REPORT OF ADULT FUNCTIONING - EMPLOYER
SSA-3385-BK

Answers for Employers about this Questionnaire

~~One of your former employees~~ has filed a claim for Social Security Disability Insurance Benefits (DIB) or for Supplemental Security Income (SSI) payments based on disability. We need information from you to help us make our decision. ~~If you cannot give us all the information we need, we may try, with your permission, to get it from your employer.~~ Please ask the individual's direct supervisor or another person having direct knowledge of the former employee's job performance to complete this questionnaire.

Q. Why do you need information from me?

A. The information you provide about this individual's day-to-day functioning in the work setting is important because it will help us determine the effects of the person's impairment on his or her disability status. We need this information from you even if he or she worked for you for only a short time. The information is not the only evidence we will be considering when we decide if this person qualifies for disability benefits, but it is very important to us. We also use evidence from both medical and other non-medical sources to determine whether a person is disabled according to the Social Security Act. Medical sources include doctors and other health care professionals; non-medical sources include employers like yourself and other people who spend time with and know the person well.

Q. I have a personal opinion as to whether the individual is disabled. Should I complete this form?

A. Yes. We are responsible for determining whether this person is disabled under the Social Security Act, and we will make our decision based on all of the medical and other information we receive. Your observations will give us information on the individual's daily function in an employment setting and help constitute an endorsement of our decision.

DO NOT ASK THE INDIVIDUAL TO ANSWER THESE QUESTIONS

- Print or type your responses.
- Please respond to all of the items in Sections ~~A and B~~. If you do not know the answer, please enter "do not know".
- The items in Section ~~B~~ include questions intended to help you understand the information we are requesting. Please respond to the questions and include any additional information you think would be helpful to us.
- If you need more space to answer questions, use the "REMARKS" section on Page 4, and include the number of the Questionnaire item to which you are responding.
- Sign the form and provide your contact information.

We appreciate your cooperation, time, and effort in completing the questionnaire.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(a) and (d), and 1631 of the Social Security Act, as amended, and 20 CFR 404.1512, 416.912, and 416.924a, allow us to collect this information. We will use the information you provide to determine eligibility for disability benefits.

Furnishing us this information is voluntary; however, failing to provide us with all or part of the information may prevent us from making an accurate and timely decision on eligibility, or could result in the loss of benefits.

We rarely use the information you supply for any purpose other than what we state above; however, we may use the information for the administration of our programs including sharing information:

1. 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); and,

2. To facilitate statistical research, audit, or investigative 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).

A complete list of when we may share your information with others, called routine uses, 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 and our programs is available from our Internet website at www.socialsecurity.gov, or at your local Social Security office.

We may share the information you provide to other agencies through 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.

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 (OMB) control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. If you have questions about how to complete the form, contact 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 1-800 328-0778). 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

REPORT OF ADULT FUNCTIONING - EMPLOYER

SECTION A - CASE IDENTIFICATION INFORMATION

Name:

Case ID:	SSA Bar Code

SECTION B - EMPLOYMENT INFORMATION

Refer to the above identified individual when responding to the questions in sections B, C, and D.

1. EMPLOYER (company name and address)

Individual's dates of employment:

a. Start Date:	b. End Date:

3. On average, how many hours per week did the individual work?

4. If the individual is no longer working for the company, why did he or she stop working?

5. List the individual's job title(s)

6. Describe his/her job duties.

SECTION C - INFORMATION ABOUT INDIVIDUAL'S FUNCTIONING

We need to know how independently, appropriately, and effectively the individual was able to function on the job; the quality of his/her work; and whether he/she was able to sustain work activity according to the requirements of the position.

7. Describe the individual's ability to perform the required job duties. Did you provide any special help or supervision? If so, please describe it, why it was needed, and how often it occurred.

8. Describe the individual's ability to understand, remember, and apply information related to job duties. Did he/she need an extra level of instruction, repetition, or correction?

9. Describe the individual's ability to meet quality and production standards. Did you modify expectations/requirements regarding quality, quantity or timeliness of work/work product to accommodate this individual.

10. Describe the individual's behavior in the work setting. Did the individual handle stress, deal with changes in the work procedures, work schedule or work place, and manage his/her emotional expression, behavior, and self-care adequately and appropriately?

11.Describe the individual's ability to maintain attendance and punctuality.

12. Describe the individual's ability to interact with others. Did the individual cooperate with you and co-workers~~; respond appropriately~~

SECTION D- REMARKS

Please use this section to provide any additional comments or information. Thank you.

SECTION E- COMPLETE INFORMATION AND SIGNATURE

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

13. YOUR NAME (person completing the form)	14. YOUR TITLE (job title)

15. YOUR SIGNATURE (required)

16. YOUR DAYTIME TELEPHONE NUMBER (Include Area Code)