SOCIAL SECURITY APPLICATION INTAKE FORM

Today's Date:________ Date of Birth: __________ Place of Birth:___________________

Name: ______________________ __________________ ________________________
First Middle Last

Address:________________________________,____________________, MI______________

Telephone home:____________________________Alternate:____________________________

Email Address: ____

Social Security Number:___________________________Right handed or Left?_____________

Height and Weight: ____

Spouse's Name_________________________Is spouse receiving SSD or SSI? ______________

Spouse's Date of Birth: ____________ Date and City/State of Marriage:____________________

Have you or your spouse worked for a foreign government or the US Railroad system? ________

Have you been married to anyone before your current spouse? __________________

If yes, did the marriage last for at least 10 years? ______________________

For all marriages lasting at least 10 years, please state the former spouse(s) name, approximate age as well as the date(s) and city/state of each marriage as well as the date(s) city/state of each divorce:

____

____

Highest Grade You Completed and When:: ____________ Special education:________________

Dependent Child's Name:___________________________Date of Birth:__________________

Dependent Child's Name:___________________________Date of Birth:____________________

Are any of your children receiving SSI?____

Do you have an adult child of any age that is disabled: __________________________________

Have you had formal vocational training:____

Military Service with dates served and branch of service ________________________:____________

Past Work History: (For 15 years since you last worked): Start with your most recent job

1. Name of Employer:____

   Dates of Employment: ___________________Job Title:_____________________________

   Full-time or Part-Time: ________ Earnings in last year of employment ______________

   Lifting Requirements (10, 20, 30 lbs.):_____________Standing/Walking:________________

   Reason for Termination:____

   Hourly/Yearly Rate of Pay: ____

2. Name of Employer:____

   Dates of Employment:___________________ Job Title:_____________________________

   Full-time or Part-Time: __________

   Lifting Requirements:____________________Standing/Walking:_____________________

   Reason for Termination:____

   Hourly/Yearly Rate of Pay: ____

3. Name of Employer: ____

   Dates of Employment:___________________ Job Title:______________________________

   Full-time or Part-Time: ___________

   Lifting Requirements:___________________Standing/Walking:______________________

   Reason for Termination:____

   Hourly/Yearly Rate of Pay: ____

4. Name of Employer: ____
   Dates of Employment: __________________ Job Title:______________________________

   Full-time or Part-Time: ___________

Lifting Requirement:__________________Standing/Walking:______________________

Reason for Termination:____

Hourly/Yearly Rate of Pay: ____

SINCE YOU LAST WORKED, have you applied for OR received any of the following benefits:

Unemployment Compensation:	Yes ___ No ___
Workers' Compensation:	Yes ___ No ___
Automobile no-fault benefits:	Yes ___ No ___
Short term or long term disability benefits:	Yes ___ No ___
Veteran's Benefits:	Yes ___ No ___
State Disability Assistance through DHS:	Yes ___ No ___
Unused vacation/personal time/sick pay	Yes ___ No ___
Retirement Benefits through Social Security	Yes ___ No ___
Pension or Retirement Benefits from any source	Yes ___ No ___

If yes to any of the above questions, please specify date benefits began/ended and amount received or bring a copy of any documentation reflecting this information:

____

Are you currently receiving money from any source other than listed above? __________________

If yes, please detail the amount and the source of the money (child support, alimony, sick pay, etc.) ____

Do you have a Disability Rating through the Veterans Administration?__________. If yes, please provide a copy of your Disability Rating/Award letter from the VA.

Do you have a child support obligation through the Friend of the Court?______. If yes, please provide the case number(s), the county and the amount of the arrearage(s). __________________

____

Do you have any IRS liens, State tax liens or other governmental liens of any nature?__________

If yes, please provide the nature of the lien, amount of the lien and any enforcement proceedings that have been initiated or that you know will be: ______________________________

Treating Physicians:

1. Dr.______________________ Address:____

____

Telephone#: ____

Date of first, last and next appointment: ____________________________________

2. Dr.____________________ Address:______________________________________

____

Telephone#: _______________________________________

Date of first, last and next appointment: ____________________________________

3. Dr.____________________ Address: _______________________________________

____

Telephone#: ____

Date of first, last and next appointment: ____________________________________

Written restrictions imposed by any physician: _______________________________________

____

List all Hospitals/Med Centers/Psychiatric Hospitals where you have been seen and dates:

1.____

2.____

3.____

Prior applications for Social Security? Yes_________ No_________

Date of prior application(s) and/or decision(s):____

Have you ever been overpaid by SSA? Yes _______ No _______

Have you ever been treated for alcohol and/or drug (prescription or non-prescription) dependence:

Yes_________ No_________

Do you have a medical marijuana card? Yes_________ No_________

Will your medical records note any alcohol abuse, illegal drug use or the fact that you have a medical marijuana card? Yes______ No_________

Have you ever violated a narcotic pain medication contract with any physician's office? If yes, please provide details and date(s):

____

Have you been incarcerated *for any length of time* since your disability began? _______________

If yes, please details with dates of incarceration:_______________________________________

____

Have you ever been convicted of a crime? Yes_______________ No__________

If yes, please specify the crime and date(s) of conviction:__________________________________

____

U.S. Citizen? Yes___ No___ If no, what is your status:______________________

Do you have any social media accounts such as Facebook, Twitter, Tumblr, etc? _____________

List injuries/conditions limiting your ability to work:

1.____

2.____

3.____

4.____

5. ____

Medications:

NAME/DOSAGE WHO PRESCRIBED REASON SIDE EFFECTS

1.____

2.____

3.____

4.____

5.____

What doctor(s) would be supportive of your disability claim? ____________________________

If you are approved and would like our office to set you up for direct deposit, please provide your routing number and checking account number at your application appointment.

How did you hear of our firm:

Friend/Relative/Client/Another Attorney:____

Phone book: ________ Internet: ___________ Other: _________________________

** Have you or a family member been involved in any type of accident in the last 2 years and sustained injuries? Yes ____ No ____

** Have you or a family member ever suffered any serious injuries from a medical procedure/treatment or from taking a prescribed medication? Yes ____ No ____

** Are you or a family member in need of legal assistance for any other matter? Yes ____ No ____