Empire Justice Center
Making the law work for all New Yorkers

HIV AS A DISABLING CONDITION:

Maximizing SSI / SSD

SSI & SSD Benefits Program ◆ Rules ◆ Appeals Process

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Islandia, New York

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Empire Justice Center

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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

Social Security Disability Insurance (SSD)	**Supplemental Security Income (SSI)**
This program may be called one of many names: RSDHI (Retirement, Survivor, Disability, Health Insurance), SSDI (Social Security Disability Insurance), Title II, DIB (Disability Insurance Benefits)	This program may be called one of two names: SSI (Supplemental Security Income) or Title XVI
Wage Earner must have worked to earn sufficient "quarters of coverage".	No work history is required.
Benefits to worker's (wage-earner) family: **Spouses**: If at least age 62, or if caring for either a child under 16 or a disabled child of the worker. **Divorced Spouses**: If the marriage lasted at least 10 years, and the person is age 62 years old or older and remains unmarried. **Child**: 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. **Disabled Adult Child**: Adult Children (18 or older) of a retired, disabled, or deceased worker, if the disability began before the age of 22.	No family member of the SSI recipient will be eligible for SSI benefits unless he or she independently establishes eligibility for SSI.
From the date one becomes disabled, there is a five-month waiting period prior to receipt of benefits.	No waiting period. An individual may receive benefits as of the first day of the month following month of application.
Provision for payment up to 12 months before the date of application.	Only paid as of first day of month following month of application.
Claimants may receive retroactive benefits up to one year before the date of application.	Retroactive benefits to first day of month following month of application.
Only Worker's Compensation or other Federal or State disability payments may affect payment level.	Any income (earned or unearned) affects benefits.
No resource limits.	Resources must be below $2000 for an individual and $3000 for an eligible couple.
Checks are paid one month behind, i.e., check received in May is recipient's April check.	Checks are paid for the month in which they are received.
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.	Checks are paid on the 1st of the month.
Eligible for Medicare 24 months after establishing eligibility for SSDI.	In New York state, eligible for Medicaid if receiving even $1.00 of SSI.

Some individuals will get both SSD and SSI if the amount they receive from SSD is low.

SSI Benefit Levels Chart effective January 1, 2008 (reflects the 2.3% federal COLA for January 2008)

Fed L/A Code	State Supp Code	New York State Living Arrangement	Individual			Couple		
			Federal	State	TOTAL [1]	Federal	State	TOTAL [1]
A	A	**Living Alone**	$637	$87	**$724**	$956	$104	**$1,060**
A, C (B)	B (F)	**Living With Others** (Living in the Household of Another) [2]	637 (424.67)	23	**660** (447.67)	956 (637.34)	46	**1002** (683.34)
A	C	**Congregate Care Level 1 - *Family Care*** ❑ OCFS certified Family Type Homes ❑ OMH or OMRDD certified Family Care Homes *NYC, Nassau, Rockland, Suffolk and Westchester Counties*	637	266.48	**903.48**	956	850.96	**1,806.96**
		Rest of State	637	228.48	**865.48**	956	774.96	**1,730.96**
A	D	**Congregate Care Level 2 - *Residential Care*** ❑ DOH certified Residences for Adults ❑ OMH or OMRDD certified Community Residences, Individualized Residential Alternatives and OASAS certified Chemical Dependence Residential Services *NYC, Nassau, Rockland, Suffolk and Westchester Counties*	637	435	**1,072**	956	1,188	**2,144**
		Rest of State	637	405	**1,042**	956	1,128	**2,084**
A	E	**Congregate Care Level 3 – *Enhanced Residential Care*** ❑ DOH certified Adult Homes and Enriched Housing programs ❑ OMRDD certified Schools for the Mentally Retarded	637	656	**1,293**	956	1,630	**2,586**
D	Z	**Title XIX (Medicaid certified) Institutions** [3]	30	0 [4]	**30** [4]	60	0 [4]	**60** [4]
A	Z	(see below) [5]	637	0	**637**	956	0	**956**

Minimum Personal Needs Allowances

- ❑ Congregate Care Level 1 - $123
- ❑ Congregate Care Level 2 - $142
- ❑ Congregate Care Level 3 - $168

Limits on Countable Resources

- ❑ Individuals $2,000
- ❑ Couples $3,000

Revised 18 Oct 2007

Statutory References: Chap. 57 of L. 2006 and Chap. 132 of L. 2007

[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] This zero federally-administered State supplement applies: *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.

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 2008 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.

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.

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?

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

You should have as much of the following information as possible ready **for your interview**. **Keep your appointment,** even if you do not have all of the information**.** We will help you get any missing information.

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

Medical Information:

- ☐ Names, addresses and phone numbers of all doctors, hospitals and clinics.
- ☐ Patient ID number(s)
- ☐ Dates seen
- ☐ Name(s) of medicine(s) you are taking
- ☐ Medical records in your possession

☐ An original or certified copy of your birth certificate. If you were born in another country, we also need proof of U.S. citizenship or legal residency.

☐ If you were in the military service, the original or certified copy of your military discharge papers (Form DD 214) for all periods of active duty.

☐ If you worked, your W-2 Form from last year; or if you were self-employed, your federal income tax return (IRS 1040 and Schedules C and SE).

☐ Workers' compensation information**,** including date of injury, claim number and proof of payment amounts.

☐ Social Security Number(s) for your spouse and minor children.

☐ Your checking or savings account number, if you have one.

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

☐ Kinds of jobs and dates you worked in the 15 years before you became unable to work.

The enclosed Worksheet will help you collect the information you need for your interview.

MEDICAL AND JOB WORKSHEET - ADULT

Help us to help you!

Completing this worksheet will help you get ready for the interview. Or, you can complete the Adult Disability Report on the Internet at ***www.socialsecurity.gov/adultdisabilityreport***. We may ask for additional information at the interview. *If you need more space, use blank sheets of paper.*

A. Illnesses, injuries or conditions limiting your ability to work. ______________________

____

____

B. Date you became unable to work because of your medical condition *(month/day/year)*. __________

C. If applicable, **Medical Assistance Number** *(Medicaid or other).* ______________________

D. Doctor/HMO/therapist/ or other person who treated your illnesses, injuries, or conditions, or who you expect to treat you in the future.

NAME	ADDRESS, ZIP CODE, and PHONE NUMBER	PATIENT I.D. NUMBER	DATE FIRST SEEN	DATE LAST SEEN

E. Hospitals, clinics, or emergency rooms you visited or expect to visit because of your **illnesses, injuries, or conditions**.

