



## NEW CLIENT -- SOCIAL SECURITY

Please attach your denial letter. If you do not have it handy, please email it to newclientinfo@ghitterman.com before your appointment.

Appointment Date and Time: \_\_\_\_\_

### **BACKGROUND**

What benefits are you seeking? (check all that apply)

Social Security Disability Insurance (SSDI)    Supplemental Security Income (SSI)

Long Term Disability

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone No.: \_\_\_\_\_

Alternate phone No.: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_                      SSN: \_\_\_\_\_

Primary Language: \_\_\_\_\_    Need Interpreter? \_\_\_\_\_

Do you have a smart phone? \_\_\_\_\_    Do you use texting? \_\_\_\_\_

Read English? \_\_\_\_\_                      Write English? \_\_\_\_\_

Emergency contact (Name, Relationship, Cell Phone): \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Do you have another attorney or have you had another attorney? If so, for how long and why are you seeking additional legal counsel? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **CLAIM INFO:**

Are you currently or have you received SSDI/SSI benefits in the last year? \_\_\_\_\_

If yes, please provide the date of last check \_\_\_\_\_

If no, please answer the following:

Date applied for SSDI/SSI: \_\_\_\_\_ Date(s) of denial letters: \_\_\_\_\_

On your application, what date did you state as the day you became unable to work?: \_\_\_\_\_ What date did you last work: \_\_\_\_\_

Do you have a hearing scheduled, and if so, when? \_\_\_\_\_

Have you already had a hearing, and if so, when? \_\_\_\_\_

Have you ever worked? \_\_\_\_\_

If yes, why did you stop working? \_\_\_\_\_

Why can't you work now? (describe your limitations): \_\_\_\_\_

All medical conditions/diagnosis affecting your ability to work: \_\_\_\_\_

Name, address, phone and email address for your family doctor: \_\_\_\_\_

Name, address, phone number, & specialty of each health care provider you have seen: \_\_\_\_\_

**CURRENT MEDICATIONS:**

Name of medication, prescribing doctor, condition treating, side effects, if any:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Since you applied for benefits, has your condition/diagnosis changed? \_\_\_\_\_

If yes, please describe how your condition/diagnosis has changed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMPLOYMENT INFO:**

Prior employment (over the last 15 years):

Employer: \_\_\_\_\_ Job title: \_\_\_\_\_

Dates of employment From: \_\_\_\_\_ To: \_\_\_\_\_

Duties: \_\_\_\_\_

Employer: \_\_\_\_\_ Job title: \_\_\_\_\_

Dates of employment From: \_\_\_\_\_ To: \_\_\_\_\_

Duties: \_\_\_\_\_

Employer: \_\_\_\_\_ Job title: \_\_\_\_\_

Dates of employment From: \_\_\_\_\_ To: \_\_\_\_\_

Duties: \_\_\_\_\_

Employer: \_\_\_\_\_ Job title: \_\_\_\_\_

Dates of employment From: \_\_\_\_\_ To: \_\_\_\_\_

Duties: \_\_\_\_\_

Employer: \_\_\_\_\_ Job title: \_\_\_\_\_

Dates of employment From: \_\_\_\_\_ To: \_\_\_\_\_

Duties: \_\_\_\_\_

**EDUCATION:**

What was the highest grade you completed in school? \_\_\_\_\_

If you left school before completing high school, did you earn a GED? \_\_\_\_\_

Please identify any college, vocational or certificate programs that you have attended, the type of training and whether you completed the program:

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*Send completed form to [newclientinfo@ghitterman.com](mailto:newclientinfo@ghitterman.com) or bring with you day of appt.*

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