Fax Transmission

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RE: Nyman Tukish- MAT-25040358307
Pages: 72

From: Nyman Turkish
Fax: 19162184341
Date: Thursday, February 19, 2026 11:47 AM, PST

Comments:
MAT-25040358307

SOCIAL SECURITY ADMINISTRATION
Form **SSA-10** (10-2023) UF
Discontinue Prior Editions

Form Approved
OMB No. 0960-0004

APPLICATION FOR SOCIAL SECURITY BENEFITS | (Do not write in this space)

With this application, you are applying for all insurance benefits for which you are eligible under Title II (Federal Old-Age, Survivors, and Disability Insurance) and Part A of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act as presently amended. The information you furnish on this application will ordinarily be sufficient for a determination on the lump-sum death payment. If you were receiving spouse's benefits at the time of your spouse's death, you only need to complete the circled items. All other claimants must complete the entire form.*This may also serve as an application for survivors benefits under the Railroad Retirement Act and for Veterans Administration payments under title 38 U.S.C., Veterans Benefits, Chapter 13 (which is, as such, an application for other types of death benefits under title 38).

1. (a) PRINT name of deceased wage earner or self-employed person (herein referred to as the "deceased")	FIRST NAME, MIDDLE INITIAL, LAST NAME
(b) Enter deceased's Social Security Number	
2. (a) PRINT your name	FIRST NAME, MIDDLE INITIAL, LAST NAME
(b) Enter your Social Security Number	111-23-4444
(c) Enter your name at birth if different from item 2(a)	FIRST NAME, MIDDLE INITIAL, LAST NAME Jason N Jones

PART I - INFORMATION ABOUT THE DECEASED

3. Enter date of birth of deceased	MONTH, DAY, YEAR
4. (a) Enter date of death	MONTH, DAY, YEAR
(b) Enter place of death	CITY AND STATE
5. Enter name of the State or foreign country where the deceased had a fixed, permanent home at the time of death.	

Answer Item 6 Only if the Deceased Died Prior to Full Retirement Age or Prior to 1 Year Past Full Retirement Age, and Within the Past 4 Months.

6. (a) Was the deceased unable to work because of illnesses, injuries or conditions at the time of death?	☐ Yes (If "Yes," answer (b).) ☐ No (If "No," go on to item 8.)
(b) Enter the date the deceased became unable to work.	MONTH,DAY,YEAR

ANSWER ITEM 7 ONLY IF DEATH OCCURRED WITHIN THE LAST 2 YEARS.

7. (a) How much did the deceased earn from employment and self-employment during the year of death?	Amount $
(b) How much did the deceased earn the year before death?	Amount $
8. (a) Did the deceased have wages or self-employment income covered under Social Security in all years from 1978 through last year?	☐ Yes (If "Yes," skip to item 9.) ☐ No (If "No," answer (b).)
(b) List the years from 1978 through last year in which the deceased did not have wages or self-employment income covered under Social Security.	

9. CHECK IF APPLICABLE

☐ I am not submitting evidence of the deceased's earnings that are not yet on his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in my benefits will be paid with full retroactivity.

INFORMATION ABOUT THE DECEASED'S MARRIAGE(S)

10. Answer this item ONLY if the deceased had other marriages.
(a) If the deceased married **after** his or her marriage to you, enter the information on the last marriage.
(If none, write "NONE".)

Spouse's Name *(including maiden name)*	When *(Month, Day, and Year)*	Where *(Name of City and State)*
None		
How Marriage Ended	When *(Month, Day, and Year)*	Where *(Name of City and State)*
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	Spouse's date of birth (or age)	If spouse deceased, give date of death

Spouse's Social Security Number *(If none or unknown, so indicate)*

(b) If the deceased had any other marriages, and the marriage lasted at least 10 years or ended due to death of the spouse (whether before or after you married the deceased), enter the information below. If the deceased divorced then remarried the same individual within the year immediately following the year of the divorce, and the combined period of marriage totaled 10 years or more, include the marriage. **(If none, write "NONE".)**

Spouse's Name *(including maiden name)*	When *(Month, Day, and Year)*	Where *(Name of City and State)*
None		
How Marriage Ended	When *(Month, Day, and Year)*	Where *(Name of City and State)*
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	Spouse's date of birth (or age)	If spouse deceased, give date of death

Spouse's Social Security Number *(If none or unknown, so indicate)*

USE "REMARKS" SPACE ON BACK PAGE FOR INFORMATION ABOUT ANY OTHER MARRIAGE AS DESCRIBED IN 10b.

11. Is there a surviving parent (or parents) who was receiving support from the deceased at the time of death or at the time the deceased became disabled under Social Security Law? ☐ Yes (If "Yes," enter the name and address in"Remarks.")

PART II - INFORMATION ABOUT YOURSELF

12. (a) Enter name of State or foreign country where you were born. US

13. (a) Are you a U.S. citizen? ☐ Yes ☐ No

(b) Are you an alien lawfully present in the U.S.? ☐ Yes ☐ No

If yes, when were you lawfully admitted into the U.S.?

INFORMATION ABOUT YOUR MARRIAGE(S)

14. (a) Enter information about your marriage to the deceased.

Spouse's Name *(including maiden name)*	When *(Month, Day, and Year)*	Where *(Name of City and State)*
How Marriage Ended	When *(Month, Day, and Year)*	Where *(Name of City and State)*
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	Spouse's date of birth (or age)	If spouse deceased, give date of death

Spouse's Social Security Number *(If none or unknown, so indicate)*

(b) If you remarried **after** the marriage shown in 14.(a), enter information about the last marriage. **(If none, write "NONE".)**

Spouse's Name *(including maiden name)* None	When *(Month, Day, and Year)*	Where *(Name of City and State)*
How Marriage Ended	When *(Month, Day, and Year)*	Where *(Name of City and State)*
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	Spouse's date of birth (or age)	If spouse deceased, give date of death

Spouse's Social Security Number *(If none or unknown, so indicate)*

(c) Enter information about any other marriage you may have had that lasted at least 10 years (see item 14(b) for counting consecutive multiple marriages to the same individual) or ended due to death of the spouse (whether before or after you married the deceased). **(If none, write "NONE".)**

Spouse's Name *(including maiden name)* None	When *(Month, Day, and Year)*	Where *(Name of City and State)*
How Marriage Ended	When *(Month, Day, and Year)*	Where *(Name of City and State)*
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	Spouse's date of birth (or age)	If spouse deceased, give date of death

Spouse's Social Security Number *(If none or unknown, so indicate)*

***USE "REMARKS" SPACE ON BACK PAGE FOR INFORMATION ABOUT ANY OTHER MARRIAGE AS DESCRIBED IN 14c.**

IF YOU ARE APPLYING FOR SURVIVING DIVORCED SPOUSE'S BENEFITS, OMIT 15 AND GO ON TO ITEM 16.

15. (a) Were you and the deceased living together at the same address when the deceased died? ☐ Yes (If "Yes," go to item 16.) ☐ No No(If "No," answer (b).)

(b) If either you or the deceased were away from home (whether or not temporarily) when the deceased died, give the following: Who was away? ☐ Deceased ☐ Surviving Spouse

Date last at home:	Reason absence began:	Reason you were apart at time of death:

If separated because of illness, enter nature of illness or disabling condition.

DO NOT ANSWER QUESTION 16 IF YOU ARE FULL RETIREMENT AGE OR OLDER. GO ON TO QUESTION 17.

16. (a) Are you, or during the past 14 months have you been, unable to work because of illnesses, injuries or conditions?	☐ Yes	(If "Yes," answer (b) .)	☐ No	(If "No," go on to item 17.)
(b) Enter the date you became unable to work.	(Month, day, year) 1/1/2026			
17. Did you or the deceased work in the railroad industry for 5 years or more?	☐ Yes		☐ No	
18. (a) Did you or the deceased have Social Security credits (for example, based on work or residence) under another country's Social Security System?	☐ Yes	(If "Yes," answer (b).)	☐ No	(If "No," go on to item 19.)
(b) If "Yes," list the country(ies)				
(c) Are you filing for foreign Social Security benefits?				

19. (a) Have you qualified for, or do you expect to qualify for, a pension or annuity (or a lump sum in place of a pension or annuity) based on your own employment and earnings for the Federal Government of the United States, or one of its States or local subdivisions that was not covered under Social Security? (Social Security benefits are not government pensions.)	☐ Yes	(If "Yes," check which of the items in item (b) applies to you.)	☐ No	(If "No," go on to item 20.)

(b)

☐ I receive a government pension or annuity.

☐ I received a lump sum in place of a government pension or annuity.

☐ I applied for and am awaiting a decision on my pension or lump sum.

☐ I have not applied for but I expect to begin receiving my pension or annuity:

Unknown

(Month, day, year)

(If the date is not known, enter "Unknown".)

MEDICARE INFORMATION

If this claim is approved and you are still entitled to benefits at age 65, or you are within 3 months of Age 65 or older you could automatically receive Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage at age 65. If you live in Puerto Rico or a foreign country, you are not eligible for automatic enrollment in Medicare Part B, and you will need to contact Social Security to request enrollment.

COMPLETE ITEM 20 ONLY IF YOU ARE WITHIN 3 MONTHS OF AGE 65 OR OLDER

Medicare Part B (Medical Insurance) helps cover doctor's services and outpatient care. It also covers some other services that Medicare Part A doesn't cover, such as some of the services of physical and occupational therapists and some home health care. If you enroll in Medicare Part B, you will have to pay a monthly premium. The amount of your premium will be determined when your coverage begins. In some cases, your premium may be higher based on information about your income we receive from the Internal Revenue Service. Your premiums will be deducted from any monthly Social Security, Railroad Retirement, or Office of Personnel Management benefits you receive. If you do not receive any of these benefits, you will get a letter explaining how to pay your premiums. You will also get a letter if there is any change in the amount of your premium.

You can also enroll in a Medicare prescription drug plan (Part D). To learn more about the Medicare prescription drug plans and when you can enroll visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Medicare also can tell you about agencies in your area that can help you choose your prescription drug coverage. The amount of your premium varies based on the prescription drug plan provider. The amount you pay for Part D coverage may be higher than the listed plan premium, based on information about your income we receive from the Internal Revenue Service.

If you have limited income and resources, we encourage you to apply for the Extra Help that is available to assist you with Medicare prescription drug costs. The Extra Help can pay the monthly premiums, annual deductibles and prescription co-payments. To learn more or apply, please visit www.ssa.gov, call 1-800-772-1213 (TTY 1-800-325-0778) or visit the nearest Social Security office.

20.Do you want to enroll in the Medicare Part B (Medical Insurance)?	☐ Yes	☐ No

ANSWER ITEM 21 ONLY IF THE DECEASED DIED BEFORE THIS YEAR.

21 (a) How much were your total earnings last year? $

(b) Place an "X" in each block for each month of last year in which you did not earn more than *$_____ in wages, and did not perform substantial services in self-employment. These months are exempt months. If no months were exempt months, place an "X" in "NONE." If all months were exempt months, place an "X" in "ALL."

*Enter the appropriate monthly limit after reading the information, "How Work Affects Your Benefits" (Publication No. 05-10069).

NONE ☐		ALL ☐	
Jan. ☐	Feb. ☐	Mar. ☐	Apr. ☐
May ☐	Jun. ☐	Jul. ☐	Aug. ☐
Sept. ☐	Oct. ☐	Nov. ☐	Dec. ☐

22 (a) How much do you expect your total earnings to be this year? $

(b) Place an "X" in each block for each month of this year in which you did not or will not earn more than *$ _____ in wages, and did not or will not perform substantial services in self-employment. These months are exempt months. If no months are or will be exempt months, place an "X" in "NONE." If all months are or will be exempt months, place an "X" in "ALL."

*Enter the appropriate monthly limit after reading the information, "How Work Affects Your Benefits" (Publication No. 05-10069).

NONE ☐		ALL ☐	
Jan. ☐	Feb. ☐	Mar. ☐	Apr. ☐
May ☐	Jun. ☐	Jul. ☐	Aug. ☐
Sept. ☐	Oct. ☐	Nov. ☐	Dec. ☐

ANSWER ITEM 23 ONLY IF YOU ARE NOW IN THE LAST 4 MONTHS OF YOUR TAXABLE YEAR (SEPT., OCT., NOV., AND DEC., IF YOUR TAXABLE YEAR IS A CALENDAR YEAR).

23 (a) How much do you expect to earn next year? $

(b) Place an "X" in each block for each month of next year in which you do not expect to earn more than *$ _____ in wages, and do not expect to perform substantial services in self-employment. These months will be exempt months. If no months are expected to be exempt months, place an "X" in "NONE." If all months are expected to be exempt months, place an "X" in "ALL."

*Enter the appropriate monthly limit after reading the information, "How Work Affects Your Benefits."

NONE ☐		ALL ☐	
Jan. ☐	Feb. ☐	Mar. ☐	Apr. ☐
May ☐	Jun. ☐	Jul. ☐	Aug. ☐
Sept. ☐	Oct. ☐	Nov. ☐	Dec. ☐

24 If you use a fiscal year, that is, a taxable year that does not end December 31 (with income tax return due April 15), enter here the month your fiscal year ends. Month: 12

IF YOU ARE FULL RETIREMENT AGE OR OLDER, GO ON TO ITEM 26. OTHERWISE, PLEASE READ CAREFULLY THE INFORMATION ON PAGE 8 AND ANSWER ONE OF THE FOLLOWING ITEMS.

25 After reading the information on page 8, check one of thefollowing:

(a) I want benefits beginning with the earliest possible month. ☐

(b) I am full retirement age (or will be within 4 months) and I want benefits beginning with the earliest possible month, providing that there is no permanent reduction in my ongoing monthly benefits. ☐

(c) I want benefits beginning with 0 . I understand that either a higher initial payment or a higher continuing monthly benefit amount may be possible, but I choose not to take it. ☐

ANSWER QUESTION 26 ONLY IF YOU ARE NOW AT LEAST AGE 61 YEARS, 8 MONTHS.

26. Do you wish this application to be considered an application for retirement benefits on your own earnings record? ☐ Yes ☐ No

REMARKS *(You may use this space for any explanations. If you need more space, attach a separate sheet.)*

See attached...

Direct Deposit Payment Address (Financial Institution)

Routing Transit Number	Account Number	☐ Checking	☐ Enroll in Direct Express
		☐ Savings	☐ Direct Deposit Refused

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to fine or imprisonment, or both.

SIGNATURE OF APPLICANT	Date (Month, day, year) 2/6/2026
Signature (First name, middle initial, last name) (**Write in ink**)	Telephone number(s) at which you may be contacted during the day
	AREA CODE 111-111-1111

Applicant's Mailing Address (Number and street, Apt. No., P.O. Box, or Rural Route)
(Enter Residence Address in "Remarks," if different.)

1 Mailing Ave PO Box 5

City and State	ZIP Code	Country (if any) in which you now live
Los Angeles CA	11223	USA

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in the Signature block.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY BENEFITS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	**BEFORE** YOU RECEIVE A NOTICE OF AWARD	SSA OFFICE	DATE CLAIM RECEIVED
	AFTER YOU RECEIVE A NOTICE OF AWARD		

Your application for Social Security benefits has been received and will be processed as quickly as possible.

You should hear from us within ____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect your claim, you - or someone for you - should report the change. The changes to be reported are listed on page 8. Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	DECEASED'S SURNAME IF DIFFERENT FROM CLAIMANT'S	BENEFICIARY NOTICE CONTROL (BNC) NUMBER

PRIVACY ACT NOTICE
Collection and Use of Personal Information

Sections 202(e) and 202(f) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate and timely decision on your entitlement for widow or widower benefits.

We will use the information to make a determination for entitlement to widow or widower benefits. We may also share your information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for assisting Social Security Administration (SSA) in the efficient administration of its programs. We contemplate disclosing information under this routine use only in situations in which SSA may enter a contractual or similar agreement, with a third party to assist in accomplishing an agency function relating to this system of records; and

- To third party contacts, especially in situations where the party to be contacted has, or is expected to have, information relating to the individual' capability to manage his/her affairs or his/her eligibility for or entitlement to benefits under the Social Security
program; when the data are needed to establish the validity of evidence; to verify the accuracy of information presented by the individual and, if it concerns his/her eligibility for benefits under the Social Security program.

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' 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 Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784 and 60-0090 entitled Master Beneficiary Record, as published in the FR on January 11, 2006, at 71 FR 1826. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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 30 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments relating to this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.**

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAID, AND IN POSSIBLE MONETARY PENALTIES.

- You change your mailing address for checks or residence. (To avoid delay in receipt of checks, you should ALSO file a regular change of address notice with your post office.)
- Your citizenship or immigration status changes.
- You go outside the U.S.A. for 30 consecutive days or longer.
- Any beneficiary dies or becomes unable to handle benefits.
- Work Changes - On your application you told us you expect total earnings for _____ to be $ _____ .

You ☐ (are) ☐ (are not) earning wages of more than $ _____ a month

You ☐ (are) ☐ (are not) self-employed rendering substantial services in your trade or business.

(Report AT ONCE if this work pattern changes.)

- Change of Marital Status - Marriage, divorce, annulment of marriage. You must report a change in marital status even if you believe that an exception applies.
- You are confined for more than 30 continuous days to jail, prison, penal institution, or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.
- Custody Change - Report if a person for whom you are filing, or who is in your care dies, leaves your care or custody, or changes address.
- You begin to receive a pension, annuity, or a lump sum payment based on your government employment not covered by Social Security or your pension or annuity amount changes or stops.
- You have an unsatisfied warrant for more than 30 continuous days for your arrest for a crime or attempted crime that is a felony or flight to avoid prosecution or confinement, escape from custody, and flight-escape. In most jurisdictions that do not classify crimes as felonies, this applies to a crime that is punishable by death or imprisonment for a term exceeding 1 year (regardless of the actual sentence imposed).

Disability Applicants

1. You return to work (as an employee or self-employed) regardless of amount of earnings.
2. Your condition improves.

WORK AND EARNINGS

For those under full retirement age, the law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return (if applicable) as the report of earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct. You must furnish additional information as needed when your benefit adjustment is not correct based on the earnings on your record.

HOW TO REPORT

You can make your reports by telephone, mail, in person, or online, whichever you prefer. If you are awarded benefits, and one or more of the above change(s) occur, you should report by:

- Visiting the section "Online Services" at our web site at www.ssa.gov;
- Calling us TOLL FREE at 1-800-772-1213;
- If you are deaf or hearing impaired, calling us TOLL FREE at TTY 1-800-325-0778; or
- Calling, visiting or writing your local Social Security office shown at the phone number and address on your claim receipt.

For general information about Social Security, visit our web site at www.ssa.gov.

FIGURING YOUR YEARLY EARNINGS

To figure your total yearly earnings, count all gross wages (before deductions) and net earnings from self-employment which you earn during the entire year. This includes earnings both before and after your retirement date, and applies to all earned income whether or not covered by Social Security.

In figuring your total yearly earnings, however, DO NOT COUNT ANY AMOUNTS EARNED BEGINNING WITH THE MONTH YOU ATTAIN FULL RETIREMENT AGE. Count only amounts earned before the you attain full retirement age.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE ANSWERING QUESTION 28.

Benefits may be payable for some months prior to the month in which you file this claim (but not for any month before you reach age 60 (unless you are disabled)) if:

- YOU WILL EARN OVER THE EXEMPT AMOUNT THIS YEAR.

(For the appropriate exempt amount, see "How Work Affects Your Benefits" (Publication No. 05-10069)

If your first month of entitlement is prior to full retirement age, your benefit rate will be reduced. However, if you do not actually receive your full benefit amount for one or more months before full retirement age because benefits are withheld due to your earnings, your benefit will be increased at full retirement age to give credit for this withholding. Thus, your benefit amount at full retirement age will be reduced only if you receive one or more full benefit payments prior to the month you attain full retirement age.

15a. Marriage performed by:

Form **SSA-16** (09-2025) UF
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0618

APPLICATION FOR DISABILITY INSURANCE BENEFITS

(Do not write in this space)

I apply for a period of disability and/or all insurance benefits for which I am eligible under Title II and Part A of Title XVIII of the Social Security Act, as presently amended.

1.	**PRINT your name**	FIRST NAME, MIDDLE INITIAL, LAST NAME	Jason N Mraz
2.	Enter your Social Security Number		111-23-4444

Answer question 3 if English is not your preferred language. Otherwise, go to item 4.

3.	Enter the language you prefer to:	speak Spanish	write Arabic
4.	(a) Enter your date of birth		1/1/1972
	(b) Enter name of city and state or foreign country where you were born.		Los Angeles, US
5.	(a) Are you a U.S. citizen?	☑ Yes (If "Yes," go to item 6)	☐ No (If "No," answer (b))
	(b) Are you an alien lawfully present in the U.S.?	☐ Yes (If "Yes," answer (c))	☑ No (If "No," go to item 6)
	(c) When were you lawfully admitted to the U.S.?		
6.	(a) Enter your name at birth if different from item (1)		Jason Neal Jones
	(b) Have you used any other names?	☑ Yes (If "Yes," answer (c))	☐ No (If "No," go to item 7)
	(c) Other name(s) used.		Jason Neal Marx
7.	(a) Have you used any other Social Security number(s)?	☑ Yes (If "Yes," answer (b))	☐ No (If "No" go to item 8)
	(b) Enter Social Security number(s) used.		444-23-1111
8.	When do you believe your condition(s) became severe enough to keep you from working (even if you have never worked)?		12/1/2025
9.	Did you or your spouse (or prior spouse) work in the railroad industry for 5 years or more?	☐ Yes	☑ No
10.	(a) Do you have Social Security credits (for example, based on work or residence) under another country's Social Security System?	☐ Yes (If "Yes," answer (b))	☑ No (If "No," go to item 11)
	(b) List the country(ies):		

11. (a) Have you ever been married? ☑ Yes (If "Yes," answer (b)) ☐ No (If "No," go to item 12)

(b) Give the following information about your current marriage. If not currently married, write "None." _____ (If "None," go on to item 12(c))

Spouse's name (including maiden name)	When (Month, day, year)	Where (Name of City and State)
Maria Lydia Mraz	1/1/2025	San Diego

Marriage performed by:	Spouse's date of birth (or age)	Spouse's Social Security Number (If none or unknown, so indicate)
☐ Clergyman or public official ☑ Other (Explain in Remarks)	2/2/1971	123-99-9999

(c) Enter information about any other marriage if you:

- Had a marriage that lasted at least 10 years; or
- Had a marriage that ended due to the death of your spouse, regardless of duration; or
- Were divorced, remarried the same individual within the year immediately following the year of the divorce, and the combined period of marriage totaled 10 years or more. If none, write "None." _____ Go on to item 12 (d) if you have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22) and you are divorced from the child's other parent who is now deceased and the marriage lasted less than 10 years.

Spouse's name (including maiden name)	When (Month, day, year)	Where (Name of City and State)
Louisa	1/2/2001	Detroit

How marriage ended	When (Month, day, year)	Where (Name of City and State)
Divorce	1/2/2004	Ann Arbor

Marriage performed by:	Spouse's date of birth (or age)	Date of spouse's death	Spouse's Social Security Number (If none or unknown, so indicate)
☐ Clergyman or public official ☑ Other (Explain in Remarks)	40	1/1/2010	123-88-8885

(d) Enter information about any marriage if you:

- Have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22); and
- Were married for less than 10 years to the child's mother or father, who is now deceased; and
- The marriage ended in divorce

If none, write "None." None

Spouse's name (including maiden name)	When (Month, day, year)	Where (Name of City and State)

Date of divorce (Month, day, year)	Where (Name of City and State)

Marriage performed by:	Spouse's date of birth (or age)	Date of spouse's death	Spouse's Social Security Number (If none or unknown, so indicate)
☐ Clergyman or public official ☐ Other (Explain in Remarks)			

Use the "REMARKS" space on page 5 for marriage continuation or explanation.

12. If your claim for disability benefits is approved, your children (including adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) may be eligible for benefits based on your earnings record.

List below: FULL NAME OF ALL such children who are now or were in the past 12 months UNMARRIED and:

- UNDER AGE 18
- AGE 18 TO 19 AND ATTENDING ELEMENTARY OR SECONDARY SCHOOL FULL-TIME
- DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)

Mandy J Mraz, Sarah J Mraz, Luis C Mraz, Linda M Mraz

13.	(a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year?	☑ Yes (If "Yes," go to item 14) ☐ No (If "No," answer (b))
	(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.	

14. Enter below the names and addresses of all the persons, companies, or Government agencies for whom you have worked this year and last year. IF NONE, WRITE "NONE" BELOW AND GO TO ITEM 16.

NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer)	Work Began		Work Ended (If still working show "Not Ended")	
	MONTH	YEAR	MONTH	YEAR
Amber's Automobiles	1	2000	1	2026
Amber's Automobiles 1 Amber Ln Santa Monica, CA 12333	1	2000	1	2026
Jason Mraz LTD	1	1980	1	2026

(If you need more space, use "Remarks".)

15. Complete item 15 even if you were an employee.

	(a) Were you self-employed this year or last year?		☑ Yes (If "Yes," answer (b)) ☐ No (If "No," go to item 16)
	(b) Check the year (or years) you were self-employed	In what type of trade/business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from the trade or business $400 or more? (Check "Yes" or "No")
	☑ This year	Singer	
	☑ Last year	Singer	☐ Yes ☑ No

16.	(a) How much were your total earnings last year? Count both wage and self-employment income. (If none, write "None.") _____	Amount $ $1
	(b) How much have you earned so far this year? (If none, write "None.") _____	Amount $ None
17.	(a) Are you still unable to work because of your illnesses, injuries, or conditions?	☑ Yes (If "Yes," go to item 18) ☑ No (If "No," answer (b))
	(b) Enter the date you became able to work.	MONTH, DAY, YEAR
18.	Are your illnesses, injuries, or conditions related to your work in any way?	☐ Yes ☑ No
19.	Are you blind or do you have low vision even with glasses or contacts?	☑ Yes ☐ No

20.	(a) Have you filed, or do you intend to file, for any other public disability benefits (including workers' compensation, Black Lung benefits and SSI)?	☐ Yes (If "Yes," answer (b)) ☑ No (If "No," go to item 21)
	(b) The other public disability benefit(s) you have filed (or intend to file) for is (Check as many as apply): ☐ Veterans Administration Benefits ☐ Welfare ☐ Supplemental Security Income ☐ Other (If "Other," complete a Workers' Compensation/Public Disability Benefit Questionnaire)	
21.	(a) Did you receive any money from an employer(s) on or after the date in item 8 when you became unable to work because of your illnesses, injuries, or conditions? If "Yes", give the amounts and explain in "Remarks".	☑ Yes ☐ No Amount $ _____
	(b) Do you expect to receive any additional money from an employer, such as sick pay, vacation pay, other special pay? If "Yes," please give amounts and explain in "Remarks".	☐ Yes ☑ No Amount $ _____
22.	Do you, or did you, have a child under age 3 (your own or your spouse's) living with you in one or more calendar years when you had no earnings?	☐ Yes ☑ No
23.	Do you have a dependent parent who was receiving at least one-half support from you when you became unable to work because of your disability? If "Yes," enter the parent's name and address and Social Security number, if known, in "Remarks".	☐ Yes ☑ No
24.	If you were unable to work before age 22 because of an illness, injury or condition, do you have a parent (including adoptive or stepparent) or grandparent who is receiving social security retirement or disability benefits or who is deceased? If yes, enter the name(s) and Social Security number, if known, in "Remarks" (if unknown, check "Unknown").	☐ Yes ☑ No ☐ Unknown

REMARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

See attached

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF APPLICANT	Date (Month, Day, Year) 2/11/2026
Signature (First name, middle initial, last name) (Write in ink)	Telephone Number(s) at which you may be contacted during the day. (Include the area code) 111-111-1111

DIRECT DEPOSIT PAYMENT INFORMATION (FINANCIAL INSTITUTION)

Routing Transit Number	Account Number	☐ Checking ☐ Savings	☐ Enroll in Direct Express ☐ Direct Deposit Refused

Applicant's Mailing Address *(Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)*

City and State	ZIP Code	County *(if any)* in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in Signature block.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State and ZIP Code)*	Address *(Number and street, City, State and ZIP Code)*

FOR YOUR INFORMATION

An agency in your State that works with us in administering the Social Security disability program is responsible for making the disability decision on your claim. In some cases, it is necessary for them to get additional information about your condition or to arrange for you to have a medical examination at Government expense.

Privacy Act Statement
Collection and Use of Information

Sections 202, 205, 223(a), and 226 of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on the claim for benefits.

We will use the information you provide to establish or determine benefits eligibility. We may also share the information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of our programs; and

- To student volunteers, individuals working under a personal services contract, and other workers who technically do not have the status of Federal employees, when they are performing work for SSA, as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned agency functions.

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 Notices (SORN) 60-0059, entitled Earnings Recording and Self-Employment Income System, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819 and 60-0089, entitled Claims Folders System, as published in the FR on October 31, 2019, at 84 FR 58422. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov. **Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

Person to Contact About Your Claim	SSA OFFICE	Date Claim Received
Telephone Number (Include Area Code)		

Your application for Social Security disability benefits has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect your claim, you - or someone for you - should report the change. The changes to be reported are listed below.

Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	SOCIAL SECURITY CLAIM NUMBER

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAID

- You change your mailing address for checks or residence. To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.
- Your citizenship or immigration status changes.
- You go outside the U.S.A. for 30 consecutive days or longer.
- Any beneficiary dies or becomes unable to handle benefits.
- Custody Change - Report if a person for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.
- You are confined to a jail, prison, penal institution or correctional facility for more than 30 continuous days for conviction of a crime, or you are confined for more than 30 continuous days to a public institution by a court order in connection with a crime.
- You become entitled to a pension, an annuity, or a lump sum payment based on your employment not covered by Social Security, or if such pension or annuity stops.
- Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.
- You have an unsatisfied warrant for more than 30 continuous days for your arrest for a crime or attempted crime that is a felony of flight to avoid prosecution or confinement, escape from custody and flight-escape. In most jurisdictions that do not classify crimes as felonies, this applies to a crime that is punishable by death or imprisonment for a term exceeding one year (regardless of the actual sentence imposed).
- You have an unsatisfied warrant for more than 30 continuous days for a violation of probation or parole under Federal or State law.
- Change of Marital Status - Marriage, divorce, annulment of marriage.
- If you become the parent of a child (including an adopted child) after you have filed your claim, let us know about the child so we can decide if the child is eligible for benefits. Failure to report the existence of these children may result in the loss of possible benefits to the child(ren).
- You return to work (as an employee or self-employed) regardless of amount of earnings.
- Your condition improves.
- You are under full retirement and you apply for or begin to receive workers' compensation (including black lung benefits) or another public disability benefit, or the amount of your present workers' compensation or public disability benefit changes or stops, or you receive a lump-sum settlement.

HOW TO REPORT

You can make your reports online, by telephone, mail, or in person, whichever you prefer. If you are awarded benefits, and one or more of the above change(s) occur, you should report by:

- Visiting the section "my Social Security" at our web site at www.socialsecurity.gov;
- Calling us TOLL FREE at 1-800-772-1213;
- If you are deaf or hearing impaired, calling us TOLL FREE at TTY 1-800-325-0778; or
- Calling, visiting or writing your local Social Security office at the phone number and address shown on your claim receipt.

For general information about Social Security, visit our web site at www.socialsecurity.gov.

12b. Marriage performance details: Friend

12c. Marriage performance details: Clown

12c. Prior Marriages (Continued):
Kylie
Married on 2/1/1990 in Las Vegas, null
Cause of separation: Death
Ended on 1/1/2000 in Reno, null
Officiant Details: null
2/2/1980
Date of Death: 1/1/2000
SSN: Unknown

15. Jobs This and Last Year (Continued):
Jason Mraz LTD
Address:
Start: 1/1980 | End: 1/2026

21a. Reason:

SSA 16 Remarks

Form **SSA-3368-BK** (06-2024) UF
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0579

DISABILITY REPORT - ADULT

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that makes the disability decision on your case will use the information you provide in this report to decide whether you are disabled. Please complete as much of the report as you can.

You may be able to apply online at: www.ssa.gov/apply.

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or is expected to result in death. So when we ask "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. **Please do not ask your healthcare provider to complete this report.** If you cannot complete the report, you may contact us at 1-800-772-1213 (TTY 1-800-325-0778). A Social Security Representative will assist you. Have the information available from the bulleted items below when you call us. If you have an appointment, please have the information available, or the completed report ready when we contact you. If we ask you to do so, please mail the completed report to us ahead of time. **If you cannot speak or understand English, we will provide an interpreter free of charge.**

YOUR MEDICAL RECORDS

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS. If you have consented to us obtaining medical records from your providers, we will request your records directly from them. The information that you give us on this report tells us where to request your medical and other records.

WHAT YOU NEED TO COMPLETE THIS REPORT

- Names, addresses, and phone numbers of two people (other than your doctors) we can contact who know about your medical condition(s) and can help with your case, if needed.
- Information about any education you have completed.
- Information about all the jobs you had in the 5 years before you became unable to work.
- Any prescription or non-prescription medicines you take.
- Names, addresses, and phone numbers of any healthcare providers and information about the medical treatment you received, or testing performed.
- If you cannot remember information about your healthcare providers, the treatment you received, or the testing performed, you may be able to get that information from the telephone book, the Internet, an online medical chart, medical bills, prescriptions, or prescription medicine containers.
- If you cannot remember exact dates, provide the closest date you can remember.
- Name of organization(s) we can contact that would have medical information about your condition(s), such as Department of Veterans Affairs, social services agencies, vocational rehabilitation agencies, welfare agencies, attorneys, prisons, workers' compensation, and insurance companies who have paid you disability benefits.
- Information about any vocational rehabilitation, employment, or other support services if you are receiving Supplemental Security Income (SSI).
- **ANSWER EVERY QUESTION,** unless the report indicates otherwise: Provide as much detail as possible. If you do not know an answer, or the answer is "none" or "does not apply," please write "don't know," or "none," or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you want to provide additional information. If you need more space to answer any question, use **Section 11 - Remarks**.

HOW TO SUBMIT THIS REPORT

Send or bring this completed report to your local Social Security office. If you have internet access, you can locate your nearest Social Security office by ZIP code at www.socialsecurity.gov/locator. Our offices are also listed under U.S. Government agencies in your telephone directory, or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), and 1631 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 prevent an accurate and timely decision on any claim filed.

We will use the information to determine eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To applicants, claimants, prospective applicants or claimants, other than the data subject, and their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (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 Systems of Records Notice (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS

DISABILITY REPORT ADULT	**For SSA Use Only- Do not write in this box.** **Related SSN Number Holder**

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION 1 - INFORMATION ABOUT YOU

When a question refers to "you" or "your," it refers to the person who is applying for disability benefits. **If you are completing this report for someone else**, provide information about them.

1.A. NAME (First, Middle Initial, Last, Suffix)	**1.B.** SOCIAL SECURITY NUMBER
Jason N Mraz	111-23-4444

1.C. Have you used any other names on your medical or educational records? Examples include maiden name, other married names, other names, or nickname. ☑ YES ☐ NO

If YES, please list names used: Jason Neal Jones, Jason Neal Marx

1.D. MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.

1 Mailing Ave, PO Box 5

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (If not USA)
Los Angeles	CA	11223	USA

1.E. EMAIL ADDRESS

jasonm@testnt.com

1.F. DAYTIME PHONE NUMBER(S) where we can call to speak with you or leave a message, if needed. Include area code or IDD and country code if outside the USA or Canada.

Primary: 111-111-1111 Secondary: (if available) _____

1.G. Can you speak and understand English? ☑ YES ☐ NO

If NO, what language do you prefer? _____

If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.H. Can you read and understand English? ☑ YES ☐ NO

1.I. Can you write more than your name in English? ☑ YES ☐ NO

SECTION 2 - CONTACTS

Is there someone we can contact who can help with your claim, if needed? Examples include a family member, friend, or neighbor.

☑ YES Please provide the names of two people **(other than your doctors)** we can contact who know about your medical condition(s) and can help you with your claim and can help us reach you if you become unavailable.

☐ NO **We recommend that you provide at least one contact, if available.** Providing the name of someone who knows you may help us to make a decision on your claim.

2.A. NAME (First, Middle Initial, Last)	**2.B.** Relationship to the Person in **1.A.**
Maria L Mraz	Family Member

2.C. MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.

1 Mailing Ave PO Box 5

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Los Angeles	CA	11223	USA

2.D. DAYTIME PHONE NUMBER (as described in **1.F.** above)

221-112-1212

SECTION 2 - CONTACTS (continued)

2.E. Can this person speak and understand English? ☑ YES ☐ NO

If NO, what language is preferred?

2.F. NAME (First, Middle Initial, Last)	**2.G.** Relationship to the Person in **1.A.**
Mandy J Mraz	Child

2.H. MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

2.I. DAYTIME PHONE NUMBER (as described in **1.F.** above)

2.J. Can this person speak and understand English? ☑ YES ☐ NO

If NO, what language is preferred?

SECTION 3 - MEDICAL INFORMATION

3.A. Separately list each physical and/or mental condition that limits your ability to work. If you have cancer, please include the type and stage.

1. DDD
2. Depression
3. Hypertension
4. ADHD
5.

If you need more space, go to Section 11

3.B. What is your height? 5 feet 7 inches OR ____ centimeters

3.C. What is your weight? 190 pounds OR ____ kilograms

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

☐ NO, I have never worked (Go to question **4.B.**)

☑ NO, I have stopped working (Go to question **4.C.**)

☐ YES, I am currently working (Go to question **4.F.**)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your conditions(s) became severe enough to keep you from working (even though you have never worked)? (MM/DD/YYYY) _____ (Go to **Section 5**)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (MM/DD/YYYY) 1/1/2026

Why did you stop working?

☐ Because of my condition(s).

☑ Because of other reasons.

Please explain why you stopped working. Examples include laid off, early retirement, seasonal work ended, or business closed.

Because it was so hard

Even though you stopped working for other reasons, when do you believe your conditions(s) became severe enough to keep you from working? (MM/DD/YYYY) 12/1/2025

SECTION 4 - WORK ACTIVITY (continued)

4.D. Did your condition(s) cause you or your employer to make changes in your work activity? Examples include job duties, hours, or rate of pay.

☐ NO (Go to **Section 5**)

☑ YES, When did the changes start? (MM/DD/YYYY) 12/1/2025

4.E. Since the date in **4.D.** above, have you had earnings greater than $1,550 before tax in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ YES (Go to **Section 5**) ☑ NO (Go to **Section 5**)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you or your employer to make changes in your work activity? Examples include job duties, hours, or rate of pay.

☐ YES When did the changes start? (MM/DD/YYYY) _____

☐ NO When did your condition(s) first start bothering you? (MM/DD/YYYY) _____

4.G. Since your condition(s) first bothered you, have you had earnings greater than $1,550 before tax in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ YES ☐ NO

SECTION 5 - EDUCATION, TRAINING, AND LITERACY

5.A. Select the highest level of school completed, including homeschooling, online education, and education received in another country.

															College:			
0	K	1	2	3	4	5	6	7	8	9	10	11	12	GED	1	2	3	4 or more
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐

Date completed: 5/2000 (MM/YYYY)

Name of school: Mraz High School

City: San Bernadino State/Province: CA Country (if not USA): US

5.B. Were you in special education? ☐ NO (Go to **5.C.**) ☑ YES (Complete below)

Dates from: 1/1998 (MM/YYYY) to 5/1999 (MM/YYYY)

If YES, select the last grade you were in special education.

Pre K	K	1	2	3	4	5	6	7	8	9	10	11	12
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐

Reason(s) for special education: ADHD

The school where you were last in special education:

☐ Same as **5.A.**

☐ If different from **5.A.**, complete below.

Name of school: Special Ed Mraz

City: Oakland State/Province: CA Country (if not USA): US

SECTION 5 - EDUCATION, TRAINING, AND LITERACY (continued)

5.C. Have you received any type of **training** (specialized job, trade, or vocational training)?

☐ NO (Go to **5.D.**) ☑ YES (Complete the table below.)

NAME OF TRAINING FACILITY	PHONE NUMBER
Trucking LTD	111-444-4444

ADDRESS			
1 Trucking Ln			
CITY	**STATE/Province**	**ZIP/Postal Code**	**COUNTRY (if not USA)**
Oakland	CA	55555	US

TYPE OF PROGRAM	Date Completed (or scheduled to be completed)
Truck Drivin	1/1998 (MM/YYYY)

5.D. What written language do you use every day in most situations (at home, work, school, in community, etc.)?

Arabic

5.E. READING - In the language you identified in **5.D.**, can you read a simple message, such as a shopping list or short and simple notes? ☑ YES ☐ NO

5.F. WRITING - In the language you identified in **5.D.**, can you write a simple message, such as a shopping list or short and simple notes? ☑ YES ☐ NO

SECTION 6 - WORK HISTORY

(If you need more space, use Section 11)

6.A. Did you have a job in the 5 years before you became unable to work because of your medical conditions?

☐ NO (Go to **Section 7**) ☑ YES (Complete the table below.)

List all the jobs you had in the 5 years before you became unable to work because of your medical conditions:

- List your most recent job first
- List all job titles even if they were for the same employer
- **Do not include jobs you held less than 30 calendar days**
- Include self-employment (e.g., rideshare driver, hair stylist)
- Include work in a foreign country

	Job Title (e.g., Cashier)	**Type of Business** (e.g., Grocery Store)	**Dates Worked** From: MM/YYYY	**Dates Worked** To: MM/YYYY	**Hours per Day**	**Days per Week**	**Rate of Pay** Amount	**Rate of Pay** Frequency (per) hour, day, week, month, or year
1.	Driver	Car Lot	1/2000	1/2026	8	5	15	hourly
2.	Singer	Entertainment	1/1980	1/2026	4	5	100	daily
3.	Driver	Car Lot	1/2000	1/2026	8	5	15	hourly
4.	Singer	Entertainment	1/1980	1/2026	4	5	100	daily
5.								

SECTION 6 - WORK HISTORY (continued)

Check the box below that applies to you.

☑ **I had more than one job.** (If you had more than one job, we may contact you for more information. **Do not** answer the questions in **Section 6.B** through **6.D**. Go to **Section 7**.)

☐ I had **only one job**. (If you had only one job, complete the questions in **6.B.** through **6.D.**)

6.B. Information about your work

6.B.1. For the job you listed in **6.A.**, describe in detail the tasks you did in a typical workday. Examples of tasks include stocking shelves, greeting customers, scheduling appointments, or maintaining records.

6.B.2. If any of the tasks listed above involved writing or completing reports, describe the type of report you wrote or completed and how much time you spent on it per workday or workweek.

6.B.3. If any of the tasks listed above involved supervising others, describe who or what you supervised and what supervisory duties you had. Examples of supervisory duties include evaluating employee job performance, making schedules, or maintaining time records.

6.B.4. List the machines, tools, and equipment you used regularly when doing this job and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.

6.B.5. Did this job require you to interact with coworkers, the general public, or anyone else? ☐ YES ☐ NO

If YES, **describe** who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek. Examples include answering customer questions on the telephone for 5 hours per day or showing clients sale properties in person for 4 hours per day.

SECTION 6 - WORK HISTORY (continued)

6.C. Physical and environmental requirements of your work

Tell us how much time you spent doing the following physical activities in a typical workday. The total hours/minutes for standing, walking, and sitting should equal the Hours per Day reported in **6.A.** The example below shows an 8-hour workday with 2 hours standing and walking and 6 hours sitting (8 hours total).

Activity	How much of your workday? (Hours/Minutes)	Example:
Standing and walking (combined)		2 hours
Sitting		6 hours
Stooping (i.e., bending down & forward at waist)		15 minutes
Kneeling (i.e., bending legs to rest on knees)		15 minutes
Crouching (i.e., bending legs & back down & forward)		None
Crawling (i.e., moving on hands and knees)		None
Using fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt): ☐ One Hand ☐ Both Hands		2 hours (both hands)
Using hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a hammer, or water bottle): ☐ One Hand ☐ Both Hands		1 hour (both hands)
Reaching at or below the shoulder: ☐ One Arm ☐ Both Arms		1 hour (both arms)
Reaching overhead (above the shoulder): ☐ One Arm ☐ Both Arms		None
Climbing stairs or ramps		None
Climbing ladders, ropes, or scaffolds		None

If you need more space, use **Section 11**

Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.

Select the **heaviest** weight lifted:

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs.
☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

Select the weight **frequently** lifted (i.e., 1/3 to 2/3 of the workday):

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs.
☐ 50 lbs. or more ☐ Other _____

Did this job expose you to any of the following? Check all that apply.

☐ Outdoors ☐ Extreme heat (non-weather related) ☐ Extreme cold (non-weather related)
☐ Wetness ☐ Humidity ☐ Hazardous substances
☐ Moving mechanical parts ☐ High, exposed places ☐ Heavy vibrations
☐ Loud noise ☐ Other

If one or more boxes are checked, tell us about the exposure(s) and how often you were exposed.

SECTION 6 - WORK HISTORY (continued)

6.D. Explain how your medical conditions would affect your ability to do this job.

SECTION 7 - MEDICINES

7. Are you currently taking any prescription or non-prescription medicine(s)?

☐ NO (Go to **Section 8**)

☐ YES (Complete the information below. You may need to look at your medicine containers.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE DOCTOR NAME (IF KNOWN)	REASON FOR MEDICINE (IF KNOWN)
Ativan	Dr. Jones	
Percocet	Mario Brothers MD	
TYLENOL Extra Strength	Mario Brothers MD	DDD

If you need to list more medicines, use **Section 11.**

SECTION 8 - MEDICAL TREATMENT

8.A. Have you seen or received treatment from a healthcare provider (doctor, hospital, clinic, psychiatrist, nurse practitioner, therapist, physical therapist, or other medical professional), or **do you have a future appointment scheduled**?

☐ NO (Go to **Section 9**)

☑ YES (Complete the chart(s) below)

You may find this information on medical bills, online medical chart, or the Internet.

8.A.1.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU
Dr. Jones	

What medical conditions were treated or evaluated?
ADHD, Depression

PHONE NUMBER	DATE FIRST SEEN:	DATE LAST SEEN:	DATE OF NEXT APPOINTMENT: (IF KNOWN)
124-444-4000	1/1980 MM/YYYY	1/2026 MM/YYYY	2/2026 MM/YYYY

ADDRESS
3 Jones Rd

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Los Angeles	CA	11111	US

8.A.2.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU
Mario Brothers MD	

What medical conditions were treated or evaluated?
DDD

PHONE NUMBER	DATE FIRST SEEN:	DATE LAST SEEN:	DATE OF NEXT APPOINTMENT: (IF KNOWN)
555-555-5555	2/1980 MM/YYYY	2/2025 MM/YYYY	11/2026 MM/YYYY

ADDRESS
3 Mario Ln

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Rhedondo Beach	CA	00000	US

8.A.3.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN:	DATE LAST SEEN:	DATE OF NEXT APPOINTMENT: (IF KNOWN)
	MM/YYYY	MM/YYYY	MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

SECTION 8 - MEDICAL TREATMENT (continued)

8.A.4

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

8.A.5.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

8.A.6.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

If you need to list more facilities or healthcare providers, use **Section 11.**

SECTION 8 - MEDICAL TREATMENT (continued)

8.B. Did any of the healthcare providers listed in **8.A.** order any medical tests for you? Include tests already performed and scheduled in the future.

☑ NO (Go to **Section 9**)

☐ YES (Select tests from the chart below)

TEST	NAME OF HEALTHCARE PROVIDER OR FACILITY	DATE OF TEST (MM/YYYY)
Blood test (not HIV)		
Breathing test		
Cardiac catheterization		
EEG (brain wave test)		
EKG (heart test)		
Hearing test		
HIV test		
Speech/language test		
Treadmill (exercise test)		
Vision test		
Psychological/IQ test		
Biopsy (list body part):		
MRI/CT scan (list body part):		
X-ray (list body part):		
Other - please specify:		

If you need to list more tests, use **Section 11.**

SECTION 9 - OTHER MEDICAL INFORMATION

9. Does anyone else (other than your healthcare providers) have your medical information? Examples include Department of Veterans Affairs, social service agencies, vocational rehabilitation agencies, welfare agencies, attorneys, prisons, workers' compensation, and insurance companies who have paid you disability benefits.

☐ NO (Go to **Section 10** if you are receiving Supplemental Security Income (SSI) and have been asked to complete this report; if not, go to **Section 11**.)

☑ YES (Complete the information below)

NAME OF ORGANIZATION	PHONE NUMBER
Workers Comp	111-455-8888

ADDRESS
8 WC Ln

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Los Angeles	CA	11223	US

NAME OF CONTACT PERSON	CLAIM NUMBER (if any)
Mary Margo	123

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts
For Fun

If you need to list other people or organizations, use **Section 11**

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.

SECTION 10 - SUPPORT SERVICES

Provide information about your participation in support services, if applicable. Examples of support services can include:

- An Individualized Education Program (IEP) through a school (if a student aged 18-21)
- An individual work plan with an employment network under the Ticket to Work Program
- A Plan to Achieve Self-Support (PASS)
- An individualized plan for employment with a vocational rehabilitation agency or any other organization

10.A. Have you participated or are you participating in any support services mentioned above or any other vocational rehabilitation, employment services, or other support services to help you to go to work?

☐ YES (Complete the information below) ☐ NO (Go to **Section 11**)

10.B. FACILITY OR ORGANIZATION NAME	PHONE NUMBER

COUNSELOR, INSTRUCTOR, OR JOB COACH NAME

ADDRESS (Street or PO Box) Include Suite, Building, etc.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

SECTION 10 - SUPPORT SERVICES (continued)

10.C. Are you still participating in the plan or program? (Select answer below)

☐ YES Date began: _____ (MM/YYYY) Expected completion date: _____ (MM/YYYY)

☐ NO Date began: _____ (MM/YYYY) Date stopped: _____ (MM/YYYY)

Reason stopped: _____

10.D. What types of services, tests, or evaluation were provided?

Select all that apply:

☐ Vision test ☐ Psychological/IQ test ☐ Work classes ☐ Hearing test ☐ Work evaluation

☐ Other - Please explain: _____

If you need to list another plan or program, use **Section 11**

SECTION 11 - REMARKS

Please provide any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to provide the requested information, please use this space to provide the additional information requested in those sections. Be sure to include the section and question number to which you are referring.

See attached...

If you need additional space, use **Section 11 - Remarks (continued)**

SECTION 11 - Remarks (continued)

SECTION 12 - WHO IS COMPLETING THIS REPORT

Date Report Completed (MM/DD/YYYY) 2/12/2026

Who is completing this report?

- ☐ The person listed in **1.A.**
- ☐ The person listed in **2.A.**
- ☐ The person listed in **2.F.**
- ☑ Someone else (Complete the information below)

NAME (First, Middle Initial, Last)	Relationship to the Person in **1.A.**
Shmuel Chaikin	Legal Assistant to Claimant's Attorney

MAILING ADDRESS (Street or PO Box) Include the apartment number, if applicable.
P.O. Box 580

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Roseville	California	95661	

DAYTIME PHONE NUMBER where we may reach you or leave a message, if needed. Include the area code or IDD and country code if outside the USA or Canada.
1-877-529-4773

daily activities are affected
Specialists List
Restrictions
MAD list
Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 3368Notes for 33

Form **SSA-3369-BK** (06-2024) UF
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0578

WORK HISTORY REPORT

PLEASE READ ALL OF THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that makes the disability decision on your case will use the information you provide in this report to understand how your illnesses, injuries, or conditions might affect your ability to do work for which you are qualified. This information tells us about the kinds of work that you did, including the physical and mental requirements of each job.

IF YOU NEED HELP

If you need help with this report, complete as much of it as you can. Then call the phone number provided on the letter sent with the report or the phone number of the person who asked you to complete the report for help to finish it. **If you cannot speak or understand English, we will provide an interpreter free of charge.**

WHAT YOU NEED TO COMPLETE THIS REPORT

- Information about all the jobs that you had in the last 5 years before you became unable to work.
- **ANSWER EVERY QUESTION FOR EACH JOB YOU DESCRIBE** unless the report indicates otherwise. Provide as much detail as possible.
- If you cannot remember all the information about your jobs, provide what you do remember. If you do not know an answer, or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you want to provide additional information.
- If you need more space to answer any questions, use **Section 3 - Remarks.**

REMEMBER TO PROVIDE THE INFORMATION ABOUT THE PERSON COMPLETING THIS REPORT IN SECTION 4.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), and 1631 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 prevent an accurate and timely decision on any claim filed.

We will use the information to make a determination on eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs; and

- To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

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 Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 control number. We estimate that it will take about 40 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE STATE AGENCY THAT REQUESTED IT. If you have questions about how to complete the form, contact the State Agency that requested it. If you need the address or phone number for your State Agency, you can get it by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate or any other aspects of this collection to this address, not the completed form.***

AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS

Form **SSA-3369-BK** (06-2024) UF
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Social Security Administration

OMB No. 0960-0578

WORK HISTORY REPORT

For SSA Use Only- Do not write in this box.
Related SSN Number Holder

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION 1 - INFORMATION ABOUT YOU

When a question refers to "you" or "your," it refers to the person who is applying for disability benefits. **If you are completing this report for someone else**, provide information about them.

A. NAME (First, Middle Initial, Last, Suffix)	B. SOCIAL SECURITY NUMBER
Jason Neal Mraz	111-23-4444

C. DAYTIME PHONE NUMBER(S) where we can call to speak with you or leave a message, if needed. Include area code or IDD and country code if outside the USA or Canada.

Primary: 111-111-1111 Secondary: (if available) 222-222-2222

SECTION 2 - WORK HISTORY

List all the jobs you had in the **5 years before you became unable to work** because of your medical conditions:

- List your most recent job first
- List all job titles even if they were for the same employer
- **Do not include jobs you held less than 30 calendar days**
- Include self-employment (e.g., rideshare driver, hair stylist)
- Include work in a foreign country

	Job Title (e.g., Cashier)	**Type of Business** (e.g., Grocery Store)	**Dates Worked**	
			From (MM/YYYY)	**To** (MM/YYYY)
1.	Driver	Car Lot	1/2000	1/2026
2.	Driver	Car Lot	1/2000	1/2026
3.	Singer	Entertainment	1/1980	1/2026
4.	Singer	Entertainment	1/1980	1/2026
5.				
6.				
7.				
8.				
9.				
10.				

SECTION 2 - WORK HISTORY (continued)

Provide more information about Job No. 1 listed in Section 2. Estimate hours and pay, if needed. If you need more space, use section 3.

JOB TITLE NO. 1 Driver

Rate of Pay	Per *(Check One)*					Hours per Day	Days per Week
$15	☑ Hour	☐ Day	☐ Week	☐ Month	☐ Year	8	5

For the job you listed in **Job Title No. 1**, describe in detail the tasks you did in a typical workday. Examples of tasks include stocking shelves, greeting customers, scheduling appointments, or maintaining records.

If any of the tasks listed above involved writing or completing reports, describe the type of report you wrote or completed and how much time you spent on it per workday or workweek.

If any of the tasks listed above involved supervising others, describe who or what you supervised and what supervisory duties you had. Examples of supervisory duties include evaluating employee job performance, making schedules, or maintaining time records.

List the machines, tools, and equipment you used regularly when doing this job, and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.

Did this job require you to interact with coworkers, the general public, or anyone else? ☐ YES ☑ NO

If YES, describe who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek. Examples include answering customer questions on the telephone for 5 hours per day or showing clients properties for sale in person for 4 hours per day.

SECTION 2 - WORK HISTORY (continued)

Tell us how much time you spent doing the following physical activities in a typical workday. The total hours/minutes for standing, walking, and sitting should equal the Hours per Day. The example below shows an 8-hour workday with 2 hours standing and walking, and 6 hours sitting (8 hours total).

Activity	How much of your workday? (Hours/Minutes)	Example:
Standing and walking (combined)		2 hours
Sitting		6 hours
Stooping (i.e., bending down & forward at waist)		15 minutes
Kneeling (i.e., bending legs to rest on knees)		15 minutes
Crouching (i.e., bending legs & back down & forward)		None
Crawling (i.e., moving on hands and knees)		None
Using fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt): ☐ One Hand ☐ Both Hands		2 hours (both hands)
Using hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a hammer, or water bottle): ☐ One Hand ☐ Both Hands		1 hour (both hands)
Reaching at or below the shoulder: ☐ One Arm ☐ Both Arms		1 hour (both arms)
Reaching overhead (above the shoulder): ☐ One Arm ☐ Both Arms		None
Climbing stairs or ramps		None
Climbing ladders, ropes, or scaffolds		None

Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.

Select the **heaviest** weight lifted:

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs.
☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

Select the weight **frequently** lifted (i.e., 1/3 to 2/3 of the workday):

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

Did this job expose you to any of the following? Check all that apply.

☐ Outdoors ☐ Extreme heat (non-weather related) ☐ Extreme cold (non-weather related) ☐ Wetness
☐ Humidity ☐ Hazardous substances ☐ Moving mechanical parts ☐ High, exposed places
☐ Heavy vibrations ☐ Loud noises ☐ Other _____

If one or more boxes are checked, tell us about the exposure(s) and how often you were exposed.

Explain how your medical conditions would affect your ability to do this job.

SECTION 2 - WORK HISTORY (continued)

Provide more information about Job No. 2 listed in Section 2. Estimate hours and pay, if needed. If you need more space, use section 3.

JOB TITLE NO. 2 Driver

Rate of Pay	Per *(Check One)*	Hours per Day	Days per Week
$15	☑ Hour ☐ Day ☐ Week ☐ Month ☐ Year	8	5

For the job you listed in **Job Title No. 2**, describe in detail the tasks you did in a typical workday. Examples of tasks include stocking shelves, greeting customers, scheduling appointments, or maintaining records.

Describe Tasks

If any of the tasks listed above involved writing or completing reports, describe the type of report you wrote or completed and how much time you spent on it per workday or workweek.

Writing

If any of the tasks listed above involved supervising others, describe who or what you supervised and what supervisory duties you had. Examples of supervisory duties include evaluating employee job performance, making schedules, or maintaining time records.

Supervising

List the machines, tools, and equipment you used regularly when doing this job, and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.

Machines

Did this job require you to interact with coworkers, the general public, or anyone else? ☑ YES ☐ NO

If YES, describe who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek. Examples include answering customer questions on the telephone for 5 hours per day or showing clients properties for sale in person for 4 hours per day.

interacted

SECTION 2 - WORK HISTORY (continued)

Tell us how much time you spent doing the following physical activities in a typical workday. The total hours/minutes for standing, walking, and sitting should equal the Hours per Day.

Activity		How much of your workday? (Hours/Minutes)
Standing and walking (combined)		1 Hour 1 Minute
Sitting		2 hours
Stooping (i.e., bending down & forward at waist)		3 hours
Kneeling (i.e., bending legs to rest on knees)		4 hours
Crouching (i.e., bending legs & back down & forward)		5 hours
Crawling (i.e., moving on hands and knees)		6 hours
Using fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt):	☑ One Hand ☐ Both Hands	7 hours
Using hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a hammer, or water bottle):	☐ One Hand ☑ Both Hands	8 hours 15 minutes
Reaching at or below the shoulder:	☑ One Arm ☐ Both Arms	1 hour
Reaching overhead (above the shoulder):	☐ One Arm ☑ Both Arms	2 hours
Climbing stairs or ramps		3 hours
Climbing ladders, ropes, or scaffolds		4 hours 1 minute

Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.
lifting

Select the **heaviest** weight lifted:

☐ Less than 1 lb. ☑ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs.
☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

Select the weight **frequently** lifted (i.e., 1/3 to 2/3 of the workday):

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☑ Other 200

Did this job expose you to any of the following? Check all that apply.

☑ Outdoors ☐ Extreme heat (non-weather related) ☐ Extreme cold (non-weather related) ☐ Wetness
☐ Humidity ☐ Hazardous substances ☐ Moving mechanical parts ☐ High, exposed places
☐ Heavy vibrations ☑ Loud noises ☑ Other exposed

If one or more boxes are checked, tell us about the exposure(s) and how often you were exposed.
exposure detail

Explain how your medical conditions would affect your ability to do this job.
I could no longer drive

SECTION 2 - WORK HISTORY (continued)

Provide more information about Job No. 3 listed in Section 2. Estimate hours and pay, if needed. If you need more space, use section 3.

JOB TITLE NO. 3 Singer

Rate of Pay	Per *(Check One)*					Hours per Day	Days per Week
$100	☐ Hour	☑ Day	☐ Week	☐ Month	☐ Year	4	5

For the job you listed in **Job Title No. 3**, describe in detail the tasks you did in a typical workday. Examples of tasks include stocking shelves, greeting customers, scheduling appointments, or maintaining records.

If any of the tasks listed above involved writing or completing reports, describe the type of report you wrote or completed and how much time you spent on it per workday or workweek.

If any of the tasks listed above involved supervising others, describe who or what you supervised and what supervisory duties you had. Examples of supervisory duties include evaluating employee job performance, making schedules, or maintaining time records.

List the machines, tools, and equipment you used regularly when doing this job, and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.

Did this job require you to interact with coworkers, the general public, or anyone else? ☐ YES ☑ NO

If YES, describe who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek. Examples include answering customer questions on the telephone for 5 hours per day or showing clients properties for sale in person for 4 hours per day.

SECTION 2 - WORK HISTORY (continued)

Tell us how much time you spent doing the following physical activities in a typical workday. The total hours/minutes for standing, walking, and sitting should equal the Hours per Day.

Activity		How much of your workday? (Hours/Minutes)
Standing and walking (combined)		
Sitting		
Stooping (i.e., bending down & forward at waist)		
Kneeling (i.e., bending legs to rest on knees)		
Crouching (i.e., bending legs & back down & forward)		
Crawling (i.e., moving on hands and knees)		
Using fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt):	☐ One Hand ☐ Both Hands	
Using hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a hammer, or water bottle):	☐ One Hand ☐ Both Hands	
Reaching at or below the shoulder:	☐ One Arm ☐ Both Arms	
Reaching overhead (above the shoulder):	☐ One Arm ☐ Both Arms	
Climbing stairs or ramps		
Climbing ladders, ropes, or scaffolds		

Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.

