SUMMONS

IN RE THE MARRIAGE OF:

_____

_____

_____

Petitioner

AND

_____

_____

_____

Respondent

THE STATE OF INDIANA

IN THE DELAWARE CIRCUIT COURT NO.

Cause No.: _____

To Respondent: _____

Be advised that a Petition for Dissolution of Marriage has been filed by the person named "Petitioner" in the Court stated above.

The nature of the action is stated in the Petition which is attached to this document. It also states the prayer which the Petitioner has made and wants from you.*

You must answer in opposition to the Petition in writing, by you or your attorney, within twenty (20)** days commencing the day after you receive this summons, or a dissolution of marriage and/or order of support will be entered granting what the petitioner has demanded at the expiration of the statutory period.

If you have a claim for relief against the petitioner arising from the said marriage, you must assert it in your written appearance.

The following manner of service of summons is hereby designated: **PERSONAL SERVICE**

Date _____

_____ _____

Attorney for Petitioner

Clerk of the Circuit Court

Linda Clark Dague
Attorney #4744-18
DAGUE & BUCK, LLP
1100 South Martin Luther King, Jr., Blvd., Suite 2
Muncie, Indiana 47304
(765) 289-4505

(Seal)

* If the petition is not attached, a copy is available for you in the office of the Clerk of said court.
** Or, if this summons is served by registered or certified mail, within twenty-three (23) days.

Summons-
Dissolution

STATE OF INDIANA)
) SS:
COUNTY OF DELAWARE)

IN THE DELAWARE COUNTY COURTS

2003 TERM

IN RE THE MARRIAGE OF

CAUSE NUMBER: 18C0_____

_____,
Petitioner,

and

_____,
Respondent.

VERIFIED WAIVER OF FINAL HEARING

Pursuant to Indiana Code Section 31-15-2-13, the parties waive the right to a final hearing and request the court to enter a Decree of Dissolution of Marriage under this cause. The parties represent they have both entered into a written Agreement that settles any and all contested issues arising out of the parties' dissolution of marriage. The written Agreement, entitled, "PROPERTY SETTLEMENT AGREEMENT," is being filed simultaneously with this pleading, marked Exhibit A, and is now incorporated herein by reference.

Each party affirms and agrees that he or she has and/or will disclose to the other party any material change in the value of the property he or she has knowledge of up until the time of the entering of the Decree of Dissolution of Marriage in this cause.

The parties represent that there are no other contested issues in this action.

THE UNDERSIGNED PARTIES HEREBY AFFIRM, UNDER PENALTIES FOR PERJURY, THAT THE ABOVE AND FOREGOING STATEMENTS ARE TRUE AND CORRECT.

_____ _____

_____, PETITIONER _____, RESPONDENT

_____ _____

Date Date

Waiver of Final Hearing - Dissolution

Approved as to form:

_____

Linda Clark Dague
Attorney #4744-18
DAGUE & BUCK, LLP
1100 South Martin Luther King, Jr., Blvd., Suite 2
Muncie, Indiana 47304
(765) 289-4505
ATTORNEYS FOR _____

STATE OF INDIANA)
) SS:
COUNTY OF DELAWARE)

IN THE DELAWARE COUNTY COURTS

2003 TERM

IN RE THE MARRIAGE OF

CAUSE NUMBER: 18D0_____

_____,
Petitioner,
and
_____,
Respondent.

PERSONAL SERVICE TO:

REQUEST FOR PRODUCTION OF DOCUMENTS

The petitioner herein, _____, by counsel, Linda Clark Dague of DAGUE & BUCK, LLP, requests, pursuant to Trial Rule 34 of the Indiana Rules of Trial Procedure, that the original respondent, _____, produce the following documents and things that are in his/her custody, possession, or control for inspection and copying, at 1100 South Martin Luther King, Jr., Blvd., Suite 2, Muncie, Indiana 47304, within thirty (30) days of receipt of this request:

1. Your federal and state income tax returns for calendar years 2001 and 2002.
2. Your W-2 form(s) for calendar years 2001 and 2002.
3. Your three (3) most recent paycheck stubs.

Respectfully submitted,

DAGUE & BUCK, LLP

_____
Linda Clark Dague

Request for Production of Documents

Linda Clark Dague
Attorney #4744-18
DAGUE & BUCK, LLP
1100 South Martin Luther King, Jr., Boulevard
Suite 2
Muncie, Indiana 47304
(765) 289-4505
ATTORNEYS FOR PETITIONER

STATE OF INDIANA)
) SS:
COUNTY OF DELAWARE)

IN THE DELAWARE COUNTY COURTS

2003 TERM

IN RE THE MARRIAGE OF

CAUSE NO.: 18C0_____

_____,
Petitioner,

and

_____,
Respondent.

COURT ORDER REFERRING PARTIES TO SEMINAR FOR DIVORCING PARENTS

HEARING DATE: undetermined

Petitioner:
Address:

Home Telephone:
Petitioner's Attorney:
Linda Clark Dague
Attorney #4744-18
Attorney's Address:
DAGUE & BUCK, LLP
1100 S. Martin Luther King, Jr., Blvd.
Suite 2
Muncie, Indiana 47304
Telephone: (765) 289-4505

Respondent:
Address:

Home Telephone:
Respondent's Attorney:
_____
_____
Attorney's Address:
_____
_____
_____
_____
Telephone: _____

ON THIS DATE, IT IS ORDERED that the parties to this cause report to Ball Memorial Hospital for the purpose of attending and successfully completing a program entitled "Seminar for Divorcing Parents" as required by Courts' Local Rule No. 1993-1.

IT IS FURTHER ORDERED that each party shall pay a seminar fee of Forty Dollars ($40.00) prior to attending seminar.

Dated this _____ day of _____, 2003.

_____
JUDGE, DELAWARE COUNTY COURTS

INSTRUCTIONS: This shall be prepared and submitted to the court by counsel at the time of filing pleading. Upon signature by judge, the clerk shall forward a copy to Family Services of Delaware County, 806 West Jackson Street, Muncie, Indiana 47305; Telephone (765) 284-7789.

Court Order Seminar
Dissolution

Distribution to:

Linda Clark Dague
Attorney #4744-18
DAGUE & BUCK, LLP
1100 South Martin Luther King, Jr., Boulevard
Suite 2
Muncie, Indiana 47304
(765) 289-4505
ATTORNEYS FOR PETITIONER

PERSONAL SERVICE TO:

STATE OF INDIANA)
) SS:
COUNTY OF DELAWARE)

IN THE DELAWARE COUNTY COURTS

2003 TERM

IN RE THE MARRIAGE OF

CAUSE NUMBER: 18C0_____

_____,
Petitioner,

and

_____,
Respondent.

VERIFIED PETITION FOR TRIAL RULE 65(E)(1)
JOINT PRELIMINARY INJUNCTION

Petitioner, being first duly sworn upon his/her oath, respectfully moves the court pursuant to *Indiana Rules of Procedure, Trial Rule 65(E)(1)*, for a Joint Preliminary Injunction as follows:

1. Petitioner initiated this cause by filing a Petition for Dissolution of Marriage.

2. To preserve the marital estate, Petitioner requests that a Joint Preliminary Injunction be entered, without notice, restraining both parties from transferring, encumbering, concealing, selling or otherwise disposing of any property of the parties or asset of the marriage except in the normal course of business or for the necessities of life, without the written consent of the parties of the permission of the court.

3. Petitioner requests that a Joint Preliminary Injunction be entered, without notice, restraining both parties from removing any child of the parties then residing in the State of Indiana from the State of Indiana with the intent to

Petition for JPI-Dissolution

deprive the court of jurisdiction over such child without the prior written consent of all parties or the court's permission.

4. Injury will result to the moving party if an immediate Joint Preliminary Injunction is not issued.

_____

_____, Petitioner

SUBSCRIBED and sworn to before me this _____ day of _____, 2003.

_____

Linda Clark Dague (Printed Name)
Notary Public, A resident of Delaware County

My Commission Expires:

February 12, 2008

Prepared and approved as to form by:

_____

Linda Clark Dague
Attorney #4744-18
DAGUE & BUCK, LLP
1100 Martin Luther King, Jr., Blvd., Suite 2
Muncie, Indiana 47304
(765) 289-4505
ATTORNEYS FOR PETITIONER,

_____

STATE OF INDIANA)
) SS:
COUNTY OF DELAWARE)

IN THE DELAWARE COUNTY COURTS

2003 TERM

IN RE THE MARRIAGE OF

CAUSE NUMBER: 18C_____

_____,
Petitioner,

and

_____,
Respondent.

ORDER GRANTING TRIAL RULE 65(E)(1)
JOINT PRELIMINARY INJUNCTION

Comes now the court, having reviewed the Verified Petition for Joint Preliminary Injunction pursuant to Trial Rule 65(E)(1) filed by Petitioner, and the court being duly advised, finds that a joint preliminary injunction should be entered.

IT IS THEREFORE ORDERED, ADJUDGED, AND DECREED by the court that the parties are temporarily restrained and enjoined from:

1. Transferring, encumbering, concealing, selling or otherwise disposing of any property of the parties or asset of the marriage except in the normal course of business or for the necessities of life, without written consent of the parties or the permission of the court.
2. Removing any child of the parties then residing in the State of Indiana from the State of Indiana with the intent to deprive the court of the jurisdiction over such child without the prior written consent of all the parties or the court's permission.

Order Granting JPI-
Dissolution

If you are making a claim for maintenance, please answer the following interrogatories:

1a. If you claim disability, state:

a. Dates of total disability from normal activity, work or otherwise
b. Dates of partial disability from normal activity, work or otherwise
c. Name and address of medical practitioner who diagnosed said disability

ANSWER:

2a. As a result of your alleged disability, how long and between what dates were you:

a. Wholly confined to bed
b. Wholly confined to the house
c. Wholly restricted from continuing activities, i.e. work, leisure, etc.
d. Wholly incapacitated from normal activity, including work or otherwise, giving particulars in which you were so incapacitated.
e. Name and address of doctor who prescribed incapacity

ANSWER:

Interrogatories

3a. If you claim you are totally disabled, during the period which you claim total disability, itemize each and every activity as to which you were totally disabled, giving inclusive dates of such disability as to each and every activity.

ANSWER:

4a. If you claim you are partially disabled, during the period of which you claim partial disability, itemize each and every activity as to which you were partially disabled, giving inclusive dates of such disability as to each and every activity.

ANSWER:

5a. If, as a result of your alleged disability, you suffered a loss of income, state:

a. Dates from which you were prevented from earning an income in your chosen profession.
b. Other sources of income that were denied due to your incapacitation
c. If self-employed, dates which business ceased operation due to disability

ANSWER:

6a. If any x-rays have been made of any part of your body since January 1, 1992, state:

a. The dates when made and where each was made
b. By whom they were made
c. The names and addresses of every person or institution having custody of any such x-rays and designating which x-rays are in the custody of each

ANSWER:

7a. If you have submitted to any physical and/or mental examinations since January 1, 1992, other than those mentioned in answer to the above questions, state as to each such examination:

a. The date
b. The place where examined
c. The name and present address of each person conducting or participating in the examination.
d. The name and address of the person and/or entity that requested or required the examination
e. The reason for the examination
f. The name and present address of each person and/or entity having present custody of any report, record, document, or x-ray concerning such examination

ANSWER:

8a. Describe any and all physical and mental diseases, infirmities, impairments and disabilities that you have had since January 1, 1992.

ANSWER:

9a. State the names and addresses of all hospitals where you have been either an in-patient or an out-patient at any time since January 1, 1992, and state the dates on which you were hospitalized and the reasons for such hospitalizations.

ANSWER:

10a. State the names and addresses of all doctors you have seen or consulted since January 1, 1992, and state the dates of the consultations and the nature of the ailment or illness or other reason for which such doctor was consulted.

ANSWER:

11a. State the names and addresses of all hospitals where you have been either an in-patient or an out-patient on account of the disability you allege in this case and state the dates on which you were so hospitalized.

ANSWER:

12a. If you have made any trips outside Indiana since January 1, 1992, state the dates, destinations, and modes of transportation of such trips.

ANSWER:

13a. State all of the facts upon which you base the allegations of your disability and state the source of those facts, listing the name and address of every person from who you obtained said facts.

ANSWER:

State Form 9966 (R/7-97)

STATE OFFICE USE ONLY

INSTRUCTIONS ARE PROVIDED ON REVERSE SIDE

SECTION I - Affirmation

In the _____ County _____ Court: Cause No. _____ Date: _____

In the matter of the adoption of _____ Date of Birth _____

(NAME AT BIRTH)

I affirm, under the penalties for perjury, that these medical history representations are true to the best of my knowledge and belief.

Mailing Address: _____

_____ _____

(Written Signature)

_____ _____

(Typed or Printed Name) (City, State and Zip Code)

SECTION II - Medical History

INDIANA ADOPTION MEDICAL HISTORY REPORT

State Registrar of Vital Statistics
Indiana State Department of Health
2 N. Meridian, Section B4
Indianapolis, Indiana 46204

AUTHORITY: I.C. 31-3-1-2

	Mother	Father	Family	Adoptee
1. CONGENITAL OR GENETIC HISTORY				
a. MALFORMATIONS/DEFORMITIES				
b. BLOOD DISEASES				
c. MULTIPLE BIRTHS				
d. Other				
2. PSYCHOSOCIAL HISTORY				
a. LEARNING DISABILITIES				
b. PSYCHOSIS				
c. ALCOHOL/SUBSTANCE ABUSE				
d. Other				
3. CHRONIC DISEASES				
a. NEUROLOGICAL				
b. PULMONARY (Lungs)				
c. RENAL (Kidney)				
d. IMMUNE				
e. CANCER				
f. HYPERTENSION				
g. DIABETES				
h. ARTERIOSCLEROSIS				
i. Other				
4. INFECTIOUS DISEASES				
a. VENEREAL				
b. HEPATITIS				
c. TUBERCULOSIS				
d. Other				
5. ALLERGIES				
6. PREGNANCY/BIRTH HISTORY				
a. TOXEMIA				
b. MISCARRIAGES				
c. NEONATAL DEATHS				
d. ALCOHOL/DRUG EXPOSURE				
e. ISOIMMUNE				
f. HYPOXIA				
g. PREMATURITY				
h. COMPLICATIONS OF DELIVERY				
i. OTHER				
j. NEWBORN SCREENING DISORDERS				
k. BIRTH WEIGHT, LENGTH AND APGAR SCORES				
7. DEATHS OF BIRTH FAMILY MEMBERS that may affect the MEDICAL HISTORY (see instructions)				

Item	Details (Type or Print)

Page # _____ of _____ page(s)

Medical History Report
Adoption

ADOPT 1-2/VR 1

STATUTORY AUTHORITY: I.C.31-3-1-2

TIME OF FILING: The **original copy** of this form shall be filed with the Clerk of Court accompanying the petition, or within sixty (60) days of the filing of the petition for adoption.

Fee: The Clerk of Court shall collect an Adoption Medical History Fee of twenty dollars ($20) in each proceeding for adoption.

DISPOSITION: The **original copy** of this form, including additional pages (if applicable), is to be sent to the State Registrar attached to the Record of Adoption (SDH 06-019). A photocopy of the Medical History Report (Section II) should be given to the adoptive parents anytime during the proceeding.

Subsequent requests for copies of this report, or any other information contained in the Indiana Adoption Medical History Registry, MUST BE directed to the State Registrar of Vital Records. (I.C. 31-3-4-12)

GENERAL INSTRUCTIONS: All items, except the **written signature** in Section I, must be **typed** or **printed clearly**. As this form will be photocopied and microfilmed, **use black ink only.**

SECTION I - Affirmation: When completed, Section I will contain **confidential information** and is for the use of the **COURT** and **STATE REGISTRAR ONLY**. THIS SECTION WILL NOT BE PHOTOCOPIED WHEN MAKING A COPY OF THE MEDICAL HISTORY.

SECTION II - Medical History: When completing the medical history, please keep in mind that the recipient of this information will probably not be a physician or attorney. The medical history should be completed in the manner that the **average person** would give the information to their family physician.

☐ Check boxes are provided for the conditions stated in items 1 through 6(i). Medical history information may be given for the birth mother, birth father, birth family and adopted person.

FOR THE PURPOSE OF THIS REPORT, THE BIRTH (BIOLOGICAL) FAMILY OF THE ADOPTED PERSON SHOULD BE LIMITED TO THEIR GRANDPARENTS AND SIBLINGS ONLY. **OTHER FAMILY MEMBERS MAY BE INCLUDED IF THE MEDICAL INFORMATION IS SIGNIFICANTLY PERTINENT TO THE MEDICAL HISTORY.**

The medical history for conditions stated in items 1 through 6(i) are noted first by checking the box for the person having the history to be reported and then expanding the information in the Details Section.

☐ Shaded check boxes indicate that the condition stated is **not applicable** or **medically insignificant** for that person or class of persons.

6(j) - NEWBORN SCREENING DISORDERS: Effective July 1, 1985, I.C. 16-8-6-1 requires that all newborn infants are to be screened for six (6) hereditary disorders. The tests for these disorders [Phenylketonuria (PKU), Galactosemia, Hypothyroidism, Homocystinuria, Maple Syrup Urine Disease (MSUD) and Hemoglobinopathies (including sickle cell anemia)] **are not diagnostic tests**, but any positive results require follow-up diagnostic tests.

- Item 6(j) is applicable **only** for children born **after July 1, 1985**.
- **POSITIVE RESULTS** and/or follow-up tests are to be noted in the **Details Section**.

6(k) - BIRTH WEIGHT, LENGTH AND APGAR SCORES: If the adopted person is less than three (3) years of age and the information is known, include the birth weight, length and APGAR scores as item 6(k) in the **Details Section**.

7 - DEATHS OF BIRTH FAMILY MEMBERS THAT MAY AFFECT THE MEDICAL HISTORY: Information **must be** limited to deaths due to causes that are significantly pertinent to the medical history and is stated in the **Details Section**.

DETAILS SECTION:

Medical conditions reported are to be expanded in the Details Section. Identify the condition by item number and suffix and briefly state additional information that **must include** the person having the history (title only) and may include the age at onset if significant.

- CARE MUST BE TAKEN IN THE DETAILING OF MEDICAL CONDITIONS AS THE CONTENTS OF THIS REPORT CAN CONTAIN **NO INFORMATION THAT COULD LEAD TO THE IDENTIFICATION OF A PERSON**.
- IF APPLICABLE, Items 6(j), 6(k) and 7 are reported only in this section.
- If additional space is required, attach plain white stationary (8-½ x 11") headed the same as the Details Section (Item/Details). Use one side of the page only.
- Each page, including the original, is to be identified by PAGE NUMBER and the TOTAL NUMBER OF PAGE(S) in the report.

Notes for Clients on Social Security Cases

Thank you for asking me to represent you on your Social Security case. I will do my best to give you the legal help you need in this important matter.

There are some things I would like you to keep in mind while we are working on your case. These suggestions are put together to help take care of your case as quickly and effectively as possible, with the best representation we can give.

Please take a few minutes to read through these instructions, and keep them at hand at home. Let us know if you ever need another copy.

Calling the Office: You should call us whenever you get a letter from Social Security 1) approving or denying your claim; or 2) setting an appointment for you to see a doctor of their choice.

Also be sure to call if, for any reason, 1) you see a new doctor; 2) you go into the hospital; 3) your condition gets much worse or better; 4) you move or change your telephone number; or 5) you try to go back to work.

Most of the time, I will not be able to answer questions when you first call in about whether some particular information, medical report, etc., has been received since that requires checking our file. If you need some specific information about your case, please ask for my secretary and ask him or her to check the file for you.

Sometimes I can be hard to get on the phone, since I am in court, out at Social Security, interviewing doctors or seeing clients in my office much of the time. If I am not able to come to the phone when you call, leave a message with the person who answers the phone. I prefer that you leave your name and number too and not just tell the receptionist that you will call back later. That way there is less chance that we will miss each other.

Since your records are all at my office, I will have difficulty answering any questions about your case at my home. If it is an emergency I can be reached at my home at night or on the weekend.

Questions About What Is Happening on Your Case: Social Security sends a written notice of any action directly to you. They are supposed to send me a copy of what they send you. For this reason there is really no point in calling to ask if we have heard anything about your case. Social Security NEVER sends me a decision without letting you know. They ALWAYS send you the original of a decision, and they are supposed to send us a copy at the same time. I usually get the decision on the same day you do. Remember that Social Security often takes many months to send out a decision. Call me when the decision comes in and I will go over it with you. If you are worried about an unusual delay please let us know and we will check for you. It is a good idea to let us know if you have not received your first check two months after notice of a favorable decision has reached you.

Notes for New SSD Clients

The only situation where you are not notified of a decision directly is when we have gone through all your appeals inside Social Security and we have to sue them in federal court. The court sends its decision only to the lawyers. I will always notify you immediately when I get the court's decision. Suing Social Security in federal court usually takes a year.

Office Hours: Our office is normally open from ***Office hours opening TE*** to ***Office hours closing TE***, Monday through Friday. Personal conferences at the office are by appointment only.

Medical Evidence: Your disability claim can't be successful without medical proof that you can't work. Only you can make sure that there are doctors who know you well enough to give me a report on your case. You must be under regular medical care, and this is your responsibility. While we are working together, NEVER miss an appointment to see a doctor. Too many cases are lost because people don't keep appointments, particularly at clinics. Then Social Security says there is not enough medical proof that they are disabled.

New Cases: We are always happy to talk to people you know who have a problem with Social Security—just have them give us a call to set up an appointment. Also, we can help you or people you know with most legal matters. Please feel free to call for an appointment on any new matters.

Please keep these few points in mind, so that we can work together toward success on your case.

SOCIAL SECURITY ADMINISTRATION | TOE 710 | Form Approved OMB No. 0960-0622

[redacted] | *(Do not write in this space)*

NAME OF CLAIMANT	NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from claimant)*
SOCIAL SECURITY CLAIM NUMBER	SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER
SPOUSE'S NAME *(Complete ONLY in SSI cases)*	SPOUSE'S SOCIAL SECURITY NUMBER *(Complete ONLY in SSI cases)*

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital insurance, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY
(See reverse of claimant's copy)

"I want to appeal your decision about my claim for supplemental security income (SSI) or special veterans benefits (SVB). I've read the back of this form about the three ways to appeal. I've checked the box below."

☐ Case Review ☐ Informal Conference ☐ Formal Conference

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

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.

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY		
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (Include area code)	DATE		TELEPHONE NUMBER (Include area code)	DATE	

[redacted]

See reverse of claim folder copy for list of initial determinations

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ YES ☐ NO

2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO

3. IS THIS REQUEST FILED TIMELY? ☐ YES ☐ NO
(If "NO", attach claimant's explanation for delay and attach only pertinent letter, material, or information in social security office.)

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)

☐ NO FURTHER DEVELOPMENT REQUIRED (PGN 03102.125P)

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS

ROUTING INSTRUCTIONS (CHECK ONE) →

☐ DISABILITY DETERMINATION SERVICES *(ROUTE WITH DISABILITY FOLDER)*
☐ ODO, BALTIMORE
☐ PROGRAM SERVICE CENTER
☐ OIO, BALTIMORE
☐ OEO, BALTIMORE
☐ DISTRICT OFFICE RECONSIDERATION
☐ CENTRAL PROCESSING SITE (SVB)

[redacted]

Form [redacted] (9-2002) ef (10-2002)
Destroy Prior Editions

[redacted]

Request for Reconsideration

Form Approved
OMB No. 0960-0316

CLAIMANT'S STATEMENT WHEN REQUEST FOR HEARING IS FILED AND THE ISSUE IS DISABILITY

Print, type or write clearly and answer all questions to the best of your ability. Complete answers will aid in processing the claim. IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE STATEMENT TO THIS FORM.

CLAIMANT'S NAME	SOCIAL SECURITY NUMBER
WAGE EARNER (Leave blank if name is the same as the claimant's)	SOCIAL SECURITY NUMBER

PRIVACY ACT AND PAPERWORK ACT NOTICE: The Social Security Act (section 205(a), 702, 1631 (e)(1)(A) and (B), and 1869(b)(1) and (c), as appropriate authorized the collection of information on this form. We will use the information on your recent activities, condition, medical treatment, and medications to help us decide if we need to obtain more information. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out the information an this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring an your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

TIME IT TAKES TO COMPLETE THIS FORM

We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate or on any other aspect of this form, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001, and to the Office of Management and Budget, Paperwork Reduction Project 10960-0316), Washington D.C. 20503. **Send only comments relating to our estimate or other aspects of this form to the offices listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office whose address is listed in your local telephone directory under the Department of Health and Human Services.**

1. Have you worked since _____, the date your request for reconsideration was filed? (If *yes, describe the nature and extent of work.*) ☐ Yes ☐ No

2. Has there been any change in your condition since the above date? *(If yes, describe the change.)* ☐ Yes ☐ No

3. Have your daily activities and/or social functioning changed since the above date? *(If yes, describe the changes.)* ☐ Yes ☐ No

