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Form **SSA-3380** (10-2020)
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0635

FUNCTION REPORT - ADULT - THIRD PARTY Form SSA-3380-BK

Third Party Application

It is important to tell what you know.

Do not ask the claimant, a doctor, or the hospital.

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 (TTY 1-800-325-0778).

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to make a decision on the disabled person's claim. You can help by completing as much of the form as you can. When a question refers to the "disabled person," it refers to the person who is applying for or receiving disability benefits.

It is important that you tell us what you know about the disabled person's activities and abilities.

DO NOT ASK THE DISABLED PERSON TO GIVE YOU ANSWERS

- 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 you need more space to answer any questions, use the "REMARKS" section on Page 10, and show the number of the question being answered.

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

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Privacy Act and Paperwork Reduction Act Statements

Sections 205(a), 223(d), and 1631 of the Social Security Act (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 Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all of our SORNs, is available on our website at https://www.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.

Notice the Privacy Act and Paperwork Reduction Act Statements

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FUNCTION REPORT- ADULT - THIRD PARTY

How the disabled person's illnesses, injuries, or conditions limit his/her 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.

Complete General Information of the applicant.

SECTION A - GENERAL INFORMATION

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

2. **YOUR NAME** *(Person completing the form)*

3. **RELATIONSHIP** *(To disabled person)*

4. **DATE** *(MM/DD/YYYY)*

5. **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

6. a. How long have you known the disabled person?

b. How much time do you spend with the disabled person and what do you do together?

7. a. Where does the disabled person live? *(Check one.)*

☐ House ☐ Apartment ☐ Boarding House ☐ Nursing Home

☐ Shelter ☐ Group Home ☐ Other (What?)

b. With whom does he/she live? *(Check one.)*

☐ Alone ☐ With Family ☐ With Friends

☐ Other (describe relationship)

Explain how the person's illness, injuries, or conditions limits their ability to work.

SECTION B - INFORMATION ABOUT ILLNESSES, INJURIES, OR CONDITIONS

8. How does this person's illnesses, injuries, or conditions limit his/her ability to work?

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Describe information about the applicant's daily activities.

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

9. Describe what the disabled person does from the time he/she wakes up until going to bed.

10. Does this person take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? ☐ Yes ☐ No

If "YES," for whom does he/she care, and what does he/she do for them?

11. Does he/she take care of pets or other animals? ☐ Yes ☐ No

If "YES," what does he/she do for them?

12. Does anyone help this person care for other people or animals? ☐ Yes ☐ No

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

13. What was the disabled person able to do before his/her illnesses, injuries, or conditions that he/she can't do now?

14. Do the illnesses, injuries, or conditions affect his/her sleep? ☐ Yes ☐ No

If "YES," how?

Describe how the person's illness, injuries, or conditions limits their daily activities.

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

a. Explain how the illnesses, injuries, or conditions affect this person's ability to:

Dress

Bathe

Care for hair

Shave

Feed self

Use the toilet

Other

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b. Does he/she 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. Does he/she need help or reminders taking medicine? ☐ Yes ☐ No

If "YES," what kind of help does he/she need?

Describe how the person's illness, injuries, or conditions impacts their daily meals.

16. **MEALS**

a. Does the disabled person prepare his/her own meals? ☐ Yes ☐ No

If "Yes," what kind of food is prepared? (For example, sandwiches, frozen dinners, or complete meals with several courses.)

How often does he/she prepare food or meals? (For example, daily, weekly, monthly.)

How long does it take him/her?

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

b. If "No," explain why he/she cannot or does not prepare meals.

Describe how the person's illness, injuries, or conditions impacts their ability to do house and yard work.

17. **HOUSE AND YARD WORK**

a . List household chores, both indoors and outdoors, that the disabled person is able to do . *(For example, cleaning, laundry, household repairs, ironing, mowing, etc.)*

b. How much time do chores take, and how often does he/she do each of these things?

c. Does he/she need help or encouragement doing these things? ☐ Yes ☐ No

If "YES," what help is needed?

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d. If the disabled person doesn't do house or yard work, explain why not.

Describe how the person's illness, injuries, or conditions impacts their mobility.

18. **GETTING AROUND**

a. How often does this person go outside?

If he/she doesn't go out at all, explain why not.

b. When going out, how does he/she 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 he/she go out alone? ☐ Yes ☐ No

If "NO," explain why he/she can't go out alone.

d. Does the disabled person drive? ☐ Yes ☐ No

If he/she doesn't drive, explain why not.

Describe how the person's illness, injuries, or conditions impacts their ability to go shopping.

19. **SHOPPING**

a. If the disabled person does any shopping, does he/she shop: *(Check all that apply.)*

☐ In stores ☐ By phone ☐ By mail ☐ By computer

b. Describe what he/she shops for.

c. How often does he/she shop and how long does it take?

20. **MONEY**

a. Is he/she 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.

Describe how the person's illness, injuries, or conditions impacts their ability to manage their finances.

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b. Has the disabled person's 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.

21. **HOBBIES AND INTERESTS**

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

b. How often and how well does he/she do these things?

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

Describe how the person's illness, injuries, or conditions impacts their ability to socialize with others.

22. **SOCIAL ACTIVITIES**

a. How does the disabled person 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 he/she does with others.

How often does he/she do these things?

c. List the places he/she goes on a regular basis. (For example, church, community center, sports events, social groups, etc.)

Does he/she need to be reminded to go places? ☐ Yes ☐ No

How often does he/she go and how much does he/she take part?

Does he/she need someone to accompany him/her? ☐ Yes ☐ No

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d. Does this person 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.

SECTION D - INFORMATION ABOUT ABILITIES

Describe the person's illness, injuries, or conditions.

23. a. Check any of the following items the disabled person's 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 his/her illnesses, injuries, or conditions affect each of the items you checked. (For example, he/she can only lift [how many pounds], or he/she can only walk [how far])

b. Is the disabled person: ☐ Right Handed? ☐ Left Handed?

c. How far can he/she walk before needing to stop and rest?

If he/she has to rest, how long before he/she can resume walking?

Describe how the applicant manages their illness, injuries, or conditions.

d. For how long can the disabled person pay attention?

e. Does the disabled person finish what he/she starts? (For example, a conversation, chores, reading, watching a movie.) ☐ Yes ☐ No

f. How well does the disabled person follow written instructions? (For example, a recipe.)

g. How well does the disabled person follow spoken instructions?

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h. How well does the disabled person get along with authority figures? (For example, police, bosses, landlords or teachers.)

Describe how the applicant manages their illness, injuries, or conditions considering outside factors.

i. Has he/she 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 does the disabled person handle stress?

k. How well does he/she handle changes in routine?

l. Have you noticed any unusual behavior or fears in the disabled person? ☐ Yes ☐ No

If "YES," please explain.

Describe what equipment or devices the applicant utilizes.

24. Does the disabled person 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*)

Which of these were prescribed by a doctor?

When was it prescribed?

When does this person need to use these aids?

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Describe how the applicant manages their illness, injuries, or conditions.

Share any additional information in the Remarks section.

25. Does the disabled person currently take any medicines for his/her illnesses, injuries, or conditions? ☐ Yes ☐ No

If " YES," do any of the medicines cause side effects? ☐ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that the disabled person takes. List only the medicines that cause side effects for the disabled person.)

NAME OF MEDICINE	SIDE EFFECTS PERSON HAS

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 *(MM/DD/YYYY)*
Address (Number and Street)	**Email address (optional)**	
City	**State**	**ZIP Code**

Thank you for completing the application.