

Function Report - Child Age 6 to 12th 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 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, 1338 Annex Building, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

**FUNCTION REPORT - CHILD
AGE 6 TO 12th 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><input type="checkbox"/> Child cannot be fitted for glasses or contact lenses. Explain:</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>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><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><input type="checkbox"/> Child uses American Sign Language.</p> <p><input type="checkbox"/> Child reads lips.</p>

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

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 Has friends his or her own age

Yes No Can make new friends

Yes No Generally gets along with you or other adults

Yes No Generally gets along with school teachers

Yes No Plays team sports (for example, baseball, basketball, soccer)

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

Horizontal lines for providing an explanation.

2. H. Does the child's impairment(s) affect his or her ability to help himself or herself and cooperate with others in taking care of personal needs?

- YES (Continue)
- NO (Go to 2.I.)
- 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** Uses zipper by self
- Yes** **No** Buttons clothes by self
- Yes** **No** Ties shoelaces
- Yes** **No** Takes a bath or shower without help
- Yes** **No** Brushes teeth
- Yes** **No** Combs or brushes hair
- Yes** **No** Washes hair by self
- Yes** **No** Chooses clothes by self
- Yes** **No** Eats by self using a knife, fork, and spoon
- Yes** **No** Picks up and puts away toys
- Yes** **No** Hangs up clothes
- Yes** **No** Helps around the house (for example, washes or dries dishes, makes bed(s), sweeps/vacuums floor, rakes or mows yard, helps with laundry)
- Yes** **No** Does what he or she is told most of the time
- Yes** **No** Obeys safety rules; for instance, looks for cars before crossing street
- Yes** **No** Gets to school on time
- Yes** **No** Accepts criticism or correction

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to help him or herself and cooperate with others in caring for personal needs:
