Initial Application Questionnaire and Disability Report Information
Please answer EACH question completely

Applicant Information

Full Name: _____ Maiden Name(s): _____
Social Security #: _____ Birthdate: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Alternate Phone #: (with a/c): _____
Email Address: _____

Birth & Citizenship Information

*Place of Birth: _____ (City, State, Country)

Citizenship: ☐ US Born ☐ Naturalized. Date of Naturalization: ____/____/_____ (mm/dd/yyyy)
Do you speak English? ☐ Yes ☐ No
Can you read English? ☐ Yes ☐ No
Can you write English? ☐ Yes ☐ No
If No, what language do you speak _____
Are you legally blind? ☐ Yes ☐ No
Have you used any other Social Security Numbers? ☐ Yes ☐ No If *yes*, ___ ___ ___ - ___ ___ - ___ ___ ___ ___
What is your mother's *maiden* name (*required*)? _____
What is your father's name (*required*)? _____

What was the last date you worked? ____/____/_____ (mm/dd/yyyy)

Have you been denied for Social Security/SSD/SSI in the last 60 days? ☐ Yes ☐ No
What was the date of your most recent denial for Social Security/SSD/SSI? ____/____/_____ (mm/dd/yyyy)
What was the date of your most recent hearing in front of an Administrative Law Judge? ____/____/_____

Did you file a tax return LAST year? ☐ Yes ☐ No How much did you earn? _____
Will you file a tax return THIS year? ☐ Yes ☐ No How much did you earn? _____
Were you a Federal Employee in 1983? ☐ Yes ☐ No
What year was your last tax return? _____

Emergency Contact (friend or relative):
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone (with a/c): _____
Relationship: _____

Marriage Information

Marital Status: ☐ Widowed ☐ Married ☐ Separated ☐ Divorced ☐ Never been married

Current or Most Recent Marriage (please write in **wife's maiden name**, in all previous marriages):

Spouse's First AND Maiden Name: _____

Date of Birth: ____ /____ / ____ Social Security #: __ __ __ - __ __ - __ __ __ __

Date of Marriage: ____ /____ / ____ City/State where marriage took place: _____

Did the marriage end? ☐ Yes ☐ No If *yes*, how? ☐ Divorce ☐ Death

When did it end? ____ /____ / ____ Where did it end (City/State)? _____

Previous Marriage (please write in **wife's maiden name**, in all previous marriages):

Ex-Spouse's First AND Maiden Name: _____

Date of Birth: ____ /____ / ____ Social Security #: __ __ __ - __ __ - __ __ __ __

Date of Marriage: ____ /____ / ____ City/State where marriage took place: _____

Did the marriage end? ☐ Yes ☐ No If *yes*, how? ☐ Divorce ☐ Death

When did it end? ____ /____ / ____ Where did it end (City/State)? _____

Previous Marriage (please write in **wife's maiden name**, in all previous marriages):

Ex-Spouse's First AND Maiden Name: _____

Date of Birth: ____ /____ / ____ Social Security #: __ __ __ - __ __ - __ __ __ __

Date of Marriage: ____ /____ / ____ City/State where marriage took place: _____

Did the marriage end? ☐ Yes ☐ No If *yes*, how? ☐ Divorce ☐ Death

When did it end? ____ /____ / ____ Where did it end (City/State)? _____

Children

These questions ALSO apply to children born out of wedlock, adopted children, and step-children.
Note: If a child reached the age limit within the last twelve months, please answer "Yes".

Do you have any children? ☐ Yes ☐ No

Do you have any children unmarried and under age 18? ☐ Yes ☐ No

Are any of your children unmarried, aged 18 to 19, and still attending elementary or high school full time? ☐ Yes ☐ No

List Children under the age of 18 or on Disability below:

Child's Name	Age	Date of Birth (mm/dd/yyyy)	Was the child disabled before 22 years of age?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Employer Details

Did you work for an employer this year? ☐ Yes ☐ No How much did you earn? _____

Will you work for an employer next year? ☐ Yes ☐ No

List ALL employers for the last 9 years starting with most recent job

Employer	Address	Start Date (mm/yyyy)	Last Date Worked (mm/yyyy)
Name: Last Job Title:			
Name: Previous Job Title:			
Name: Previous Job Title:			

Previous Job 1:

Business/Industry: _____ How many hours per day? _____

How many days per week: _____ Rate of pay: $_____ ☐ Hourly ☐ Annually

Previous Job 2:

Business/Industry: _____ How many hours per day? _____

How many days per week: _____ Rate of pay: $_____ ☐ Hourly ☐ Annually

Previous Job 3:

Business/Industry: _____ How many hours per day? _____

How many days per week: _____ Rate of pay: $_____ ☐ Hourly ☐ Annually

Military Details

Were you in the U.S. Military Service prior to 1968? ☐ Yes ☐ No

Self-Employment Details

Were you Self-Employed LAST YEAR? ☐ Yes ☐ No

Are you Self-Employed THIS YEAR? ☐ Yes ☐ No

How much did you claim on your taxes? _____

Foreign Social Security

Did you ever work outside the United States? ☐ Yes ☐ No

Did your spouse work outside the United States? ☐ Yes ☐ No

Social Security Statement

Do you agree with your earnings history as shown on your Social Security Statement?

☐ Yes ☐ No ☐ Not sure, I do not have a statement.

Total Earnings

Show the total of all wages and tips earned LAST YEAR _____

Did you work outside the United States for salary, wages, or self-employment LAST YEAR? ☐ Yes ☐ No

Do any of the total earnings include special payments paid in one year but earned in another? ☐ Yes ☐ No

Show the total of all wages and tips earned THIS YEAR _____

Did you work outside the United States for salary, wages, or self-employment THIS YEAR? ☐ Yes ☐ No

Do any of the total earnings include special payments paid in one year but earned in another? ☐ Yes ☐ No

Other Pensions/Annuities

Did you ever work in a job where U.S. Social Security taxes were not deducted or withheld? ☐ Yes ☐ No

Did you or your spouse work for the Railroad 5 years or more? ☐ Yes ☐ No

Direct Deposit Details

Do you have a bank account that can be used for direct deposit monthly? ☐ Checking ☐ Savings

Routing Number: _____ Account Number: _____

Benefit Information

Do you intend on applying for Supplemental Security Income? ☐ Yes ☐ No

Have you recently applied for?			Date (mm/dd/yyyy)	Amount
Social Security Retirement	☐ Yes	☐ No		
State Disability Assistance/ Medicaid	☐ Yes	☐ No		
Veteran's Benefits	☐ Yes	☐ No		
Workers' Compensation	☐ Yes	☐ No		

Unearned Income Payments

Have you filed or intend to file for workers' compensation or other public disability benefits? ☐ Yes ☐ No

Have you received money from your employer on or after the date you became unable to work? ☐ Yes ☐ No
Total amount of pay received: $ _____
Type of pay received (select all that apply): ☐ Sick Pay ☐ Vacation Pay ☐ Other

Do you expect to receive any money from an employer in the future? ☐ Yes ☐ No
Total amount of pay received: $ _____
Type of pay received (select all that apply): ☐ Sick Pay ☐ Vacation Pay ☐ Other

Dependents

*Do you have a **parent** who receives one-half support from you? ☐ Yes ☐ No

Other Contact

Give the name of someone we can contact who knows about your medical conditions and can help with this claim. This may be a family member or friend who knows about his daily life. Do not include his doctor.

Name and Phone number: _____

Height: _____ ft _____ in Weight: _____ Lbs.

Conditions

List ALL the Physical or Mental Condition(s) that you are in treatment which limits your ability to work

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Doctors and Other Healthcare Professionals

Current Doctor:

Doctor's Name: _____ Phone # (with a/c): _____

Address: _____

City: _____ State: _____ Zip: _____

Why do you see this doctor? _____ How Often: _____

First Visit (month/year): _____ Last Visit (month/year): _____

Medications: _____

Tests ordered by this doctor and when: _____

Current Doctor:

Doctor's Name: _____ Phone # (with a/c): _____

Address: _____

City: _____ State: _____ City: _____

Why do you see this doctor? _____ How Often: _____

First Visit (month/year): _____ Last Visit (month/year): _____

Medications: _____

Tests ordered by this doctor and when: _____

Current Doctor:

Doctor's Name: _____ Phone # (with a/c): _____

Address: _____

City: _____ State: _____ Zip: _____

Why do you see this doctor? _____ How Often: _____

First Visit (month/year): _____ Last Visit (month/year): _____

Medications: _____

Tests ordered by this doctor and when: _____

Current Mental Health Facility:

Psychiatrist's Name: ______________________ Phone # (with a/c): ______________

Facility Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

Why do you see this doctor? ______________ How Often: ______________

First Visit (month/year): ______________ Last Visit (month/year): ______________

Medications: ______________________

Tests ordered by this doctor and when: ______________________

Therapist's Name: ______________________ ☐ NCPsyA ☐ MA ☐ LCP ☐ LCSW

Case Worker: ______________________

Former Mental Health Facility:

Psychiatrist's Name: ______________________ Phone # (with a/c): ______________

Facility Name: ______________________

Address: ______________________

City: ______________________ State: __________ City: __________

First Appointment (month/year): ______________ Last Appointment ______________

Hospitals & Clinics:

Please write let us know about each hospital that has treated you in the last 2 years.

Address and Telephone Number	Why did you go to this hospital?	Treatment Dates (month/year)
(Name of Hospital/Urgent Care Facility) (Telephone # w/ac) (Street Address) (City) (State) (Zip)		(Emergency Room) (Inpatient/Hospitalized) (Outpatient)
(Name of Hospital/Urgent Care Facility) (Telephone # w/ac) (Street Address) (City) (State) (Zip)		(Emergency Room) (Inpatient/Hospitalized) (Outpatient)
(Name of Hospital/Urgent Care Facility) (Telephone # w/ac) (Street Address) (City) (State) (Zip)		(Emergency Room) (Inpatient/Hospitalized) (Outpatient)

Work Status

When did you stop working? ____/____/_____ (mm/dd/yyyy)

Work Activity

Why did you stop working (check only one)?

☐ Because of my condition
☐ Because of my condition AND other reasons
☐ Because of other reasons

Did your condition(s) cause you to make changes in your work activity before he stopped working? ☐ Yes ☐ No

If *yes*, what changes? _____

_____

Job History

Since you became unable to work, have you had gross **earnings** greater than $1090 in any month (do not count sick leave, vacation, or disability pay)? ☐ Yes ☐ No

Most Recent Job:

Business/Industry: _____ How many hours per day? _____

How many days per week: _____ Rate of pay: $_____ ☐ Hourly ☐ Annually

Describe this job. What did you do all day? Explain a typical day at this job (physical demands):

_____

_____

In this job, did you: (check all that apply)

☐ Used machines, tools, or equipment ☐ Used technical knowledge or skills ☐ Did writing, completed reports

In this job, how many hours each day were spent:

Walking:		Standing:		Sitting:		Climbing:		Stooping:	
Kneeling:		Crouching:		Crawling:		Reaching:			
Handling big objects:			Typing or handling small objects:						

Please describe what you lifted, how far you carried things, and how often you were required to do:

_____

_____

How heavy were the items frequently lifted (1/3 to 2/3 of the work day) in this job? ☐ 10 ☐ 25 ☐ 50 pounds

What was the heaviest weight you ever lifted in this job? ☐ 10 ☐ 20 ☐ 50 ☐ 100 pounds Other _____

Did you supervise other people? ☐ Yes ☐ No

If *yes*, how much of your day was spent supervising? _____ hours _____ minutes

Were you a lead worker? ☐ Yes ☐ No

Education

Can you read? ☐ Yes ☐ No

Can you understand the newspaper? ☐ Yes ☐ No

Can you write? ☐ Yes ☐ No

What is the highest Grade you completed?

☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ Some College ☐ BS/BA ☐ MS ☐ PhD

What year did you graduate from high school or attend college: ____/____/_____ (mm/dd/yyyy)

Were you ever in special Education? ☐ Yes ☐ No

If *yes*, where? _____

Have you ever completed any special job training, trade or vocational schools? ☐ Yes ☐ No

If *yes*, type of program: _____

How did you hear about the Social Security Counseling Center?

☐ Union/Local: _____
☐ Business Agent: _____
☐ Pamphlet in Dr. _____ office
☐ Social Worker
Name & phone #: _____
☐ Former Client
Name & phone #: _____
☐ Attorney Referral
Name & phone #: _____
☐ Other: _____
☐ Atticus
☐ Logbook
☐ Aiello Law Group Website
☐ Google
☐ Grosse Pointe News
☐ Michigan/Oakland County State Bar

We understand this is hard to do, so thank you.

Return this to us within 10 days along with the required signed forms.