



COMMUNITY ADVOCATES
Where Meeting Basic Needs Inspires Hope

communityadvocates.net
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DISABILITY ADVOCACY SERVICES CHILDREN'S QUESTIONNAIRE

CHILD'S NAME _____

YOUR NAME _____

ADDRESS _____

CITY _____

STATE _____

ZIP _____

PHONE NUMBER(S) _____

CHILD'S DATE OF BIRTH _____

CHILD'S SOCIAL SECURITY NUMBER _____

ABOUT YOUR SOCIAL SECURITY DISABILITY CLAIM

When did you first apply for Supplemental Security Income benefits for your child? _____

Have they been denied Social Security Disability benefits? Yes No

What is the date of the last denial? _____

Have you appealed the last denial? Yes No

Have you worked with another lawyer or representative who helped you with your child's disability claim? Yes No

If so, give name and address: _____

Is the doctor or doctors supportive of your child's disability claim? Yes No

ABOUT YOUR CHILD'S CONDITION

What are all of the physical or mental conditions affecting your child, no matter how serious?

When did these conditions first affect your child? Please be specific.

What medications are they taking? Please be specific. Please add additional pages if you need to list more medications. Include over-the-counter medications.

1. _____
NAME OF DRUG DOSAGE/FREQUENCY

WHO PRESCRIBED IT?

WHY DO THEY TAKE IT?

2. _____
NAME OF DRUG DOSAGE/FREQUENCY

WHO PRESCRIBED IT?

WHY DO THEY TAKE IT?

3. _____
NAME OF DRUG DOSAGE/FREQUENCY

WHO PRESCRIBED IT?

WHY DO THEY TAKE IT?

4. _____
NAME OF DRUG DOSAGE/FREQUENCY

WHO PRESCRIBED IT?

WHY DO THEY TAKE IT?

Does your child have any side effects from the medications:

What doctors do they see for their condition(s)?

1. _____
NAME OF DOCTOR

COMPLETE ADDRESS

PHONE NUMBER

WHY DO THEY SEE THIS DOCTOR?

2. _____
NAME OF DOCTOR

COMPLETE ADDRESS

PHONE NUMBER

WHY DO THEY SEE THIS DOCTOR?

3. _____
NAME OF DOCTOR

COMPLETE ADDRESS

PHONE NUMBER

WHY DO THEY SEE THIS DOCTOR?

4. _____
NAME OF DOCTOR

COMPLETE ADDRESS

PHONE NUMBER

WHY DO THEY SEE THIS DOCTOR?

ABOUT YOUR CHILD'S EDUCATION

What year in school is your child currently enrolled in? _____

Is your child's performance in school at grade level? Yes No

Is your child enrolled in a special education program? Yes No

Does your child get in trouble at school? Yes No

Is your child frequently absent from school? Yes No

What school is your child enrolled in? _____

ABOUT YOUR CHILD'S DAILY LIFE

How does their condition or conditions affect their ability to take care of their own needs, interact and play with others, their ability to understand directions, finish activities that they start, and ability to use their hands and arms (such as picking up toys or writing, etc.)? Please be specific and give examples. If your child needs help doing certain things, explain.

Why do you think your child is different from other children? What do you think makes them disabled?

Additional information:

If you are not the child's natural or adoptive parent, what is your relationship to the child?

If you are not the child's natural or adoptive parent, do you have legal custody or guardianship of the child? Yes No

YOUR SIGNATURE

TODAY'S DATE