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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.

REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM ON PAGE 10

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.

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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.

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**

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?

1) Write in applicant's name (preferably as it appears on the Social Security card)

2) Write in applicant's Social Security number

3) Write in applicant's phone number. (preferably have voice message option set-up). Consider an alternative contact number, if marking 'none'.

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.

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SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

6) Provide applicant's typical daily activities during a 24-hour period.

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

7) Indicate if applicant is caring for another person or family member. If Yes, explain the type of care provided and for whom. If no, indicate No.

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) Indicate if applicant is caring for pets or animals. If Yes, provide explanation on the type of care provided. If no, indicate No.

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

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

9) Indicate if applicant receives any assistance to care for pets or animals. If Yes, provide explanation on type of care provided and by whom. If no, indicate No.

9. Does anyone help you care for other people or animals?

If "YES," who helps, and what do they do to help? ☐ Yes ☐ No

10) List all activities that applicant was able to perform prior to his/her conditions, that he/she cannot do now.

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

11) Indicate if applicant's sleep is affected by his/her conditions. If Yes, provide explanation on how sleep is affected. If no, indicate No.

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

If "YES," how?

12) Mark 'No Problem' if applicant has no issues with personal care. 12(a) If applicant has conditions that affects his/her ability to do any of the self grooming activities, then provide explanation for all that applies.

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

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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?

Indicate if applicant requires help or reminders for 12(b)personal care and 12(c) taking any medication. If Yes, provide explanation on the types of reminders. If no, indicate No.

13(a) This is a 3-part question, if applicant answers 'Yes' to preparing or cooking any meals. If No, provide explanation in 13(b). (1) Provide explanation on what kind of meals are prepared. (2)Then provide how often and how long it takes to prepare the meals. (3) Write in if applicant's conditions caused any changes in cooking habits.

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.

13(b) If applicant answers No to 13(a) preparing meals, then provide explanation as to why applicant cannot prepare his/her own 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.)

14(a) List any household work or chores that applicant is capable of doing. If None, provide explanation in 14(d).

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

14(b) For the household work listed in 14(a), indicate the time it takes and how often it takes to complete the tasks.

14(c) Indicate if applicant requires assistance or encouragement to do household work or chores. If Yes, provide explanation on type of help needed.

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.

14(d) Explain why applicant don't do household work.

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15(a) Indicate how often applicant leaves his/her home to go outside. Provide explanation if applicant does not go outside.

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)*

15(b) If applicant goes out, select all the modes of transportation used. If 'Other' is marked, provide explanation.

c. When going out, can you go out alone? ☐ Yes ☐ No

If "NO," explain why you can't go out alone.

15(c) Indicate if applicant can go out by himself/herself. If No, provide explanation. If yes, answer Yes.

15(d) Indicate if applicant drives. If No, provide explanation. If yes, answer Yes.

d. Do you drive? ☐ Yes ☐ No

If you don't drive, explain why not.

16. SHOPPING

16(a) Select all the different options that applicant uses when shopping.
16(b) Describe what applicant purchase.
16(c) Indicate how often shopping is done by applicant and how long it takes.

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

17(a) Indicate if applicant is capable of paying bills, counting changes, managing a savings account and using a checkbook or money order. Provide explanation for all 'No' answers.

Explain all "NO" answers.

17(b) Did applicant's conditions cause changes in his/her ability to handle money? If Yes, provide explanation of how ability has changed. If no, indicate No.

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.

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18(a) Write in any hobbies or interests of applicant's.
18(b) If hobbies are listed in 18(a), describe how often and how well applicant performs these activities.

18(c) Write in if applicant's conditions caused any changes when performing activities listed in 18(a).

19(a) Select all the methods applicant uses to socialize with others.
19(b) Describe the things applicant does when socializing with others and how often this is done.

19(c) List places where applicant may regularly visit as an attendee, volunteer, or even engage.

19(c)(cont.) Indicate if applicant require reminders to go places.
19(c)(cont.) Describe how often and how much applicant engages at these places he/she visits regularly.
19(c)(cont.) Indicate if applicant can go places by himself/herself. If no, provide explanation.

19(d) Indicate if applicant has problems getting along with people. If Yes, provide explanation. If no, indicate No.

19(e) Indicate if applicant's conditions caused any changes in social activities.

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. How do you spend time with others? *(Check all that apply.)*

☐ In person ☐ On the phone ☐ Email ☐ Texting ☐ Mail

☐ Video Chat (for example Skype or Facetime) ☐ Other *(Explain)*

b. Describe the kinds of things you do with others.

How often do you do these things?

c. 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

If "YES", explain.

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

If "YES," explain.

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

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SECTION D - INFORMATION ABOUT ABILITIES

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

☐ Lifting	☐ Walking	☐ Stair Climbing	☐ Understanding
☐ Squatting	☐ Sitting	☐ Seeing	☐ Following Instructions
☐ Bending	☐ Kneeling	☐ Memory	☐ Using Hands
☐ Standing	☐ Talking	☐ Completing Tasks	☐ Getting Along With Others
☐ Reaching	☐ Hearing	☐ 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.

20(a) Select any activities that are affected by applicant's conditions. Provide explanation for each marked activity.

20(b) Mark whether applicant is right or left-handed.

20(c) Write in the distance applicant can walk before needing to rest. Then indicate the time needed to rest before resuming walk.

20(d) Write in how long applicant can pay attention. 20(e) Indicate if applicant can finish what he/she started.

20(f) Explain how well applicant can follow instructions when it's written out and 20(g) how well for spoken instructions.

20(h) Explain how well applicant gets along with authority figures.

20(i) Indicate whether applicant has been terminated/fired from a job because he/she had problems getting along with others. If Yes, provide explanation and name of employer. If no, indicate No.

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j. How well do you handle stress?

k. How well do you handle changes in routine?

Provide explanation on 20(j) how well applicant handles stress and 20(k) how well applicant handles changes in routine.

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

If "YES," please explain.

20(l) Indicate if applicant notice any unusual behaviors or fears. If Yes, provide explanation. If no, indicate No.

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

☐ Crutches ☐ Cane ☐ Hearing Aid
☐ Walker ☐ Brace/Splint ☐ Glasses/Contact Lenses
☐ Wheelchair ☐ Artificial Limb ☐ Artificial Voice Box
☐ Other (Explain)

21) Select all support aids that applicant may be using. If any items are marked, indicate which aids were prescribed by a doctor and when it was prescribed.

Which of these were prescribed by a doctor?

When was it prescribed?

When do you need to use these aids?

21(cont.) Indicate when applicant need to use any of the support aids marked.

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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

22) Indicate if applicant is currently taking any medication related to his/her conditions and if the medication causes any side effects.

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

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.

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.

Name of person completing this form (Please print)	Date *(MM/DD/YYYY)*

Provide name of person completing form along with completion date.

Address (Number and Street)	Email address (optional)	
City	State	ZIP Code

Provide applicant's mailing address and email address.

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.