HIV as a Disabling Condition
Accessing SSI & SSD Benefits Today

Presented by:
Doris Cortes, Sr. Disability Paralegal

Empire Justice Center
The Honorable Michael A. Telesca Center for Justice
One West Main Street
Suite 200
Rochester, NY 14614

www.empirejustice.org

This training was supported by a grant from the New York State Department of Health, AIDS Institute and by the Legal Action Center
Empire Justice is the only statewide, multi-issue, multi-strategy non-profit law firm focused on changing the "systems" within which poor and low income families live. With a focus on poverty law, Empire Justice undertakes research and training, acts as an informational clearinghouse, and provides litigation backup to local legal services programs and community based organizations. As an advocacy organization, we engage in legislative and administrative advocacy on behalf of those impacted by poverty and discrimination. As a non-profit law firm, we provide legal assistance to those in need and undertake impact litigation in order to protect and defend the rights of disenfranchised New Yorkers.

**Empire Justice Vision**

To be a statewide leader working to achieve social and economic justice for people in New York State who are poor, disabled or disenfranchised.

**Empire Justice Mission**

Empire Justice protects and strengthens the legal rights of those who are poor, disabled or disenfranchised through: systems change advocacy, training and support to other advocates and organizations, and high quality legal representation in civil matters.

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Module 1

Social Security Disability Program Overview
Module 1 – Social Security Disability Programs Overview

The Social Security Administration (SSA) pays disability benefits under two programs: the Social Security Disability Insurance program (SSD) and the Supplemental Security Income (SSI) program.

- **Social Security Disability** (SSD) is a program that allows people who have worked a certain amount of time to continue to receive income when they become disabled.
- Medicare Eligibility
- 5 month waiting period
- Benefits are available to the disabled worker and, in many cases, the worker’s dependents or survivors.
- Benefits can be paid up to 12 months before the date of application.
- Monthly benefits are based upon previous earnings

- **Supplemental Security Income** (SSI) is for people who are 65 years of age or older or people of any age who are blind or disabled (including children). It provides monthly cash benefits from the federal government.
- Income and resource limits. Must have little or no regular income or resources.
- Medicaid eligibility.
- Monthly benefits are set amounts. (See attached chart).
- Some individuals can get both SSD and SSI if the amount they receive from SSD is low enough.
# The Two Social Security Disability Programs

<table>
<thead>
<tr>
<th>Social Security Disability Insurance (SSD)</th>
<th>Supplemental Security Income (SSI)</th>
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<tbody>
<tr>
<td><strong>This program may be called one of many names:</strong> RSDHI (Retirement, Survivor, Disability, Health Insurance), SSDI (Social Security Disability Insurance), Title II, DIB (Disability Insurance Benefits)</td>
<td><strong>This program may be called one of two names:</strong> SSI (Supplemental Security Income) or Title XVI</td>
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<td><strong>Wage Earner must have worked to earn sufficient &quot;quarters of coverage&quot;.</strong></td>
<td><strong>No work history is required.</strong></td>
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<td><strong>Benefits to worker's (wage-earner) family:</strong></td>
<td><strong>No family member of the SSI recipient will be eligible for SSI benefits unless he or she independently establishes eligibility for SSI.</strong></td>
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<td><strong>Spouses:</strong> If at least age 62, or if caring for either a child under 16 or a disabled child of the worker.</td>
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<td><strong>Divorced Spouses:</strong> If the marriage lasted at least 10 years, and the person is age 62 years old or older and remains unmarried.</td>
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<td><strong>Child:</strong> If under age 18 (or under 19 if a full-time high school or elementary student) and dependent unmarried child of an insured eligible worker.</td>
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<td><strong>Disabled Adult Child:</strong> Adult Children (18 or older) of a retired, disabled, or deceased worker, if the disability began before the age of 22.</td>
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<td>From the date one becomes disabled, there is a five-month waiting period prior to receipt of benefits.</td>
<td><strong>No waiting period. An individual may receive benefits as of the first day of the month following month of application.</strong></td>
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<tr>
<td>Provision for payment up to 12 months before the date of application.</td>
<td><strong>Only paid as of first day of month following month of application.</strong></td>
</tr>
<tr>
<td>Claimants may receive retroactive benefits up to one year before the date of application.</td>
<td><strong>Retroactive benefits to first day of month following month of application.</strong></td>
</tr>
<tr>
<td><strong>Only Worker's Compensation or other Federal or State disability payments may affect payment level.</strong></td>
<td><strong>Any income (earned or unearned) affects benefits.</strong></td>
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<td><strong>No resource limits.</strong></td>
<td><strong>Resources must be below $2000 for an individual and $3000 for an eligible couple.</strong></td>
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<td>Checks are paid one month behind, i.e., check received in May is recipient's April check.</td>
<td>Checks are paid for the month in which they are received.</td>
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<td>Checks are paid on the 3rd of the month for beneficiaries who filed for benefits prior to May 1997; most beneficiaries who apply subsequently will receive checks on either the second, third or fourth Wednesday based on their dates of birth.</td>
<td>Checks are paid on the 1st of the month.</td>
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<td>Eligible for Medicare 24 months after establishing eligibility for SSDI.</td>
<td>In New York state, eligible for Medicaid if receiving even $1.00 of SSI.</td>
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Some individuals will get both SSD and SSI if the amount they receive from SSD is low.
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<tr>
<td>A</td>
<td>A</td>
<td>Living Alone</td>
<td>$750</td>
<td>$87</td>
<td>$837</td>
<td>$1,125</td>
<td>$104</td>
<td>$1,229</td>
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<tr>
<td>A, C</td>
<td>B</td>
<td>Living With Others</td>
<td>$750</td>
<td>$23</td>
<td>$773</td>
<td>$1,125</td>
<td>$46</td>
<td>$1,171</td>
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<td>B</td>
<td>F</td>
<td>Living in the Household of Another ²</td>
<td>$500</td>
<td>$23</td>
<td>$523</td>
<td>$750</td>
<td>$46</td>
<td>$796</td>
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<tr>
<td>A</td>
<td>C</td>
<td>Congregate Care Level 1 - Family Care</td>
<td>$750</td>
<td>$266.48</td>
<td>$1,016.48</td>
<td>$1,125</td>
<td>$907.96</td>
<td>$2,032.96</td>
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<td>A</td>
<td>D</td>
<td>Congregate Care Level 2 - Residential Care</td>
<td>$750</td>
<td>$435</td>
<td>$1,185</td>
<td>$1,125</td>
<td>$1,245</td>
<td>$2,370</td>
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<td>A</td>
<td>E</td>
<td>Congregate Care Level 3 – Enhanced Residential Care</td>
<td>$750</td>
<td>$694</td>
<td>$1,444</td>
<td>$1,125</td>
<td>$1,763</td>
<td>$2,888</td>
</tr>
<tr>
<td>D</td>
<td>Z</td>
<td>Title XIX (Medicaid certified) Institutions ³</td>
<td>$30</td>
<td>$0[^4]</td>
<td>$30</td>
<td>N/A</td>
<td></td>
<td></td>
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<tr>
<td>A</td>
<td>Z</td>
<td>(see below)⁵</td>
<td>$750</td>
<td>0</td>
<td>$750</td>
<td>$1,125</td>
<td>0</td>
<td>$1,125</td>
</tr>
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</table>

### Minimum Personal Needs Allowances
- Congregate Care Level 1 - $144
- Congregate Care Level 2 - $166
- Congregate Care Level 3 - $198

### Limits on Countable Resources
- Individuals: $2,000
- Couples: $3,000

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1 The combined federal and State SSI benefit provided to eligible individuals and eligible couples with no countable income.
2 The Living With Others category includes recipients whose federal benefit has been reduced by the "value of the 1/3 reduction" (VTR) due to the federal determination that they are both: a) Living in someone else's household, and b) receiving some amount of free or subsidized food and shelter (room and board).
3 Applies when an SSI recipient is residing in a medical facility, is not expected to return home within 90 days, and Medicaid is paying for at least 50% of the cost of care.
4 Recipients in nursing homes licensed by DOH receive an additional monthly grant of $25 issued by OTDA called a State Supplemental Personal Needs Allowance (SSPNA). Residents of other medical facilities receive an SSPNA of $5.
5 No State supplement is provided: a) when an SSI recipient is residing in a private medical facility and Medicaid is paying for less than 50% of the cost of care, or b) when a recipient resides in certain publicly operated residential facilities serving 16 or fewer residents, or c) while a recipient resides in a public emergency shelter for 6 calendar months during a 9 month period.

Revised 6 Nov 2017

Statutory References: Chap. 56 of L. 2017
Module 2

Non-Disability Eligibility Requirements
Module 2 – Non-disability eligibility requirements

Does a person have to be in financial need to be eligible for SSD?

No. SSD benefits are not based on need. This program is for people who used to be wage earners. When they worked some of their earnings were set aside by the government. After they become disabled, monthly cash benefits are paid from these funds to replace part of the earnings they or their family have lost. The amount paid monthly is based upon the person’s prior earnings.

Does the person have to be in financial need to be eligible for SSI?

Yes. That is the difference between SSD and SSI. To be eligible for SSI payments, a person must have little or no regular cash income or resources that can be turned into cash. Resources must be below $2000 for an individual and $3000 for an eligible couple.

Income: Anything received in cash or in kind that can be used to meet needs for food or shelter.

Two Types of Income: Earned Income and Unearned Income

Earned Income: Typically, gross wages - salaries, commissions, bonuses, severance pay and in-kind value of food or shelter; or net income from self-employment; sheltered workshop earnings; royalties from publications; and garnished funds.

Earned Income Exclusions: Some earned income that is excluded, or not counted in determining SSI eligibility - income tax refund payments, any portion of the $20 general exclusion not applied to unearned income, $65 per month and one-half of remaining earned income in a month

Unearned Income: All income that is not earned income. Unearned income is counted when it is actually or constructively received.

Unearned Income Exclusions: Many items, like needs-based assistance wholly funded by state or city, disaster relief assistance, and interest on excluded burial resources are excluded from unearned income.

Non-income Items: These are not considered income by the Social Security Administration. Some of these include medical care and services (includes VA payments for unusual medical expenses), clothing, income tax refunds, money borrowed and money received as repayment of a loan.

Special Income Exclusions: Some of these include payments to Japanese internees by the United States and Agent Orange settlement payments.
**Resources:** Cash or other liquid assets or real or personal property that an individual owns and could convert to cash that can be used to provide for food or shelter.

- Before an asset will be considered a resource an individual must have an ownership interest in property; a legal right to access to the property; and the legal ability to use the property for personal support and maintenance.
- The resource is counted or excluded "as of the first moment of the month."
- The general rule is that an item received in a month is income and, unless spent, becomes a resource in the following month.
- General resource limit in 2018 is $2,000 for an individual, $3,000 for an eligible couple.

**Liquid Resources:**

Cash, or other property, that can be converted to cash within 20 working days. Some types of liquid resources include stocks, bonds, promissory notes, mortgages, and bank accounts.

**Non-Liquid Resources:**

Property that is not cash and which cannot be converted to cash within 20 working days. Except for automobiles, the equity value of the non-liquid resource is countable. Some types of non-liquid resources are automobiles, trucks, tractors, boats, machinery, livestock, buildings and land.

**Exclusions from Resources:**

Resources that are not counted for purposes of the $2,000 or $3,000 limits. Some of these are the home the claimant lives in, regardless of value, household goods and personal effects, and the total value of an automobile if necessary for transportation.
Module 3

How To Apply For Benefits
Module 3 – How to apply for benefits

How do you apply for SSI or SSD?
Visit the local Social Security office or call 1-800-772-1213 (1-800-325-0778 TTY for deaf or hard of hearing) to make an appointment to file an application. SSD applications may be filed on line at www.ssa.gov.

Can you apply on-line?
SSD applications may be filed on-line at www.ssa.gov. SSI applications cannot be filed on-line and must be made at the office or by telephone. The Disability Report – Adult (see attached) can be filed on-line for both SSI and SSD applications.

Can applications be made by telephone?
Yes. If the applicant is unable to go to the Social Security office, call 1-800-772-1213 and ask for a telephone application. An appointment should be made at that time, and a Claims Representative from one of the local offices should take the application over the telephone on the day and time of the appointment.

What type of information will be needed to make the application appointment?

- name and address
- telephone number
- Social Security number
- whether the application is for SSD or SSI

What type of information is needed for the application?

If applying for SSD, the person who interviews the applicant will ask about such things as work background and the name of his/her doctor or doctors.

If applying for SSI, the applicant may be asked about work background, but the emphasis will be on income and resources.

See attached checklist.

An application for SSI is automatically an application for both disability programs but, an application for SSD is not automatically an application for SSI
Checklist – Adult Disability Interview

We encourage you to begin the application process online.

Visit www.socialsecurity.gov/applyfordisability to get started!

Use this Checklist to get ready for your appointment or when filing online. We need your personal and income information to complete the interview to determine if you are eligible for disability benefits. Keep your appointment even if you do not have all of the information. We will help you get any missing information.

☑ Check off the applicable items below as you get them together for your interview.

☐ Medical records already in your possession. (We will help you get the rest of your medical records. Please bring whatever medical records you have to the interview).

☐ Workers’ compensation information, including the settlement agreement, date of injury, claim number, and proof of other disability awarded payment amounts.

☐ Names and dates of birth of your minor children and your spouse.

☐ Dates of marriages and divorces.

☐ Checking or savings account number, including the bank’s 9-digit routing number, if you want Direct Deposit for your benefit checks.

☐ Name, address, and phone number of a person we can contact if we are unable to get in touch with you.

☐ If a medical release Form SSA-827 (Authorization to Disclose Information to the Social Security Administration) was included with this package, please complete (sign and date with witness signature) and return it as directed.

☐ If unable to file online, complete the “Medical and Job Worksheet – Adult” and bring to your interview.

Bring the Checklist items and information to your appointment or have them with you if your appointment is by telephone.

Do not delay filing your application, even if you do not have all of the information.
MEDICAL AND JOB WORKSHEET - ADULT

Please do not mail this worksheet to your local office.
Did you know that you can start the application process online?
Visit [www.socialsecurity.gov/applyfordisability](http://www.socialsecurity.gov/applyfordisability) for more information!
Complete this worksheet to get ready for the appointment or when filing online. This worksheet is not the application for Social Security disability benefits. You should bring this worksheet to your appointment or have it with you if your appointment is by telephone.

### A. Medical Conditions

List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

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<th>CONDITIONS</th>
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</table>

### B. If you are not working, when did you stop working?

### C. Height without shoes: _____ feet _____ inches  Weight without shoes: _____ pounds

### D. Medical Sources

Please list any doctors, hospitals, clinics, therapists, or emergency rooms you have visited because of your conditions.

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>PHONE NUMBER (with area code)</th>
<th>DATE FIRST SEEN OR ADMISSION DATE</th>
<th>DATE LAST SEEN OR DISCHARGE DATE</th>
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Form SSA-3381 (12-2009) Destroy prior editions
E. Medicines

Please list any medicines you take and why you take them. If prescribed, please provide the doctor's name.

<table>
<thead>
<tr>
<th>NAME OF MEDICINE</th>
<th>WHY YOU TAKE IT</th>
<th>PRESCRIBED BY</th>
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F. Medical Tests

Please list any medical tests you had or are going to have in the future.

