Activities of Daily Living for a Homeless Applicant

Your Name _____ **Social Security Number** _____

Please give the name address and phone number of at least one other person who can be contacted about your claim: _____

1. Living arrangements
   - How long have you been homeless? _____
   - Where do you stay? _____
   - How long have you stayed there? _____
   - Where do you spend your day? _____
   - What do you usually do during the day? _____
   - _____
   - _____

2. Sleep
   - Do you take medicine to help you sleep? Yes_____No_____
   - What do you take? _____
   - How many hours a night do you sleep? _____
   - Do you sleep during the day? Yes _____No_____
   - Where do you sleep during the day? _____

3. Personal care
   - Do you need to be reminded to care for your personal needs? Yes _____No_____
   - Does someone help you with your personal care? Yes _____No_____
   - How do they help you? _____

4. Meals/eating habits
   - How many meals do you eat each day? _____
   - Where do you eat your meals? _____
   - _____
   - Do you sometimes prepare your own food? Yes_____ No_____
   - How have your eating habits changed since becoming homeless? _____
   - _____
   - Please indicate your current weight_____ height. _____

5. Shopping
   - Where do you get your clothes? _____
   - Where do you get your personal grooming products? _____
   - Do you have difficulty handling your own money or food stamps? _____
   - _____

6. Social contacts
   - Do you spend time with other homeless individuals? Yes _____ No_____
   - Do you spend time with friends or relatives? Yes_____ No_____
   - Do you prefer to be with others or by yourself? _____
   - Do you find you get along with others? _____
   - How do you get around? _____

7. Concentration/memory

Do you have any problems remembering things? Yes _____No_____
Do you have any problems following written or verbal instructions? Yes _____No_____
Do you finish what you start out to do? If not, please give an example. Yes _____ No_____
_____
Do you have problems concentrating? Yes_____ No_____

8. Treatment
Do you take any medication? Yes_____ No _____
If not, do you think medication would help you? Yes_____ No _____
If you take medications, what are they? _____
_____
Who prescribes the medication for you? _____
Does someone help you remember to take the medication? Yes _____No_____
Have you had any new treatment for physical or mental problems since you first applied for social security disability? _____
_____

If anyone assisted you in completing this form, please indicate:

Name_____
Address _____
Telephone _____

Please sign here _____Date _____