American Disability Solutions

Background Information for:_____
Your information was received on:_____

APPLICANT IDENTIFICATION

Name:
Social Security Number:
Date of Birth:
Gender:
Blind:
Disabled:
Start Date of Disability:
Denied Benefits within last 60 days:
Diagnosed with condition that is expected to end in death:

APPLICANT'S CONTACT INFORMATION

CONTACT INFORMATION
Mailing Address:
Reside at this address:
Phone:
Best time to call:
Email address:
Confirm Email address:

Ability to communicate in English
Speak English:
Read English:
Write English:

Language Preference
Preferred language for speaking:
Preferred language for reading:

Birth and Citizenship Information

Place of Birth:
U.S. Citizen:
Type of Citizenship: US Citizen born inside USA

Other Social Security Numbers and Names

Other Social Security Numbers
Any other Social Security Numbers Used:
Other Names
Other Names Used:

General Background Information

Marriage Information

Currently Married:

Prior Marriages

Any Prior Marriages:
Any Prior Marriages that lasted at least 10 years:
Any Prior Marriages that ended due to the death of a spouse:

Children

Have any Children:
Any children who became disabled prior to age 22:
Any unmarried children under age 18:
Any unmarried children aged 18-19 still attending elementary or secondary school (below college level) full time:
Child #1:
More than ten (10) children:

Employer Details

Work for an employer in 2013:
Worked or will work for an employer in 2014:
Will work for an employer in 2015:

Self-Employed Details

Self-Employed in 2013:
Self-Employed in 2014:
Self-Employed in 2015:

Supplemental Information

Worked outside the US:
Agree with the earnings history as shown on the Social Security Statement:

Total Earnings:

Neither working for an employer nor self-employed in 2013 or later, last year worked:

Other Pensions/Annuities

Ever work in a job where the U.S. Social Security taxes were not deducted or withheld:

Direct Deposit Details

Own or Co-Own a bank account to use for Direct Deposit:

Benefit Information

Recent application for Supplemental Security Income submitted to SSA:
Intend to apply for Supplemental Security Income benefits:
Any previous applications for Medicare, Social Security or Supplemental Security Income Benefits:

Ability to Work

Illnesses, injuries, conditions related to work:
Now able to Work:

Disability Payments

File or intend to file for Workers Compensation or other public disability benefits:
Received money from employer on/after date unable to work:
Expect to receive money from employer in the future:

Dependents

Has one parent who receives one-half support:

Background Information Remarks:

Disability Information for:_____
Your information was received on:_____

Applicant Information
Identification Information
Name:
Social Security Number:
Date of Birth:
Gender:

Contact Information
Mailing address:
Daytime Phone Number:
Alternate Phone Number:
Email address:

Ability to Communicate in English
Speak English:
Read English:
Write English:

Other names used on medical or educational records:

Disability Information: Medical

List of physical and mental conditions:

1.
2.

Height without shoes:
Weight without shoes:
Conditions cause pain or other symptoms:

Seen a healthcare provider or received treatment or have an appointment scheduled:
For physical conditions:
For mental conditions:

Other Contact

Name:
Relationship to Applicant:
Same address as Applicant:
Phone Number:
Speak English:

Doctor/Healthcare Professional #1

Doctor/Healthcare Professional Details:
Name:
Office name:
Address:
Phone Number:
Patient ID Number:

Treatment

First Visit:
Last Visit:
Next Scheduled Appointment:
Medical Conditions Treated:
Treatment Received:

Doctor/Healthcare Professional #2

Doctor/Healthcare Professional Details
Name:
Office Name:
Address:
Phone Number:
Patient ID Number:

Treatment
First Visit:
Last Visit:
Next Scheduled Appointment:
Medical Conditions Treated:
Treatment Received:

Hospitals and Clinics

Name:
Office Name:
Address:
Phone Number:
Patient ID Number

Test #1
Kind of Test:
Body Part:
Date of Test:
Sent for Tests by Dr.:

Medicine #1
Medicine:
Reason:
Prescribed by:

Medicine #2
Medicine:
Reason:
Prescribed by:

Other Medical Records

Issued from:
Issued when:

Disability Information: Work/Education

Work Status

Currently Working:

Work Activity

Date Stopped Working:
Reason for Stopping:
Changes in Work Activity:

Job History

Earnings greater than $ since April 15, 2010:
Number of jobs in past 15 years:

Most Recent Job

Job Title:
Type of Business:
Start Date:
End Date:
Hours per day:
Days per week:
Pay Amount:
Pay Frequency:

Job Details

Job Description:
Used Equipment:
Used Technical Knowledge:
Completed Records:

Hours Walking:
Hours Standing:
Hours Sitting:
Hours Climbing:
Hours Stooping:
Hours Kneeling:
Hours Crouching:
Hours Crawling:
Hours handling large objects:
Hours writing, typing or handling small objects:
Hours Reaching:
Description of lifting and carrying:
Weight of frequently lifted items:
Description of other weight frequently lifted:
Maximum weight lifted:
Supervised others:
Number of people supervised:
Time spent supervising:
Hired and fired employees:
Lead worker:

Education

Education and Training
Highest Grade Completed:
Date Completed:
Special Training, trade or vocational school:

Special Education:
Attended Special Education:

Remarks
Additional Information:

Medical Release Forms For:_____
Your Information was Received On**:**_____