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<thead>
<tr>
<th>NAME OF TEST</th>
<th>PROVIDER WHO SENT YOU</th>
<th>DATE(S)</th>
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G. Job History

List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

<table>
<thead>
<tr>
<th>JOB TITLE (e.g., cook)</th>
<th>TYPE OF BUSINESS (e.g., restaurant)</th>
<th>DATES WORKED FROM Mo/Yr TO Mo/Yr</th>
<th>HOURS PER DAY</th>
<th>DAYS PER WEEK</th>
<th>RATE OF PAY Amount Frequency</th>
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Bring this worksheet to your appointment or have it with you if your appointment is by telephone. Do not delay filing your application, even if you do not have all of the information. We will help you get any missing information.
DISABILITY REPORT - ADULT
SSA-3368-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The information you give us on this report will be used by the office that makes the disability decision on your disability claim. Completing this report accurately and completely will help us expedite your claim. Please complete as much of the report as you can.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. Please do not ask your health care provider to complete this report. If you cannot complete the report, a Social Security Representative will assist you. If you have an appointment, please have the completed report ready when we contact you. If we ask you to do so, please mail the completed report to us ahead of time.

Note: If you are assisting someone else with this report, please answer the questions as if that person were completing the report.

HOW TO COMPLETE THIS REPORT

- 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 the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- 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 question, please use Section 11 - Remarks on the last page to finish your answer. Write the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any of your medical records, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and the 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.
WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or is expected to result in death. So when we ask "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

Privacy Act Statement
Collection and Use of Personal Information

Section 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a decision on the named claimant’s claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate and timely decision on the named claimant’s claim.

We rarely use the information you supply for any purpose other than to make decisions regarding claims. 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 assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

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.

A complete list of routine uses for this information is available in Systems of Records Notice entitled, Claims Folders Systems, 60-0089. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - 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 60 minutes to read the instructions, gather the facts, and answer the questions.

SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. You can find your local Social Security office through SSA’s website at www.socialsecurity.gov. 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). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, 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

Form SSA-3368-BK (11-2014) ef (11-2014)
DISABILITY REPORT
ADULT

For SSA Use Only - 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 Initial, Last) 1.B. Social Security Number

1.C. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City State/Province ZIP/Postal Code Country (If not USA)

1.D. Email Address

1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada. Phone number

☐ Check this box if you do not have a phone or a number where we can leave a message.

1.F. Alternate Phone Number - another number where we may reach you, if any.

Alternate phone number

1.G. Can you speak and understand English? ☐ Yes ☐ No

If no, what language do you prefer?
If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.H. Can you read and understand English? ☐ Yes ☐ No

1.I. Can you write more than your name in English? ☐ Yes ☐ No

1.J. 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 them here:

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.

2.A. Name (First, Middle Initial, Last) 2.B. Relationship to you

2.C. Daytime Phone Number (as described in 1.E. above)

2.D. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City State/Province ZIP/Postal Code Country (If not USA)

2.E. Can this person speak and understand English? ☐ Yes ☐ No

If no, what language is preferred?
SECTION 2 - CONTACTS (continued)

2.F. Who is completing this report?
   □ 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 (Complete the rest of Section 2 below)

2.G. Name (First, Middle Initial, Last)  

2.H. Relationship to Person Applying

2.I. Daytime Phone Number

2.J. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

<table>
<thead>
<tr>
<th>City</th>
<th>State/Province</th>
<th>ZIP/Postal Code</th>
<th>Country (If not USA)</th>
</tr>
</thead>
</table>

SECTION 3 - MEDICAL CONDITIONS

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1. 
2. 
3. 
4. 
5. 

If you need more space, go to Section 11 - Remarks on the last page

3.B. What is your height without shoes?
   feet  inches  OR  centimeters (if outside USA)

3.C. What is your weight without shoes?
   pounds  OR  kilograms (if outside USA)

3.D. Do your conditions cause you pain or other symptoms?
   □ Yes  □ No

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?
   □ No, I have never worked (Go to question 4.B. below)
   □ No, I have stopped working (Go to question 4.C. below)
   □ Yes, I am currently working (Go to question 4.F. on page 3)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year)  

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year)  
   Why did you stop working?
   □ Because of my condition(s).
   □ Because of other reasons. Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed)

Even though you stopped working for other reasons, when do you believe your condition(s) became severe enough to keep you from working? (month/day/year)  

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours, or rate of pay)
   □ No (Go to Section 5 - Education and Training on page 3)
   □ Yes When did you make changes? (month/day/year)  

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SECTION 4 - WORK ACTIVITY (continued)

4.E. Since the date in 4.D. above, have you had gross earnings greater than $1,010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No (Go to Section 5)  ☐ Yes (Go to Section 5)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

☐ No  When did your condition(s) first start bothering you? (month/day/year) ____________

☐ Yes  When did you make changes? (month/day/year) ____________

4.G. Since your condition(s) first bothered you, have you had gross earnings greater than $1,010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No  ☐ Yes

SECTION 5 - EDUCATION AND TRAINING

5.A. Check the highest grade of school completed.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>GED</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4 or more</th>
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</thead>
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<td>☐</td>
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</tr>
</tbody>
</table>

Date completed: ________________________________

5.B. Did you attend special education classes?

☐ Yes  ☐ No (Go to 5.C.)

Name of School ________________________________

City ____________________________ State/Province ________ Country (If not USA) ___________

Dates attended special education classes: from ________ to ________

5.C. Have you completed any type of specialized job training, trade, or vocational school?

☐ Yes  ☐ No

If "Yes," what type? ___________________________ Date completed: ________________________________

If you need to list other education or training use Section 11 - Remarks on the last page.

SECTION 6 - JOB HISTORY

6.A. List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

☐ Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Type of Business</th>
<th>Dates Worked</th>
<th>Hours Per Day</th>
<th>Days Per Week</th>
<th>Rate of Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>From MM/YY</td>
<td>To MM/YY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

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SECTION 6 - JOB HISTORY (continued)

Check the box below that applies to you.

☐ I had only one job in the last 15 years before I became unable to work. Answer the questions below.

☐ I had more than one job in the last 15 years before I became unable to work. Do not answer the questions on this page; go to Section 7 on page 5. (We may contact you for more information.)

Do not complete this page if you had more than one job in the last 15 years before you became unable to work.

6.B. Describe this job. What did you do all day?

(If you need more space, use Section 11 - Remarks on the last page.)

6.C. In this job, did you:

Use machines, tools or equipment? ☐ Yes ☐ No

Use technical knowledge or skills? ☐ Yes ☐ No

Do any writing, complete reports, or perform any duties like this? ☐ Yes ☐ No

6.D. In this job, how many total hours each day did you do each of the tasks listed:

<table>
<thead>
<tr>
<th>Task</th>
<th>Hours</th>
<th>Task</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk</td>
<td></td>
<td>Stoop (Bend down &amp; forward at waist.)</td>
<td></td>
</tr>
<tr>
<td>Stand</td>
<td></td>
<td>Kneel (Bend legs to rest on knees.)</td>
<td></td>
</tr>
<tr>
<td>Sit</td>
<td></td>
<td>Crouch (Bend legs &amp; back down &amp; forward.)</td>
<td></td>
</tr>
<tr>
<td>Climb</td>
<td></td>
<td>Crawl (Move on hands &amp; knees.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Handle large objects</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Write, type, or handle small objects</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reach</td>
<td></td>
</tr>
</tbody>
</table>

6.E. Lifting and carrying (Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job.)

6.F. Check heaviest weight lifted:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other __________

6.G. Check weight frequently lifted: (by frequently, we mean from 1/3 to 2/3 of the workday.)

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other __________

6.H. Did you supervise other people in this job? ☐ Yes (Complete items below.) ☐ No (if No, go to 6.I.)

How many people did you supervise? __________

What part of your time did you spend supervising people? __________

Did you hire and fire employees? ☐ Yes ☐ No

6.I. Were you a lead worker? ☐ Yes ☐ No
SECTION 7 - MEDICINES

7. Are you taking any medicines (prescription or non-prescription)?

☐ Yes  (Give the information requested below. You may need to look at your medicine containers.)

☐ No  (Go to Section 8-Medical Treatment.)

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>If prescribed, give name of doctor</th>
<th>Reason for medicine</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

If you need to list other medicines, go to Section 11 - Remarks on the last page.

SECTION 8 - MEDICAL TREATMENT

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled?

8.A. For any physical condition(s)?

☐ Yes  ☐ No

8.B. For any mental condition(s) (including emotional or learning problems)?

☐ Yes  ☐ No

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.
SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office
Name of health care professional who treated you

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

Phone Number
Patient ID# (if known)

Mailing Address

City
State/Province
ZIP/Postal Code
Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits

2. Emergency Room visits
List the most recent date first

3. Overnight hospital stays
List the most recent date first

First Visit

A.

A. Date in

Date out

Last Visit

B.

B. Date in

Date out

Next scheduled appointment (if any)

C.

C. Date in

Date out

What medical conditions were treated or evaluated?

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

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11-Remarks on the last page.

☐ Check this box if no tests by this provider or at this facility.

<table>
<thead>
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<td>HIV Test</td>
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</tr>
<tr>
<td>Cardiac Catheterization</td>
<td></td>
<td>Blood Test (not HIV)</td>
<td></td>
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<tr>
<td>Biopsy (list body part)</td>
<td></td>
<td>X-Ray (list body part)</td>
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<td>Other (please describe)</td>
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<td>Vision Test</td>
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If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.
**SECTION 8 - MEDICAL TREATMENT (continued)**

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.D. Name of Facility or Office

| Name of health care professional who treated you |

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

| Phone Number | Patient ID# (if known) |

Mailing Address

| City | State/Province | ZIP/Postal Code | Country (If not USA) |

**Dates of Treatment**

1. **Office, Clinic or Outpatient visits**

| 2. **Emergency Room visits** List the most recent date first |

| 3. **Overnight hospital stays** List the most recent date first |

| First Visit | A. | A. Date in | Date out |

| Last Visit | B. | B. Date in | Date out |

| Next scheduled appointment (if any) | C. | C. Date in | Date out |

**What medical conditions were treated or evaluated?**

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

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

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Tell us who may have medical records about any of your physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors’ offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.E. Name of Facility or Office

Name of health care professional who treated you

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

Phone Number

Patient ID# (if known)

Mailing Address

City

State/Province

ZIP/Postal Code

Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits

List the most recent date first

First Visit

A.

A. Date in

Date out

Last Visit

B.

B. Date in

Date out

Next scheduled appointment (if any)

C.

C. Date in

Date out

What medical conditions were treated or evaluated?

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

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

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Form SSA-3368-BK (11-2014) ef (11-2014) PAGE 8
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8.F. Name of Facility or Office
Name of health care professional who treated you

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Phone Number
Patient ID# (if known)

Mailing Address

City
State/Province
ZIP/Postal Code
Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits
2. Emergency Room visits
   List the most recent date first
3. Overnight hospital stays
   List the most recent date first

First Visit
A.
A. Date in
Date out

Last Visit
B.
B. Date in
Date out

Next scheduled appointment (if any)
C.
C. Date in
Date out

What medical conditions were treated or evaluated?

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

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

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8.G. Name of Facility or Office
Name of health care professional who treated you

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

Phone Number
Patient ID# (if known)

Mailing Address

<table>
<thead>
<tr>
<th>City</th>
<th>State/Province</th>
<th>ZIP/Postal Code</th>
<th>Country (If not USA)</th>
</tr>
</thead>
</table>

Dates of Treatment

1. Office, Clinic or Outpatient visits
List the most recent date first

<table>
<thead>
<tr>
<th>First Visit</th>
<th>A. Date in</th>
<th>Date out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Visit</td>
<td>B. Date in</td>
<td>Date out</td>
</tr>
</tbody>
</table>

Next scheduled appointment (if any)

| C. Date in | Date out |

What medical conditions were treated or evaluated?

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

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ Check this box if no tests by this provider or at this facility.

<table>
<thead>
<tr>
<th>Kind of Test</th>
<th>Dates of Tests</th>
<th>Kind of Test</th>
<th>Dates of Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>EKG (heart test)</td>
<td>□</td>
<td>EEG (brain wave test)</td>
<td>□</td>
</tr>
<tr>
<td>Treadmill (exercise test)</td>
<td>□</td>
<td>HIV Test</td>
<td>□</td>
</tr>
<tr>
<td>Cardiac Catheterization</td>
<td>□</td>
<td>Blood Test (not HIV)</td>
<td>□</td>
</tr>
<tr>
<td>Biopsy (list body part)</td>
<td>□</td>
<td>X-Ray (list body part)</td>
<td>□</td>
</tr>
<tr>
<td>Hearing Test</td>
<td>□</td>
<td>MRI/CT Scan (list body part)</td>
<td>□</td>
</tr>
<tr>
<td>Speech/Language Test</td>
<td>□</td>
<td>Other (please describe)</td>
<td></td>
</tr>
<tr>
<td>Vision Test</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathing Test</td>
<td>□</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have been treated by more than five doctors or hospitals, use Section 11 - Remarks on the last page and give the same detailed information as above for each healthcare provider.
SECTION 9 - OTHER MEDICAL INFORMATION

9. Does anyone else have medical information about your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

☐ Yes (Please complete the information below.)

☐ No (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11 on the last page.)

Name of Organization

Phone Number

Mailing Address

City

State/Province

ZIP/Postal Code

Country (If not USA)

Name of Contact Person

Claim or ID number (if any)

Date of First Contact

Date of Last Contact

Date of Next Contact (if any)

Reasons for Contacts

If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.

SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

10.A. 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 a school (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 (Complete the following information) ☐ No (Go to Section 11)

10.B. Name of Organization or School

Name of Counselor, Instructor, or Job Coach

Phone Number

Mailing Address

City

State/Province

ZIP/Postal Code

Country (If not USA)

10.C. When did you start participating in the plan or program?
SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES  
(continued)

10.D. Are you still participating in the plan or program?

☐ Yes, I am scheduled to complete the plan or program on: ______________________

☐ No. I completed the plan or program on: ______________________

☐ No. I stopped participating in the plan or program before completing it because:

10.E. List the types of services, tests, or evaluations that you received (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluations, or classes).

If you need to list another plan or program use Section 11 - Remarks and give the same detailed information as above.

SECTION 11 - REMARKS

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

Date Report Completed

________________________________________________________________________

month, day, year

Form SSA-3368-BK (11-2014) ef (11-2014) PAGE 12
Module 4

What Happens After the Application is Filed?
Module 4 - What happens after the application is filed?

The case is sent to a “Disability Analyst” who may contact the claimant to see if there has been any change in their condition. It will most likely take 3 – 5 months for a decision to be made. The disability analyst should be informed if:

- There is any significant change in the claimant’s condition
- There has been a change in treatment or doctors
- The claimant has been hospitalized

The disability analyst will send a letter to the claimant. A contact phone number will be on the letter.

The claimant will most likely be asked to go to an appointment with a doctor or doctors arranged for by SSA.

Important things to remember throughout the application process:

- Always respond to requests for additional information. If Social Security does not have enough information, the application is likely to be denied.
- Provide complete and accurate information, to the best of your ability.
- If Social Security schedules a consultative examination with a doctor, it is very important that the applicant go to that appointment. A Social Security application can be denied solely due to a failure to attend a consultative exam.

If the application is denied:

The claimant has only **60 DAYS** to request an appeal. The request should be **IN WRITING**, a telephone call to SSA is not sufficient. You can now also file appeals online at SSA.gov
Module 5

How SSA Determines Disability
Module 5 – How SSA determines disability

1. Defining Disability

   a. The term disability does not always mean the same thing; how disability is defined depends on the program. Veterans Administration, Workers Compensation, private pensions, Welfare all have different definitions.

   b. SSA has a very specific definition of disability and method for determining if and individual is disabled.

2. Social Security’s definition of disability

   “Inability to perform substantial gainful activity by reason of a medically determinable physical or mental impairment, or combination of impairments, which has lasted or is expected to last at least 12 consecutive months, or end in death, taking into account the individual’s age, education and work history.” 42 U.S.C. § 423(d); 20 C.F.R. §§ 404.1505; 416.905.

   Method of analyzing whether a disability exists: THE SEQUENTIAL EVALUATION

Social Security uses a five step series of questions to decide if an adult is disabled. The questions must be answered in order and if the SSA can make a decision at any step, the process ends.

1. Are you working? Generally, you cannot be working and be considered disabled. If you are working and earning more than $1180 per month in 2018, your application will be denied. There are some exceptions to this rule, so it may be worth putting in an application if the client’s earnings are low.

2. Do you have a severe condition or combination of conditions that keeps you from working? A severe condition means you have a physical or mental problem that is expected to last at least a year or result in death. (Almost all disabilities will satisfy this test.)

3. Is the condition one that appears on Social Security’s listing of impairments? The SSA maintains a list of impairments for 14 major body systems for adults. Impairments described in these listings are so severe that the SSA presumes that an individual whose impairment(s) meet a listing is disabled. If your impairment meets a listing, your claim should be approved. If not, SSA will move on to the next question. (See attached HIV listings).

4. If you have worked in the past, can you do the work you previously did? If so, your claim will be denied. If the answer is no, SSA goes to the last question.

5. Can you do any other type of work? SSA will consider your medical conditions, age, education and work experience to answer this question. If SSA decides that you can do other work, the claim is denied.
How does SSA make the determination at steps 4 & 5?

This is based on the applicant’s Residual Functional Capacity as well as age, education and past relevant work experience.

If the claimant has HIV will he or she be considered disabled and eligible for SSD or SSI?

Maybe. A diagnosis of HIV or AIDS does not automatically qualify someone for benefits. Certain HIV related illnesses such as esophageal candidiasis, pcp pneumonia, or other opportunistic infections/HIV related conditions can meet the listing requirements. (See step 3 above.) It is important to note that a person may meet a listing for another impairment although HIV is also present. If the claimant’s condition does not meet an SSA listing, they will consider the claimant’s medical conditions, age, education and work experience to determine if the person is disabled.
14.11 Human immunodeficiency virus (HIV) infection. With documentation as described in 14.00F1 and one of the following:

A. Multicentric (not localized or unicentric) Castleman disease affecting multiple groups of lymph nodes or organs containing lymphoid tissue (see 14.00F3a).

OR

B. Primary central nervous system lymphoma (see 14.00F3b).

OR

C. Primary effusion lymphoma (see 14.00F3c).

OR

D. Progressive multifocal leukoencephalopathy (see 14.00F3d).

OR

E. Pulmonary Kaposi sarcoma (see 14.00F3e).

OR

F. Absolute CD4 count of 50 cells/mm3 or less (see 14.00F4).

OR

G. Absolute CD4 count of less than 200 cells/mm3 or CD4 percentage of less than 14 percent, and one of the following (values do not have to be measured on the same date) (see 14.00F5):

1. BMI measurement of less than 18.5; or

2. Hemoglobin measurement of less than 8.0 grams per deciliter (g/dL).

OR

H. Complication(s) of HIV infection requiring at least three hospitalizations within a 12-month period and at least 30 days apart (see 14.00F6). Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

OR

I. Repeated (as defined in 14.00I3) manifestations of HIV infection, including those listed in 14.11A-H, but without the requisite findings for those listings (for example, Kaposi sarcoma not meeting the criteria in 14.11E), or other manifestations (including, but not limited to, cardiovascular disease (including myocarditis, pericardial effusion, pericarditis, endocarditis, or pulmonary arteritis), diarrhea, distal sensory polyneuropathy, glucose intolerance, gynecologic conditions (including cervical cancer or pelvic inflammatory disease, see 14.00F7), hepatitis,
cervix not meeting the criteria in 14.08E, diarrhea not meeting the criteria in 14.08I), or other manifestations (for example, oral hairy leukoplakia, myositis, pancreatitis, hepatitis, peripheral neuropathy, glucose intolerance, muscle weakness, cognitive or other mental limitation) resulting in significant, documented symptoms or signs (for example, severe fatigue, fever, malaise, involuntary weight loss, pain, night sweats, nausea, vomiting, headaches, or insomnia) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.
MEDICAL REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

The individual named below has filed an application for a period of disability and/or disability payments. If you complete this form, your patient may be able to receive early payments. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)," attached.
☐ I hereby authorize the medical source named below to release or disclose to the Social Security Administration or State agency any medical records or other information regarding my treatment for human immunodeficiency virus (HIV) infection.

CLAIMANT'S SIGNATURE (Required only if Form SSA-827 is NOT attached)  DATE

A. IDENTIFYING INFORMATION

CLAIMANT'S NAME

CLAIMANT'S SSN

CLAIMANT'S ADDRESS

CLAIMANT'S DATE OF BIRTH

CLAIMANT'S PHONE NUMBER

MEDICAL SOURCE'S NAME

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. CONDITIONS RELATED TO HIV INFECTION: Please check if applicable.

ALL INFORMATION PROVIDED IN THIS SECTION MUST BE SUPPORTED BY DOCUMENTATION IN THE MEDICAL RECORD. We will request your patient's medical records as part of our case adjudication process.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Multicentric (not localized or unicentric) Castleman disease</td>
<td>☐ Affecting multiple groups of lymph nodes&lt;br&gt;☐ Affecting organs containing lymphoid tissue</td>
</tr>
<tr>
<td>2. ☐ Primary central nervous system lymphoma</td>
<td></td>
</tr>
<tr>
<td>3. ☐ Primary effusion lymphoma</td>
<td></td>
</tr>
<tr>
<td>4. ☐ Progressive multifocal leukoencephalopathy</td>
<td></td>
</tr>
<tr>
<td>5. ☐ Pulmonary Kaposi sarcoma</td>
<td></td>
</tr>
<tr>
<td>6. CD4 Count:</td>
<td>Absolute CD4 count of 50 cells/mm³ or less&lt;br&gt;Please indicate measurement, date recorded, AND ordering provider</td>
</tr>
<tr>
<td>7. CD4 level and BMI or hemoglobin measurements</td>
<td>(values do not have to be measured on the same date), with a and b. a. CD4 level&lt;br&gt;☐ Absolute CD4 count of 200 cells/mm³ or less&lt;br&gt;☐ CD4 percentage of less than 14 percent&lt;br&gt;Please indicate measurement, date recorded, AND ordering provider</td>
</tr>
</tbody>
</table>
8. Complication(s) of HIV infection requiring **at least three** hospitalizations within a 12-month period and at least 30 days apart. Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization. Complications of HIV infection may include infections (common or opportunistic), cancers, and other conditions.

<table>
<thead>
<tr>
<th>Complication of HIV Infection</th>
<th>Date of Hospitalization</th>
<th>Duration</th>
<th>Name of Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Diarrhea</td>
<td>Example: December 2, 2015</td>
<td>Example: 2 days</td>
<td>Example: Memorial Hospital</td>
</tr>
</tbody>
</table>

D. REMARKS: *(Please use this space to provide any other comments you wish about your patient.)*

---

E. MEDICAL SOURCE’S NAME AND ADDRESS *(Print or type)*

<table>
<thead>
<tr>
<th>TELEPHONE NUMBER (Include Area Code)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
</tr>
</tbody>
</table>

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

F. SIGNATURE AND TITLE (e.g., physician, R.N.) OF PERSON COMPLETING THIS FORM

□ FIELD OFFICE DISPOSITION:

□ DISABILITY DETERMINATION SERVICES DISPOSITION:
MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED SSA-4814
(Medical Report On Adult With Allegation Of Human Immunodeficiency Virus (HIV) Infection)

Your patient, identified in section A of the attached form, has filed a claim for Supplemental Security Income disability payments based on HIV infection. MEDICAL SOURCE: Please detach this instruction sheet and use it to complete the attached form.

1. PURPOSE OF THIS FORM:

   IF YOU COMPLETE AND RETURN THE ATTACHED FORM PROMPTLY, YOUR PATIENT MAY BE ABLE TO RECEIVE PAYMENTS WHILE WE ARE PROCESSING HIS OR HER CLAIM FOR ONGOING DISABILITY PAYMENTS. This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Determination Services will contact you later to obtain further evidence needed to process your patient's claim.

2. WHO MAY COMPLETE THIS FORM:

   A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

3. MEDICAL RELEASE:

   An SSA medical release (an SSA-827) signed by your patient should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient.

4. HOW TO COMPLETE THE FORM:

   • If you receive the form from your patient and section A has not been completed, please fill in the identifying information about your patient.
   • You may not have to complete all of the sections on the form.
   • ALWAYS COMPLETE SECTION B.
   • COMPLETE SECTION C, IF APPROPRIATE. If you complete at least one of the items in section C, go to section D.
   • COMPLETE SECTION D IF YOU WISH TO PROVIDE COMMENTS ON YOUR PATIENT'S CONDITION(S).
   • ALWAYS COMPLETE SECTIONS E AND F. Note: This form is not complete until it is signed.

5. HOW TO RETURN THE FORM TO US:

   • Mail the completed, signed form, as soon as possible, in the return envelope provided.
   • If you received the form from your patient without a return envelope, give the completed, signed form back to your patient for return to the SSA field office.
Privacy Act Statement
Collection and Use of Personal Information

Sections 1614(a)(3), 1631(a)(4), 1631(e)(1), and 1633 of the Social Security Act, as amended, allow us to collect this information. We will use the information you provide to make a determination on the named individual's disability claim.

Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on the claim. We rarely use the information you supply for any purpose other than what we state above, however, we may use the information for the administration of our programs, including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices, 60-0103, entitled Supplemental Security Income Record, and Special Veterans Benefits, and 60-0320, entitled Electronic Disability (eDiB) Claim File. Additional information about these and other system of records notices and our programs is available from our Internet website 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 incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - 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 (OMB) control number. The OMB control number for this collection is 0960-0500. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions. Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.
Module 6

Developing Strong Applications
Module 6: Developing strong applications

What types of evidence can be submitted?

Medical evidence
  Records
  Opinions

  This is the evidence given the most weight by SSA. Treating doctor's opinions are given considerably more weight than those of other health care providers. SSA should consider all opinions, but will evaluate the persuasiveness of the opinions based on several factors, including how much support there is in the medical record, and to some extent, the treating relationship.

Other Evidence
  Social worker’s non–medical reports/observations
  Observations by supervisors or co-workers
  Observations of family, friends, neighbors with a basis for knowledge of the individual

Detailed descriptions of activities of daily living
  Cooking, cleaning, shopping
  Taking public transportation
  Make and keep appointments on his own
  Maintain a residence
  Perform activities on a sustained basis at a reasonable pace

Detailed descriptions of Social Functioning:
  Does the individual get along with others in and outside his home?
  Can he establish and maintain meaningful relationships?
  Is he inappropriately fearful or suspicious of others?
  Is he capable of participating in group activities?
  Does he have the energy and endurance for normal social interactions on a regular and sustained basis?

Detailed descriptions of mental work functions:
  Can an individual maintain attention and concentration for prolonged periods of time or is he easily distracted?
  Can he follow instructions?
  Can he maintain a schedule and regular attendance?
  Can he sustain an ordinary routine without special supervision or rest periods?
  Can he work in coordination with others?
  Can he make simple work-related decisions?
  Can he complete a normal workday and workweek without experiencing physical or psychological symptoms?
  Does he finish tasks he begins, and if so, does he finish them in a timely fashion?
  Can he maintain a consistent pace in performing activities?
  How well does the individual deal with the stress of keeping a schedule, being on time, dealing with other people, accepting criticism from supervisors, being around co-workers or other people generally; or having his performance evaluated?
Note: If an individual is impaired in any of the above areas, how serious is the impact? This should be included in any descriptions.

How Social Workers and Case Managers can help:

- Get letters from treating sources detailing the claimant’s condition and limitations
- Request reports and/or medical records from treating sources
- Assist the claimant to record symptoms and limitations and submit that documentation to SSA. (See attached Functional Capacity Report).
- Submit a report detailing your observations
- Gather letters from family, friends or neighbors

Points to remember when asking doctors or other sources for information, letters etc.

- Social Security only considers full time competitive work in determining disability.
- Remind sources that this means the claimant must be able to work eight hours a day, five days a week on a sustained basis.
- The claimant must be able to travel to and from work twice a day, five days a week.
- Disability is not necessarily forever. From time to time SSA will conduct a review of the claimant’s medical condition to determine if there has been improvement. This is called a Continuing Disability Review (CDR). If they determine the claimant is no longer disabled, benefits will cease.

Expediting a decision –

- “Dire need” cases
  
  Terminal illness – TERI
  
  Compassionate Allowances
  
  Financial Emergencies – imminent homelessness, facing bankruptcy
CLAIMANT SELF REPORT / CASE MANAGER FUNCTIONAL CAPACITY REPORT

CLIENT NAME
SSN
DATE

Fatigue
I require rest or nap(s). (Circle number and indicate information when requested).

1. Only get out of bed for medical appointments, etc.
2. Twice or more per day (number of hours)
3. Once a day (number of hours)
4. Rarely require naps or rests
5. I sleep hours at night

Diarrhea
I experience diarrhea: (Circle box and indicate # where appropriate)

Daily Frequently
Occasionally Never

I normally experience diarrhea:

A.M. hours Frequency
P.M. hours Frequency

I am incontinent: (Please circle)

Frequently Occasionally Never
Night Sweats and Fevers

I experience night sweats: (Please circle)

Nightly  Frequently  Occasionally  Never

I experience fevers: (Please circle)

Daily  Frequently  Occasionally  Never

I experience fevers at these times: (Please circle)

A.M. hours  P.M. hours  Both A.M. & P.M.

Night Rest

My night rest is interrupted: (Please circle)

Nightly  Frequently  Occasionally  Never

My night rest is interrupted by: Please check any and all appropriate answers)

- Night sweats
- Anxiety, nervousness, depression
- Fevers
- Itching
- Headaches
- Pain
- Diarrhea
- Need to take medication
- Respiratory Problems
- Nausea
- Sinusitis
- Other: describe
I take sleeping medication:
Yes ________  No ________
Name of medication: 
How often sleeping medication is taken

**Medication**

I experience side effects of medication(s)  Yes_______  No_______
Describe:
Name of medication  Side effect of medication

**Daily Activities**

I groom and dress myself: (Please circle)
Daily  Frequently  Occasionally  Never

I require assistance to groom and dress myself: Yes ________  No ________
Describe assistance needed:

I require assistance with household chores:
Yes  No
If yes, who helps you, with what, and how often?
I do my own laundry:

Daily  Weekly  Monthly  Never

This job takes me______________ (time)

I do/do not have to rest during the doing of my laundry

When I go out I utilize: (Please circle)

A car  Public transportation

Taxi  Someone drives me

I go out of home to visit friends or relatives: (Please circle)

Frequently  Occasionally  Never

I do the following:

Prepare my own meals from scratch
Cook pre-prepared or canned foods
Utilize Meal deliver program
Friends and family assist with cooking

Mental Health

I experience: (Please circle)

Depression  Anxiety  Confusion

Anger  Fear  No Mental Problems

Panic Attacks

These conditions significantly impair or prevent my daily functioning:

Daily  Frequently  Occasionally  Never
I have difficulty with my memory, concentration, orientation:

- Daily
- Frequently
- Occasionally
- Never

I think of suicide:

- Yes
- No

If yes, how often?

- Daily
- Frequently
- Occasionally
- Rarely

I have trouble completing tasks in a timely manner:

- Daily
- Frequently
- Occasionally
- Never

**Respiratory Functioning**

(Please circle)

I suffer from respiratory problems:

- Constantly
- Frequently
- Occasionally
- Never

I have shortness of breath:

- Daily
- Nightly
- Frequently
- Occasionally
- Never

I have shortness of breath on exertion:

- Frequently
- Occasionally
- Never

I have had bouts of pneumonia or severe upper respiratory infections:

- Dates:

**Stamina** (Please circle)

I can walk for: 30 min 1 2 3 4 5 6 7 8 hours

Need to rest afterward? How Long?