NAME	ADDRESS, ZIP CODE, and PHONE NUMBER	PATIENT I.D. NUMBER	DATE IN	DATE OUT

F. Medications you take and **why** you take them. If **prescribed**, provide the **doctor's name.**

NAME OF MEDICINE	WHY YOU TAKE IT	PRESCRIBED BY

G. Medical tests you had or are going to have in the future.

NAME OF TEST	PLACE OF TEST	PERSON WHO SENT YOU	DATE(S)

H. Jobs you had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

JOB TITLE *(e.g., cook)*	**TYPE OF BUSINESS** *(e.g., restaurant)*	**DATES WORKED** *(month/year)* **FROM - TO**	**HOURS PER DAY**	**DAYS PER WEEK**	**RATE OF PAY** *(per hour/ week/year)*

Social Security Online
Disability Home

Disability Programs

Disability Report Form Guide (Text Version)

Return To: Introduction | Forms | How To Apply

Go To Section:

1. Information About the Disabled Person
2. Your Illnesses, Injuries or Conditions and How They Affect You
3. Information About Your Work
4. Information About Your Medical Records
5. Medications
6. Tests
7. Education / Training Information
8. Vocational Rehabilitation, Employment, or Other Support Services Information
9. Remarks

Information about Person Completing this Form.

Select **Back to top** to return to the top of this page.

Section 1 - Information About the Disabled Person

A. Name, B. Social Security Number

We need your name and Social Security number to identify your medical and work records. If you have used other names, please list those names in Section 4.C. Many doctors and hospitals use Social Security numbers as patient identification numbers. Your number may help them to locate and send us your medical records faster.

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C. Daytime Telephone Number

We need an area code and phone number where we can reach you or leave a message, because we may need to contact you for additional information. If you do not have a phone, please give us the name and phone number of someone who can get in touch with you quickly. Let them know that we may call them with a message for you.

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D. Name of a Friend or Relative

We ask you to identify a friend or relative who knows about your illnesses, injuries, or conditions because he or she can often tell us how your medical problems affect you. Reports from doctors and hospitals provide a lot of information we need, but they don't always give us a complete picture of how your illnesses, injuries, or conditions affect you in your daily life. For this reason, we may, with your permission, contact a friend or relative who may be able to help with your claim, help you obtain medical records, or get you to a medical examination. Please give a complete mailing address of your friend or relative.

If you need to give us more than one name, please write the other name(s), phone number, and relationship to you in Section 9 - Remarks.

FREQUENTLY ASKED QUESTIONS:

Can I list my husband or wife or older children?
Yes. In fact, we are very interested in hearing from people who know you best and can tell us about your illnesses, injuries, or conditions and how they affect you.

Should I tell the person that I list that you may be calling him or her?
Yes. You should tell the person that we may call or write him or her for information about your illnesses, injuries, or conditions or your activities.

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E. Height and F. Weight

We ask you for your height and weight because this information may be important in evaluating your illnesses, injuries, or conditions. Even though your height and weight may be in your medical records, the information you give us can show us if it is the most accurate and up-to-date information.

FREQUENTLY ASKED QUESTIONS:

What if I don't know my height or weight?
If you don't know your height or weight, just write the words "don't know" on the line. However, if you know approximately how tall you are or how much you weigh, you can write the word "about" followed by your height or weight. For example, "about 5 feet, 6 inches."

I haven't been weighed recently and I am not sure if my weight has changed. What should I write?
You can write the last weight that you remember and tell us approximately when you were last weighed. For example, "150

pounds last summer." If you think that you may have gained or lost weight since you were last weighed, you can also mention that in Section 9 - Remarks.

I don't like to tell people how much I weigh. Do I need to tell you?
We certainly understand your feelings. However, the information that you give us is private, and we use it only as part of your medical evaluation. Medical reports don't always include your height or weight, so the information you give us may be very helpful.

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G. Medical Assistance Card

If you have a Medicaid, Medi-Cal, or other medical assistance card from your State government, your card number can help us obtain your medical records. This may help us complete your claim sooner.

FREQUENTLY ASKED QUESTIONS:
Do you want the number of any health insurance card that I have?
No. We only want your card number if you receive medical assistance from your State government, such as Medicaid or Medi-Cal. This number may help us obtain your medical records more easily. We do not need a number if you have commercial health insurance, such as Blue Cross, Medicare, or an HMO.

What if I don't know my number?
If you know the State office that gave you the card, you can call them for your number. Or, you can call your doctor's office. If you still do not know what your card number is, just write the words "don't know" on the line.

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H., I., J. Can You Speak, Read, Write, and Understand English?

We need to know if you can speak and understand English for several reasons:

1. If you cannot speak or understand English, we will be able to help you by providing an interpreter, free of charge, when we talk with you about your claim.
2. If you cannot speak, read, or write English, is there someone who does, and will give you messages, if we need to contact you?
3. Many of our booklets and letters are written in languages other than English. If we know that you read another language, we may be able to give you information in a language that you understand.

4. If you are unable to do the type of work you did in the past, we will decide if you can do other types of work. We will consider your age, education, and skill level. Education includes your ability to communicate in English. If you cannot speak, read, or write English, it may be harder for you to do some jobs.

MORE INFORMATION:

- Publications in Non-English Languages
- Interpreter Services

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Section 2 - Your Illnesses, Injuries, or Conditions and How They Affect You

General Information About Section 2

We will consider all the facts, including medical evidence from your doctors, hospitals, and clinics where you have been treated in deciding if you are disabled. Please describe your illnesses, injuries, or conditions, when they began, and how they limit your activities. If you give us a full description of your illnesses, injuries, or conditions, it will help us decide your case quicker.

We will consider all your illnesses, injuries, and conditions, whether or not you have been receiving treatment for them.

It is important that you give the date you became unable to work. If you are disabled, the date you became unable to work may affect when you can begin receiving benefits and the amount of your benefits. We also ask about any work you have done after the date your condition first interfered with your ability to work because this helps us decide the earliest date that your disability began.

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A. What are the illnesses, injuries, or conditions that limit your ability to work?

It is important that you list all of your illnesses, injuries, or conditions that affect your ability to work, including any mental and emotional illnesses. We will consider all your illnesses, injuries, or conditions, whether or not you have been receiving treatment for them. Use your own words if you don't know the medical names.

If you need more room to write, use the space in Section 9 -

Remarks.

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B. How do your illnesses, injuries, or conditions limit your ability to work?

To help us decide if you are disabled you should describe how your illnesses, injuries, or conditions limit your ability to do work-related activities, such as walking, sitting, lifting and carrying, or remembering instructions. See Section 2.C., for information about how symptoms, such as pain, shortness of breath, or fatigue may affect your ability to function. If you need more room to write, use the space in Section 9 - Remarks.

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C. Do your illnesses, injuries, or conditions cause you pain or other symptoms?

We consider the effects of symptoms, such as pain, shortness of breath, or fatigue on your ability to function. Symptoms may restrict your ability to do daily activities, such as personal care (bathing, hair care, and dressing), food preparation, household maintenance, and recreational activities. They may also limit your ability to do work-related activities, such as walking, sitting, lifting, carrying, or remembering instructions. You should tell us in Section 2.B how your symptoms affect your ability to work.

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D. When did your illnesses, injuries, or conditions first interfere with your ability to work?
Some illnesses, injuries, or conditions may start suddenly or get worse over time. To evaluate your illnesses, injuries, or conditions and decide when your disability began, we will consider the date you list here and in Section 2.E., and Section 2.I. For illnesses, injuries, or conditions that occur suddenly, such as a stroke or heart attack, the dates in Section 2.D., Section 2.E. and Section 2.I. may be the same.

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E. When did you become unable to work because of your illnesses, injuries, or conditions?

Disability under our rules is based on your inability to work because of your illnesses, injuries, or conditions, even if you have never worked. As closely as possible, you should give the date that your illnesses, injuries, or conditions caused you to become unable to work. This

date may or may not be the same as the date in Section 2.D.

To determine the beginning date of your disability, we will look at the date you list here (even if you have never worked), the dates in Section 2.D., and Section 2.I., and evidence from your medical records.

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F. Have you ever worked?

We need to know if you have ever worked because you may have done work that is not shown in our records. We will look at your age, education, past work experience, and any work skills that you may have in deciding your claim. If you have worked, we will need more information about your work in Section 3.

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G. Did you work at any time after the date your illnesses, injuries, or conditions first interfered with your ability to work?

If we find that you are disabled, we will decide the earliest date that your disability began. You must be unable to work because of your illnesses, injuries, or conditions to qualify for disability under Social Security rules. However, some people keep working after their illnesses, injuries, or conditions first started. To determine the earliest date that you became disabled, we need to know if you tried to work after the date you wrote in Section 2.D. We also need to understand how your illnesses, injuries, or conditions affected your ability to work.

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H. If you did work after the date your illnesses, injuries, or conditions first interfered with your ability to work, did they cause you to work fewer hours, change your job duties, or make any other job-related changes?

If you worked after your illnesses, injuries, or conditions first interfered with your ability to work, you may have made changes in your job, such as working fewer hours, doing lighter job duties, or receiving extra help from your employer. Please explain any changes in the way you did your job because of your illnesses, injuries, or conditions.

FREQUENTLY ASKED QUESTIONS:

Why do you want to know about changes in my work patterns caused by my illnesses, injuries, or conditions?
We ask you questions about changes in your work patterns caused

by your illnesses, injuries, or conditions because it helps us decide the beginning date of your disability.

What do you mean by extra help from my employer?
Some examples include extra supervision, help lifting or carrying, or extra rest breaks. If you worked under special conditions during a period that you say you were disabled, we will ask you to tell us about those special conditions.

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I. Are you working now? If No, when was the last day you worked?

Because your work activity is important in determining whether you are disabled, we must know if you are working now. If you stopped working, you should enter the date you stopped working. This may or may not be the same as the date in Section 2.E. If you are working now, we will be asking you for more information about your work.

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J. Why did you stop working?

If you stopped working for medical reasons, enter your illnesses, injuries, or conditions here.

If you stopped work for any reason other than your disability, such as retirement, plant closure, layoff, or you quit, please explain.

If we find you disabled under our rules, we need to know the date you became unable to work because of your illnesses, injuries, or conditions. The date that we find you disabled is your established onset date. This date may affect when your benefits will start and the amount of your benefits.

MORE INFORMATION - HOW THE ONSET DATE MAY AFFECT YOUR BENEFITS:

If you are applying for Social Security Disability Insurance benefits, your benefits may be paid beginning with the sixth full month after your disability began. You may also receive up to 12 months of prior payments, depending on when your disability began and when you filed your claim.

If you are applying for Supplemental Security Income, your benefits will begin the first month after…. either the date your disability began or the date you filed your application, whichever is later.

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Section 3 - Information About Your Work

General Information About Section 3

We need to find out about your past work to decide if you can still do it. To make this decision, we need to know how you did your job. We also need to know if you learned skills on your job.

We need this information to see if there are other jobs that you have done other than your usual work. If you cannot do your usual work, we will decide if you can do another job that you did in the last 15 years. Remember that you are not disabled according to our rules unless your illnesses, injuries, or conditions prevent you from doing any job. Because people lose job skills if they do not use them for a long time, we do not consider them and you do not need to include jobs you did more than 15 years before you became disabled. If you need more room to list your jobs, use the space in Section 9 - Remarks.

FREQUENTLY ASKED QUESTIONS:

Can't you get this information from my Social Security records?
The information about the kind of job that you did and the skills that you needed to do that job is not in our records. Our records only show who paid you and how much they paid you in a given year.

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A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

Please list all your jobs in the 15 years before you became unable to work because of your illnesses, injuries, or conditions, starting with your most recent job and working back. For each job, list the title of the job (for example, waitress, truck driver, bank teller), the type of business where you worked (fast food, laundry, bank, etc.), the dates you worked there (month and year are enough), the number of hours a day you worked, the number of days per week, and your most recent pay rate.

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B. Which job did you do the longest?

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C. Describe this job. What did you do all day? (If you need more space, write in Section 9- Remarks.)

This information is very important because we need to decide if your illnesses, injuries, or conditions prevent you from doing your past work. Please tell us about your job duties. This is your chance to tell us what you actually did on the job. We need this information so we can understand what your job was like. If you need more room, you can use Section 9 - Remarks to continue your description, or you may add additional sheets of paper.

FREQUENTLY ASKED QUESTIONS:

Why can't I just list the job I did the longest without describing it?
We need more information than that. There are jobs with the same name but very different job duties. There are also jobs that have the same job duties but have different names. That is why a job title is not enough to describe your work.

Please try to describe what you did on the job so that someone who has never done it will understand how you did it. We need this information to decide if you can do your past work.

How much information do you want about my job(s)?
Tell us what you did on the job that you held the longest. We need enough information to get a good picture of what you did in a normal workday. Remember that most people have no idea what it takes to do your job.

What if I had more than one major job in the 15 years before I became unable to work because of my illnesses, injuries, or conditions?
If we need more information about these jobs, we will send you another form with enough room to describe all of your jobs.

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THE FOLLOWING QUESTIONS ASK FOR INFORMATION ABOUT THE JOB YOU DID THE LONGEST IN THE 15 YEARS BEFORE YOU BECAME UNABLE TO WORK BECAUSE OF YOUR ILLNESSES, INJURIES, OR CONDITIONS, THAT YOU DESCRIBED IN Section 3.C.

D. In this job (the one you described in 3.C), did you use machines, tools, or equipment? Use technical knowledge or skills? Do any writing, complete reports, or perform any duties like this?

This checklist asks you about your job skills. Check "YES" or "NO" for each of the items listed.

FREQUENTLY ASKED QUESTIONS:

What do you mean by machines, tools, and equipment?
We are trying to understand what you did on the job. For example, if you were a carpenter, did you only use hand tools like hammers and saws? For another example, if you were a secretary, did you use a computer for word processing?

What do you mean by technical knowledge?
We mean special skills you learned on the job. For example, an electrician learns about the basic laws of electricity, the electrical codes and how to use special tools.

What do you mean by writing and completing reports?
This question asks you if you did any writing or if you had to complete reports as part of your job. For example, a bookkeeper completes accounting reports as part of his or her job duties.

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E. In this job (the one you described in 3.C) , how many total hours each day did you: walk, stand, sit, climb, stoop, kneel, crouch, crawl, handle, grab, or grasp big objects, write, type, or handle small objects?

This item asks you for the number of hours that you usually did certain physical activities in a normal day on your job. If the list does not really describe what you did on your job, then be sure to explain it in Section 9 - Remarks. In a normal workday, most people would have to do some of the activities listed. Please try to tell us how long you did the activities in a normal workday. For example, a security guard might sit for 4 hours and walk for 4 hours in an 8-hour workday.

FREQUENTLY ASKED QUESTIONS:

Why are standing and walking separated?
Some jobs may require standing in one place for long periods of time and other jobs require mostly walking or a combination of walking and standing. We need this information to understand the physical requirements of your job.

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F. Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this)

This item asks you what lifting and carrying you had to do on your job (the one you described in 3.C) . Be sure to tell us how often and for how long you had to lift and carry things on your job. We use the

information in deciding how your illnesses, injuries, or conditions affect your ability to work.

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G. Check heaviest weight lifted.

This item asks you to check the heaviest weight you had to lift on the job (the one you described in 3.C) every day. We need this information to decide if you can still do this job.

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H. Check weight frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday).

This item asks you how much weight you had to lift frequently on your job (the one you described in 3.C). We realize that it is difficult to know exactly how much certain items weigh, but you may give us an estimate about how much you think they weigh.

For example, a gallon of milk weighs about 8 pounds, and bags of sugar, flour, dry dog food, and kitty litter have their weights listed on the package. You can compare those weights to the weights you had to lift frequently on the job.

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I. Did you supervise other people in this job?

Check “Yes” or “No”. If “No” go to question J. If “Yes”, tell us how many people you supervised, how much of your day was spent supervising the work of others, and whether you hired and fired employees in your job.

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J. Were you a lead worker?

What we mean by “lead worker” is someone who performs some kind of non-supervisory work but who may have additional responsibility for setting the pace of work or for ensuring the completion of work.

All of the information we ask you to provide about your job gives us a good idea about the physical requirements of your job. We will use this information to decide if your illnesses, injuries, or conditions prevent you from doing your past work.

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Section 4 - Information About Your Medical Records

General Information About Section 4

If you have received treatment, we will ask for your medical records. We use your medical records and other information to decide if you are disabled under our rules.

We need information about your medical treatment for any illnesses, injuries, or conditions that limit your ability to work. If you already have copies of your medical records in your possession from your doctors, hospitals, clinics, and other medical sources, we will not have to request them. This will allow us to decide your claim faster. Do not wait to file your claim if you do not have these records. With your permission, we will ask the medical sources you list to send them to us. If you have not received treatment, or we do not get enough information about your illnesses, injuries, or conditions, we may ask you to have a special examination or test.

We need this information because we use your medical records and other information to decide if you are disabled. We will contact the medical sources that have treated you for illnesses, injuries, or conditions and ask them to send us copies of your medical records.

We also ask for information such as:

- What are your illnesses, injuries, or conditions?
- When did they begin?
- How do they limit your activities?
- What did medical tests show?
- What treatment did you receive?

In addition, we ask for information about your ability to do work-related activities, such as walking, sitting, lifting, carrying, and understanding and remembering instructions.

We do **NOT** ask your doctors to decide if you are disabled. Rather, we decide if you are disabled under our rules.

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A. Have you been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries or conditions that limit your ability to work?

We need to know if you have been treated for any illnesses, injuries, or conditions that limit your ability to work, even if you have not been

seen recently.

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B. Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work?

We need to know if you have been treated for any emotional or mental problems that limit your ability to work, even if you have not been seen recently. We need this information because we consider emotional and mental difficulties, in addition to physical problems, when we decide your claim. It's important that we know about treatment for ALL of your illnesses, injuries, and conditions. If you have received treatment, we will ask for your medical records.

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C. List other names you have used on your medical records.

When we request your medical records, we must know the name you were using at the time you received treatment. This information will help us get your medical records faster. Include your maiden name or previous married name(s), nicknames, or any other names that would appear on your medical records. When completing Section 4.D. through Section 4.F. below, it is also helpful if you give other names your records may be listed under for each doctor, hospital, or other source of treatment.

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D. List each DOCTOR / HMO / THERAPIST / OTHER.

We need names and addresses for your medical sources so that we can request your medical records. We use these records along with other information to decide if you are disabled under our rules.

List ALL health care professionals you have seen for your illnesses, injuries, or conditions. Include physicians, psychologists, optometrists, nurse-practitioners, physician assistants, therapists, chiropractors, social workers, and counselors. Also include alternative medicine professionals, such as acupuncturists.

It is important that you provide the full name of the doctor or other medical source, and the complete mailing address. For example, do not simply list "Dr. Smith on Taylor Rd in Clarksville." We may not be able to obtain your records with an incomplete address. You can check the phone book, your appointment card, your billing statement, or call the doctor's office to get the mailing address. Some doctors have more than one office, so give us the address for the location

where you are treated or where your medical records are kept. We also need a phone number because we may need to call their office.

Your dates of treatment tell us how long you have been seen, and when your next appointment will be. If you can't remember the exact dates, try to give us the approximate dates. For example, you can write "about 2 years ago," "last year," or "6 months ago." Information about the reasons for your visits and the treatment received will help us decide which records to request. If you know your patient identification number, it may help us get your medical records faster.

If you need more room to list additional health care professionals, use the space in Section 9 - Remarks. Remember that we need to know about all of your treatment.

FREQUENTLY ASKED QUESTIONS:

How far back should I go when listing my medical treatment?
We need to know about your medical treatment since at least the time you became unable to work. If you were treated for your illnesses, injuries, or conditions before then, we also need to know about that treatment. In addition to deciding if you are disabled under our rules now, we must also decide when you first became disabled. We also use your medical records to see how your illnesses, injuries, or conditions have changed over time.

If I have an appointment scheduled with a new doctor I haven't seen before, should I list this? What about future hospital and clinic appointments?
Yes, you should list these appointments and give us the appointment dates. We always need your most current treatment records.

What if I don't know my patient identification number or hospital/clinic number?
We can still get your records without this number, but sometimes the medical source can find your records quicker if they have this information. This number is usually available on your medical records or bills.

What happens if I don't know the complete addresses for the places where I have been treated?
If you do not give us complete addresses, or if you give us the wrong addresses, we may be delayed in getting your medical records. Therefore, it is important that you try to find the complete address by checking the phone book, appointment cards, billing statements, or calling the office for the address.

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E. List each HOSPITAL / CLINIC.

We need the names and addresses of hospitals and clinics that have treated you for your illnesses, injuries, or conditions so that we can request your medical records. We use these records along with other information to see if you are disabled under our rules.

Be sure to include the complete name, address, and phone number of the hospital or clinic where you were treated. Some hospitals and clinics have more than one location, so providing the exact address is important. You can check the phone book, your appointment card, your billing statement, or call the hospital or clinic to get the mailing address for requesting your medical records. If you have already listed a clinic or clinic doctor in Section 4.D., you do not need to list them again here.

We need your dates of treatment and the date of your next appointment. If you can't remember the exact dates, try to give us the approximate dates. For example, you can write "about 2 years ago," "last year," or "6 months ago." Hospitals and clinics often need these dates to give us your medical records. Also include your hospital or clinic number if you know it.

Your type of visit should be shown as:

- Inpatient Stays (Stayed at least overnight)
- Outpatient Visits (Sent home the same day)
- Emergency Room (ER) Visits (Seen in ER and sent home after treatment)

Make sure you list ALL hospitals, clinics, and treatment centers where you received treatment for your illnesses, injuries, or conditions. If you do not have enough room, use the space in Section 9 - Remarks.

Include as much information as possible about the reasons for your visits, the types of treatment you received, and the names of the doctors or other health care professionals that treated you. This information allows us to ask for the specific records we need from your doctors.

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F. Does anyone else have medical records or information about your illnesses, injuries or conditions?

We need information about anyone else who would have medical records or information about your illnesses, injuries, or conditions. Sometimes sources other than the doctors, hospitals, and clinics you listed in items 4.D. and 4.E. will have copies of your medical records,

and they may give them to us more quickly.

These sources may include State workers' compensation, insurance companies, prisons, attorneys, public welfare offices, and others. If you have any of your medical records, you should give them to us with the Disability Report.

Be sure to provide all information, including the complete name and address. We need a phone number because we may have to call these sources about your medical records. Your dates of visits, next appointment, claim number, and reasons for visits help us ask for the information we need. If you do not have enough room, please use the space in Section 9 - Remarks.

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Section 5 - Medications

General Information About Section 5

This section tells us a little more about you and how you are being treated for your illnesses, injuries, or conditions. We need to know about the medicines your doctor(s) prescribed and any "over-the-counter" medicines you take, such as aspirin or Tylenol. It is very important that you list ALL of the medicines you take, even if they are not for the current illnesses, injuries, or conditions for which you are filing a disability claim.

The kinds of medication, how often you take them, and how they affect you can help us learn more about you so that we can make a better decision on your claim. If you are using any other types of medicines, such as herbs or home remedies, we also need to know this because it may tell us about other medical problems that may affect your current illnesses, injuries, or conditions. We will look at all other illnesses, injuries, or conditions you may have when we make a decision on your claim.

FREQUENTLY ASKED QUESTIONS:

Why don't you get this information from my doctor?
We not only need the medicines that are prescribed by a doctor, but also any over-the-counter medicines or herbal remedies you may be taking. These other types of medicines might not be listed in your doctor’s records. Also, a doctor's records don't always show how the medicine "makes you feel."

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Name of Medicine

For prescription medicine, you will be able to get this information from the container. If you do not have the container, you can give us the common name or the type of medicine (such as heart medicine or arthritis medicine).

For non-prescription (over-the-counter) or herbal medicines, give us the name of the medicine.

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If Prescribed, Give Name of Doctor

We need the name of the doctor who prescribed the medicine you are taking. This does not have to be your current doctor. It may be a doctor you have seen before for another illness, injury, or condition. If you cannot remember the doctor's name, please write "unknown" in the space.

Reminder: If you have not already listed the name of this doctor, please enter the information in Section 4. If there is not enough room to list this doctor in Section 4, list the doctor in Section 9 - Remarks. Be sure to include all the information that Section 4 asks for.

If you give us complete information, we will be able to get a better picture of you and how your illnesses, injuries, or conditions affect your ability to work. When we review your claim, we look at your entire physical and mental medical history to decide if you are disabled under our rules. By giving us complete information, you will help us decide your claim quicker.

If the medicine you are taking was not prescribed by a doctor, just write "over-the-counter" or what other type of medication it may be (like "herbal" or "home remedy").

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Reason for Medicine

What we need for you to write here is why you are taking the medicine. Examples of this would be "to slow down my heart rate," "for high blood pressure," "to help me sleep at night," "for pain relief," "for headaches," or "for depression." This is important because some medicines can be prescribed for different reasons.

This helps us find out how you are being treated for your illnesses, injuries, or conditions and how well that treatment is working for you. We will use this information to help us, as we decide how your

illnesses, injuries, or conditions affect your ability to work.

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Side Effects You Have

This section describes how the medicine you take affects you either physically or mentally. Examples here would be "It just makes me so tired that I can't do anything but sleep," or "I can't go anywhere because I get diarrhea when I take my medicine," "or "It makes me sick to my stomach." You should also list any allergic reactions you have to the medicines you are taking.

Your reaction to the medicine you take may affect your ability to work. We need to know this information since the ability to work is an important part of how we decide whether or not you are disabled.

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Section 6- Tests

General Information About Section 6

We need the results of your medical tests to better understand the nature of your illnesses, injuries, or conditions. We are interested in tests that are planned for you in the future and also tests that have been completed. We use the results of some kinds of tests to confirm the presence of a medical problem. For example, an x-ray can show the presence of a bone fracture. We use the results of other kinds of tests to find out the extent of physical limitations caused by an illness, injury, or condition. For example, a breathing test can show limitations caused by a lung condition. We will use this information and other evidence to decide what you can still do.

NOTE: Select the name of any test (on page 7) for more information.

FREQUENTLY ASKED QUESTIONS:

Why can't you get this information from my doctor?
You may have tests scheduled in the future, and your doctor will not have the results of those tests. You may also have had tests done as an outpatient or as an emergency room patient, and your doctor may not have the results from such testing. Or, you may have been tested while you were in the hospital, and the hospital did not include the results in your records. We will try to get your test results, but we have to know what tests you had and when and where you had them done so that we can get all the information that tells us about your

illnesses, injuries, or conditions.

What information do I put in this section of the form?
A number of tests are listed in this section. If you had or are going to have any of these tests, please give us the dates, location and who asked you to have the test(s). If you had or are going to have a test performed that is not listed in this section, you can give us the information in Section 9 - Remarks on page 10. Be sure to tell us the name of the doctor who sent you for testing so we can obtain these records.

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EKG (Heart Test)

In this test the patient sits, stands, or lies down while wires are placed on the skin. A machine attached to the other ends of the wires prints out wavy lines on a chart that shows the electrical activity of the heart.

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Treadmill (Exercise Test)

This is a heart test done while the patient exercises. There are different kinds of exercise methods but the most common is the treadmill test in which the patient has an EKG recorded as he or she walks on a treadmill.

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Cardiac Catheterization

This is a test of the blood circulation in the heart. In this test the doctor passes a thin wire into the heart through an artery (usually through the groin area). With this test, a doctor can see pictures of the inside of the heart.

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Biopsy

Name of body part-This is a test in which the doctor removes tissue from a part of the body to see if disease is present. You should enter the name of the body part on the line.

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Hearing Test

This a test in which a specialist plays different tones through earphones to detect any hearing loss.

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Speech-Language Test

This is a test that helps a speech-language pathologist to evaluate your ability to use speech and language to communicate with others.

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Vision Test

This is an eye test that may require reading letters from a chart. It may also require reading letters through a machine with adjustable lenses, or it may check side vision with dots of light.

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IQ Testing

This is a test that measures a person's ability to understand information and solve problems. This test is made up of a series of short tasks that require either a written or spoken response.

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EEG (Brain Wave Test)

This test involves placing wires on the scalp. These wires lead to a machine that measures and records brain wave activity. This test can detect seizure activity and other problems in the brain.

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HIV Test

This is a blood test that detects the presence of the human immunodeficiency virus (HIV).

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Blood Test (Not HIV)

In this test, a technician draws blood that is tested for abnormalities in a laboratory.

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Breathing Test

In this test, the patient exhales as hard and as long as possible into a machine that measures the breathing capacity of the lungs.

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X-Ray

This is a test in which a large machine takes pictures of body parts. You should enter the name of the body part on the line.

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MRI / CT Scan

These testing methods are like x-rays, but use different methods in making images of the body parts. Both methods show soft tissue far better than x-ray. A CT scan is also called a CAT scan. You should enter the name of the body part on the line.

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Section 7- Education / Training Information

General Information About Section 7

Information about your education and training are very important to us. If you cannot do your past job, we look at your age, education, training, and job skills to see if you can do other kinds of work.

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A. Check the highest grade of school completed.

If you did not complete the entire school year, check the previous year that you completed. For example, if you started the 10th grade but did not finish the entire school year, check 9 as the highest grade completed.

If you are not sure how many college credits are in a school year, you may list the number of college credits you have completed. We also need for you to list the date you most recently completed your education.

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B. Did you attend special education classes?

By "special" education classes, we mean any kind of education services that you received other than what is provided for in a regular classroom. Examples of this could be special classes related to a physical, emotional, or learning disability.

If you attended these types of classes, we need information about them because we may need to contact someone at the school to get your records to use in deciding whether or not you are able to do different kinds of work. Please list the name(s) of the school, the address (as close as you can remember it), the dates you attended these classes, and the type of program you attended.

By "type of program," we mean the kind of services you may have received, like special classes or special help for an emotional disability or a learning disability, such as a reading disorder. Other examples include special classes or special help for a physical disability, such as blindness or deafness.

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

If you completed any special job training, or trade or vocational school, you should explain the type of training that you received and the approximate date you completed the training. Examples of this could be auto mechanic, electronics, cosmetology, heating and air conditioning, computer repair, data entry or word processing courses. If you need more room, please go to Section 9 - Remarks.

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Section 8 - Vocational Rehabilitation, Employment, or other Support Services Information

Have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support;
- an individualized education program through an educational institution (if a student age 18-21); or
- any program providing vocational rehabilitation, employment

services, or other support services to help you go to work?

If "Yes", provide the name of the organization or school, the name of your counselor or instructor, the address, phone number, dates when you received services, and types of services, tests, or evaluations performed.

Any information from vocational rehabilitation or other support services could help us understand the nature and extent of your disabling illnesses, injuries, or conditions more fully.

"Other support services" could include sheltered workshops, job coaches, or any group that has given you job training, coaching, or evaluation services.

Provide all details to allow us to call or write for your records. If you cannot get the complete address, show whatever information you know. For example, you may not be able to obtain a full street address, but you know, "They were in the tall office building next to the Smith County Courthouse." Or, you may not know the name of the organization, but you know, "They worked with me at the request of my guidance counselor, Ms. Jones, at Boone County Community College." Be sure to show any such information you believe may help us obtain those records.

Once we obtain this information, we will consider what those trained professionals say about your ability to work. We will consider such things as environmental limitations, ability to carry out physical activities, ability to work with others, ability to receive and understand work instructions, etc. We will consider how their findings fit with other medical records to get a complete picture of your medical limitations.

MORE INFORMATION:

- Social Security Employment Support Programs

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Section 9 - Remarks

Remarks

Use this section for any information you could not fit into the designated space for any question in earlier parts of this form. Be sure to show which section your remarks relate to. For example, if you did not have enough room to list your illnesses, injuries, or conditions in Section 2.A., you should write "Section 2. A," followed by

whatever additional information you want us to know.

You may use this section to show any other information you think would be helpful in understanding your work limitations. For example, if you showed in section 3 that you worked as a dishwasher, but the way you performed your job as a dishwasher was different than for most dishwashers, you should explain those differences in this section.

In this section, you can tell us anything else you wish to explain about why you are unable to work.

If you run out of room in this section, please continue to write or type on additional sheets, again referring to the sections of the form about which you are providing additional information.

We will consider any information you give us in this section to gain a complete picture of your illnesses, injuries, or conditions and any limitations you have.

When you are finished with this section (or if you don't have anything to add), be sure to complete the information requested on the bottom of page 10.

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Name of Person Completing this Form if other than the Disabled Person

The person completing this form should **print** his or her name, enter his or her address, and the date the form was completed. Providing an e-mail address is optional. If the person completing this form is other than the disabled person or the person identified in Section 1 Item D., be sure to also give the relationship to the disabled person, daytime phone number, and address.

Learn More About Disability Benefits and How We Decide If You Are Disabled

Privacy Policy | Website Policies & Other Important Information | Site Map
Last reviewed or modified Wednesday Apr 09, 2008
Need Larger Text?

DISABILITY REPORT - ADULT - Form SSA-3368-BK

PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

THIS IS NOT AN APPLICATION

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the Internet, you may access the Disability Report Form Guide at http://www.socialsecurity.gov/disability/3368/index.htm.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Please fill out as much of this form as you can before your interview appointment.
- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/ OTHER/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 9 and 10, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. Also, bring any medicine containers with you. If you need the records back, tell us and we will photocopy them and return them to you.

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

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 that 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 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.

The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or 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 the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the 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 give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

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 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT

For SSA Use Only
Do not write in this box.

Related SSN ______ – ______ – ______

Number Holder ______________________

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

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

B. **SOCIAL SECURITY NUMBER**
– –

C. **DAYTIME TELEPHONE NUMBER** *(If you do not have a number where we can reach you, give us a daytime number where we can leave a message for you.)*

( ) –
Area Code *Number*

☐ Your Number ☐ Message Number ☐ None

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME ______________________ RELATIONSHIP ______________

ADDRESS ______________________________________
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

City *State* *ZIP* – DAYTIME PHONE ( ) –
Area Code *Number*

E. What is your **height** without shoes? ______ *feet* ______ *inches*

F. What is your **weight** without shoes? ______ *pounds*

G. Do you have a **medical assistance card**? (For Example, Medicaid or Medi-Cal) ☐ YES ☐ NO If "YES," show the **number** here: ______________

H. Can you **speak and understand English**? ☐ YES ☐ NO If "**NO,**" what is your preferred language?______________

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

If you cannot **speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO *(If "YES," and that person is the same as in "D" above show "SAME" here. If not, complete the following information.)*

NAME ______________________ **RELATIONSHIP** ______________

ADDRESS ______________________________________
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

City *State* *ZIP* – **DAYTIME PHONE** ( ) –
Area Code *Number*

I. Can you **read and understand English**? ☐ YES ☐ NO

J. Can you **write more than your name in English**? ☐ YES ☐ NO

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries, or conditions** that limit your ability to work? ____________

B. How do your illnesses, injuries, or conditions limit your ability to work? ____________

C. Do your illnesses, injuries or conditions cause you **pain** or **other symptoms**? ☐ YES ☐ NO

D. When did your illnesses, injuries, or conditions **first interfere with your ability to work**?

Month	Day	Year

E. When did you become **unable to work** because of your illnesses, injuries, or conditions?

Month	Day	Year

F. Have you **ever worked**? ☐ YES ☐ NO *(If "NO," go to Section 4.)*

G. Did you **work at any time** after the date your illnesses, injuries, or conditions first interfered with your ability to work? ☐ YES ☐ NO

H. If "YES," did your illnesses, injuries, or conditions cause you to: *(check all that apply)*

- ☐ **work fewer hours?** *(Explain below)*
- ☐ **change your job duties?** *(Explain below)*
- ☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. Are you **working now**? ☐ YES ☐ NO

If "NO," when was the last day you worked?

Month	Day	Year

J. Why did you **stop working**? ____________

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries or conditions.

JOB TITLE (*Example, Cook*)	TYPE OF BUSINESS (*Example, Restaurant*)	DATES WORKED (*month & year*)		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (*Per hour, day, week, month or year*)	
		FROM	TO				
						$	
						$	
						$	
						$	
						$	
						$	

B. Which job did you do the longest? ______

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.) ______

______

D. 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 duties like this? ☐ YES ☐ NO

E. In **this job**, how many total hours each day did you:

Walk? ____ Stoop? *(Bend down & forward at waist.)* ____ Handle, grab, or grasp big objects? ____

Stand? ____ Kneel? *(Bend legs to rest on knees.)* ____ Reach? ____

Sit? ____ Crouch? *(Bend legs & back down & forward.)* ____ Write, type, or handle small objects? ____

Climb? ____ Crawl? *(Move on hands & knees.)* ____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

______

______

G. Check **heaviest** weight lifted:

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

H. 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 ____

I. Did you supervise other people in this job? ☐ YES (Complete items below.) ☐ NO (If NO, go to J.)

How many people did you supervise? ____

What part of your time was spent supervising people? ____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5.

C. List **other names** you have used on your medical records. ______________________

____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment.**

1

			DATES
NAME			
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP** –	**LAST** VISIT
PHONE ( ) – (*Area Code*, *Phone Number*)	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

2

			DATES
NAME			
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP** –	**LAST** VISIT
PHONE ( ) – (*Area Code*, *Phone Number*)	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3.

NAME				DATES
STREET ADDRESS				**FIRST VISIT**
CITY	**STATE**	**ZIP** –		**LAST VISIT**
PHONE ( ) – *Area Code* *Phone Number*		**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS				
WHAT **TREATMENT** WAS RECEIVED?				

If you need more space, use Section 9 - Remarks.

E. **List each HOSPITAL/CLINIC.** Include your **next appointment.**

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP –	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE ( ) – *Area Code* *Phone Number*			☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS	

Next **appointment** ____________________ Your hospital/clinic **number** ________________

Reasons for visits ______________________________

____

What **treatment** did you receive? ______________________________

____

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

____

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
			☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP –			
PHONE ( ) – Area Code Phone Number			☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS	

Next **appointment** ____________________ Your hospital/clinic **number** ________________

Reasons for visits ____

____

What **treatment** did you receive? ____

____

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

____

If you need more space, use Section 9 - Remarks.

F. Does **anyone else have medical records or information** about your illnesses, injuries, or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP** –	**LAST** VISIT
PHONE ( ) – Area Code Phone Number			NEXT **APPOINTMENT**
CLAIM NUMBER (if any)			
REASONS FOR VISITS			

If you need more space, use Section 9 - REMARKS.

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? ☐ YES ☐ NO
If "YES," please tell us the following: *(Look at your medicine containers, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Section 9 - Remarks.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries, or conditions?
☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN WAS/ WILL TESTS BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY -- Name of body part ______			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY -- Name of body part ______			
MRI/CT SCAN -- Name of body part ______			

If you have had other tests, list them in Section 9 - Remarks.

SECTION 7-EDUCATION/TRAINING INFORMATION

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

Grade school: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Approximate **date** completed: ______________________

B. Did you attend **special education** classes? ☐ YES ☐ NO *(If "NO," go to part C)*

NAME OF SCHOOL ______________________

ADDRESS ______________________
(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

______________________ –
City *State* *ZIP*

DATES ATTENDED ____________ TO ____________

TYPE OF PROGRAM ______________________

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

☐ YES ☐ NO If "YES," what type? ______________________

Approximate date completed: ______________________

SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support;
- an individualized education program through an educational institution (if a student age 18-21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION OR SCHOOL ______________________

NAME OF COUNSELOR OR INSTRUCTOR ______________________

ADDRESS ______________________
(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

______________________ –
City *State* *ZIP*

DAYTIME PHONE NUMBER ( ) –
Area Code *Number*

DATES SEEN ____________ TO ____________

TYPE OF SERVICES, TESTS OR EVALUATIONS PERFORMED ______________________
(IQ, vision, physicals, hearing, workshops, classes, etc.)

SECTION 9 - REMARKS

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

SECTION 9 - REMARKS

Name of person completing this form if other than the disabled person *(Please print)*	**Date Form Completed** *(Month, day, year)*

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

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

Relationship to Disabled Person	**Daytime Telephone Number**
	( ) –

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

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED SSA-4814-F5
(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.

I. 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.

II. 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.

III. 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.

IV. 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 check at least one of the items in section C, go right to section E.
- **ONLY COMPLETE SECTION D IF YOU HAVE NOT CHECKED ANY ITEM IN SECTION C.** See the special information below which will help you to complete section D.
- **COMPLETE SECTION E IF YOU WISH TO PROVIDE COMMENTS ON YOUR PATIENT'S CONDITION(S).**
- **ALWAYS COMPLETE SECTIONS F AND G. NOTE: This form is not complete until it is signed.**

V. 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.

VI. SPECIAL INFORMATION TO HELP YOU COMPLETE SECTION D

HOW WE USE SECTION D:

- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to a "marked" degree in any of the areas listed. See below for an explanation of the term "marked."

SPECIAL TERMS USED IN SECTION D

WHAT WE MEAN BY "REPEATED" MANIFESTATIONS OF HIV INFECTION: ***(See Item 42.a)***

"Repeated" means that a condition or combination of conditions:

- Occurs an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; or
- Does not last for 2 weeks, but occurs substantially more frequently than 3 times in a year or once every 4 months; or
- Occurs less often than an average of 3 times a year or once every 4 months but lasts substantially longer than 2 weeks.

