



**DISABILITY
LAW CENTER**

O F A L A S K A



**APPLYING FOR
SOCIAL SECURITY
DISABILITY
INSURANCE (SSDI)
BENEFITS IN ALASKA**

**M E M B E R , O F , T H E
N A T I O N A L , D I S A B I L I T Y
R I G H T S , N E T W O R K**

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This publication is a Public Education resource and is not intended to be legal advice. All laws are subject to change by legislation and by court decisions. Readers should use this handbook as a guide, then ask questions about their own individual needs.

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MEETING THE DEFINITION OF DISABILITY

To be approved for Social Security disability benefits, you must meet Social Security's legal definition for disability.

There are two ways to meet the definition of disability used by Social Security; (1) a person's disabling condition(s) can "meet a listing" or (2) a person can be unable to perform their past work and any other work.

Meeting a Listing

Social Security has something called Listing of Impairments. The Listing describes impairments considered severe enough to prevent an individual from doing any work. Most of the listed impairments are permanent or expected to result in death. For all other listings, the evidence must show that the impairment has lasted or is expected to last at least 12 months. Having an impairment that meets the criteria in the Listing is usually enough to establish disability. However, just because you don't meet a Listing-level impairment does not mean you are not disabled.

Unable to Perform Past Work or Other Work

People who do not meet a Listing may still be found disabled by Social Security. If a person's disability is so severe that they are unable to perform their past work to the extent that they do not earn the minimum amount of money each month, Social Security will find that person disabled. For 2019, the minimum amount of money (called "substantial gainful activity" or "SGA" by Social Security) is \$1,220.00 in pre-tax dollars (\$1,970 if you are blind). Additionally, to be found disabled through this process, Social Security must conclude that an individual is also not capable of doing "other work."

What exactly is "other work?" Simply put, "other work" means a type of work that the individual has not done in the past. According to Social Security regulations, other work that a claimant might be able to perform must be related to several factors: a person's age, level of education, and the type of work they did in the past.

For example, a person with a 9th grade education who cannot do their past work will never be expected to perform other work that goes beyond their educational limits. And individuals with mental or affective impairments (low IQ or depression or anxiety) will not be expected to perform other work that requires detailed attention and concentration. Also, as a third example, individuals who are physically incapable of doing more than sedentary work will never be expected to perform work that requires medium (lifting 50 lbs. on an occasional basis) or even light (lifting 25 lbs. on an occasional basis) exertion.

WHAT IS THE DIFFERENCE BETWEEN SSI AND SSDI?

There are two types of Social Security disability benefits, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). An individual who meets Social Security's definition for disability may qualify for one or both benefit programs depending on their earnings history and disposable assets.

What is Supplemental Security Income (SSI)?

SSI is a needs-based program. Individuals who have never worked or whose earnings in recent years have been so low that they result in a small Social Security benefit, or no benefit at all, may only qualify for benefits under SSI.

****Note:** This booklet only covers the SSDI application process. For SSI only applications, call Social Security at 1-800-772-1213 to schedule a telephonic interview to start the process.**

For people whose SSDI benefit would be low, SSI does exactly what its name implies, it supplements their income. For example, if an approved claimant received SSDI monthly benefits in the amount of \$385.00, an SSI award could be used to guarantee that the claimant's total monthly benefits were equal to a certain minimum amount.

What is that minimum amount? The minimum is equal to the full monthly benefit amount for SSI which was \$750.00 per month for 2018. Therefore, in the example above, an SSDI recipient who received \$385.00 per month might also receive an additional \$365.00 in SSI to bring their total monthly benefits to \$750.00, a sum equal to the full SSI monthly benefit amount.

This scenario will not happen in every such case. Because SSI has resource limits (currently, an individual cannot have more than \$2,000.00 in disposable assets), many individuals will not be eligible to receive Supplemental Security Income, no matter how low their monthly SSDI benefit amount is.

What is Social Security Disability Insurance (SSDI)?

SSDI is an insurance program administered by the federal government. It is reserved for individuals who have worked and paid into the Social Security system above a certain required amount. Monthly benefits under SSDI are based on the individual's prior earnings and payments into Social Security.

How can I find out if I qualify for SSDI?

You can check earnings records at www.ssa.gov by signing up for a My Social Security account. You will then be able to check to see how much you would be eligible for under SSDI if you were to be found disabled today.

Do I need representation for an SSDI application?

No, it is possible to apply for SSDI without representation.

APPLYING FOR SOCIAL SECURITY DISABILITY BENEFITS

How do I apply for SSDI?

There are 3 different ways of applying for benefits. You can:

- 1) Visit your local Social Security office and apply in person. This can generally take a good deal of time.
- 2) Apply over the phone by calling 1-800-772-1213. This number is often very busy so you must be patient.
- 3) Go online to www.ssa.gov/benefits/disability and click the link for “Apply for Disability.”

If you have internet access, the online application is the quickest and easiest way to apply for SSDI benefits.

PLEASE NOTE: It can take anywhere from 6 to 9 months *or longer* to receive a decision after completing your application.

What information do I need before I complete my online application?

To apply online you will need your “My Social Security” user name and password. If you do not have one, go to www.ssa.gov to sign up for an account.

There are three parts to the online application. Part I requests information for personal identification. Part II requests information about family size, earnings, pensions, and government benefits. Part III requests information about medical conditions and treatment and work history.

The details of these three parts are listed next. Be sure to read though all of the requirements and gather the information *before* starting your online application. Also, be sure to answer every question to the best of your ability. It is okay to write “I don’t remember” or “I am not sure.” If you are unsure of the answer, you can write a brief explanation at the end of the application in the “Remarks” section.

****IMPORTANT TIP****

Use a computer that you can print from when completing your online application. You will want to print copies of the application as you complete it to keep a record of everything that you submit to Social Security.

Part I: Personal Identification

Identification: Name, social security number, date of birth, gender, start date of disability.

Contact information: Mailing address, residence address, phone number, email address.

Birth and Citizenship information: Place of birth, type of citizenship.

****IMPORTANT TIP****

Once you submit this information, you will receive a re-entry number. Be sure to **WRITE THIS NUMBER DOWN AND SAVE IT** in case you need to exit the application and come back to it.

Part II: General Information

Marriage information: Are you currently married? What is your spouse's name, social security number, and date of birth? What was the date of your marriage, place of marriage, marriage type (clergy or public official, etc.)?

Prior Marriages (list all prior marriages): Have any of your marriages lasted at least 10 years? Did any prior marriage end due to spouse's death? If so, what was your prior spouse's name, social security number, and date of birth? What was the date of marriage, marriage type, and date marriage ended? How did marriage end (divorce, dissolution, death, etc.)? What was the date of death?

Children: Do you have any children who became disabled prior to age 22, any unmarried children under the age of 18, any unmarried children aged 18 to 19 still attending school below college level? What are the names of your children?

Military service: Did you serve in the military prior to 1968?

Employer details: Did you work for an employer this year? Will you work for an employer next year?

Employer Details: What is your current/latest employer's name and address, date employment began, and date employment ended?

Self-Employment: Were you self-employed this year? Will you be self-employed next year?

Supplement information: Did you or your spouse work outside the US? Do you agree with your earnings history as shown on your Social Security statement?

Total earnings: What are the total wages and tips you earned this year? Have you received any special payments paid in one year but earned in another?

Other Pensions/Annuities: Have you ever worked at a job where US Social Security taxes were not deducted or withheld? Are you receiving a pension or annuity on this non-covered work or expecting to receive a pension or annuity based on non-covered work? Have you ever received a lump sum payment instead of a pension or annuity based on non-covered work? Did your spouse or prior spouse work for the Railroad for 5 years or more?

Direct Deposit Details: What is your Account type, routing number, account number?

Benefit information: Do you intend to apply for SSI benefits? Have you previously applied for Medicare, SSDI, or SSI?

Ability to Work: Are your illnesses, injuries, conditions related to work? Are you now able to work?

Disability Payments: Have you filed or do you intend to file for workers' compensation or other public disability benefit? Have you received money from an employer on/after the date you became unable to work? Do you expect to receive money from an employer on/after the date you became unable to work?

Dependents: Do you have a parent that receives one-half support from you?

****IMPORTANT TIP****

BEFORE you agree to the Electronic Signature Agreement and hit the Accept & Continue button, be sure to **REVIEW** the information you provided. The best practice is to print out a copy of what you have so far, review it, then continue. That way you will have a copy of what you submitted for your records.

Part III: Medical and Employment Information

Medical Information: List ALL of your physical and mental conditions, height, and weight. Do your conditions cause pain or other symptoms? Have you seen a health care provider or received treatment? Do you have an appointment scheduled for your physical and/or mental conditions?

Other Contact: Is there someone (other than a health care provider) that the Social Security Administration (SSA) can contact to get more information about your conditions? What is their name, relationship to you, address, phone number?

Doctors and Other Healthcare Professionals & Hospital/Clinics (List every provider that has treated you for your listed conditions):

- Name, address, phone number;
- Emergency room visit dates;
- Inpatient stay dates;

- Outpatient visit dates;
- Tests administered and dates of tests;
- Next scheduled visit date;
- Medications prescribed and reason (if you have more medications than room to provide them, you can add them after you complete this section by clicking on the Medicine tab);
- Medical conditions treated; and
- Treatment received.

Other Medical Records: Were you ever given medical treatment while in jail or prison? Did you receive medical treatment through a vocational rehabilitation program?

Work Status: Are you currently working?

Work Activity: What is the date you stopped working and your reason for stopping? Did you make any changes to your work activity before you stopped? If yes, what date were those changes made?

Job History: Did you have earnings greater than \$1,220.00 since your last day of work? How many jobs have you had in the past 15 years?

Most Recent Job:

- Job Title;
- Type of Business;
- Start Date;
- End Date;
- Hours per day;
- Days per week;
- Pay amount; and
- Pay frequency (weekly, monthly, yearly).

Previous Job #1:

- Job Title;
- Type of Business;
- Start Date;
- End Date;
- Hours per day;
- Days per week;
- Pay amount; and
- Pay frequency (weekly, monthly, yearly).

Education: What is the highest grade that you have completed and the date you completed it? Have you received any special training? Have you attended a vocational school? Did you attend special education?

Remarks: If you did not have the exact dates or other information requested throughout the application, this is where you would explain that. As you complete the application, keep track of information that you are missing so that you can explain that in the remarks section.

****IMPORTANT TIP****

BEFORE you agree to the Electronic Signature Agreement and click the Accept & Continue button, be sure to **REVIEW** the information you provided. The best practice is to print out a copy of what you have so far, review it, then continue. That way you will have a copy of what you submitted for your records.

CONFIRMATION:

Once you have completed the application, you will be directed to a confirmation page. You will then need to do the following:

- Print out the confirmation page;
- Click on the Print and Sign hyperlink to electronically sign the medical release form;
- Click on the Print hyperlink to print out copy of your personalized Cover Sheet;
- Place the Cover Sheet on top of the records that you have gathered from your doctor; and
- Mail your records to the Social Security address listed on your Cover Sheet.

****IMPORTANT TIP****

Sending your medical records Certified with Return Receipt, while expensive, will provide you proof that your information was received by the SSA.

I completed my online application and mailed my records to Social Security. Now what?

Now you wait.

What am I waiting for?

Basically, there are two parts to the Social Security's decision process. The first is the non-medical determination. This is when Social Security looks at your work history and how much you have paid into the system to see if you qualify for SSDI. The second is the disability determination. This is when the Disability Determination Services (DDS) reviews your medical records to determine whether your condition(s) meet Social Security's definition for disability.

If there are any questions about your income and/or qualification during the non-medical part of the determination, Social Security may contact you for more information such as pay stubs or other employment information. Give them the information they need as soon as possible in order to avoid delaying a decision to your application.

At the disability determination stage, you will be sent an Adult Function Report and Third-Party Function Report. You may also receive a Work History Report. These reports are to be completed and sent back to DDS within 14 days. If the DDS needs more information on your

disability, they may request you attend an additional physical or mental examination. This is called a Consultative Exam (CE) and it will be of no cost to you. It is very important that you attend this exam or contact the DDS right away to reschedule to a more convenient time.

****IMPORTANT TIP****

Be sure to check your mail as often as possible for Social Security correspondence so you don't miss any deadlines. If you miss a deadline, your application may be delayed or denied. If Social Security denied your application, you will have to reapply.

What are the Adult Function Report, Third-Party Function Report, and Work History Report?

The **Adult Function Report** focuses on how well you are able to do activities of daily living on a day to day basis. When completing the Adult Function Report, answer the questions honestly and with as much detail as you can provide.

Some example questions are:

- How do your illnesses, injuries or conditions limit your ability to work?
- Describe what you do from the time you wake up until you go to bed?
- Explain how the illnesses, injuries, or conditions affect your ability to dress, bathe, care for hair, shave, feed self, use the toilet.
- Do you prepare your own meals? If yes, what do you prepare, how long does it take you, and how often do you do it?
- Do you do housework or chores? If yes, what do you do, how long does it take you, and how well do you do it?

See Appendix A for examples of answers to these questions

The **Third-Party Function Report** focuses on what someone close to you observes of your daily activities. The questions in the Third-Party Function Report are basically the same questions asked in the Adult Function Report just from a different point of view. It is important to have someone that knows you well and sees you often to fill out this report (i.e. spouse, family member, friend, etc.). Your doctor or other medical provider *should not* complete this report.

See Appendix B for examples of answers to these questions

The **Work History Report** is just that, a list of jobs that you did in the past.

Some example questions are:

- Describe the job. What did you do all day?
- In this job how many hours did you do the following: walk, stand, sit, climb, stoop, kneel, crouch, crawl, handle large objects, handle small objects?
- What did you lift, how far did you carry it, and how often did you do this?

- Did you supervise other people?
- Did you hire and fire employees?

See Appendix C for examples of answers to these questions

I received, completed, and returned all of the reports to Social Security. Now what?

You wait for the decision.

Hurray! I was approved! Now what?

YAY! Congratulations!

Your monthly benefit amount will be stated on your Notice of Approved Claim letter. You should check your bank account to make sure money was deposited.

You may also receive back pay. An individual may receive back pay from the time they filed their application, and as much as 12 months retroactive to this date. Bear in mind, 12 months is the maximum and the actual amount received will depend on the onset date (the date Social Security had decided that an individual's disability actually began) and the date of entitlement (which is, due to the five month waiting period, a claimant's first month of eligibility to receive benefits).

In either case, back pay can amount to thousands of dollars simply because disability applications take so long to reach a decision.

You will also receive Medicare two years after the time your eligibility for Social Security benefits is established. For more information on Medicare eligibility go to www.ssa.gov/benefits/medicare.

If you are not approved:

You have three choices of what to do if you are not approved.

- 1) Appeal the decision;
- 2) File a new claim; or
- 3) Quit pursuing SSDI.

I want to appeal the decision.

You can appeal the decision by completing and submitting a Request for a Hearing before an Administrative Law Judge form. This form must be submitted to Social Security within 60 days from the date of your decision.

The Request for Hearing is the first step in the Social Security Administration's disability appeals process in Alaska. Simply go online at www.ssa.gov and download the Request for

Hearing by Administrative Law Judge form HA-501 or contact the Social Security office and request the appropriate appeal forms.

If you have disability representation, you should call your attorney or non-attorney representative. Once the office handling your representation is aware of the denial, the Request for Hearing should be submitted shortly. However not every representative completes or submits the Request for Hearing forms. For the most part this is the responsibility of the claimant.

The request is submitted to the local Social Security office which then forwards the request and the claimant's file to the appropriate Office of Hearings Operations (OHO).

Sometime after a case has been transferred to OHO, it will be assigned to an Administrative Law Judge (ALJ) who will schedule the case for a hearing date. Typically, this process takes several months and may even take longer than a year. The amount of time will depend on the hearing office, as some OHO locations have more cases and greater backlogs than others.

I want to re-apply.

If you didn't appeal, or you missed the appeal deadline, you may file a new claim. You will simply go through the same process that you did the first time. When you reapply, be sure to include any and all new information about your disability(ies). This is especially important if your medical condition has deteriorated.

There is a downside of re-applying vs. appealing. If you re-apply, you risk losing any back pay that you may have been entitled to had the ALJ approved your claim and agreed with the disability onset date. However, the process of re-applying takes less time (around 6 months or so) compared to appealing to an ALJ (one year or more, on average)

Are there things I can do to have a better chance of getting benefits? Yes!

- Get regular medical treatment and follow your health care provider's orders;
- Submit copies of your records when you apply for disability;
- Never miss deadlines for anything involving Social Security disability;
- Keep a copy of everything you submit to or get from Social Security;
- Never speak rudely to anyone involved in your case. There is a good chance you may need their help at some point and, honestly, they have no motivation to move your case any faster if you make their job harder;
- If you get updated medical records, call DDS at 907-771-8100 and ask how they would like you to submit them. If you have a representative, give them to this individual who can review them before submitting them (not all records are helpful); and
- Submit your appeal requests immediately and never wait to do them near the end of the 60-day deadline.

Appendix A

Adult Function Report

FUNCTION REPORT - ADULT - Form SSA-3373-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 call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213.

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.

It is important that you tell us about your activities and abilities.

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

Function Report - Adult - Form SSA-3373-BK

Privacy Act Statements
Collection and Use of Personal Information

Sections 205(a), 223(d)(5)(A), 1631(d)(1), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to assist us in making a decision on your claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making a decision on your claim.

We rarely use the information you supply for any purpose other than the reason stated above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to:

1. 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); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and private entities under contract with us).

A list of when we may share your information with others, called routine uses, is available in our System of Records Notices entitled, Master Files of Social Security Number (SSN) Holders and SSN Applications System, 60-0058; Claims Folders System, 60-0089; and Master Beneficiary Record, 60-0090. Additional information about these and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may also share the information you provide to other agencies through 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 or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not have that address, 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 Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.***

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

FUNCTION REPORT - ADULT*How your illnesses, injuries, or conditions limit your activities***For SSA Use Only****Do not write in this box.**

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION A - GENERAL INFORMATION

1. NAME OF DISABLED PERSON (First, Middle Initial, Last) John S. Doe	2. SOCIAL SECURITY NUMBER 123-45-6789
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3. YOUR DAYTIME TELEPHONE NUMBER (If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)

907 123-4567 ☒ Your Number ☐ Message Number ☐ None
Area Code Phone Number

4. a. Where do you live? (Check one.)

☐ House ☒ Apartment ☐ Boarding House ☐ Nursing Home
☐ Shelter ☐ Group Home ☐ Other (What?) _____

b. With whom do you live? (Check one.)

☐ Alone ☒ With Family ☐ With Friends
☐ Other (Describe relationship.) _____

SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

5. How do your illnesses, injuries, or conditions limit your ability to work?

I have an extremely hard time just leaving the house due to my depression, anxiety, and agoraphobia. I have panic attacks when I am out of the house or around other people. Even in my house I have overwhelming paranoia and feel someone is watching me. I am very anxious around other people. My back injury prevents me from sitting or standing for long periods of time.

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

I get up and make lunch for my wife, feed the dog, take my medications, read or play games on my Kindle, go back to bed and sleep for most of the day, read/watch tv, make dinner, take medication, go back to bed.

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other?

☒ Yes

☐ No

If "YES," for whom do you care, and what do you do for them?

Wife. I make her lunch and dinner.

8. Do you take care of pets or other animals?

☒ Yes

☐ No

If "YES," what do you do for them?

I feed and play with our dog.

9. Does anyone help you care for other people or animals?

☒ Yes

☐ No

If "YES," who helps, and what do they do to help?

Wife takes him on walks and cleans up yard. She also reminds me to feed him.

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

Work, play basketball, go out in public, go to movies, enjoy life

11. Do the illnesses, injuries, or conditions affect your sleep?

☒ Yes

☐ No

If "YES," how?

The pain from my back injury wakes me up several times a night.

12. **PERSONAL CARE** (Check here ☐ if **NO PROBLEM** with personal care.)

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress Hard to bend over to put pants or socks on

Bathe I don't have the energy or desire to bathe.

Care for hair Same as bathing

Shave Same as bathing

Feed self no problems

Use the toilet I have to lean on the sink for balance getting on/off the toilet

Other n/a

b. Do you need any special reminders to take care of personal needs and grooming?

☒ Yes ☐ No

If "YES," what type of help or reminders are needed?

I will go days without bathing. Wife has to prompt/remind me.

c. Do you need help or reminders taking medicine?

☒ Yes ☐ No

If "YES," what kind of help do you need?

I have an app on my phone to remind me or my wife reminds me

13. MEALS

a. Do you prepare your own meals?

☒ Yes ☐ No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.)

Simple, microwave meals, sandwiches, pre-made dinners.

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

Daily

How long does it take you? Longer than average. It's difficult to stand b/c my back

Any changes in cooking habits since the illness, injuries, or conditions began?

Yes, I used to cook for a living. Can't stand long enough to make a meal anymore

b. If "No," explain why you cannot or do not prepare meals.

14. HOUSE AND YARD WORK

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.)

I do light cleaning on days my back isn't hurting.

b. How much time does it take you, and how often do you do each of these things?

It takes a long time and I need frequent breaks due to pain.

c. Do you need help or encouragement doing these things?

☒ Yes ☐ No

If "YES," what help is needed?

Depression makes it hard to motivate to do things. Wife encourages me.

d. If you don't do house or yard work, explain why not.

n/a

15. GETTING AROUND

a. How often do you go outside? Rarely due to agoraphobia

If you don't go out at all, explain why not.

Panic attacks, and anxiety prevent me from leaving the house.

b. When going out, how do you travel? (Check all that apply.)

☒ Walk

☐ Drive a car

☒ Ride in a car

☐ Ride a bicycle

☐ Use public transportation

☐ Other (Explain) _____

c. When going out, can you go out alone?

☒ Yes

☐ No

If "NO," explain why you can't go out alone.

d. Do you drive?

☐ Yes

☒ No

If you don't drive, explain why not.

Panic attacks prevent me from driving. Wife drives if I need to go somewhere.

16. SHOPPING

a. If you do any shopping, do you shop: (Check all that apply.)

☒ In stores

☐ By phone

☐ By mail

☐ By computer

b. Describe what you shop for.

Basic grocery items.

c. How often do you shop and how long does it take?

Rarely, I go at night to avoid crowds. I am in and out as quick as possible.

17. MONEY

a. Are you able to:

Pay bills

☐ Yes

☒ No

Handle a savings account

☐ Yes

☒ No

Count change

☒ Yes

☐ No

Use a checkbook/money orders

☒ Yes

☐ No

Explain all "NO" answers.

Mentally cannot think about numbers. I get anxiety attacks when dealing with money.

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began?

☒ Yes ☐ No

If "YES," explain how the ability to handle money has changed.

I used to manage household finances but my wife has to do it now.

18. HOBBIES AND INTERESTS

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

Reading the newspaper and watching TV.

b. How often and how well do you do these things?

Everyday but I can't concentrate or remember what was read or on TV.

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

Used to be able to read and retain information, sports and outdoor activities are impossible now.

19. SOCIAL ACTIVITIES

a. Do you spend time with others? (In person, on the phone, on the computer, etc.)

☐ Yes ☒ No

If "YES," describe the kinds of things you do with others.

How often do you do these things?

b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)

Doctor appointments

Do you need to be reminded to go places?

☒ Yes ☐ No

How often do you go and how much do you take part?

Once a month or so. I try to take part like normal. Anxiety causes some issues.

Do you need someone to accompany you?

☒ Yes ☐ No

- c. Do you have any problems getting along with family, friends, neighbors, or others? ☒ Yes ☐ No

If "YES," explain.

My depression and anxiety causes me to get frustrated easily with my wife, then I get angry and have to walk away to go lay down.

- d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

Never fought with wife before the depression and anxiety.

SECTION D - INFORMATION ABOUT ABILITIES

20. a. Check any of the following items that your illnesses, injuries, or conditions affect:

- | | | | |
|---|--|--|---|
| <input checked="" type="checkbox"/> Lifting | <input checked="" type="checkbox"/> Walking | <input type="checkbox"/> Stair Climbing | <input type="checkbox"/> Understanding |
| <input checked="" type="checkbox"/> Squatting | <input checked="" type="checkbox"/> Sitting | <input type="checkbox"/> Seeing | <input checked="" type="checkbox"/> Following Instructions |
| <input checked="" type="checkbox"/> Bending | <input checked="" type="checkbox"/> Kneeling | <input checked="" type="checkbox"/> Memory | <input type="checkbox"/> Using Hands |
| <input checked="" type="checkbox"/> Standing | <input type="checkbox"/> Talking | <input checked="" type="checkbox"/> Completing Tasks | <input checked="" type="checkbox"/> Getting Along With Others |
| <input checked="" type="checkbox"/> Reaching | <input type="checkbox"/> Hearing | <input type="checkbox"/> Concentration | |

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far])

My back injury prevents me from doing anything physical. Depression and anxiety make it difficult to complete or even get started on tasks.

- b. Are you: ☐ Right Handed? ☒ Left Handed?

- c. How far can you walk before needing to stop and rest? About 150 feet

If you have to rest, how long before you can resume walking?

About 10 minutes

- d. For how long can you pay attention? 30 minutes

- e. Do you finish what you start? (For example, a conversation, chores, reading, watching a movie.)

☐ Yes ☒ No

- f. How well do you follow written instructions? (For example, a recipe.)

Not well at all- have to re-read it several times

- g. How well do you follow spoken instructions?

Not well at all- I forget almost immediately.

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.)

No problems

i. Have you ever been fired or laid off from a job because of problems getting along with other people?

☐ Yes

☒ No

If "YES," please explain.

If "YES," please give name of employer.

j. How well do you handle stress?

Not well at all. I isolate in my bedroom with the curtains closed when stressed.

k. How well do you handle changes in routine?

Ok but it's less stressful when I do the same routine

l. Have you noticed any unusual behavior or fears?

☐ Yes

☒ No

If "YES," please explain.

21. Do you use any of the following? (Check all that apply.)

☐ Crutches

☒ Cane

☐ Hearing Aid

☐ Walker

☐ Brace/Splint

☐ Glasses/Contact Lenses

☐ Wheelchair

☐ Artificial Limb

☐ Artificial Voice Box

☐ Other (Explain)

Which of these were prescribed by a doctor?

Cane

When was it prescribed?

May 2016

When do you need to use these aids?

Everyday for balance.

22. Do you currently take any medicines for your illnesses, injuries, or conditions? ☒ Yes ☐ No

If "YES," do any of your medicines cause side effects? ☒ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE	SIDE EFFECTS YOU HAVE
Percocet	Makes me tired and it's hard to think

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

Name of person completing this form (Please print)

John S. Doe

Date (month, day, year)

1/1/11

Address (Number and Street)

1234 Main Street

Email address (optional)

City

Anchorage

State

AK

ZIP Code

99506

Appendix B

Third-Party Function Report

FUNCTION REPORT - ADULT - THIRD PARTY Form SSA-3380-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 call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to make a decision on the disabled person's claim. You can help by completing as much of the form as you can. When a question refers to the "disabled person," it refers to the person who is applying for or receiving disability benefits.

It is important that you tell us what you know about the disabled person's activities and abilities.

DO NOT ASK THE DISABLED PERSON TO GIVE YOU ANSWERS

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If you need more space to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

Function Report - Adult - Third Party Form SSA-3380-BK

Privacy Act and Paperwork Reduction Act Statements

Sections 205(a), 223(d)(5)(A), 1631(d)(1) and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a determination of eligibility for Social Security benefits.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. 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); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0089, entitled Claims Folders Systems; and, 60-0320, entitled Electronic Disability (eDIB) Claim File. Additional information about these and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

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. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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 Blvd, Baltimore, MD 21235-0001. **Send only comments relating to our time estimate to this address, not the completed form.***

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

FUNCTION REPORT- ADULT - THIRD PARTY*How the disabled person's illnesses, injuries, or conditions limit his/her activities***For SSA Use Only**
Do not write in this box.

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION A - GENERAL INFORMATION**1. NAME OF DISABLED PERSON** (*First, Middle, Last*)

John S. Doe

2. YOUR NAME (*Person completing the form*)

Jane P. Doe

3. RELATIONSHIP
(*To disabled person*)

Wife

4. DATE (*Month, Day, Year*)

12/12/12

5. YOUR DAYTIME TELEPHONE NUMBER (*If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.*)907 123 - 4567
Area Code Phone Number☒ Your Number☐ Message Number☐ None**6. a. How long have you known the disabled person?** 14 years**b. How much time do you spend with the disabled person and what do you do together?**50% Monday-Friday and 100% on weekends. We live together, eat meals, watch TV.**7. a. Where does the disabled person live?** (*Check one.*)☐ House☒ Apartment☐ Boarding House☐ Nursing Home☐ Shelter☐ Group Home☐ Other (What?) _____**b. With whom does he/she live?** (*Check one.*)☐ Alone☒ With Family☐ With Friends☐ Other (describe relationship) _____**SECTION B - INFORMATION ABOUT ILLNESSES, INJURIES, OR CONDITIONS****8. How does this person's illnesses, injuries, or conditions limit his/her ability to work?**

John is unable to work or handle certain daily functions like leaving the house due to anxiety, taking care of his personal hygiene on a regular basis, sleeping full night without being woken up from back pain.

