② **OPTIONAL WORKSHEET –** You can complete this Optional Worksheet to get ready for your interview or as you prepare to complete the Child Disability Report. If you decide to complete it, please have it with you when you start the Child Disability Report or when it is time for your appointment. *If you need more space, use blank sheets of paper.*

PLEASE DO NOT MAIL THIS WORKSHEET TO SOCIAL SECURITY. IT IS NOT THE APPLICATION FOR CHILD DISABILITY PAYMENTS.

A. Child's height and weight. _____

B. Name, address, phone number, and relationship of another adult who helps care for the child and can help us get information about the child if necessary.

_____

_____

C. The child's illnesses, injuries, or conditions. _____

D. Date the child's condition(s) began. _____

E. How the child's condition(s) affect the child's activities.

_____

_____

F. The child's current grade, if in school. _____

G. Schools or preschools the child is currently attending, and any other schools the child attended in the last 12 months.

Name	Address, Zip Code, and Phone Number	Dates Attended	Kind(s) of Special Ed. Services (if any)

H. Current or most recent teacher's name(s) and school. _____

I. School testing the child has had, such as tests for behavior or learning problems.

Name or Kind of Test	Date(s)	Name of School

J. Name of any school therapist the child is seeing or has seen *(for example, speech, physical, or occupational)* and the school name.

_____

_____

K. Hospitals, clinics, doctors, or therapists that have seen the child in the last 12 months.

Name	Address, Zip Code, and Phone Number	Date First Seen	Date Last Seen

L. Other agencies or programs that tested or examined the child, or that provided services *(such as Headstart, Early Intervention Services or Special Education, Public or Community Health, Welfare or Social Service Agency, Mental Health/Developmental Disabilities Center)*.

Name	Address, Zip Code, and Phone Number	Kind of Test or Service	Date(s)

M. List of medicine(s) the child takes and why they take them, if known. Include the names of the healthcare providers who prescribed any prescription medicines.

Name of Medicine	Reason for Medicine	Prescribed By

N. All medical tests the child had or has scheduled for their illnesses, injuries, or conditions. *(For example, hearing test, vision test, IQ testing, blood tests, breathing tests, x-rays.)*

Name of Test	Date(s)	Where Done	Provider Who Sent Child for Test

Remember, you can get started online!
Visit *www.ssa.gov/apply* for information.

Also, please do not delaying filing an application if you do not have or remember all of the information on this worksheet. We will help you get any missing information.