

DISABILITY REPORT - CHILD - Form SSA-3820-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

HOW TO COMPLETE THIS FORM

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

- Fill out this form before your interview appointment.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 10 and 11, and show the number of the question being answered.

ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records
- Copies of the child's prescriptions
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

The Privacy and Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 1 hour to read the instructions, gather the necessary facts, and answer the questions.

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

DISABILITY REPORT - CHILD

SECTION 1 -- INFORMATION ABOUT THE CHILD

A. CHILD'S NAME <i>(First, Middle Initial, Last)</i>	B. CHILD'S SOCIAL SECURITY NUMBER
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C. YOUR NAME *(If agency, provide name of agency and contact person)*

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

CITY	STATE	ZIP CODE
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D. YOUR DAYTIME PHONE NUMBER *(If you have no phone number, give us a daytime number where we can leave a message for you)*

_____ Your Number
 _____ Message Number
 _____ None
Area Code Number

E. What is your relationship to the child? _____

F. Can you speak English? YES NO

If "NO", what languages can you speak? _____

If you **cannot speak English**, is there someone we may contact who speaks English and will give you messages?

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

<small>City</small>	<small>State</small>	<small>ZIP</small>	DAYTIME PHONE	<small>Area Code</small>	<small>Number</small>
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Can you **read English**? YES NO

G. Does the child live with you? YES NO If "NO", with whom does the child live?

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

<small>City</small>	<small>State</small>	<small>ZIP</small>	DAYTIME PHONE	<small>Area Code</small>	<small>Number</small>
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Can this person **speak English**? YES NO

If "NO", what languages can this person speak? _____

Can this person **read English**? YES NO

SECTION 1 - INFORMATION ABOUT THE CHILD

H. Can the child speak English? YES NO

If "NO," what languages can the child speak? _____

I. What is the child's height (*without shoes*)? _____

What is the child's weight (*without shoes*)? _____

J. Does the child have a **medical assistance** card? (for example Medicaid, Medi-Cal)

YES NO

If "YES", show the **number** here: _____

SECTION 2 - CONTACT INFORMATION

A. Does the child have a legal guardian or custodian other than you?

YES (*Enter name, address, phone number, relationship*) NO

NAME _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City State ZIP

DAYTIME PHONE NUMBER _____
Area Code Number

RELATIONSHIP TO CHILD _____

B. Is there another adult who helps care for the child and can help us get information about the child if necessary?

YES (*Enter name, address, phone number, relationship*) NO

NAME OF CONTACT _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City State ZIP

DAYTIME PHONE NUMBER _____
Area Code Number

RELATIONSHIP TO CHILD _____

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

YES NO

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

YES NO

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each DOCTOR/HMO/THERAPIST/OTHER**. Include the child's **next appointment**.

1. NAME		DATES
STREET ADDRESS		FIRST VISIT
CITY	STATE	ZIP
PHONE	CHART/HMO # (If known)	NEXT APPOINTMENT
<small>Area Code</small>	<small>Number</small>	
REASONS FOR VISITS		
WHAT TREATMENT WAS RECEIVED?		

2. NAME		DATES
STREET ADDRESS		FIRST VISIT
CITY	STATE	ZIP
PHONE	CHART/HMO # (If known)	NEXT APPOINTMENT
<small>Area Code</small>	<small>Number</small>	
REASONS FOR VISITS		
WHAT TREATMENT WAS RECEIVED?		

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3. NAME		DATES
STREET ADDRESS		FIRST VISIT
CITY	STATE	ZIP
LAST SEEN		NEXT APPOINTMENT
PHONE _____ <small>Area Code Number</small>	CHART/HMO # (If known)	
REASONS FOR VISITS		
WHAT TREATMENT WAS RECEIVED?		

If you need more space, use Remarks, Section 10.

D. List each HOSPITAL/CLINIC. Include the child's next appointment.

1. HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
		DATE IN	DATE OUT
NAME	<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>		
STREET ADDRESS			
CITY _____			
STATE _____ ZIP _____	<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
PHONE _____ <small>Area Code Number</small>			
	<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	

Next appointment _____ **The child's hospital/clinic number** _____

Reasons for visits

What treatment did the child receive?

