

QUESTIONNAIRE FOR CHILDREN CLAIMING SSI BENEFITS

Please print, type, or write clearly and answer all items to the best of your ability. If you need help completing any part of this form, we will help you. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. If you do not know the answer, enter "unknown." If the question does not apply, enter "N/A." If you need more space to answer any of the questions, please use "REMARKS" and enter the number of the question next to your answer.

Child's Full Name		Social Security Number - -	Date (month, day, year)
Informant's Name	Relationship to Child	Daytime Telephone Number (including Area Code)	

1. Is (was) the child cared for by a baby sitter? Does (did) the child attend any type of preschool, daycare and/or after school program? If so, please specify. If more than one of the above, use the "REMARKS" section.

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	Dates Attended

2. a. Is (was) the child in school? → Yes No

If "yes," and the school was not listed in Item 12A of the SSA-3820-F6, please show it here.
(If more than one, use the "REMARKS" section.)

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	Dates Attended
Grade Level Completed	Last Teacher's Name

2.b. Is the child in a special education program? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
c. Does the school make any special accommodations for the child; e.g., adaptive furniture, wheelchair ramps, extra assistance or attention? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
If "yes" in 2.b. or 2.c., indicate type of program and/or accommodations:	Specify number of hours per week the child is in special education program:
d. Do you have a copy of the child's individual education plan (IEP), the report in which the teacher outlines the child's problems and lists the plans for correcting them? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes," please provide a copy.	
3. Does the child receive any special counseling or tutoring?	
a. In school _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Outside school _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No

If **"yes,"** in 3.a. or 3.b., please indicate: *(If more than one, use the "REMARKS" section.)*

Type of Counseling, Tutoring

Date Began and Ended (If completed)	Frequency of Visits
Counselor's or Tutor's Name	Telephone Number (including Area Code)
Address (Number, Street, City, State, ZIP Code)	

4. Does the child or family have a child welfare, social services or early intervention caseworker? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If **"yes,"** please provide the following information: *(If more than one, use the "REMARKS" section.)*

Caseworker's Name	Organization
Address (Number, Street, City, State, ZIP Code)	Telephone Number (including Area Code)
File or Record Number	Date First Saw/Last Saw Caseworker

6. Does (did) the child receive any special therapy (physical, speech and language, occupational), exercises, or any other services for his/her impairments? →

Yes No

Include information about any therapy or exercises the parent, guardian or caregiver provides the child.

If **"yes,"** indicate below the therapist's name, the name of the person who PRESCRIBED AND/OR DESIGNED the therapy program, the type(s) and frequency of treatment, when treatment began and ended (if completed), and where treatment was received (*e.g., home, hospital, therapist's office, clinic.*)

Therapist's Name

Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

Therapist's Name

Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

7. Does (did) the child receive vocational rehabilitation services? → If "yes," describe services received below the rehabilitation counselor's information. Include dates and record number.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Rehabilitation Counselor's Name	Telephone No. (including Area Code)
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Address (Number, Street, City, State, ZIP Code)

Services received:

(If additional space is needed, use "REMARKS" section.)

NOTE: PROVIDING INFORMATION ABOUT THE CHILD'S INVOLVEMENT WITH THE COURT SYSTEM IS OPTIONAL

8. Has the child ever been involved with the court system other than in custody proceedings? → If "yes," please explain involvement, including testing and evaluation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Youth Development Center's Name

Address (Number, Street, City, State, ZIP Code)

Probation or Parole Officer's Name	Telephone No. (including Area Code)
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Address (Number, Street, City, State, ZIP Code)

Involvement including any testing and evaluation:
