Name of Disability Applicant:
Social Security number:

SSI/SSDI Case Manager Report

This form should be completed by a case manager, social worker, agency worker or shelter worker who has spent sufficient time with the client to comment on the client's day to day functioning and limitations imposed by the client's mental disability

Below is a list of areas of functioning. For any areas your client has limitations, please describe those limitations in as much detail as possible and how the limitations prevents the client from functioning adequately in his or her day to day life.

Concentration: _____

Persistence: _____

Cooperation: _____

Judgment: _____

Memory: _____

Hygiene: _____

Reliability: _____

Social Interactions: _____

Interactions with Authority: _____

Following instructions: _____

Following program rules: _____

Problems at work (if you have knowledge of work attempts): _____

Other: _____

How frequently do you see the client? _____

How reliable is the client in keeping appointments? _____

Does the client have any problems following prescribed treatment? If so, describe problems. _____

Describe the client's behavior, please include details such as any unusual behavior, indications of responding to internal stimuli, etc. Please be specific and include how frequently the problems are present:

_____

Does your client use drugs or alcohol currently?

☐yes ☐no

Has your client had any periods of sobriety since you began working with him/her?

☐yes ☐no

If yes, please indicate approximate dates of sobriety:

_____

If your client has a history of use but no current use, indicate how long the client has been sober: _____

If your client is not currently using drugs or alcohol, you can skip to the comment section below.

Have you observed your client during a period of sobriety? Yes☐ No☐

Is the information provided above regarding the client's functioning representative of how the client functions during an extended period of sobriety? Yes☐ No☐ Unknown☐

If no, please describe the any changes in the client's disability during a period of extended sobriety, specifically addressing changes in your client's functioning during a period of sobriety versus during periods when the client is using. Provide specific examples whenever possible. _____

Other comments:

_____

_____ _____

Signature/title Date

_____ _____ _____

Printed name Phone number Best time to reach you