COMPLETE IF YOU HAVE NOT FILED AN APPLICATION FOR BENEFITS!

Please complete this form and bring it with you to your appointment. You MUST complete this form prior to meeting with the attorney.

Name: _____
Appointment Date: _____ Time:_____

Palmyra Office Hannibal Office

1) When was the last day you worked? _____/_____/_____
How many hours per week were you working when you quit? _____
If you were working part-time when you quit, when was the last date you worked full-time? _____/_____/_____

2) Where were you working and why did you quit?
_____
_____
_____

3) Have you worked five out of the last ten years? Yes or No

4) Have you applied for Social Security Disability? Yes or No
If Yes, is your case still open? Yes or No

5) What date do you feel you became disabled? _____/_____/_____

6) Do you have health insurance? Yes or No
Do you have Medicaid? Yes or No

7) What are the illnesses, injuries, or conditions that limit your ability to work?
_____
_____
_____
_____

8) How do your illnesses, injuries, or conditions limit your ability to work?
_____
_____
_____

9) Your Height: _____ Your Weight: _____

10) **Please list the healthcare providers (mental and physical) you have seen in the last year.**

Name of Healthcare Provider #1: _____
Complete mailing address: Street or P.O. Box _____
City: _____State:_____ Zip Code:_____
Telephone Number: _____
Approximate Date you first saw this healthcare provider: _____
Approximate Date you last saw this healthcare provider: _____
Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____
What was the reason for your last visit to this healthcare provider? _____
_____
What treatment was received? _____

Name of Healthcare Provider #2: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____
Telephone Number: _____
Approximate Date you first saw this healthcare provider: _____
Approximate Date you last saw this healthcare provider: _____
Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____
What was the reason for your last visit to this healthcare provider? _____
_____
What treatment was received? _____

Name of Healthcare Provider #3: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____
Telephone Number: _____
Approximate Date you first saw this healthcare provider: _____
Approximate Date you last saw this healthcare provider: _____
Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____
What was the reason for your last visit to this healthcare provider? _____
_____
What treatment was received? _____

If you need more space to list additional Healthcare Providers please use a separate sheet of paper and list the same information that is requested above.

11) **Please list any hospitals where you have been a patient (inpatient or outpatient). List**
ONLY the ones you have seen in the last year.

Name of Hospital #1: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____

Telephone Number: _____
Inpatient Stays: Date admitted: _____ Date released: _____
Reason for Inpatient Stay: _____
Treatment received at Inpatient stay: _____
Outpatient Visits: Dates _____
Reason for Outpatient Visit: _____
Treatment received at Outpatient Visit: _____
Emergency Room Visits: Dates _____
Reason for ER Visit: _____
Treatment received at ER Visit: _____

Name of Hospital #2: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____
Telephone Number: _____
Inpatient Stays: Date admitted: _____ Date released: _____
Reason for Inpatient Stay: _____
Treatment received at Inpatient stay: _____
Outpatient Visits: Dates _____
Reason for Outpatient Visit: _____
Treatment received at Outpatient Visit: _____
Emergency Room Visits: Dates _____
Reason for ER Visit: _____
Treatment received at ER Visit: _____

Name of Hospital #3: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____
Telephone Number: _____
Inpatient Stays: Date admitted: _____ Date released: _____
Reason for Inpatient Stay: _____
Treatment received at Inpatient stay: _____
Outpatient Visits: Dates _____
Reason for Outpatient Visit: _____
Treatment received at Outpatient Visit: _____
Emergency Room Visits: Dates _____
Reason for ER Visit: _____
Treatment received at ER Visit: _____

If you need additional space to list more Hospitals please use a separate sheet of paper and list the same information as requested above.

12) **Please list ALL the medications you take (also include any over-the-counter medications). If you need additional space please use a separate sheet of paper.**
Name of Medicine
If prescribed, give name of doctor

Reason for Medicine
Side effects you have

13) How many years of education do you have? (High School = 12 years. If you have any college credit, indicate number of years and degree. If you have a GED, please include highest grade you completed before dropping out.)

14) Please name the last school you attended identifying town and state where it is located.

15) Were you in special education classes? Yes or No

16) Have you served in the military? If so, please identify the branch of service and what type of discharge you have.

17) Have you ever been convicted of a felony? If so please state the year and sentence for each offense.

18) Have any of your physicians or counselors suggested you have a problem with drugs or alcohol?

19) Do you have children under the age of 18? If so, list for each

Name	Age	Social Security Number
1.		
2.		
3.		
4.		
5.		

20) What was the city and state of your birth? (Required to communicate with social security)

21) What is your mother's maiden name? (Required to communicate with social security)

22) Have you ever applied for social security benefits *before*? If so, please state the year and whether or not you went to a hearing before a judge.

23) Are you married? Yes or No
    If yes, does your spouse work? Yes or No
    If yes, does your spouse work full-time or part-time?
    If part-time, how many hours per week does your spouse work and at what rate of pay? _____ hours at $ _____/hour.

24) Do you have a pending workers compensation claim? Yes or No
25) **Work History**

Please list every job you have had in the past 15 years. Use more space if you need it.

A. Employer: Job Title:
Years worked: _____/_____/_____ through _____/_____/_____
Job Description:
Amount of weight routinely lifted:
How much time standing:
How much time sitting:

B. Employer: Job Title:
Years worked: _____/_____/_____ through _____/_____/_____
Job Description:
Amount of weight routinely lifted:
How much time standing:
How much time sitting:

C. Employer: Job Title:
Years worked: _____/_____/_____ through _____/_____/_____
Job Description:
Amount of weight routinely lifted:
How much time standing:
How much time sitting:

If you need additional space to list all your employers for the last 15 years please use a separate sheet of paper and list the same information as requested above.

26) Please list 2 people who know your condition(s) other than healthcare providers:

1) Name: Relationship to you:
   Address: Phone #:
2) Name Relationship to you:
   Address: Phone #:

27) Please list two people (who do not live with you or with each other) who will be able to help us find you, if we lose contact with you:

1) Name Relationship to you:
   Address: Phone #:
2) Name Relationship to you:
   Address: Phone#:

WHAT YOU NEED FOR YOUR DISABILITY APPLICATION APPOINTMENT

You should have as much of the following information as possible for your interview. Use this checklist to keep track of the information you gather.

- An original or certified copy of your **birth certificate is required**. If you were born in another country, we need **proof of U.S. Citizenship** or legal residency.

- If you were in the military service, the original or a certified copy of your **military discharge papers** (Form DD214) for all periods of active duty.

- Your **W-2 Form** from last year, or if you were self-employed, your federal tax return (IRS 1040 and Schedule C and SE).

- **Workers' Compensation Information**, including date of injury, claim number and payment amount.

- **Social Security Number** and **Date of Birth** of your spouse.

- Your **checking or savings account and routing numbers** if you wish benefits to be direct deposited.

- **Date Married** on current marriage. **Date of Marriage & Date of Divorce / Annulment / Death** on any and all former marriages.

It is very important that you fill out this form completely!

If you do not know the exact dates of your visits/hospital stays, please at least estimate the month and year. This information is required to complete the application. ***DO NOT*** *get your medical records from your healthcare providers. Social Security will order all records from the information we provide them.*

Thank you.