Select the **heaviest** weight lifted:

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs.
☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

Select the weight **frequently** lifted (i.e., 1/3 to 2/3 of the workday):

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

Did this job expose you to any of the following? Check all that apply.

☐ Outdoors ☐ Extreme heat (non-weather related) ☐ Extreme cold (non-weather related) ☐ Wetness
☐ Humidity ☐ Hazardous substances ☐ Moving mechanical parts ☐ High, exposed places
☐ Heavy vibrations ☐ Loud noises ☐ Other _____

If one or more boxes are checked, tell us about the exposure(s) and how often you were exposed.

Explain how your medical conditions would affect your ability to do this job.

SECTION 2 - WORK HISTORY (continued)

Provide more information about Job No. 4 listed in Section 2. Estimate hours and pay, if needed. If you need more space, use section 3.

JOB TITLE NO. 4 Singer

Rate of Pay	Per *(Check One)*					Hours per Day	Days per Week
$100	☐ Hour	☑ Day	☐ Week	☐ Month	☐ Year	4	5

For the job you listed in **Job Title No. 4**, describe in detail the tasks you did in a typical workday. Examples of tasks include stocking shelves, greeting customers, scheduling appointments, or maintaining records.
detail tasks 2

If any of the tasks listed above involved writing or completing reports, describe the type of report you wrote or completed and how much time you spent on it per workday or workweek.
writing 2

If any of the tasks listed above involved supervising others, describe who or what you supervised and what supervisory duties you had. Examples of supervisory duties include evaluating employee job performance, making schedules, or maintaining time records.
supervise2

List the machines, tools, and equipment you used regularly when doing this job, and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.
machines 2

Did this job require you to interact with coworkers, the general public, or anyone else? ☑ YES ☐ NO

If YES, describe who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek. Examples include answering customer questions on the telephone for 5 hours per day or showing clients properties for sale in person for 4 hours per day.
public 2

SECTION 2 - WORK HISTORY (continued)

Tell us how much time you spent doing the following physical activities in a typical workday. The total hours/minutes for standing, walking, and sitting should equal the Hours per Day.

Activity		How much of your workday? (Hours/Minutes)
Standing and walking (combined)		9 Hours
Sitting		8 hours
Stooping (i.e., bending down & forward at waist)		7 hours 1 minute
Kneeling (i.e., bending legs to rest on knees)		6 hours
Crouching (i.e., bending legs & back down & forward)		5 hours
Crawling (i.e., moving on hands and knees)		4 hours
Using fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt):	☐ One Hand ☑ Both Hands	3 hours
Using hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a hammer, or water bottle):	☑ One Hand ☐ Both Hands	2 hours
Reaching at or below the shoulder:	☐ One Arm ☑ Both Arms	1 hour 30 minutes
Reaching overhead (above the shoulder):	☑ One Arm ☐ Both Arms	0 hours
Climbing stairs or ramps		1 hour
Climbing ladders, ropes, or scaffolds		2 hours

Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.
lifting 2

Select the **heaviest** weight lifted:

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs.
☐ 50 lbs. ☐ 100 lbs. or more ☑ Other 300

Select the weight **frequently** lifted (i.e., 1/3 to 2/3 of the workday):

☐ Less than 1 lb. ☐ Less than 10 lbs. ☑ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other

Did this job expose you to any of the following? Check all that apply.

☐ Outdoors ☐ Extreme heat (non-weather related) ☑ Extreme cold (non-weather related) ☐ Wetness
☐ Humidity ☐ Hazardous substances ☑ Moving mechanical parts ☑ High, exposed places
☐ Heavy vibrations ☐ Loud noises ☐ Other

If one or more boxes are checked, tell us about the exposure(s) and how often you were exposed.
exposures detail 2

Explain how your medical conditions would affect your ability to do this job.
couldn't focus

SECTION 2 - WORK HISTORY (continued)

Provide more information about Job No. 5 listed in Section 2. Estimate hours and pay, if needed. If you need more space, use section 3.

JOB TITLE NO. 5 _____

Rate of Pay	Per *(Check One)*	Hours per Day	Days per Week
$ _____	☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year		

For the job you listed in **Job Title No. 5**, describe in detail the tasks you did in a typical workday. Examples of tasks include stocking shelves, greeting customers, scheduling appointments, or maintaining records.

If any of the tasks listed above involved writing or completing reports, describe the type of report you wrote or completed and how much time you spent on it per workday or workweek.

If any of the tasks listed above involved supervising others, describe who or what you supervised and what supervisory duties you had. Examples of supervisory duties include evaluating employee job performance, making schedules, or maintaining time records.

List the machines, tools, and equipment you used regularly when doing this job, and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.

Did this job require you to interact with coworkers, the general public, or anyone else? ☐ YES ☐ NO

If YES, describe who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek. Examples include answering customer questions on the telephone for 5 hours per day or showing clients properties for sale in person for 4 hours per day.

SECTION 2 - WORK HISTORY (continued)

Tell us how much time you spent doing the following physical activities in a typical workday. The total hours/minutes for standing, walking, and sitting should equal the Hours per Day.

Activity		How much of your workday? (Hours/Minutes)
Standing and walking (combined)		
Sitting		
Stooping (i.e., bending down & forward at waist)		
Kneeling (i.e., bending legs to rest on knees)		
Crouching (i.e., bending legs & back down & forward)		
Crawling (i.e., moving on hands and knees)		
Using fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt):	☐ One Hand ☐ Both Hands	
Using hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a hammer, or water bottle):	☐ One Hand ☐ Both Hands	
Reaching at or below the shoulder:	☐ One Arm ☐ Both Arms	
Reaching overhead (above the shoulder):	☐ One Arm ☐ Both Arms	
Climbing stairs or ramps		
Climbing ladders, ropes, or scaffolds		

Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.

Select the **heaviest** weight lifted:

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs.
☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

Select the weight **frequently** lifted (i.e., 1/3 to 2/3 of the workday):

☐ Less than 1 lb. ☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

Did this job expose you to any of the following? Check all that apply.

☐ Outdoors ☐ Extreme heat (non-weather related) ☐ Extreme cold (non-weather related) ☐ Wetness
☐ Humidity ☐ Hazardous substances ☐ Moving mechanical parts ☐ High, exposed places
☐ Heavy vibrations ☐ Loud noises ☐ Other _____

If one or more boxes are checked, tell us about the exposure(s) and how often you were exposed.

Explain how your medical conditions would affect your ability to do this job.

SECTION 3 - REMARKS

Please provide any additional information you did not give in earlier parts of this report. If you did not have enough space in the prior sections of this report to provide the requested information, please use this space to provide the additional information requested in those sections. Be sure to include the job title number and question to which you are referring. If you add more jobs than the 5 jobs listed, please provide the same information as you did for job titles numbers 1-5 on a separate sheet of paper(s).

BE SURE TO COMPLETE THE BOTTOM OF THIS PAGE.

SECTION 4 - WHO IS COMPLETING THIS REPORT

Date Report Completed (MM/DD/YYYY) 2/6/2026

Who is completing this report?

☐ The person listed in **1.A.**

☑ Someone else (Complete the information below)

NAME (First, Middle Initial, Last)	Relationship to the Person in **1.A.**
Sarah Luna	Legal Assistant to Claimant's Attorney

MAILING ADDRESS (Street or PO Box) Include the apartment number, if applicable.
P.O. Box 580

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
Roseville	California	95661	

DAYTIME PHONE NUMBER where we may reach you or leave a message, if needed. Include the area code or IDD and country code if outside the USA or Canada.
1-877-529-4773

Form **SSA-3373** (02-2024) UF
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Social Security Administration

OMB No. 0960-0681

FUNCTION REPORT - ADULT

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213.

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.

It is important that you tell us about your activities and abilities.

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 10, and show the number of the question being answered.
- If a specific activity is performed with the help of others, please indicate that.

REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM ON PAGE 10

Privacy Act Statements
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631 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 prevent an accurate and timely decision on any claim filed.

We will use the information you provide to determine benefits eligibility. We may also share the information for the following purposes, called routine uses:

- To third party contacts (e.g., employers and private pension plans) in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his or her benefits or payments, or his or her eligibility for entitlement to benefits or eligibility for payments, under the Social Security program; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement to obtain assistance in accomplishing an SSA function relating to this system record.

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 Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on June 6, 2020 at 85 FR 34477. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 control number. We estimate that it will take about 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate or other aspects of this collection to this address, not the completed form.***

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Form **SSA-3373** (02-2024) UF
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0681

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only

Do not write in this box.

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle Initial, Last)*	2. **SOCIAL SECURITY NUMBER**
Jason N Mraz	111-23-4444

3. **YOUR DAYTIME TELEPHONE NUMBER** *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

111 (*Area Code*) 111-1111 (*Phone Number*) ☑ Your Number ☐ Message Number ☐ None

4. a. Where do you live? *(Check one.)*

☑ House ☐ Apartment ☐ Boarding House ☐ Nursing Home
☐ Shelter ☐ Group Home ☐ Other *(What?)* _____

b. With whom do you live? *(Check one.)*

☑ Alone ☐ With Family ☐ With Friends
☐ Other *(Describe relationship.)* _____

SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

5. How do your illnesses, injuries, or conditions limit your ability to work?

It was so hard

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

Describe what you do from the time you wake up until going to bed.

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? ☑ Yes ☐ No

If "YES," for whom do you care, and what do you do for them?

For whom do you care, and what do you do for them?

8. Do you take care of pets or other animals? ☑ Yes ☐ No

If "YES," what do you do for them?

What do you do for them?

9. Does anyone help you care for other people or animals?

If "YES," who helps, and what do they do to help? ☑ Yes ☐ No

Who helps and what do they do to help?

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

What were you able to do before your illnesses, injuries, or conditions that you can't do now?

11. Do the illnesses, injuries, or conditions affect your sleep? ☑ Yes ☐ No

If "YES," how?

How?

12. **PERSONAL CARE** (Check here ☐ if **NO PROBLEM** with personal care.)

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress Dress

Bathe bathe

Care for hair Care for hair

Shave shave

Feed self feed self

Use the toilet use the toilet

Other other

b. Do you need any special reminders to take care of personal needs and grooming? ☑ Yes ☐ No

If "YES," what type of help or reminders are needed?

What type of help or reminders are needed?

c. Do you need help or reminders taking medicine? ☑ Yes ☐ No

If "YES," what kind of help do you need?

What kind of help do you need?

13. **MEALS**

a. Do you prepare your own meals? ☑ Yes ☐ No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.)

What kind of food do you prepare? (Examples: sandwiches, frozen dinners, or complete meals with several courses)

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

How often do you prepare food? (Examples: daily, weekly, monthly)

How long does it take you? How long does it take you?

Any changes in cooking habits since the illness, injuries, or conditions began?

Any changes in cooking habits since the illness, injuries, or conditions began?

b. If "No," explain why you cannot or do not prepare meals.

14. **HOUSE AND YARD WORK**

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.)

List household chores, both indoors and outdoors, that you are able to do (Examples: cleaning, laundry, household repairs, ironing, mowing, etc.)

b. How much time does it take you, and how often do you do each of these things?

How much time does it take you and how often do you do each of these things?

c. Do you need help or encouragement doing these things? ☑ Yes ☐ No

If "YES," what help is needed?

What help is needed?

d. If you don't do house or yard work, explain why not.

If you do not do house or yard work, explain why not.

15. GETTING AROUND

a. How often do you go outside? How often do you go outside?

If you don't go out at all, explain why not.

If you don't go out at all, explain why not.

b. When going out, how do you travel? *(Check all that apply.)*

☑ Walk ☐ Drive a car ☑ Ride in a car ☐ Ride a bicycle

☑ Use public transportation ☑ Other *(Explain)* other

c. When going out, can you go out alone? ☐ Yes ☑ No

If "NO," explain why you can't go out alone.

Explain why you can not go out alone.

d. Do you drive? ☐ Yes ☑ No

If you don't drive, explain why not.

Explain why you don't drive.

16. **SHOPPING**

a. If you do any shopping, do you shop: *(Check all that apply.)*

☑ In stores ☐ By phone ☑ By mail ☐ By computer

b. Describe what you shop for.

Describe what you shop for.

c. How often do you shop and how long does it take?

How often do you shop and how long does it take?

17. **MONEY**

a. Are you able to:

Pay bills	☐ Yes	☑ No	Handle a savings account	☐ Yes	☑ No
Count change	☑ Yes	☐ No	Use a checkbook/money orders	☑ Yes	☐ No

Explain all "NO" answers.

Explain all "no" answers.

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? ☑ Yes ☐ No

If "YES," explain how the ability to handle money has changed.

Explain how the ability to handle money has changed.

18. HOBBIES AND INTERESTS

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

What are your hobbies and interests? (For example: reading, watching TV, sewing, playing sports, etc.)

b. How often and how well do you do these things?

How often and how well do you do these things?

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

Describe any changes in these activities since the illnesses, injuries, or conditions began.

19. SOCIAL ACTIVITIES

a. How do you spend time with others? *(Check all that apply.)*

☑ In person ☐ On the phone ☑ Email ☐ Texting ☑ Mail
☐ Video Chat (for example Skype or Facetime) ☑ Other *(Explain)* If other, explain:

b. Describe the kinds of things you do with others.

Describe the kinds of things you do with others.

How often do you do these things? How often do you do these things?

c. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)

List the places you go on a regular basis (Examples: church, community center, sports events, social groups, etc.)

Do you need to be reminded to go places? ☑ Yes ☐ No

How often do you go and how much do you take part?

How often do you go and how much do you take part?

Do you need someone to accompany you? ☑ Yes ☐ No

If "YES", explain.

Explain why you need someone to accompany you.

d. Do you have any problems getting along with family, friends, neighbors, or others? ☑ Yes ☐ No
If "YES," explain.

Explain why you have problems getting along with others.

e. Describe any changes in social activities since the illnesses, injuries, or conditions began.

Describe any changes in social activities since the illnesses, injuries, or conditions began.

SECTION D - INFORMATION ABOUT ABILITIES

20. a. Check any of the following items that your illnesses, injuries, or conditions affect:

☑ Lifting	☐ Walking	☑ Stair Climbing	☐ Understanding
☐ Squatting	☑ Sitting	☐ Seeing	☑ Following Instructions
☑ Bending	☐ Kneeling	☑ Memory	☐ Using Hands
☐ Standing	☑ Talking	☐ Completing Tasks	☑ Getting Along With Others
☑ Reaching	☐ Hearing	☑ Concentration	

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far])

Please explain how your illnesses, injuries, or conditions affect each of the items you (see remarks)

b. Are you: ☑ Right Handed? ☐ Left Handed?

c. How far can you walk before needing to stop and rest? How far can you walk before (see remarks)

If you have to rest, how long before you can resume walking?

If you have to rest, how long before you can resume walking?

d. For how long can you pay attention? For how long can you pay attention?

e. Do you finish what you start? *(For example, a conversation, chores, reading, watching a movie.)* ☐ Yes ☑ No

f. How well do you follow written instructions? (For example, a recipe.)

How well do you follow written instructions? (Example: a recipe)

g. How well do you follow spoken instructions?

How well do you follow written instructions? (Example: a recipe)

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.)

i. Have you ever been fired or laid off from a job because of problems getting along with other people? ☑ Yes ☐ No

If "YES," please explain.

If you have been fired because of problems getting along with others, please explain.

If "YES," please give name of employer. Name of employer you were fired or laid off by:

j. How well do you handle stress?

How well do you handle stress?

k. How well do you handle changes in routine?

How well do you handle changes in routine?

l. Have you noticed any unusual behavior or fears? ☑ Yes ☐ No

If "YES," please explain.

Please explain any unusual behaviors or fears.

21. Do you use any of the following? *(Check all that apply.)*

☑ Crutches	☐ Cane	☑ Hearing Aid
☐ Walker	☑ Brace/Splint	☐ Glasses/Contact Lenses
☑ Wheelchair	☐ Artificial Limb	☑ Artificial Voice Box

☑ Other (Explain) If other, explain.

Which of these were prescribed by a doctor?

Which of these were prescribed by a doctor?

When was it prescribed?

When was this prescribed?

When do you need to use these aids?

When do you need to use these aids?

22. Do you currently take any medicines for your illnesses, injuries, or conditions? ☑ Yes ☐ No

If "YES, "do any of your medicines cause side effects? ☑ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE	SIDE EFFECTS YOU HAVE
Ativan	Sedation, Loss of Balance, Aches
Percocet	Nausea, Constipation, Somnolence, Vomiting

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

See attached...

Name of person completing this form (Please print)	Date *(MM/DD/YYYY)*
Sarah Luna Legal Asst. to Claimants Atty	2/11/2026

Address (Number and Street)	Email address (optional)	
PO Box 580		
City	**State**	**ZIP Code**
Roseville	CA	95661

20a. (Continued): checked (Examples: you can only lift ___, you can only walk ___)

20c. Distance (Continued): needing to stop and rest?

Form **SSA-8001-BK** (07-2023) UF
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0444

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)
(Deferred or Abbreviated)

Do Not Write in This Space

I am/We are applying for Supplemental Security Income and any federally administered state supplementation under Title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under Title XIX of the Social Security Act.

☐ DEFERRED	☐ ABAP
☐ SNAP-SSA/APP	☐ SNAP-REFERRED
Filing Date (MM/DD/YYYY) 2/13/2026	
☐ Receipt	☐ Protective
Preferred Language:	
Written: Arabic	
Spoken: Spanish	

TYPE OF CLAIM ☑ Individual ☐ Individual with Ineligible Spouse ☐ Couple ☐ Child ☐ Child with Parent(s)

PART 1 - BASIC ELIGIBILITY - Answer the questions below beginning with the first moment of the filing date month.

1(a) First Name, Middle Initial, Last Name	(b) Birthdate (MM/DD/YYYY)	(c) Social Security Number
Jason N Mraz	1/1/1972	111-23-4444
2(a) If filing as spouse or couple Spouse's Name(s)	(b) Birthdate (MM/DD/YYYY)	(c) Social Security Number(s)
3(a) If filing for child Parent 1's Name(s)	(b) Birthdate (MM/DD/YYYY)	(c) Social Security Number(s)
(d) If filing for child Parent 2's Name(s)	(e) Birthdate (MM/DD/YYYY)	(f) Social Security Number(s)

4(a) Are you married?
☑ YES ☐ NO, Go to #5.
(b) Date of Marriage (MM/DD/YYYY) 1/1/2025

(c). Are you and your spouse living together?
☐ YES ☑ NO If no, date you began living apart 1/2/2026

5(a) Are you and another person living together in the same household and presenting to others or the community as a married couple?
☐ YES, provide the date holding out began (MM/DD/YYYY) _____ . Go to (b).
☑ NO Go to #6.

*(b) Other person's name (First, middle initial, last)	(c) Other person's Social Security Number

*Use SSA-4178 to develop the holding out relationship.

6. Other Name(s) and Social Security Number(s) you or your spouse used. If filing for child benefits go to (c) and (d).

(a) Your Other Name(s) (including Name at Birth) Jason Neal Jones, Jason Neal Marx	Social Security Number 444-23-1111
(b) Spouse's Other Name(s) (including Name at Birth)	Social Security Number
(c) Parent 1's Other Name(s) (including Name at Birth)	Social Security Number
(d) Parent 2's Other Name(s) (including Name at Birth)	Social Security Number

7. Your Place of Birth (City and State or Foreign Country)

Los Angeles

8. Spouse's Place of Birth (City and State or Foreign Country)

9. If you are filing for yourself, go to (a); if you are filing for a child, go to (e).

	You		Your Spouse, if filing	
(a) Are you unable to work or is your work limited because of illnesses, injuries, or conditions?	☑ YES Go to (b)	☐ NO Go to #10	☐ YES Go to (b)	☐ NO Go to #10
(b) Enter the date you became unable to work	(MM/DD/YYYY) Go to (c)		(MM/DD/YYYY) Go to (c)	
(c) Are you blind or do you have low vision even with glasses or contacts?	☑ YES	☐ NO Go to (d)	☐ YES	☐ NO Go to (d)

(d) If you were unable to work because of illnesses, injuries, or conditions before age 22, do you have a parent or stepparent who is age 62 or older, unable to work because of illnesses, injuries, or conditions, or deceased?	☐ YES Provide name(s) and Social Security Number(s) in Remarks Go to #10	☑ NO Go to #10
(e) When did the child become disabled? (MM/DD/YYYY) Go to (f)		
(f) Is the child blind or does he or she have low vision even with glasses or contacts?	☐ YES Go to (g)	☐ NO Go to (g)
(g) Does the child have a parent or stepparent who is 62 or older, unable to work because of illnesses, injuries, or conditions, or deceased?	☐ YES Provide name(s) and Social Security Number(s) in Remarks Go to #10	☐ NO Go to #10

10. If you (and your spouse filing for benefits) were a United States citizen at birth, go to #14; otherwise go to (a).

	You		Your Spouse, if filing	
(a) Are you a naturalized United States citizen?	☐ YES Go to #14	☐ NO Go to (b)	☐ YES Go to #14	☐ NO Go to (b)
(b) Are you an American Indian born outside the United States?	☐ YES Go to (c)	☐ NO Go to (d)	☐ YES Go to (c)	☐ NO Go to (d)

10. (c) Check the block that shows your American Indian status.

You	Your Spouse, if filing
☐ American Indian born in Canada — Go to #14	☐ American Indian born in Canada — Go to #14
☐ Member of a Federally recognized Indian Tribe; Name of Tribe: — Go to #14	☐ Member of a Federally recognized Indian Tribe; Name of Tribe: — Go to #14
☐ Other American Indian — Explain in Remarks, then Go to (d)	☐ Other American Indian — Explain in Remarks, then Go to (d)

(d) Check the block below that shows your current immigration status.

You	Your Spouse, if filing
☐ **Amerasian Immigrant** — Go to #11	☐ **Amerasian Immigrant** — Go to #11
☐ **Asylee** Date status granted (MM/DD/YYYY): — Go to #13	☐ **Asylee** Date status granted (MM/DD/YYYY): — Go to #13
☐ **Conditional Entrant** Date status granted (MM/DD/YYYY): — Go to #13	☐ **Conditional Entrant** Date status granted (MM/DD/YYYY): — Go to #13
☐ **Cuban/Haitian Entrant** — Go to #13	☐ **Cuban/Haitian Entrant** — Go to #13
☐ **Deportation/Removal Withheld** Date (MM/DD/YYYY): — Go to #13	☐ **Deportation/Removal Withheld** Date (MM/DD/YYYY): — Go to #13
☐ **Lawful Permanent Resident** — Go to #11	☐ **Lawful Permanent Resident** — Go to #11
☐ **Parolee for One Year** — Go to #13	☐ **Parolee for One Year** — Go to #13
☐ **Refugee** Date of entry (MM/DD/YYYY): — Go to #13	☐ **Refugee** Date of entry (MM/DD/YYYY): — Go to #13
☐ Unknown/Other — Explain in Remarks, then Go to (e)	☐ Unknown/Other — Explain in Remarks, then Go to (e)

(e) If you have status, or have applied for status, as the spouse, child, or parent of a child of a United States citizen, or a lawfully admitted permanent resident, Go to #12; otherwise, Go to #14.

	You	Your Spouse, if filing
11(a) Date of admission:	(MM/DD/YYYY)	(MM/DD/YYYY)
(b) Was your entry into the United States sponsored by any person or promoted by an institution or group?	☐ YES Go to (c) ☑ NO Go to (d)	☐ YES Go to (c) ☐ NO Go to (d)

(c) Give the following information about the person, institution or group:

Name	Address	Phone Number

	You	Your Spouse, if filing
(d) What was your immigration status, if any, before adjustment to lawful permanent resident?	(MM/DD/YYYY) From: To:	(MM/DD/YYYY) From: To:
(e) If filing as an adult, did your parents ever work in the United States before you were 18?	☐ YES Go to (f) ☑ NO Go to #13	☐ YES Go to (f) ☐ NO Go to #13

(f) Name and Social Security Number of parent(s) who worked.

Name	Social Security Number
Name	Social Security Number

	You	Your Spouse, if filing
12(a) Have you, your child, or your parent, been subjected to battery or extreme cruelty while in the United States?	☐ YES Go to (b) ☑ NO Go to #14	☐ YES Go to (b) ☐ NO Go to #14
(b) Have you, your child, or your parent filed a petition with the Department of Homeland Security for a change in immigration status because of being subjected to battery or extreme cruelty?	☐ YES Go to #14 ☑ NO Go to #14	☐ YES Go to #14 ☐ NO Go to #14
13. Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	☐ YES Explain in Remarks, then Go to #14 ☐ NO Go to #14	☐ YES Explain in Remarks, then Go to #14 ☐ NO Go to #14
14(a) When did you first make your home in the United States?	(MM/DD/YYYY) 1/1/1972	(MM/DD/YYYY)
(b) Have you lived outside of the United States since then?	☑ YES Go to (c) ☐ NO Go to #15	☐ YES Go to (c) ☐ NO Go to #15
(c) Give the date(s) of residence outside the United States.	Date Left: (MM/DD/YYYY) Date Returned: (MM/DD/YYYY)	Date Left: (MM/DD/YYYY) Date Returned: (MM/DD/YYYY)

	You	Your Spouse, if filing
15(a) Have you been outside the United States (the 50 States, District of Columbia and Northern Mariana Islands) 30 days prior to the filing date?	☑ YES Go to (b) ☐ NO Go to #16	☐ YES Go to (b) ☐ NO Go to #16
(b) Give the date (MM/DD/YYYY) you left the United States and the date you returned to the United States.	Date Left: (MM/DD/YYYY) 11/1/2025	Date Left: (MM/DD/YYYY)
	Date Returned: (MM/DD/YYYY) 11/15/2025	Date Returned: (MM/DD/YYYY)

16. Claimant's Mailing Address (Number & Street, Apt. No., P.O. Box, or Rural Route)

1 Mailing Ave, PO Box 5

City and State (U.S.)	ZIP Code	Name of County in which you live	Telephone Number
Los Angeles CA	11223		111-111-1111

State/Province/Region (Foreign)	Postal Code	Country

	You	Your Spouse, if filing
17(a) Do you have any felony warrants for escape from custody, flight to avoid prosecution or confinement, or flight escape?	☑ YES Go to (b) ☐ NO Go to #18	☐ YES Go to (b) ☐ NO Go to #18
(b) In which State or country was the warrant issued?	Name of State/Country California Go to (c)	Name of State/Country Go to (c)
(c) Was the warrant satisfied?	☑ YES Go to (d) ☐ NO Go to #18	☐ YES Go to (d) ☐ NO Go to #18
(d) Date warrant satisfied:	(MM/DD/YYYY) 5/1/2025	(MM/DD/YYYY)

PART 2 - LIVING ARRANGEMENT (Use "Remarks" to explain any change between the first moment of the filing date month and today.)

18. Claimant's Residence Address (Number & Street, Apt. No., P.O. Box, or Rural Route)

1 Living Ave PO Box 9

City and State (U.S.)	ZIP Code	Name of County in which you live
Los Angeles CA	11223	
State/Province/Region (Foreign)	Postal Code	Country

19(a) Mark the box that describes where you live.

- ☑ House, apartment, mobile home, houseboat
- ☐ Room in commercial establishment
- ☐ Room in private home
- ☐ Noninstitution (rest home, retirement home, foster home, or group home)
- ☐ Institution (hospital, rehabilitation center, prison, or school)
- ☐ Transient or homeless

(b) Date you began living there: (MM/DD/YYYY) 1/1/2008

20. Mark the box that describes with whom you live. If you live in a foster home, group home, or an institution, or if you are a transient or homeless, do not answer but explain in remarks.

☑ Alone ☐ Spouse/Parents and/or Children ☐ Other People

PART 3 - RESOURCES (Show resources as of the first moment of the filing date month. Use "Remarks" to explain any changes.)

21. If you own, or your name or your spouse's/parent's name(s) appear on any of the following items (either alone or with other people's name(s)), enter the total cash value of item(s) on each line.

	Yes	No	Description of Items Marked Yes	Co-owned With Others		Dollar Value You Own	Dollar Value Spouse or Parents Own
				Yes	No		
(a) Trust.	☑	☐	Trust 1	☐	☑	$ $200	$
(b) Vehicle.	☐	☑		☐	☐	$	$
(c) Real Property Other Than Home.	☐	☑		☐	☐	$	$
(d) Business Equipment.	☐	☑		☐	☐	$	$
(e) Achieving a Better Life Experience (ABLE) Account.	☐	☑		☐	☐	$	$
(f) Financial Institution Account.	☐	☑		☐	☐	$	$
(g) Cash.	☐	☑		☐	☐	$	$
(h) Stock, Bond or Mutual Fund.	☐	☑		☐	☐	$	$
(i) Promissory Note, Loan, or Property Agreement.	☐	☑		☐	☐	$	$
(j) Items Held for Potential Value or Investment.	☐	☑		☐	☐	$	$
(k) Life Insurance.	☐	☑		☐	☐	$	$
(l) Burial Fund.	☐	☑		☐	☐	$	$
(m) Burial Space or Related Item.	☐	☑		☐	☐	$	$
(n) Other Resource.	☐	☑		☐	☐	$	$

22. Are there any assets set aside to meet burial expenses for you or your spouse/parent(s)? (If"Yes" describe the item in "Remarks".			
	Your answer	☐ YES	☑ NO
	Spouse's answer	☐ YES	☐ NO
	Parent 1's answer	☐ YES	☐ NO
	Parent 2's answer	☐ YES	☐ NO

	You	Your Spouse, if filing
23(a) Have you or your spouse sold, transferred title, disposed of or given away, any money or other property, including money or property in foreign countries, since the first moment of the filing date month or within the 36 months prior to filing date month?	☐ YES ☑ NO	☐ YES ☐ NO
b) If you co-owned any money or property with another person(s), did you or any co-owner sell, transfer, or give away any co-owned money or property within the 36 months prior to the filing date month?	☐ YES ☑ NO	☐ YES ☐ NO

IF YOU ANSWERED "YES" TO (a) or (b), GO TO (c). IF "NO" TO BOTH, GO TO #24.

(c)	Owner's/Co-Owner's Name	Description of Property	Date of Disposal
Item #1			
Item #2			
Item #3			
	Name and Address of Purchaser or Recipient	**Relationship to Owner**	**Value of Property and/ or Amount of Cash Gift**
Item #1			$
Item #2			$
Item #3			$
	Sale Price or Other Consideration	**Are Other Considerations or Proceeds Expected? Explain**	**Do You Still Own Part of the Property?**
Item #1			☐ YES ☐ NO
Item #2			☐ YES ☐ NO
Item #3			☐ YES ☐ NO
	Sold on Open Market?	**Given Away?**	**Traded for Goods/ Services?**
Item #1	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Item #2	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Item #3	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

	You	Your Spouse, if filing
24. Do you give us permission to obtain any financial records from any financial institution?	☑ YES ☐ NO	☐ YES ☐ NO

PART 4 - INCOME (List all income received since the first moment of the filing date month or expected in the next 3 months.) Include you, your spouse/parents.

25. List cash, checks, and direct payment to bank accounts you (your spouse/parents) received or expect to receive. Include income from wages, sick pay, self-employment, interest, social security, assistance based on need, VA, gifts, pensions, and any other type of income. Give date last paid if income will stop in the next 3 months.

Person Receiving Income	Type of Income	Amount	Frequency Received	Date Last Paid	Source of Income
Self	Cash	$ $200	Monthly	12/1/2025	Mother
Self	Cash	$ $200	Monthly	12/1/2025	Mother
		$			

Also, note here if anyone pays any bills for you directly or gives you money to pay them.

26(a) Does your spouse/parent pay court ordered child support?	☐ YES Go to (b)	☑ NO Go to #27

(b) Give the amount and frequency of payment:

$

PART 5 - POTENTIAL ELIGIBILITY FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)/ MEDICAL ASSISTANCE

	You		Your Spouse, if filing	
27(a) Are you currently receiving SNAP benefits (formerly food stamps)?	☐ YES Go to (b)	☐ NO Go to (c)	☐ YES Go to (b)	☐ NO Go to (c)
(b) Have you received a recertification notice within the past 30 days?	☐ YES Go to (e)	☐ NO Go to #28	☐ YES Go to (e)	☐ NO Go to #28
(c) Have you filed for SNAP benefits in the last 60 days?	☐ YES Go to (d)	☐ NO Go to (e)	☐ YES Go to (d)	☐ NO Go to (e)
(d) Have you received a favorable decision?	☐ YES Go to #28	☐ NO Go to (e)	☐ YES Go to #28	☐ NO Go to (e)
(e) May I take your SNAP application today?	☐ YES Go to #28	☐ NO Explain in (f)	☐ YES Go to #28	☐ NO Explain in (f)

(f) Explanation:

28. You may be eligible for Medicaid. However, you must help your State identify other sources that pay for medical care. Also, you must give information to help the State get medical support for any child(ren) who is your legal responsibility. This includes information to help the State determine who a child's parent is. If you want Medicaid, you must agree to allow your State to seek payments from sources, such as insurance companies, that are available to pay for your medical care. This includes payments for medical care for you or any person who receives Medicaid and is your legal responsibility. The State cannot provide you Medicaid if you do not agree to this Medicaid requirement. If you need further information, you may contact your Medicaid Agency.

IN STATES WITH AUTOMATIC ASSIGNMENT OF RIGHTS LAWS, Go to (b)

	You		Your Spouse, if filing	
(a) Do you agree to assign your rights (or the rights of anyone for whom you can legally assign rights) to payments for medical support and other medical care to the State Medicaid agency?	☑ YES Go to (b)	☐ NO Go to #29	☐ YES Go to (b)	☐ NO Go to #29

	You		Your Spouse, if filing	
28(b) Do you, your spouse, parent or stepparent have any private, group, or governmental health insurance that pays the cost of your medical care? (Do not include Medicare or Medicaid.)	☐ YES Go to (c)	☑ NO Go to (c)	☐ YES Go to (c)	☐ NO Go to (c)
(c) Do you have any unpaid medical expenses for the 3 months prior to the filing date month?	☐ YES Go to #29	☑ NO Go to #29	☐ YES Go to #29	☐ NO Go to #29

PART 6 - MISCELLANEOUS

ANSWER #29(a) ONLY IF YOU ARE REQUESTING BENEFITS ON BEHALF OF SOMEONE ELSE; OTHERWISE GO TO #29(b).

29(a) Name of Person Requesting Benefits	Relationship to Claimant	Your Social Security Number

(b) Have you ever served as representative payee for a Social Security beneficiary or SSI claimant?	☐ YES	☐ NO

PART 7 - REMARKS - (You may use this space for any explanations. Enter the item number before each explanation. If you need more space, use a signed form SSA-795.)

See attached...

PART 8 - IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The Social Security Administration will check your statements and compare its records with records from other state and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount. We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you or your spouse notify us in writing that you are canceling your permission, (2) your application for SSI is denied in a final decision, (3) your eligibility for SSI terminates, or (4) we no longer consider your spouse's income and resources to be available to you. If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

PART 9 - SIGNATURES

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

Your Signature (First name, middle initial, last name) (Write in ink.)	Date (MM/DD/YYYY)

Spouse's Signature (First name, middle initial, last name) (Write in ink.) (Sign only if applying for payments.)

If you are blind or visually impaired, check the type of mail you want to receive from us

- ☐ Standard notice First-Class
- ☐ Standard notice First-Class with a follow-up phone call
- ☐ Standard notice & data CD by First-Class
- ☐ Standard notice Certified
- ☐ Standard & Braille notices by First-Class
- ☐ Standard & large print notices
- ☐ Standard notice & audio CD

WITNESSES

Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing, who know you, must sign below giving their full address.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and ZIP Code)	Address (Number and Street, City, State, and ZIP Code)

RECEIPT FOR YOUR CLAIM FOR SUPPLEMENTAL SECURITY INCOME

Name	Social Security Number	Date
Name	Social Security Number	Date

If you have a question or something to report call:	Social Security Office you may visit or write to:

Your application for Supplemental Security Income will be processed as quickly as possible. You should hear from us within ____ days. If you do not hear from us within that time, please get in touch with us in person, by mail, or call us at the telephone number shown at the top of this page.

We may need more information before we can decide whether or not you are eligible for SSI payments. If we need more information, we will contact you. In the meantime, if you move or change your mailing address, you (or someone for you) should report the change to the office shown at the top of this page.

You (or someone for you) must let us know if your immigration status changes.

Also, you (or someone for you) must let us know if you are admitted to a hospital or other medical facility. You could lose some SSI payments if you do not let us know right away.

Always give your Social Security Number when writing or telephoning about your claim. If you have any questions about your claim, we will be glad to help you.

Privacy Act Statement
Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended, allows us to collect this information. Furnishing this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information to determine eligibility for Supplemental Security Income (SSI) payments. We may also share your information for the following purposes, called routine uses:

- To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the Act; and
- To State agencies to enable them to assist in the effective and efficient administration of the SSI program.

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 Notices (SORN) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR) on April 01, 2003, at 68FR 15784, and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits, as published in the FR on January 11, 2006, at 71 FR 1830. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 control number. We estimate that it will take about 19-20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE**. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). ***You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401***. Send only comments relating to our time estimate to this address, not the completed form.

2,000
DDD
Depression
Hypertension
ADHD
8001 Remark Test