DISABILITY REPORT - APPEAL

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that 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, address, 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 closet 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 details 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 THE DISABLED PERSON

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

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 previously described 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 new or updated medical conditions were treated or evaluated?

What new or updated 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 TEST(S)**	**KIND OF TEST**	**DATES OF TEST(S)**
☐ 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 8.

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 (if any)	Date	Date in	Date out
	☐ None	☐ None	

What new or updated medical conditions were treated or evaluated?

What new or updated 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 TEST(S)	KIND OF TEST	DATES OF TEST(S)
☐ 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 8.

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	**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 new or updated medical conditions were treated or evaluated?

What new or updated 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 TEST(S)**	**KIND OF TEST**	**DATES OF TEST(S)**
☐ 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 previously described 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 GED classes, specialized job training, trade school, vocational school or college classes?

☐ Yes ☐ No

If yes, what type?

Date(s) attended:

Degree(s) attained, if any:

Date of attainment (MM/YYYY):

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 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: