DISABILITY REPORT - CHILD - Form SSA-3820-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM
THIS IS NOT AN APPLICATION

IF YOU NEED HELP

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

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

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

ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

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

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

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

The Privacy and Paperwork Reduction Acts

See Revised Privacy Act Statement

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

We rarely use the information provided on this form for any purpose other than for the reasons stated above. However, we may use it for administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1) To enable a third party or an agency to assist Social Security in establishing right to Medicare benefits or coverage;

2) To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans Affairs);

3) To make determination for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4) To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Medicare programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

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

See Revised Paperwork Reduction Act

PAPERWORK REDUCTION ACT: This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Form Approved
OMB No. 0960-0577

DISABILITY REPORT - CHILD

SECTION 1 -- INFORMATION ABOUT THE CHILD

A. **CHILD'S NAME** *(First, Middle Initial, Last)*

B. **CHILD'S SOCIAL SECURITY NUMBER**

C. **YOUR NAME** *(If agency, provide name of agency and contact person)*

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

CITY | **STATE** | **ZIP CODE**

YOUR EMAIL ADDRESS (Optional)

D. **YOUR DAYTIME PHONE NUMBER**

(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)

_____ _____ ☐ Your Number ☐ Message Number ☐ None
Area Code *Number*

E. What is **your relationship to the child**? _____

F. Can you **speak and understand English**? ☐ YES ☐ NO

If "NO", what is your preferred language? _____

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

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

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

NAME _____ RELATIONSHIP TO CHILD _____

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

_____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Number*

Can you **read and understand English**? ☐ YES ☐ NO

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

NAME _____ RELATIONSHIP TO CHILD _____

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

_____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Number*

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

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

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

Disability Report - Child - Form SSA-3820-BK

SECTION 1 - INFORMATION ABOUT THE CHILD

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

If "NO," what languages can the child speak? _____

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

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

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

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

☐ YES ☐ NO

If "YES", show the **number** here: _____

SECTION 2 - CONTACT INFORMATION

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

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

NAME _____

ADDRESS _____

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

_____

City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

RELATIONSHIP TO CHILD _____

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

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

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

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

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

NAME OF CONTACT _____

ADDRESS _____

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

_____ _____

City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

RELATIONSHIP TO CHILD _____

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

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

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

SECTION 3 - THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER

A. What are the child's disabling **illnesses, injuries, or conditions**?

B. When did the child become disabled?

Month	*Day*	*Year*

C. Do the child's illnesses, injuries or conditions cause **pain** or other symptoms? ☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

☐ YES ☐ NO

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

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

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

1.

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

2.

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

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3.

NAME		DATES
STREET ADDRESS		FIRST VISIT
CITY STATE ZIP		LAST VISIT
PHONE ____ (Area Code) ____ (Number)	Patient ID # (If known)	NEXT APPOINTMENT
REASONS FOR VISITS		
WHAT TREATMENT WAS RECEIVED?		

If you need more space, use Section 10.

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

1.

HOSPITAL/CLINIC	TYPE OF VISIT	DATES
NAME	☐ INPATIENT STAYS *(Stayed at least overnight)*	DATE IN / DATE OUT
STREET ADDRESS		
CITY ____ STATE ____ ZIP ____ PHONE ____ (Area Code) ____ (Number)	☐ OUTPATIENT VISITS *(Sent home same day)*	DATE FIRST VISIT / DATE LAST VISIT
	☐ EMERGENCY ROOM VISITS	DATES OF VISITS

Next **appointment** _____ The child's hospital/clinic **number** _____

Reasons for visits

What **treatment** did the child receive?

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

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC	TYPE OF VISIT	DATES
NAME	☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN / DATE OUT
STREET ADDRESS		
CITY _____ **STATE** _____ **ZIP** _____	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT / DATE LAST VISIT
PHONE _____ (Area Code) _____ (Number)	☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS

Next **appointment** _____ The child's hospital/clinic **number** _____

Reasons for visits

What **treatment** did the child receive?

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

If you need more space, use Section 10.

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

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME	**DATES**
ADDRESS	**FIRST** VISIT
CITY **STATE** **ZIP**	**LAST** SEEN
PHONE _____ (Area Code) _____ (Number)	NEXT APPOINTMENT

CLAIM NUMBER *(If any)* _____

REASONS FOR VISITS

If you need more space, use Section 10.

SECTION 5 - MEDICATIONS

Does the child currently take any **medications** for illnesses, injuries or conditions? ☐ YES ☐ NO

If "YES", tell us the following: *(Look at the child's medicine containers, if necessary.)*

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

If you need more space, use Section 10.

SECTION 6 - TESTS

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

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

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

SECTION 7 - ADDITIONAL INFORMATION

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

Headstart (Title V)	☐ YES	☐ NO
Public or Community Health Department	☐ YES	☐ NO
Child Welfare or Social Service Agency or WIC	☐ YES	☐ NO
Early Intervention Services	☐ YES	☐ NO
Program for Children with Special Health Care Needs	☐ YES	☐ NO
Mental Health/Mental Retardation Center	☐ YES	☐ NO

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

☐ YES ☐ NO

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

C. 1. NAME OF AGENCY _____

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

_____
City *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

2. NAME OF AGENCY _____

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

_____
City *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

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

SECTION 8 - EDUCATION

A. Is the child currently enrolled in any school? ☐ YES, grade: _____ ☐ NO, too young

☐ NO, other reason (complete B)

B. Other reason the child is not enrolled in school:

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

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

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Has the child been tested for behavioral or learning problems? ☐ YES ☐ NO
If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? ☐ YES ☐ NO

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

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech/language therapy? ☐ YES ☐ NO

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

NAME OF SPEECH/LANGUAGE THERAPIST _____

SECTION 8 - EDUCATION

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

NAME OF SCHOOL _____

ADDRESS _____

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

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems? ☐ YES ☐ NO
If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Was the child in special education? ☐ YES ☐ NO
If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech/language therapy? ☐ YES ☐ NO
If "YES", and different from above, give:

NAME OF SPEECH/LANGUAGE THERAPIST _____

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

E. Is the child attending Daycare/Preschool? ☐ YES ☐ NO
If "YES", complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____

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

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

SECTION 9 - WORK HISTORY

A. Has the child ever worked (including sheltered work)? ☐ YES ☐ NO

If "YES", complete the following:

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____

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

_____

City *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

NAME OF SUPERVISOR _____

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

_____

_____

_____

_____

_____

_____

SECTION 10 - DATE AND REMARKS

Please give the date you filled out this disability report.

Date (MM/DD/YYYY) / /

Use this section for any additional information about your child.

_____

_____

_____

_____

_____

_____

_____

SECTION 10 - REMARKS

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

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631 of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to determine if a child is eligibility for benefit payments.

Furnishing us this information is voluntary. However, failing to provide us with the requested information could prevent us from making an accurate and timely decision on your claim.

We rarely use the information you supply for any purpose other than the reason stated above. However, we may use the information for the efficient administration and integrity of our programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these matching programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of Records Notice entitled Claims Folder System (60-0089). This notice, additional information regarding this form, and information regarding our programs, are available on-line at www.socialsecurity.gov or at your local Social Security office.

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

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