4a. Have you been treated or examined by a physician (other than as a patient in a hospital) since the above date? *(If yes, complete the following.)* ☐ Yes ☐ No

NAME OF PHYSICIAN	ADDRESS *(Include ZIP code)*
AREA CODE AND TELEPHONE NUMBER	
HOW OFTEN DO YOU SEE THIS PHYSICIAN	DATES YOU SAW THIS PHYSICIAN
REASON FOR VISIT	
TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*	

Claimant's Statement

4b. Have you seen any other physician since the above date? ☐ Yes ☐ No
(If Yes, show the following:)

NAME OF PHYSICIAN	ADDRESS *(Include ZIP code)*
AREA CODE AND TELEPHONE NUMBER	
HOW OFTEN DO YOU SEE THIS PHYSICIAN	DATES YOU SAW THIS PHYSICIAN
REASON FOR VISIT	
TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*	

If you have seen other physicians since you filed your claim, attach a list of their names, addresses, dates and reasons for visits.

5. Have you been hospitalized, or treated at a clinic or confined in a nursing home or extended care facility for your illness or injury since the above date? ☐ Yes ☐ No
(If yes, show the following:)

NAME OF FACILITY	ADDRESS *(Include ZIP code)*
PATIENT OR CLINIC NUMBER	
WERE YOU AN INPATIENT? (Stayed at least overnight) ☐ Yes ☐ No *If yes, show*	DATES OF ADMISSIONS AND DISCHARGES
WERE YOU AN OUTPATIENT ☐ Yes ☐ No *If yes, show*	DATES OF VISITS
REASON FOR HOSPITALIZATION, CLINIC VISITS, OR CONFINEMENT	
TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*	

If you have been in other hospitals, clinics, nursing homes, or extended care facilities for your illness or injury, attach a list of the names, addresses, patient or clinic numbers, dates and reasons for hospitalization, clinic visits, or confinement.

6. Have you received medical or vocational services from a Community agency since the above date? (If yes, indicate below the name, address and telephone number of the agency.) ☐ Yes ☐ No

7. Are you now taking any prescription drugs or medications? ☐ Yes ☐ No
(If Yes, list them below.)

NAME OF MEDICATION(S)	DOSAGE BEING TAKEN	NAME OF PHYSICIAN(S)

8. Are you now taking any nonprescription drugs or medications? ☐ Yes ☐ No
(If yes, list them below.)

NAME OF MEDICATION(S)	DOSAGE BEING TAKEN

9. Have you filed (or do you intend to file) for workers' compensation? ☐ Yes ☐ No

(if you have filed for workers' compensation and have received an award, please bring a copy of the award notice, redemption order, or settlement to your hearing.)

Form Approved
OMB No. 0960-0623

TO BE COMPLETED BY SSA

NUMBER HOLDER

SOCIAL SECURITY NUMBER

EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 7332.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) **All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;**
2) **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;**
3) **Information about how my impairment(s) affected my ability to work.**

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE

STREET ADDRESS	TELEPHONE NUMBER (Area Code)

CITY	STATE	ZIP CODE

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
CITY	STATE	ZIP CODE

Form SSA-827 (02-2002) Use Prior Editions EF (02-2002)

Authorization to Release Info to SSA

SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT	3. SOC. SEC. CLAIM NUMBER	4. SPOUSE's CLAIM NUMBER
		- -	- -

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because:

An Administrative Law Judge of the Office of Hearings and Appeals will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

6. I have additional evidence to submit. ☐ Yes ☐ No

Name and address of source of additional evidence:

(Please submit it to the hearing office within 10 days. Your servicing Social Security Office will provide the address. Attach an additional sheet if you need more space.)

7. Check one of the blocks:
- ☐ I wish to appear at a hearing.
- ☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. (If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative).)

[You should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 9.]

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.

8. (CLAIMANT'S SIGNATURE) (DATE)	9. (REPRESENTATIVE'S SIGNATURE/NAME) (DATE)
ADDRESS	(ADDRESS) ☐ ATTORNEY; ☐ NON ATTORNEY;
CITY STATE ZIP CODE -	CITY STATE ZIP CODE -
TELEPHONE NUMBER ( ) -	TELEPHONE NUMBER ( ) -
FAX NUMBER ( ) -	FAX NUMBER ( ) -

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION-ACKNOWLEDGMENT OF REQUEST FOR HEARING

10. Request received for the Social Security Administration on _____ (Date) by: _____ (Print Name)

_____ (Title) _____ (Address) _____ (Servicing FO Code) _____ (PC Code)

11. Was the request for hearing received within 65 days of the reconsidered determination? ☐ YES ☐ NO
If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.

