

FUNCTION REPORT - ADULT - Form SSA-3373-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213.

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.

It is important that you tell us about your activities and abilities.

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

Privacy Act and Paperwork Reduction Act Statements

Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. 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. We generally use the information you supply for the purpose of making decisions regarding claims. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (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); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 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.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at any 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 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not have that address, 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.***

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

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only
Do not write in this box.

Related SSN - -
Number Holder _____

SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle Initial, Last)*

2. **SOCIAL SECURITY NUMBER**

- -

3. **YOUR DAYTIME TELEPHONE NUMBER** *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

() - _____
Area Code Phone Number

Your Number Message Number None

4. a. **Where do you live?** *(Check one.)*

House Apartment Boarding House Nursing Home
 Shelter Group Home Other *(What?)* _____

b. **With whom do you live?** *(Check one.)*

Alone With Family With Friends
 Other *(Describe relationship.)* _____

SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

5. **How do your illnesses, injuries, or conditions limit your ability to work?**

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? Yes No

If "YES," for whom do you care, and what do you do for them?

8. Do you take care of pets or other animals? Yes No

If "YES," what do you do for them?

9. Does anyone help you care for other people or animals? Yes No

If "YES," who helps, and what do they do to help?

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

11. Do the illnesses, injuries, or conditions affect your sleep? Yes No

If "YES," how?

12. **PERSONAL CARE** (Check here if **NO PROBLEM** with personal care.)

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress _____

Bathe _____

Care for hair _____

Shave _____

Feed self _____

Use the toilet _____

Other _____

b. Do you need any special reminders to take care of personal needs and grooming? Yes No

If "YES," what type of help or reminders are needed? _____

c. Do you need help or reminders taking medicine? Yes No

If "YES," what kind of help do you need? _____

13. MEALS

a. Do you prepare your own meals? Yes No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.) _____

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

How long does it take you? _____

Any changes in cooking habits since the illness, injuries, or conditions began?

b. If "No," explain why you cannot or do not prepare meals. _____

14. HOUSE AND YARD WORK

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.) _____

b. How much time does it take you, and how often do you do each of these things?

c. Do you need help or encouragement doing these things? Yes No

If "YES," what help is needed? _____

d. If you don't do house or yard work, explain why not. _____

15. GETTING AROUND

a. How often do you go outside? _____
If you don't go out at all, explain why not. _____

b. When going out, how do you travel? *(Check all that apply.)*
 Walk Drive a car Ride in a car Ride a bicycle
 Use public transportation Other *(Explain)* _____

c. When going out, can you go out alone? Yes No
If "NO," explain why you can't go out alone. _____

d. Do you drive? Yes No
If you don't drive, explain why not. _____

16. SHOPPING

a. If you do any shopping, do you shop: *(Check all that apply.)*
 In stores By phone By mail By computer

b. Describe what you shop for. _____

c. How often do you shop and how long does it take? _____

17. MONEY

a. Are you able to:
Pay bills Yes No Handle a savings account Yes No
Count change Yes No Use a checkbook/money orders Yes No
Explain all "NO" answers. _____

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? Yes No

If "YES," explain how the ability to handle money has changed. _____

18. HOBBIES AND INTERESTS

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.) _____

b. How often and how well do you do these things? _____

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

19. SOCIAL ACTIVITIES

a. Do you spend time with others? (*In person, on the phone, on the computer, etc.*) Yes No

If "YES," describe the kinds of things you do with others. _____

How often do you do these things? _____

b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.) _____

Do you need to be reminded to go places? Yes No

How often do you go and how much do you take part? _____

Do you need someone to accompany you? Yes No

c. Do you have any problems getting along with family, friends, neighbors, or others? Yes No

If "YES," explain. _____

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

SECTION D - INFORMATION ABOUT ABILITIES

20. a. Check any of the following items that your illnesses, injuries, or conditions affect:

- | | | | |
|------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Walking | <input type="checkbox"/> Stair Climbing | <input type="checkbox"/> Understanding |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Seeing | <input type="checkbox"/> Following Instructions |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Memory | <input type="checkbox"/> Using Hands |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Talking | <input type="checkbox"/> Completing Tasks | <input type="checkbox"/> Getting Along With Others |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Hearing | <input type="checkbox"/> Concentration | |

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far])

b. Are you: Right Handed? Left Handed?

c. How far can you walk before needing to stop and rest? _____
If you have to rest, how long before you can resume walking? _____

d. For how long can you pay attention? _____

e. Do you finish what you start? (For example, a conversation, chores, reading, watching a movie.) Yes No

f. How well do you follow written instructions? (For example, a recipe.) _____

g. How well do you follow spoken instructions? _____

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.) _____

i. Have you ever been fired or laid off from a job because of problems getting along with other people? Yes No

If "YES," please explain. _____

If "YES," please give name of employer. _____

j. How well do you handle stress? _____

k. How well do you handle changes in routine? _____

l. Have you noticed any unusual behavior or fears? Yes No

If "YES," please explain. _____

21. Do you use any of the following? (*Check all that apply.*)

- | | | |
|---|--|---|
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Brace/Splint | <input type="checkbox"/> Glasses/Contact Lenses |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Artificial Limb | <input type="checkbox"/> Artificial Voice Box |
| <input type="checkbox"/> Other (<i>Explain</i>) _____ | | |

Which of these were prescribed by a doctor? _____

When was it prescribed? _____

When do you need to use these aids? _____

22. Do you currently take any medicines for your illnesses, injuries, or conditions?

Yes

No

If "YES," do any of your medicines cause side effects?

Yes

No

If "YES," please explain. (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE	SIDE EFFECTS YOU HAVE

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

Name of person completing this form (Please print)		Date (month, day, year)	
Address (Number and Street)		Email address (optional)	
City	State	Zip Code	