United States
Office of Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017-0045

Form Approved:
OMB Number 3206-0179

Disabled Dependent Questionnaire

1. Name of disabled dependent *(last, first, middle)*	2. Dependent's date of birth *(mm/dd/yyyy)*
3. Name of annuitant or deceased annuitant *(last, first, middle)*	4. Claim number **CS**

Complete Part A below and ask the physician to complete Part B on the other side of this form.

Part A.   To Be Completed by Disabled Dependent or Dependent's Guardian or Other Fiduciary

1. Disabled dependent's Social Security Number ➡

2a. The unmarried disabled dependent lives:

☐ with parent(s) *(go to 2b)* ➡

☐ with guardian or other fiduciary *(go to 2b)* ➡

☐ in a licensed facility *(go to 2b)* ➡

2b. Please provide the disabled dependent's address and the name of the person he or she lives with.

2c. ☐ The disabled dependent is married. *(Provide a copy of the marriage certificate, complete item 7, and return the form to us.)*

3. Is there a court appointed guardian or other fiduciary to handle the affairs of the disabled dependent?

☐ Yes. If "yes," the guardian or other fiduciary must attach a copy of the court appointment, provide his or her Social Security or Taxpayer Identification Number, and complete item 7 below. ▶ SSN or TIN

☐ No

4. Has the disabled dependent been employed during the last twelve months?

☐ Yes   ☐ No ➡ Go to question 6.

5a. Periods and type of employment:

From *(mm/dd/yyyy)*	To *(mm/dd/yyyy)*	Description of work performed

5b. Total earnings during periods of employment listed in 5a:

$

5c. Was employment in a closely supervised environment, e.g., closed workshop?

☐ Yes   ☐ No

6. Highest level of education of disabled dependent:

7. Certification

I certify that the above statements are true to the best of my knowledge and belief. I hereby authorize the release of medical evidence and information to the Office of Personnel Management (OPM).

Signature of disabled dependent, guardian, or other fiduciary	Telephone number ( )	Date *(mm/dd/yyyy)*

Please have the unmarried disabled dependent's physician complete the back of this form and return the completed form to the above address.

Part B. To Be Completed by the Physician

In order to determine if your patient is eligible for benefits under the retirement law, we need information regarding the patient's current medical condition.

1. Diagnosis of disability:

2. Estimate of the expected date of full or partial recovery:	3. Age at onset:	4. Severity of disability: ☐ Mild ☐ Moderate ☐ Severe	5. If patient is mentally retarded, state approximate mental age:	6. If patient is mentally retarded, give results of IQ tests:

In addition, please attach a narrative (on your letterhead stationery) addressing the following points:

1. The history of the specific medical condition(s), including references to findings from previous examinations, treatment, and responses to treatment.

2. Clinical findings from your most recent medical evaluation, including findings of physical examinations, results of laboratory tests, X-rays, EKG's and other special evaluations or diagnostic procedures and, in the case of psychiatric disease, the findings of mental status examinations and the results of psychological tests.

3. Assessment of the current clinical status and plans for future treatment.

4. Assessment of the degree to which the medical condition has or has not become static, well stabilized, or controlled, and an explanation of the medical basis for the conclusion.

5. Specify the physical and/or mental limitations or restrictions caused by the patient's medical condition(s).

6. Does the patient's condition preclude or limit self-supporting employment? Explain your answer.

7. If the patient is incapable of self-support, at what age did the patient become incapable?

8. Can the patient handle his or her own finances?

Signature	Print or type name	Date
Address		Telephone number *(including area code)*

Return the completed form and the narrative to the address on the front of the form.