NEW APPLICATION QUESTIONNAIRE

Please use *black ink* to complete this document

NAME: ______________________________ SSN: ________________________

Birth Place (City and State): ____

Date of Birth: ____

Mother's Maiden Name: ____

Mailing Address: ____

____

____

Height without shoes: ________ Weight without shoes: ____________________

Reference Contact for SSA to reach out to to verify your situation and conditions:

(Name, Relationship, Address, Contact number): ___________________________

____

____

____

WHEN DID YOU BECOME TOO DISABLED TO WORK? _________________

(***MUST INCLUDE MONTH, DAY and YEAR***)

Please answer all questions and leave none blank. If you are unsure of an answer, please respond to the best of your knowledge.

MARRIAGE INFORMATION

If more than one marriage, please provide the information listed below for other marriages on the back of this document. *Note: Even if you are not currently married, please provide all information regarding all marriages.*

Currently, Married? ✕ YES ✕ NO

Current or former Spouse's full name (incl. maiden name) ___________________

Spouse's SSN: ____________________ Date of Birth: ____________________

Date of Marriage: ____________________ City/State of Marriage:_____________

How you were married: Clergy______ Public Official ______

Did your marriage end in the United States? ✕ YES ✕ NO

What date did your marriage end? ____________________

What city and state did your marriage end in? ___________________

How did your marriage end? (Divorce, annulment, death or other) _______

If your spouse is deceased, please provide the date of death

PRIOR MARRIAGES

Had any prior marriages ✕ YES ✕ NO

Had prior marriage that lasted at least 10 years ✕ YES ✕ NO

If you answered **Yes**, please answer the following questions:

Spouse's full name (including maiden name) ____________________

Spouse's SSN: ____________________ Date of Birth: ____________________

Date of Marriage: ___________________ City/State of Marriage: ______________

How you were married: Clergy ________ Public Official________

Did your marriage end in the United States? ✕ YES ✕ NO

What date did your marriage end? ____________________

What city and state did your marriage end in? ____________________

How did your marriage end? (Divorce, annulment, death or other) __________

If your spouse is deceased, please provide the date of death ______________

INFORMATION ABOUT CHILDREN

Do you have any children who became disabled prior to age 22? ✕ YES ✕ NO

Do you have any unmarried children under age 18? ✕ YES ✕ NO

Do you have any unmarried children aged 18 to 19 still attending elementary or secondary school (below college level) full-time? ✕ YES ✕ NO

(If you answered "**Yes,**" to any of the above, please list child(ren)'s name(s) below.

LIST CHILDREN

Child 1: ________________ Child 2: ________________ Child 3: ________________

EMPLOYER INFORMATION

Did you work for an employer in 2024? ✕ YES ✕ NO

If yes, how much employment income did you have in 2024? __________

Please provide the **name/address/phone** of the employer(s) **and dates of employment:** ____

____

Do you work or will you work for an employer in 2025? ✕ YES ✕ NO

If yes, how much employment income did you have in 2025? ___________

Please provide the **name/address/phone** of the employer(s) **and dates of employment**: ____

____

SELF EMPLOYMENT INFORMATION

Were you self-employed in 2024? ✕ YES ✕ NO

If yes, how much self-employment income did you have in 2024? ________

Type of business if self employed __________________________

Net income greater than $400 if self employed ✕ YES ✕ NO

Will you be self-employed in 2025? ✕ YES ✕ NO

IF you were neither working for an employer nor self-employed in 2024 or later, when was the last year you worked? ___

SUPPLEMENTAL INFORMATION

Did you ever work outside the US? ✕ YES ✕ NO

Did your spouse work outside the US? ✕ YES ✕ NO

Were you in the military prior to 1968? ___ YES __ NO

Do you agree with earning history as shown on Social Security Statement?

✕ YES ✕ NO

Were you a Corporate Officer of an employer? ✕ YES ✕ NO

Were you related to a Corporate Officer of an employer? ✕ YES ✕ NO

Did you receive earnings from a Family Corporation or other closely held corporation? ✕ YES ✕ NO

BENEFIT INFORMATION

A recent application for Supplemental Security Income submitted to SSA:
✕ YES ✕ NO

Do you intend to apply for Supplemental Security Income Benefits?
✕ YES ✕ NO

Any previous application(s) for Medicare, Social Security, or Supplemental
✕ YES ✕ NO

OTHER PENSIONS/ANNUITIES

Ever worked in a job where Social Security taxes were not deducted or withheld?

✕ YES ✕ NO

If yes, please explain: ________________ ________________________________

Are you receiving a pension or annuity based on this non-covered work? ______

Do you expect to receive a pension or annuity based on this non-covered work?
✕ YES ✕ NO

What date is the pension or annuity expected to begin? ____________________

Did you receive a lump sum payment instead of a pension or annuity based on this non-covered work? ✕ YES ✕ NO

Have you or your spouse(s) ever worked for the railroad? ✕ YES ✕ NO

Does your spouse receive or is he/she eligible to receive a Railroad pension or annuity? ✕ YES ✕ NO

Are you receiving or are you eligible to receive a Railroad pension or annuity?

✕ YES ✕ NO

Security Income Benefits? ✕ YES ✕ NO

LIVING ARRANGEMENTS

Address where you live: ____

____

____

Select the option that best describes where you live:

You must choose an option for this field.

- ☐ House, apartment, mobile home, houseboat
- ☐ Room in commercial establishment (example: hotel or motel)
- ☐ Room in private residence
- ☐ Institution (example: nursing home, rehabilitation center, hospital, school, or jail)
- ☐ Non-institutional care (example: placed by an agency in foster care, adult foster care, retirement home, or family care by an agency)
- ☐ Transient or homeless

SICK PAY

Are you receiving, or do you expect to receive sick pay in January 2025?

✕ YES ✕ NO

INCOME SOURCES

Select the income source(s) you received or expects to receive in January 2025:

If you do not know the exact amount, provide your best estimate.

- ☐ Alimony
- ☐ Child support
- ☐ Gambling winnings or prizes
- ☐ Gifts
- ☐ Monthly cash from family or friends
- ☐ Pensions or other retirement
- ☐ Settlements
- ☐ State disability insurance
- ☐ State or local assistance
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Unemployment compensation
- ☐ Veterans Affairs (VA) benefits
- ☐ Workers' compensation
- ☐ Other
- ☐ None of the above

RESOURCES

Select the items you own, either alone or with other people, as of January 1, 2025:

If you do not know the exact amount, provide your best estimate.

- ☐ Cash (at home, with you, or anywhere else)

  $ _______________

- ☐ Financial institution accounts (examples: checking or savings accounts, credit union, holiday club, time deposits, Individual Indian Money account, or Direct Express)

  $ _______________

- ☐ Stocks

  $ _______________

- ☐ Mutual funds

  $ _______________

- ☐ U.S. savings bonds

  $ _______________

- ☐ None of the above

ADDITIONAL RESOURCES

Are you an owner or beneficiary of any trusts as of January 1, 2025?

This includes, but not limited to, special needs or pooled trusts, or any other trust where funds are being held for your benefit.

✕ YES ✕ NO

How many vehicles do you have in your name as of January 1, 2025? Examples of vehicles: automobiles, trucks, motorcycles, campers, or boats. Include those secured by loan or lease. ___________

Not counting the home where you live, do you own any real estate or property, either alone or with other people, as of January 1, 2025? This includes land, buildings, and homes in the U.S. or a foreign country.

✕ YES ✕ NO

Do you own any life insurance policies as of January 1, 2025?

✕ YES ✕ NO

Do you own anything else that could be turned into cash and used to pay for food

and shelter as of January 1, 2025? Do not count your household goods (such as furniture, appliances, electronic devices) or personal items (such as clothes, personal jewelry, pets).

✕ YES ✕ NO

Since January 1, 2022, have you sold, transferred title, or given away any money or property - either alone or with other people?

✕ YES ✕ NO

DISABILITY QUESTIONS SECTION

Illnesses, injuries, conditions that limit the ability to work: ____________________

____

____

Are your illnesses, injuries, conditions related to work? ✕ YES ✕ NO

Have you filed or intend to file for worker's compensation or other public disability benefits? ✕ YES ✕ NO

If so, did you receive a lump sum or temporary benefits only?

___________ Lump Sum ___________ Temporary Benefits

Please list amounts received and approximate dates: ________________________

____

____

Will you receive money from the employer on/after the date unable to work?

✕YES ✕ NO

Do you expect to receive money from your employer in the future? ✕ YES ✕ NO

Does one parent receive one-half of his/her support from you? ✕ YES ✕ NO

Do you authorize the disclosure of medical information? ✕ YES ✕ NO

Medical Treatment Information

Please list all doctors, hospitals, or clinics at which you have received medical treatment in the past year. If you need more space, please use the back of this form. If you have any questions about completing this form, please contact our office.

Name of Dr. or Facility:____
Phone #: _________________
Address: __________________________________
Reason for treatment: ____
Date of First visit: _____________Most Recent: __________
Upcoming: _________
Tests ordered by Doctor/Facility (Maximum of 2, if applicable):
Body part tested:
Date of test:

Name of Dr. or Facility:____
Phone #: _________________
Address:__________________________________
Reason for treatment: ____
Date of First visit: _____________Most Recent: __________
Upcoming: _________
Tests ordered by Doctor/Facility (Maximum of 2, if applicable):
Type of test and body part tested:
Date of test:

Name of Dr. or Facility:____
Phone #: _________________
Address:__________________________________
Reason for treatment: ____
Date of First visit: _____________Most Recent: __________
Upcoming: _________
Tests ordered by Doctor/Facility (Maximum of 2, if applicable):
Type of test and body part tested:
Date of test:

Name of Dr. or Facility:____
Phone #: _________________
Address:__________________________________
Reason for treatment: ____
Date of First visit: _____________Most Recent: __________
Upcoming: _________
Tests ordered by Doctor/Facility (Maximum of 2, if applicable):
Type of test and body part tested:
Date of test:

PLEASE USE THE BACKSIDE OF THIS PAGE FOR ANY ADDITIONAL MEDICAL TREATMENT INFORMATION RELATED TO YOUR DISABLING CONDITION.

