DISABILITY REPORT - APPEAL

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that makes the disability decision on your case will use the information you provide in this report to update your disability appeal. Please complete as much of the report as you can.

You may be able to appeal online at www.ssa.gov/disability/appeal.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. **Please do not ask your healthcare provider to complete this report.** If you cannot complete this report, you may contact us at 1-800-772-1213 (TTY 1-800-328-0778). A Social Security Representative will assist you. Have the information available from the bulleted items below when you call us. If you have an appointment, have the information available, or the completed report ready when we contact you. **If you cannot speak or understand English, we will provide an interpreter free of charge.**

YOUR MEDICAL RECORDS

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS. If you have consented to us obtaining medical records from your providers, we will request your records directly from them. The information that you give us on this report tells us where to request your medical and other records.

WHAT YOU NEED TO COMPLETE THIS REPORT

- Names, addresses, and phone numbers of two people (other than your doctors) we can contact who know about your medical condition(s) and can help with your case, if needed.
- Information about any education since you last told us about your education.
- Any prescription or non-prescription medicines you take.
- Names, addresses, and phone numbers of any healthcare providers and information about the medical treatment you received, or testing performed since you last told us about your medical treatment**.**
- If you cannot remember the information about your healthcare providers, the treatment you received, or the testing performed, you may be able to get that information from the telephone book, Internet, online medical chart, medical bills, prescriptions, or prescription medicine containers.
- If you cannot remember the exact dates, provide the closest date you can remember.
- Name(s) of organization(s) we can contact that would have medical information about your condition(s) since you last told us about your other medical information, such as Department of Veterans Affairs, social services agencies, vocational rehabilitation agencies, welfare agencies, attorneys, prisons, workers' compensation, and insurance companies who have paid you disability benefits.
- Information about any vocational rehabilitation, employment, or other support services since you last told us about your support services.
- **ANSWER EVERY QUESTION** unless this report indicates otherwise. Provide as much detail as possible. If you do not know an answer, or the answer is “none” or “does not apply,” please write "don't know," or "none," or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you want to provide additional information. If you need more space to answer any question, use **Section 10 - Remarks.**

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 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
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), and 1631 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 an accurate and timely decision on any claim filed.

We will use the information to reconsider and review an initial disability determination; review a continuing disability; and evaluate a request for a hearing. We may also share your information for the following purposes, called routine uses:

- To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting the Social Security Administration in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and

- To Federal, State, or local agencies (or agents on their behalf) for administering cash or non-cash income maintenance or health maintenance programs (including programs under the Act).

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) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all our SORNs, is 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 (OMB) control number. We estimate that it will take about 50 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

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

DISABILITY REPORT - APPEAL

For SSA Use Only - Do not write in this box.
Related SSN
Number Holder

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION 1 - INFORMATION ABOUT YOU

When a question refers to "you" or "your," it refers to the person who is applying for disability benefits. **If you are completing this report for someone else**, provide information about them.

1.A. NAME (First, Middle Initial, Last, Suffix)

1.B. SOCIAL SECURITY NUMBER

1.C. Have you used any other names on your medical or educational records? Examples include maiden name, other married names, other names, or nickname. ☐ YES ☐ NO

If YES, please list names used:

1.D. MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (If not USA)

1.E. EMAIL ADDRESS

1.F. DAYTIME PHONE NUMBER(S) where we can call to speak with you or leave a message, if needed. Include area code or IDD and country code if outside the USA or Canada.

Primary: _____ Secondary: (if available) _____

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

If NO, what language is preferred? _____

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

1.H. Can you read and understand English? ☐ YES ☐ NO

1.I. Can you write more than your name in English? ☐ YES ☐ NO

SECTION 2 - CONTACTS

Is there someone we can contact who can help with your claim, if needed? Examples include a family member, friend, or neighbor.

☐ YES Please provide the names of two people **(other than your doctors)** we can contact who know about your medical condition(s) and can help you with your claim and can help us reach you if you become unavailable.

☐ NO **We recommend that you provide at least one contact, if available.** Providing the name of someone who knows you may help us to make a decision on your claim.

2.A. NAME (First, Middle Initial, Last)

2.B. Relationship to the Person in **1.A.**

2.C. MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

2.D. DAYTIME PHONE NUMBER (as described in **1.F.** above)

2.E. Can this person speak and understand English? ☐ YES ☐ NO

If NO, what language is preferred?

2.F. NAME (First, Middle Initial, Last)	**2.G.** Relationship to the Person in **1.A.**

2.H. MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

2.I. DAYTIME PHONE NUMBER (as described in **1.F.** above)

2.J. Can this person speak and understand English? ☐ YES ☐ NO

If NO, what language is preferred?

SECTION 3 - MEDICAL INFORMATION

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

☐ NO **(Go to 3.B.)** ☐ YES **(Complete the information below)**

Approximate date the change(s) occurred (MM/DD/YYYY) _____

If yes, please describe the change(s) in detail:

3.B. Since you last told us about your medical condition(s), do you have any **NEW** medical condition(s)?

☐ NO **(Go to 4.A.)** ☐ YES **(Complete the information below)**

Approximate date the change(s) occurred (MM/DD/YYYY) _____

If yes, please describe your new medical condition(s) in detail:

If you need more space, use SECTION 10

SECTION 4 - MEDICAL TREATMENT

4.A. Since you last told us about your medical treatment, have you seen or received treatment from a healthcare provider (doctor, hospital, clinic, psychiatrist, nurse practitioner, therapist, physical therapist, or other medical professional), or **do you have a future appointment scheduled**?

