

Function Report - Child Age 1 to 3rd Birthday

Filling Out The Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

The information that you give us on this form will be used by the office that makes the disability decision on the child's claim. You can help them by completing as much of the form as you can.

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

**PLEASE REMOVE THIS SHEET BEFORE
RETURNING THE COMPLETED FORM.**

~~Privacy Act Statement~~

See Revised Privacy Act
Statement Attached

~~Collection and Use of Personal Information~~

~~Sections 205(a), 223(d), and 1631(e)(1), of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on behalf of the minor child to determine his or her benefit eligibility.~~

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

~~We rarely use the information for any purpose other than for making a decision regarding entitlements to benefits. 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 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 assure 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 and administered benefit programs and for repayment of incorrect payment's or delinquent debts under these programs.~~

~~A complete list of routine uses of this information is available in our Privacy Act System of Records Notices entitled, Claims Folders Systems, 60-0089. Additional information about this and other system of records notices and our programs are 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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is 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 Boulevard, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

FUNCTION REPORT - CHILD AGE 1 TO 3rd BIRTHDAY

SECTION 1 - IDENTIFYING INFORMATION

1. A. Print **NAME OF CHILD:**

FIRST

MIDDLE

LAST

B. Child's **SOCIAL SECURITY NUMBER:**

C. Child's **DATE OF BIRTH:**

Month/Day/Year

D. PERSON COMPLETING FORM

NAME:

RELATIONSHIP TO CHILD:

DATE FORM COMPLETED:

Month/Day/Year

DAYTIME TELEPHONE NUMBER *(including Area Code)* :

MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)* :

CITY

STATE

ZIP CODE

SECTION 2 - FUNCTION DETAILS

<p>2. A. Does the child have problems seeing?</p> <p><input type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.B.)</p>	<p>If " yes," please mark <u>every</u> statement below that is <u>generally</u> true about the child:</p> <p><input type="checkbox"/> Child uses glasses or contact lenses. If the child has problems seeing even with glasses or contact lenses, please explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Child cannot be fitted for glasses or contact lenses. Explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Child has other seeing problems. If so, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>B. Does the child have problems hearing?</p> <p><input type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.C.)</p>	<p>If " yes," please mark <u>every</u> statement below that is <u>generally</u> true about the child:</p> <p><input type="checkbox"/> Child uses hearing aid(s). If the child has problems hearing even with a hearing aid(s) OR has trouble using a hearing aid, please explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Child cannot be fitted for hearing aid(s)</p> <p><input type="checkbox"/> Child has other hearing problems. If so, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Child uses American Sign Language</p> <p><input type="checkbox"/> Child reads lips</p>

2. C. Is the child totally unable to talk?

YES (Go to 2.D.)

NO (Continue)

Does the child have problems talking (for example, saying simple words)?

Yes (answer questions below)

No (continue to question 2.D.)

If " **yes** ," please mark every statement below that is generally true about the child:

Says simple words like "he," "bottle," "doggy"

Uses two-word phrases, such as "mommy go" or "push toy"

Uses short sentences of 4 or more words, such as "Can I go out?"

Has a vocabulary of at least 50 words

For each of the two statements below, mark the block that best describes the child, and then describe any other speech problems:

The child's speech can be understood by people who know the child well:

Most of the time, or

Some of the time, or

Hardly ever

The child's speech can be understood by people who don't know the child well:

Most of the time, or

Some of the time, or

Hardly ever

If the child has other problems talking, please explain:

2. E. Are the child's physical abilities limited?

YES (Continue)

NO (Go to 2.F.)

NOT SURE (Continue)

If "yes," or "not sure," please tell us what the child does or can do by checking "yes" or "no" for each of the following. Check "yes" if it is something the child used to do but doesn't do any more just because he or she is older. For example, if the child used to stand with help, and can now stand without help, check "yes" for both.

- Yes No Crawl
- Yes No Stand with help
- Yes No Stand without help
- Yes No Walk holding on to someone or something
- Yes No Walk without holding on
- Yes No Climb onto furniture
- Yes No Throw a ball or other object
- Yes No Dance or jump up and down
- Yes No Walk up and down steps by self
- Yes No Run, but may fall down sometimes
- Yes No Run without falling
- Yes No Stack small blocks 2 high
- Yes No Stack small blocks 4 high
- Yes No Stack small blocks 6 high
- Yes No Push and pull small toys
- Yes No Scribble with a crayon or pencil
- Yes No Hold crayon or pencil with thumb and fingers, not fist

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's physical abilities:

2. F. Does the child's impairment(s) affect his or her behavior with other people?

YES (Continue)

NO (Go to 2.G.)

NOT SURE (Continue)

If " **yes**," or " **not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

Yes **No** Is affectionate towards parents

Yes **No** Says "no" a lot

Yes **No** Plays next to other children but not with them

Yes **No** Plays "catch" or other simple games with other children

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's behavior around other people:

G. Is the child's ability to help take care of his or her personal needs limited?

YES (Continue)

NO (Go to 2.H.)

NOT SURE (Continue)

If " **yes**," or " **not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

Yes **No** Cooperates in getting dressed

Yes **No** Cooperates in brushing teeth

Yes **No** Drinks from a cup or glass without help

Yes **No** Feeds self with spoon

Yes **No** Can undress by self

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to take care of his or her personal needs:

H. Please tell us anything else about the child that you think we should know.