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

9. Describe what the disabled person does from the time he/she wakes up until going to bed.

On a good day, he will get out of bed, take his medications, eat breakfast, watch TV or read the newspaper, feed the dog, and interact with me. On bad days, he is in bed all day due to the depression and pain.

10. Does this person take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other?

☐ Yes ☒ No

If "YES," for whom does he/she care, and what does he/she do for them?

11. Does he/she take care of pets or other animals?

☒ Yes ☐ No

If "YES," what does he/she do for them?

He feeds and pets the dog.

12. Does anyone help this person care for other people or animals?

☒ Yes ☐ No

If "YES," who helps, and what do they do to help?

I clean up after the dog outside since Joe is unable to bend over to pick up waste. I also remind him to feed the dog since he is forgetful or unmotivated to get out of bed to do anything.

13. What was the disabled person able to do before his/her illnesses, injuries, or conditions that he/she can't do now? He was very active with sports and friends. He also worked full time, took care of the house and vehicles, walked the dogs, was a voluntary football coach. He can't do any of these things now.

14. Do the illnesses, injuries, or conditions affect his/her sleep?

☒ Yes ☐ No

If "YES," how?

Yes, he wakes up many times at night due to pain.

15. **PERSONAL CARE** (Check here ☐ if **NO PROBLEM** with personal care.)

a. Explain how the illnesses, injuries, or conditions affect this person's ability to:

Dress Hard to bend over to put on shoes and socks, I help him.

Bathe Has balance issues- needs shower seat and help in and out of bathtub

Care for hair He neglects his personal hygiene when depressed

Shave same as hair

Feed self Won't eat if he is depressed and in bed.

Use the toilet no problem

Other

b. Does he/she need any special reminders to take care of personal needs and grooming?

☒ Yes ☐ No

If "YES," what type of help or reminders are needed?

Needs to be reminded to change clothes and complete daily upkeep

c. Does he/she need help or reminders taking medicine?

☒ Yes ☐ No

If "YES," what kind of help does he/she need?

I remind him daily to take his medication. He also has a reminder on his phone.

16. MEALS

a. Does the disabled person prepare his/her own meals?

☐ Yes ☒ No

If "Yes," what kind of food is prepared? (For example, sandwiches, frozen dinners, or complete meals with several courses.)

How often does he/she prepare food or meals? (For example, daily, weekly, monthly.)

Meals need to be made available or he doesn't eat.

How long does it take him/her? n/a

Any changes in cooking habits since the illness, injuries, or conditions began?

He used to cook all the time, has not cooked for years now.

b. If "No," explain why he/she cannot or does not prepare meals.

He is unable to stand long enough to prepare meals due to back pain. His depression has left him completely unmotivated/uninterested in preparing food.

17. HOUSE AND YARD WORK

a. List household chores, both indoors and outdoors, that the disabled person is able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.)

He tries to do light housework but has to take frequent breaks if he is even motivated to get started in the first place.

b. How much time do chores take, and how often does he/she do each of these things?

A lot longer than it used to. He rarely finishes the chores that he starts.

c. Does he/she need help or encouragement doing these things?

☒ Yes ☐ No

If "YES," what help is needed?

Reminders and gently encouragement to motivate him to do something.

d. If the disabled person doesn't do house or yard work, explain why not.

18. GETTING AROUND

a. How often does this person go outside? Rarely no

If he/she doesn't go out at all, explain why not.

He has panic attacks when going outside.

b. When going out, how does he/she travel? (Check all that apply.)

☒ Walk ☐ Drive a car ☒ Ride in a car ☐ Ride a bicycle

☐ Use public transportation ☐ Other (Explain) _____

c. When going out, can he/she go out alone?

☐ Yes ☒ No

If "NO," explain why he/she can't go out alone.

He has panic attacks and needs me to keep him calm

d. Does the disabled person drive?

☐ Yes ☒ No

If he/she doesn't drive, explain why not.

His panic attacks prevent him from driving.

19. SHOPPING

a. If the disabled person does any shopping, does he/she shop: (Check all that apply.)

☒ In stores ☐ By phone ☐ By mail ☐ By computer

b. Describe what he/she shops for.

Groceries

c. How often does he/she shop and how long does it take?

Rarely. I do the majority of shopping. If he goes shopping, it is a night when there are few people around. He will use the motorized cart to get around and will get only what he needs as quickly as possible.

20. MONEY

a. Is he/she able to:

Pay bills ☐ Yes ☒ No Handle a savings account ☐ Yes ☒ No

Count change ☒ Yes ☐ No Use a checkbook/money orders ☐ Yes ☒ No

Explain all "NO" answers.

He gets overwhelmed when dealing with money. I pay the bills now.

b. Has the disabled person's ability to handle money changed since the illnesses, injuries, or conditions began?

☒ Yes ☐ No

If "YES," explain how the ability to handle money has changed.

He used to do the household finances but forgets to pay bills and will fill out check incorrectly.

21. HOBBIES AND INTERESTS

a. What are his/her hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

Sports, coaching, working, reading the newspaper, doing the crossword puzzle.

b. How often and how well does he/she do these things?

He only reads the newspaper now but has a hard time retaining the information.

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

He does none of his prior hobbies or work now.

22. SOCIAL ACTIVITIES

a. Does the disabled person spend time with others? (In person, on the phone, on the computer, etc.)

☐ Yes ☒ No

If "YES," describe the kinds of things he/she does with others.

How often does he/she do these things?

b. List the places he/she goes on a regular basis. (For example, church, community center, sports events, social groups, etc.)

Does he/she need to be reminded to go places?

☒ Yes ☐ No

How often does he/she go and how much does he/she take part?

Monthly doctor appointments. He takes part most of the time.

Does he/she need someone to accompany him/her?

☒ Yes ☐ No

c. Does this person have any problems getting along with family, friends, neighbors, or others?

☐ Yes ☒ No

If "YES," explain.

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

He used to be very social but doesn't interact with anyone other than me on a regular basis.

SECTION D - INFORMATION ABOUT ABILITIES

23. a. Check any of the following items the disabled person's illnesses, injuries, or conditions affect:

- | | | | |
|---|--|--|--|
| <input checked="" type="checkbox"/> Lifting | <input checked="" type="checkbox"/> Walking | <input checked="" type="checkbox"/> Stair Climbing | <input type="checkbox"/> Understanding |
| <input checked="" type="checkbox"/> Squatting | <input checked="" type="checkbox"/> Sitting | <input type="checkbox"/> Seeing | <input checked="" type="checkbox"/> Following Instructions |
| <input checked="" type="checkbox"/> Bending | <input checked="" type="checkbox"/> Kneeling | <input checked="" type="checkbox"/> Memory | <input type="checkbox"/> Using Hands |
| <input checked="" type="checkbox"/> Standing | <input type="checkbox"/> Talking | <input checked="" type="checkbox"/> Completing Tasks | <input type="checkbox"/> Getting Along with Others |
| <input checked="" type="checkbox"/> Reaching | <input type="checkbox"/> Hearing | <input checked="" type="checkbox"/> Concentration | |

Please explain how his/her illnesses, injuries, or conditions affect each of the items you checked. (For example, he/she can only lift [how many pounds], or he/she can only walk [how far])

His back pain keeps him from physical activities and his depression/anxiety makes even simple tasks overwhelming for him.

b. Is the disabled person: ☐ Right Handed? ☒ Left Handed?

c. How far can he/she walk before needing to stop and rest? About 200 feet

If he/she has to rest, how long before he/she can resume walking?

About 10 minutes

d. For how long can the disabled person pay attention? Not very long. 10 minutes or so

e. Does the disabled person finish what he/she starts? (For example, a conversation, chores, reading, watching a movie.)

☐ Yes ☒ No

f. How well does the disabled person follow written instructions? (For example, a recipe.)

He has to re-read instructions and asks questions while trying to do the tasks. Still doesn't finish even with help and encouragement.

g. How well does the disabled person follow spoken instructions?

He forgets and has to be reminded and/or motivated constantly.

h. How well does the disabled person get along with authority figures? (For example, police, bosses, landlords or teachers.)

no problem

i. Has he/she ever been fired or laid off from a job because of problems getting along with other people?

☐ Yes ☒ No

If "YES," please explain.

If "YES," please give name of employer.

j. How well does the disabled person handle stress?

Not well at all. If he has a stressful day, he will stay in bed for a day or two after and completely isolate himself.

k. How well does he/she handle changes in routine?

No well but can adapt to small changes

l. Have you noticed any unusual behavior or fears in the disabled person?

☒ Yes ☐ No

If "YES," please explain.

He has started having nightmares recently which he never had before

24. Does the disabled person use any of the following? (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Crutches | <input checked="" type="checkbox"/> Cane | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Brace/Splint | <input type="checkbox"/> Glasses/Contact Lenses |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Artificial Limb | <input type="checkbox"/> Artificial Voice Box |
| <input type="checkbox"/> Other (Explain) _____ | | |

Which of these were prescribed by a doctor?

Cane

When was it prescribed?

unknown

When does this person need to use these aids?

Daily for balance

25. Does the disabled person currently take any medicines for his/her illnesses, injuries, or conditions?

☒ Yes ☐ No

If " YES," do any of the medicines cause side effects?

☐ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that the disabled person takes. List only the medicines that cause side effects for the disabled person.)

NAME OF MEDICINE	SIDE EFFECTS PERSON HAS
Unknown	Unknown

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

[illegible]

Name of person completing this form (Please print)		Date (<i>month, day, year</i>)
Jane P. Doe		1/11/11
Address (Number and Street)	Email address (optional)	
1234 Main Street		
City	State	ZIP Code
Anchorage	AK	99506

Appendix C

Work History Report

WORK HISTORY REPORT- Form SSA-3369-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. Then call the phone number provided on the letter sent with the form or the phone number of the person who asked you to complete the form for help to 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.

- Print or type.
- A reference to "you," "your," or "the Disabled Person," or "claimant" means the person who is applying for disability benefits. If you are filling out the form for someone else, provide information about him or her.
- **ANSWER ALL OF THE QUESTIONS FOR EACH JOB YOU DESCRIBE.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

WHY THIS INFORMATION IS IMPORTANT

The information we ask for on this form will help us understand how your illnesses, injuries, or conditions might affect your ability to do work for which you are qualified. The information tells us about the kinds of work you did, including the types of skills you needed and the physical and mental requirements of each job. In Section 2, be sure to give us all of the different jobs you did in the 15 years before you became unable to work because of your illnesses, injuries, or conditions. There is a separate page to describe each different job.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

Privacy Act Statement 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 to make a determination of eligibility for Social Security benefits.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. 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); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0089, entitled, Claims Folders Systems; and, 60-0090, entitled, Master Beneficiary Record. Additional information about these and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through 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 or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 1 hour to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE STATE AGENCY THAT REQUESTED IT.** If you have questions about how to complete the form, contact the State Agency that requested it. If you need the address or phone number for your State Agency, you can get it by calling 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 Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

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

WORK HISTORY REPORT

For SSA Use Only
Do not write in this box.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON**A. NAME (First, Middle Initial, Last)**

John S. Doe

B. SOCIAL SECURITY NUMBER

123-45-6789

C. DAYTIME TELEPHONE NUMBER *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

(907) 123 - 4567

Area Code Phone Number☒ Your Number☐ Message Number☐ None**SECTION 2 - INFORMATION ABOUT YOUR WORK**

List all the jobs that you have had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

	Job Title	Type of Business	Dates Worked	
			From	To
1.	Customer Service	Automotive parts store	12/2016	5/2017
2.	Body Shop Manager	Automotive body shop	6/2007	10/2016
3.	Estimator	Automotive body shop	1/2000	5/2007
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Work History Report - Form SSA-3369-BK

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1

Rate of Pay	Per (Check One)	Hours per day	Days Per Week
\$ 15.00	<input checked="" type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	7.00	5.00

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

Sold auto parts, used register, counted money, dealt with phone orders or customers in

person, pulled parts from warehouse.

In this job, did you:

Use machines, tools, or equipment?	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
Use technical knowledge or skills?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk?	2	Kneel? (Bend legs to rest on knees)	1
Stand?	6	Crouch? (Bend legs & back down & forward)	2
Sit?	0	Crawl? (Move on hands & knees)	0
Climb?	1.2	Handle, grab, or grasp big objects?	1
Stoop? (Bend down and forward at waist)	1	Reach?	1
		Write, type, or handle small objects?	1

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Auto parts that were on the racks and floor-some were high, some were low-carried some 100

feet up to 300 feet. Did this for 2 hours per day. Carried heavy items on a cart 10% of the time.

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☒ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

☒ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☒ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 2 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 2

Rate of Pay	Per (Check One)	Hours per day	Days per week
\$ 90000	<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input checked="" type="checkbox"/> Year	10.00	5.00

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

Did a lot of paperwork and reports, closed out work orders, check on progress of work being performed, ordered and returned parts.

In this job, did you:

Use machines, tools, or equipment?	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
Use technical knowledge or skills?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk?	3	Kneel? (Bend legs to rest on knees)	2
Stand?	2	Crouch? (Bend legs & back down & forward)	2
Sit?	3	Crawl? (Move on hands & knees)	0
Climb?	0	Handle, grab, or grasp big objects?	0
Stoop? (Bend down and forward at waist)	2	Reach?	0
		Write, type, or handle small objects?	3

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Small auto parts to the techs and small damaged parts to trash bin. Carried about 50 feet ten times a day.

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☒ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

☐ Less than 10 lbs ☐ 10 lbs ☒ 25 lbs ☐ 50 lbs or more ☐ Other _____

Did you supervise other people in this job? ☒ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? 8

What part of your time was spent supervising people? 1 hour

Did you hire and fire employees? ☐ YES ☒ NO

Were you a lead worker? ☒ YES ☐ NO

Give us more information about Job No. 3 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 3

Rate of Pay	Per (Check One)					Hours per day	Days per week
\$ 55000.00	<input type="checkbox"/> Hour	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input checked="" type="checkbox"/> Year	10.00	5.00

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

Wrote estimates for damaged vehicles, cleaned cars before and after repairs, drove vehicles for repairs, delivered vehicles to customers.

In this job, did you:

Use machines, tools, or equipment?	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
Use technical knowledge or skills?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk?	4	Kneel? (Bend legs to rest on knees)	2
Stand?	2	Crouch? (Bend legs & back down & forward)	2
Sit?	3	Crawl? (Move on hands & knees)	1/2
Climb?	0	Handle, grab, or grasp big objects?	0
Stoop? (Bend down and forward at waist)	2	Reach?	0
		Write, type, or handle small objects?	3

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Carried and dragged auto parts to body techs about 150 feet for 2 hours per day.

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☒ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

☒ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☒ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 4 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 4

Rate of Pay	Per (Check One)						Hours per day	Days per week
\$ _____	<input type="checkbox"/> Hour	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Year			

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

- | | | |
|--|------------------------------|-----------------------------|
| Use machines, tools, or equipment? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Use technical knowledge or skills? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do any writing, complete reports, or perform duties like this? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

In **this job**, how many total hours each day did you:

- | | |
|---|---|
| Walk? _____ | Kneel? (Bend legs to rest on knees) _____ |
| Stand? _____ | Crouch? (Bend legs & back down & forward) _____ |
| Sit? _____ | Crawl? (Move on hands & knees) _____ |
| Climb? _____ | Handle, grab, or grasp big objects? _____ |
| Stoop? (Bend down and forward at waist) _____ | Reach? _____ |
| | Write, type, or handle small objects? _____ |

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:

- ☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

- ☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 5 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 5

Rate of Pay	Per (Check One)					Hours per day	Days per week
\$ _____	<input type="checkbox"/> Hour	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Year		

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use machines, tools, or equipment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Use technical knowledge or skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do any writing, complete reports, or perform duties like this?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

In **this job**, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down & forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab, or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type, or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

Give us more information about Job No. 6 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 6

Rate of Pay	Per (Check One)	Hours per day	Days per week
\$ _____	<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

- | | | |
|--|------------------------------|-----------------------------|
| Use machines, tools, or equipment? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Use technical knowledge or skills? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do any writing, complete reports, or perform duties like this? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

In **this job**, how many total hours each day did you:

- | | |
|---|---|
| Walk? _____ | Kneel? (Bend legs to rest on knees) _____ |
| Stand? _____ | Crouch? (Bend legs & back down & forward) _____ |
| Sit? _____ | Crawl? (Move on hands & knees) _____ |
| Climb? _____ | Handle, grab, or grasp big objects? _____ |
| Stoop? (Bend down and forward at waist) _____ | Reach? _____ |
| | Write, type, or handle small objects? _____ |

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:

- ☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

- ☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other _____

Did you supervise other people in this job? ☐ YES (Complete the next 3 items.) ☐ NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

SECTION 3 - REMARKS

Use this section to add any information you did not have space for in other parts of the form. Show the page number of the part you are continuing.

BE SURE TO COMPLETE THE BOTTOM OF THIS PAGE.

Name of person completing this form if other than the disabled <i>person</i> (Please print) John S. Doe		Date (Month, day, year) 1/11/11	
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