SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT - APPEAL

For SSA Use Only
Do not write in this box.

Individual is filing:

Related SSN _____

☐ **Reconsideration**

Number Holder _____

☐ **Request for Review by Federal Reviewing Official**

Date of Last Disability Report _____

☐ **Reconsideration for Disability Cessation**

☐ **Request for ALJ Hearing**

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.)*

☐ Your Number ☐ Message Number ☐ None

_____ _____
Area Code *Number*

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)

_____ _____ _____ DAYTIME PHONE _____ _____
City *State* *ZIP* *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

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

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

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 _____ *Area Code* _____ *Phone Number*	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**

REASONS FOR VISITS _____

WHAT **TREATMENT** DID YOU RECEIVE? _____

2.

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST VISIT
PHONE (Area Code / Phone Number)	PATIENT ID # (If known)		NEXT APPOINTMENT
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			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE (Area Code / Phone Number)			☐ **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.)

SECTION 10 - REMARKS

Use this section for any additional information you did not show in earlier parts of this form. When you are finished with this section (or if you don't have anything to add), be sure to go to the next page and complete the blocks there.

SECTION 10 - REMARKS

Name of person completing this form if other than the disabled person *(Please print)*

Date Form Completed *(Month, day, year)*

E-Mail Address of person completing this form *(optional)*

If the person completing this form is other than the disabled person or the person identified in Section 1. Item D., please complete the following information.

Relationship to Disabled Person

Daytime Telephone Number

Address *(Number and street)* **City** **State** **ZIP**