Social Security Administration

Retirement, Survivors, and Disability Insurance

Important Information

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Date:
Claim Number:

Phone:

We are writing to you because we need to know more about your work.

The enclosed pamphlet, "Working While Disabled … How Social Security Can Help", will tell you more about why we need to know about your work.

What You Need To Do

The enclosed form asks for facts we need to know. Please sign, date, and return the completed form within 15 days. We have enclosed an envelope for you to use.

If You Have Any Questions

If you have any questions, please let us know. You may also call, write, or visit any Social Security office. If you do contact an office, please have this letter with you. It will help us answer your questions.

Enclosure:
SSA Pub. No. 05-10095
Pre-addressed Envelope

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0059

WORK ACTIVITY REPORT — EMPLOYEE

IDENTIFICATION - TO BE COMPLETED BY SSA

Name of Claimant or Beneficiary	Claimant or Beneficiary's SSN	☐ Blind ☐ Not Blind

Name of Wage Earner (if different from Claimant or Beneficiary)	Wage Earner's SSN

Claimant or Beneficiary is Receiving:

☐ Social Security Disability Insurance (SSDI) Benefits

☐ Supplemental Security Income (SSI) Disability Benefits

☐ Both SSDI and SSI Disability Benefits

☐ Neither SSDI or SSI Disability Benefits

PART I - TO BE COMPLETED BY SSA

1 . Please use this form to tell us about your work since → Date

2. We need to know this information because:

ANSWER THE QUESTIONS ON THIS FORM AND RETURN IT AND ANY OTHER INFORMATION ABOUT YOUR CLAIM TO THE SOCIAL SECURITY OFFICE THAT GAVE (OR SENT) YOU THE FORM.

PART II - TO BE COMPLETED BY PERSONS APPLYING FOR OR RECEIVING BENEFITS

You should answer each of the questions below as best and with as many details as you can. This information will help us decide if you should get or keep getting benefits. For any question below, if you need more space, use item 9, on pages 5 and 6. Remember to write the number of the question that you are answering in item 9.

1 . HAVE YOU WORKED SINCE THE DATE SHOWN IN ITEM 1 OF PART 1, ABOVE?

☐ YES If you did work, go to item 3 below and answer the rest of the questions and sign and date the form.

☐ NO If you did not work, but earnings were reported for you as shown in item 2 of Part I above, go to item 2 below.

2. REPORTED WORK OR EARNINGS

If you did not work, but earnings were reported for you as shown in Item 2 of Part 1, explain what the pay was for.

For example, sometimes pay is sick pay, vacation pay or holiday pay that you earned, or for work that you did before becoming unable to work because of your condition.

If you can't explain the earnings reported for you or you don't remember what the total earnings are for, ask your employer(s). If your employer(s) cannot help you, ask your local Social Security Office to help you.

Explanation of Earnings:

If you need more space, use Item 9. Then go to Items 8 and 10.

3. TELL US ABOUT YOUR WORK SINCE THE DATE IN ITEM 1 OF PART 1 ABOVE.
(If you are not sure about some things, ask your employer to help you. If you need more space, use Item 9, on pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)

A.

Employer's Name		Employer's Address *(Include Street, City, State, & Zip)*	
Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Job Title	Number of Hours (on average) Worked ________ ☐ Per Day ☐ Per Week	Supervisor's Name	Supervisor's Telephone Number *(Include area code)*

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (e.g., You were a plumber and changed to lighter work.) because:

☐ of my medical condition.

☐ special conditions at work related to my medical condition that allowed me to work were removed.

☐ I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

B.

Prior Employer's Name		Employer's Address *(Include street, city, state, &zip)*	
Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Job Title	Number of Hours (on average) Worked ________ ☐ Per Day ☐ Per Week	Supervisor's Name	Supervisor's Telephone Number *(Include area code)*

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (e.g., You were a plumber and changed to lighter work.) because:

☐ of my medical condition.

☐ special conditions at work related to my medical condition that allowed me to work were removed.

☐ I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

3. TELL US ABOUT YOUR WORK SINCE THE DATE IN ITEM 1 OF PART 1 ABOVE.
(If you are not sure about some things, ask your employer to help you. If you need more space, use Item 9, on pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)

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B.

Prior Employer's Name		Employer's Address *(Include street, city, state, &zip)*	
Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Job Title	Number of Hours (on average) Worked ____________ ☐ Per Day ☐ Per Week	Supervisor's Name	Supervisor's Telephone Number *(Include area code)*

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☐ special conditions at work related to my medical condition that allowed me to work were removed.

☐ I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

C.

Prior Employer's Name		Employer's Address *(Include Street, City, State, & Zip)*	
Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay
Job Title	Number of Hours (on average) Worked ______ ☐ Per Day ☐ Per Week	Supervisor's Name	Supervisor's Telephone Number *(Include area code)*

Check each block below that is true for this work:

I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (e.g., You were a plumber and changed to lighter work.) because:

☐ of my medical condition.

☐ special conditions at work related to my medical condition that allowed me to work were removed.

☐ I stopped working or changed the type of work I was doing for other reasons. (Tell us what the other reasons were below.)

4. Since the date you started working on or after the date shown in Item 1 of Part 1, above, have there been any months during which you earned over $200 per month through 12/2000 or over $530 beginning 01/2001(before anything was withheld; e.g., taxes)?

☐ No (Go to Item 5.)

☐ Yes (Tell us which month and year and the amount you earned that month in the chart below. If you need more space, use Item 9, on pages 5 and 6. Remember to write the number of the question that you are

MONTH/YEAR	AMOUNT	MONTH/YEAR	AMOUNT	MONTH/YEAR	AMOUNT
	$		$		$
	$		$		$
	$		$		$
	$		$		$

5. SPECIAL WORK CONDITIONS - Do (Did) you get special help on-the-job or extra pay in any of the jobs that you told us about in Item 3?

☐ No (Go to Item 6.)

☐ Yes Check all of the boxes that are true for you and tell us for which job(s) you received that help and tell us about any other special condition(s) or help that you got on a job.

☐ I needed and got special help from other workers in doing my job.

☐ I was given special equipment or was given work that was suited to my condition.

☐ I was allowed to work at a lower standard of productivity.

☐ I worked for a relative or friend.

☐ I was given a job based on my past services to an employer.

☐ I worked irregular hours or took frequent rest periods.

☐ I worked in a sheltered work center.

☐ I was hired through a special program for training or therapy (e.g., vocational rehabilitation, supported employment).

7. SPECIAL WORK EXPENSES (IMPAIRMENT-RELATED WORK EXPENSES) - Continued

ITEM OR SERVICE	COST	DATE(S) PAID (MONTH & YEAR)
	$	
	$	
	$	
	$	
	$	
	$	

SPECIAL TRANSPORTATION	COST	
MODIFIED VEHICLE	$	
TAXI-TYPE SERVICE	$	

8. VOCATIONAL REHABILITATION - Are (Were) you getting any help from a vocational rehabilitation or employment services provider to get the services and/or training you need to get ready to start working, find work or keep working?

☐ No If you answered no, would you like to get these services? ☐ Yes ☐ No Go to Item 10.

☐ Yes Tell us the name and address of the people who are (were) giving you vocational rehabilitation or employment services and training.

Vocational Rehabilitation/Employment Services Provider

Name	Address *(Include Street, City, State & Zip)*
Counselor's Name	Counselor's Telephone Number *(Include Area Code)*

If you need more space, go to Item 9, below.

9. More Space. For any question above, if you need more space, use space below. Remember to write the number of the question that you are answering before you begin.

9. More Space - Continued. For any question above, if you need more space, use space below. Remember to write the number of the question that you are answering before you begin.

10. I authorize any employer, agency or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits any information about my medical condition or my work.

SIGN AND DATE THIS FORM

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of Claimant, Beneficiary or Representative	Date	Telephone Number (Include area code & e-mail address)

Mailing Address (Number and Street)

City and State	ZIP Code	County

Witnesses must sign ONLY if this statement is signed by mark (e.g., X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

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)*
Telephone Number *(Include Area Code)*	Telephone Number *(Include Area Code)*

PRIVACY ACT/PAPERWORK REDUCTION ACT STATEMENT

The Social Security Administration is authorized to collect the information on this form under Sections 205(a), 223(d), 1612, 1613 and 1633(a) of the Social Security Act. The information on this form is needed by the Social Security Administration to make a decision on your claim. While giving us the information on this form is voluntary, failure to provide all of the requested information could prevent an accurate or timely decision on your claim and could result in a loss of benefits. Although the information you furnish on this form is almost never used for any purpose other than making a determination on your disability claim, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist the Social Security Administration in establishing rights to Social Security benefits or coverage, (2) to comply with Federal laws requiring the release of information from Social Security records (for example, the General Accounting Office and the Department of Veterans Affairs), and (3) to facilitate statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (for example, to the Bureau of Census and Private concerns under contract to the Social Security Administration).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 45 to read the instructions, gather the necessary facts, and answer the questions.

FOR SSA USE ONLY - DO NOT WRITE ON THIS PAGE

11. A. Contact made:

☐ In person ☐ By Mail ☐ By Telephone ☐ Other ________________

B. Completed by:

☐ Claimant ☐ SSA Representative ☐ Other ________________

If "Other," show:

Name	Address	Telephone Number
		Relationship

12. Interviewer/Reviewer Checklist. SSA interviewers and reviewers should check all items that apply and discuss all "YES" or "NO" answers below, except for reminder items or when a final determination is prepared.

A. Work within waiting period or within 12 months of onset (SGA denial or reopening/revision to denial applies)	☐ YES	☐ NO
B. MIE diary involved - DDS referral needed	☐ YES	☐ NO
C. Title II TWP determination	☐ YES	☐ NO
D. Special considerations, situations, assistance (Subsidy - specific or nonspecific)	☐ YES	☐ NO
E. IRWE	☐ YES	☐ NO
F. SGA (after applicable subsidy/IRWE deduction(s))	☐ YES	☐ NO
G. UWA (initial claim - DDS jurisdiction. FO has documented significant break in work and made UWA recommendation to DDS for a final determination)	☐ YES	☐ NO
H. UWA (Continuing disability review - FO jurisdiction)	☐ YES	☐ NO
I. EPE impairment severity issue - DDS referral needed (reminder item)	☐ YES	☐ NO
J. EPE reinstatement/suspension/termination	☐ YES	☐ NO
K. Due process required	☐ YES	☐ NO
L. Concurrent Title II & Title XVI Income & Resources or 1619 action needed	☐ YES	☐ NO
M. Other issue(s)/comment(s) not noted above	☐ YES	☐ NO

Discussion:

13. Signature and title of SSA interviewer/reviewer	14. FO/PSC code	15. Telephone Number	16. Date