SOCIAL SECURITY & DISABILITY BENEFITS CLIENT INTAKE QUESTIONNAIRE:

APPEAL DEADLINES ARE SHORT — generally 60 days from the date on each denial notice. Send us every letter from Social Security as soon as you receive it, and keep the envelope. Missing a deadline can mean starting over and losing back benefits.

CONFIDENTIAL. This questionnaire covers Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), retirement and survivors benefits, and related public benefits, at any stage from application through appeal. Please answer as completely as you can; medical details help us build your claim. If a question does not apply, write "N/A." If unknown, write "Unknown."

NAME OF THE CLIENT:

This form is completed by:

[__] The claimant [__] Spouse / family member helping

[__] Parent or guardian of a child claimant [__] Representative payee

[__] Claimant's Full Legal Name: _____ Date of Birth: _____

Other names used: _____ SSN (last 4 only): _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Syndicate Plan Member ID: _____ Primary language: _____

Preferred method of contact:

[__] Phone [__] Text [__] Email [__] Mail

Do you need any accommodation to communicate with us? [__] Yes [__] No

PART 1 — BENEFITS INVOLVED

1.1 Check all that apply:

[__] SSDI (disability insurance) [__] SSI (supplemental security income)

[__] SSI for a child [__] Social Security retirement

[__] Survivors / widow(er) benefits [__] Disabled adult child benefits

[__] Medi-Cal / Medicaid [__] CalFresh (food benefits)

[__] CalWORKs [__] General Relief

[__] CAPI [__] Other state or county benefits

1.2 Current status:

[__] Have not applied yet [__] Application pending

[__] Denied — initial [__] Denied — reconsideration

[__] Hearing requested / scheduled [__] Appeals Council

[__] Federal court [__] Benefits stopped or suspended

[__] Overpayment notice received [__] Continuing review (CDR)

PART 2 — KEY DATES

Event	Date
Date you applied	
Date of initial denial letter	
Date of reconsideration denial	
Date hearing was requested	
Hearing date (if scheduled)	
Date of any other notice received	

2.1 Date you became unable to work (alleged onset date): _____

2.2 Date you last worked: _____ Last employer: _____

2.3 Are you working now, including part-time or self-employment? [__] Yes [__] No

Monthly earnings: $ _____

PART 3 — WORK HISTORY (LAST 15 YEARS)

Job Title	Employer	Dates (from – to)	Duties & Physical Demands (lifting, standing, sitting)

3.1 Highest grade completed / degrees: _____ Special training: _____

3.2 Have you tried to return to work since becoming disabled? [__] Yes [__] No

If yes, explain: _____

_____

3.3 Can you read and write English? [__] Yes [__] No

PART 4 — MEDICAL CONDITIONS & TREATMENT

4.1 List the conditions that keep you from working (physical and mental): _____

_____

_____

4.2 Treating Doctors, Clinics & Hospitals:

Provider / Facility	Type of Treatment	City	Dates of Treatment	Still Treating?

4.3 Have you been hospitalized or had surgery for these conditions? [__] Yes [__] No

If yes, explain: _____

_____

4.4 Are you receiving mental health treatment or counseling? [__] Yes [__] No

4.5 Do you take prescription medications? [__] Yes [__] No

Main medications and side effects: _____

4.6 Do you have health insurance or a way to keep getting treatment? [__] Yes [__] No

Ongoing treatment records are the strongest evidence in a disability claim. Tell us if cost or transportation is keeping you from care.

PART 5 — DAILY ACTIVITIES & LIMITATIONS

Activity	No Problem	Some Difficulty	Cannot Do
Standing / walking	[__]	[__]	[__]
Sitting for long periods	[__]	[__]	[__]
Lifting & carrying	[__]	[__]	[__]
Bending, kneeling, reaching	[__]	[__]	[__]
Using hands / fingers	[__]	[__]	[__]
Concentrating & remembering	[__]	[__]	[__]
Following instructions	[__]	[__]	[__]
Being around others	[__]	[__]	[__]
Sleeping	[__]	[__]	[__]
Personal care (bathing, dressing)	[__]	[__]	[__]
Cooking, cleaning, shopping	[__]	[__]	[__]
Driving / transportation	[__]	[__]	[__]

5.1 Assistive devices used:

[__] Cane [__] Walker [__] Wheelchair

[__] Oxygen [__] Hearing aids [__] Other device

5.2 Who helps you with daily activities? _____

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PART 6 — OTHER INCOME, BENEFITS & HOUSEHOLD (SSI QUESTIONS)

6.1 Other income or benefits received:

[__] Workers' compensation
[__] Veterans benefits
[__] Private / employer disability
[__] Unemployment
[__] Pension / retirement
[__] Child support
[__] Spouse's income
[__] None

6.2 Total household monthly income: $ _____ People in household: _____

6.3 Living arrangement:

[__] Own home
[__] Rent
[__] Live with family / friends
[__] Homeless / temporary housing
[__] Facility

6.4 Does someone else pay your rent, food, or utilities? [__] Yes [__] No

6.5 Approximate value of bank accounts and other resources: $ _____

SSI has income and resource limits and counts help with food and housing; SSDI does not. These questions help us confirm which program fits.

PART 7 — OVERPAYMENTS & REVIEWS

7.1 Has Social Security said you were overpaid? [__] Yes [__] No

Amount: $ _____ Date of notice: _____

7.2 What would you like to do?

[__] Request reconsideration (I disagree)
[__] Request a waiver
[__] Request a payment plan
[__] Not sure

7.3 Is a continuing review underway, or have benefits stopped? [__] Yes [__] No

PART 8 — REPRESENTATION

8.1 Do you have, or have you had, a representative or lawyer for this claim? [__] Yes [__] No

Name / firm and dates: _____

8.2 Did you sign an appointment of representative or fee agreement? [__] Yes [__] No

Social Security must approve any fee charged for representing a claimant, and fees are usually paid from past-due benefits. We will explain how fees work in your case before you sign anything.

PART 9 — DOCUMENTS & AUTHORIZATION

Please provide copies of the following, if available. Check each item you are including.

[__] All letters from Social Security
[__] Denial notices (with envelopes)
[__] Application confirmation
[__] Medical records you have
[__] List of doctors & medications
[__] Work history / pay stubs / W-2s
[__] Photo ID & Social Security card
[__] Other benefit award letters
[__] Overpayment notice
[__] Hearing notice

Syndicate Subscription Legal Plans

[__] I authorize Syndicate Subscription Legal Plans to request my medical records and to communicate with the Social Security Administration and other benefit agencies about my claim.

Certification:

I declare that the information provided in this questionnaire is true, correct, and complete to the best of my knowledge. I understand this information is provided to Syndicate Subscription Legal Plans in confidence for the purpose of assisting with my benefits claim.

Signed and dated this ____ day of _____, 20___

Signature: _____

Print Name: _____

Please Print and Email to STEVE@STEVEMUELLERLEGAL.COM, or save this document as a PDF and email to STEVE@STEVEMUELLERLEGAL.COM,
Your information will be reviewed within one hour.