Internet

Adult Disability and Work History Report

Should You Complete This Report?

Not everyone will be able to complete an Adult Disability and Work History Report online. You must answer all of the following questions to help determine if you should use this Internet Report or if it would be better for you to speak with a Social Security representative first. 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 approval number for the Internet Adult Disability and Work History Report is 0960-0579; expiration date 1/31/2008.

General Information:

What is your Social Security number?

Please enter your Social Security Number with no dashes.

What is your date of birth?

Do you live in the United States or its territories or possessions? Yes No

Any Prior Applications:

Have you previously been denied for Social Security or SSI disability benefits?

- Yes, more than 60 days ago
- Yes, less than 60 days ago
- No

Preferred Language:

Can you speak Yes No, I prefer this language:

and understand English?

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

Can you write more than your name in English?	**Yes**	**No**
Can you read and understand English?	**Yes**	**No**

Your Condition:

Does your condition keep you from working or seriously limit your ability to work?	**Yes**	**No**

Will you be unable to work because of your condition for at least a year?

Yes
No
I am not sure

Have you been diagnosed with a condition that is expected to end in death?

Yes
No
I am not sure

Are you working now?

Yes
No, not any more
I never worked

Continue

Sign Off

Name: **John Public**
SSN: **743-17-2230**

About You: Your Illnesses, Injuries, or Conditions

Please tell us about all of your illnesses, injuries, or conditions (referred to from here on as conditions) that limit your ability to work:

- If you have more than one condition, list and describe each of them.
- Use your own words if you do not know the medical names.
- Include all physical, mental, or emotional conditions, including any major complications resulting from your condition.
- We will consider these conditions whether or not you have been receiving treatment.

After you leave this page, the information you entered will be locked. If you need to correct the information you gave us, you will be able to make changes on following pages where we ask you for more details. Or, you can make changes from the summary page at the end of each section, or at the end of this report.

You must answer all of the questions on this page before you can continue. We will ask you for more information about these conditions later.

List ALL the conditions that limit your ability to work.

Examples: Back injury, Arthritis, Diabetes, Glaucoma, Depression, Blind

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

When did any of the above first interfere with your

ability to work?

Enter the closest date you can remember. Examples: June 2001; 6/2/01; June 2, 2001; Dec 2, 2001; at birth; summer 2001; 6/??/02; etc.

Do any of the above ever cause you pain or other symptoms? **Yes** **No**

We will ask more about this on the next page.

Treatments You Have Received

We will ask you for more information about your treatments later.

Have you gone to a doctor, HMO, therapist, hospital, clinic, or anyone else for the conditions you listed above? **Yes** **No**

Have you had any medical tests, or do you have any tests scheduled for the conditions you listed above? **Yes** **No**

Do you currently take any prescription medicines for the conditions you listed above? **Yes** **No**

Do you currently take any "over the counter" medicines or herbal remedies **Yes** **No**

for the conditions you listed above?

Have you gone to a doctor, HMO, therapist, hospital, clinic, or anyone else for mental or emotional problems that limit your daily activities?	**Yes**	**No**

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Sign Off | About You | Medical History | Review and Send

Name: John Public
SSN: 743-17-2230

Work/Education: When and Why You Stopped Work

You told us that you **worked in the past, but are not working now.**

If this is not correct, please Change Your Answer

We need to know more about your reasons for stopping work, and whether you made any changes in your work as a result of your condition.

When was the last day you worked?

If you don't know the exact date, give us the closest date you can remember.

Why did you stop working?

Because of my condition

Because of my condition AND other reasons

Example:
I'm a teacher and school was over for the year. By the end of the summer I was too sick to go back to work.

Because of other reasons

Example:
I stopped work to raise my children.
I sold my business and retired.

Did you work any time after the date your condition first interfered with your ability to work?

Yes **No**

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Contact SSA | How to Move Around This Report

Sign Off About You Work/Education Review and Submit

Name: **John Public**
SSN: **743-17-3230**

See revision

Medical History: About Your Medical Records at Vocational Rehabilitation

Information from Vocational Rehabilitation helps us understand your condition more fully. Please give as much information as you can so we can contact the correct organization. If you cannot find the complete address, fill in whatever information you can that might help us find your records. We need to know the dates of your visits and a description of any tests and/or services you were given so we can ask for the exact information we need.

Name of Counselor or Instructor:

(First, Last)

Vocational Rehabilitation Organization: Agency or School Name:

If you don't know the exact name, tell us as closely as you remember.

Example: Maryland State Vocational Service

Address:

If you don't have the full street address, give us as much as you can, and be sure to include the city and state. Please do NOT use punctuation marks; for example, no periods or commas.

Example: "On Main St next to the Courthouse"

(Street Address 1)

(Street Address 2)

(Street Address 3)

Medical History: About Your Vocational Rehabilitation, Employment, Other Support Services Information, or Individualized Education Program

Information from plans or programs you have participated or are participating in helps us understand your condition more fully. We need to know whether you have participated or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support;
- an individualized education program through an educational institution (if a student age 18-21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work.

Please give as much information as you can so we can contact the correct organization or school. If you cannot find the complete address, fill in whatever information you can that might help us find your records. We need to know the dates of your visits and a description of any tests and/or services you were given so we can ask for the exact information we need.

(City, State, ZIP)

Phone Number: ( ) -

Extension:

Be sure to give us the area code.

Example: (999) 999-9999

When did you first visit?

Please give us the closest date you can remember.

Examples:
June 2001; 6/2/01; June 2, 2001; Dec 2, 2001; summer 2001; 6/??/02, etc.

When did you last visit?

Please give us the closest date you can remember.

Examples:
June 2001; 6/2/01; June 2, 2001; Dec 2, 2001; summer 2001; 6/??/02, etc.

Types of Services, or Tests, or Evaluations Performed:

Examples: IQ tests, vision tests, hearing tests, or workshops, or classes.

1000 characters maximum.
This 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

a plan or program

I had Vocational rehab at more than one organization

Delete this Rehab Previous Page **Continue**

Contact SSA | How to Move Around This Report

Sign Off | **About You** | **Medical History** | **Work/Education**

Name: **John Public**
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Review and Send: Additional Remarks About Your Case

Before you send this report, do you have any additional comments or information about your condition(s) that you think we should know when reviewing your case? If so, please describe them here.

If you checked a box anywhere on this report to show that you had more information than the space allowed (for example, "Check here if you have more hospitals or clinics than this. List any additional hospitals or clinics in the Remarks section of this report."), you may give us that information here.

If you do not have enough room to enter all the information you want to give us, please write the information on a separate sheet of paper and send it to us at the address we will give you.

Enter Your Remarks:

3000 Characters Maximum. This is about 60 lines of typing.

Count Characters You have entered 0 characters

Information About the Person Completing this Report:

I completed this report for myself the disabled
I completed this report for another person

the disabled

If you completed this report for another person, provide the information requested below. Skip this part if you completed the report for yourself. and you are not the person identified on the screen "About You: Someone Else We Can Contact About Your Illnesses, Injuries, or Conditions,"

Name of person completing this report:

(First, Middle Initial, Last)

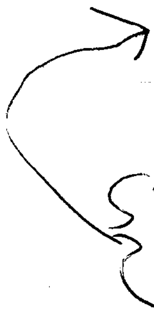
Address:

(Street Address 1)

(Street Address 2)

(City, State, ZIP)

Email Address (Optional):



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Contact SSA | How to Move Around This Report

Relationship to Disabled Person ________

Daytime Telephone Number ________