listed below under the heading, "Who May File an Application on the Claimant's Behalf."

Social Security Disability Benefits
If you are one of the individuals listed below under the heading, Who May File an Application On the Claimant's Behalf, we may use the date you started completing this report as the claimant's application filing date if you file an application on the claimant's behalf within 6 months after the date you started completing this report.

If you are not one of the individuals listed, we will contact the claimant to determine if he or she would like to file an application for benefits.

Supplemental Security Income Disability Benefits
If you are one of the individuals listed under the heading, Who May File an Application on the Claimant's Behalf, we may use the date you started this report as the claimant's application filing date, if you file an application on the claimant's behalf within 60 days after the date you started completing this report.

If you are not one of the individuals listed under the heading, Who May File an Application on the Claimant's Behalf, we may use the date you started completing this report as the claimant's application filing date if the claimant files an application within the time period specified in our contact with him or her explaining the need to file.

Who May File An Application on the Claimant's Behalf
A claimant 18 years old or over must file his or her own application. However, we may accept an application filed by you on the claimant's behalf if you are the:

- claimant's court-appointed legal representative or person responsible for the claimant's care because the claimant is adjudged legally incompetent or is physically unable to file his or her own application, or
- manager or principal officer of the institution where the claimant resides.

When dire circumstances exist, we may accept an application filed by someone other than the individuals listed above to prevent the claimant from losing benefits. These situations are rare. If you believe dire circumstances are involved, you should contact us right away to file an application on the claimant's behalf.

If you are one of the individuals listed above you will need to contact us to file the application.

To arrange for an application appointment, you can 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.

Close this window to return to the report.

Header

Applying in Person or Over the Phone

If you prefer not to fill out this report on the Internet, you can use any of the following ways to complete the Appeal Disability Report:

- Call our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free "TTY" number, 1-8**00-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.
- Visit your local Social Security office.
- Print a paper SSA-3368 from the Internet. This form is in Portable Document Format (PDF) and requires Adobe Acrobat Reader to open and print it. If you don't have Adobe Acrobat Reader on your computer you can download it at http://access.adobe.com.
- If you live outside the United States, see Service Around the World.

Header

This Report Is Only for Claimants Age 18 or Older

This Adult Disability and Work History Report is only for disabled adults age 18 or older. There are different disability reports for children under age 18.

Please contact Social Security for assistance in applying for disability benefits for a child:

- 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 your local Social Security office.

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Header

Full Retirement Age Reached

Based on the date of birth you entered, the claimant has reached the "Full Retirement Age" for Social Security benefits on **Month Day, Year,** which is **X** months ago. If a person becomes disabled after reaching "Full Retirement Age" a disability application would not usually be taken. Instead, we would take an application for Social Security retirement benefits or Supplemental Security Income payments for the aged.

There are some exceptions. If you want to know about these exceptions to see if they apply to the claimant or if you want to apply for any other type of benefit for this claimant, please contact us:

- 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 your local Social Security office.

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Header

The Claimant Does Not Live in the United States

This Internet Adult Disability and Work History Report cannot be used for people who live outside of the United States. You or the claimant may need to contact a Social Security representative to make other arrangements to apply for benefits.

To contact Social Security, see our Service Around the World web page.

Select the Exit button to leave this report. You will be taken to the Social Security home page.

Exit

Header

Check the Information You Entered

The information you entered does not match our records.

- If you typed the wrong information, you will need to correct it before continuing.
- If the information is correct, please confirm it by reentering the same information.
- To do either of the above, select the Previous button below.

If you prefer, you can contact Social Security to make other arrangements to complete a Disability Report for this claimant. Be sure to tell the representative that you tried the Internet Disability Report and received this message.

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 your local Social Security office.

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Header

Benefits Denied Fewer Than 60 Days Ago

Since the claimant's prior application was denied within the last 60 days, it may be better to appeal that decision rather than start a new Disability Report.

