SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

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	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)		☐ Other (please describe) _____	
☐ Hearing Test			
☐ 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.

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)		☐ Other (please describe) _____	
☐ Hearing Test			
☐ 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.

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 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)		☐ Other (please describe) _____	
☐ Hearing Test			
☐ 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 <u>currently</u> 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: