SOCIAL SECURITY DISABILITY

What a Paralegal Can Do

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Social Security Disability
What a Paralegal Can Do

In 2006, The National Association of Legal Assistants/Paralegals was offering one of its first Advanced Paralegal Certifications in Social Security Disability. After reading that a Paralegal, or anyone for that matter, could assist someone with a disability case, I decided as a way to fund by "retirement" I would sit for the course and find out more about social security disability. I passed the course and that was the beginning of an eye opening second career with the shocking world of dealing with the Social Security Administration and the Federal Government.

A very wise attorney I met in my years with NALA told me at dinner in Tulsa, Oklahoma that your clients either have to be dead or almost there when you represent them. I'm sorry to say he was right. I have lost several clients before they were approved or before they received their first check. It has been heart breaking. The last eight years beginning in 2008 have been the worst since I began this work. I am praying it will improve with the current administration, but I'm not holding my breath. I can tell you war stories, but what I want to do is explain how to do the work and do the work right, in the time I have, the best I can.

STARTING YOUR PRACTICE

A. Because federal law allows anyone to help a person seeking social security disability, this is an area that we as paralegals can render services. We are called non-attorney representatives. We have to submit to the Social Security Administration (hereafter "SSA") a form SSA 1696-U4 (Form #1) and a fee agreement (Form #2) for approval and collect a fee of 25% of the back pay or no more than $6000.00. There is an exam offered by SSA which will allow one direct pay even before a claimant received the back pay. The exam costs $1,000.00 and is given once a year. Call you local hearing office for more information.

B. Working my practice part time makes me a little different than full time workers. However the procedure is the same. I started by creating an LLC. You can have a lawyer to set up yours. I did my own. The instructions are on our Secretary of State's website. An assumed name needs to be obtained at your county's Register of Deeds office and a federal tax id number. I do estimated taxes. Just keep up with every scrap of paper you have! I have a part time assistant even though I only do this work part time! I could not keep up alone. She is a life saver.

PREPARING & ANALYZING INFORMATION

A. I am unmarried and live alone. I do not advertise. My first claimant was an old friend from high school who I talked into letting me try to represent him. He had a terrible case of bipolar, no money and didn't care if he lived or died. He lived with his mother who helped him and kept

insurance on him. He had open heart surgery while I was representing him. His case went to the hearing stage. I wrote the judge a letter and he was approved! My first back pay. At that time, the most I could get was $5200.00. He referred his cousin. I won that case and that cousin referred another family member. I was telling my Sunday school class about how good the Lord had been to me and more referrals came. This is how I get my claimants. This provides me with safety.

i. When people call me I ask their name, address, phone number Social Security number, marital status, minor children, whether they can read and write, ever in the military, their work history, name and location of their most recent job, why did the job end, and THE LAST DAY THEY WORKED. Then I ask their medical history prior to the last day they worked. Did they have significant health problems prior to the last day they worked? How has their health problems affected their daily living?

ii. If I determine the claimant is eligible for SSI (Social Security Insurance or SSD (Social Security Disability) my assistant sends them a pack of information. The packet is included in the forms section of this manuscript. (Form #3). No matter how detailed I ask them to be, they never are. I will be at the computer asking those questions, looking up addresses and phone numbers. The average application takes me 3 – 4 hours. Always, always, be sure that you send them the SSA-821. This is the Release for Medical

Information. (Form #4) The SSA can get the records for $15.00. It will cost you a small fortune. I have the clients pick up the information themselves. Most hospitals now have dukemychart.org, myconehealth, etc. The records aren't totally complete but do help with costs. If records do cost me to obtain, I immediately send the claimants the bill and ask them to pay. If they cannot pay, they cannot.

FILING THE APPLICATION

A. Go to SSA.Gov. Click on File a disability application. The site will ask you if you are filing the application for yourself or someone else. If for someone else is that person with you. ALWAYS be honest. If they are not with you, say NO!! The site will ask you questions knowing the person is not with you. At the end when you have completed all the sections properly, you will be allowed to print out a copy of all of your answers for yourself and your claimant. You will also be promoted to print out the medical release (which you should already have a signed copy) and a cover sheet which will need to be mailed to your local SSA office with all the forms that you have had them complete, the function report (Form #5), the third party function report (Form #6,); and, the work history report (Form #7.) NOW YOU WAIT!

B. Often your client will receive calls from the SSA office. They may receive additional forms. The SSA office may ask for forms that you mailed in with the cover sheet in your initial packet. Don't ask the client

to do it again. Just fax it yourself. The Greensboro Office is notorious for asking for the same forms over and over.

C. Realize that more than 65% of the claims filed are denied the first round. When or if your claimant receives a denial then you file for Request for Reconsideration. Go to ssa.gov and click on file an appeal. The site will ask for the date on the denial letter and your claimant's social security number. You will need to update prescription drugs and doctor visits. The approval rate at this level is around 20%.

D. If your Claimant is denied at the Request for Reconsideration level you then file for a Hearing Before An Administrative Law Judge. All of the appeals are filed on line. Once again the site will ask for the date on the denial letter and your claimant's social security number. You then have a year and a half to two year wait. During this time you continually update the claimant's electronic file.

E. Just as a point of information, I registered with the Social Security Administration's Appointed Representative Services. I had to go to Greensboro to register, but it was worth the time and the drive to your local hearing office. This allows me to view the electronic folder documents in real time, to download efolder contents including multimedia files, and upload medical evidence and other documents directly into a claimant's efolder. I can download status reports with key information regarding their pending and recently closed cases. This is only at the hearing level. You have to call and request an invitation to

enroll. This is an in-person enrollment. I have included some information regarding this process (Form #8.)

MEDICAL EVIDENCE

A. The regulations discuss medical evidence at 20 C.F.R., Sections 404-1525 through 1546. Your need for medical evidence is never-ending. While SSA and the ALJs are usually content to ask just enough questions, which approach the disability issues in a surface searching kind of way, it is your job to be certain that the questions are directly answered by the claimant's physicians. Throughout the process, the Administration relies upon that evidence which it obtains, independent of but also from the claimant's doctors. The nature of the information gained by the administration depends upon where the case is. It is your responsibility to communicate with the claimant's doctors to try to obtain that information which will assure success.

B. The best information you can get is the doctor's file or chart. Can the doctor explain the ailment? What diagnostic test and procedures were performed which support the diagnosis? To what specialists was the claimant referred? What were their findings?

C. The administration's doctors. At both the initial application level and the reconsideration level, the administration often will send your claimants to

their own doctors. A large number of these doctors are retired. The decisions these physicians render is almost always not on the side of your claimant. There is, however, no reason why you cannot submit medical evidence in the hope it might convince the Administration otherwise. Remember at these two levels since the decision are always based ONLY on the written record – at early stages of the process, it is unlikely that your client's physicians have submitted anything of great substance or length.

D. Burden of Proof: The burden of proof is on the claimant. If in a hearing, it is possible that the burden might shift to the Administration, but that requires certain facts be demonstrated. You must always assume that the burden is going to be on the claimant. You cannot be lulled into believing that the Administration or the ALJ will work to make your case.

WITNESSES

A. Vocational Experts – I once had an attorney friend who told me when I first started my practice that the more a vocational expert talked the less he liked them. It did not take me long to understand what he was talking about.

Vocational considerations are covered by 20 C.F.R. Sec 404.1560 through -1569a. The vocational factors (age, education, work history and residual functional capacity) appear again: this is the vocational profile. This profile recurs through disability cases whether regular disability or SSI. The Administration generally is satisfied with proof of the claimant's

work over the past 15 years; however, it is wise to go as far back as can be shown, even if back to high school. Each job which the claimant has worked must be listed, the exertion level required, skill level attained and skills learned, why the job ended, whether some special skill helped the claimant get the job or advance in it.

It is vital that you know of and be familiar with the Dictionary of Occupational Titles. It was produced by the US Department of Labor back in the year 2000. Yes, it is old but the Administration still uses it. It lists jobs in various ways, including skill and exertion levels. Its importance in SSA disability cases is that in situations where the ALJ believes that a case for disability can be made, a Vocational Expert is brought in. Often, these are employment counselors who are familiar with the dictionary of Occupational Titles. If you can demonstration error in the selection of the proposed job, which the claimant can supposedly do, the credibility of the Vocational Expert and worth of his/her testimony may be dented. The DOT can be found on the internet and on US Government websites.

Something I have found beneficial to do is to send my claimant to the Local Vocational Rehab office for placement. If they are not able to find a job for your claimant, that is wonderful!

B. Lay Testimony: **The claimant** is his/her own best witness. Evidence is given in an administrative, non-courtroom setting. The ALJ doesn't use strict rules of evidence and your client can include hearsay, such as what

the claimant was told by doctors, or vocational rehab people or by his employer or supervisor. These are just as valuable as any other evidence. Your claimant should be counseled that putting on a show is not merely bad form but an invitation to disaster. However, if your client can't sit very long because of a back injury, let them stand up for relief. If they have to squirm, let them squirm. It is your job to ask your claimant: Are you nervous? What makes you nervous? Are you able to take care of yourself? How much housework do you do? Do you go to church? Do you go out with others? Do you go grocery shopping? If not, why do you not do those things? Do you sleep well? Are you nervous, upset, or tense? On a scale of 1-10, what is your pain level? What prevents them from working? Are there any jobs that you think you can do?

I spend time with my claimants prior to the hearing and ask them these questions and type all of the questions and answers that we may use during the hearing. This way they are prepared for at least my questions. Often, we have also hit many of the ALJ's questions and the claimant is prepared with answers for those as well.

It is imperative that you ask your claimant about depression or other mental impairments suffered by him/her. The reason is simple: those who have worked all their lives, especially if at arduous physical work, and suddenly find that they are no longer capable of doing this, now encounter financial and perhaps marital distress, and are spending their days sitting around incapable of functioning. These people will be depressed. They

rarely see a psychiatrist, psychologist or mental health counselor. It is possible that a general practitioner might prescribe anti-depressants. However, ALJs tend to discount such prescriptions, because the doctor issuing it is not a specialist. Fair? No, but it regularly occurs. Sleep disturbance, unexplained weight loss/gain, feelings of hopelessness, worthlessness, suicidal thoughts anxiety, all are symptoms prevalent in disability cases and often ignored by those of us doing these cases.

Spouses or and adult child of the claimant is a potentially valuable witness. He or she could do more than support. Does the claimant understate his/her problems? Is the claimant unwilling to accurately testify as to how bad his/her symptoms are? The spouse must be as well prepared as the claimant.

WORKING WHILE FILING FOR OR RECEIVING DISABILITY

Federal regulations use the national average wage index to set the income limit for determining the substantial gainful activity (SGA) each year. In 2017, the amount is $1,170 for disabled applicants. While a disabled personal applying for or receiving disability cannot EARN more than $1,170 per month by working a person can have an amount of income from investments, interest, or a spouse's income.

FORM #1

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
	– –
Wage Earner (If Different)	Social Security Number
	– –

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, Belinda Ann Thomas
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☑ Title II (RSDI) ☐ Title XVI (SSI) ☑ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☑ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is _____
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) –	Fax Number (with Area Code) ( ) –	Date

Part II ACCEPTANCE OF APPOINTMENT

I, Belinda Ann Thomas, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☑ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency ☐ YES ☑ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Belinda Ann Thomas		
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date
(336) 675 - 5851	( ) –	

Part III FEE ARRANGEMENT

(Select an option, sign and date this section.)

☐ Charging a fee and requesting direct payment of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☑ Charging a fee but waiving direct payment of the fee from withheld past-due benefits —I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ Waiving fees and expenses from the claimant and any auxiliary beneficiaries —By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ Waiving fees from any source —I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date
Belinda Ann Thomas	

FORM #2

NORTH CAROLINA

ALAMANCE COUNTY

FEE AGREEMENT

I, the undersigned, do hereby employ and retain Belinda Ann Thomas of Thomas Superior Services LLC, to represent my interest in my Social Security Disability matter.

