DISABILITY REPORT - CHILD - Form SSA-3820-BK
READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM THIS IS NOT AN APPLICATION

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

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.

- Fill out as much of this form as you can before your interview appointment. Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or " none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/ OTHER/ HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use Section 10, "DATE AND REMARKS," on Pages 11 and 12, and show the number of the question being answered.

ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records
- Copies of the child's prescriptions or medicine containers
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and medicine containers.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 1631(e)(1), and 223(d)(5)(A) 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 affect the decision on the claim.

We will use the information to make a decision regarding if a child is eligible for benefit payments. We may also share your information for the following purposes, called routine uses:

1. To Federal, State, or local agencies that conduct business with the Social Security Administration (SSA) and the release of records is determined to be relevant and necessary; and disclosure is compatible to the reason why the records were collected;

2. To third party contacts when additional information about the child is needed or verification of eligibility for benefits; and

3. To workers who are performing work for SSA as authorized by law and who technically do not have the status of Federal employees; and other Federal agencies for assisting SSA in the efficient administration of its programs.

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 Notice (SORN) 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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 (OMB) control number. We estimate that it will take about 90 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.*

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

DISABILITY REPORT - CHILD

SECTION 1 - INFORMATION ABOUT THE CHILD

A. **CHILD'S NAME** *(First, Middle Initial, Last)*: Sonny Day

B. **CHILD'S SOCIAL SECURITY NUMBER**: 012-34-5678

C. **YOUR NAME** *(If agency, provide name of agency and contact person)*: Maria Martinez, LA County Dept. of Children & Family Services

YOUR MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*: 955 Overland Ave., Suite 100

CITY	STATE	ZIP CODE
San Dimas	CA	91773

YOUR EMAIL ADDRESS (Optional)

D. **YOUR DAYTIME PHONE NUMBER**: 626 456-7890 (*Area Code* / *Number*)

(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)

☒ Your Number ☐ Message Number ☐ None

E. What is **your relationship to the child**? Children's Social Worker

F. Can you **speak and understand English**? ☒ YES ☐ NO

If "NO", what is your preferred language?

NOTE: If you cannot speak and understand English, we will provide you an interpreter, free of charge. **If you cannot speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages?

☐ YES (Enter name, address, phone number, relationship) ☐ NO

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ DAYTIME PHONE _____
City *State* *ZIP* *Area Code* *Number*

Can you **read and understand English**? ☒ YES ☐ NO

G. Does the child live with you? ☐ YES ☒ NO If "NO", with whom does the child live?

NAME Mary Night RELATIONSHIP TO CHILD foster parent

ADDRESS 123 Fire Lane
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

San Gabriel CA 91770 DAYTIME PHONE 626 888-1212
City *State* *ZIP* *Area Code* *Number*

Can this person **speak and understand English**? ☒ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☒ YES ☐ NO

SECTION 1 - INFORMATION ABOUT THE CHILD

H. Can the child speak and understand English? ☒ YES ☐ NO

If "NO," what languages can the child speak? _____

If the child understands any other languages, list them here: _____

I. What is the child's height *(without shoes)*? 5 ft 7'

What is the child's weight *(without shoes)*? 155 lbs

J. Does the child have a **medical assistance** card? (for example Medicaid, Medi-Cal) ☒ YES ☐ NO

If "YES", show the **number** here: C234-1234

SECTION 2 - CONTACT INFORMATION

A. Does the child have a legal guardian or custodian other than you?

☒ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME Mary Night

ADDRESS 123 Fire Lane

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

San Gabriel	CA	91770
City	*State*	*ZIP*

DAYTIME PHONE NUMBER 626 (*Area Code*) 888-1212 (*Number*)

RELATIONSHIP TO CHILD foster parent

Can this person **speak and understand English**? ☒ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☒ YES ☐ NO

B. Is there another adult who helps care for the child and can help us get information about the child if necessary?

☒ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME OF CONTACT Ron Night

ADDRESS 123 Fire Lane

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

San Gabriel	CA	91770
City	*State*	*ZIP*

DAYTIME PHONE NUMBER 626 (*Area Code*) 888-1212 (*Number*)

RELATIONSHIP TO CHILD foster parent

Can this person **speak and understand English**? ☒ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☒ YES ☐ NO

SECTION 3 - THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER

A. What are the child's disabling **illnesses, injuries, or conditions**?

Sonny was diagnosed with Bipolar Disorder and Intellectual Disability. His Bipolar Disorder includes medical documentation of the following: severe mood swings; impulsive and risk-taking behavior; distractability; insomnia; aggression; pressured speech; and suicidal ideation. His medical and school records also show extreme marked limitation in the areas of mental functioning, understanding, remembering or applying information, interacting with others, concentration, persistence, and maintaining pace.

Sonny has difficulty adapting and managing himself, and he has minimal capacity to adapt to changes in his daily environment. Sonny has significant deficits in adaptive functioning and needs supervision to adequately meet personal needs (e.g., preparing food, dressing, managing personal hygiene) in excess of age-appropriate dependence. His mental diagnoses are serious and persistent, with medically documented history over a period of at least 2 years. There is evidence of medical treatment, mental health therapy, and psychosocial support in a highly structured setting that is ongoing. Records show that he is significantly subaverage in general intellectual functioning and has difficulty participating in standardized tests to assess his acadmemic progress.

B. When did the child become disabled? January (*Month*) 1 (*Day*) 2018 (*Year*)

C. Do the child's illnesses, injuries or conditions cause **pain** or other symptoms? ☒ YES ☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

☒ YES ☐ NO

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

☒ YES ☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each DOCTOR/HMO/THERAPIST/OTHER**. Include the child's **next appointment**.

1. **NAME**
Dr. Sara Shah

DATES

STREET ADDRESS
USC/LACDMH, 123 Sunset Blvd.

FIRST VISIT
1/1/2018

CITY	**STATE**	**ZIP**	**LAST VISIT**
LA	CA	90028	12/20/2020

PHONE 323 777-6666 (*Area Code* / *Number*)

Patient ID # (If known)
00456123

NEXT APPOINTMENT
pending

REASONS FOR VISITS
To treat Bipolar Disorder and associated symptoms

WHAT **TREATMENT** WAS RECEIVED?
psychothereapy and medication

2. **NAME**
Dr. Andrea Harris

DATES

STREET ADDRESS
USC/LACDMH, 456 State St.

FIRST VISIT
12/4/2017

CITY	**STATE**	**ZIP**	**LAST VISIT**
LA	CA	90012	12/9/2017

PHONE 323 782-9897 (*Area Code* / *Number*)

Patient ID # (If known)
00456123

NEXT APPOINTMENT

REASONS FOR VISITS
5150 Hold

WHAT **TREATMENT** WAS RECEIVED?
psychological assessment and medication management

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3. **NAME**
Seth Davidson, LCSW

DATES

STREET ADDRESS
10101 Firestone Blvd.

FIRST VISIT
1/29/2018

CITY	**STATE**	**ZIP**	**LAST VISIT**
Southgate	CA	90280	12/29/2020

PHONE 323 (Area Code) 724-2670 (Number)

Patient ID # (If known)
00456123

NEXT APPOINTMENT
pending

REASONS FOR VISITS
to treat Bipolar Disorder and associated symptoms

WHAT **TREATMENT** WAS RECEIVED?
psychotherapy

If you need more space, use Section 10.

D. List each **HOSPITAL/CLINIC.** Include the child's **next appointment.**

1. HOSPITAL/CLINIC

NAME
USC/LACDMH

STREET ADDRESS
456 State St.

CITY LA
STATE CA **ZIP** 90012

PHONE 323 (Area Code) 782-9897 (Number)

TYPE OF VISIT

☒ **INPATIENT STAYS** *(Stayed at least overnight)*

☐ **OUTPATIENT VISITS** *(Sent home same day)*

☒ **EMERGENCY ROOM VISITS**

DATES

DATE IN	DATE OUT
12/4/2017	12/9/2017

DATE FIRST VISIT	**DATE LAST VISIT**
12/4/2017	1/10/2019

DATES OF VISITS

Next **appointment**
none scheduled

The child's hospital/clinic **number**

Reasons for visits
5150 hold

What **treatment** did the child receive?
psychotherapy and medication management

What **doctors** does the child see at this hospital/clinic on a regular basis?
Dr. Sara Shah

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
NAME	☐ **INPATIENT STAYS** *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS	☐ **OUTPATIENT VISITS** *(Sent home same day)*		
CITY	☐ **EMERGENCY ROOM VISITS**	**DATE FIRST VISIT**	**DATE LAST VISIT**
STATE **ZIP**			
PHONE *Area Code* *Number*		**DATES OF VISITS**	

Next **appointment**

The child's hospital/clinic **number**

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

If you need more space, use Section 10.

E. Does **anyone else have medical records or information** about the child's illnesses, injuries or conditions (foster parents, social workers, counselors, tutors, school nurses, detention centers, attorneys, insurance companies, and/or Worker's Compensation), or is the child scheduled to see anyone else?

☒ YES *(If "YES," complete information below.)* ☐ NO

NAME			**DATES**
Dr. Cynthia Forrest, school psychologist			
ADDRESS			**FIRST** VISIT
Mark Kepple High School, 1111 Orchard Lane			February 2019
CITY	**STATE**	**ZIP**	**LAST** SEEN
San Gabriel	CA	91778	April 2019
PHONE 323 *Area Code* 999-1213 *Number*			NEXT APPOINTMENT
			unknown

CLAIM NUMBER *(If any)*

REASONS FOR VISITS

Weschler IQ test and additional psychological testing for IEP process.

