

Worksheet 3

Applicant Tracking Worksheet

(use additional sheets, if necessary)

Name: _____ **DOB:** _____ **SSN:** _____

Phone: _____ **Address:** _____

Third Party Contact (N/A if no one): _____

Third Party Phone: _____ **Third Party Address:** _____

Area of town where person stays: _____

Food kitchens/shelters/etc.: _____

Other staff/programs involved: _____

Program/Staff person: _____

Protected filing date _____

Application date: _____

By Phone: _____ In Person: _____

SSA Claims Representative

Name: _____ **Phone:** _____

Office address _____

Medical evidence submitted with application? Yes _____ No _____

Medical records sent for

Source _____

Date(s) requested: _____ Date received: _____ Date sent to SSA/DDS: _____

Source _____

Date(s) requested: _____ Date received: _____ Date sent to SSA/DDS: _____

Source _____

Date(s) requested: _____ Date received: _____ Date sent to SSA/DDS: _____

DDS Disability Examiner

Name _____ **Phone** _____

Dates of follow-up contact with DDS examiner

Consultative examination appointment? Yes _____ No _____ If yes, Date _____

Decision Approved _____ Denied _____ Date _____

Reconsideration filed (N/A if person is approved) _____

Place of Birth: _____

Mother's Maiden Name: _____

Father's Name: _____