12. Claimant is represented ☐ Yes ☐ No
☐ List of legal referral and service organizations provided

13. Interpreter needed ☐ Yes ☐ No
Language (including sign language): _____

14. Check one:
- ☐ Initial Entitlement Case
- ☐ Disability Cessation Case
- ☐ Other Postentitlement Case

16. **HO COPY SENT TO** _____ HO on _____
- ☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; or
- ☐ Title II CF held in FO to establish CAPS ORBIT; or
- ☐ CF requested ☐ Title II; ☐ Title XVI ☐ Title VIII
(Copy of teletype or phone report attached)

17. **CF COPY SENT TO:** _____ HO on _____
- ☐ CF Attached: ☐ Title II; ☐ Title XVI
- ☐ Other Attached: _____

15. Check all claim types that apply:

☐ RSI only	(RSI)
☐ Title II Disablility-worker or child only	(DIWC)
☐ Title II Disability-Widow(er) only	(DIWW)
☐ SSI Aged only	(SSIA)
☐ SSI Blind only	(SSIB)
☐ SSI Disability only	(SSID)
☐ SSI Aged/Title II	(SSAC)
☐ SSI Blind/Title II	(SSBC)
☐ SSI Disability/Title II	(SSDC)
☐ HI Entitlement	(HIE)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify: _____	

Form **HA-501-U5** (10-2002) ef (01-2003)
Destroy Prior Editions

TAKE OR SEND ORIGINAL

Request for Hearing by ALJ

Social Security Administration

Please read the back of the last copy before you complete 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, _____,
(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 IV FMSHA (Black Lung) ☐ 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 am appointing, or I now have, more than one representative. My main representative is _____.
(Name of Principal Representative)

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

Part II **ACCEPTANCE OF APPOINTMENT**

I, _____, 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.)

☐ I am an attorney. ☐ I am not an attorney. (Check one.)

Signature (Representative)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part III (Optional) **WAIVER OF FEE**

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date

Part IV (Optional) **ATTORNEY'S WAIVER OF DIRECT PAYMENT**

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney Representative)	Date

Appointment of Representative

WRITTEN FEE AGREEMENT

I, ***Client name CO***, hereby employ ***Attorney name CO***, Attorney at Law, to represent me in my ***Claim type MC*** case. My attorney and I understand that for a fee to be payable, the Social Security Administration (SSA) must approve any fee my attorney charges or collects from me for services my attorney provides in proceedings before SSA in connection with my claim(s) for benefits, or must approve this agreement.

We agree that if SSA favorably decides the claim[s], at any stage through the first hearing at the Administrative Law Judge level, I will pay my attorney a fee equal to the lesser of 25 percent of the past-due benefits resulting from my claim[s], or the dollar limit imposed under 42 USC § 406(a)(2)(A) at the time of the decision, currently $5,300.00, whichever is less. If the Social Security Administration or Federal law raises or lowers the maximum amount to be charged by an attorney, that amount will apply, including amounts which may be approved by an Administrative Law Judge. If this case goes to Federal District Court, the fee maximum does not apply. **No attorney fee will be charged if we do not win.**

I agree to pay my attorney's reasonable expenses which are incurred in representing me, whether we win or lose my case. Such expenses may include medical reports, photocopying and mileage. I understand that the 25% attorney fee does not include expenses, and that **I am responsible for those expenses, whether we win or lose, and that the expenses are in addition to the 25% fee if we win.** I further agree to call my attorney's office as soon as I receive any back benefit check, or as soon as I am notified of a direct deposit of back benefits and **to pay the fees and expenses immediately from that check or deposit.** In the event that the claimant is receiving Long Term Disability, expenses are the employer's responsibility.

My attorney may agree with another attorney to help in my case, but I will not pay any more fees for being represented, even if ***Attorney gender MC*** does bring in another lawyer to help in my case. I understand that, if at any time my attorney determines that there is not sufficient merit to continue with the appeal, ***Attorney gender MC*** will advise me of the need to withdraw from representing me in this case.

I understand that Social Security past-due benefits are the total amount of money to which I [and any auxiliary beneficiary(ies)] become entitled through the month before the month SSA effectuates a favorable administrative determination or decision on my Social Security claim and that Supplemental Security Income (SSI) past-due benefits are the total amount of money for which I become eligible through the month SSA effectuates a favorable administrative determination or decision on my SSI claim. We further understand that the fee for both claims may not exceed the lesser of 25 percent of the combined past-due benefits, or the dollar limit imposed under 42 USC § 406(a)(2)(A) at the time of the decision , currently $5,300.00, whichever is less *except* as set out above, including any increases by statute or regulation. If the Social Security Administration or Federal law raises or lowers the maximum amount I may charge, that amount will apply.

Written Fee Agreement

I have not been promised I would win, but that my attorney would do ***Attorney gender MC*** best in this case. We have both received signed copies of this agreement.

_____ _____

(Date) ***Client name CO***

_____ _____

(Date) ***Attorney name CO***, Attorney at Law
Law firm name TE

DISABILITY REPORT- ADULT - Form SSA-3368-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the internet, you may access the Disability Report Form Guide at http://www.ssa.gov/disability/3368/.

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.

- Please fill out as much of this form as you can before your interview appointment.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your," or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 9 and 10, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you.

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

Disability Report-Adult-Form SSA-3368-BK

Disability Report - Adult

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means that you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and your disability is expected to last (or has lasted) for at least a year or to result in death. So when we ask, "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

The Privacy And Paperwork Reduction Acts

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

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about his, contact any Social Security Office.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 60 minutes to read the instructions, gather the necessary facts, and answer the questions.

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT
ADULT

For SSA Use Only
Do not write in this box.

Related SSN _____

Number Holder _____

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* _____ *Number* ☐ Your Number ☐ Message Number ☐ None

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME _____ RELATIONSHIP _____

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

_____ *City* _____ *State* _____ *ZIP* DAYTIME PHONE _____ *Area Code* _____ *Number*

E. What is your **height** without shoes? _____ *feet* _____ *inches*

F. What is your **weight** without shoes? _____ *pounds*

G. Do you have a **medical assistance card?** (For Example, Medicaid or Medi-Cal) If "YES," show the **number** here: ☐ YES ☐ NO _____

H. Can you **speak English?** ☐ YES ☐ NO If "NO," what languages can you speak? _____

If you **cannot speak English,** is there someone we may contact who speaks English and will give you messages. *(If this is the same person as in "D" above show "SAME" here.)*

NAME _____ RELATIONSHIP _____

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

_____ *City* _____ *State* _____ *ZIP* DAYTIME PHONE _____ *Area Code* _____ *Number*

I. Can you **read English?** ☐ YES ☐ NO J. Can you **write more than your name in English?** ☐ YES ☐ NO

Disability Report-Adult-Form SSA-3368-BK

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries or conditions** that limit your ability to work? _____

_____

_____

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

_____

_____

C. Do your illnesses, injuries or conditions cause you **pain** or other symptoms? ☐ YES ☐ NO

D. When did your illnesses, injuries or conditions **first bother you?**

Month	*Day*	*Year*

E. When did you become **unable to work** because of your illnesses, injuries or conditions?

Month	*Day*	*Year*

F. Have you **ever worked?** ☐ YES ☐ NO *(If "NO," go to Section 4.)*

G. Did you **work at any time** after the date your illnesses, injuries or conditions first bothered you? ☐ YES ☐ NO

H. If "YES," did your illnesses, injuries or conditions cause you to: *(check all that apply)*

- ☐ **work fewer hours?** *(Explain below)*
- ☐ **change your job duties?** *(Explain below)*
- ☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

_____

_____

_____

_____

I. Are you **working now?** ☐ YES ☐ NO

If "NO," when **did you stop working?**

Month	*Day*	*Year*

J. Why did you **stop working?** _____

_____

_____

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List the **kinds of jobs** that you have had in the **last 15 years that you worked.**

JOB TITLE *(Example, Cook)*	TYPE OF BUSINESS *(Example, Restaurant)*	DATES WORKED *(month & year)*		HOURS PER DAY	DAYS PER WEEK	*RATE OF PAY (Per hour, day, week, month or year)*	
		From	To				
						$	
						$	
						$	
						$	
						$	
						$	
						$	

B. Which job did you do the longest? _____

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

D. 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

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

Walk? ____ Stoop? *(Bend down & forward at waist.)* ____ Handle, grab or grasp big objects? ____

Stand? ____ Kneel? *(Bend legs to rest on knees.)* ____ Reach? ____

sit? ____ Crouch? *(Bend legs & back down & forward.)* ____ Write, type or handle small objects? ____

Climb? ____ Crawl? *(Move on hands & knees.)* ____

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

G. Check **heaviest** weight lifted:

☐ Less than 1 0 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

H. Check weight 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 _____

I. Did you supervise other people in this job? ☐ YES (Complete items below.) ☐ NO (Skip to next page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5.

C. List **other names** you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment**

1.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number	**CHART/HMO #**		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

2.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number	**CHART/HMO #**		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3. **NAME**			**DATES**
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number	**CHART/HMO #**		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

If you need more space, use Remarks, Section 9.

E. **List each HOSPITAL/CLINIC.** Include your **next appointment.**

1. HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE Area Code Phone Number			☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS	

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE Area Code Phone Number			☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS	

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does **anyone else have medical records or information** about your illness, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME			**DATES**
ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number			NEXT APPOINTMENT
CLAIM NUMBER (If any)			
REASONS FOR VISITS			

If you need more space, use Remarks, Section 9.

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? ☐ YES ☐ NO
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for your illnesses, injuries or conditions?
☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN DONE, OR WHEN IT WILL BE DONE. (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY–Name of body part _____			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY–Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you have had other tests, list them in Remarks, Section 9.

SECTION 7-EDUCATION/TRAINING INFORMATION

A. Check the highest grade of **school** completed.

Grade school: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Approximate **date** completed: _____

B. Did you attend **special education** classes? ☐ YES ☐ NO *(If "NO," go to part C)*

NAME OF SCHOOL _____

ADDRESS _____

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

_____

City *State* *Zip*

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school?**

☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

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

_____

City *State* *Zip*

DAYTIME PHONE NUMBER _____

Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____

(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 9 - REMARKS

Use this section for any added information you did not show in earlier parts of the form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

SECTION 9 - REMARKS

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of **claimant** or person filing on claimant's behalf ***(parent, guardian)***	**Date** *(Month, day, year)*

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of **Witness**	2. Signature of **Witness**
Address *(Number and street, City, state, and ZIP code)*	**Address** *(Number and street, city, state, and ZIP code)*