

Function Report - Child Age 6 to 12th Birthday

Filling Out The Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

The information that you give us on this form will be used by the office that makes the disability decision on the child's claim. You can help them by completing as much of the form as you can.

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

**PLEASE REMOVE THIS SHEET BEFORE
RETURNING THE COMPLETED FORM.**

Privacy Act Statement

Collection and Use of Personal Information

Sections 1614(a)(3) and 1631(e) 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 to make a determination of eligibility for Supplemental Security Income benefits. We may also share your information for the following purposes, called routine uses:

1. To Federal, State, or local agencies for administering cash or non-cash income maintenance or health maintenance programs;
2. To appropriate State agencies, or other agencies providing services to disabled children, to identify Title XVI eligible under the age of 16 for the consideration of rehabilitation services; and
3. To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits.

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 (SORNs) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR), on April 1, 2003, at 68 FR 15784; 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits, as published in the FR on January 11, 2006 at 71 FR 1830; and 60-0320, entitled Electronic Disability (eDIB) Claim File, as published in the FR on December 22, 2003 at 68 FR 71210. Additional information, and a full listing of all of our SORNs, are available on our website at 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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is 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, 1338 Annex Building, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

**FUNCTION REPORT - CHILD
AGE 6 TO 12th BIRTHDAY**

SECTION 1 - IDENTIFYING INFORMATION

1. A. Print **NAME OF CHILD:**

FIRST

MIDDLE

LAST

B. Child's **SOCIAL SECURITY NUMBER:**

C. Child's **DATE OF BIRTH:**

Month/Day/Year

D. PERSON COMPLETING FORM

NAME:

RELATIONSHIP TO CHILD:

DATE FORM COMPLETED:

Month/Day/Year

DAYTIME TELEPHONE NUMBER *(including Area Code):*

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

CITY

STATE

ZIP CODE

SECTION 2 - FUNCTION DETAILS

<p>2. A. Does the child have problems seeing?</p> <p><input type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.B.)</p>	<p>If "yes," please mark <u>every</u> statement below that is <u>generally</u> true about the child:</p> <p><input type="checkbox"/> Child uses glasses or contact lenses. If the child has problems seeing even with glasses or contact lenses, please explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Child cannot be fitted for glasses or contact lenses. Explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Child has other seeing problems. If so, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>B. Does the child have problems hearing?</p> <p><input type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.C.)</p>	<p>If "yes," please mark <u>every</u> statement below that is <u>generally</u> true about the child:</p> <p><input type="checkbox"/> Child uses hearing aid(s). If the child has problems hearing even with a hearing aid(s) OR has trouble using a hearing aid, please explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Child cannot be fitted for hearing aid(s).</p> <p><input type="checkbox"/> Child has other hearing problems. If so, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Child uses American Sign Language.</p> <p><input type="checkbox"/> Child reads lips.</p>

2. H. Does the child's impairment(s) affect his or her ability to help himself or herself and cooperate with others in taking care of personal needs?

- YES (Continue)
- NO (Go to 2.I.)
- NOT SURE (Continue)

If "**yes**," or "**not sure**," please tell us what the child does or can do by checking "yes" or "no" for each of the following:

- Yes** **No** Uses zipper by self
- Yes** **No** Buttons clothes by self
- Yes** **No** Ties shoelaces
- Yes** **No** Takes a bath or shower without help
- Yes** **No** Brushes teeth
- Yes** **No** Combs or brushes hair
- Yes** **No** Washes hair by self
- Yes** **No** Chooses clothes by self
- Yes** **No** Eats by self using a knife, fork, and spoon
- Yes** **No** Picks up and puts away toys
- Yes** **No** Hangs up clothes
- Yes** **No** Helps around the house (for example, washes or dries dishes, makes bed(s), sweeps/vacuums floor, rakes or mows yard, helps with laundry)
- Yes** **No** Does what he or she is told most of the time
- Yes** **No** Obeys safety rules; for instance, looks for cars before crossing street
- Yes** **No** Gets to school on time
- Yes** **No** Accepts criticism or correction

If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to help him or herself and cooperate with others in caring for personal needs:
