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FUNCTION REPORT - ADULT

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 10, and show the number of the question being answered.

Function Report - Adult - Form SSA-3373-BK

The purpose of the function report is for the applicant to provide information about his/her abilities. The information furnished will be provided to the Disability Determination Services. To ensure questions are not skipped, please avoid leaving blank answers. Instead write 'N/A' or 'none' if the question does not apply to the applicant.

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Privacy Act Statements Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information you provide to make a determination of eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs; and
- To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all our SORNs, is available on our website at https://ssa.gov/privacy.

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 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 regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden 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. Please remove page and provide the Privacy Act Statements to the applicant. Form SSA-3373 (10-2020) Discontinue Prior Editions Social Security Administration

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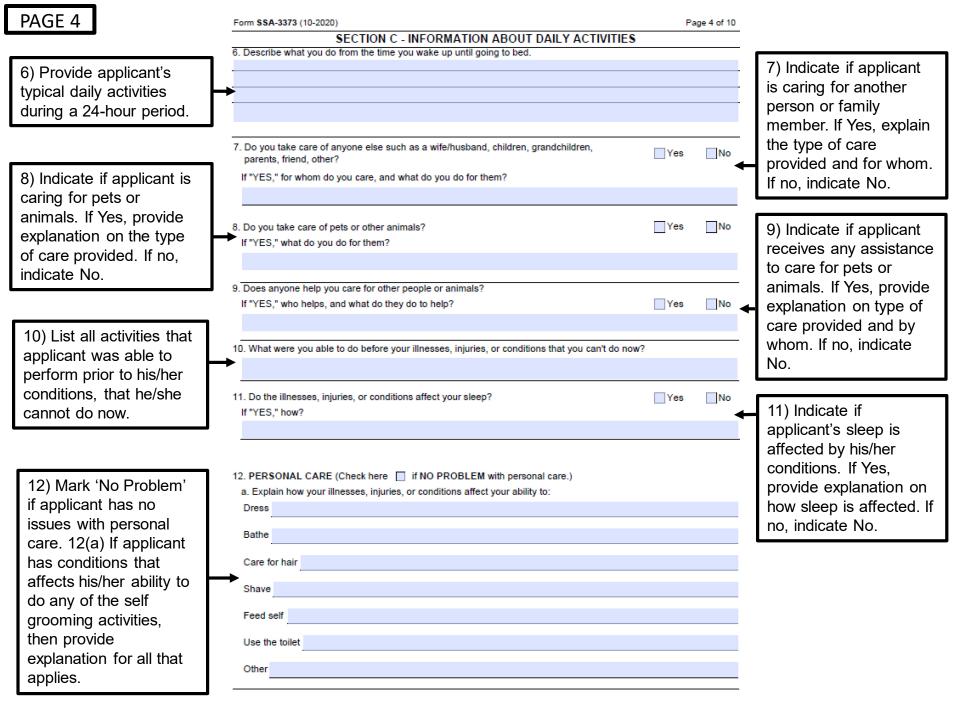
FUNCTION REPORT - ADULT

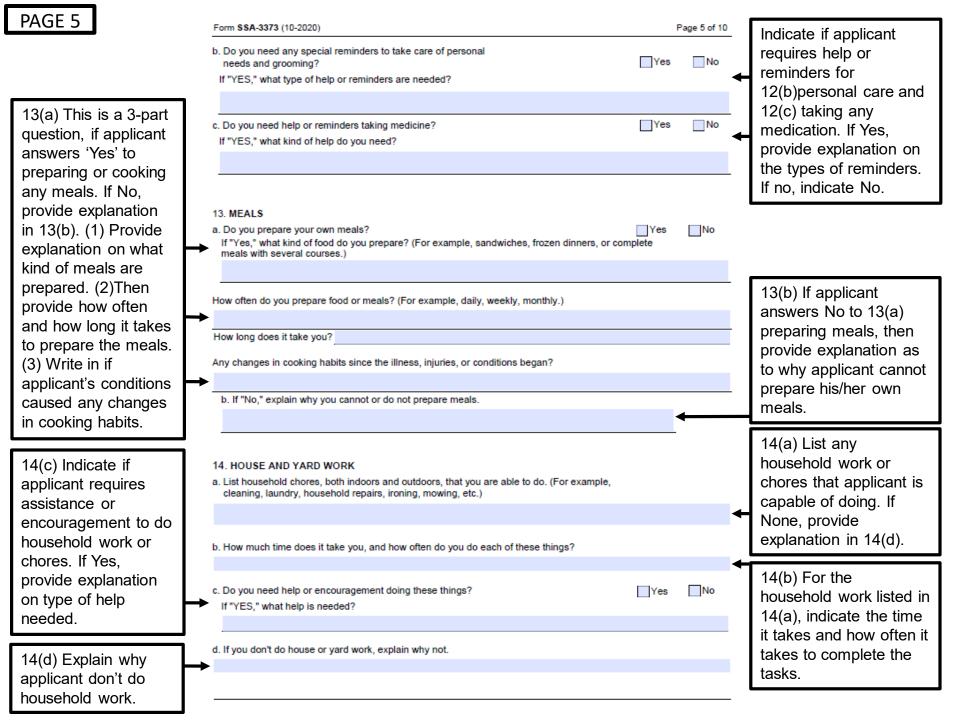
How your illnesses, injuries, or conditions limit your activities

For SSA Use Only

Do not write in this box.

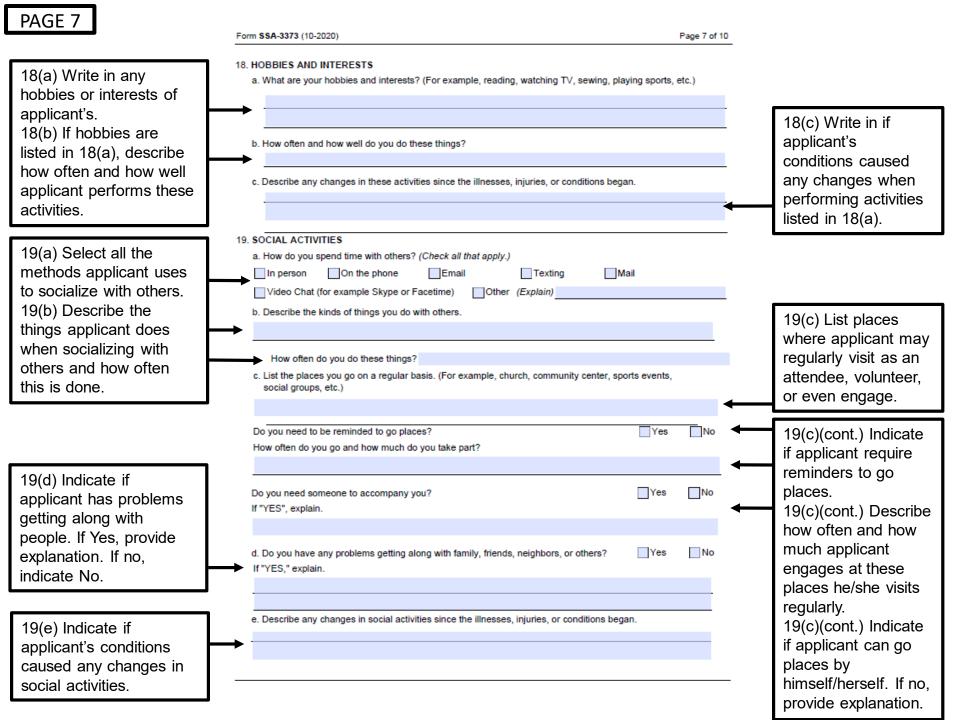
1) Write in applicant's name (preferably as it appears on the Social Security card)	Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions. SECTION A - GENERAL INFORMATION 1. NAME OF DISABLED PERSON (First, Middle Initial, Last) 2. SOCIAL SECURITY NUMBER	2) Write in applicant's Social Security number
Write in applicant's phone 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.) Your Number Message Number None	
(preferably have voice message option set-up). Consider an alternative contact number, if marking 'none'.	Area Code Phone Number 4. a. Where do you live? (Check one.) House	4(a) Select the type of housing where applicant is living. If 'other' is marked, provide living situation and 4(b) Select whether applicant is living alone or with someone. If 'other' is marked, provide description of the relationship.
5) Describe how the applicant's conditions prevent him/her from working either part-time or full-time.		

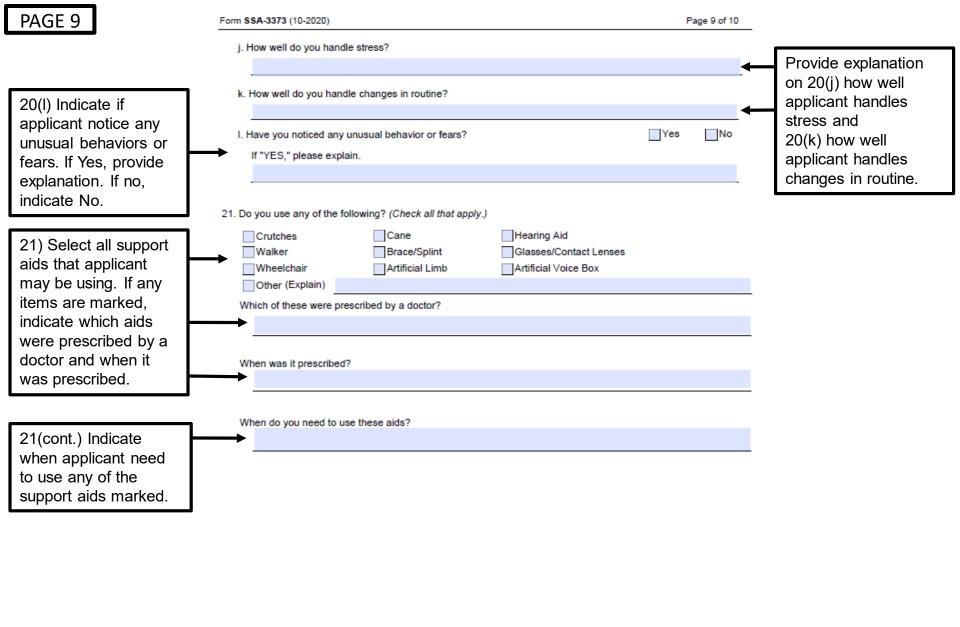




PAGE 6

Form SSA-3373 (10-2020) Page 6 of 10 15(a) Indicate how 15. GETTING AROUND 15(b) If applicant goes a. How often do you go outside? often applicant leaves out, select all the modes If you don't go out at all, explain why not. his/her home to go of transportation used. If outside. Provide b. When going out, how do you travel? (Check all that apply.) 'Other' is marked, provide explanation if applicant Walk Drive a car Ride in a car Ride a bicycle explanation. does not go outside. Other (Explain) Use public transportation c. When going out, can you go out alone? Yes 15(c) Indicate if applicant If "NO," explain why you can't go out alone. can go out by himself/herself. If No. 15(d) Indicate if No d. Do you drive? provide explanation. If applicant drives. If No. If you don't drive, explain why not yes, answer Yes. provide explanation. If yes, answer Yes. 16. SHOPPING a. If you do any shopping, do you shop: (Check all that apply.) 16(a) Select all the In stores By mail By computer By phone different options that b. Describe what you shop for. applicant uses when 17(a) Indicate if applicant shopping. is capable of paying bills, 16(b) Describe what c. How often do you shop and how long does it take? counting changes, applicant purchase. managing a savings 16(c) Indicate how often 17. MONEY account and using a shopping is done by a. Are you able to: checkbook or money applicant and how long Pay bills Yes No Handle a savings account order. Provide No Yes Yes Count change Use a checkbook/money orders it takes. explanation for all 'No' Explain all "NO" answers. answers. 17(b) Did applicant's b. Has your ability to handle money changed since the illnesses, Yes No conditions cause injuries, or conditions began? changes in his/her If "YES," explain how the ability to handle money has changed. ability to handle money? If Yes, provide explanation of how ability has changed. If no, indicate No.





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If "VES," please explain, (Do not list all of the medicines that you take. List only the medicines

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

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

22(cont.) If applicant answers 'Yes' to medicine causing side effects, then list only the medication that causes the side effects.

this page.

side effects.)		
NAME OF MEDICINE	SIDE EFFECTS YOU HAVE	
SECTION	N 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

Remarks) Indicate any additional information applicant may want to add. The additional space is also provided for responses that may not be captured in previous sections of the form.

22) Indicate if applicant is

the medication causes any

currently taking any

side effects.

medication related to his/her conditions and if

More about Email address- Upon request, SSA can easily send direct links for users to access forms, publications, and fact sheets. This feature serves as quick and easy access to SSA material.

Provide name of person completing this form (Please print)

Date (MM/DD/YYYY)

Address (Number and Street)

Email address (optional)

City

State

ZIP Code

Provide name of person completing form along with completion date.

Provide applicant's mailing address and email address.