I can stand for: 0 1 2 3 4 5 6 7 8 hours

Need to rest afterward? How Long?

I can sit for: 0 1 2 3 4 5 6 7 8 hours
Need to rest afterward? ______ How Long? ______

<table>
<thead>
<tr>
<th>I can bend:</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
</table>

| I can lift: | less than 10 pounds, | 10 lbs. | 20 lbs. | 30 lbs. | 40 lbs. | 50 lbs |
|------------|------------------------|--------|--------|--------|--------|

I can lift the above indicated weight:

<table>
<thead>
<tr>
<th>Constantly</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
</table>

Need to rest afterward? ______ How Long? ______

List other conditions that are not listed that may affect you in your daily functioning (fatigue, neuropathy, lymph infections, medication side effects, etc.)

I hereby certify under penalty of law that the statements here are true.

________________________________________
Client name, signature  Date

I hereby certify under penalty of law that the patient’s limitations as described above are consistent with my observation of and contact with this patient. I have had regular contact with this client since ________.

I estimate that this patient would miss _____ days of work per month due to health related problems. Explain:

________________________________________
Name, Title
**I-3-1-6. Exhibit - TERI Flag (Form SSA-2200)**

<table>
<thead>
<tr>
<th>TERI CASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME ________________________</td>
</tr>
<tr>
<td>CLAIM NUMBER ________________________</td>
</tr>
<tr>
<td>TITLE II ______ TITLE XVI ______ CONCURRENT ______</td>
</tr>
<tr>
<td>DATE IDENTIFIED AS TERI CASE ______</td>
</tr>
</tbody>
</table>

DATE SENT TO: HEARING OFFICE ______ AC ______

<table>
<thead>
<tr>
<th>ATTORNEY FEE</th>
<th>ATTORNEY FEE DIRECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAIVED ______</td>
<td>PAYMENT WAIVED ______</td>
</tr>
</tbody>
</table>

DO NOT REMOVE THIS FLAG UNTIL ALL ADJUDICATIVE ACTIONS HAVE BEEN COMPLETED AND THE APPEALS PROCESS HAS BEEN EXHAUSTED.

**Form SSA-2200 (12-2000)**

**LIST OF DESCRIPTORS**

(Check the reason this case was identified as TERI.)

<table>
<thead>
<tr>
<th>LIST OF DESCRIPTORS</th>
<th>A claim may be identified as a potential TERI case by using the following criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SITUATION</td>
<td>______ An allegation (e.g., from the claimant, a friend, family member, doctor or other medical source) that the illness is terminal; ______ An allegation or diagnosis of AIDS; ______ The claimant is registered in a Medicare-designated hospice or is receiving hospice care; e.g., in-home counseling or nursing care; or</td>
</tr>
<tr>
<td>2. CONDITION</td>
<td>The claimant has a condition which medical records indicate is untreatable; that is, the condition cannot be reversed and is</td>
</tr>
</tbody>
</table>

https://www.ssa.gov/OP_Home/hallex/I-03/I-3-1-6.html
<table>
<thead>
<tr>
<th></th>
<th>Chronic dependence on a cardiopulmonary life-sustaining device.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chronic pulmonary or heart failure requiring continuous home oxygen and is unable to care for personal needs.</td>
</tr>
<tr>
<td></td>
<td>Diabetic with one or more of the following: multiple amputations due to diabetic gangrene, recurrent cardiovascular events (infarction, failure), recurrent cerebrovascular events with neurological deficit.</td>
</tr>
<tr>
<td></td>
<td>Comatose for 30 days or more.</td>
</tr>
<tr>
<td></td>
<td>Awaiting a heart, heart/lung, liver, or bone marrow transplant (excludes kidney and corneal transplants).</td>
</tr>
<tr>
<td></td>
<td>A malignant disease (e.g., cancer), is home confined or institutionalized, with inability to care for personal needs and is unresponsive to therapy.</td>
</tr>
<tr>
<td></td>
<td>Chronic liver disease; e.g., cirrhosis, hepatitis, with history of massive gastrointestinal hemorrhage.</td>
</tr>
<tr>
<td></td>
<td>Newborn with a lethal genetic or congenital defect.</td>
</tr>
<tr>
<td></td>
<td>Other:</td>
</tr>
<tr>
<td></td>
<td>(Identify)</td>
</tr>
</tbody>
</table>
Module 7

Appeals Rights & Time Limits for Denied Application
Module 7 - Appeal rights and time limits for denied applications

What can be done if the initial application is denied?

Beginning in January 2019, claimants must ask for reconsideration within 60 days of the date of the initial denial. Forms are available at local Social Security offices or online at www.ssa.gov.

What if reconsideration is denied?

The claimant can ask for a hearing. If he or she receives an unfavorable decision, a hearing must be requested in writing within 60 days from the date the decision was received. Forms are available at local Social Security offices or on line at www.ssa.gov. Take or mail the form to the local Social Security office. You can also request a hearing online at www.ssa.gov. A hearing will then be scheduled before and Administrative Law Judge. Also see page 67 of this manual for SSA’s Request for Reconsideration form.

The administrative law judge will notify the claimant by letter of the time and place of the hearing.

The claimant has a right to be represented at the hearing. A skilled representative, familiar with Social Security law and hearing procedures is strongly recommended.

Where to find an advocate: http://www.lawhelp.org/ny/

The claimant and his/her representative, if he/she has one one, may come to the hearing and explain the case in person. A claimant may look at the information in the file and give new information.

The administrative law judge will question the claimant and any witnesses brought to the hearing. Other witnesses, such as medical or vocational experts, may give the judge information at the hearing. The claimant or representative also may question the witnesses.

It is to the claimant’s advantage to attend the hearing.

After the hearing, SSA will send out a letter and a copy of the administrative law judge’s decision

Appeals Council

If the claimant disagrees with the hearing decision, they must ask for a review by Social Security’s Appeals Council. This review must be requested in writing within 60 days from the date the decision was received. Appeals can be filed online at www.ssa.gov or you can take or mail the forms to the local Social Security office.
The Appeals Council will either review the case or decline to review it. If the Appeals Council decides to review the case, it will either decide the case itself or return it to an administrative law judge for further review. (i.e. another hearing).

**Federal Court**

If you disagree with the Appeals Council’s decision or if the Appeals Council decides not to review the case, you may file a lawsuit in a federal district court.
REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

(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)

1. Claimant Name
2. Claimant SSN
3. Claim Number, if different

4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

5. I have additional evidence to submit. ☐ Yes ☐ No
   Name and source of additional evidence, if not included.

Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.

