QUESTIONNAIRE FOR CHILDREN CLAIMING SSI BENEFITS

Please print, type, or write clearly and answer all items to the best of your ability. If you need help completing any part of this form, we will help you. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. If you do not know the answer, enter "unknown." If the question does not apply, enter "N/A." If you need more space to answer any of the questions, please use "REMARKS" and enter the number of the question next to your answer.

Child's Full Name	Social Security Number	Date (mm/dd/yyyy)

Informant's Name	Relationship to Child	Daytime Telephone Number (including Area Code)

1. Is (was) the child cared for by a baby sitter? Does (did) the child attend any type of preschool, daycare and/or after school program? If so, please specify. If more than one of the above, use the "REMARKS" section.

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	Dates Attended
2. a. Is (was) the child in school?	☐ Yes ☐ No

If "***yes***," and the school was not listed in the SSA-3820, please show it here.
(If more than one, use the "REMARKS" section.)

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	Dates Attended
Grade Level Completed	Last Teacher's Name

2.b. Is the child in a special education program?	☐ Yes ☐ No ☐ Don't Know
c. Does the school make any special accommodations for the child; e.g., adaptive furniture, wheelchair ramps, extra assistance or attention?	☐ Yes ☐ No ☐ Don't Know
If **"yes"** in 2.b. or 2.c., indicate type of program and/or accommodations:	Specify number of hours per week the child is in special education program:
d. Do you have a copy of the child's individual education plan (IEP), the report in which the teacher outlines the child's problems and lists the plans for correcting them? If "***yes***," please provide a copy.	☐ Yes ☐ No
3. Does the child receive any special counseling or tutoring?	
a. In school	☐ Yes ☐ No
b. Outside school	☐ Yes ☐ No

If "***yes***," in 3.a. or 3.b., please indicate: *(If more than one, use the "REMARKS" section.)*

Type of Counseling, Tutoring	
Date Began and Ended (If completed)	Frequency of Visits
Counselor's or Tutor's Name	Telephone Number (including Area Code)
Address (Number, Street, City, State, ZIP Code)	

4. Does the child or family have a child welfare, social services or early intervention caseworker?	☐ Yes ☐ No

If "***yes***," please provide the following information: *(If more than one, use the "REMARKS" section.)*

Caseworker's Name	Organization
Address (Number, Street, City, State, ZIP Code)	Telephone Number (including Area Code)
File or Record Number	Date First Saw/Last Saw Caseworker

5. Has the child ever been tested or evaluated by any of the following agencies or organizations? If "***yes***," indicate in the space provided below the agency name, address, telephone number, record number, and the type and date of test or evaluation performed *(e.g., vision, hearing, speech, physical).*

a. Public/Community Health Department	☐ Yes	☐ No
b. Child Welfare/Social Services Agency	☐ Yes	☐ No
c. Developmental Evaluation Center	☐ Yes	☐ No
d. Mental Health/Intellectual Disability	☐ Yes	☐ No
e. Special Needs/Crippled Children Agency	☐ Yes	☐ No
f. Speech and Hearing Center	☐ Yes	☐ No
g. Women, Infants, and Children (WIC) Program	☐ Yes	☐ No

Use the letter designation *(5a, 5b, etc.)* to identify the agency.

If additional space is needed, use "REMARKS" section.

6. Does (did) the child receive any special therapy (physical, speech and language, occupational), exercises, or any other services for his/her impairments? Include information about any therapy or exercises the parent, guardian or caregiver provides the child.	☐ Yes ☐ No

If **"yes,"** indicate below the therapist's name, the name of the person who PRESCRIBED AND/OR DESIGNED the therapy program, the type(s) and frequency of treatment, when treatment began and ended (if completed), and where treatment was received *(e.g., home, hospital, therapist's office, clinic.)*

Therapist's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

Therapist's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

7. Does (did) the child receive vocational rehabilitation services? If "***yes***," describe services received below the rehabilitation counselor's information. Include dates and record number.	☐ Yes ☐ No
Rehabilitation Counselor's Name	Telephone No. (including Area Code)
Address (Number, Street, City, State, ZIP Code)	
Services received:	

(If additional space is needed, use "REMARKS" section.)

NOTE: PROVIDING INFORMATION ABOUT THE CHILD'S INVOLVEMENT WITH THE COURT SYSTEM IS OPTIONAL

8. Has the child ever been involved with the court system other than in custody proceedings? If "***yes***," please explain involvement, including testing and evaluation.	☐ Yes ☐ No
Youth Development Center's Name	
Address (Number, Street, City, State, ZIP Code)	
Probation or Parole Officer's Name	Telephone No. (including Area Code)
Address (Number, Street, City, State, ZIP Code)	
Involvement including any testing and evaluation:	

9. Does (did) the child participate in any community or school activities, such as choir, Special Olympics, Boy's/Girl's Club, Scouts, or sports?	☐ Yes ☐ No

If "yes," describe involvement, amount of time spent in activity, and level of participation. Provide name, address, and telephone number of individual who supervises the activity. Include dates of involvement. If involvement ended, explain why.

10. If the child takes any medication on an ongoing basis, please indicate the following:

MEDICATION DOSAGE/ FREQUENCY	PRESCRIBED BY (NAME)	REASON FOR MEDICATION	DESCRIBE ANY SIDE EFFECTS

How well does the medication(s) work? Please explain:

11 a. If you are unable to give us information we need about the child, is there someone else who helps care for the child and, knows of the child's impairment who can help us get the information we need, and, if necessary, bring the child to a consultative examination?

☐ Yes ☐ No

b. If "yes," please provide the following information about this person

Name _____

Address (Number, Street, City, State, ZIP Code)

_____

Daytime telephone number (including Area Code) _____

Relationship *(e.g., relative, neighbor, family friend)* to the child? _____

REMARKS:

REMARKS (continued):

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(b), 1614, and 1631(e)(1) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may delay the determination or continued eligibility for benefits.

See Revised PA Statement attached

We will use the information to make a decision on your claim. We may also share your information for the following purposes, called routine uses:

1. To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the Act;

2. To the appropriate State agencies (or other agencies providing services to disabled children) to identify Title XVI eligibles under the age of 16 for the consideration of rehabilitation services in accordance with section 1615 of the Act, 42 U.S.C. 1382d; and

3. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0089, entitled Claims Folders System; 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits; and 60-0320, entitled Electronic Disability (eDIB) Claim File. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*