DISABILITY REPORT - APPEAL
SSA-3441-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

This report is used to update your information for your disability appeal. Completing this report accurately helps us process your claim. Please complete as much of this report as you can.

IF YOU NEED HELP

Please do **not** ask your health care provider to complete this report. You can get help from other people, such as a friend or family member. If you cannot complete this report, a Social Security representative can assist you. If you make an appointment with us, please complete as much of this report as you can and have it with you for your appointment.

HOW TO COMPLETE THIS REPORT

If you have Internet access, you may be able to complete this report online at www.ssa.gov/disability/appeal

If you complete this report on paper:

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers, including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION,** unless this report indicates otherwise. You can write "don't know," or "none," or "does not apply" if you need to.
- If you need more space to answer any question, please use the REMARKS section on the last page, SECTION 10. Include the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any medical records that you have not given to us, send or bring them to our office with this completed report. Please tell us if you want us to return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and this completed report with 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 request your records. The information that you give us on this report tells us where to request your medical and other records.

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 also 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
Disability Report - Appeal
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(e) 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 us from reconsidering and reviewing your initial or continuing disability determination or evaluating any request for a hearing.

We will use the information you provide to update your disability appeal information. The information we collect also assists the State DDSs and administrative law judges in preparing for the appeals and hearings, and issuing a determination or decision on an individual's entitlement (initial or continuing) to disability benefits.

We may also share your information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations;

2. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and

3. To Federal, State or local agencies for administering cash or non-cash income maintenance or health maintenance programs.

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 (SORNs) 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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.

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 REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

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
Annie M. Farnsworth	111-11-1111

1. C. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)
444-444-4444

☐ 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)
hjones@sometown.org

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
Harriet Jones	SOAR Outreach Worker

2. C. Mailing Address (Street or PO Box), include apartment number or unit if applicable.
Some Town Family Shelter

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Some Town	YY	12345	

2. D. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)
444-444-4444

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: 1/01/19 ☐ No

If yes, please describe in detail: Symptoms related to Epilepsy have worsened, resulting in one hospitalization since denial. Also, school attendance is poor due to hospitalizations and behavioral issues. Epilepsy medication has increased.

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
Some Town Neurology	Dr. Brain, Pediatric Neurologist

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)
123-456-7890	MCO 123456

Address
444 Some Street

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Some Town	YY	12345	

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 01/01/2019	Date _____	Date in _____ Date out _____
Last Visit _____	Date _____	Date in _____ Date out _____
Next scheduled appointment (if any) 02/02/2019	Date _____	Date in _____ Date out _____
	☐ None	☐ None

What medical conditions were treated or evaluated?

Epilepsy, medication increase

What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

neurological evaluations, medication

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)			
☐ 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 6.

SECTION 4 – MEDICAL TREATMENT (continued)
Provider 2

4. D. Name of facility or office	Name of health care provider who treated you
Some Town Hospital	Attending pediatric neurologist

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)
555-555-5555	45678

Address
124 Some Street

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Some Town	YY	12345	

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 1/5/19 Date out 1/7/19
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?

Seizure activity due to epilepsy

What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

EEG medication adjustment

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)	Jan 6, 2019	☐ 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 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)			
☐ 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)
Some Town Elementary School	

Address
123 School Street

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Some Town	YY	12345	

Name of Contact Person	Phone Number
Nancy Nice	777-777-7777

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)
September 1, 2018	January 12, 2019	continuing

Reasons for Contacts
Updated IEP

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
Tegretol	Dr. Betty Brain	Epilepsy	drowsiness
Depakote	Dr. Betty Brain	Epilepsy	drowsiness

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: Child missed 12 days of school this year due to symptoms related to epilepsy and behavioral problems. Child has not been able to participate in most school activities and community recreational programs due to increase in seizures and behavioral health symptoms.

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.).

Annie Farnsworth continues to experience severe functional limitations as a result of epilepsy, ADHD and ODD. Also, based on a review of Annie's Electronic Folder, it appears that relevant medical and school records were missing from the file. Attached to the request for reconsideration submission are medical records from Some Town Hospital and updated IEP plan from Some Town Elementary School

This is a SOAR-assisted Request for Reconsideration claim. Annie is currently homeless with her family, but can be contacted through Harriet Jones, SOAR Outreach Worker at the family shelter.

Date Report Completed MM/DD/YYYY: 01/15/2019