CUSTOMER DECLARATION OF DISABILITY FORM

LOCAL DEPARTMENT USE ONLY
AU #
CLIENT ID #

Please complete all sections (front and back) of this form and sign where indicated. If you need help completing this form, please contact your case manager at:_____and have the form with you when you call. You **must** return the completed form to the person and address below.

Case Manager
Name_____
First **Last**
Local Department
Name_____

Local Department
Address_____

_____
City **State** **Zip Code**

If the person completing this form is someone other than the disabled person, please complete the following information:

Name_____

Relationship to Disabled Person_____

Daytime Telephone Number _____

Address_____

_____
City **State** **Zip Code**

SIGN HERE_____ **DATE** _____
YOUR **SIGNATURE**

TO BE COMPLETED BY THE DISABLED PERSON:

Name _____
Last **First**

Social Security Number _____ **Date of Birth** _____

Address _____

_____
City **State** **Zip Code**

1. Has there been any change (for better or worse) in your illnesses, injuries, or conditions since **you last applied for Social Security disability benefits?** ☐ **Yes** ☐ **No**
If **"Yes"**, please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	**DAY**	**YEAR**

2. Do you have any new physical or mental limitations as a result of your illnesses, injuries or conditions **since you last applied for Social Security disability benefits?** ☐ **Yes** ☐ **No**
If **"Yes"**, please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	**DAY**	**YEAR**

3. Do you have any new illnesses, injuries, or conditions **since you last applied for Social Security disability benefits?** ☐ **Yes** ☐ **No**
If **"Yes"**, please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	**DAY**	**YEAR**

SIGN HERE _____ **DATE** _____
YOUR SIGNATURE