The purpose of the Child Disability Report is for the reporter to provide information about the child's disabling condition and how it affects their ability to function. 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 applicant.

DISABILITY REPORT - CHILD - Form SSA-3820-BK
READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM THIS IS NOT AN APPLICATION

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

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.

- Fill out as much of this form as you can before your interview appointment. Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or " none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/ OTHER/ HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use Section 10, "DATE AND REMARKS," on Pages 11 and 12, and show the number of the question being answered.

ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records
- Copies of the child's prescriptions or medicine containers
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and medicine containers.

NOTE: The Child Disability Report can also be completed online. After the form is completed online, a Social Security representative will contact you to review the completed medical report, discuss whether the income and resources of the parents and the child are within the allowed limits, and start the SSI application process.

For more information, go to: https://www.ssa.gov/benefits/disability/apply-child.html

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 1631(e)(1), and 223(d)(5)(A) 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 affect the decision on the claim.

We will use the information to make a decision regarding if a child is eligible for benefit payments. We may also share your information for the following purposes, called routine uses:

1. To Federal, State, or local agencies that conduct business with the Social Security Administration (SSA) and the release of records is determined to be relevant and necessary; and disclosure is compatible to the reason why the records were collected;

2. To third party contacts when additional information about the child is needed or verification of eligibility for benefits; and

3. To workers who are performing work for SSA as authorized by law and who technically do not have the status of Federal employees; and other Federal agencies for assisting SSA in the efficient administration of its programs.

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 Notice (SORN) 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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 (OMB) control number. We estimate that it will take about 90 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to**: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

PAGE 1

A) Write in the applicant's name (preferably as it appears on their Social Security Number card).
B) Enter the applicant's Social Security number.
C) Enter the reporter's name (agency, guardian, parent, etc.), mailing address, and a valid email address will provide an additional contact method.

SOCIAL SECURITY ADMINISTRATION
Form Approved
OMB No. 0960-0577

Form **SSA-3820-BK** (03-2017) UF
Page 1 of 12

DISABILITY REPORT - CHILD

SECTION 1 - INFORMATION ABOUT THE CHILD

A. **CHILD'S NAME** *(First, Middle Initial, Last)*

B. **CHILD'S SOCIAL SECURITY NUMBER**

C. **YOUR NAME** *(If agency, provide name of agency and contact person)*

YOUR MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*

CITY | **STATE** | **ZIP CODE**

YOUR EMAIL ADDRESS (Optional)

D. **YOUR DAYTIME PHONE NUMBER** *(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)*

Area Code *Number*

☐ Your Number ☐ Message Number ☐ None

E. What is **your relationship to the child**?

F. Can you **speak and understand English**? ☐ YES ☐ NO

If "NO", what is your preferred language?

NOTE: If you cannot speak and understand English, we will provide you an interpreter, free of charge. **If you cannot speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages?

☐ YES (Enter name, address, phone number, relationship) ☐ NO

NAME RELATIONSHIP TO CHILD

ADDRESS

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *State* *ZIP* DAYTIME PHONE *Area Code* *Number*

Can you **read and understand English**? ☐ YES ☐ NO

G. Does the child live with you? ☐ YES ☐ NO If "NO", with whom does the child live?

NAME RELATIONSHIP TO CHILD

ADDRESS

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *State* *ZIP* DAYTIME PHONE *Area Code* *Number*

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language?

Can this person **read and understand English**? ☐ YES ☐ NO

Disability Report - Child - Form SSA-3820-BK

D) Write the reporter's phone number. (preferably have voice message option set-up)

E) Write the reporter's relationship to the child

F) Mark the reporter's ability to understand English. If "NO", write the preferred language. Although the agency provides an interpreter free of charge, mark if there is someone who speaks and understands English and will give you messages. If "YES", write their name, relationship to child, address and daytime telephone number. If no, mark NO

G) Mark if the child lives with the reporter. If "NO", write the contact information with whom the child lives with, address, and daytime telephone phone number. Mark if they can speak, read and understand English. If "NO", write their preferred language

