

Mailed 10/2

JOSEPH MICHAEL BASILE
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VERNON-ROCKVILLE CT 06066

CONFIDENTIALITY NOTICE: The accompanying material contains sensitive information. This information may be privileged and confidential, and intended for the use of the recipient named in this correspondence. If you have received this information in error, please contact us immediately.





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STATE OF CONNECTICUT
Department of Aging and Disability Services
DISABILITY DETERMINATION SERVICES

Date: Sep 28, 2020
Case ID: 470757

JOSEPH MICHAEL BASILE
25 OAK STREET
BSMT-SOUTH
VERNON-ROCKVILLE CT 06066

We are the office that makes disability decisions for the Social Security Administration. We are writing about your disability claim because we need more information about your condition, daily activities, or work history.

What You Need To Do

Complete this form with black or blue ink. We realize that some of the questions may not seem relevant to the case, but please answer all of the questions to the best of your ability.

Return the completed form(s) by October 8, 2020. If you do not return the form(s), we may decide the case based on the information we already have on file. This means that we could find that you are not disabled based on our rules or that your disability has ended if you are already getting benefits.

How To Return The Form

You may use the enclosed return envelope or fax your completed form to us. Please note the return address may be to a scanning center who works with us. **The completed form must include the barcode page on top of the form.**

If You Have Questions

If you have any questions, please contact us at the number(s) shown below Monday - Friday between 8:00 am and 4:00 pm. When you call or leave a message, please provide the Case ID: 470757, your name, and a call back number.

Thank you for your help.

Marta A.
(800) 842-8320 EXT.6160
(866) 394-4132 (FAX)

Enclosures:
SSA-3373 Activities of Daily Living Questionnaire
Return Envelope

3603070200

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**

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 are 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 instruction, 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 on our time estimate above 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.**

* 3603070300*

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only

Do not write in this box.



ROID:DCM331650 SITE:508 DR:S
SSN:***** DOCTYPE:0075 RF:D CS:154

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)

Joseph Michael Basile

2. SOCIAL SECURITY NUMBER

035-60-0521

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.)

401 450-1873 Your Number Message Number None
Area Code Phone Number

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?

In 2017 I was an Engineer at Electric Boat. I started to organize a labor-union for engineers and during that effort my motorcycle was vandalized.

I live in fear all of the time. U.S.

I believe that I am known among business leaders and they are opposed to all the breathing I'm doing. I have no proof, but I assure you I have reasons for thinking this.

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

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

In the morning I drink coffee, shower, and watch TV.

Late morning I usually either hike or do errands such as food shopping.

In the Evening I typically cook a meal (chicken soup etc). and then watch TV or play video games until about 11pm, then sleep.

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?

N/A

8. Do you take care of pets or other animals?

 Yes No

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

N/A

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

 Yes No

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

N/A

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

Work for a company as an employee.

11. Do the illnesses, injuries, or conditions affect your sleep?

 Yes No

If "YES," how?

Extreme anxiety can make me stay awake all night.

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



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?

N/A

c. Do you need help or reminders taking medicine?

Yes No

If "YES," what kind of help do you need?

N/A

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.)

Dinners, lunches, etc.

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

Daily

How long does it take you? As long as it takes? Normal amount of time.

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

Cooking more since I have more time.

b. If "No," explain why you cannot or do not prepare meals.

N/A

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.)

Any.

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

Takes anormal amount of time to do chores

c. Do you need help or encouragement doing these things?

Yes No

If "YES," what help is needed?

N/A

d. If you don't do house or yard work, explain why not.

No yard work - I live in an apartment

15. GETTING AROUND

a. How often do you go outside?

Daily

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)

c. When going out, can you go out alone?

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

 Yes No

N/A

d. Do you drive?

If you don't drive, explain why not.

 Yes No

N/A

16. SHOPPING

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.

Food mostly. Sometimes clothing or electronics.

c. How often do you shop and how long does it take?

I rarely shop except for food. Takes ~~never~~ maybe 1 hr/week.**17. MONEY**

a. Are you able to:

- | | | |
|--------------|---|-----------------------------|
| Pay bills | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Count change | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

- | | | |
|------------------------------|---|-----------------------------|
| Handle a savings account | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use a checkbook/money orders | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

Explain all "NO" answers.

N/A



b. Has your ability to handle money changed since the illnesses, injuries, or conditions began?

 Yes

✓

If "YES," explain how the ability to handle money has changed.

N/A

18. HOBBIES AND INTERESTS

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

Hiking, video games.

- b. How often and how well do you do these things?

I do both daily and I'm good at both.

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

More hiking since I have more time.

19. SOCIAL ACTIVITIES

- a. 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.

Campfire, yard games etc.

How often do you do these things? several times per month

- c. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)

N/A

Do you need to be reminded to go places?

Yes

No

How often do you go and how much do you take part?

None

Yes

No

Do you need someone to accompany you?

If "YES", explain.

N/A

- d. Do you have any problems getting along with family, friends, neighbors, or others?

Yes

No

If "YES," explain.

(Some) People like to screw with me.

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

I'm now very wary of meeting new people because I have no way to assess their intentions.

SECTION D - INFORMATION ABOUT ABILITIES

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

- | | | | |
|------------------------------------|-----------------------------------|---|---|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Walking | <input type="checkbox"/> Stair Climbing | <input type="checkbox"/> Understanding |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Seeing | <input type="checkbox"/> Following Instructions |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Memory | <input type="checkbox"/> Using Hands |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Talking | <input type="checkbox"/> Completing Tasks | <input checked="" type="checkbox"/> Getting Along With Others |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Hearing | <input checked="" type="checkbox"/> 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].)

People screw with me despite my attempts to cooperate with them.

If you would like an example, ask me about the "command line Search"

b. Are you: Right Handed? Left Handed?

c. How far can you walk before needing to stop and rest? Indefinitely ~10 miles

If you have to rest, how long before you can resume walking? 5 minutes

d. For how long can you pay attention? Hours if necessary

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.)

Very well

g. How well do you follow spoken instructions?

Very well

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.)

Normally very well. I'm always cooperative and friendly.

i. Have you ever been fired or laid off from a job because of problems getting along with other people? Yes

If "YES," please explain.

N/A

If "YES," please give name of employer. N/A



j. How well do you handle stress?

O.K.

k. How well do you handle changes in routine?

O.K.

l. Have you noticed any unusual behavior or fears?

Yes No

If "YES," please explain.

I'm always afraid that people are setting "traps" for me by tricking me into a bad situation. I am always forced to ponder other's intentions and it sucks.

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Brace/Splint | <input checked="" type="checkbox"/> Glasses/Contact Lenses |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Artificial Limb | <input type="checkbox"/> Artificial Voice Box |
| <input type="checkbox"/> Other (Explain) _____ | | |

Which of these were prescribed by a doctor?

Glasses and Contact lenses

When was it prescribed?

2019

When do you need to use these aids?

Always.

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

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. Please Help me! And thank you for your consideration.

In 2017 I was an Engineer at Electric Boat. I started to organize a labor union and shortly after my motorcycle was vandalized on company property, and EB would not help.

In 2018 I left EB and hiked the Appalachian Trail. After the trail I almost died in a river in Massachusetts. A TV show called ^(1/2019) Disenchantment freaked me out so bad I ran for my life and got hypothermia and frostbite. I was very close to death.

In 2019 I worked at Collins Aerospace and ~~was~~ almost got hit by a B-17 that crashed at Bradley (it just missed my building).

In 2020 I tried to work at Putnam Plastics, but many of

the people there were screwing with me and I almost moved into a house that I think was designed to burn.

Name of person completing this form (Please print)

Joseph Basile

Date (MM/DD/YYYY)

10/2/2020

Address (Number and Street)

25 oak Street BSMF

Email address (optional)

josephm.basile@gmail.com

City

Vernon

State

CT

ZIP Code

06066

