

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.

NOTE: This is the only portion of the SSI application process that can currently be done online. If you submit this online, please provide the Social Security Liaison with the Confirmation # for tracking purposes. (Print at least two copies - one for your file, and one to turn in as a cover sheet for the supporting documents with all the other paperwork.)

DISABILITY REPORT - CHILD

SECTION 1 -- INFORMATION ABOUT THE CHILD

A. CHILD'S NAME <i>(First, Middle Initial, Last)</i>	B. CHILD'S SOCIAL SECURITY NUMBER
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C. YOUR NAME *(If agency, provide name of agency and contact person)*
Child & Family Connections - Schella Lapomarel or Sol Gonzalez.

YOUR MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*
4100 Okeechobee Blvd.

CITY West Palm Beach	STATE FL	ZIP CODE 33409
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YOUR EMAIL ADDRESS (Optional) slapomorel@cfcpsc.org or sgonzalez@cfcpsc.org

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.)*
Schella Lapomarel (561) 352-2451
Sol Gonzalez (561) 352-2465
 Your Number Message Number None

E. What is your relationship to the child? Rep Payee

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)

DAYTIME PHONE _____
 City State ZIP 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 Foster Parent or Group Home
 ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

DAYTIME PHONE _____
 City State ZIP 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 Department of Children & Families / Child & Family Connections
- ADDRESS 4100 Okeechobee Blvd.
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)
West Palm Beach, FL 33409
ZIP
- DAYTIME PHONE NUMBER Schella Lapomarel (561) 352-2451
Sol Gonzalez (561) 352-2465
- RELATIONSHIP TO CHILD Rep Payee
- 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 Case Manager's Name
- ADDRESS 4100 Okeechobee Blvd.
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)
West Palm Beach, FL 33409
City State ZIP
- DAYTIME PHONE NUMBER Case Manager's Cell #
Area Code Number
- RELATIONSHIP TO CHILD Dependency Case Manager
- 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 3 - THE CHILD'S ILLNESSES, INJURIES OR
CONDITIONS AND HOW THEY AFFECT HIM/HER**

A. What are the child's disabling **illnesses, injuries, or conditions**?

Give details and examples using common everyday language, not medical or clinical terminology.
Explain the interaction between the physical and emotional, and side effects of medication.
Give specific examples of how their condition affects (limits) their daily life
Include exposure to traumatic events.

B. When did the child become disabled?

<i>Month</i>	<i>Day</i>	<i>Year</i>
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The date here must coincide with the 8000 application. DOB may be used if unknown.

C. Do the child's illnesses, injuries or conditions cause **pain** YES NO
or other symptoms?

Usually Yes - think of side effects.

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

YES NO

Think of the date as 6 months to 2 years prior to applying for SSI.

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

YES NO

Usually yes

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List each DOCTOR/HMO/THERAPIST/OTHER. Include the child's next appointment.

1. NAME EPSDT may be used here

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

2. NAME CBHA may be used here

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

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

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

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	
NAME _____ STREET ADDRESS _____	<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT
CITY _____ STATE _____ ZIP _____	<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
PHONE _____ <small>Area Code Number</small>	<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	
		<div style="border: 1px solid red; padding: 2px; color: red;"> ER visits don't count since their purpose is to stabilize rather than treat the patient. </div>	

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

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**

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

Schools, Insurance Companies, and sometimes Attorneys will have info on a child's medical condition. CFC Clinical Dept. may also have information.

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
Be sure to list all medicines and side effects. Sometimes there may be an adverse interaction between two medications. If medications are unknown, it's ok to say "see medical records"			

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)	List all that are known. Use another sheet if necessary. Ok to say "See Medical Records"		
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) YES NO
- Public or Community Health Department YES **Often** NO
- Child Welfare or Social Service Agency YES NO
- Women, Infant and Children (WIC) Program YES **Often** NO
- Program for Children with Special Health Care Needs YES NO
- Mental Health/Mental Retardation Center YES NO

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

- YES NO **Unlikely unless older teen & SIL / IL**

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

C. 1. NAME OF AGENCY

contact info of the healthcare provider who did the test

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.

List the name and school currently attending. If over summer, use "highest grade completed" and the school they were at most recently. Homeschooling and GED count.

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 _____

IQ, Speech,
Hearing, Vision,
Behavior, etc.

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.

If child has been in lots of different schools for short periods of time, it's helpful to list the others on a separate sheet of paper.

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.

Often

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:

Almost never, but may apply to older teens and SIL / IL

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.

It's better to include something here that will help the application be approved. Again, day-to-day examples in layman's terms are preferred. There's plenty of space here - tell about a recent situation that illustrates the child's problems. Or explain the trauma they experienced in the past and how it affects them now. Finally, use the phrase "Case manager completed to the best of ability based on the information available at the time" and sign it.