The claimant has the right to file a new application at any time, but filing a new application is not the same as appealing a decision. If the claimant disagrees with the decision made on his/her prior application and files a new application instead of appealing:

- The claimant might lose some benefits, or not qualify for any benefits, and
- We could deny the new application using the decision on the claimant's prior application, if the facts and issues are the same.

So, if the claimant disagrees with the decision made on his/her prior application, he/she should file an appeal within 60 days.

To appeal you or the claimant can:

- 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 your local Social Security office.

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The Claimant May Not Be Disabled Under Our Rules

We consider the claimant disabled under Social Security rules if, due to a medical or mental condition:

- He/she cannot do work that he/she did before and we decide that he/she cannot adjust to other work because of his/her condition(s), and
- His/her disability is expected to last for at least one year or to result in death.

Unlike other programs, Social Security pays only for total disability. No benefits are payable for partial disability or for short-term disability. Social Security program rules assume that working families have access to other resources to provide support during periods of short-term disabilities, including workers' compensation, insurance, savings, and investments.

More Information

The above explanation of Social Security's definition of disability is written in easy-to-understand language. For more details, read the official definition as written in the Social Security Act. Using this link opens a new window. To return to this page, close the new window.

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Header

Prior Application Denied More Than 60 Days Ago

There are two things the claimant should consider before continuing:

1. If his/her prior application was denied **more than 60 days ago:**

   - He/she needs to fill out a new Adult Disability and Work History Report.
   - Please give us all the information requested even if he/she told us about it before. The forms the claimant gave usbefore may have been sent to permanent storage. By giving all the information on this new report, he/she can speed up the application.

2. If he/she did not appeal the denial within 60 days **and** had a good reason for not filing an appeal within 60 days:

   - It may be better for the claimant to file an appeal of the denial on the prior application.
   - Contact Social Security as explained below. The claimant will be asked to sign a statement about why he/she is filing an appeal late.

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 your local Social Security office.

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Header

Check the Social Security Number You Entered

Our system cannot accept an Internet Adult Disability and Work History Report on the Social Security Number you entered:
743-17-0024

Please check this number:

- If you typed the wrong number, you will need to correct it before continuing.
- If this is the claimant's correct Social Security Number, contact Social Security to make other arrangements to complete a Disability Report.

Be sure to tell the representative that you tried the Internet Disability Report and received this message.

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 your local Social Security office.

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Sign-In Problem

We could not find a match for the Social Security Number and Reentry Number you entered.

Please check the numbers and sign in again. You can retry no more than 3 times for this claimant.

If you can't sign in after 3 tries, the prior record will be locked. You can start an Adult Disability and Work History Report over again for this claimant or call us to help you file the claim. To ensure the claimant's privacy, we cannot access the Reentry 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 Monday through Friday from 7 a.m. to 7 p.m.
- Visit your local Social Security Office.

Reentry Sign In | Start a New Report

Header

There Is a Pending Report for this Social Security Number

Based on the Social Security Number you entered, it appears you or the claimant have already started to complete this report. If the report was started at the web site http://www.socialsecurity.gov/adultdisabilityreport and you wish to continue it, you must return to that web site and use the Reentry Number issued for that report. To continue with the report already started through this web site, select the "Reentry Sign In" button below. If you or the claimant haven't already started an Adult Disability and Work History Report, check the Social Security Number you entered and enter it again using the "Start a New Report" button below.

If you have lost the claimant's Reentry Number, you can start over, but you will lose all of the information you entered before. To ensure the claimant's privacy, we cannot access the Reentry Number.

If you decide to start over, select the "Start a New Report" button below. Starting a new report does NOT extend the time the claimant has to complete a formal application for either Social Security (SS) or Supplemental Security Income (SSI) benefits. The claimant may lose benefits if we do not receive a signed application within 6 months (SS benefits) or 60 days (SSI benefits) from when you or the claimant first started completing an online disability report.

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 your local Social Security office.

Reentry Sign In

Start a New Report

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The Claimant Has Already Sent an Adult Disability and Work History Report

An Adult Disability and Work History Report has already been electronically submitted to Social Security for this claimant. If you or the claimant have new information, you must contact us. We cannot accept additional information over the Internet. Please contact your local Social Security office to:

- Tell us about any changes in the claimant's condition(s) or treatments,
- Report a change of address or contact information
- Report a return to work
- Check on the status of the claim

If the claimant had a prior application that was denied more than 60 days ago and he or she wants to reapply, please contact Social Security.

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 your local Social Security office.

Select the Exit button to leave this report. You will be taken to the Social Security home page.

Exit

Header

Special Message About Claimants Currently Working

When we make a disability decision about a claimant who is still working, we need to consider many things about that person's work situation.

Working While Disabled

1. The first thing we look at is the **amount of money the claimant earns each month.** This amount may change in January of each year. Claimants who are working and earning more than the allowable monthly amount for a given year would not meet Social Security's definition of being totally disabled unless some special situation applies. For claimants who are legally blind, a higher earnings limit applies. Click here to view the allowable monthly amounts for this year. Using this link opens a new window. To return to this page, close the new window.
2. Next we take into consideration any **special work arrangements** that allow the claimant to continue to work in spite of his/her disability. These might include extra help, lower production quotas, time off and others.
3. We also look at **special work expenses** the claimant has because of his/her condition(s). For example, the claimant may have bought a special computer or a specially-equipped van to drive to work.

Working After Recovery from Disability

In some situations it benefits the claimant to apply for Social Security disability if he/she was disabled and unable to work for at least 12 months, but has now recovered and returned to work. If this applies to the claimant, we suggest that you or the claimant contact Social Security to discuss the situation.

If the claimant has already contacted Social Security, or thinks he/she qualifies for benefits based on the information above, you may continue with this report.

If you or the claimant want to discuss his/her case with a Social Security representative first, call our toll-free number, **1-800-772-1213.** For 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.

Continue with Report

Header

Special Message About Claimants Who Never Worked

For your information, there are four types of disability benefits available to people who have never worked. Each type is briefly described below:

Supplemental Security Income (SSI) Payments

SSI provides money for such basic needs as food, clothing, and shelter for aged, blind, and disabled people who have little or no income or resources.

Disabled widow or widower benefits

These benefits are payable to a disabled person whose deceased spouse paid into Social Security. In general, the claimant must:

- Be a widow or widower between age 50 and 65
- Have become disabled before or within 7 years of the date the claimant's husband or wife died.

There are some exceptions to these rules.

Disabled adult child benefits

If the claimant is age 18 or older, he/she may be able to receive benefits on a parent's record if he/she:

- Is not married
- Became disabled before reaching age 22
- Has a parent (either mother or father) who either:
  - ❑ is receiving Social Security benefits or
  - ❑ who worked and paid enough into Social Security before he or she died.

There are some exceptions to these rules.

Medicare

Social Security has a special program for people of all ages who have kidney problems requiring dialysis or a kidney transplant.

For more information, visit the Social Security Administration Disability Programs web site. If you or the claimant have already contacted Social Security, or if you think the claimant fits into one of the categories above, you may continue with this report.

If you want to discuss your case with a Social Security representative first, 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.

Continue with Report

Header

How the Online Adult Disability and Work History Report Works

This report does not have to be completed all at once. After you provide us with your organization details, you will receive a Reentry Number for the specific claimant. You will be able to stop working on the report whenever you want, and then use the Reentry Number to return to the report.

We have Special Instructions for Blind Users. Otherwise the following are tips on how to use the online report:

- When you start a new report, you will have to enter some basic information before we can provide you with access to other parts of the report. During this stage, you can use the "Continue" button to move forward, or the "Previous" button to move backward. Both these buttons are located at the bottom of the page.
- If you Sign Out of the report before completing this basic information, we will return to you the place where you last left off when you return to the report.
- Once you have completed the basic information, you will have access to various sections of the report. To move from section to section in the report, use the Tabs at the top of the page.
- Additional buttons, other than "Done", may appear at the bottom of a page. These buttons allow you to take an action such as deleting a page or moving back and forth through a series of related pages.
- Do NOT use the "Back" button on your browser to move backward.
- IMPORTANT: DO NOT USE THE ENTER KEY TO MOVE AROUND IN THE REPORT OR TO SELECT FROM THE DROP DOWN LISTS.

Time Limits

There are time limits for your work on each page. You will receive a warning after 25 minutes, and you will be able to extend your time on the page. After the third warning on a page, you must move to another page or your time will run out, and your work on that page will be lost. If you have turned JavaScript off in your browser, you will not receive any warnings. If you do not go to another page after 30 minutes, your disability report session will end, and your work on the last page will be lost.

Need More Space

If you run out of space in giving an answer, you can provide it to us on the Remarks page in the Review and Send section at the end of the report. If you have more information to give us than will fit on the report, including the Remarks section, please write the information on a separate sheet of paper and send it to us at the address we will give you after you've completed this online report.

Locked Entries and Changing Answers

On a tabbed page, if you answer the Yes/No question as "Yes" and then enter at least one page of detailed information, the "Yes" answer will be locked. To subsequently change the "Yes" answer to "No", you must first delete the detailed information.

Close this window to return to the report.

Header

Special Instructions for Users Who Are Blind

The following instructions are for users with screen readers, such as JAWS and Window-Eyes, and browser-based readers, such as Home Page Reader.

Filling out these reports is best accomplished in a Forms or MSAA mode that allows the user to tab to controls and fill in input boxes, radio buttons, check boxes, and list boxes. Instructional text usually occurs at the beginning of these screens and can be accessed in non-MSAA or virtual-cursor mode. Tabindices have also been added to allow for tabbing through text.

In addition, help text is available using the Help/FAQ link at the top of each page.

There is a time limit on all pages. Unless you have turned JavaScript off in your browser, you will receive a warning after 25 minutes on a page. The warning includes instructions for extending your time on the page for an additional 30 minutes. After the third warning, you must move to another page, or your time will run out and your work on that page will be lost.

At the end of most screens, there is a continue button to allow the user to go to the next page and a prior page button to return to the previous page. The hotkey ALT + C is associated with the Continue button and ALT + P for the prior page. Press Alt + C or ALT + P and then press Enter to move forward or back.

Close this window to return to the report.

Header

Your Session Has Expired

If you would like to continue completing the Adult Disability and Work History Report for this claimant, you may try again by selecting the Return to Report button below.

Select the Exit button to leave this report. You will be taken to the Social Security home page.

Exit | Return to Report

Header

We Cannot Process Your Request

We have not been able to match the information you entered with our records.
If the information that you provided is correct, then it may be necessary to correct your information with Social Security.
To resolve this problem, please call **1-800-772-1213** or contact your local Social Security office.

Select the Exit button to leave this report. You will be taken to the Social Security home page.

Exit

Header

We Cannot Process Your Request

If you still wish to complete the Adult Disability and Work History Report for this claimant, you may try again later, or call **1-800-772-1213** or contact your local Social Security office.

Select the Exit button to leave this report. You will be taken to the Social Security home page.

Exit

Header

We Cannot Process Your Request

Please try again during business hours.

This service is available during the following hours (Eastern Time):

Monday through Friday: 5:00 AM - 1:00 AM
Saturday: 5:00 AM - 11:00 PM
Sunday: 8:00 AM - 10:00 PM
Holidays: 5:00 AM - 11:00 PM

Select the Exit button to leave this report. You will be taken to the Social Security home page.

Exit

Header

Limit on the Number of Restarts on a Partial Report

You have reached the limit on the number of requests to reenter the Adult Disability and Work History Report you already started for this claimant. You can start a new Adult Disability and Work History Report for this claimant or call us to help you complete this report.

To ensure the claimant's privacy, the prior Adult Disability and Work History Report is now locked. If you start a new Adult Disability and Work History Report for this claimant, you will have to reenter any information that you already entered on the prior one.

