

Function Report Child Age 3 to 6th 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 3 TO 6th 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 (<i>including Area Code</i>):			

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 every statement below that is generally 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 every statement below that is generally 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>_____</p> <p>_____</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. F. Are the child's physical abilities limited?

- 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 Catch a large ball, like a beach ball
- Yes No Ride a big wheel, tricycle, or bike with training wheels
- Yes No Wind up a toy
- Yes No Print at least some letters
- Yes No Copy first name
- Yes No Use scissors fairly well

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

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 Enjoys being with other children the same age
- Yes No Shows affection towards other children
- Yes No Is affectionate towards parents
- Yes No Shares toys
- Yes No Takes turns
- Yes No Plays "pretend" with other children
- Yes No Plays games like tag, hide-and-seek
- Yes No Plays board games (like checkers or Candyland)

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

<p>2. H. Does the child's impairment(s) affect his or her habits and ability to take care of personal needs?</p> <p><input type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.I.)</p> <p><input type="checkbox"/> NOT SURE (Continue)</p>	<p>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 dress with help but now dresses without help, check "yes" for both.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Usually controls bowels and bladder during the day</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Eats using a fork and spoon by self</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Dresses self with help</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Dresses self without help (except tying shoes)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Washes or bathes without help</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Brushes teeth with help</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Brushes teeth without help</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Puts toys away</p> <p>If necessary, please explain. In addition, please tell us anything else you think we should know about the child's habits and ability to take care of personal needs:</p> <hr/> <hr/> <hr/> <hr/>
<p>I. Is the child's ability to pay attention and stick with a task limited?</p> <p><input type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.J.)</p> <p><input type="checkbox"/> NOT SURE (Continue)</p>	<p>If "yes," or "not sure," how long can the child pay attention to TV, music, reading aloud or games?</p> <p><input type="checkbox"/> 15 minutes <input type="checkbox"/> 30 minutes</p> <p>If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to pay attention and stick with a task:</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

