Please complete the following and bring it with you to your appointment. You MUST have this completed in order to meet with the attorney.

Please keep in mind this information is needed for the attorney to evaluate your case properly. It is also needed to complete the application process. This will not be filed with the Social Security Administration. It is for the attorney's use only.

If you do not have this completed when you arrive, you will be asked for the answers at the front desk. Please avoid this situation by completing it fully before you arrive.

If you do not know the answers, please find them before you arrive at your appointment. If you need to make phone calls or ask doctors' offices for information, please do so. We do not have ready access to any information that is on file with Social Security. Do not tell us that Social Security already has this information. Fill out everything. If you absolutely cannot get accurate information, give us your best guess. Approximate dates are much better than no dates.

Please Arrive 15 Minutes Early.

Thank you and we look forward to meeting with you.

DEMPSEY, DEMPSEY & HILTS P.C.

Attorneys at Law - Missouri & Illinois

Reply to: Quincy Office

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Fax (573) 221-2808

Please complete the following and bring it with you to your appointment.
You MUST have this completed in order to meet with the attorney.
Please Arrive 15 Minutes Early.

Name: _____

Appointment Date: _____ Time:_____

Quincy Office Hannibal Office.

Please bring your Social Security card to your appointment. If you have already applied and been denied, bring your denial letter.

1) When was the last day you worked? ____/____/____

How many hours per week were you working when you quit? _____

If you were working part-time when you quit, when was the last date you worked full-time? ____/____/_____

Have you received unemployment since you became unable to work? Yes or No

2) Where were you working and why did you quit?

_____

_____

_____

3) Have you worked five out of the last ten years? Yes or No

4) Have you applied for Social Security Disability? Yes or No

If Yes, is your case still open? Yes or No

5) What date do you feel you became disabled? ____/____/____

6) Are you receiving Long Term Disability Benefits? Yes or No

7) Are you receiving any type of benefits from Social Security? Yes or No

8) Do you have any liens for child support? Yes or No

9) Do you have any debt with the Internal Revenue Service? Yes or No

10) Do you have health insurance? Yes or No

Do you have Medicaid? Yes or No

11) *What* are the illnesses, injuries, or conditions that limit your ability to work?

_____

_____

_____

_____

THIS BOX FOR ATTORNEY USE ONLY: DISABILITY:

12) *How* do your illnesses, injuries, or conditions limit your ability to work?

_____

_____

_____

13) Your Height: _____ Your Weight: _____

14) **Please list the medications you take (also include any over-the-counter medications).**

Name of Medicine	If prescribed, give name of doctor	Reason for Medicine	Side effects you have

15) How many years of education do you have? _____
(High School = 12 years. If you have any college credit, indicate number of years and degree. If you have a GED, please include highest grade you completed before dropping out.)

Also, check all that apply:

☐ Dropped out of high school Date: ____/____/_____

☐ Obtained GED Date: ____/____/_____

☐ Graduated high school Date: ____/____/_____

☐ Graduated (past high school) Date: ____/____/_____

Are you currently attending school (including online classes)? Yes or No

16) Please name the last school you attended identifying town and state where it is located.

17) Were you in special education classes? Yes or No

If yes, please list the name and address of the school where you attended special education classes.

_____

18) Have you completed any Vocational School or Job Training? Yes or No
What type of schooling/training (ex. CNA/Truck Driver) _____
Location of Vocational School or Job training: _____

Date completed: _____/_____/_____

19) Have you served in the military? If so, please identify the branch of service and what type of discharge you have.

20) Have you ever been convicted of a felony? If so please state the year and sentence for each offense.

21) Have any of your physicians or counselors suggested you have a problem with drugs or alcohol?

22) Do you have children under the age of 18? If so, list for each

	Name	Age	Social Security Number
1.			
2.			
3.			
4.			
5.			

23) What was the city and state of your birth? (Required to communicate with social security)

If not born in the United States, what was the date of your citizenship? _____/_____/_____

Where did you become a citizen? _____

24) What is your mother's maiden name? (Required to communicate with social security)

_____ _____
First Last

25) Have you ever applied for social security benefits *before*? If so, please state the year and whether or not you went to a hearing before a judge.

26) Have you ever had a workers compensation claim. Yes or No
If yes, please state the approximate year and whether or not the claim is still open.

_____

This box for attorney use only:

27) Are you married? Yes or No
If yes, does your spouse work? Yes or No
If yes, how many hours per week does your spouse work and
at what rate of pay? _____ hours at $ _____/hour.

If No, what other income does the household have such as retirement, pension, VA, Social Security Retirement or Disability?

_____

_____

Are you separated from your spouse? Yes or No
If Yes, do you continue to reside together? Yes or No
If No, what date did you stop residing together? _____/____/_____

28) Do you receive V.A. Benefits? Yes or No
If Yes, are they:

Pension Benefits ☐

Compensation Benefits ☐
Rating? _____

If you are unsure, please bring a copy of the decision awarding you the V.A. benefits or any correspondence that might clarify this to your appointment.

29) For your current marriage and all previous marriages, please list the following:

Current or ***Former*** Marriage (Circle One) Name of Spouse: ____________	Spouse's D.O.B ___/___/_____ SS# ____________ (if known)
Date of Marriage: ____________ Date Marriage Ended: ____________	City and State of Marriage: ____________ City and State of Divorce: ____________
Reason Marriage Ended? (Circle One) Divorce or Death	Is this individual still living? If no, list date of death: ____________

Current or ***Former*** Marriage (Circle One) Name of Spouse: ____________	Spouse's D.O.B ___/___/_____ SS# ____________ (if known)
Date of Marriage: ____________ Date Marriage Ended: ____________	City and State of Marriage: ____________ City and State of Divorce: ____________
Reason Marriage Ended? (Circle One) Divorce or Death	Is this individual still living? If no, list date of death: ____________

Current or ***Former*** Marriage (Circle One) Name of Spouse: ____________	Spouse's D.O.B ___/___/_____ SS# ____________ (if known)
Date of Marriage: ____________ Date Marriage Ended: ____________	City and State of Marriage: ____________ City and State of Divorce: ____________
Reason Marriage Ended? (Circle One) Divorce or Death	Is this individual still living? If no, list date of death: ____________

Current or ***Former*** Marriage (Circle One) Name of Spouse: ____________	Spouse's D.O.B ___/___/_____ SS# ____________ (if known)
Date of Marriage: ____________ Date Marriage Ended: ____________	City and State of Marriage: ____________ City and State of Divorce: ____________
Reason Marriage Ended? (Circle One) Divorce or Death	Is this individual still living? If no, list date of death: ____________

30) Please list 2 people who know your condition(s) other than healthcare providers:

Name:	Relationship to you:
Street Address: City and State:	Phone #

Name:	Relationship to you:
Street Address: City and State:	Phone #

31) Please list two people (who do not live with you or with each other) who will be able to help us find you, if we lose contact with you:

Name:	Relationship to you:
Street Address: City and State:	Phone #

Name:	Relationship to you:
Street Address: City and State:	Phone #

32) Medical Tests - Please select tests you have had (or expect to have).

Test Done or Will Be Done	Test	Most recent date done or expected to be done	Where was this done or where will it be done	Who sent you or will send you for this test	How many times has it been done
☐	EKG (heart test)				
☐	Treadmill (Exercise Test)				
☐	Cardiac Catheterization				
☐	Biopsy (What part) _____				
☐	Hearing Test				
☐	Vision Test				
☐	IQ Test				
☐	EEG (Brain Wave Test)				
☐	HIV Test				
☐	Blood Test				
☐	Breathing Test *see note below				
☐	X-Ray (What did you have Xray on) _____				
☐	MRI-CT Scan _____				
☐	Speech/Lang. Test				
☐	Other				
☐	Other				

*If you have had a Pulmonary Function Test (PFT) in the last year, please bring a copy of the test results to your appointment.

WHAT YOU NEED FOR YOUR DISABILITY APPLICATION APPOINTMENT

You should have as much of the following information as possible for your interview. Use this checklist to keep track of the information you gather.

☐If you were in the military service, the original or a certified copy of your **military discharge papers** (Form DD214) for all periods of active duty.

☐ Your **W-2 Form** from last year, or if you were self-employed, your federal tax return (IRS 1040 and Schedule C and SE).

☐ **Worker's Compensation Information**, including date of injury, claim number and payment amount.

☐ **Social Security Number** and **Date of Birth** of your current spouse.

☐ Your **checking or savings account and routing numbers** if you wish benefits to be direct deposited.

☐ If you receive Medicaid/Medical Card, we will need your case # _____

☐ If you have the ability to do so, please log on to http://www.ssa.gov/myaccount/ and request a copy of your Social Security Statement.

☐ Are you 25 years old or under and have a parent who is disabled, blind or deceased? Yes or No **If Yes, list the parent's name and SS # below.**

It is very important that you fill out this form completely!

