Rocky Mountain DISABILITY LAW GROUP

Rocky Mountain Disability Law Group

Initial Application Questionnaire

Applicant Identification:

Name: _____

SSN:_____

Mailing Address:

Street/P.O. Box:_____

City: _____ State: _____ Zip: _____

Do you live at this address? ☐ Yes ☐ No

Daytime Phone Number: (___)____-_____ Best time to call? ◯ Morning ◯ Evening ◯ Either

Gender: ◯ M ◯ F DOB: ___/__/_____ E-Mail:_____

Language Preferred for Speaking: _____

Language Preferred for Reading: _____

Are you blind? ☐ Yes ☐ No

During the last 14 months, have you been unable to work because of illnesses, injuries or conditions that have lasted or are expected to last at least 12 months *or* can be expected to result in death? ☐ Yes ☐ No

What date did you become unable to work? Estimate if necessary. ____/_____/_____

Birth, Citizenship, and Additional Information:

Place of Birth: ☐ United States or U.S. Territory → City, State:_____

__Other → City, Country: _____

Type of Citizenship: ☐ orn inside the U.S. ☐ Born outside the U.S ☐ Naturalized Citizen

If you are a naturalized citizen, please list date of citizenship: __/___/_____

Have you used any other Social Security Numbers? If yes, please list:

_____

Have you used any other names? If yes, please list:

_____

Marriage Information:

Are you currently married? ◯ Yes ◯ No

If yes, please provide the following:

Spouse's Name: _____

Spouse's SSN: _____

Spouse's DOB: ____/____/_____ Spouse's Age: _____

Date of Marriage: ____/____/_____

Place of Marriage: City: _____ State: _____

Marriage Type: ☐ Married by Clergy or Public Official ☐ Common Law ☐ Other

If Other, please explain: _____

Prior Marriages:

Do you have any prior marriages? ☐ Yes ☐ No

If yes, do you have a prior marriage that lasted at least 10 years? ☐ Yes ☐ No

If yes, please give spouse's name: _____ Spouse's SSN: _____

Do you have a prior marriage that ended due to the spouse's death? ☐ Yes ☐ No

Children:

1. Do you have any children who became disabled prior to the age of 22? ☐ Yes ☐ No

2. Do you have any unmarried children under the age of 18? ☐ Yes ☐ No

3. Do you have any unmarried children aged 18 to 19 still attending school below a college level full time? ☐ Yes ☐ No

If you answered "Yes" to Question 1, 2 or 3 above, please enter the children's names:

Child's Name 1: _____

Child's Name 2: _____

Child's Name 3: _____

Child's Name 4: _____

Child's Name 5: _____

Any more children? ☐ Yes ☐ No If Yes, please list: _____

_____

Military Details:

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

If yes, are you receiving or eligible to receive a military or civilian Federal agency benefit? ☐ Yes ☐ No If Yes, is the benefit: ☐ Military ☐ Civilian ☐ Both

If you were in U.S. Military Service prior to 1968, please answer the following:

Type of Duty ☐ Active ☐ ACDUTRA ☐ Reserve

Branch of Service ☐ Air Force ☐ Army ☐ CGS ☐ Coast Guard ☐ Marine Corps ☐ National Guard ☐ Navy ☐ PHS

Start Date of Military Service Period: ___/___/_____ End Date: ___/___/_____

Earnings Details:

Did you work for an employer in 2011? ☐ Yes ☐ No

Were you self-employed in 2011? ☐ Yes ☐ No

Did you or will you work for an employer in 2012? ☐ Yes ☐ No

Were you self-employed in 2012? ☐ Yes ☐ No

Have you ever worked outside the United States? ☐ Yes ☐ No

If yes, are you eligible for benefits under a foreign Social Security system? ☐ Yes

If you have a spouse, has he/she ever worked outside the United States? ☐ Yes ☐ No ☐ N/A

If yes, is your spouse covered under a foreign Social Security system? ☐ Yes ☐ No

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

☐ Yes ☐ No ☐ Not sure or do not have a statement.

If employed, are you a Corporate Officer of your employer? ☐ Yes ☐ No

If employed, are you related to a Corporate Officer of your employer? ☐ Yes ☐ No

Do you receive earnings from a Family Corp or other closely held corporation? ☐ Yes ☐ No

If you were neither working for an employer nor self-employed in 2011 or later, when was the last year that you worked? _____

Have you ever worked in a job where Soc. Sec. taxes were not deducted/withheld? ☐ Yes ☐ No

If yes, do you receive a pension or annuity based on this non-covered work? ☐ Yes ☐ No

If yes, is the pension or annuity based on government employment? ☐ Yes ☐ No

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

If yes, do you or your spouse receive or are you eligible to receive a Railroad pension or annuity? ☐ Yes ☐ No

If yes: ☐ You ☐ Your Spouse ☐ Both

Direct Deposit Details:

Account Type: ☐ Checking ☐ Savings

Routing Number: _____ Account Number: _____

☐ I do not have an account at a bank or other financial institution.

Benefit Information:

Have you recently applied for Supplemental Security Income? ☐ Yes ☐ No

Have you previously applied for Medicare, Social Security, or Supplemental Security Income (SSI) benefits? ☐ Y ☐ N

If yes, which type of benefits? ☐ Medicare ☐ Social Security Benefits ☐ SSI Benefits

If yes, did you apply on your own Social Security Number? ☐ Yes ☐ No

Ability to Work:

Please list the illnesses, injuries or conditions that limit your ability to work. Include mental or emotional conditions.

_____

_____

_____

Are these illnesses, injuries or conditions related to work in any way? For example, did they occur while you were at work, or are they a result of a job responsibility? ☐ Yes ☐ No

If yes, have you applied or do you intend to apply for any workers' compensation or other public disability benefits? ☐ Yes ☐ No

If your injury is work related and you have not applied or do not intend to apply for workers' compensation or other public disability benefits, please provide a reason for not filing:

_____

Are you now able to work? ☐ Yes ☐ No

If yes, what is the date you became able to work? Month: _____Year:_____

Have you received money from your employer on or after the date you became unable to work?

☐ Yes ☐ No *If yes*, total amount of pay received: _____

If yes, type of pay received: ☐ Sick Pay ☐ Vacation Pay ☐ Other

Do you expect to receive any money from your employer in the future? ☐ Yes ☐ No

If yes, total amount of pay you expect to receive: _____

If yes, type of pay you expect to receive: ☐ Sick Pay ☐ Vacation Pay ☐ Other

Parent Information

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

If yes, please list full name and the following contact information for the parent:

Parent Name: _____

Parent Street Address: _____

Parent City, State and Zip: _____

If you have another parent who receives one-half support from you, please list the second parent's name and address (if not the same address as the first parent) below:

Parent Name: _____

Parent Street Address: _____

Parent City, State and Zip: _____

Authorization:

In order to make a decision about your disability claim, the Social Security Administration needs to have medical information that shows you have a disability. You must authorize your medical sources to disclose any medical records or other information about your disability. The SSA may not be able to approve your disability claim without this written authorization.

Do you authorize disclosure of medical information? ☐ Yes ☐ No

Please Sign: _____

Please provide any additional information or remarks you want to send with your application. If you estimated any dates, places, or amounts, please explain briefly. For example, if you estimated a date of marriage, please explain. **Please list any and all reasons you believe you cannot work in detail.**_____

_____

_____

_____

_____

_____

_____

(use back of page to continue if necessary)

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Adult Disability Report Questionnaire

Contact Person's Information:

Give the name of someone (*other than your doctors*) we can contact who knows about your medical conditions and can help you with your claim. This may be a family member or friend who knows about your daily life.

Contact Person's Full Name: _____

Relationship to You: _____

Contact Person's Address: Street: _____

City: _____ State: _____Zip: _____

Contact Individual's Phone #: (_____) _____ - _____

Can this person speak and understand English? ☐ Yes ☐ No

If no, what language does he/she prefer? _____

OR

☐ I do not have a contact.

Identification and Disability Overview:

Have you previously been denied for Social Security or SSI disability benefits?

☐ Yes, more than 60 days ago ☐ Yes, less than 60 days ago ☐ No

Does your condition keep you from working or seriously limit your ability to work?

☐ Yes ☐ No ☐ I am not sure

Have you been diagnosed with any specific condition that is expected to end in death?