☐ NO **(Go to 4.B.)**

☐ YES **(Complete the chart(s) below)**

Only list the healthcare providers you have seen since you last told us about your medical treatment or are scheduled to see in the future.You may find this information on medical bills, online medical chart, or the Internet.

4.A.1.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

4.A.2.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

4.A.3.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

4.A.4.

NAME OF FACILITY OR OFFICE	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE FIRST SEEN: MM/YYYY	DATE LAST SEEN: MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) MM/YYYY

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

4.B. Since you last told us about your medical treatment, did any of the healthcare providers listed in **4.A.** order any medical tests for you? Include tests performed and scheduled in the future.

☐ NO **(Go to Section 5)**

☐ YES **(Select tests from the chart below)**

TEST	NAME OF HEALTHCARE PROVIDER OR FACILITY	DATE OF TEST (MM/YYYY)
Blood test (not HIV)		
Breathing test		
Cardiac catheterization		
EEG (brain wave test)		
EKG (heart test)		
Hearing test		
HIV test		
Speech/language test		
Treadmill (exercise test)		
Vision test		
Psychological/IQ test		
Biopsy (list body part):		
MRI/CT scan (list body part):		
X-ray (list body part):		
Other - please specify:		

If you need to list more tests, use **Section 10.**

SECTION 5 - OTHER MEDICAL INFORMATION

5. Since you last told us about your other medical information, does anyone else (other than your healthcare providers) have your medical information? Examples include Department of Veterans Affairs, social service agencies, vocational rehabilitation agencies, welfare agencies, attorneys, prisons, workers' compensation, and insurance companies who have paid you disability benefits.

☐ NO **(Go to Section 6)**

☐ YES **(Complete the information below)**

NAME OF ORGANIZATION	PHONE NUMBER

ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

NAME OF CONTACT PERSON	CLAIM NUMBER (if any)

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

Reason(s) for Contacts

If you need to list other people or organizations, use **Section 10**

SECTION 6 - MEDICINES

6. Are you <u>currently</u> taking any medicines (prescription or non-prescription)?

☐ NO **(Go to SECTION 7)**

☐ YES (Please complete the information below. You may need to look at your medicine containers.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR (IF KNOWN)	REASON FOR MEDICINE (IF KNOWN)	SIDE EFFECTS (IF ANY)

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 medical conditions? Examples of daily activities include household chores, preparing meals, personal care, getting around, hobbies, interests, and social activities, etc.

☐ NO **(Go to 8.A.)** ☐ YES **(Complete the information below)**

Describe these changes 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?

☐ NO **(Go to 8.B)** ☐ YES **(Complete the information below)**

Explain in detail. We may ask you to provide additional information.

8.B. Since you last told us about your education, have you enrolled in or completed any classes? Examples include GED classes, specialized job training, trade school, vocational school, college classes or online education.

☐ NO **(Go to Section 9)** ☐ YES **(Complete the information)**

NAME OF SCHOOL	DATE(S) OF ATTENDANCE MM/YYYY TO MM/YYYY
ADDRESS	

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

TYPE OF PROGRAM/DEGREE	Date completed (or scheduled to be completed) MM/YYYY

SECTION 9 - SUPPORT SERVICES

Provide the information about your participation in support services, If applicable. Examples of support services may include:

- An Individualized Education Plan (IEP) through a school (if a student aged 18-21)
- An individualized work plan with an employment network under the Ticket to Work Program
- A Plan to Achieve Self-Support (PASS)
- An individualized plan for employment with a vocational rehabilitation agency or any other organization

9.A. **Since you last told us about your support services**, have you participated or are you participating in any support services mentioned above or any other vocational rehabilitation, employment services, or other support services to help you go work?

☐ NO **(Go to Section 10)**

☐ YES **(Complete the information below)**

FACILITY OR ORGANIZATION NAME

COUNSELOR, INSTRUCTOR, OR JOB COACH NAME	PHONE NUMBER

ADDRESS (Street or PO Box)

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (If not USA)

9.B. Are you still participating in the plan or program? (Select answer below)

☐ YES Date began: _____ MM/YYYY Expected completion date: _____ MM/YYYY

☐ NO Date began: _____ MM/YYYY Date stopped: _____ MM/YYYY

Reason stopped: _____

9.C. Since you last told us about your support services, what types of services, tests, or evaluations were provided?

Select all that apply:

☐ Vision test ☐ Psychological/IQ test ☐ Work classes ☐ Hearing test ☐ Work evaluation

☐ Other - Please explain: _____

If you need to list another plan or program, use Section 10

SECTION 10 - REMARKS

Please provide any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to provide the requested information, please use this space to provide the additional information requested in those sections. If you need additional space, please attach a separate sheet of paper(s). Be sure to include the section and question number to which you are referring.

SECTION 11 - WHO IS COMPLETING THIS REPORT

Date Report Completed MM/DD/YYYY:

Who is completing this report?

- ☐ The person listed in **1.A.**
- ☐ The person listed in **2.A.**
- ☐ The person listed in **2.F.**
- ☐ Someone else (Complete information below)

NAME (First, Middle Initial, Last)	Relationship to the Person in **1.A.**

MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

DAYTIME PHONE NUMBER where we may reach you or leave a message, if needed. Include the area code or IDD and country code if outside the USA or Canada.