DISABILITY REPORT - APPEAL - Form SSA-3441-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

We will use the information that you give us on this form to update your disability report information for your appeal. We will use the form to update your disability information **since you last completed a disability report.** Please complete as much of the form as you can. If you need help, your interviewer will help you finish it. If you have an appointment for an interview by telephone, have the form ready to discuss with us when we call you. If you have an appointment for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so. If you have access to the Internet, you may access the Disability Report Form - Appeal instructions at http://www.ssa.gov/online/ssa-3441.html.

If you are filling out the form for someone else, please provide information about him or her. When a question refers to "you," "your," or the "Disabled Person," it refers to the person who is applying for or has been entitled to disability benefits.

HOW TO COMPLETE THIS FORM

- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 3, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/OTHER/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THIS FORM.** However, you can get help from other people, like a friend or family member.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use Section 10 - REMARKS on Page 7, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records or copies of prescriptions at home, send them to our office with your completed form or, if you are having an interview in our office, bring them and any medicine containers with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of your medical sources, you may be able to get that information from the telephone book, medical bills, prescriptions, or prescription containers.

The Privacy Act

We are authorized to collect the information on this form under sections 205(a) and (b), 223(d), and 1631(e)(1) of the Social Security Act. We will use the information you provide on this form to make a decision on your claim or case. Your response to this request is voluntary. However, failure to provide all or part of the information could prevent us from making an accurate and timely decision on your claim or case.

We rarely use the information you supply for any purpose other than for determining your living arrangements. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (1) to enable a third party or an agency to assist Social Security in establishing rights to Special Veterans Benefits; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at any local Social Security office.

The Paperwork Reduction Act

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 control number. We estimate that it will take about 45 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is 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).** *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

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

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT - APPEAL

For SSA Use Only
Do not write in this box.

Related SSN ___ – ___ – ___

Individual is filing:

Number Holder ___

☐ **Reconsideration**

Date of Last Disability Report ___

☐ **Request for Review by Federal Reviewing Official** ☐ **Reconsideration for Disability Cessation** ☐ **Request for ALJ Hearing**

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

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

Annette M. Farnsworth

B. SOCIAL SECURITY NUMBER

222-22-2222

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.)*

Anytown

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 Harriet Jones, LCSW RELATIONSHIP SOAR CaseWorker

ADDRESS Somerset Counseling Case Management, 30 W. ave.
(Number, Street, Apt. No (If any), P.O. Box, or Rural Route)

Anytown *City* YY *State* 12345 *ZIP*

DAYTIME PHONE ___ *Area Code* 444-4445 *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:

Annette is diagnosed with chronic schizophrenia and psychotic disorder and has experienced severe symptoms resulting in two psychiatric admissions since 11/1/13, date of disability denial. Her symptoms included auditory hallucinations. Dr. Jones, treating psychiatrist increased Clozaril dosage and added Lithium which has caused Annette to become lethargic with poor attention and concentration.

Approximate date the changes occurred:

Month	Day	Year
11	15	13

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:

Annette requires reminders from clinical staff to take her medications, bathe and le

Approximate date the changes occurred:

Month	Day	Year
11	15	13

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:

During recent hospital admission on 11/5/13, heart testing found congestive heart failure which affects her ability to walk at a reasonable pace and perform activities of daily living, such as cooking, cleaning and shopping.

Approximate date the changes occurred:

Month	Day	Year
11	5	15

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 Dr. Jones, Psychiatrist			**DATES**
STREET ADDRESS Somerset Case Management			**FIRST** VISIT 10/1/13-8/1/13
CITY Anytown	**STATE** YY	**ZIP** 12345	**LAST** VISIT 11/1/13
PHONE 444-4445	**PATIENT ID #** (If known)		NEXT **APPOINTMENT** 12/15/13
REASONS FOR VISITS Counseling and medication monitoring related to Schizophrenia and psychosis.			
WHAT **TREATMENT** DID YOU RECEIVE? Individual, weekly counseling, medications, e.g.) Clozaril, Lithium, labwork every 3 months			

2.

NAME Holy Cross Mobile Treatment			**DATES**
STREET ADDRESS 100 3rd St			**FIRST** VISIT 3/25/09
CITY Anytown	**STATE** YY	**ZIP** 12345	**LAST** VISIT 11/28/13
PHONE (444) 444-2222	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**

REASONS FOR VISITS

Intensive case management, labs, medication management for psychosis and recently diagnosed congestive heart failure.

WHAT **TREATMENT** DID YOU RECEIVE?

counseling, medication, labwork, heart testing, case managment.

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 Union Hospital			■ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
				11/5/13	11/22/13
STREET ADDRESS 534 Main St			☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
CITY Anytown	STATE YY	ZIP 12344			
PHONE (444)123-1000 *Area Code / Phone Number*			☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS	

Next **appointment** 1/3/14 Your hospital/clinic **number**

Reasons for visits

Admitted due to symptoms related to Schizophrenia and difficulty breathing as a result of congestive heart failure

What **treatment** did you receive?

Heart testing, lab work, medications adjusted, psychiatric stabilization

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

Dr. Sagamore, psychiatrist; Dr DeBakey, cardiologist. However, Annette signed herself out against medical advice due to her pschosis.

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 Union Hospital ACT Team			**DATES**
STREET ADDRESS 534 Main St			**FIRST** VISIT 2/3/10
CITY Anytown	**STATE** YY	**ZIP** 12345	**LAST** VISIT 12/2/13
PHONE (444)123-1000			NEXT **APPOINTMENT** 1/20/13
CLAIM NUMBER (if any)			
REASONS FOR VISITS Intensive case management for mental health impairments, e.g.) Schizoprenia, Psychosis. Goals to improve ability to function even minimally in the community and follow-up cardiology appointments. Crisis intervention daily.			

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
Clozaril	Dr Jones	Schizophrenia/Psychosis	seizures, chest pain, lethargic
Lithium	Dr. Jones	Schizophrenia	fatigue, weakness

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)	11/7/13	Union Hospital	staff cardiologist
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)	11/9/13	Union Hospital	Staff doctor
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?

I must be transported to my cardiology and mental health appointments by my ACT (Assertive Community Treatment) case manager. I must be reminded to bathe and to wear appropriate clothing. I spend most of my day yelling a commuters at the train station. (See Section 10 Remarks for more details)

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

If none, show "**NONE**."

Dr. Debakey, Cardiologist, diagnosed me with congestive heart failure. He said that I cannot spend my days outside at the train station or bus station. I must be closely supervised and must avoid mental stress and extremes in temperature. (See Remarks section)

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.

Annette has a severe chronic metal disorder and newly diagnosed congestive heart failure. Contrary to what DDS stated when they denied her claims, Annette's mental condition has not significantly improved and is even worsening. DDS says she can work. Annette's hear condition limits her physically now, in addition to her medical condition. She had cardiac testing found congestive heart failure.
From Section 2C: Annette also states that her new heart medications makes her feel weaker. The doctor said sh should not live outside, but Annette is out of touch with reality, so she continues to live outside despite supportive housing being available to her at this time.
From Section 7A: Annette can occasionally pick up cans and bottle and do simple chores or tasks such as walking to soup kitchen or drop-in center. She has extreme shortness of breath walking a few blocks. She must sit and rest.

From Section 7B: Dr. Jones and Dr. Sagamore emphasized we must provide a highly supportive environment for Annette to present relapse. However, Annette refuses most services because of her psychosis.

SECTION 10 - REMARKS

Name of person completing this form if other than the disabled person *(Please print)*	**Date Form Completed** *(Month, day, year)*
Harriet Jones, LCSW	12/30/13

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**
SOAR Case Manager	(444) 444-4445

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