☐ Yes ☐ No ☐ I am not sure

Are you currently working?

☐ No, I have never worked ☐ No, I have stopped working ☐ Yes, I am currently working

Have you used any other names on medical or educational records?
☐ Yes ☐ No

If yes, please list the full name(s) used:

1. _____

2. _____

3. _____

Can you speak and understand English? ☐ Yes ☐ No

If no, please list preferred language: _____

Can you read and understand English? ☐ Yes ☐ No

If no, please list preferred language: _____

Can you write more than your name in English? ☐ Yes ☐ No

Medical:

List **ALL** the physical or mental condition(s) (including emotional or learning problems) that limit your ability to work.

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

What is your height without shoes? _____ feet _____ inches

What is your weight without shoes? _____ lbs.

Does your condition cause you pain or other symptoms? ☐ Yes ☐ No

Have you seen a doctor or other healthcare professional or received treatment at a hospital or clinic or do you have a future appointment scheduled?

For any physical condition(s): ☐ Yes ☐ No

For any mental condition(s): ☐ Yes ☐ No

If yes, please read and complete the following carefully:

Comprehensive Medical History:

On the following pages, please list your doctor, clinic and/or healthcare provider information as thoroughly as possible. Please only fill out information that corresponds with ONE provider per page. If you run out of pages, please use the back of the sheets to complete your medical background information.

Please make sure that you are as accurate as possible with the clinic or hospital you list. Many providers have different locations, and providing us with the right location is important. Your attention to detail will help us acquire your medical records in a timely fashion.

THE MORE ACCURATE YOU ARE WITH THIS INFORMATION, THE MORE IT WILL HELP SOCIAL SECURITY GET AN ACCURATE RECORD OF YOUR MEDICAL HISTORY! IT WILL ALSO HELP US REPRESENT YOU TO THE BEST OF OUR ABILITY IN YOUR DISABILITY CLAIM.

Please begin on the next page.

DOCTOR/CLINIC/HEALTHCARE PROVIDER #1

Doctor/Healthcare Provider #1: _____

Please note if individual is not a doctor but a nurse, therapist, etc.

AND/OR

Office Name or Clinic:_____

Doctor/Healthcare Professional's Address: _____

City: _____ State: _____ Zip: _____

U.S. Phone Number: _____

Visit Type (please select all that apply): ☐ ER ☐ Inpatient Stay ☐ Outpatient Stay

Treatment Dates: First Visit: _____ Last Visit: _____

Next Visit (leave blank if no appointment scheduled): _____

What medical conditions were treated or evaluated by this doctor/healthcare professional? _____

_____

What treatment did you receive from this doctor/healthcare professional?

_____

_____

Medications Prescribed:

1. _____ Prescribed for: _____
2. _____ Prescribed for: _____
3. _____ Prescribed for: _____
4. _____ Prescribed for: _____
5. _____ Prescribed for: _____

Tests (e.g. x-ray, MRI, blood test, EKG, vision, EEG, breathing, HIV, biopsy, hearing, etc.):

1. _____ Date: _____ Part of Body: _____
2. _____ Date: _____ Part of Body: _____
3. _____ Date: _____ Part of Body: _____
4. _____ Date: _____ Part of Body: _____
5. _____ Date: _____ Part of Body: _____

Additional remarks, if any: _____

_____

DOCTOR/CLINIC/HEALTHCARE PROVIDER #2

Doctor/Healthcare Provider #2: _____

Please note if individual is not a doctor but a nurse, therapist, etc.

AND/OR

Office Name or Clinic:_____

Doctor/Healthcare Professional's Address: _____

City: _____ State: _____ Zip: _____

U.S. Phone Number: _____

Visit Type (please select all that apply): ☐ ER ☐ Inpatient Stay ☐ Outpatient Stay

Treatment Dates: First Visit: _____ Last Visit: _____

Next Visit (leave blank if no appointment scheduled): _____

What medical conditions were treated or evaluated by this doctor/healthcare professional? _____

_____

What treatment did you receive from this doctor/healthcare professional?

_____

_____

Medications Prescribed:

1. _____ Prescribed for: _____
2. _____ Prescribed for: _____
3. _____ Prescribed for: _____
4. _____ Prescribed for: _____
5. _____ Prescribed for: _____

Tests (e.g. x-ray, MRI, blood test, EKG, vision, EEG, breathing, HIV, biopsy, hearing, etc.):

1. _____ Date: _____ Part of Body: _____
2. _____ Date: _____ Part of Body: _____
3. _____ Date: _____ Part of Body: _____
4. _____ Date: _____ Part of Body: _____
5. _____ Date: _____ Part of Body: _____

Additional remarks, if any: _____

_____

DOCTOR/CLINIC/HEALTHCARE PROVIDER #3

Doctor/Healthcare Provider #3: _____

Please note if individual is not a doctor but a nurse, therapist, etc.

AND/OR

Office Name or Clinic:_____

Doctor/Healthcare Professional's Address: _____

City: _____ State: _____ Zip: _____

U.S. Phone Number: _____

Visit Type (please select all that apply): ☐ ER ☐ Inpatient Stay ☐ Outpatient Stay

Treatment Dates: First Visit: _____ Last Visit: _____

Next Visit (leave blank if no appointment scheduled): _____

What medical conditions were treated or evaluated by this doctor/healthcare professional? _____

_____

What treatment did you receive from this doctor/healthcare professional?

_____

_____

Medications Prescribed:

1. _____ Prescribed for: _____
2. _____ Prescribed for: _____
3. _____ Prescribed for: _____
4. _____ Prescribed for: _____
5. _____ Prescribed for: _____

Tests (e.g. x-ray, MRI, blood test, EKG, vision, EEG, breathing, HIV, biopsy, hearing, etc.):

1. _____ Date: _____ Part of Body: _____
2. _____ Date: _____ Part of Body: _____
3. _____ Date: _____ Part of Body: _____
4. _____ Date: _____ Part of Body: _____
5. _____ Date: _____ Part of Body: _____

Additional remarks, if any: _____

_____

DOCTOR/CLINIC/HEALTHCARE PROVIDER #4

Doctor/Healthcare Provider #4: _____

Please note if individual is not a doctor but a nurse, therapist, etc.

AND/OR

Office Name or Clinic:_____

Doctor/Healthcare Professional's Address: _____

City: _____ State: _____ Zip: _____

U.S. Phone Number: _____

Visit Type (please select all that apply): ☐ ER ☐ Inpatient Stay ☐ Outpatient Stay

Treatment Dates: First Visit: _____ Last Visit: _____

Next Visit (leave blank if no appointment scheduled): _____

What medical conditions were treated or evaluated by this doctor/healthcare professional? _____

_____

What treatment did you receive from this doctor/healthcare professional?

_____

_____

Medications Prescribed:

1. _____ Prescribed for: _____
2. _____ Prescribed for: _____
3. _____ Prescribed for: _____
4. _____ Prescribed for: _____
5. _____ Prescribed for: _____

Tests (e.g. x-ray, MRI, blood test, EKG, vision, EEG, breathing, HIV, biopsy, hearing, etc.):

1. _____ Date: _____ Part of Body: _____
2. _____ Date: _____ Part of Body: _____
3. _____ Date: _____ Part of Body: _____
4. _____ Date: _____ Part of Body: _____
5. _____ Date: _____ Part of Body: _____

Additional remarks, if any: _____

_____

DOCTOR/CLINIC/HEALTHCARE PROVIDER #5

Doctor/Healthcare Provider #5: _____

Please note if individual is not a doctor but a nurse, therapist, etc.

AND/OR

Office Name or Clinic:_____

Doctor/Healthcare Professional's Address: _____

City: _____ State: _____ Zip: _____

U.S. Phone Number: _____

Visit Type (please select all that apply): ☐ ER ☐ Inpatient Stay ☐ Outpatient Stay

Treatment Dates: First Visit: _____ Last Visit: _____

Next Visit (leave blank if no appointment scheduled): _____

What medical conditions were treated or evaluated by this doctor/healthcare professional? _____

_____

What treatment did you receive from this doctor/healthcare professional?

_____

_____

Medications Prescribed:

1. _____ Prescribed for: _____
2. _____ Prescribed for: _____
3. _____ Prescribed for: _____
4. _____ Prescribed for: _____
5. _____ Prescribed for: _____

Tests (e.g. x-ray, MRI, blood test, EKG, vision, EEG, breathing, HIV, biopsy, hearing, etc.):

1. _____ Date: _____ Part of Body: _____
2. _____ Date: _____ Part of Body: _____
3. _____ Date: _____ Part of Body: _____
4. _____ Date: _____ Part of Body: _____
5. _____ Date: _____ Part of Body: _____

Additional remarks, if any: _____

_____

Work History and Information:

Please select a reason for stopping working:

☐ My condition ☐ My condition AND other reasons ☐ Other reasons

If you stopped working for any other reasons than your condition, please explain the other reasons you stopped working:

_____

_____

_____

Did your condition(s) cause you to change your work activity before you stopped working?

☐ No ☐ Yes If yes, please estimate the date you made changes: ___/___/_____

Please list the jobs that you have had in the past 15 years (up to 5) before becoming unable to work because of your condition(s). Start with your most recent job.

Job 1 (Most Recent):

Job Title: _____ Type of Business: _____

Start Date (mm/yyyy): _____ End Date (mm/yyyy): _____

Hours per Day: _____ Days per Week: ____ Rate of Pay: $____ per Year

***If your hours/days/pay varied, please estimate salary or monthly income to the best of your ability.**

Please describe the job. What did you do all day?

_____

_____

_____

In this job, did you use machines, tools, or equipment? ☐ Yes ☐ No

In this job, did you use technical knowledge or skills? ☐ Yes ☐ No

In this job, did you do any writing, complete reports, or similar duties? ☐ Yes ☐ No

In this job, how many hours a day did you do each of the following tasks?

☐ Walking ☐ Standing ☐ Sitting ☐ Climbing ☐ Stooping ☐ Kneeling

☐ Crouching ☐ Crawling ☐ Handling large objects ☐ Writing, typing ☐ Reaching

Please describe what you lifted, how far you carried things, and how often you did this in your job: _____

_____

What was the heaviest weight you ever lifted in your job? _____

Did you supervise other people in this job? ☐ Yes ☐ No

Were you a lead worker in this job? ☐ Yes ☐ No

Job 2:

Job Title: _____ Type of Business: _____

Start Date (mm/yyyy): _____ End Date (mm/yyyy): _____

Hours per Day: _____ Days per Week: ____ Rate of Pay: $____ per Year

***If your hours/days/pay varied, please estimate salary or monthly income to the best of your ability.**

Please describe the job. What did you do all day?

_____

_____

_____

Job 3:

Job Title: _____ Type of Business: _____

Start Date (mm/yyyy): _____ End Date (mm/yyyy): _____

Hours per Day: _____ Days per Week: ____ Rate of Pay: $____ per Year

***If your hours/days/pay varied, please estimate salary or monthly income to the best of your ability.**

Please describe the job. What did you do all day?

_____

_____

_____

Job 4:

Job Title: _____ Type of Business: _____

Start Date (mm/yyyy): _____ End Date (mm/yyyy): _____

Hours per Day: _____ Days per Week: ____ Rate of Pay: $____ per Year

***If your hours/days/pay varied, please estimate salary or monthly income to the best of your ability.**

Please describe the job. What did you do all day?

_____

_____

_____

Job 5:

Job Title: _____ Type of Business: _____

Start Date (mm/yyyy): _____ End Date (mm/yyyy): _____

Hours per Day: _____ Days per Week: ____ Rate of Pay: $____ per Year

***If your hours/days/pay varied, please estimate salary or monthly income to the best of your ability.**

Please describe the job. What did you do all day?

_____

_____

_____

Education and Training:

What is the highest grade you completed? _____

To the best of your memory, when was your most recently completed school year? _____

Have you completed any type of special job training, trade, or vocational school? ☐ Yes ☐ No

If yes, *please explain the type of program:* _____

_____

_____

If yes, *date program completed:* _____

Did you attend special education classes? ◯ Yes ◯ No

If yes, School Name: _____ City/State: _____

Dates Attended: from _____ to _____

If special education at more than one school, please list the additional school here:

_____

Please add any additional remarks regarding this application here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this application. Please mail back to our office in the enclosed envelope at your earliest convenience. You may reach us at (303) 534-1958 with any additional questions.

Rocky Mountain DISABILITY LAW GROUP

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