I AGREE AS FOLLOWS:

1. I will pay my representative 25 percent of any past-due benefits from my claim or, no more than $6,000.00, the maximum dollar amount allowed pursuant to section 206(a)(2)(A) of the Social Security Act based on the date SSA approves my fee agreement.

2. To pay my Representative in advance for any reasonable expenses and disbursements which are incurred by my Representative. These expenses may include discovery expenses, records, expert witnesses, cost of transcripts, appeal costs and any and all expenses that my Representative considers reasonable and necessary for the proper representation of my interests.

3. To cooperate with my Representative in every way possible in the preparation of my case, including, but not limited to, the location of witnesses, documents and other forms of evidence to be used in my case.

4. I understand and agree that my Representative has made no promises as to the outcome of this case, except that she has promised to devote her best professional skill to my interest.

5. For non-payment of expenses or the reimbursement to my Representative for the payments of such expenses as set forth herein or for non-cooperation my Representative shall be permitted to withdraw from further representation in this case by mailing me written notice at my last address known to her.

I have read this Agreement and understand its terms which I acknowledge to be fair and reasonable.

This the _____ day of _____, _____.

APPROVED AND ACCEPTED:

By Belinda Ann Thomas
Representative

_____
Claimant

FORM #3

SOCIAL SECURITY DISABILITY INTAKE FORM

ABOUT YOU:

Name: _____

Any other names used? (Maiden, etc.)_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell Phone: _____

Social Security number: _____ Any other Soc.Sec. Numbers?_____

Date of Birth: _____ Born in U.S.?_____If not, where?_____

City of Birth:_____State of Birth:_____Type of Citizenship:_____

Email Address: _____

Mother's Maiden Name:_____ Father's Full Name: _____

EDUCATION:

Highest grade of school completed: _____ Date completed: _____

Name and address of school: _____

Any special training, trade, or vocational school: ____

Special education: _____ Where did you get Special training? _____

Name and adddress of school: _____

Started attendance: ____ Ended attendance: ____ Special ed at more than one school?: _____

ANOTHER CONTACT PERSON BESIDES YOU:

Name: _____Relationship: _____

Mailing address: _____

Daytime Phone number: _____ Extension: _____

Speak and Understand English: _____

FAMILY:

1. Currently married?_____ If so, Spouse's name:_____

Spouse's date of birth: _____ Spouse's social sec. No._____

Date of marriage: _____City and state of marriage: _____

County of marriage: _____Type of marriage: _____

Prior marriages? _____If so, Name of prior spouse_____

Date of birth of previous spouse: _____ Soc. Sec. No.(if known)_____

Address of prior spouse (if known):_____

If more marriages, attach an additional page.

2. Do you have any children under the age of 19? _____ If so, complete the following chart:

Name	Address	Date of birth

Do you have any children who became disabled prior to age 22? _____
Name: _____Date of birth:_____

MILITARY:

Any military service: _____

Date entered: _____ Date discharged: _____

Any military service prior to 1968: _____

BANKING INFORMATION (For Direct Deposit):

Checking Account Routing Number: _____

Checking Account Number: _____

CRIMINAL BACKGROUND:

Have you ever been convicted of a Felony? YES_____ NO_____

EMPLOYMENT AND EARNINGS (start with most recent):

Name & address of company	Your job title	Hours per day/days per week	Date started job	Date ended job	Starting pay	Ending pay

Do you agree with the earning history as shown on your Social Security statement? _____

Are you a corporate office of your employer? _____

Are you related to a corporate office of your employer? _____

Do you receive earnings from a family corporation or other closely held corporation? _____

Permission granted to contact employer(s) if necessary? _____

Total of all wages and tips this year: _____ Total of all wages and tips last year: _____

Ever worked in a job where Social Security taxes were not withheld?_____

OTHER BENEFITS:

Have you recently applied for Supplemental Security Income?_____

Do you intend to apply for Supplemental Security Income (SSI)? _____

Any previous application(s) for Medicare, Social Security, or Supplemental Security Income benefits:_____

DISABILITY QUESTIONS:

What are your illnesses, injuries, conditions that limit your ability to work: _____