If you need more space, use Section 10.

SECTION 5 - MEDICATIONS

Does the child currently take any **medications** for illnesses, injuries or conditions? ☒ YES ☐ NO

If "YES", tell us the following: *(Look at the child's medicine containers, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS
Risperidone	Dr. Sara Shah	Bipolar Disorder	constipation
Flouxetine	Dr. Sara Shah	Bipolar Disorder	insomnia

If you need more space, use Section 10.

SECTION 6 - TESTS

Has the child had, or will he/she have, any **medical tests** for illnesses, injuries or conditions?

☐ YES ☒ NO If "YES", tell us the following (give approximate dates, if necessary).

KIND OF TEST	WHEN WAS/WILL TESTS BE DONE? *(Month, day, year)*	WHERE DONE *(Name of Facility)*	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY - Name of body part			
SPEECH/LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY - Name of body part			
MRI/CAT SCAN - Name of body part _____			

If the child has had other tests, list them in Section 10.

SECTION 7 - ADDITIONAL INFORMATION

A. Has the child been **tested or examined** by any of the following?

Headstart (Title V)	☐ YES	☒ NO
Public or Community Health Department	☒ YES	☐ NO
Child Welfare or Social Service Agency or WIC	☒ YES	☐ NO
Early Intervention Services	☐ YES	☒ NO
Program for Children with Special Health Care Needs	☒ YES	☐ NO
Mental Health/Mental Retardation Center	☒ YES	☐ NO

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work?

☐ YES ☒ NO

If you answered "YES" to any of the above in A. or B., please complete C. below:

C. 1. NAME OF AGENCY LA County Dept. of Children & Family Services

ADDRESS 955 Overland Ave., Suite 100

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

San Dimas	CA	91773
City	*State*	*ZIP*

PHONE NUMBER 626 456-7890

Area Code *Number*

TYPE OF TEST Multidisciplinary Assessment Team	WHEN DONE 4/09/2014
TYPE OF TEST	WHEN DONE

FILE OR RECORD NUMBER

2. NAME OF AGENCY LAC Dept. of Mental Health

ADDRESS 456 State St.

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

Los Angeles	CA	90012
City	*State*	*ZIP*

PHONE NUMBER 323 722-3333

Area Code *Number*

TYPE OF TEST psychological assessment	WHEN DONE 12/4/2017
TYPE OF TEST	WHEN DONE

FILE OR RECORD NUMBER

If there are any other agencies, show them in Section 10.

SECTION 8 - EDUCATION

A. Is the child currently enrolled in any school? ☒ YES, grade: 9th ☐ NO, too young

☐ NO, other reason (complete B)

B. Other reason the child is not enrolled in school:

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL Mark Keppel High School

ADDRESS 1111 Orchard Lane

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

San Gabriel	LA	CA	91778
City	*County*	*State*	*ZIP*

PHONE NUMBER 323 999-1213

Area Code *Number*

DATES ATTENDED January 2019 to present

TEACHER'S NAME Mr. Gerald Smith

Has the child been tested for behavioral or learning problems? ☒ YES ☐ NO

If "YES", complete the following:

TYPE OF TEST Weschler IQ test WHEN DONE 2/2019

TYPE OF TEST Psychological testing WHEN DONE 4/2019

Is the child in special education? ☒ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER Ms. Joan Smart

Is the child in speech/language therapy? ☒ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH/LANGUAGE THERAPIST Ms. Rebekah Jones

SECTION 8 - EDUCATION

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems? ☐ YES ☐ NO

If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Was the child in special education? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech/language therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH/LANGUAGE THERAPIST _____

If there are other schools, show them in Section 10.

E. Is the child attending Daycare/Preschool? ☐ YES ☒ NO

If "YES", complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

SECTION 9 - WORK HISTORY

A. Has the child ever worked (including sheltered work)? ☐ YES ☒ NO

If "YES", complete the following:

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ _____ _____ _____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

NAME OF SUPERVISOR _____

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

SECTION 10 - DATE AND REMARKS

Please give the date you filled out this disability report.

2/16/2021

Date (MM/DD/YYYY)

Use this section for any additional information about your child.

In addition to Sonny's Bipolar Disorder diagnosis in January 2018, Sonny was diagnosed with Intellectual Disability in April 2019 by his school psychologist after Sonny completed the Weschler IQ test and additional educational assessments as part of his IEP assessment. Sonny receives special education services at his high school.

SECTION 10 - REMARKS