If you do not know the exact dates of your visits/hospital stays, please at least estimate the month and year. This information is required to complete the application. ***DO NOT*** *get your medical records from your healthcare providers. We will take care of getting your records.*

ON THE FOLLOWING PAGES,
PLEASE LIST THE HEALTHCARE PROVIDERS
(MENTAL AND PHYSICAL)
YOU HAVE SEEN IN THE LAST YEAR

Please list only one provider per page.

Additional sheets are attached.

Name of Healthcare provider: (Example: Dr. Robert Jones)
Name of facility where healthcare provider provides services: (Example: City Clinic)
Complete Mailing Address of facility: Street of P.O. Box #: _____ City: _____ State: _____ Zip Code: _____
Telephone number of healthcare provider:
Approximate date you <u>first</u> saw healthcare provider: _____/_____/_____
Approximate date you <u>last</u> saw healthcare provider: _____/_____/_____
Do you have another appointment scheduled to see this healthcare provider? **Yes or No** If so, please list the date: _____/_____/_____
What was the reason for the last visit to this healthcare provider?
What treatment was received?

Name of Healthcare provider: (Example: Dr. Robert Jones)
Name of facility where healthcare provider provides services: (Example: City Clinic)
Complete Mailing Address of facility: Street of P.O. Box #: _____ City: _____ State: _____ Zip Code: _____
Telephone number of healthcare provider:
Approximate date you first saw healthcare provider: _____/_____/_____
Approximate date you last saw healthcare provider: _____/_____/_____
Do you have another appointment scheduled to see this healthcare provider? **Yes or No** If so, please list the date: _____/_____/_____
What was the reason for the last visit to this healthcare provider?
What treatment was received?

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Name of facility where healthcare provider provides services: (Example: City Clinic)
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Telephone number of healthcare provider:
Approximate date you <u>first</u> saw healthcare provider: _____/_____/_____
Approximate date you <u>last</u> saw healthcare provider: _____/_____/_____
Do you have another appointment scheduled to see this healthcare provider? **Yes or No** If so, please list the date: _____/_____/_____
What was the reason for the last visit to this healthcare provider?
What treatment was received?

Name of Healthcare provider: (Example: Dr. Robert Jones)
Name of facility where healthcare provider provides services: (Example: City Clinic)
Complete Mailing Address of facility: Street of P.O. Box #: _____ City: _____ State: _____ Zip Code: _____
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Approximate date you <u>first</u> saw healthcare provider: _____/_____/_____
Approximate date you <u>last</u> saw healthcare provider: _____/_____/_____
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What was the reason for the last visit to this healthcare provider?
What treatment was received?

Name of Healthcare provider: (Example: Dr. Robert Jones)
Name of facility where healthcare provider provides services: (Example: City Clinic)
Complete Mailing Address of facility: Street of P.O. Box #: _____ City: _____ State: _____ Zip Code: _____
Telephone number of healthcare provider:
Approximate date you <u>first</u> saw healthcare provider: _____/_____/_____
Approximate date you <u>last</u> saw healthcare provider: _____/_____/_____
Do you have another appointment scheduled to see this healthcare provider? **Yes or No** If so, please list the date: _____/_____/_____
What was the reason for the last visit to this healthcare provider?
What treatment was received?

PLEASE LIST ANY HOSPITALS WHERE YOU HAVE BEEN A PATIENT (INPATIENT OR OUTPATIENT). LIST ONLY THOSE YOU HAVE SEEN IN THE LAST YEAR

Please list only one provider per page. Please note there are separate sections for Inpatient visits, Outpatient visits and ER visits. Additional sheets are attached.

Name of hospital:

Complete Mailing Address of facility:
Street of P.O. Box #: _____

City: _____

State: _____

Zip Code: _____

Telephone number of hospital:

Approximate date you were admitted: ***Inpatient stays only in this box***

_____/_____/_____ Illness or Injury requiring treatment: _____

_____

Approximate date you were discharged: ***Inpatient stays only in this box***

_____/_____/_____ What treatment did you receive and what doctor

treated you in the hospital. _____

Approximate date you were seen: ***Outpatient visits only in this box***

_____/_____/_____ Illness or Injury requiring treatment:_____

_____

Treatment received during outpatient visit and name of doctor who treated you ***at*** the hospital.

_____

Approximate date you were seen: ***ER visits only in this box***

_____/_____/_____ Reason for ER visit: _____

_____

What treatment did you receive and what doctor treated you in the hospital.

_____

Name of hospital:

Complete Mailing Address of facility:
Street of P.O. Box #: _____

City: _____

State: _____

Zip Code: _____

Telephone number of hospital:

Approximate date you were admitted: ***Inpatient stays only in this box***

_____/_____/_____ Illness or Injury requiring treatment: _____

_____

Approximate date you were discharged: ***Inpatient stays only in this box***

_____/_____/_____ What treatment did you receive and what doctor

treated you in the hospital. _____

Approximate date you were seen: ***Outpatient visits only in this box***

_____/_____/_____ Illness or Injury requiring treatment:_____

_____

Treatment received during outpatient visit and name of doctor who treated you ***at*** the hospital.

_____

Approximate date you were seen: ***ER visits only in this box***

_____/_____/_____ Reason for ER visit: _____

_____

What treatment did you receive and what doctor treated you in the hospital.

_____

Name of hospital:

Complete Mailing Address of facility:
Street of P.O. Box #: _____

City: _____

State: _____

Zip Code: _____

Telephone number of hospital:

Approximate date you were admitted: ***Inpatient stays only in this box***

_____/_____/_____ Illness or Injury requiring treatment: _____

_____

Approximate date you were discharged: ***Inpatient stays only in this box***

_____/_____/_____ What treatment did you receive and what doctor

treated you in the hospital. _____

Approximate date you were seen: ***Outpatient visits only in this box***

_____/_____/_____ Illness or Injury requiring treatment:_____

_____

Treatment received during outpatient visit and name of doctor who treated you ***at*** the hospital.

_____

Approximate date you were seen: ***ER visits only in this box***

_____/_____/_____ Reason for ER visit: _____

_____

What treatment did you receive and what doctor treated you **in** the hospital.

_____

WORK HISTORY

Please list every job you have had
in the past 15 years.
This includes work you have done for
wages, cash or anything of value.

If more space is needed,
please use a separate page.

Name of Employer:
Address of Employer:
Years worked: _____/_____ /_____ through _____/_____ /
Current or ending pay (per hours) $ _____ How many hours per week did you work?_____
Job Title:
Job Description:
Were you a Supervisor? Yes or No If yes, how many people did you supervise?_____ How many hours were spent supervising?_____
Amount of weight routinely lifted: _____ What did you lift?_____ Amount of time standing? _____ sitting?_____

Name of Employer:
Address of Employer:
Years worked: _____/_____ /_____ through _____ /_____ /
Current or ending pay (per hours) $ _____ How many hours per week did you work?_____
Job Title:
Job Description:
Were you a Supervisor? Yes or No If yes, how many people did you supervise?_____ How many hours were spent supervising?_____
Amount of weight routinely lifted: _____ What did you lift?_____ Amount of time standing? _____ sitting?_____

Name of Employer:
Address of Employer:
Years worked: _____/_____ /_____ through _____/_____ /
Current or ending pay (per hours) $ _____ How many hours per week did you work?_____
Job Title:
Job Description:
Were you a Supervisor? Yes or No If yes, how many people did you supervise?_____ How many hours were spent supervising?_____
Amount of weight routinely lifted: _____ What did you lift?_____ Amount of time standing? _____ sitting?_____

Name of Employer:
Address of Employer:
Years worked: _____/_____ /_____ through _____ /_____ /
Current or ending pay (per hours) $ _____ How many hours per week did you work?_____
Job Title:
Job Description:
Were you a Supervisor? Yes or No If yes, how many people did you supervise?_____ How many hours were spent supervising?_____
Amount of weight routinely lifted: _____ What did you lift?_____ Amount of time standing? _____ sitting?_____

Name of Employer:
Address of Employer:
Years worked: _____/_____ /_____ through _____/_____ /
Current or ending pay (per hours) $ _____ How many hours per week did you work?_____
Job Title:
Job Description:
Were you a Supervisor? Yes or No If yes, how many people did you supervise?_____ How many hours were spent supervising?_____
Amount of weight routinely lifted: _____ What did you lift?_____ Amount of time standing? _____ sitting?_____

Name of Employer:
Address of Employer:
Years worked: _____/_____ /_____ through _____ /_____ /
Current or ending pay (per hours) $ _____ How many hours per week did you work?_____
Job Title:
Job Description:
Were you a Supervisor? Yes or No If yes, how many people did you supervise?_____ How many hours were spent supervising?_____
Amount of weight routinely lifted: _____ What did you lift?_____ Amount of time standing? _____ sitting?_____