

**SOCIAL SECURITY ADMINISTRATION**

**INFORMATION REQUEST**

**Office Address:**

**TO: Commander, Supervisor or NCOIC  
of Wounded Warrior**

We are writing to ask for your help in obtaining work information about the service member named on the attached pages. We are requesting this information in order to determine whether the military service member's work activity was subsidized, or whether there was an Unsuccessful Work Attempt (UWA) under Social Security rules.

A person in the military service who is being treated for a severe impairment usually continues to receive full military pay. However, for Social Security Substantial Gainful Activity (SGA) purposes, it is not appropriate to evaluate his or her work activity based on the amount of military pay received.

Instead, it is generally necessary to use **nonmonetary** SGA criteria in assessing the work activity of a service member assigned to a Warrior Transition Unit, receiving treatment at a military hospital, working in a designated therapy program, or on limited duty. We must compare the work activity with similar work in the civilian work force and determine its reasonable worth.

Please answer the questions below, sign and return it to Social Security within 15 days when possible. We appreciate your help in this matter.

Field Office Manager

**SSA 3033 form substitute**

(locally produced 01/17/12)

Supervisor/Squad Leader Complete

**WORK QUESTIONNAIRE FOR MILITARY SERVICE MEMBER  
(Information for form SSA 3033):**

**Name and Rank of Service Member:** \_\_\_\_\_

1. Military Occupation Specialty (MOS) title or Branch: \_\_\_\_\_

2. Please list below the dates when the service member was assigned to the Warrior Transition Unit (WTU), was on Medical hold status, or on periods of convalescent leaves:

WTU assignment began date \_\_\_\_\_ end date \_\_\_\_\_

Medical hold began date \_\_\_\_\_ end date \_\_\_\_\_

Convalescent Leave Periods \_\_\_\_\_

3. What daily duties or work activities has the service member been **performing since being assigned to the WTU/medical hold unit or hospital?**: \_\_\_\_\_

- Number of hours per day \_\_\_\_\_ Number of days per Week \_\_\_\_\_

4. Are (were) the duties being performed the same as his/her assigned Military Occupational Specialty/Branch and are/were they comparable to that of other service members of his/her rank in terms of hours and pay?

Yes \_\_\_\_\_ or No \_\_\_\_\_ If, no, explain \_\_\_\_\_

5. Is (was) the service member frequently absent from work due to his/her impairment/illness?

Yes \_\_\_\_\_ No \_\_\_\_\_ if yes, please explain

6. Is (was) this service member given any special considerations? Yes \_\_\_\_\_ No \_\_\_\_\_  
Special conditions would be present if the service member: (explain in remarks section)

- Required and received special assistance from other service members in performing his/her job duties
- Was assigned work especially suited to his/her impairment?
- Was permitted to perform at a lower standard of productivity or efficiency than other employees in the same job.
- Was on limited duty or worked less hours during duty time.

(cont) Name, SSN and Rank of Service Member \_\_\_\_\_

7. Based on the information above, **if the service member is performing in his/her MOS/Branch**, approximately how would you rate his/her productivity compared to the other service members in similar positions and similar pay rate?

If working in his/her branch or MOS please check one block below or N/A \_\_\_\_\_

50% or less of other service members' productivity \_\_\_\_\_

60% or less of other service members' productivity \_\_\_\_\_

70% or less of other service members' productivity \_\_\_\_\_

80% or less of other service members' productivity \_\_\_\_\_

90% or less of other service members' productivity \_\_\_\_\_

100% of other service members' productivity \_\_\_\_\_

8. If the service member has now stopped working, was the service member's medical condition, or, his/her inability to perform the work activity a factor in the decision to stop performing the work activities work?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_ if no, why did he/she stop work.

9. Additional Remarks:

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Person providing information \_\_\_\_\_

Job Title and Relationship to Service Member: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Email address/optional \_\_\_\_\_

Unit of Assignment \_\_\_\_\_