Social Security Administration

Retirement, Survivors, and Disability Insurance

Important Information

•

Date:

Claim Number: _ _

Phone:

We are writing to you because we need to know more about your work.

The enclosed pamphlet, "Working While Disabled ... How Social Security Can Help", will tell you more about why we need to know about your work.

What You Need To Do

The enclosed form asks for facts we need to know. Please sign, date, and return the completed form within 15 days. We have enclosed an envelope for you to use.

If You Have Any Questions

If you have any questions, please let us know. You may also call, write, or visit any Social Security office. If you do contact an office, please have this letter with you. It will help us answer your questions.

Enclosure:
SSA Pub. No. 05-10095
Pre-addressed Envelope

Form Approved
OMB No. 0960-0059

WORK ACTIVITY REPORT — EMPLOYEE

IDENTIFICATION - TO BE COMPLETED BY SSA

Name of Claimant or Beneficiary	Claimant or Beneficiary's SSN	☐ Blind ☐ Not Blind
	- -	

Name of Wage Earner (if different from Claimant or Beneficiary)	Wage Earner's SSN
	- -

Claimant or Beneficiary is Receiving:

☐ Social Security Disability Insurance (SSDI) Benefits

☐ Both SSDI and SSI Disability Benefits

☐ Supplemental Security Income (SSI) Disability Benefits

☐ Neither SSDI or SSI Disability Benefits

PART I - TO BE COMPLETED BY SSA

1. Please use this form to tell us about your work since → Date

2. We need to know this information because:

ANSWER THE QUESTIONS ON THIS FORM AND RETURN IT AND ANY OTHER INFORMATION ABOUT YOUR CLAIM TO THE SOCIAL SECURITY OFFICE THAT GAVE (OR SENT) YOU THE FORM.

PART II - TO BE COMPLETED BY PERSONS APPLYING FOR OR RECEIVING BENEFITS

You should answer each of the questions below as best and with as many details as you can. This information will help us decide if you should get or keep getting benefits. For any question below, if you need more space, use item 9, on pages 5 and 6. Remember to write the number of the question that you are answering in item 9.

1. HAVE YOU WORKED SINCE THE DATE SHOWN IN ITEM 1 OF PART 1, ABOVE?

☐ YES If you did work, go to item 3 and answer the rest of the questions and sign and date the form.

☐ NO If you did not work, but earnings were reported for you as shown in item 2 of Part I above, go to item 2 below.

2. REPORTED WORK OR EARNINGS

If you did not work, but earnings were reported for you as shown in Item 2 of Part 1, explain what the pay was for.

For example, sometimes pay is sick pay, vacation pay or holiday pay that you earned, or for work that you did before becoming unable to work because of your condition.

If you can't explain the earnings reported for you or you don't remember what the total earnings are for, ask your employer(s). If your employer(s) cannot help you, ask your local Social Security Office to help you.

Explanation of Earnings:

If you need more space, use Item 9. Then go to Items 8 and 10.

3. TELL US ABOUT YOUR WORK SINCE THE DATE IN ITEM 1 OF PART 1 ABOVE.
(If you are not sure about some things, ask your employer to help you. If you need more space, use Item 9, on pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)

A.

Employer's Name		Employer's Address (Include street, city, state, & ZIP)	
Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Job Title	Number of Hours (on average) Worked _____ ☐ Per Day ☐ Per Week	Supervisor's Name	Supervisor's Telephone Number *(Include area code)*

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (e.g., You were a plumber and changed to lighter work.) because:

☐ of my medical condition.

☐ special conditions at work related to my medical condition that allowed me to work were removed.

☐ I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

B.

Prior Employer's Name		Employer's Address (Include street, city, state, & ZIP)	
Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Job Title	Number of Hours (on average) Worked _____ ☐ Per Day ☐ Per Week	Supervisor's Name	Supervisor's Telephone Number *(Include area code)*

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (e.g., You were a plumber and changed to lighter work.) because:

☐ of my medical condition.

☐ special conditions at work related to my medical condition that allowed me to work were removed.

☐ I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

C.

Prior Employer's Name		Employer's Address (Include street, city, state, & ZIP)	
Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Job Title	Number of Hours (on average) Worked _____ ☐ Per Day ☐ Per Week	Supervisor's Name	Supervisor's Telephone Number *(Include area code)*

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (e.g., You were a plumber and changed to lighter work.) because:

☐ of my medical condition.

☐ special conditions at work related to my medical condition that allowed me to work were removed.

☐ I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

4. Since the date you started working on or after the date shown in Item 1 of Part 1, above, have there been any months during which you earned over $200 per month through 12/2000 or over $530 beginning 01/2001(before anything was withheld; e.g., taxes)?

☐ No (Go to Item 5.)

☐ Yes (Tell us which month and year and the amount you earned that month in the chart below. If you need more space, use Item 9, on pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)

MONTH/YEAR	AMOUNT	MONTH/YEAR	AMOUNT	MONTH/YEAR	AMOUNT
	$		$		$
	$		$		$
	$		$		$
	$		$		$

5. SPECIAL WORK CONDITIONS - Do (Did) you get special help on-the-job or extra pay in any of the jobs that you told us about in Item 3?

☐ No (Go to Item 6.)

☐ Yes Check all of the boxes that are true for you and tell us for which job(s) you received that help and tell us about any other special condition(s) or help that you got on a job.

☐ I needed and got special help from other workers in doing my job.

☐ I was given special equipment or was given work that was suited to my condition.

☐ I was allowed to work at a lower standard of productivity.

☐ I worked for a relative or friend.

☐ I was given a job based on my past services to an employer.

☐ I worked irregular hours or took frequent rest periods.

☐ I worked in a sheltered work center.

☐ I was hired through a special program for training or therapy (e.g., vocational rehabilitation, supported employment).

5. SPECIAL WORK CONDITIONS - Continued

Check all of the boxes that are true for you and tell us for which job(s) you received that help and tell us about any other special condition(s) or help that you got on a job.

My job duties were different than other workers' job duties doing the same work because:

- ☐ I worked fewer hours.
- ☐ I got different pay.
- ☐ I had different duties; fewer or easier duties.
- ☐ I had extra help, extra supervision, or a job coach.
- ☐ I was given special transportation to and from work.
- ☐ I got special help getting ready for work.
- ☐ I was paid for extra rest periods at work or extra time off from work and other workers were not.
- ☐ Other special help. (Explain below.)

In the space below, tell us for which job(s) you received the special help. If you need more space, use Item 9.

6. OTHER/SPECIAL PAYMENTS - Do (Did) you get any payment(s) from an employer in addition to regular pay? For example, did you get any tips, bonuses, sick or disability pay, vacation pay, meals, room or rent, transportation or use of a car or vehicle, or childcare?

- ☐ No Go to Item 7.
- ☐ Yes Tell us below what these payments were. If you need more space, use Item 9.

EMPLOYER	TYPE OF PAYMENT	AMOUNT OR ESTIMATE OF THE DOLLAR VALUE	MONTH & YEAR
		$	
		$	
		$	
		$	
		$	

7. SPECIAL WORK EXPENSES (IMPAIRMENT-RELATED WORK EXPENSES) - Do (Did) you spend any money of your own earnings for any things or services related to your condition that allowed you to work and for which you did not get paid back?

For example, medicines, bandages, braces, wheelchair, artificial arm or leg, braille equipment, special telephone or computer equipment, modifications to home (wider doorways, roll-in shower, ramps, wheelchair-lift), or modifications to a car (automatic wheelchair-lift), personal assistance (personal care attendant).

- ☐ No Go to Item 8.
- ☐ Yes Tell us below about the bills, or part of the bills, that you paid for things or services related to your medical condition that you needed in order to work. (Upon review, you may be required to provide proof of these expenses.) Do not show any bills or amounts paid by an insurance company or any other organization or person or paid back to you by an insurance company or other organization or person. (Example: An insurance company might pay all or part of the bill at a later time.)

7. SPECIAL WORK EXPENSES (IMPAIRMENT-RELATED WORK EXPENSES) - Continued

ITEM OR SERVICE	COST	DATE(S) PAID (MONTH & YEAR)
	$	
	$	
	$	
	$	
	$	
	$	
SPECIAL TRANSPORTATION	COST	
MODIFIED VEHICLE	$	
TAXI-TYPE SERVICE	$	

8. VOCATIONAL REHABILITATION - Are (Were) you getting any help from a vocational rehabilitation or employment services provider to get the services and/or training you need to get ready to start working, find work or keep working?

☐ No If you answered no, would you like to get these services? ☐ Yes ☐ No Go to Item 10.

☐ Yes Tell us the name and address of the people who are (were) giving you vocational rehabilitation or employment services and training.

Vocational Rehabilitation/Employment Services Provider

Name	Address (Include street, city, state & ZIP)
Counselor's Name	Counselor's Telephone Number *(Include area code)*

If you need more space, go to Item 9, below .

9. More Space. For any question above, if you need more space, use space below. Remember to write the number of the question that you are answering before you begin.

9. More Space - Continued. For any question above, if you need more space, use space below. Remember to write the number of the question that you are answering before you begin.

10. I authorize any employer, agency or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits any information about my medical condition or my work.

SIGN AND DATE THIS FORM

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of Claimant, Beneficiary, or Representative	Date	Telephone Number (Include area code & e-mail address)

Mailing Address (Number and Street)

City and State	ZIP Code	County
	-	

Witnesses must sign ONLY if this statement is signed by mark (e.g., X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, city, state, and ZIP code)	Address (Number and street, city, state, and ZIP code)
Telephone Number (Include area code)	Telephone Number (Include area code)

Sections 205(a), 223(d), 1612, 1613 and 1633(a) of the Social Security Act, as amended, authorize us to collect this information. The information is needed to make a determination on your claim. The information you furnish on this form is voluntary. However, failure to provide all or part of the information could prevent an accurate and timely decision on your benefit eligibility.

We rarely use the information you supply for any purpose other than for making a determination on your disability claim. However, we may use it for the 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: (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 comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; (4) to State agencies or other agencies providing services to disabled children; (5) to contractors for the purpose of assisting SSA in the administration of the Ticket to Work and Self Sufficiency Program; and (6) 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 and 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 System of Records Notice 60-0050, 60-0089, 60-0295, 60-0320. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.ssa.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 45 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213 TTY# (TTY 1-800-325-0778).** Send **only** comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

FOR SSA USE ONLY - DO NOT WRITE ON THIS PAGE

11. A. Contact made:

☐ In Person ☐ By Mail ☐ By Telephone ☐ Other _____

B. Completed by:

☐ Claimant ☐ SSA Representative ☐ Other _____

If "Other," show:

Name	Address	Telephone Number
		Relationship

12. Interviewer/Reviewer Checklist. SSA interviewers and reviewers should check all items that apply and discuss all "YES" or "NO" answers below, except for reminder items or when a final determination is prepared.

A. Work within waiting period or within 12 months of onset (SGA denial or reopening/revision to denial applies)	☐ YES	☐ NO
B. MIE diary involved - DDS referral needed	☐ YES	☐ NO
C. Title II TWP determination	☐ YES	☐ NO
D. Special considerations, situations, assistance (Subsidy - specific or nonspecific)	☐ YES	☐ NO
E. IRWE	☐ YES	☐ NO
F. SGA (after applicable subsidy /IRWE deduction (s))	☐ YES	☐ NO
G. UWA (initial claim - DDS jurisdiction. FO has documented significant break in work and made UWA recommendation to DDS for a final determination)	☐ YES	☐ NO
H. UWA (Continuing disability review - FO jurisdiction)	☐ YES	☐ NO
I. EPE impairment severity issue - DDS referral needed (reminder item)	☐ YES	☐ NO
J. EPE reinstatement/suspension/termination	☐ YES	☐ NO
K. Due process required	☐ YES	☐ NO
L. Concurrent Title II & Title XVI Income & Resources or 1619 action needed	☐ YES	☐ NO
M. Other issue(s)/comment(s) not noted above	☐ YES	☐ NO

Discussion:

13. Signature and title of SSA interviewer/reviewer	14. FO/PSC code	15. Telephone Number	16. Date