OTHER INFORMATION

1. Are you covered (either by work or residence) under another country's social security system? ✕ YES ✕ NO
   If yes, what country: ________________
2. Do you currently support a disabled parent or child that lives with you?
   ✕ YES ✕ NO
   If yes, please list name: _______________ and SSN________________

WORK INFORMATION

Social Security will review any types of jobs you have done in the fifteen (15) years prior to the year you are claiming disability. Please start with your most recent job and go back from there. List any other jobs on the back of the page if necessary.

(1) JOB TITLE: ____
Dates of employment: From: Month___ Year__ TO: Month__ Year __
DESCRIBE THIS JOB (what did you do all day?) __________________________
____
____
____
Hours worked per day ___ Number of days per week ___ Rate of pay ________

(2) JOB TITLE: ____
Dates of employment: From: Month___ Year__ TO: Month__ Year __
DESCRIBE THIS JOB (what did you do all day?) ________________________
____
____
____
Hours worked per day: ___ Number of days per week ___ Rate of pay _______

(3) JOB TITLE: ____
Dates of employment: From: Month___ Year__ TO: Month__ Year __
DESCRIBE THIS JOB (what did you do all day?) __________________________
____
____
____
Hours worked per day: ___ Number of days per week ___ Rate of pay _______

(4) JOB TITLE: ____

Dates of employment: From: Month___ Year__ TO: Month__ Year __

DESCRIBE THIS JOB (what did you do all day?) ______________________

____

____

____

Hours worked per day: ___ Number of days per week ___ Rate of pay _______

(5) JOB TITLE: ____

Dates of employment: From: __________________ To: ________________

DESCRIBE THIS JOB (what did you do all day?) ______________________

____

____

____

Hours worked per day: ___ Number of days per week ___ Rate of pay _______

Please list the job you did for the longest period of time: ________________

<u>JOB DETAILS</u>

In a typical workday, about how many hours were you on your feet or seated?

The hours/minutes for standing, walking, and sitting should equal the hours per day reported for this job. Do not include breaks and lunch.

Did you stand and walk (combined)?

✕ YES ✕ NO

How long did you stand and walk (combined)?

______ [Hours] ______ [Minutes]

Did you sit?

✕ YES ✕ NO

In a typical workday, did you do any of these tasks at your most recent job? If so, how long did you do it?

The hours/minutes for these tasks should not exceed the hours per day reported for this job. This information tells us about the physical and mental requirements of your job.

Did you stoop (i.e., bending down & forward at the waist)?

✕ YES ✕ NO

Did you kneel (i.e., bending legs to rest on knees)?

✕ YES ✕ NO

Did you crouch (i.e., bending legs & back down & forward)?

✕ YES ✕ NO

Did you crawl (i.e., moving on hands & knees)?

✕ YES ✕ NO

Did you use fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt)?

✕ One Hand ✕ Both Hands ✕ No

Did you use hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a hammer, or water bottle)?

✕ One Hand ✕ Both Hands ✕ No

Did you reach at or below the shoulder?

✕ One Arm ✕ Both Arms ✕ No

Did you reach overhead (above the shoulder)?

✕ One Arm ✕ Both Arms ✕ No

Did you climb stairs or ramps?

✕ YES ✕ NO

Did you climb ladders, ropes, or scaffolds?

✕ YES ✕ NO

For this job, describe in detail the tasks that you did in a typical workday.

____

____

____

____

In this job, did you do any writing, complete reports, or perform any duties like this?

✕ YES ✕ NO

In this job, did you supervise other people?

✕ YES ✕ NO

In this job, did you use machines, tools, or equipment?

✕ YES ✕ NO

In this job, did you interact with coworkers, the general public, or anyone else?

✕ YES ✕ NO

Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.

____

____

____

Select the heaviest weight lifted: _________

Select the weight frequently lifted (i.e., 1/3 to 2/3 of the workday): ________

Did this job expose you to any of the following?

Check all that apply.

- ☐ Outdoors
- ☐ Extreme heat (non-weather related)
- ☐ Extreme cold (non-weather related)
- ☐ Wetness
- ☐ Humidity
- ☐ Hazardous substances
- ☐ Moving mechanical parts
- ☐ High, exposed places
- ☐ Heavy vibrations
- ☐ Loud noise
- ☐ Other

Explain how your current medical condition(s) would affect your ability to do this job.

____

____

____

____

EDUCATION

Highest Grade completed:

Name of school:

City and state of school:

Date completed:

Did you receive any IEP's or Special education: ✕ YES ✕ NO

Did you complete any specialized training, trade, or vocational courses?

✕ YES ✕ NO

If yes, please provide what you were and what month and year you were completed below: