How to File a Social Security Request for Reconsideration

1) **Fill out these forms** yourself or with someone you trust. You do not need a lawyer or doctor to fill this out.

   Do not worry about explaining in detail why you disagree with Social Security's decision. You can keep it simple.

   Example: I disagree with the decision and am disabled.

2) **Take these forms in person** to your local Social Security office.

3) When you turn these in, **ask Social Security to stamp a copy of your Request for Reconsideration with that day's date** and give it back to you.

****<u>Deadline to give these forms to Social Security:</u> 60 days after the date on Social Security letter saying that you are not disabled.****

<u>If you miss this 60-day deadline, your case will be closed in Social Security's office</u>. To try to re-open it, tell Social Security <u>in writing</u> the reason why you missed the deadline. Whether Social Security agrees to re-open your case depends on if it believes you have a good reason for missing the deadline.

Examples of good reasons: I never got the notice, I was sick, etc.

Although Legal Aid has been happy to provide you with this information, we are not agreeing to represent you at this time and we are not your lawyers. You are responsible for meeting all of your deadlines in this matter.

SOCIAL SECURITY ADMINISTRATION | TOE 710 | Form Approved OMB No. 0960-0622

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT	CLAIMANT SSN	CLAIM NUMBER (If different than SSN)

ISSUE BEING APPEALED (Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.
My reasons are:

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

I want to appeal your determination about my claim for SSI or SVB. I have read about the three ways to appeal. I have checked the box below.

THREE WAYS TO APPEAL

☐ **CASE REVIEW - You can pick this kind of appeal in all cases**. You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.

☐ **INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment.** You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.

☐ **FORMAL CONFERENCE - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment.** This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

CONTACT INFORMATION

CLAIMANT SIGNATURE - OPTIONAL			NAME OF CLAIMANT'S REPRESENTATIVE (If any)		
MAILING ADDRESS			MAILING ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (Include area code)	DATE		TELEPHONE NUMBER (Include area code)	DATE	

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No

2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No

(If "NO", attach claimant's explanation for delay. Refer to GN 03102.125)

FIELD OFFICE DEVELOPMENT (GN 03102.300)

☐ NO FURTHER DEVELOPMENT REQUIRED
☐ REQUIRED DEVELOPMENT ATTACHED
☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED

SSI CASES ONLY - GOLDBERG KELLY (GK)
(SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:

☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;
☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT
☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

SOCIAL SECURITY ADMINISTRATION | TOE 710 | Form Approved OMB No. 0960-0622

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT	CLAIMANT SSN	CLAIM NUMBER (If different than SSN)

ISSUE BEING APPEALED (Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)

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☐ **CASE REVIEW - You can pick this kind of appeal in all cases**. You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.

☐ **INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment.** You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.

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CONTACT INFORMATION

CLAIMANT SIGNATURE - OPTIONAL			NAME OF CLAIMANT'S REPRESENTATIVE (If any)		
MAILING ADDRESS			MAILING ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (Include area code)	DATE		TELEPHONE NUMBER (Include area code)	DATE	

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No

2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No

(If "NO", attach claimant's explanation for delay. Refer to GN 03102.125)

FIELD OFFICE DEVELOPMENT (GN 03102.300)

☐ NO FURTHER DEVELOPMENT REQUIRED
☐ REQUIRED DEVELOPMENT ATTACHED
☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED

SSI CASES ONLY - GOLDBERG KELLY (GK)
(SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:

☐ WITHIN 10 DAYS AFTER RECIEVING THE ADVANCE NOTICE;
☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT
☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*	
SSN	Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange)**:**
OF WHAT *All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including* , and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

Phone Number (or Address)

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ▶

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

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 (42 U.S.C. 405 (a) and (b)), 223 (42 U.S.C. 423 (d)), and 1631 (42 U.S.C. 1383 (e)(1)) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to update your disability report information.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on your appeal for your claim.

We rarely use the information you provide on this form for any purpose other than to update your disability information. 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 Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and 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 ensure the integrity of Social Security programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System (60-0089) and Electronic Disability (60-0320). Additional information about these and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

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.

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

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)			
☐ 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

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)			
☐ 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	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)			
☐ 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)

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: _____