WORK ACTIVITY REPORT (Self-Employed Person)

Name of disabled person	☐ Blind ☐ Not Blind	Social Security Number - -
Name of W/E (If other than disabled person)		Social Security Number - -

PAPERWORK/PRIVACY ACT NOTICE

The information requested on this form is authorized by Section 223 and Section 1632 of the Social Security Act. The information provided will be used in making a decision on your claim. While completion of this form is voluntary, failure to provide all or part of the requested information could prevent an accurate and timely decision on your claim and could result in the loss of benefits. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal law requiring the exchange of information between Social Security and another agency.
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.

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 30 minutes to read the instructions, gather the necessary facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213**. *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 use this form to describe your work activity since (Date disability began or, if later, date of prior investigation) ▶

1. Date *(to be entered by SSA)*

ANSWER EACH QUESTION AS FULLY AS POSSIBLE

2.

A. List name and address of business (include zip code)

B. Please Check if ☐ Farm ☐ Non-Farm

C. Briefly indicate the primary product or service

3.

A. Describe the business in terms of arrangement and /or ownership (Check one)

☐ Sole Owner ☐ Partnership ☐ Farm Tenant ☐ Farm Landlord

B. Give your monthly self-employment income since the above date (average if not sure)

Month	Year	Gross	Net	Month	Year	Gross	Net	Month	Year	Gross	Net
Month	Year	Gross	Net	Month	Year	Gross	Net	Month	Year	Gross	Net

C. List any months in which you earned more than $200.00 or worked more than 40 hours in your business since the date shown in item 1. ▶

4.

A. Describe *(briefly)* what you did in the business in terms of management decisions, responsibilities, hours, production and services before your illness or injury.

B. Was this business your sole livelihood prior to your illness or injury? ☐ YES ☐ NO

5.

Please describe your present work activities and any changes in your business because of your illness or injury. Explain such things as reduced hours of business, lower volume, fewer acres under cultivation or other. (If you use extra help, write "extra help" here and provide the details when you get to item 9).

6. Do (did) you make management decisions after your illness or injury? ☐ YES ☐ NO

(If "yes," describe the kinds of decisions made, the time spent making them and any changes that have taken place).

7. A. If you began your business after you were injured or became ill, did you receive any special assistance from an agency or other source in setting up your business? ☐ YES ☐ NO

B. Does this assistance continue or have additional special services been supplied? ☐ YES ☐ NO
(If "yes," please describe)

8. A. What is the value of any normal business expense which you do (did) not pay including that which is furnished or paid for by another person or organization (such as free space or utilities)? Why were such items supplied to you for free and by whom were they furnished?

B. Describe any special expenses related to your illness or injury that you paid which are necessary for you to work (for example, attendant care, medical devices, equipment, prostheses, or similar items or services).

DESCRIBE ANY ADDITIONAL HELP YOU NEED (NEEDED) IN PERFORMING YOUR USUAL DUTIES BECAUSE OF YOUR ILLNESS OR INJURY.

9.

A. Number of assistants	B. Time they devoted to helping you	C. What do (did) they do?
D. Are/were assistants (check one) ☐ PAID ☐ UNPAID	E. If paid, how much?	
F. Is (are) assistant(s) related to you? (check one) ☐ YES ☐ NO	G. If yes, what is the relationship?	

H. Why was the additional help needed?

10. Use this section for additional space to answer any previous questions and to give any additional information you think will be helpful. Please refer to the previous questions by number, such as 4A or 4B or 5.

If more space is needed, use an extra sheet.

11. Check the appropriate block below:

- ☐ I am **not** receiving Social Security disability benefits and/or Supplemental Security Income (SSI).
- ☐ I **am** receiving Social Security disability benefits and/or Supplemental Security Income (SSI), and I understand understand that the information provided above may result in my benefits being stopped. I have been given the opportunity to submit any evidence I wanted and to make any statements concerning my claim.

PLEASE READ THE FOLLOWING STATEMENT, THEN SIGN, DATE AND PROVIDE ADDRESS AND TELEPHONE NUMBER.

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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of claimant/beneficiary or representative			Date
Mailing address (Number and Street, Apt. no., P.O. Box, or Rural Route.)			Telephone (Include area code)
City	State	County	Zip Code -

SSA USE ONLY

12.

A. Contact made: (check one) ☐ IN PERSON ☐ BY MAIL ☐ BY TELEPHONE

B. Completed by: (check one) ☐ CLAIMANT ☐ SSA REPRESENTATIVE ☐ OTHER

C. If "Other" show

Name:	Address (include zip code)
Phone Number (include area code)	Relationship

13. Interviewer/reviewer check list ("Yes" answers should be developed in accordance with DI 13010ff. Rationalize "Yes" or "No" answers below except when it is necessary to complete the SSA-831-U3 and SSA-833-U3). Check all that apply:

A. Unpaid business expenses (Rent, utilities, etc.)	☐ Yes	☐ No
B. Impairment-related work expenses	☐ Yes	☐ No
C. Unpaid help, or business sponsored by an agency	☐ Yes	☐ No
D. Unsuccessful work attempt (CDI - no medical issue - DO jurisdiction for a final determination)	☐ Yes	☐ No
E. Unsuccessful work attempt (DO recommendation only - DDS jurisdiction for a final determination.)	☐ Yes	☐ No
F. Substantial gainful activity	☐ Yes	☐ No

Note: If work continues and is determined to be substantial gainful activity and no medical issue exists, prepare the appropriate final determination (SSA-831-U3 or SSA-833-U3) rationalizing the work issue. Keep in mind that preparation of the SSA-831-U3 or the SSA-833-U3 would not be appropriate if there is a possibility of a closed period of disability, a trial work period or an unsuccessful work attempt.

Rationale:

14. Remarks

15. Signature of SSA interviewer or reviewer	Title	DO code	Date