Representation: You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks
   ☐ I wish to appear at a hearing.
   ☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

7. CLAIMANT SIGNATURE (OPTIONAL) DATE 8. NAME OF REPRESENTATIVE (if any) DATE

RESIDENCE ADDRESS

CITY STATE ZIP CODE CITY STATE ZIP CODE

TELEPHONE NUMBER FAX NUMBER TELEPHONE NUMBER FAX NUMBER

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING

9. Request received on __________ by: ____________________ ____________________
   (Date) (Print Name) (Title)
   (Address) (Servicing FO Code) (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination? ☐ Yes ☐ No
   If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided? ☐ Yes ☐ No

12. Interpreter needed ☐ Yes ☐ No

Language (including sign language):

13. Check one: ☐ Initial Entitlement Case ☐ Disability Cessation Case or ☐ Other Postentitlement Case

14. HO COPY SENT TO: ☐ HO on
   ☐ Claims Folder (CF) Attached: ☐ Title (T) II; ☐ T XVI; ☐ T VIII; ☐ T XVIII; ☐ T II CF held in FO ☐ Electronic Folder
   ☐ CF requested ☐ T II; ☐ T XVI; ☐ T VIII; ☐ T XVIII (Copy of email or phone report attached)

15. Check all claim types that apply:
   ☐ Retirement and Survivors Insurance Only (RSI)
   ☐ Title II Disability - Worker or child only (DIWC)
   ☐ Title II Disability - Widow(er) only (DIWW)
   ☐ Title XVI (SSI) Aged only (SSIA)
   ☐ Title XVI Blind only (SSIB)
   ☐ Title XVI Disability only (SSID)
   ☐ Title XVI/Title II Concurrent Aged Claim (SSAC)
   ☐ Title XVI/Title II Concurrent Blind (SSBC)
   ☐ Title XVI/Title II Concurrent Disability (SSDC)
   ☐ Title XVIII Hospital/Supplementary Insurance (HI/SMI)
   ☐ Title VIII Only Special Veterans Benefits (SVB)
   ☐ Title VIII/Title XVI (SVB/SSI)
   ☐ Other - Specify:

Form HA-501-U5 (01-2015) ef (01-2015)
Use 08-2012 Edition Until Stock is Exhausted

TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS
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)

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

First Visit
   ____________________________

Date
   ____________________________

Last Visit
   ____________________________

Date
   ____________________________

Next scheduled appointment (if any)
   ____________________________

Date
   ____________________________

☐ None

Emergency Room visits at this facility

Date
   ____________________________

Overnight hospital stays at this facility

Date in    Date out
   ____________________________

Date in    Date out
   ____________________________

Date in    Date out
   ____________________________

☐ 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.)

<table>
<thead>
<tr>
<th>KIND OF TEST</th>
<th>DATES OF TESTS</th>
<th>KIND OF TEST</th>
<th>DATES OF TESTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Biopsy (list body part)</td>
<td></td>
<td>☐ MRI/ICT Scan (list body part)</td>
<td></td>
</tr>
<tr>
<td>☐ Blood Test (not HIV)</td>
<td></td>
<td>☐ Speech/Language Test</td>
<td></td>
</tr>
<tr>
<td>☐ Breathing Test</td>
<td></td>
<td>☐ Treadmill (exercise test)</td>
<td></td>
</tr>
<tr>
<td>☐ Cardiac Catheterization</td>
<td></td>
<td>☐ Vision Test</td>
<td></td>
</tr>
<tr>
<td>☐ EEG (brain wave test)</td>
<td></td>
<td>☐ X-ray (list body part)</td>
<td></td>
</tr>
<tr>
<td>☐ EKG (heart test)</td>
<td></td>
<td>☐ Other (please describe)</td>
<td></td>
</tr>
<tr>
<td>☐ Hearing Test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ HIV Test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ IQ Testing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Office, Clinic or Outpatient visits at this facility</th>
<th>Emergency Room visits at this facility</th>
<th>Overnight hospital stays at this facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Visit</td>
<td>Date</td>
<td>Date in ___ Date out ___</td>
</tr>
<tr>
<td>Last Visit</td>
<td>Date</td>
<td>Date in ___ Date out ___</td>
</tr>
<tr>
<td>Next scheduled appointment (if any)</td>
<td>Date</td>
<td>Date in ___ Date out ___</td>
</tr>
<tr>
<td></td>
<td>□ None</td>
<td>□ None</td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>KIND OF TEST</th>
<th>DATES OF TESTS</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>☐ IQ Testing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
First Visit

Last Visit

Next scheduled appointment
(if any)

Emergency Room visits at this facility
Date

Date

Date

Overnight hospital stays at this facility
Date in

Date out

Date in

Date out

Date in

Date out

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.)

<table>
<thead>
<tr>
<th>KIND OF TEST</th>
<th>DATES OF TESTS</th>
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</tr>
<tr>
<td>□ IQ Testing</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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 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)

<table>
<thead>
<tr>
<th>NAME OF MEDICINE</th>
<th>IF PRESCRIBED, NAME OF DOCTOR</th>
<th>REASON FOR MEDICINE</th>
<th>SIDE EFFECTS YOU HAVE</th>
</tr>
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<tr>
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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:

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Module 8

Some Common Issues You May Appeal and Time Limits for Doing So
Module 8 – Some common issues you may appeal and time limits for doing so

Other decisions made by Social Security may be appealed.

Continuing Disability Reviews (CDRs). Periodically, SSA will conduct a review of the claimant’s medical condition to determine if there has been improvement. If they determine the claimant is no longer disabled, benefits will cease.

Fleeing felons: A person with an outstanding warrant for a felony is not eligible to get Social Security benefits. Under the 2009 settlement agreement reached in Martinez v. Astrue, this prohibition applies only if the individual’s outstanding felony warrant was issued for:

- Escape (Offense Code 4901);
- Flight to avoid prosecution, confinement, etc. (Offense Code 4902); or
- Flight-Escape (Offense Code 4999).

Resources: A person who has resources in excess of $2000 for a single person or $3000 for a married couple is not eligible for Social Security benefits.

There is a two tiered appeals system for decisions other than disability determinations.

1. RECONSIDERATION. See Attached Form

2. HEARING REQUEST See Attached Form

Ensuring that benefits continue during the appeal
In some cases, the claimant can request that SSA continues to pay benefits while a decision is being made on the appeal. A request for benefits to continue can be made when:

- The claimant is appealing a decision to discontinue benefits because SSA no longer considers them to be disabled.
- The claimant is appealing a decision that they are no longer eligible for SSI payments, or that their SSI payment should be reduced or suspended.

If a claimant wants benefits to continue, the decision must be appealed within 10 days of receiving the letter from SSA. (If the appeal is denied, the claimant may be charged with an overpayment for any money they were not eligible to receive.

The assistance of an experienced Social Security attorney or advocate is highly beneficial to the claimant in any appeal.
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

THREE WAYS TO APPEAL

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:

☐ 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

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.

Claims Folder
ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS
(See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

Title XVI
1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

Title XVII (See VB 02501.035)
1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II-items 3, 4, 10, 11 & 16.

Title XVIII
1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SIMB);
3. Termination of benefits (including termination of entitlement to Hl and SIMI);
4. Initial determinations regarding Medicare Part B income-related premium subsidy reductions.
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

THREE WAYS TO APPEAL
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:

☐ 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:

CITY:  STATE:  ZIP CODE:

TELEPHONE NUMBER:  DATE:

MAILING ADDRESS:

CITY:  STATE:  ZIP CODE:

TELEPHONE NUMBER:  DATE:

TELEPHONE NUMBER:  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)

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

FIELD OFFICE DEVELOPMENT (GN 03102.300)

☐ NO FURTHER DEVELOPMENT REQUIRED

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

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.

Claimant
HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI)
OR SPECIAL VETERANS BENEFIT (SVB) DECISION

Now that you picked the kind of appeal that fits your case, fill out this form or we'll help you fill it out. You can have a lawyer, friend, or someone else help you with your appeal. There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (SSA-789-U4) FOR YOUR APPEAL.

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

Privacy Act Statement
Request for Reconsideration

Sections 205, 702(a)(5), 809(a), 809(b), 1631, 1633, and 1869(b) 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 re-evaluating the decision on your claim.

We will use the information to determine your eligibility for benefits and administer our programs. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his/her affairs or his/her eligibility for or entitlement to benefits under the Social Security program.

2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

3. To the Center for Medicare & Medicaid Services (CMS), for the purpose of administering Medicare Part A, Part B, Medicare Advantage Part C, and Medicare Part D, including but not limited to: Medicare Part C enrollment and premium collection processes; Part D enrollment and premium collection processes; Medicare Part B premium reduction based on participation in a Part C plan; and Medicare Part B enrollment and income-related monthly adjustment amount determinations, appeals of determinations, and premium collections.

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). There are several SORNs that govern the collection of this information, including 60-0089, entitled Claims Folder System, and 60-0321, entitled Medicare Database File. Additional information and a full listing of all our SORNs and applicable routine uses are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1980. 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 8 minutes to read the instructions, gather the facts, and answer the questions.

SEND 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 Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.