To contact Social Security to help file this claim:

- 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 7a.m. to 7p.m.
- Visit your local Social Security office.

Start a New Report | Exit

Header

We Are Processing This Request

Please wait a moment before selecting the Continue button.

Continue

Header

Limit on the Number of New Reports Started

You have reached the limit on the number of requests you can make to start a new Adult Disability and Work History Report for this Social Security Number.

Please contact Social Security to make other arrangements to complete a Disability Report for this claimant. Be sure to tell the representative that you tried the Internet Disability Report and received this message.

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 7a.m. to 7p.m.
- Visit your local Social Security office.

Select the Exit button to leave this report. You will be taken to the Social Security home page.

Exit

Header

Illness Expected to End in Death

You told us that the claimant has been diagnosed with an illness that is expected to end in death. Please contact the claimant's local Social Security office. We may be able to speed processing of the claim. When you contact the office, tell the representative that you are completing an Online Adult Disability and Work History Report for the claimant and received this message.

If the claimant's illness is not expected to end in death, please use the Previous button below to go back and correct the answer.

Previous | Continue with Report

Header

How to Complete the Medical Release Form

1. Read the entire form, front and back. The information on the back explains more about how the form will be used and explains the possible consequences of not signing the form. Additional instructions are also on the form. If you have any questions, please contact us.

2. Be sure the name of the person whose records must be disclosed (the applicant or beneficiary) is written in the upper right corner of the form, with his/her own Social Security Number. SSA will fill in the rest of that block if needed.

3. Do not fill in the large empty box in the middle of the form; SSA will use this space to help the source identify the information we need.

4. Do not put a check in the empty block under "PURPOSE" unless SSA specifically asks you to.

5. INDIVIDUAL SIGN - Sign each form in this block.

- An adult should sign his/her own form.
- An individual can sign with an "X" if necessary.
- If an individual has been declared legally incompetent, his/her legal guardian or legally recognized representative should sign the form.
- If the individual whose information is going to be disclosed is not the one signing the form, be sure to check the box to the right that shows that person's authority to sign (parent, guardian, etc.) and then give proof of that legal relationship to SSA. If the subject of disclosure is a minor, then a custodial parent, guardian or other legally recognized representative should sign the form.
- If the subject of the disclosure is age 12 or older but still considered to be a minor under State law, he or she should sign the form and the parent, guardian or other legally recognized representative should sign in the "Parent/guardian sign" area to the right.

6. ALWAYS enter the DATE the form is signed.

7. Enter the address and daytime phone number of the individual signing the form.

8. WITNESS SIGN - The signature of the individual signing the forms must be witnessed by at least one other individual. Many sources will not honor our request unless it is witnessed.

- The witness can be any competent adult (spouse, social worker, Social Security employee, etc.).
- The witness should sign and provide his or her address information in case the source wants to confirm the signature.
- A second witness is usually only required if the subject of the disclosure signs with an "X".

Close this window to return to the report.

Header

Limit on the Number of Tries to Start the Adult Disability and Work History Report

You have reached the limit on the number of tries to start a Adult Disability and Work History Report for this claimant.

Please contact Social Security to make other arrangements to complete this report.

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 7a.m. to 7p.m.
- Visit your local Social Security office.

Select the Exit button to leave this report. You will be taken to the Social Security home page.

Exit

Header

We Cannot Match the Zip Code You Entered

We are unable to verify this ZIP code. Please check the number you entered and make sure it is correct. If the Post Office recently gave this area a new ZIP code, it may not be on our records yet. In that case, use the prior ZIP code for this address.

Please contact Social Security to make other arrangements to complete a disability report if:

- this is the claimant's correct ZIP code and not a new code recently given to the area by the Post Office, or
- this is a new ZIP code recently given by the Post Office and you or the claimant don't know the prior ZIP code.

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 7a.m. to 7p.m.
- Visit a Social Security office. To find the local Social Security office, close this window and use the link given on the previous page.

To reenter the ZIP code, close this window and type it in again.

Close this window to return to the report.