**SSI Application
Applicant Key Information Summary**

Creating a key information summary helps organize information for the SSI application.

Refer to the key information summary as you complete the forms.

**For a sample filled out information summary** [**[ click here ]**](https://allianceforchildrensrights.org/wp-content/uploads/ApplicantKeyInfoSummary_JohnDoe.pdf)

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Background Information**

Name:       DOB:       SSN:

Home address:

Mailing address:

Telephone numbers:

*
*

CSW contact:

* Name:
* Phone number:
* Address:

Names and contact information for third parties who have relevant information regarding applicant’s medical conditions:

*
*
*

Additional notes:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History**

***Medical Diagnosis:***

Date of diagnosis:

Prescribed medication:

Treatment plan:

Impact on functioning:

 ***Medical Diagnosis:***

Date of diagnosis:

Prescribed medication:

Treatment plan:

Impact on functioning:

 ***Medical Diagnosis:***

Date of diagnosis:

Prescribed medication:

Treatment plan:

Impact on functioning:

Full scale IQ score:

Date applicant became unable to work:

Additional notes:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Providers**

**Provider 1:**

* First treatment date was       by Dr.
* Hospitalization dates:       to      , due to
* Treated by psychiatrist Dr.       with the following treatment:
* Treating therapist:
* Treating psychiatrist:
* Provider address:
* Provider phone number:

**Provider 2:**

* First treatment date was       by Dr.
* Hospitalization dates:       to      , due to
* Treated by psychiatrist Dr.       with the following treatment:
* Treating therapist:
* Treating psychiatrist:
* Provider address:
* Provider phone number:

**Provider 3:**

* First treatment date was       by Dr.
* Hospitalization dates:       to      , due to
* Treated by psychiatrist Dr.       with the following treatment:
* Treating therapist:
* Treating psychiatrist:
* Provider address:
* Provider phone number:

**Provider 4:**

* First treatment date was       by Dr.
* Hospitalization dates:       to      , due to
* Treated by psychiatrist Dr.       with the following treatment:
* Treating therapist:
* Treating psychiatrist:
* Provider address:
* Provider phone number:

Additional notes:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Medications**

1. — purpose:
2. — purpose:
3. — purpose:
4. — purpose:
5. — purpose:

Additional notes:

**Key Supporting Records**

 [ ]  DCFS detention report

 [ ]  Psych medication order by court

 [ ]  Health passport

 [ ]  Psych Eval/IQ testing

 [ ]  ER records, hospital reports from

 [ ]  Educational records:

Additional notes:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational History**

Name of current school:       Dates of attendance:

Course of study:

School contact:       School contact phone number:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Job Title** | **Employer Name & Address** | **Start Date** | **End Date** | **Reason ended** | **Salary/pay** |
|       |            |       |       |       |       |
|       |            |       |       |       |       |
|       |            |       |       |       |       |
|       |            |       |       |       |       |
|       |            |       |       |       |       |

Additional notes:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 **Income Assets**

Bank Accounts:

Name of bank:

Type of account:

Amount in bank account: $

Additional notes: