

DISABILITY REPORT - APPEAL

For SSA Use Only
Do not write in this box.

Individual
is filing:

Reconsideration

Request for Review by Federal

Reviewing Official

Reconsideration for Disability Cessation

Request for ALJ Hearing

Related SSN _____ - -

Number Holder _____

Date of Last
Disability Report _____

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last)

B. SOCIAL SECURITY NUMBER

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

() -
Area Code Number

Your Number

Message Number

None

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

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

City State ZIP DAYTIME PHONE () -
Area Code Number

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

A. Has there been any change (for better or worse) in your illnesses, injuries, or conditions since you last completed a disability report? Yes No

If "Yes," please describe in detail:

Approximate date the changes occurred:

Month	Day	Year
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B. Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions since you last completed a disability report? Yes No

If "Yes," please describe in detail:

Approximate date the changes occurred:

Month	Day	Year
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C. Do you have any new illnesses, injuries, or conditions since you last completed a disability report? Yes No

If "Yes," please describe in detail:

Approximate date the changes occurred:

Month	Day	Year
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If you need more space, use Section 10 - REMARKS.

SECTION 3 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Since you last completed a disability report, have you seen or will you see a doctor/hospital/clinic or anyone else for the illnesses, injuries, or conditions that limit your ability to work? YES NO

B. Since you last completed a disability report, have you seen or will you see a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work? YES NO

C. List other names you have used on your medical records.

If you answered "NO" to both A and B, go to Section 4 - MEDICATIONS.

Tell us who may have medical records or other information about your illnesses, injuries, or conditions since you last completed a disability report.

D. List each DOCTOR/HMO/THERAPIST/OTHER. Include your next appointment.

1. NAME			DATES	
STREET ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST VISIT	
PHONE () -		PATIENT ID # (If known)	NEXT APPOINTMENT	
<small>Area Code</small>		<small>Phone Number</small>		
REASONS FOR VISITS				

WHAT TREATMENT DID YOU RECEIVE?				

2. NAME			DATES	
STREET ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST VISIT	
PHONE	() -	PATIENT ID # (if known)		NEXT APPOINTMENT
Area Code		Phone Number		
REASONS FOR VISITS				
WHAT TREATMENT DID YOU RECEIVE?				

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

E. List each HOSPITAL/CLINIC. Include your next appointment.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP			
PHONE			<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
Area Code		Phone Number			
			<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	

Next appointment _____ Your hospital/clinic number _____

Reasons for visits _____

What treatment did you receive? _____

What doctors do you see at this hospital/clinic on a regular basis? _____

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

F. Since you last completed a disability report, does anyone else have medical records or information about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else? YES NO

If "YES," complete information below:

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST VISIT
PHONE () - Area Code Phone Number			NEXT APPOINTMENT
CLAIM NUMBER (if any)			
REASONS FOR VISITS			

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

SECTION 4 - MEDICATIONS

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

YES NO

If "YES," please tell us the following: (Look at your medicine containers, if necessary.)

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

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

SECTION 5 - TESTS

Since you last completed a disability report, have you had any **medical tests** for illnesses, injuries, or conditions or do you have any such tests scheduled? YES NO
 If "YES," please tell us the following: (Give approximate dates, if necessary.)

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 - UPDATED WORK INFORMATION

Have you worked since you last completed a disability report? YES NO
 If "YES," you will be asked to give details on a separate form.

SECTION 7 - INFORMATION ABOUT YOUR ACTIVITIES

A. How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?

B. What changes have occurred in your daily activities since you last completed a disability report?

If none, show "NONE."

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

SECTION 8 - EDUCATION/TRAINING INFORMATION

Have you completed any type of **special job training, trade or vocational school since you last completed a disability report?** YES NO

If "YES," describe what type: _____

Approximate date completed: _____

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OTHER SUPPORT SERVICES INFORMATION, OR INDIVIDUALIZED EDUCATION PROGRAM

Since you last completed a disability report, 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;
- an individualized education program through an educational institution (if a student age 18-21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

YES NO

If "YES," complete the following information:

NAME OF ORGANIZATION OR SCHOOL _____

NAME OF COUNSELOR OR INSTRUCTOR _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

DAYTIME PHONE NUMBER _____

() - _____
Area Code

Number

DATES SEEN _____

TO _____

TYPE OF SERVICES,
TESTS, OR EVALUATIONS
PERFORMED _____

(IQ, vision, physicals, hearing, workshops, classes, etc.)

