

**DISABILITY REPORT - CHILD - Form SSA-3820-BK**  
**READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM**  
**THIS IS NOT AN APPLICATION**

**IF YOU NEED HELP**

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

**HOW TO COMPLETE THIS FORM**

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

- Fill out as much of this form as you can before your interview appointment.
- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/ OTHER/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 ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use Section 10, "DATE AND REMARKS," on Pages 11 and 12, and show the number of the question being answered.

**ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS**

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

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

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

## 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 Government Accountability 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 this, contact any Social Security Office.

**PAPERWORK REDUCTION ACT:** 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 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING 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 (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.*

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

### DISABILITY REPORT - CHILD

#### SECTION 1 -- INFORMATION ABOUT THE CHILD

A. CHILD'S NAME *(First, Middle Initial, Last)*

B. CHILD'S SOCIAL SECURITY NUMBER

C. YOUR NAME *(If agency, provide name of agency and contact person)*

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

CITY	STATE	ZIP CODE
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YOUR EMAIL ADDRESS (Optional)

D. YOUR DAYTIME PHONE NUMBER *(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)*

\_\_\_\_\_  
*Area Code*      \_\_\_\_\_  
*Number*       Your Number       Message Number       None

E. What is your relationship to the child? \_\_\_\_\_

F. Can you speak and understand English?     YES     NO  
If "NO", what is your preferred language? \_\_\_\_\_

**NOTE:** If you cannot speak and understand English, we will provide you an interpreter, free of charge.

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

YES *(Enter name, address, phone number, relationship)*     NO  
NAME \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

\_\_\_\_\_  
*City*                      *State*                      *ZIP*                      DAYTIME PHONE \_\_\_\_\_  
*Area Code*                      *Number*

Can you read and understand English?     YES     NO

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

NAME \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

\_\_\_\_\_  
*City*                      *State*                      *ZIP*                      DAYTIME PHONE \_\_\_\_\_  
*Area Code*                      *Number*

Can this person speak and understand English?     YES     NO

If "NO", what is this person's preferred language? \_\_\_\_\_

Can this person read and understand English?     YES     NO

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**SECTION 1 - INFORMATION ABOUT THE CHILD**

H. Can the child speak and understand English?  YES  NO

If "NO," what languages can the child speak? \_\_\_\_\_

If the child understands any other languages, list them here: \_\_\_\_\_

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

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

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

YES  NO

If "YES", show the **number** here: \_\_\_\_\_

**SECTION 2 - CONTACT INFORMATION**

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

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

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

\_\_\_\_\_  
*City State ZIP*

DAYTIME PHONE NUMBER \_\_\_\_\_

\_\_\_\_\_  
*Area Code Number*

RELATIONSHIP TO CHILD \_\_\_\_\_

Can this person **speak and understand English**?  YES  NO

If "NO", what is this person's preferred language? \_\_\_\_\_

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

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

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

NAME OF CONTACT \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

\_\_\_\_\_  
*City State ZIP*

DAYTIME PHONE NUMBER \_\_\_\_\_

\_\_\_\_\_  
*Area Code Number*

RELATIONSHIP TO CHILD \_\_\_\_\_

Can this person **speak and understand English**?  YES  NO

If "NO", what is this person's preferred language? \_\_\_\_\_

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





**SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS**

**DOCTOR/HMO/THERAPIST/OTHER**

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

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

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

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

**Next appointment** \_\_\_\_\_ **The child's hospital/clinic number** \_\_\_\_\_

**Reasons for visits**  
\_\_\_\_\_  
\_\_\_\_\_

**What treatment did the child receive?**  
\_\_\_\_\_  
\_\_\_\_\_

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

**SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS**

**HOSPITAL/CLINIC**

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

Next **appointment** \_\_\_\_\_ The child's hospital/clinic **number** \_\_\_\_\_

**Reasons for visits**  
\_\_\_\_\_  
\_\_\_\_\_

What **treatment** did the child receive?  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

**NO**

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

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

**SECTION 5 - MEDICATIONS**

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

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

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

**SECTION 6 - TESTS**

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

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

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

**SECTION 7 - ADDITIONAL INFORMATION**

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

- |   |                          |     |                          |    |
|---|--------------------------|-----|--------------------------|----|
| Headstart (Title V)                                 | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Public or Community Health Department               | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Child Welfare or Social Service Agency              | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Women, Infant and Children (WIC) Program            | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Program for Children with Special Health Care Needs | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Mental Health/Mental Retardation Center             | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work?

- YES       NO

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

C. 1. NAME OF AGENCY \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

\_\_\_\_\_  
*City State ZIP*

PHONE NUMBER \_\_\_\_\_

*Area Code Number*

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

FILE OR RECORD NUMBER \_\_\_\_\_

2. NAME OF AGENCY \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

\_\_\_\_\_  
*City State ZIP*

PHONE NUMBER \_\_\_\_\_

*Area Code Number*

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

FILE OR RECORD NUMBER \_\_\_\_\_

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

**SECTION 8 - EDUCATION**

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

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

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

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

NAME OF SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

*City*

*County*

*State*

*ZIP*

PHONE NUMBER \_\_\_\_\_

*Area Code*      *Number*

DATES ATTENDED \_\_\_\_\_

TEACHER'S NAME \_\_\_\_\_

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

If "YES", complete the following:

TYPE OF TEST \_\_\_\_\_ WHEN DONE \_\_\_\_\_

TYPE OF TEST \_\_\_\_\_ WHEN DONE \_\_\_\_\_

Is the child in special education?  YES  NO

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

NAME OF SPECIAL EDUCATION TEACHER \_\_\_\_\_

Is the child in speech therapy?  YES  NO

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

NAME OF SPEECH THERAPIST \_\_\_\_\_

**SECTION 8 - EDUCATION**

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

NAME OF SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

*City*

*County*

*State*

*ZIP*

PHONE NUMBER \_\_\_\_\_

*Area Code*

*Number*

DATES ATTENDED \_\_\_\_\_

TEACHER'S NAME \_\_\_\_\_

Was the child tested for behavioral or learning problems?

YES

NO

If "YES", complete the following:

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

TYPE OF TEST \_\_\_\_\_

WHEN DONE \_\_\_\_\_

Was the child in special education?

YES

NO

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

NAME OF SPECIAL EDUCATION TEACHER \_\_\_\_\_

Was the child in speech therapy?

YES

NO

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

NAME OF SPEECH THERAPIST \_\_\_\_\_

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

E. Is the child attending Daycare/Preschool?

YES

NO

If "YES", complete the following:

NAME OF DAYCARE/  
PRESCHOOL/CAREGIVER \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

*City*

*County*

*State*

*ZIP*

PHONE NUMBER \_\_\_\_\_

*Area Code*

*Number*

DATES ATTENDED \_\_\_\_\_

TEACHER'S/CAREGIVER'S NAME \_\_\_\_\_

**SECTION 9 - WORK HISTORY**

A. Has the child ever worked (including sheltered  YES  NO

If "YES", complete the following:

DATES WORKED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_

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

\_\_\_\_\_ *City* *State* *ZIP*

PHONE NUMBER \_\_\_\_\_  
*Area Code* *Number*

NAME OF SUPERVISOR \_\_\_\_\_

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 10 - DATE AND REMARKS**

Please give the date you filled out this disability report.

Date (MM/DD/YYYY)      /      /

**Use this section for any additional information about your child.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