What doctors does the child see at this hospital/clinic on a regular basis?

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC NAME _____ STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____ <small>Area Code Number</small>	<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATES	
		DATE IN	DATE OUT
	<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
	<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	

Next **appointment** _____ The child's hospital/clinic **number** _____

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

If you need more space, use Remarks, Section 10.

E. Does anyone else have medical records or information about the child's illnesses, injuries or conditions (Workers' Compensation, insurance companies, counselors, detention centers, attorneys, and/or tutors), or is the child scheduled to see anyone else?

YES *(If "YES," complete information below.)*

NO

NAME	DATES
ADDRESS	FIRST VISIT
CITY STATE ZIP	LAST SEEN
PHONE <small>Area Code Number</small>	NEXT APPOINTMENT
CLAIM NUMBER <i>(If any)</i> _____	
REASONS FOR VISITS _____	

If you need more space, use Remarks, Section 10.

SECTION 5 - MEDICATIONS

Does the child currently take any **medications** for illnesses, injuries or conditions? YES
 If "YES", tell us the following: *(Look at the child's medicine bottles, if necessary.)* NO

NAME OF MEDICINE	PRESCRIBED BY (Name of Doctor)	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

If you need more space, use Remarks, Section 10.

SECTION 6 - TESTS

Has the child had, or will he/she have, any **medical tests** for illnesses, injuries or conditions? YES NO If "YES", tell us the following (give approximate dates, if necessary).

KIND OF TEST	WHEN DONE, OR WHEN IT WILL BE DONE <i>(Month, day, year)</i>	WHERE DONE <i>(Name of Facility)</i>	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part _____			
SPEECH/LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part _____			
MRI/CAT SCAN - Name of body part _____			

If the child has had other tests, list them in Remarks, Section 10.

SECTION 7 - ADDITIONAL INFORMATION

A. Has the child been **tested or examined** by any of the following?

- | | | | | |
|--|--------------------------|-----|--------------------------|----|
| Headstart (Title V) | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Public or Community Health Department | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Child Welfare or Social Service Agency | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Women, Infant and Children (WIC) Program | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Program for Children with Special Health Care Needs | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Mental Health/Mental Retardation Center | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Vocational Rehabilitation | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| If "NO", and over age 15, do you want to be referred to Vocational Rehabilitation? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

B. Is the child participating in the Ticket Program or other program of vocational rehabilitation services, employment services or other support services to help him or her go to work?

- YES NO

If you answered "YES" to any of the above in A. or B., please complete C. below:

C. 1. NAME OF AGENCY _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City State ZIP

PHONE NUMBER _____

Area Code Number

TYPE OF TEST _____

WHEN DONE _____

TYPE OF TEST _____

WHEN DONE _____

FILE OR RECORD NUMBER _____

2. NAME OF AGENCY _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City State ZIP

PHONE NUMBER _____

Area Code Number

TYPE OF TEST _____

WHEN DONE _____

TYPE OF TEST _____

WHEN DONE _____

FILE OR RECORD NUMBER _____

If there are any other agencies, show them in Remarks, Section 10.

SECTION 8 - EDUCATION

A. What is the child's **current grade** in school or the **highest grade** completed?

B. Is the child currently attending school (*other than summer school*)? YES NO

If "NO", explain why the child is not attending school.

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

County

State

ZIP

PHONE NUMBER _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Has the child been tested for behavioral or learning problems? YES NO

If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? YES NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech therapy? YES NO

If "YES", and different from above, give:

NAME OF SPEECH THERAPIST _____

SECTION 8 - EDUCATION

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

County

State

ZIP

PHONE NUMBER _____

Area Code

Number

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems?

YES

NO

If "YES", complete the following:

TYPE OF TEST _____

WHEN DONE _____

TYPE OF TEST _____

WHEN DONE _____

Was the child in special education?

YES

NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech therapy?

YES

NO

If "YES", and different from above, give:

NAME OF SPEECH THERAPIST _____

If there are other schools, show them in Remarks, Section 10.

E. Is the child attending Daycare/Preschool?

YES

NO

If "YES", complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

County

State

ZIP

PHONE NUMBER _____

Area Code

Number

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

