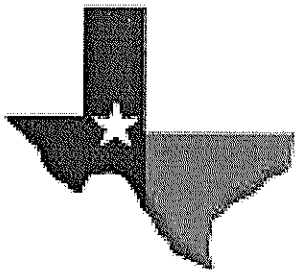
SECTION E



APPEALS/ALJ

APPEALS PROCESS FORMS CHECKLIST

1. Reconsideration – DARS will request records
    a. Request for Reconsideration (SSA-561-U2)
    b. Disability Report Appeal (SSA-3441-BK)
    c. Function Report Child/Adult
    d. Authorization to Disclose Information to SSA – 827
    e. Request for Reconsideration (SSA-789-U4

2. Request for Hearing by Administrative Law Judge – (send any new evidence at this time and when notified of hearing)
    a. Request for Hearing by ALJ (HA-501-U5)
    b. Disability Report Appeal (SSA-3441-BK
    c. Authorization to disclose information to SSA- 827

3. Request for Review of Hearing Decision/Order – Submit any new medical records at this time, there will be no request for records)
    a. Request for review of Hearing Decision/Order (HA-520-u5)
    b. Disability Report Appeal (SSA-3441-BK)
    c. Authorization to Disclose Information to SSA-827

4. Continuing Disability Review Report
    a. Continuing Disability Review Report – SSA-454-BK

Social Security Disability Evaluation Process
The 5 Step Sequential Evaluation Process

Knowledge of the 5 step sequential evaluation process is critical to making a successful Social Security disability claim

Step 1: Is your claimant working?
This step determines if a person is "working", according to the Social Security Administration definition. Earning more than 980.00 a month as an employee is enough to disqualify a person from receiving Social Security disability benefits.

Step 2: Is your claimant's condition severe?
This step evaluates if your claimant's medical condition is severe enough to significantly limit their ability to perform basic work activities. As well, the impairment must last or be expected to last for a continuous period of not less than 12 months or result in death.

Step 3: Is your claimant's condition a listed impairment?
This step asks if the impairment meets or equals a medical "listing". SSA uses many categories of medical conditions called "listings". They can be located at www.ssa.gov/disability/professionals/bluebook/AdultListings.htm. The listed conditions (which meet the requirements per listing) are severe enough to presumptively preclude them from working. If they meet or equal a listing then your client will be granted benefits. If not, then SSA/ALJ will proceed to Step 4.

Step 4: Can your claimant do work they did previously?
This step explores the claimant's ability to perform work they have done in the past 15 years, despite their physical or mental impairments. If SSA/ALJ finds that the claimant can still perform this past relevant work, benefits are denied. At this step all SSA/ALJ does is to match your physical and mental residual functional capacity with the requirements of your former job.

If your claimant cannot perform their past relevant work, then the process proceeds to the fifth and final step.

Step 5: Can your claimant do any other type of work?
This step determines what other work, if any, the claimant can perform. SSA/ALJ considers their age, education, work experience and physical/mental condition to make this determination. If SSA/ALJ finds that they cannot make the transition to other work, they will be granted benefits.

Because SSA/ALJ considers the claimant's age at this step, there are rules for persons over age 50. You can utilize the GRIDs to help with this. They can be located at www.ultimatedisabilityguide.com.

Social Security

Form HA-501 | Request For Hearing By Administrative Law Judge

If you do not agree with the reconsideration decision we made on your application for benefits, you may request a hearing before an Administrative Law Judge (ALJ). To request a hearing, you may use this form or write a letter.

HA-501, Request For Hearing By Administrative Law Judge

If you are not sure this is the form you should use, the Notice of Reconsideration (reconsideration determination) that you received will tell you that to appeal our decision, you should request a hearing before an ALJ. If the notice does not say this, or if you still are not sure this is the form you should complete, call **1-800-772-1213** (TTY **1-800-325-0778**) or your local Social Security office and we will help you to complete the right appeal form.

If you are requesting a hearing on the denial of a claim for disability benefits, you must complete and sign additional forms. These forms are:

- SSA-3441, Disability Report - Appeal , and
- SSA-827, Authorization to Disclose Information to SSA .

You may also need to complete a form SSA-1696, Appointment of Representative, if you are appointing a representative. Your representative should also sign the SSA-1696 before you send it to us.

- You must appeal within 60 days from the date you got the reconsideration decision. We assume you got the reconsideration decision within 5 days of the date shown on that notice unless you can show us you did not get it within the 5-day period.

> **Time to Submit New Evidence**
>
> You should submit any new evidence you want the ALJ to consider with the request for hearing or within 10 days after filing the request. You should make sure that all evidence is received by the ALJ or is available at the time and place set for the hearing. However, if your claim is filed in

> Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, or Connecticut, you must submit any evidence you wish to be considered at the hearing no later than 5 business days before the scheduled hearing. Failure to comply with this requirement may result in the ALJ declining to consider the evidence.

Related Information

- Disability Appeal Online
- More forms

Publications

- The Appeals Process
- Your Right to Question The Decision Made On Your Claim
- Your Right to Question A Decision Made On Your Supplemental Security Income (SSI) Claim
- Your Right To Question The Decision To Stop Your Disability Benefits
- Your Right To Representation

HEARING QUESTIONNAIRE

Name: _____ Date of Hearing: _____

SS# _____ Case # _____

Please state your name and address: _____

_____

_____

Date of Birth: _____ Age: _____ HT _____ WT _____

Normal WT? _____ Weight Gain or Loss Y/N _____

What is your disabling condition? _____

_____

_____

_____

Specific symptoms (Lack of concentration, nervousness, private, public, confusion, out of control, temper, in ability to complete tasks, unmotivated) _____

_____

_____

_____

_____

How long has this condition existed? _____

_____

Are you currently in Treatment? _____

If so, Where? _____

What type of Treatment? _____

_____

Are you currently taking medications? _____

Does the medication help? _____

Are there side effects? Y/N _____

Have you ever been hospitalized? Y/N _____

When? _____

Where? _____

How many times? _____

What type of treatment have you received? _____

_____

How do you spend an average day? _____

_____

_____

How long can you sit?

_____

Walk?

_____

Stand?

_____

How far did you go in school?

_____

Can you read?

Can you write?

Where were you last employed?

What kind of job was it?

Was it your usual job?

Did you work full time?

What hours did you work?

Why did you work those hours?

Have you ever had any type of formal training for employment?

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:	CLAIMANT SSN:	CLAIM NUMBER: *(If different than SSN)*

ISSUE BEING APPEALED: *(Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)*

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.
My reasons are:

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for **SSI** or **SVB**. I have read about the three ways to appeal. I have checked the box below:

☐ **CASE REVIEW - You can pick this kind of appeal in all cases.** You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.

☐ **INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment.** You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.

☐ **FORMAL CONFERENCE - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment.** This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

CONTACT INFORMATION

CLAIMANT SIGNATURE - *OPTIONAL:*		NAME OF CLAIMANT'S REPRESENTATIVE: *(If any)*	
MAILING ADDRESS:		MAILING ADDRESS:	
CITY: STATE: ZIP CODE:		CITY: STATE: ZIP CODE:	
TELEPHONE NUMBER: *(Include area code)*	DATE:	TELEPHONE NUMBER: *(Include area code)*	DATE:

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No
2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No
   (If "NO", attach claimant's explanation for delay. Refer to GN 03102.125)

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

FIELD OFFICE DEVELOPMENT (GN 03102.300)

☐ NO FURTHER DEVELOPMENT REQUIRED
☐ REQUIRED DEVELOPMENT ATTACHED
☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SSI CASES ONLY - GOLDBERG KELLY (GK)

(SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:

☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;
☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT
☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claims Folder

8

ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS (See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

Title II

1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefit;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf to a representative payee, u unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if we determine that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion of or continuation for a specified period of time in an appropriate v vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled;
19. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a jail, prison, or other correctional institution for conviction of a criminal offense;
20. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a mental health institution or other medical facility because a court found the individual was not guilty for reason of insanity; a court found that he/she was incompetent to stand trial or was unable to stand trial for some other similar mental defect; or, a court found that he/she was sexually dangerous.

Title XVI

1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

Title VIII (See VB 02501.035)

1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II-items 3, 4, 10, 11 & 16.

Title XVIII

1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI).
4. Initial determinations regarding Medicare Part B income-related premium subsidy reductions.

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:	CLAIMANT SSN:	CLAIM NUMBER: *(If different than SSN)*

ISSUE BEING APPEALED: *(Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)*

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.
My reasons are:

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for **SSI** or **SVB**. I have read about the three ways to appeal. I have checked the box below:

☐ **CASE REVIEW - You can pick this kind of appeal in all cases.** You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.

☐ **INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment.** You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.

☐ **FORMAL CONFERENCE - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment.** This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

CONTACT INFORMATION

CLAIMANT SIGNATURE - *OPTIONAL:*		NAME OF CLAIMANT'S REPRESENTATIVE: *(If any)*	
MAILING ADDRESS:		MAILING ADDRESS:	
CITY: STATE: ZIP CODE:		CITY: STATE: ZIP CODE:	
TELEPHONE NUMBER: *(Include area code)*	DATE:	TELEPHONE NUMBER: *(Include area code)*	DATE:

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No
2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No
   (If "NO", attach claimant's explanation for delay. Refer to GN 03102.125)

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

FIELD OFFICE DEVELOPMENT (GN 03102.300)

☐ NO FURTHER DEVELOPMENT REQUIRED
☐ REQUIRED DEVELOPMENT ATTACHED
☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SSI CASES ONLY - GOLDBERG KELLY (GK)

(SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:

☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;
☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT
☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claimant

10

HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFIT (SVB) DECISION

Now that you picked the kind of appeal that fits your case, fill out this form or we'll help you fill it out. You can have a lawyer, friend, or someone else help you with your appeal. There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (SSA-789-U4) FOR YOUR APPEAL.

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

Privacy Act Statement
Request for Reconsideration

Sections 205, 702(a)(5), 809(a), 809(b), 1631, 1633, and 1869(b) allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from re-evaluating the decision on your claim.

We will use the information to determine your eligibility for benefits and administer our programs. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his/her affairs or his/her eligibility for or entitlement to benefits under the Social Security program.

2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

3. To the Center for Medicare & Medicaid Services (CMS), for the purpose of administering Medicare Part A, Part B, Medicare Advantage Part C, and Medicare Part D, including but not limited to: Medicare Pa rt C enrollment and premium collection processes; Part D enrollment and premium collection processes; Medicare Part B premium reduction based on participation in a Part C plan; and Medicare Part B enrollment and income-related monthly adjustment amount determinations, appeals of determinations, and premium collections.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs). There are several SORNs that govern the collection of this information, including 60-0089, entitled Claims Folder System, and 60-0321, entitled Medicare Database File. Additional information and a full listing of all our SORNs and applicable routine uses are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions.

SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

11

DISABILITY REPORT - APPEAL
SSA-3441-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

This report is used to update your information for your disability appeal. Completing this report accurately helps us process your claim. Please complete as much of this report as you can.

IF YOU NEED HELP

Please do **not** ask your health care provider to complete this report. You can get help from other people, such as a friend or family member. If you cannot complete this report, a Social Security representative can assist you. If you make an appointment with us, please complete as much of this report as you can and have it with you for your appointment.

HOW TO COMPLETE THIS REPORT

If you have Internet access, you may be able to complete this report online at www.ssa.gov/disability/appeal

If you complete this report on paper:

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers, including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION,** unless this report indicates otherwise. You can write "don't know," or "none," or "does not apply" if you need to.
- If you need more space to answer any question, please use the REMARKS section on the last page, SECTION 10. Include the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any medical records that you have not given to us, send or bring them to our office with this completed report. Please tell us if you want us to return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and this completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

HOW TO SUBMIT THIS REPORT

Send or bring this completed report to your local Social Security office. If you have Internet access, you can locate your nearest Social Security office by zip code at www.socialsecurity.gov/locator. Our offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Privacy Act Statement
Disability Report - Appeal
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(e) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from reconsidering and reviewing your initial or continuing disability determination or evaluating any request for a hearing.

We will use the information you provide to update your disability appeal information. The information we collect also assists the State DDSs and administrative law judges in preparing for the appeals and hearings, and issuing a determination or decision on an individual's entitlement (initial or continuing) to disability benefits.

We may also share your information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations;

2. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and

3. To Federal, State or local agencies for administering cash or non-cash income maintenance or health maintenance programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 45 minutes to read the instructions, gather the facts, and answer the questions.

You may send comments on our time estimate above to:
SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.
Send ONLY comments relating to our time estimate to this address, not the completed form.

AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

DISABILITY REPORT – APPEAL

For SSA use only. Please do not write in this box.

Related SSN _____ Number Holder _____

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 – INFORMATION ABOUT THE DISABLED PERSON

1. A. Name (First, Middle, Last, Suffix) | **1. B.** Social Security Number

1. C. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

☐ Check this box if you do not have a phone number where we can leave a message.

1. D. Alternate Phone Number – another number where we may reach you, if any

1. E. Email Address (Optional)

SECTION 2 – CONTACTS

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim. (e.g., friend or relative)

2. A. Name (First, Middle, Last) | **2. B.** Relationship to Disabled Person

2. C. Mailing Address (Street or PO Box), include apartment number or unit if applicable.

City | State/Province | ZIP/Postal Code | Country (if not U.S.)

2. D. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

2. E. Can this person speak and understand English?

☐ Yes ☐ No

If no, what language does the contact person prefer? _____

2. F. Who is completing this form?

☐ The person who is applying for disability (Go to SECTION 3 - MEDICAL CONDITIONS).
☐ The person listed in 2.A. (Go to SECTION 3 - MEDICAL CONDITIONS).
☐ Someone else (Please complete the information below).

2. G. Name (First, Middle, Last) | **2. H.** Relationship to Disabled Person

2. I. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.

City | State/Province | ZIP/Postal Code | Country (if not U.S.)

2. J. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

SECTION 3 – MEDICAL CONDITIONS

3. A. **Since you last told us about your medical conditions,** has there been any **CHANGE** (for better or worse) in your physical or mental conditions?

☐ Yes, approximate date change occurred: _____ ☐ No

If yes, please describe in detail: _____

_____

_____

3. B. **Since you last told us about your medical conditions,** do you have any **NEW** physical or mental conditions?

☐ Yes, approximate date of new conditions: _____ ☐ No

If yes, please describe in detail: _____

_____

_____

If you need more space, use SECTION 10 – REMARKS on the last page.

SECTION 4 – MEDICAL TREATMENT

4. A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname.

☐ Yes ☐ No

If yes, please list the other names used: _____

_____

4. B. **Since you last told us about your medical treatment,** have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or **do you have a future appointment scheduled?**

☐ Yes ☐ No (Go to SECTION 6 – MEDICINES)

4. C. What type(s) of condition(s) were you treated for, or will you be seen for?

☐ Physical ☐ Mental (including emotional or learning problems)

If you answered "Yes" to 4.B., please tell us who may have **NEW** medical records about any of your **physical or mental** conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider.** If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include:

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities.

Only list the providers you have seen since you last told us about your medical treatment.

SECTION 4 – MEDICAL TREATMENT (continued)

Provider 1

4. D. Name of facility or office	Name of health care provider who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic or Outpatient visits at this facility	**Emergency Room visits at this facility**	**Overnight hospital stays at this facility**
First Visit _____	Date _____	Date in _____ Date out _____
Last Visit _____	Date _____	Date in _____ Date out _____
Next scheduled appointment (if any) _____	Date _____	Date in _____ Date out _____
	☐ None	☐ None

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	DATES OF TESTS	KIND OF TEST	DATES OF TESTS
☐ Biopsy (list body part) _____		☐ MRI/CT Scan (list body part) _____	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing Test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-ray (list body part) _____	
☐ EKG (heart test)			
☐ Hearing Test		☐ Other (please describe) _____	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe,

go to SECTION 5 – OTHER MEDICAL INFORMATION on page 6.

16

SECTION 4 – MEDICAL TREATMENT (continued)
Provider 2

4. D. Name of facility or office	Name of health care provider who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic or Outpatient visits at this facility	**Emergency Room visits at this facility**	**Overnight hospital stays at this facility**
First Visit _____	Date _____	Date in _____ Date out _____
Last Visit _____	Date _____	Date in _____ Date out _____
Next scheduled appointment	Date _____	Date in _____ Date out _____
(if any) _____	☐ None	☐ None

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	DATES OF TESTS	KIND OF TEST	DATES OF TESTS
☐ Biopsy (list body part) _____		☐ MRI/CT Scan (list body part) _____	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing Test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-ray (list body part) _____	
☐ EKG (heart test)			
☐ Hearing Test		☐ Other (please describe) _____	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe,

go to SECTION 5 – OTHER MEDICAL INFORMATION on page 6.

17

SECTION 4 – MEDICAL TREATMENT (continued)
Provider 3

4. D. Name of facility or office

Name of health care provider who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number

Patient ID# (if known)

Address

City

State/Province

ZIP/Postal Code

Country (if not U.S.)

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic or Outpatient visits at this facility

First Visit _____

Last Visit _____

Next scheduled appointment (if any) _____

Emergency Room visits at this facility

Date _____

Date _____

Date _____

☐ None

Overnight hospital stays at this facility

Date in _____ Date out _____

Date in _____ Date out _____

Date in _____ Date out _____

☐ None

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	DATES OF TESTS	KIND OF TEST	DATES OF TESTS
☐ Biopsy (list body part) _____		☐ MRI/CT Scan (list body part) _____	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing Test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-ray (list body part) _____	
☐ EKG (heart test)			
☐ Hearing Test		☐ Other (please describe) _____	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you have been treated by more providers, use section 10 - REMARKS on the last page.

SECTION 5 – OTHER MEDICAL INFORMATION

5. Since you last told us about your other medical information, does anyone else have **medical information** about any of your **physical or mental** conditions (including emotional and learning problems) or are you scheduled to see anyone else?

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

☐ Yes (Please complete the information below.)
☐ No (Go to SECTION 6 – MEDICINES)

Name of Organization	Claim or ID Number (if any)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Name of Contact Person	Phone Number

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

If you need to list more people or organizations, use SECTION 10 – REMARKS on the last page.

SECTION 6 – MEDICINES

6. Are you currently taking any medicines (prescription or non-prescription)?

☐ Yes (Please complete the information below. You may need to look at your medicine containers.)
☐ No (Go to SECTION 7 – ACTIVITIES)

NAME OF MEDICINE	IF PRESCRIBED, NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need to list more medicines, use SECTION 10 – REMARKS on the last page.

SECTION 7 - ACTIVITIES

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your daily activities due to your **physical or mental** conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

☐ Yes ☐ No

If yes, please describe in detail: _____

_____

_____

_____

If you need more space, use SECTION 10 – REMARKS on the last page.

SECTION 8 – WORK AND EDUCATION

8. A. Since you last told us about your work, have you worked or has your work changed?

☐ Yes ☐ No

If yes, you will be asked to provide additional information.

8. B. Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?

☐ Yes ☐ No

If yes, what type? _____

Date(s) attended: _____

If you need more space, use SECTION 10 – REMARKS on the last page.

SECTION 9 – VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

9. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program?
- an individualized plan for employment with a vocational rehabilitation agency or any other organization?
- a Plan to Achieve Self-Support (PASS)?
- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ Yes (Please complete the information below.)
☐ No (Go to SECTION 10 – REMARKS)

Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Date when you started participating in the plan or program:

If you need more space, use SECTION 10 – REMARKS on the last page.

SECTION 10 – REMARKS

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

Date Report Completed MM/DD/YYYY: _____

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

1. Claimant Name	2. Claimant SSN	3. Claim Number, if different

4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

5. I have additional evidence to submit. ☐ Yes ☐ No

Name and source of additional evidence, if not included.

Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.

6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks

☐ I wish to appear at a hearing.

☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

Representation: You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

7. CLAIMANT SIGNATURE (OPTIONAL)	DATE	8. NAME OF REPRESENTATIVE (if any)	DATE

RESIDENCE ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		TELEPHONE NUMBER	FAX NUMBER	

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING

9. Request received on _____ (Date) by: _____ (Print Name) _____ (Title)

_____ (Address) _____ (Servicing FO Code) _____ (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination? ☐ Yes ☐ No

If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided? ☐ Yes ☐ No

12. Interpreter needed ☐ Yes ☐ No

Language (including sign language):

13. Check one: ☐ Initial Entitlement Case

☐ Disability Cessation Case or ☐ Other Postentitlement Case

14. HO COPY SENT TO: _____ HO on _____

☐ Claims Folder (CF) Attached: ☐ Title (T) II; ☐ T XVI; ☐ T VIII; ☐ T XVIII; ☐ T II CF held in FO ☐ Electronic Folder

☐ CF requested ☐ T II; ☐ T XVI; ☐ T VIII; ☐ T XVIII

(Copy of email or phone report attached)

16. CF COPY SENT TO: _____ HO on _____

☐ CF Attached: ☐ Title (T) II; ☐ T XVI; ☐ T XVIII

☐ Other Attached:

15. Check all claim types that apply:

☐ Retirement and Survivors Insurance Only	(RSI)
☐ Title II Disability - Worker or child only	(DIWC)
☐ Title II Disability - Widow(er) only	(DIWW)
☐ Title XVI (SSI) Aged only	(SSIA)
☐ Title XVI Blind only	(SSIB)
☐ Title XVI Disability only	(SSID)
☐ Title XVI/Title II Concurrent Aged Claim	(SSAC)
☐ Title XVI/Title II Concurrent Blind	(SSBC)
☐ Title XVI/Title II Concurrent Disability	(SSDC)
☐ Title XVIII Hospital/Supplementary Insurance	(HI/SMI)
☐ Title VIII Only Special Veterans Benefits	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify:	

Form **HA-501-U5** (01-2015) ef (01-2015)
Use 08-2012 Edition Until Stock is Exhausted

TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS

22

PRIVACY ACT STATEMENT
Request for Hearing by Administrative Law Judge

Sections 205(a) (42 U.S.C. 405 (a)), 702 (42 U.S.C. 902), 1631(e) (1) (A), and; (B) (42 U.S.C. 1383(e) (1) (A) and (B)), 1839(i) (42 U.S.C. 1395r), 1869(b) (1), and (c) (42 U.S.C. 1395ff) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to continue processing your claim.

Providing this information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim.

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigate activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in System of Records Notices 60-0089, Claims Folder System and 60-0050, Completed Determination-Continuing Disablility Determinations. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to:SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0277

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended ALJ decision.)

(Either mail the signed original form to the Appeals Council at the address shown below, or take or mail the signed original to your local Social Security office, the Department of Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service Post and keep a copy for your records.)

See Privacy Act Notice

1. CLAIMANT NAME	2. CLAIMANT SSN	3. CLAIM NUMBER (If different than SSN)

4. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

☐ Please grant me an extension of time to submit evidence or argument.

ADDITIONAL EVIDENCE

If you have additional evidence that relates to the period on or before the date of the hearing decision, you must inform the Appeals Council about it or submit it. If you have a representative, then your representative must help you obtain the evidence unless the evidence falls under an exception. You may also submit any other additional evidence to the Appeals Council. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. This will ensure that the Appeals Council has the opportunity to consider the additional evidence before taking its action. If you submit neither evidence nor legal argument now or within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence currently in your file.

IMPORTANT: WRITE YOUR SOCIAL SECURITY NUMBER ON ANY LETTER OR MATERIAL YOU SEND US. IF YOU RECEIVED A BARCODE FROM US, THE BARCODE SHOULD ACCOMPANY THIS DOCUMENT AND ANY OTHER MATERIAL YOU SUBMIT TO US.

SIGNATURE BLOCKS: You should complete No. 5 and your representative (if any) should complete No. 6. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 6.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

5. CLAIMANT'S SIGNATURE	DATE	6. REPRESENTATIVE'S SIGNATURE	DATE

PRINT NAME	PRINT NAME ☐ ATTORNEY ☐ NON-ATTORNEY

ADDRESS CITY, STATE, ZIP	ADDRESS CITY, STATE, ZIP

TELEPHONE NUMBER	FAX NUMBER	TELEPHONE NUMBER	FAX NUMBER

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

7. Request received for the Social Security Administration on _____ by: _____
(Date) (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

8. Is the request for review received within 65 days of the ALJ's Decision/Dismissal? ☐ Yes ☐ No

9. If "No" checked: ☐ (1) attach claimant's explanation for delay; and
☐ (2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

10. Check one:

☐ Initial Entitlement
☐ Termination or other

APPEALS COUNCIL
OFFICE OF DISABILITY ADJUDICATION
AND REVIEW, SSA
5107 Leesburg Pike
FALLS CHURCH, VA 22041 - 3255

11. Check all claim types that apply:

☐ Retirement or survivors	(RSI)
☐ Disability-Worker	(DIWC)
☐ Disability-Widow(er)	(DIWW)
☐ Disability-Child	(DIWC)
☐ SSI Aged	(SSIA)
☐ SSI Blind	(SSIB)
☐ SSI Disability	(SSID)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify:	

Form **HA-520-U5** (01-2016) UF (01-2016)
Destroy Prior Editions

TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS

24

Privacy Act Statement
Request for Review of Hearing Decision/Order

Sections 205(a), 702, 1631(e), and 1869(b) and (c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to complete our claims process.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent the continued processing of your claim.

We rarely use the information you supply for any purpose other than to complete our claims process. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0005, entitled Administrative Law Judge Working Files and 60-0089, entitled Claims Folder. Additional information about these and other system of records notices and our programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at **www.socialsecurity.gov.** Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). ***Send only comments relating to our time estimate to this address, not the completed form.***

REQUEST FOR RECONSIDERATION - DISABILITY CESSATION RIGHT TO APPEAR

(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (if different from Claimant)	SOCIAL SECURITY NUMBER
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)	

FOR SOCIAL SECURITY OFFICE USE ONLY **(DO NOT WRITE IN THIS SPACE)**

☐ FO Code _____

☐ Benefit Continuation

☐ Foreign Language Notice _____

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ CHILD

I DO NOT AGREE WITH THE DETERMINATION TO STOP DISABILITY BENEFITS AND I REQUEST RECONSIDERATION.
My reasons are (reasons should relate to the basis for stopping disability benefits and be as specific as possible):
NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice.

I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION (If "NONE" write "NONE")
(Attach additional page if needed):

CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY OR CHECK BLOCK 2

☐ 1. **I (and/or my representative) wish to appear** at a disability hearing. The disability hearing will be with a person called a disability hearing officer and it will let me explain why I do not agree with the decision to stop benefits.

☐ I need an interpreter at the disability hearing - Language _____
(If you need an interpreter, SSA will provide one at no cost to you.)

OR

☐ 2. **I do not wish to appear nor do I wish a representative to appear for me** at the disability hearing. I have been advised of my right to have a disability hearing. I understand that a disability hearing will give me a chance to present witnesses. It will also let me explain to the disability hearing officer why my disability benefits should not end. I understand that this chance to be seen and heard could help the disability hearing officer learn about the facts in my case. The disability hearing officer would give me a chance to have people who know about my condition give information and explain how my condition keeps me from working and restricts my activities. I have been told about my right to representation at the disability hearing, including representation by an attorney or other person of my choice. Although the above has been explained to me, I do not want to appear at a disability hearing, or have someone represent me at a disability hearing. I prefer to have the disability hearing officer decide my case on the evidence in my file, plus any evidence that I submit or that may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a disability hearing prior to the writing of a decision in my case. In this case, I can make the request with any Social Security office.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE		
STREET ADDRESS			REPRESENTATIVE'S ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	DATE		TELEPHONE NUMBER	DATE	

Witnesses are required ONLY if this form has been signed by mark (X). If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (Number and Street, City, State, and ZIP Code)	ADDRESS (Number and Street, City, State, and ZIP Code)

Privacy Act Statement
Collection and Use of Personal Information

Sections 205 (a) and (b), and 1631 (c)(1)(A) and (B) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from reconsidering a determination on your claim.

We will use the information to reconsider your eligibility for disability benefits. We may also share your information for the following purposes, called routine uses:

- To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and,
- To third party contacts (including private collection agencies under contract with us) for the purpose of their assisting us in recovering overpayments.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0009, entitled Hearings and Appeals Case Control System, as published in the Federal Register (FR) on October 13, 1982, at 47 FR 45589; 60-0010, entitled Hearing Office Tracking System of Claimant Cases, as published in the FR on January 11, 2006 at 71 FR 1806; and 60-0089, entitled Claims Folders Systems, as published in the FR on April 1, 2003, at 68 FR 15784. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 13 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

CONTINUING DISABILITY REVIEW REPORT
FORM SSA-454-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

We will use the information that you give us on this form to do your continuing disability review. We will use the form to update your disability information **since the date of your last medical disability decision.** Please complete as much of the form as you can. If you need help, your interviewer will help you finish it. If you have an appointment for an interview by telephone, have the form ready to discuss with us when we call you. If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.

Reminder: If you are filling out the form for someone else, please provide the information about him or her. When a question refers to "you," "your," or the "Disabled Person," it refers to the person who is receiving disability benefits.

HOW TO COMPLETE THIS FORM

- Print or write clearly.
- Unless otherwise indicated, **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 3, PUT INFORMATION FOR ONLY ONE DOCTOR/HMO/THERAPIST/OTHER/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THIS FORM.** However, you can get help from other people, like a friend or family member.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions, please use **SECTION 10 - REMARKS**, on Page 14, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records or copies of prescriptions at home, send them to our office with your completed form or, if you are having an interview in our office, bring them and any medicine containers with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information that we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of your medical sources, you may be able to get that information from the telephone book, medical bills, prescriptions, or prescription containers.

The Privacy Act

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d), and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your case. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your case. Although the information you furnish is almost never used for any purpose other than making a determination about your disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information about Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use information that you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

AFTER COMPLETING THIS FORM, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0072

CONTINUING DISABILITY REVIEW REPORT

SSA will use this form to review your illnesses, injuries, or conditions since the date of your last medical disability decision.

For SSA Use Only
Do not write in this box.
Date of your last medical disability decision: _____

Related SSN _____ – – Number Holder _____

Type(s) of Case(s): (Check all that apply.)

TITLE II	☐ DIB	☐ DWB	☐ CDB	☐ FZ	☐ ESRD	☐ HIB
TITLE XVI	☐ DI	☐ DS	☐ DC	☐ BI	☐ BS	☐ BC

If you are currently participating in the Ticket to Work Program or working under a plan with a private or State Vocational Rehabilitation Agency, contact the Social Security Administration before completing this form.

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

1.A. NAME (first, middle, last)

1.B. SOCIAL SECURITY NUMBER – –

1.C. DAYTIME PHONE NUMBER (If you do not have a phone number where we can reach you, give us a daytime phone number where we can leave a message.)

( ) _____ – _____
(area code) (phone number)

☐ Your number
☐ Message number
☐ None

1.D. E-MAIL ADDRESS (optional)

1.E. Give the name of a friend or relative (other than your doctors) that we can contact who knows about your illnesses, injuries, or conditions, and can help you with your case.

NAME

RELATIONSHIP

ADDRESS (number, street, apt., PO Box, rural route)

CITY STATE ZIP –

DAYTIME PHONE NUMBER

( ) _____ – _____
(area code) (phone number)

1.F. Can you speak and understand English? ☐ YES ☐ NO

If "no," what is your preferred language? _____

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

If you cannot speak and understand English, is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO

If "yes," and this is the same person as in "1.E." above, write "SAME" below. If "yes," but this is a different person, complete the information below.)

NAME

RELATIONSHIP

ADDRESS (number, street, apt., PO Box, rural route)

CITY STATE ZIP –

DAYTIME PHONE NUMBER

( ) _____ – _____
(area code) (phone number)

1.G. If you are age 18 or older, can you read and understand English? ☐ YES ☐ NO

1.H. If you are age 18 or older, can you write more than your name in English? ☐ YES ☐ NO

1.I. What is your height without shoes?

1.J. What is your weight without shoes?

30

SECTION 2- INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

2.A. If you are an adult (age 18 or older), what are the disabling illnesses, injuries, or conditions that limit your ability to work? **If you are a child (under age 18)**, what are the disabling illnesses, injuries, or conditions that limit your ability to do the same things as other children of the same age?

2.B. Has there been a change (for better or worse) in your illnesses, injuries, or conditions listed in SECTION 2.A., **since the date of your last medical disability decision** (see date on top right side of Page 1)?

☐ YES (Describe specific changes below and give dates when these changes started.)

☐ NO

If you need more space, use SECTION 10 - REMARKS.

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS

3.A. Within the last 12 months, have you seen a doctor/hospital/clinic or anyone else for your illnesses, injuries, or conditions?

☐ YES ☐ NO

Do you have a **future appointment** with a doctor/hospital/clinic or anyone else for your illnesses, injuries, or conditions?

☐ YES ☐ NO

3.B. Within the last 12 months, have you seen a doctor/hospital/clinic or anyone else for emotional or mental problems?

☐ YES ☐ NO

Do you have a **future appointment** with a doctor/hospital/clinic or anyone else for emotional or mental problems?

☐ YES ☐ NO

If you answered "No" to both 3.A. and 3.B., do not complete the rest of SECTION 3; skip to SECTION 4.

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

3.C. List other names, if any, that you have used on your medical records **within the last 12 months.**

3.D. List each **DOCTOR/HMO/THERAPIST/OTHER PERSON** who has treated you **within the last 12 months.** Also, provide this information for any future appointment(s).

1. NAME			**DATES**
ADDRESS			First Visit **(within last 12 months)**
CITY	STATE	ZIP –	Last Visit
PHONE ( ) – (area code) (phone number)	PATIENT ID# (if known)		Next Appointment
Reasons for visits	What treatment was received?		

2. NAME			**DATES**
ADDRESS			First Visit **(within last 12 months)**
CITY	STATE	ZIP –	Last Visit
PHONE ( ) – (area code) (phone number)	PATIENT ID# (if known)		Next Appointment
Reasons for visits	What treatment was received?		

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

DOCTOR/HMO/THERAPIST/OTHER

3. NAME			DATES
ADDRESS			First Visit **(within last 12 months)**
CITY	STATE	ZIP –	Last Visit
PHONE ( ) – (area code) (phone number)	PATIENT ID# (if known)		Next Appointment
Reasons for visits	What treatment was received?		

If you need more space, use SECTION 10 - REMARKS.

3.E. List each **HOSPITAL/CLINIC** where you received treatment **within the last 12 months**. Also, provide this information for any future appointment(s).

1. NAME			PHONE ( ) – (area code) (phone number)
ADDRESS			PATIENT ID # (if known) / NEXT APPOINTMENT
CITY	STATE	ZIP –	What doctor(s) do you regularly see here?

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

HOSPITAL/CLINIC

2. NAME			PHONE ( ) – (area code) (phone number)
ADDRESS			PATIENT ID # (if known) / NEXT APPOINTMENT
CITY	STATE	ZIP –	What doctor(s) do you regularly see here?

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

3. NAME			PHONE ( ) – (area code) (phone number)
ADDRESS			PATIENT ID # (if known) / NEXT APPOINTMENT
CITY	STATE	ZIP –	What doctor(s) do you regularly see here?

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

If you need more space, use SECTION 10 - REMARKS.

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

If you are under age 18, do not complete question 3.F. or SECTION 4; skip to SECTION 5 - TESTS.

3.F. Does anyone else (for example, Workers' Compensation, insurance company, prisons, attorneys, or welfare agency) have medical records or information about your illnesses, injuries, or conditions, **within the last 12 months**? Also, provide this information if you are scheduled to see anyone in the future.

☐ YES (Complete the following information.) ☐ NO (Skip to SECTION 4.)

NAME			DATES
ADDRESS			FIRST VISIT**(within the last 12 months)**
CITY	STATE	ZIP –	LAST VISIT
PHONE ( ) – (area code) (phone number)			NEXT APPOINTMENT
CLAIM NUMBER (if any)			NAME OF CONTACT PERSON
REASONS FOR VISITS			

If you need more space, use SECTION 10 - REMARKS.

SECTION 4 - MEDICATIONS

Are you taking any medications for your illnesses, injuries, or conditions?

☐ YES (Complete the following information. Look at your medicine containers, if necessary.)

☐ NO (Skip to SECTION 5.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	ANY SIDE EFFECTS YOU HAVE

If you need more space, use SECTION 10 - REMARKS.

SECTION 5 - TESTS

Within the last 12 months, have you had any of the following tests for your illnesses, injuries, or conditions? Also, provide this information if you are scheduled for tests in the future.

☐ YES (Complete the following information, give approximate dates, if necessary.)

☐ NO (Skip to SECTION 6.)

KIND OF TEST	WHEN WAS/ WILL TEST BE DONE? (month, day, year)	WHERE DONE? (name of facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY - Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY -- Name of body part _____			
MRI/CT SCAN -- Name of body part _____			

If you need more space, use SECTION 10 - REMARKS.

SECTION 6 - EDUCATION/TRAINING INFORMATION

Complete SECTION 6 if you are age 18 years old or older.

6.A. Check the highest grade of school completed.

School:

None	K	1	2	3	4	5	6	7	8	9	10	11	12	GED
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

College:

1	2	3	4 or more
☐	☐	☐	☐

Approximate date completed: _____

6.B. Since the date of your last medical disability decision (see date on top right side of Page 1), have you completed or will you complete any type of special job training, trade or vocational school?

☐ YES (Complete the following information.) ☐ NO

NAME OF SCHOOL

ADDRESS

PHONE

( ) –
(area code) (phone number)

CITY | STATE | ZIP –

TYPE OF PROGRAM

APPROXIMATE DATE COMPLETED (or will complete)

If you need more space, use SECTION 10 - REMARKS.

SECTION 7 - UPDATED WORK INFORMATION

If you are under age 14, skip to SECTION 10 - REMARKS.

If you are age 14 or older, complete SECTION 7.A., and as appropriate, B., C., and D. only. Then skip to SECTION 10 - REMARKS.

If you are age 16 or older, complete all of SECTION 7.

7.A. ARE YOU WORKING NOW?

- ☐ **Full-time** (Skip to Question 7.D.)
- ☐ **Part-time** (Skip to Question 7.D.)
- ☐ **Not working now** (Continue to Question 7.B.)

7.B. If you are not working now, did you work **since the date of your last medical disability decision** (see date on top right side of Page 1).

- ☐ YES (Go to Question 7.C.)
- ☐ NO (Skip to Question 7.E.)

7.C. If you are not working now, do you believe that your medical condition has improved?

- ☐ YES
- ☐ NO

7.D. If you have worked at any time **since the date of your last medical disability decision** (see date on top right side of Page 1), complete the following information for each job you have done. List the most recent job first.

		JOB 1	JOB 2	JOB 3
JOB TITLE (example: cook)				
TYPE OF BUSINESS (example: restaurant)				
JOB DESCRIPTION				
DATES WORKED (month and year)	FROM:			
	TO:			
HOURS PER DAY				
DAYS PER WEEK				
RATE OF PAY (per hour, day, week, month, or year)				
REASON YOU STOPPED WORK				

If you need more space, use SECTION 10 - REMARKS.

SECTION 7 - UPDATED WORK INFORMATION, continued

7.E. If you are not working, do you believe that you are able to work?

- ☐ No, I don't believe that I am able to work at this time.
- ☐ Yes, and I believe that I do **not** have limitations or restrictions on my ability to work.
- ☐ Yes, but I believe that I have limitations or restrictions on my ability to work. (Please explain.)

7.F. Has your doctor(s) told you that you are able to work?

- ☐ No (Skip to Section 8.)
- ☐ Did not say (Skip to Section 8.)
- ☐ Yes, and my doctor(s) did **not** place limitations or restrictions on my ability to work.
- ☐ Yes, but my doctor(s) placed limitations or restrictions on my ability to work. (Please explain. If the same as 7.E., write "same" here.)

7.G. What is the name(s) of the doctor(s) who said you were able to work?	**7.H.** According to your doctor, when were/are you able to begin work?
(Please make sure that this doctor(s) is listed in SECTION 3.)	

If you need more space, use SECTION 10 - REMARKS.

SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Complete SECTION 8 if you are age 18 years old or older.

8.A. Since the date of your last medical disability decision (see date on top right side of Page 1), have you participated, or are you participating, in the **Ticket to Work Program**, a plan with a private or State Vocational Rehabilitation Services, an employment network, or any other support services to help you go to work? ☐ YES (Complete the following information.) ☐ NO (Skip to SECTION 9.)

NAME OF ORGANIZATION			
NAME OF COUNSELOR			
ADDRESS			PHONE
CITY	STATE	ZIP –	( ) – (area code) (phone number)

8.B. When did you start participating in the plan?

8.C. Are you still participating in the plan?

☐ YES

☐ NO. I completed the plan _____
(date completed)

☐ NO. I stopped participating in the plan before completing it. (Please explain why you are no longer participating.)

8.D. Types of services or tests provided (for example: intelligence or psychological testing, vision, physicals, hearing, workshops, schools, colleges):

If you need more space, use SECTION 10 - REMARKS.

SECTION 9 - INFORMATION ABOUT YOUR DAILY ACTIVITIES

Complete SECTION 9 if you are age 18 years old or older.

9.A. Describe what you do in a typical day.

SECTION 9 - INFORMATION ABOUT YOUR DAILY ACTIVITIES, continued	
9.B. Do you have difficulty doing any of the following? (Please explain any "Yes" answers.)	
Dressing	☐ No ☐ Yes
Bathing	☐ No ☐ Yes
Caring for hair	☐ No ☐ Yes
Taking medicine	☐ No ☐ Yes
Preparing meals	☐ No ☐ Yes
Feeding self	☐ No ☐ Yes
Doing chores (inside/outside house)	☐ No ☐ Yes
Driving or using public transportation	☐ No ☐ Yes
Shopping	☐ No ☐ Yes
Managing money	☐ No ☐ Yes
Walking	☐ No ☐ Yes
Standing	☐ No ☐ Yes
Lifting objects	☐ No ☐ Yes
Using arms	☐ No ☐ Yes
Using hands or fingers	☐ No ☐ Yes
Sitting	☐ No ☐ Yes
Seeing, hearing, or speaking	☐ No ☐ Yes

SECTION 9 - INFORMATION ABOUT YOUR DAILY ACTIVITIES, continued		
9.B. (continued) Do you have difficulty doing any of the following? (Please explain any "Yes" answers.)		
Concentrating	☐ No	☐ Yes
Remembering	☐ No	☐ Yes
Understanding/following directions	☐ No	☐ Yes
Completing tasks	☐ No	☐ Yes
Getting along with people	☐ No	☐ Yes

9.C. Do you use an assistive device (for example: eye glasses, hearing aids, braces, canes, crutch(es), walker, wheelchair)?

☐ NO

☐ YES (Please describe what kind, when and how you use it.)

9.D. Do you have hobbies or interests?

☐ NO

☐ YES (Please describe what they are and how much time you spend doing them.)

If you need more space, use SECTION 10 - REMARKS.

SECTION 10 - REMARKS

Please provide any additional information you did not show in earlier parts of this form. You may also attach any medical records, copies of prescriptions, or any other records about your current illnesses, injuries, or conditions you have at home that you wish to give us. When you are finished, or if you don't have anything to add, be sure to complete the information below.

Date Form Completed (month, day, year)

If the person completing this form is NOT the disabled person, please complete the following information.

Name (please print)

Address (number and street)			**E-mail address** (optional)
City	**State**	**ZIP** –	**Relationship to disabled person**

Completing a Social Security Appeal online

By: Dana Morgan

Social Security
Official Social Security Website

Appeal A Decision

Recent Medical Decisions

If you recently applied for Social Security disability benefits or Supplemental Security Income (SSI) and were denied for medical reasons, you may request an appeal online and provide documents to support your appeal electronically. You can file an appeal online even if you live outside of the United States.

Appeal Our Recent Medical Decision | Continue An Appeal You Already Started

Other Decisions

If you want to appeal any other kind of Social Security decision, you can call our toll-free number, **1-800-772-1213** (TTY **1-800-325-0778**) or contact your local Social Security office.

Publications

The Appeals Process

Your Right To Question The Decision Made On Your Claim

Your Right To Question A Decision Made On Your Supplemental Security Income (SSI) Claim

Your Right To An Administrative Law Judge Hearing And Appeals Council Review Of Your Social Security Case

Your Right To Representation

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Getting Ready

Before you start your appeal, you should gather the information you need to complete your disability appeal, including:

- Doctors, hospitals, medical treatments, and tests since you last gave us medical information
- Medicines you are currently taking
- Changes in your medical conditions, daily activities, work, and education
- Supporting documents including forms, medical reports, and written statements

Being prepared will help you spend less time to complete your disability appeal online.

Submit an Appeal

Completing your appeal online may take 40 to 60 minutes. Your answers will be saved automatically so you can take a break at any time.

Start a New Appeal or Return to a Saved Appeal

More Information

About This Application
Other Ways to Complete a Disability Appeal
The Appeals Process
Hours of Operation

Your privacy is important.

For details about our use of your information, we encourage you to read our Privacy Act Statement

Social Security

The Official Website of the U S Social Security Administration

Disability Appeal

Information about the Applicant

The information collected here refers to the adult or child whose disability decision is being appealed.

Name:

First Middle Last Suffix

Social Security Number (SSN):

Date of Birth:

Month Day Year

Next Previous

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Who Is Entering This Appeal?

Are you [redacted] or are you entering this appeal on his/her behalf?

- I am [redacted]
- I am entering this appeal for [redacted]

Next

Identification

Please print this page or write down the reentry number.

Reentry Number: **69845678**

Website: www.socialsecurity.gov/disability/appeal

Select "Return to a Saved Appeal".

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue the saved appeal for .

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for reentry number, nor will they have access to it. This is to protect privacy.

Would you like us to email you this reentry number?
Please note, only the reentry number will be sent.

Yes No

Next Save & Exit

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification

Information about

In this section...

Roomy Number

Representative

Applicant Information

Mailing Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2:

Add Line

City/Town:

State/Territory:

ZIP Code:

Daytime Phone Number:

U.S. International

10-digit Number Ext

Fax Number, if any:

U.S. International

10-digit Number

Next Previous Save & Exit

05

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification

Information about

Name:

First Middle Last Suffix

Gender:
We only use this information to customize how we ask the questions for this appeal.
Male Female

Mailing Address:
Country:
United States or U.S. Territory
Street Address:
Street Line 1
Street Line 2
Add Line
City/Town: State/Territory: ZIP Code:

Does live at the above address?
Yes No

Daytime Phone Number:
U.S. International

10-digit Number Ext

Alternative Phone Number, if any:
Please provide another phone number where we can reach Fred Marsh.
U.S. International

10-digit Number Ext

Email Address for Fred Marsh:

Confirm Email Address:

Next Previous Save & Exit

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0960-0622
Paperwork Reduction Act

Identification | Medical | Activities/Training | Review

Request for Reconsideration for[redacted]

In this section...

- Identification
- Representative
- Appointment Information
- **Appeal Request**

What is the date on the "Notice of Decision" [redacted] received? Where to find this date

mm/dd/yyyy

Claim Number, If different from SSN: Where to find the claim number

[redacted] disagrees with the determination made on his claim and requests reconsideration because: What details to include

Enter a brief reason for his appeal. (200 characters maximum)

Characters remaining: 200

Next | Previous | Save & Exit

95

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0960-0144
Paperwork Reduction Act

Identification | Medical | Activities/Training | Review

Someone We Can Contact about _____ ; Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about [redacted] medical conditions and can help him with this appeal.

[redacted] doesn't have a contact.

Name:

First [redacted] Middle Last Suffix

Relationship to [redacted]

Does this person live with [redacted]
Yes No

Does this person have the same daytime phone number as [redacted]
Yes No

Can this person speak and understand English?
Yes No

In this section...

- **Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

Next | Previous | Save & Exit

55

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Change in Conditions for [redacted]

Since [redacted] last told us about his medical conditions, has there been any CHANGE (for better or worse) in his physical or mental conditions? What are changes in conditions?

○ Yes ○ No

New Conditions

Since [redacted] last told us about his medical conditions, does he have any NEW physical or mental conditions? What are new conditions?

○ Yes ○ No

In this section...

- Someone We Can Contact
- **Medical Conditions**
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

Next | Previous | Save & Exit

54

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Other Names for [redacted]

Has [redacted] used any other names on his medical or educational records?
For example, maiden name, other married name, or nickname.

Yes No

Medical Treatment

Since [redacted] last told us about his medical treatment, has he seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or does he have a future appointment scheduled?

Yes No

In this section...

- Someone We Can Contact
- Medical Conditions
- **Medical Treatment**
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

Next | Previous | Save & Exit

55

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Doctors and Hospitals for [redacted]

Please tell us about anyone who has new or updated medical records about any of his physical or mental conditions (including emotional or learning problems).

Status	Doctor or Healthcare Provider	City	Actions

Add Doctor

Status	Hospital or Clinic	City	Actions

Add Hospital or Clinic

Next | Previous | Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- **Doctors and Hospitals**
- Tests
- Medicines
- Other Medical Information

DS

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated known:

Phone Number:

(•) U.S. ( ) International

10-digit Number Ext

Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1

Street Line 2

Add Line

City/Town: State/Territory: ZIP Code:

-

Patient ID Number, If known:

5

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) [redacted] remember. Examples: 6/2/2015; June 2015; Summer 2015

Did [redacted] have any outpatient visits at this hospital or clinic, or does he have any scheduled?

Outpatient visit means he went home the same day. This does not include emergency room visits.

○ Yes ○ No

Did [redacted] have any emergency room (ER) visits at this hospital or clinic?

ER visit means he went to the ER and then went home.

○ Yes ○ No

Did [redacted] have an overnight stay at this hospital or clinic?

○ Yes ○ No

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?

Examples: back injury, arthritis, diabetes, depression, blindness (1000 characters maximum)

32

Hospital or Clinic Details, Disability Appeal, Social Security

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did [redacted] receive for the above conditions at this hospital or clinic? You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for [redacted] including those scheduled in the future.
You will have another opportunity to provide this information

Status	Name of Test	Actions
Click "Add Test" to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add all prescription and non-prescription medicines [redacted] is currently taking that this hospital or clinic recommended or prescribed

Status	Name of Medicine	Reason	Actions
Click "Add Medicine" to add a medicine.			

Add Medicine

Save Cancel

69

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Tests for

Please tell us about any medical tests Fred Marsh had or will have related to his disability.

Status	Name of Test	Test Ordered by	Actions

Click "Add Test" to add a test.

Add Test

Next | Previous | Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- **Tests**
- Medicines
- Other Medical Information

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Other Medical Information for [redacted]

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- **Other Medical Information**

We need to know if anyone else has medical information about any of [redacted]'s conditions or if he is scheduled to see anyone else.

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid Fred Marsh's disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since [redacted] last told us about his other medical information, does anyone have medical information about any of his physical or mental conditions (including emotional and learning problems) or is he scheduled to see anyone else?

○ Yes ○ No

Next | Previous | Save & Exit

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Activities for [redacted]

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation

Since [redacted] last told us about his activities, has there been any change (for better or for worse) in his daily activities due to his physical or mental conditions?

Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

Yes No

Next | Previous | Save & Exit

63

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Work and Education for [redacted]

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation

Sinc[redacted]ast told us about his work, has he worked or has his work changed?

○ Yes ◉ No

Sinc[redacted]st told us about his education, has he completed or is he enrolled in any type of specialized job training, trade school, or vocational school?

○ Yes ◉ No

Next | Previous | Save & Exit

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Vocational Rehabilitation, Employment, or Other Support Services for

In this section...

Activities

Work and Education

Vocational Rehabilitation

We need to know about [redacted] participation in

- an individual work plan with an employment network under the Ticket to Work Program
- an individualized plan for employment with a vocational rehabilitation agency or any other organization
- any program providing vocational rehabilitation, employment services, or other support services to help him go to work
- a Plan to Achieve Self-Support (PASS)
- an individualized education program (IEP) through an educational institution (if a student age 16-21)

Since [redacted] last told us about his vocational rehabilitation, has he participated, or is he participating, in one of these programs?

○ Yes ○ No

Next | Previous | Save & Exit

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Additional Remarks for [redacted]

In this section...

- Remarks
- Medical Release
- Summary

Please provide any additional information

Use this space to provide any information [redacted] could not show in earlier sections of this form or any additional information Fred Marsh feels we should know about. (2000 characters maximum)

Characters remaining: 2000

Next | Previous | Save & Exit

96

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification | Medical | Activities/Training | Review

Medical Release Form for [redacted]

Do you have a signed Medical Release Form?

○ Yes ○ No

In this section...

Remarks

Medical Release

Summary

Next | Previous | Save & Exit

6.

Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Attach Files for _____

If you have any additional forms or electronic evidence that will help us obtain _____'s medical records or review his appeal, please attach them here.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: doc, docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

Click "Add File", then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

Your files will not be processed by Social Security until you click "Submit Appeal". If you click "Previous" or "Save & Exit", you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files

Click "Add File" to attach a file.

Add File

You will not be able to change your information once you submit the appeal.

When you select "Submit Appeal" below, you will be sending this completed information electronically to the Social Security Administration. Please make sure that everything is correct.

Submit Appeal Previous Save & Exit

Social Security

The Official Website of the U S Social Security Administration

Disability Appeal

You have successfully submitted [redacted] Disability Appeal on September 18, 2015 at 11:32:03 AM Eastern Time.

We highly recommend that you print or save a copy of the appeal for his records.

Print or Save

Additional Information

Although you have submitted [redacted] disability appeal online, we still need a few items from him. Please print and have him complete the following: [redacted] you are unable to print

- personalized cover sheet
- Medical Release Form (Authorization to Disclose Information to the Social Security Administration [SSA-827]) [redacted] structions for completing the Medical Release Form
- Form SSA-1696 (Appointment of Representative)

Do you want to begin a new appeal?

We can copy your contact information into the appeal. You will have the opportunity to edit it later.

Start Another Appeal

Done

69

Questions?