QUESTIONNAIRE FOR CHILDREN CLAIMING SSI BENEFITS

Please print, type, or write clearly and answer all items to the best of your ability. If you need help completing any part of this form, we will help you. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. If you do not know the answer, enter "unknown." If the question does not apply, enter "N/A." If you need more space to answer any of the questions, please use "REMARKS" and enter the number of the question next to your answer.

Child's Full Name	Social Security Number	Date (month, day, year)

Informant's Name	Relationship to Child	Daytime Telephone Number (including Area Code)

1. Is (was) the child cared for by a baby sitter? Does (did) the child attend any type of preschool, daycare and/or after school program? If so, please specify. If more than one of the above, use the "REMARKS" section.

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	**Dates Attended**

2. a. Is (was) the child in school? ☐ Yes ☐ No

If "***yes***," and the school was not listed in Item 12A of the SSA-3820-F6, please show it here. *(If more than one, use the "REMARKS" section.)*

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	**Dates Attended**
Grade Level Completed	**Last Teacher's Name**

2.b. Is the child in a special education program?	☐ Yes ☐ No ☐ Don't Know
c. Does the school make any special accommodations for the child; e.g., adaptive furniture, wheelchair ramps, extra assistance or attention?	☐ Yes ☐ No ☐ Don't Know
If **"yes"** in 2.b. or 2.c., indicate type of program and/or accommodations:	Specify number of hours per week the child is in special education program:
d. Do you have a copy of the child's individual education plan (IEP), the report in which the teacher outlines the child's problems and lists the plans for correcting them? If "***yes***," please provide a copy.	☐ Yes ☐ No
3. Does the child receive any special counseling or tutoring?	
a. In school	☐ Yes ☐ No
b. Outside school	☐ Yes ☐ No

If "***yes***," in 3.a. or 3.b., please indicate: *(If more than one, use the "REMARKS" section.)*

Type of Counseling, Tutoring

Date Began and Ended (If completed)	Frequency of Visits
Counselor's or Tutor's Name	Telephone Number (including Area Code)

Address (Number, Street, City, State, ZIP Code)

4. Does the child or family have a child welfare, social services or early intervention caseworker?	☐ Yes ☐ No

If "***yes***," please provide the following information: *(If more than one, use the "REMARKS" section.)*

Caseworker's Name	Organization
Address (Number, Street, City, State, ZIP Code)	Telephone Number (including Area Code)
File or Record Number	Date First Saw/Last Saw Caseworker

5. Has the child ever been tested or evaluated by any of the following agencies or organizations? If "***yes***," indicate in the space provided below the agency name, address, telephone number, record number, and the type and date of test or evaluation performed *(e.g., vision, hearing, speech, physical).*

a. Public/Community Health Department	☐ Yes ☐ No
b. Child Welfare/Social Services Agency	☐ Yes ☐ No
c. Developmental Evaluation Center	☐ Yes ☐ No
d. Mental Health/Intellectual Disability	☐ Yes ☐ No
e. Special Needs/Crippled Children Agency	☐ Yes ☐ No
f. Speech and Hearing Center	☐ Yes ☐ No
g. Women, Infants and Children (WIC) Program	☐ Yes ☐ No

Use the letter designation *(5a, 5b, etc.)* to identify the agency.

If additional space is needed, use "REMARKS" section.

6. Does (did) the child receive any special therapy (physical, speech and language, occupational), exercises, or any other services for his/her impairments? Include information about any therapy or exercises the parent, guardian or caregiver provides the child.	☐ Yes ☐ No

If **"yes,"** indicate below the therapist's name, the name of the person who PRESCRIBED AND/OR DESIGNED the therapy program, the type(s) and frequency of treatment, when treatment began and ended (if completed), and where treatment was received *(e.g., home, hospital, therapist's office, clinic.)*

Therapist's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

Therapist's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

7. Does (did) the child receive vocational rehabilitation services? ☐ Yes ☐ No

If "***yes***," describe services received below the rehabilitation counselor's information. Include dates and record number.

Rehabilitation Counselor's Name | Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Services received:

(If additional space is needed, use "REMARKS" section.)

NOTE: PROVIDING INFORMATION ABOUT THE CHILD'S INVOLVEMENT WITH THE COURT SYSTEM IS OPTIONAL

8. Has the child ever been involved with the court system other than in custody proceedings? ☐ Yes ☐ No

If "***yes***," please explain involvement, including testing and evaluation.

Youth Development Center's Name

Address (Number, Street, City, State, ZIP Code)

Probation or Parole Officer's Name | Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Involvement including any testing and evaluation:

9. Does (did) the child participate in any community or school activities, such as choir, Special Olympics, Boy's/Girl's Club, Scouts, or sports?

☐ Yes ☐ No

If "yes," describe involvement, amount of time spent in activity, and level of participation. Provide name, address, and telephone number of individual who supervises the activity. Include dates of involvement. If involvement ended, explain why.

10. If the child takes any medication on an ongoing basis, please indicate the following:

MEDICATION DOSAGE/ FREQUENCY	PRESCRIBED BY (NAME)	REASON FOR MEDICATION	DESCRIBE ANY SIDE EFFECTS

How well does the medication(s) work? Please explain:

11 a. If you are unable to give us information we need about the child, is there someone else who helps care for the child and, knows of the child's impairment who can help us get the information we need, and, if necessary, bring the child to a consultative examination?

☐ Yes ☐ No

b. If "yes," please provide the following information about this person

Name

Address (Number, Street, City, State, ZIP Code)

Daytime telephone number (including Area Code)

Relationship *(e.g., relative, neighbor, family friend)* to the child?

REMARKS:

REMARKS (continued):

Privacy Act Statement
Questionnaire for Children Claiming SSI Benefits

Sections 223 and 1632 of the Social Security Act, as amended, allows us to collect the information requested on this questionnaire. The information you provide will be used in making a decision on your claim. The information you furnish on this form is voluntary. However, failure to provide the requested information could prevent an accurate and timely decision on your claim and could result in the loss of benefits.

See Revised Privacy Act Statement

We rarely use the information provided on this form for any purpose other than [redacted], we may use it for the administration and integrity of Social Security programs. We [redacted]ided on this form in accordance with approved routine uses of the Privacy Act (445 U.S.C.§ 552a), which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veteran's Affairs); and,
4. To facilitate statistical research audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching 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.

A complete list of routine uses for this information is available in Systems of Records Notice entitled, Claims Folder System, 60-0089; Supplemental Security Income Record and Special Veterans Benefits, 60-0103; and Electronic Disability (eDIB) Claim File, 60-0320. These notices, additional in[redacted]rmation regarding our programs and systems, are available on-line at www.socialse[redacted]ity Office.

See Revised PRA

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***