SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0646

REQUESTING OFFICE NAME AND ADDRESS	ATTACH LABEL OR TYPE IN CLAIMANT NAME

REQUEST FOR ADMINISTRATIVE INFORMATION
Please ask the person(s) most familiar with the child's records to complete this form.
Continue any answers as needed on next page.

Name of School

1. Has there been any recent evaluation or testing of this child? If yes, kind(s) of test/evaluation: | **Date(s):**

Please send us copies of all comprehensive evaluations, triennial assessments, psychological or speech/language testing, current Individualized Education Programs, teacher/therapist progress reports, and all other records that can help us evaluate the child's functioning.

2. Has the child been referred for assessment team evaluation or special class placement or services? If yes, to whom? | **Date(s):**

3.	**Current Instructional Levels**	**Standardized Assessment Instrument**	**Score/Percentile Rank**	**Date(s):**
	Reading Level:			
	Math Level:			
	Written Language Level:			

4. Grade(s) repeated, if any:

K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐

5. Educational Disabilities, if any:

- ☐ ~~Mental Retardation/Mentally Impaired/Intellectually Limited~~ *Replace with: Intellectual Disability*
- ☐ Hearing Impairment/Deafness
- ☐ Speech or Language Impairment
- ☐ Visual Impairment/Blindness
- ☐ Emotional Disturbance/Behavior Disorder
- ☐ Orthopedic Impairment
- ☐ Autism
- ☐ Traumatic Brain Injury
- ☐ Other Health Impairment (please specify) _____
- ☐ Specific Learning Disability (please specify) _____
- ☐ Developmental Delay (please specify) _____
- ☐ Multiple Disabilities (please specify)

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

- ☐ Regular Education, no special instruction
- ☐ Special Ed. Instruction: **Hours/week:**
  - ☐ Inclusion - Sp. instr. in regular class _____
  - ☐ Resource Room _____
  - ☐ Self-contained, regular school _____
  - ☐ Self-contained, special school _____
  - ☐ Special school, non-public _____
  - ☐ Residential _____

Therapies, etc: **Hours/week:**

- ☐ Occupational Therapy _____
- ☐ Physical Therapy _____
- ☐ Speech - Language Therapy _____
- ☐ Counselling (please specify) _____ _____
- ☐ Other (please specify) _____ _____

PLEASE PROVIDE YOUR NAME AND TITLE ON NEXT PAGE

The Privacy and Paperwork Reduction Acts

Sections 202 and 223(a) and (d), and Sections 221, 1614, and 1633 of the Social Security Act, as amended, and 20 CFR 404.1513 and 416.924a (a), authorize us to collect this information. We will use the information you provide to make a decision on the named claimant's claim.

Furnishing us the information is voluntary. However, failing to provide all or part of the requested information may prevent our making an accurate and timely decision on the claim.

We rarely use the information you supply for any purpose other than to make a decision regarding a claimant's disability. However, we may use it for the administration and integrity of our programs. We may also disclose the information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing a person's rights to our benefits and 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, and investigatory activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to 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 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 of this information is available in our Privacy Act System of Records Notice 60-0089, entitled, Claims Folders Systems. Additional information about this and other system of records notices is available on-line at www.socialsecurity.gov, or at your local Social Security office.

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 40 minutes to read the instructions, gather the facts, and answer the questions. If you have questions about how to complete the form, contact the Requesting Office; see page 1, upper left corner, for the name, address, and phone number of the Requesting Office. If you need the address or phone number for the Requesting Office, you can get it by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778). SEND THE COMPLETED FORM TO THE REQUESTING OFFICE. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.