PAGE 2

SECTION 1 - INFORMATION ABOUT THE CHILD

H. Can the child speak and understand English? ☐ YES ☐ NO

If "NO," what languages can the child speak? _____

If the child understands any other languages, list them here: _____

I. What is the child's height *(without shoes)*? _____

What is the child's weight *(without shoes)*? _____

J. Does the child have a **medical assistance** card? (for example Medicaid, Medi-Cal) ☐ YES ☐ NO

If "YES", show the **number** here: _____

SECTION 2 - CONTACT INFORMATION

A. Does the child have a legal guardian or custodian other than you?

☐ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ " " _____

City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

RELATIONSHIP TO CHILD _____

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

B. Is there another adult who helps care for the child and can help us get information about the child if necessary?

☐ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME OF CONTACT _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

RELATIONSHIP TO CHILD _____

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

H) Mark if the child understands English. If "NO", write any language(s) they speak and understand.

I) Write the child's height and weight (without shoes)

J) Mark if the child has a health insurance card. If "YES" write the card number.

A) Mark if the child has a legal guardian or custodian other than the reporter. If "YES", write their name, address, daytime telephone number, relationship to the child, and their ability to speak and understand English. If "NO", write their preferred language.

B) Mark if another adult assists in care of the child and can provide information about the child if necessary. If "YES", write their name, address, daytime telephone number, relationship to the child, and their ability to speak and understand English.

PAGE 3

SECTION 3 - THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER

A. What are the child's disabling **illnesses, injuries, or conditions**?

A) Write in the child's illnesses, injuries, or conditions and how they cause marked and severe functional limitations.

B. When did the child become disabled? _____
Month *Day* *Year*

B) Indicate when the child became disabled.

C. Do the child's illnesses, injuries or conditions cause **pain** or other symptoms? ☐ YES ☐ NO

C) Mark if the child's illnesses, injuries or conditions cause them pain or other symptoms.

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?
☐ YES ☐ NO

A) Mark if the child has been seen by a doctor/hospital/clinic or anyone else for their injuries or conditions.

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?
☐ YES ☐ NO

B) Mark if the child has been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems.

PAGE 4

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each DOCTOR/HMO/THERAPIST/OTHER**. Include the child's **next appointment**.

C (1) Write the name of the doctor, HMO, therapist, or other medical source the child has seen within the last 12 months. Include their address, telephone number, dates visited and patient ID (if known).

1. **NAME** | **DATES**

STREET ADDRESS | **FIRST VISIT**

CITY | **STATE** | **ZIP** | **LAST VISIT**

PHONE (*Area Code* *Number*) | **Patient ID #** (If known) | **NEXT APPOINTMENT**

REASONS FOR VISITS

Write the reasons for visits and what treatment the child has received.

WHAT **TREATMENT** WAS RECEIVED?

Write the reasons for visits and what treatment the child has received.

C (2) Write any additional doctor, HMO, therapist, or other medical source the child has seen within the last 12 months. Include their address, telephone number, dates visited and patient ID (if known).

2. **NAME** | **DATES**

STREET ADDRESS | **FIRST VISIT**

CITY | **STATE** | **ZIP** | **LAST VISIT**

PHONE (*Area Code* *Number*) | **Patient ID #** (If known) | **NEXT APPOINTMENT**

REASONS FOR VISITS

WHAT **TREATMENT** WAS RECEIVED?

PAGE 5

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

C (3) Write any additional doctor, HMO, therapist, or other medical source the child has seen within the last 12 months. Include their address, telephone number, dates visited and patient ID (if known).

3. **NAME**

DATES

STREET ADDRESS — **FIRST VISIT**

CITY | **STATE** | **ZIP** — **LAST VISIT**

PHONE (*Area Code* *Number*) | **Patient ID #** (If known) — **NEXT APPOINTMENT**

REASONS FOR VISITS

WHAT **TREATMENT** WAS RECEIVED?

Write the reasons for visits and what treatment the child has received.

If you need more space, use Section 10.

D. List each **HOSPITAL/CLINIC**. Include the child's **next appointment**.

D (1) Write any Hospital or Clinic the child has seen within the last 12 months. Include their address, telephone number, type of visit, dates in and out of the facility and patient ID (if known).

1. HOSPITAL/CLINIC

NAME

STREET ADDRESS

CITY

STATE **ZIP**

PHONE (*Area Code* *Number*)

TYPE OF VISIT

- ☐ **INPATIENT STAYS** (*Stayed at least overnight*)
- ☐ **OUTPATIENT VISITS** (*Sent home same day*)
- ☐ **EMERGENCY ROOM VISITS**

DATES

DATE IN | DATE OUT

DATE FIRST VISIT | DATE LAST VISIT

DATES OF VISITS

Next **appointment**

The child's hospital/clinic **number**

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

Write the reasons for visits and what treatment the child has received. Include the name(s) of doctors the child sees at this facility on a regular basis.

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SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC

NAME

STREET ADDRESS

CITY

STATE **ZIP**

PHONE
Area Code *Number*

TYPE OF VISIT

☐ **INPATIENT STAYS** *(Stayed at least overnight)*

☐ **OUTPATIENT VISITS** *(Sent home same day)*

☐ **EMERGENCY ROOM VISITS**

DATES

DATE IN | DATE OUT

DATE FIRST VISIT | **DATE LAST VISIT**

DATES OF VISITS

Next **appointment**

The child's hospital/clinic **number**

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

If you need more space, use Section 10.

E. Does **anyone else have medical records or information** about the child's illnesses, injuries or conditions (foster parents, social workers, counselors, tutors, school nurses, detention centers, attorneys, insurance companies, and/or Worker's Compensation), or is the child scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME

DATES

ADDRESS

FIRST VISIT

CITY **STATE** **ZIP**

LAST SEEN

PHONE
Area Code *Number*

NEXT APPOINTMENT

CLAIM NUMBER *(If any)*

REASONS FOR VISITS

If you need more space, use Section 10.

D (2) Write any additional Hospital or Clinic the child has seen within the last 12 months. Include their address, telephone number, type of visit, dates in and out of the facility and patient ID (if known).

Indicate the reasons for visits and what treatment the child has received. Include the names of doctors the child sees at this facility on a regular basis.

E) Mark if anyone else has medical records or information about the child's illnesses, injuries or conditions (foster parents, social workers, counselors, tutors, school nurses, detention centers, attorneys, insurance companies and/or Worker's Compensation.

If "YES", write their address, telephone number, dates of visits, claim number (if any) and the reasons for visits.

PAGE 7

Mark if the child is currently taking medications for their illnesses, injuries or conditions. If “YES”, write the name of medication, name of doctor (if prescribed), reason for medication, and any side effects.

SECTION 5 - MEDICATIONS

Does the child currently take any **medications** for illnesses, injuries or conditions? ☐ YES ☐ NO

If "YES", tell us the following: *(Look at the child's medicine containers, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

If you need more space, use Section 10.

SECTION 6 - TESTS

Has the child had, or will he/she have, any **medical tests** for illnesses, injuries or conditions?

☐ YES ☐ NO If "YES", tell us the following (give approximate dates, if necessary).

Mark if the child had or will have any medical tests for their illnesses, injuries or conditions. If “YES”, identify the kind of test, when the test was/will be done, where done, and whom sent the child for the test.

KIND OF TEST	WHEN WAS/WILL TESTS BE DONE? *(Month, day, year)*	WHERE DONE *(Name of Facility)*	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY - Name of body part			
SPEECH/LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY - Name of body part			
MRI/CAT SCAN - Name of body part			

If the child has had other tests, list them in Section 10.

PAGE 8

SECTION 7 - ADDITIONAL INFORMATION

A) Mark if the child has been tested or examined by any of the sources listed.

A. Has the child been **tested or examined** by any of the following?

Headstart (Title V)	☐ YES	☐ NO
Public or Community Health Department	☐ YES	☐ NO
Child Welfare or Social Service Agency or WIC	☐ YES	☐ NO
Early Intervention Services	☐ YES	☐ NO
Program for Children with Special Health Care Needs	☐ YES	☐ NO
Mental Health/Mental Retardation Center	☐ YES	☐ NO

B) Mark if the child has received Vocational Rehabilitation or other employment support services to help them go to work. If "YES" to section A or B, complete (C).

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work?

☐ YES ☐ NO

If you answered "YES" to any of the above in A. or B., please complete C. below:

C.1) Write the name of agency where the child has been tested from any sources in sections A or B. Include address, telephone number, type of test, when done, and file or record number. Use C.2 for additional sources.

C. 1. NAME OF AGENCY

ADDRESS

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *State* *ZIP*

PHONE NUMBER *Area Code* *Number*

TYPE OF TEST WHEN DONE

TYPE OF TEST WHEN DONE

FILE OR RECORD NUMBER

2. NAME OF AGENCY

ADDRESS

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *State* *ZIP*

PHONE NUMBER *Area Code* *Number*

TYPE OF TEST WHEN DONE

TYPE OF TEST WHEN DONE

FILE OR RECORD NUMBER

If there are any other agencies, show them in Section 10.

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SECTION 8 - EDUCATION

A) Mark whether child is enrolled in school or too young to attend. Provide an explanation in (B) if child is not enrolled in school for other reasons.

A. Is the child currently enrolled in any school? ☐ YES, grade: _____ ☐ NO, too young

☐ NO, other reason (complete B)

B. Other reason the child is not enrolled in school:

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Has the child been tested for behavioral or learning problems? ☐ YES ☐ NO

If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech/language therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH/LANGUAGE THERAPIST _____

C) Write the name of school, address, telephone number, dates of attendance, and teacher's name. Mark if the child has been tested for behavioral or learning problems at school. If "YES", write the type of test and when done. Mark if the child is in special education. If "YES", write the name of the special education teacher. Mark if the child is in speech/language therapy. If "YES", write the name of the therapist.

PAGE 10

SECTION 8 - EDUCATION

D) Write the name of other schools the child has attended in the last 12 months. Include the address, telephone number, dates attended and teacher's name.

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

NAME OF SCHOOL

ADDRESS

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *County* *State* *ZIP*

PHONE NUMBER *Area Code* *Number*

DATES ATTENDED

TEACHER'S NAME

D cont.) Mark if the child has been tested for behavioral or learning problems at school. If "YES", write the type of test and when done. Mark if the child was in special education. If "YES", write the name of the special education teacher. Mark if the child was in speech/language therapy. If "YES", write the name of the therapist.

Was the child tested for behavioral or learning problems? ☐ YES ☐ NO

If "YES", complete the following:

TYPE OF TEST WHEN DONE

TYPE OF TEST WHEN DONE

Was the child in special education? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER

Was the child in speech/language therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH/LANGUAGE THERAPIST

If there are other schools, show them in Section 10.

E) Mark if the child attends Daycare/Preschool. If "YES", write the name of Daycare/Preschool, address, telephone number, dates attended and the teacher's/caregiver's name.

E. Is the child attending Daycare/Preschool? ☐ YES ☐ NO

If "YES", complete the following:

NAME OF DAYCARE/ PRESCHOOL/CAREGIVER

ADDRESS

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *County* *State* *ZIP*

PHONE NUMBER *Area Code* *Number*

DATES ATTENDED

TEACHER'S/CAREGIVER'S NAME

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SECTION 9 - WORK HISTORY

A) Mark if the child has ever worked (including sheltered work). If "YES", write the dates worked, name of employer, address, telephone number, and name of supervisor. Use section (B) to describe the child's job title, describe the work, and any problems doing the job.

A. Has the child ever worked (including sheltered work)? ☐ YES ☐ NO

If "YES", complete the following:

DATES WORKED

NAME OF EMPLOYER

ADDRESS

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *County* *State* *ZIP*

PHONE NUMBER *Area Code* *Number*

NAME OF SUPERVISOR

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

SECTION 10 - DATE AND REMARKS

Please give the date you filled out this disability report.

Date (MM/DD/YYYY)

Use Section 10 to write the date the form was completed. Include any additional information about the child that was not captured in previous sections.

Use this section for any additional information about your child.

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SECTION 10 - REMARKS

Section10 (cont.) Additional space to write information about the child that was not captured in previous sections.

REMINDER: The Child Disability Report can also be completed online. After the form is completed online, a Social Security representative will contact you to review the completed medical report, discuss whether the income and resources of the parents and the child are within the allowed limits, and start the SSI application process.

For more information, go to: https://www.ssa.gov/benefits/disability/apply-child.html