Form Approved OMB No. 0960-0499

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 Secu | rity Number | Date (month, day, year) |
|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------|----------------|------------------------------------|
| | | - | - | |
| Informant's Name | Relationship to Child | | Daytime Te | L Elephone Number Area Code) |
| Is (was) the child cared for by a b and/or after school program? If so "REMARKS" section. | • | | • • • | • |
| Name | | Address (Number, Street, City, State, ZIP Code) | | |
| Telephone Number (including Area Code) | | Dates Attended | i | |
| 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 (Numb | oer, Street, C | ity, State, ZIP Code) |
| Telephone Number (including Area | Code) | Dates Attended | i | |
| Grade Level Completed | | Last Teacher's | Name | |

| 2.b. Is the child in a special education program? | | Yes | No | ☐ Don't Know |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------|-------------|---------------------------------------|
| c. Does the school make any special accommodations child; e.g., adaptive furniture, wheelchair ramps, extraossistance or attention? | | Yes | □No | ☐ Don't Know |
| If "yes" in 2.b. or 2.c., indicate type of program and accommodations: | | • | | ours per week the ucation program: |
| d. Do you have a copy of the child's individual education (IEP), the report in which the teacher outlines the chiproblems and lists the plans for correcting them? If "yes," please provide a copy. | | Yes | □No | |
| 3. Does the child receive any special counseling or tutoring | ng? | | | |
| a. In school | .9. | ☐ Yes | □ No | |
| b. Outside school | > | Yes | No | |
| If "yes," in 3.a. or 3.b., please indicate: (If more than one | , use the "REMAI | RKS" section | 1.) | |
| Type of Counseling, Tutoring Date Began and Ended (If completed) | Frequency of V | /isits | | |
| Counselor's or Tutor's Name | Telephone Nur | nber (inclu | ding Area | Code) |
| Address (Number, Street, City, State, ZIP Code) | | | | |
| Does the child or family have a child welfare, social ser early intervention caseworker? | vices or | Yes | □No | |
| If "yes," please provide the following information: (If more | e than one, use th | ne "REMARh | (S" section | ı.) |
| 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 (| Casework | rer |

| 5. Has the child ever been tested or evaluated by any of the following agencindicate in the space provided below the agency name, address, telephone in the type and date of test or evaluation performed (e.g., vision, hearing, speed) | number, record number, and |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| a. Public/Community Health Department | ☐ Yes ☐ No |
| b. Child Welfare/Social Services Agency | ☐ Yes ☐ No |
| c. Developmental Evaluation Center | ☐ Yes ☐ No |
| d. Mental Health/Mental Retardation Center | ☐ Yes ☐ No |
| e. Special Needs/Crippled Children Agency | ☐ Yes ☐ No |
| f. Speech and Hearing Center | ☐ Yes ☐ No |
| g. Women, Infants and Children (WIC) Program | Yes No |
| Use the letter designation (5a, 5b, etc.) to identify the a | igency. |
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| If additional space is needed, use "REMARKS" | ' section |

| 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 DESIGNED the therapy program, the type(s) and frequency of treatment, we (if completed), and where treatment was received (e.g., home, hospital, therapy | when tr | eatme | ent began and ended |
| Therapist's Name Telephone No. (| | | o. (including Area Code) |
| Address (Number, Street, City, State, ZIP Code) | | | |
| Person Who Prescribed/Designed Therapy | | | |
| Information about Therapy: | | | |
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| Therapist's Name | Telepho | one No | o. (including Area Code) |
| Address (Number, Street, City, State, ZIP Code) | | | |
| Person Who Prescribed/Designed Therapy | | | |
| Information about Therapy: | | | |
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| 7. Does (did) the child receive vocational rehabilitation services? | Yes No |
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| If "yes," describe services received below the rehabilitation counselor's information. Include dates and record number. | |
| Rehabilitation Counselor's Name | Telephone No. (including Area Code) |
| Address (Number, Street, City, State, ZIP Code) | |
| Services received: | |
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| (If additional space is needed, use "REMARKS | S" section) |
| NOTE: PROVIDING INFORMATION ABOUT THE CHIL | · |
| WITH THE COURT SYSTEM IS OPTIO | |
| 8. Has the child ever been involved with the court system other than in custody proceedings? | Yes No |
| If "yes," please explain involvement, including testing and evaluation. | |
| Youth Development Center's Name | |
| Address (Number, Street, City, State, ZIP Code) | |
| Probation or Parole Officer's Name | Telephone No. (including Area Code) |
| Address (Number, Street, City, State, ZIP Code) | |
| Involvement including any testing and evaluation: | |
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| | | munity or school activities, it's Club, Scouts, or sports? | Yes No |
|---------------------------------|-------------------------|------------------------------------------------------------|-----------------------------------------------------------------|
| | number of individ | | of participation. Provide name, Include dates of involvement. I |
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|). If the child takes any me | dication on an o | ngoing basis, please indicate th | e following: |
| MEDICATION DOSAGE/ FREQUENCY | PRESCRIBED BY (NAME) | REASON FOR MEDICATION | DESCRIBE ANY SIDE EFFECTS |
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| How well does the medica | ition(s) work? Ple | ease explain: | |
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| 11 a. If you are unable to give us information we need about the child, is there someone else who helps care for the child and, knows of the child's impairment who can help us get the | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| information we need, and, if necessary, bring the child to a consultative examination? | | | | | |
| Yes No | | | | | |
| b. If "yes," please provide the following information about this person | | | | | |
| Name | | | | | |
| Address (Number, Street, City, State, ZIP Code) | | | | | |
| Daytime telephone number (including Area Code) | | | | | |
| Relationship (e.g., relative, neighbor, family friend) to the child? | | | | | |
| REMARKS: | | | | | |
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| REMARKS (continued): | |
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Privacy Act Statement Questionnaire for Children Claiming SSI Benefits

Sections 223 and 1632 of the Social Security Act, as amended, allows us to collect the information requested on this questionnaire. The information you provide will be used in making a decision on your claim. The information you furnish on this form is voluntary. However, failure to provide the requested information could prevent an accurate and timely decision on your claim and could result in the loss of benefits.

We rarely use the information provided on this form for any purpose other than for the reasons stated above. However, we may use it for the administration and integrity of Social Security programs. We may also, disclose the information provided on this form in accordance with approved routine uses of the Privacy Act (445 U.S.C.§ 552a), which include but are not limited to the following:

- 1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
- 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level:
- 3. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veteran's Affairs); and,
- 4. To facilitate statistical research audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Records Notice entitled, Claims Folder System, 60-0089; Supplemental Security Income Record and Special Veterans Benefits, 60-0103; and Electronic Disability (eDIB) Claim File, 60-0320. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security Office.

Paperwork Reduction Act Statement - 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 30 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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.