_____

Are these related to work?_____ Are you now able to work? _____

Do you intend to file for worker's compensation? _____

Have you received money from your employer on/after date unable to work? _____

Total amount received from your employer: _____

Types of pay received: _____

Do you expect to receive money from your employer in the future? _____

Total amount expected to receive from your employer: _____

Type of pay expected: _____

MEDICAL:

List of physical and mental conditions:
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Height without shoes: _____

Weight without shoes: _____

Conditions causing pain or other symptoms: _____

Seen a healthcare provider or received treatment, or have an appointment scheduled

for physical conditions: _____

for mental conditions: _____

Doctors and Other Healthcare Professionals

Doctor& Clinic Name	Address & Phone #	First Visit	Last Visit	Next Appt.	Medical Condition treated	Treatment received

Hospitals

Name, address and phone number of hospital	Dates of emergency room visits	Dates of inpatient stays	Dates of Outpatient visits	Next schedules outpatient visit	Medical condition treated	Treatment received
NEXT HOSPITAL:						
NEXT HOSPITAL						

TESTS

#	Kind of test	Body part:	Date of test:	Sent for test by:
Test 1				
Test 2				
Test 3				
Test 4				
Test 5				
Test 6				
Test 7				

MEDICINES

Medicine	Dosage (mg, etc.)	Reason(diabetes, depression, etc)	Prescribed by (which physician):

FORM #4

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*	
SSN _ _	Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT *All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to :
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am capable of managing benefits ONLY (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶	IF needed, second witness sign here (e.g., if signed with "X" above) SIGN ▶
Phone Number (or Address) (336) 675-5851	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2, 38 U.S. Code section 7332, 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

FORM #5

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0681

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only
Do not write in this box.

Related SSN _____

Number Holder _____

SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle Initial, Last)*	2. **SOCIAL SECURITY NUMBER**

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.)*

_____ _____ ☐ 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?

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

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

8. Do you take care of pets or other animals? ☐ Yes ☐ No

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

9. Does anyone help you care for other people or animals? ☐ Yes ☐ No

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

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

11. Do the illnesses, injuries, or conditions affect your sleep? ☐ Yes ☐ No

    If "YES," how?

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

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

    Dress

    Bathe

    Care for hair

    Shave

    Feed self

    Use the toilet

    Other

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? _____

_____

c. Do you need help or reminders taking medicine? ☐ Yes ☐ No

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

_____

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.) _____

_____

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

_____

How long does it take you? _____

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

_____

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.) _____

_____

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

_____

c. Do you need help or encouragement doing these things? ☐ Yes ☐ No

If "YES," what help is needed? _____

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

_____

15. **GETTING AROUND**

a. How often do you go outside? _____

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

_____

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. _____

_____

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. _____

_____

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

_____

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. _____

_____

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. _____

_____

18. HOBBIES AND INTERESTS

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

_____

_____

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

_____

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

_____

_____

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.) _____

_____

Do you need to be reminded to go places? ☐ Yes ☐ No

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

_____

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. _____

_____

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

_____

_____

_____

SECTION D - INFORMATION ABOUT ABILITIES

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

☐ Lifting	☐ Walking	☐ Stair Climbing	☐ Understanding
☐ Squatting	☐ Sitting	☐ Seeing	☐ Following Instructions
☐ Bending	☐ Kneeling	☐ Memory	☐ Using Hands
☐ Standing	☐ Talking	☐ Completing Tasks	☐ Getting Along With Others
☐ Reaching	☐ Hearing	☐ 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])

_____

_____

_____

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

c. How far can you walk before needing to stop and rest? _____

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

_____

d. For how long can you pay attention? _____

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.) _____

_____

g. How well do you follow spoken instructions? _____

_____

_____

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

_____

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? _____

_____

k. How well do you handle changes in 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? _____

_____

When was it prescribed? _____

_____

When do you need to use these aids? _____

_____

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

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)	Date *(month, day, year)*
Address (Number and Street)	Email address (optional)
City	State / ZIP Code

FORM #6

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

Privacy Act and Paperwork Reduction Act Statements

Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. 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. We generally use the information you supply for the purpose of making decisions regarding claims. 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 the following: (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 Government Accountability Office and the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs. We may also use the information you provide in computer matching programs. Matching programs compare our records with those 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 payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C., §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 61 minutes to read the instructions, gather the facts, and answer the questions. SEND 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.

SOCIAL SECURITY ADMINISTRATION

Form Approved OMB
No . 0960 - 0635

FUNCTION REPORT- ADULT - THIRD PARTY

How the disabled person's illnesses, injuries, or conditions limit his/her activities

SECTION A - GENERAL INFORMATION

1. NAME OF DISABLED PERSON *(First, Middle, Last)*

2. YOUR NAME *(Person completing the form)*	3. RELATIONSHIP *(To disabled person)*	4 . DATE *(Month, Day, Year)*

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.)*

( ) - ☐ Your Number ☐ Message Number ☐ None

Area Code *Phone Number*

6. a. How long have you known the disabled person? _____

b. How much time do you spend with the disabled person and what do you do together?

_____

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 do this person's illnesses, injuries, or conditions limit his/her ability to work?

_____

_____

_____

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

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

_____

_____

_____

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? _____

_____

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? _____

_____

13. What was the disabled person able to do before his/her illnesses, injuries, or conditions that he/she can't do now?

_____

14. Do the illnesses, injuries, or conditions affect his/her sleep? ☐ Yes ☐ No

If "YES," how? _____

_____

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 _____

Bathe _____

Care for hair _____

Shave _____

Feed self _____

Use the toilet _____

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? _____

_____

c. Does he/she need help or reminders taking medicine? ☐ Yes ☐ No

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

_____

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 w ith several courses.) _____

_____

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

_____

How long does it take him/her? _____

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

_____

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

_____

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.)*

_____

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

_____

c. Does he/she need help or encouragement doing these things? ☐ Yes ☐ No

If "YES," what help is needed? _____

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? _____

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

_____

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. _____

_____

d. Does the disabled person drive? ☐ Yes ☐ No

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

_____

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. _____

_____

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

_____

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 _____

_____

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. _____

_____

21. HOBBIES AND INTERESTS

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

_____

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

_____

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

_____

_____

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? _____

_____

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.

_____

_____

SECTION D - INFORMATION ABOUT ABILITIES

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

☐ Lifting	☐ Walking	☐ Stair Climbing	☐ Understanding
☐ Squatting	☐ Sitting	☐ Seeing	☐ Following Instructions
☐ Bending	☐ Kneeling	☐ Memory	☐ Using Hands
☐ Standing	☐ Talking	☐ Completing Tasks	☐ Getting Along With Others
☐ Reaching	☐ Hearing	☐ 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])

_____

_____

_____

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

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

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

_____

d. For how long can the disabled person pay attention? _____

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.)

_____

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

_____

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

_____

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? _____

_____

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

_____

l. Have you noticed any unusual behavior or fears in the disabled person? ☐ Yes ☐ No

If "YES," please explain. _____

_____

24. Does the disabled person 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? _____

_____

When was it prescribed? _____

_____

When does this person need to use these aids? _____

_____

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

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)	Date *(month, day, year)*
Address (Number and Street)	Email address (optional)
City	State / Zip Code

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not an insurance company, health care provider, or other covered entity, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ Date of birth: _____

Persons/organizations providing the information: _____

Department Name: _____ Telephone Number: _____

Address: _____

Please note the date(s) of service being requested: From: _____ To: _____

Please check and initital the specific information being released (used or disclosed):

History and physical	_____	Clinic Notes	_____	Social History	_____
Discharge Summary	_____	Progress Notes	_____	Diagnosis	_____
Consultation Report	_____	Radiology/Imaging	_____	Psychiatric Evaluation	_____
Operative Report	_____	Laboratory/Pathology	_____	Psychological Eval	_____
Intake/Referral Info	_____	Physician Orders	_____	Treatment Plan	_____
Emergency Room Record	_____	Immunization Record	_____	Financial Information	_____
Summary (Home Health)	_____	Discipline Notes	_____	Other (specify)	_____
Entire record	_____				

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

This information may be released to and used by the following individual: Belinda Ann Thomas, ACP, NCCP,

Address: Thomas Superior Services, LLC 408 Tarpley Street, Burlington, NC 27215

Telephone: (336) 675-5851

Will the health care provider requesting the authorization receive any financial or in-kind compensation in exchange for using or disclosing the health information described above? yes____ no____

____ Medical Review __X_Legal Review _____Insurance Review _____Personal Use ____Other: _____

I understand that I have a right to revoke this authorization at any time by notifying the Health Information Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditional based on signing this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that this authorization will expire in 90 days.

Printed Name: _____Signature: _____

Date: _____ Verified by Driver's License _____ Other: _____

County of _____
State of _____

I certify that _____ personally appeared before me this day, and acknowledged to me that he/she signed this Authorization for Release of Health Information.

Official Signature of Notary: _____

Notary's printed or typed name:_____ (Official Seal)

My commission expires: _____

FOR FACILITY USE ONLY

____ Identification verified _____Copy of authorization given to patient _____ Medical Record #_____

Employee signature: _____
Title:_____
Date: _____

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 on this form to make a decision on the named claimant's claim.

Completion of this form is voluntary; however, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim.

We rarely use the information you supply for any purpose other than for determining continuing eligibility. 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 the following:

1. To enable a third party or an 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 Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

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 payments or delinquent debts under these programs.

A complete list of routine uses for this information are available in our System of Records Notices entitled, Claims Folders Systems (60-0089) and the Master Beneficiary Record (60-0090). These notices, additional information regarding this form, routine uses of information, and our programs and systems are available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S. C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 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.

FORM #7

Form Approved
OMB No. 0960-0578

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)	B. SOCIAL SECURITY NUMBER

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.)*

( ) –
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.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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)* ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

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?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
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. 2 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 2		
Rate of Pay $ _____ Per *(Check One)* ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

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?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
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. 3 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 3			
Rate of Pay $ _____	Per *(Check One)* ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

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?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
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. 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
$ _____	☐ Hour ☐ Day ☐ Week ☐ Month ☐ 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?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
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
$ _____	☐ Hour ☐ Day ☐ Week ☐ Month ☐ 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?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
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)* ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	Hours per day _____	Days per week _____

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?	☐ YES	☐ NO
Use technical knowledge or skills?	☐ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

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

Walk? _____
Stand? _____
Sit? _____
Climb? _____
Stoop? *(Bend down and forward at waist)* _____

Kneel? *(Bend legs to rest on knees)* _____
Crouch? *(Bend legs & back down & forward)* _____
Crawl? *(Move on hands & knees)* _____
Handle, grab, or grasp big objects? _____
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 *person (Please print)*	**Date** *(Month, day, year)*	
Address *(Number and Street)*	**Email address** *(optional)*	
City	**State**	**ZIP Code**

FORM #8

Social Security

Appointed Representative Services

Appointed Representative Services

ARS is an application that allows appointed representatives to view electronic folder (eFolder) documents in real time, to download eFolder contents including multimedia files, and upload medical evidence and other documents directly into a claimant's eFolder. Representatives may also download status reports with key information regarding their pending and recently closed cases.

Using ARS will give you real time and up-to-date access to your claimant's electronic folders for cases pending at ODAR.

Enrolling in ARS

Enrollment for eFolder access has several steps:

1. Contact your local hearing office and request an invitation to enroll.
2. Receive in the mail an invitation notice and a specially marked *Form SSA-1699, Registration for Appointed Representative Services and Direct Payment.*
3. Complete and sign the SSA-1699, then fax it to 1-877-268-3827 for processing.
    - Once the 1699 is processed, you will be mailed a User ID and Rep ID.
4. Contact your local hearing office to arrange a date, time, and location to complete the in-person enrollment.
5. Attend the scheduled in-person enrollment event and bring the following:
    - Your invitation notice
    - A valid government-issued photo ID
    - A text-enabled cell phone

You must follow all the steps above to enroll for eFolder access. If you have any questions regarding the enrollment process, please contact your local hearing office.