WHAT WE MEAN BY "MANIFESTATIONS OF HIV INFECTION": ***(See Item 42.a)***

- "Manifestations of HIV infection" may include:

  Any condition listed in section C, but without the findings specified there (e.g., carcinoma of the cervix not meeting the criteria shown in item 22 of the form, diarrhea not meeting the criteria shown in item 33 of the form); or any other condition that is not listed in section C (e.g., oral hairy leukoplakia, myositis).

- Manifestations of HIV must result in significant, documented, symptoms and signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

Continued on the reverse →

WHAT WE MEAN BY "MARKED" LIMITATION OR RESTRICTION IN FUNCTIONING: *(See Item 42.b)*

- When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or in a nursing home.
- A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively.

WHAT WE MEAN BY "ACTIVITIES OF DAILY LIVING": *(See Item 42.b)*

- Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills.
- **EXAMPLE:** An individual with HIV infection who, because of symptoms such as pain, imposed by the illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

WHAT WE MEAN BY "SOCIAL FUNCTIONING": *(See Item 42.b)*

- Social functioning includes the capacity to interact appropriately and communicate effectively with others.
- **EXAMPLE:** An individual with HIV infection who, because of symptoms or a pattern of exacerbation and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to communicate with close friends or relatives) would have marked difficulty maintaining social functioning.

WHAT WE MEAN BY "COMPLETING TASKS IN A TIMELY MANNER": *(See Item 42.b)*

- Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings.
- **EXAMPLE:** An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able to do routine activities of daily living) would have marked difficulty completing tasks.

PRIVACY ACT AND PAPERWORK REDUCTION ACT STATEMENTS:

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1633(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or 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 General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the 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 give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 10 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

Form Approved
OMB No. 0960-0500

MEDICAL REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

DO/BO CODE:

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 Release Medical Information to the Social Security Administration," 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 PHONE NUMBER
	- -	( ) -
CLAIMANT's ADDRESS	CLAIMANT'S DATE OF BIRTH / /	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. OPPORTUNISTIC AND INDICATOR DISEASES: *Please check if applicable.*

BACTERIAL INFECTIONS

1. ☐ **MYCOBACTERIAL INFECTION** (e.g., caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **PULMONARY TUBERCULOSIS**, resistant to treatment
3. ☐ **NOCARDIOSIS**
4. ☐ **SALMONELLA BACTEREMIA**, recurrent non-typhoid
5. ☐ **SYPHILIS OR NEUROSYPHILIS** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **MULTIPLE OR RECURRENT BACTERIAL INFECTION(S)**, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year

FUNGAL INFECTIONS

7. ☐ **ASPERGILLOSIS**
8. ☐ **CANDIDIASIS**, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs
9. ☐ **COCCIDIOIDOMYCOSIS**, at a site other than the lungs or lymph nodes
10. ☐ **CRYPTOCOCCOSIS**, at a site other than the lungs (e.g., cryptococcal meningitis)
11. ☐ **HISTOPLASMOSIS**, at a site other than the lungs or lymph nodes
12. ☐ **MUCORMYCOSIS**

PROTOZOAN OR HELMINTHIC INFECTIONS

13. ☐ **CRYPTOSPORIDIOSIS, ISOSPORIASIS, OR MICROSPORIDIOSIS**, with diarrhea lasting for 1 month or longer
14. ☐ **PNEUMOCYSTIS CARINII PNEUMONIA OR EXTRAPULMONARY PNEUMOCYSTIS CARINII INFECTION**
15. ☐ **STRONGYLOIDIASIS**, extra-intestinal
16. ☐ **TOXOPLASMOSIS** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS

17. ☐ **CYTOMEGALOVIRUS DISEASE**, at a site other than the liver, spleen, or lymph nodes
18. ☐ **HERPES SIMPLEX VIRUS** causing mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or disseminated infection
19. ☐ **HERPES ZOSTER**, disseminated or with multidermatomal eruptions that are resistant to treatment
20. ☐ **PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY**

21. ☐ **HEPATITIS**, resulting in chronic liver disease manifested by appropriate findings (e.g., persistent ascites, bleeding esophageal varices, hepatic encephalopathy)

MALIGNANT NEOPLASMS

22. ☐ **CARCINOMA OF THE CERVIX**, invasive, FIGO stage II and beyond

23. ☐ **KAPOSI'S SARCOMA**, with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment

24. ☐ **LYMPHOMA** of any type (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkins lymphoma, Hodgkin's disease)

25. ☐ **SQUAMOUS CELL CARCINOMA OF THE ANUS**

SKIN OR MUCOUS MEMBRANES

26. ☐ **CONDITIONS OF THE SKIN OR MUCOUS MEMBRANES**, with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

HEMATOLOGIC ABNORMALITIES

27. ☐ **ANEMIA** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every 2 months

28. ☐ **GRANULOCYTOPENIA**, with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least 3 times in the last 5 months

29. ☐ **THROMBOCYTOPENIA**, with platelet counts repeatedly below 40,000/mm^3 with at least one spontaneous hemorrhage, requiring transfusion in the last 5 months; or intracranial bleeding in the last 12 months

NEUROLOGICAL ABNORMALITIES

30. ☐ **HIV ENCEPHALOPATHY**, characterized by cognitive or motor dysfunction that limits function and progresses

31. ☐ **OTHER NEUROLOGICAL MANIFESTATIONS OF HIV INFECTION** (e.g., peripheral neuropathy), with significant and persistent disorganization of motor function in 2 extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station

HIV WASTING SYNDROME

32. ☐ **HIV WASTING SYNDROME**, characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer; or chronic weakness and documented fever greater than 38° C (100.4°F) for the majority of 1 month or longer

DIARRHEA

33. ☐ **DIARRHEA**, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY

34. ☐ **CARDIOMYOPATHY** (chronic heart failure, or cor pulmonale, or other severe cardiac abnormality not responsive to treatment)

NEPHROPATHY

35. ☐ **NEPHROPATHY**, resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT 3 OR MORE TIMES IN I YEAR

36. ☐ **SEPSIS**

37. ☐ **MENINGITIS**

38. ☐ **PNEUMONIA** (non-PCP)

39. ☐ **SEPTIC ARTHRITIS**

40. ☐ **ENDOCARDITIS**

41. ☐ **SINUSITIS**, radiographically documented

NOTE: If you have checked any of the boxes in section C, proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

If you have not checked any of the boxes in section C, please complete section D. See part VI of the instruction sheet for definitions of the terms we use in section D. Proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION

42. a. **REPEATED MANIFESTATIONS OF HIV INFECTION,** including diseases mentioned in section C, items 1-41, but without the specified findings described above, or other diseases, resulting in significant, documented, symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

Please specify:

1. The manifestations your patient has had:
2. The number of episodes occurring in the same 1-year period; and
3. The approximate duration of each episode.

Remember, your patient need not have the same manifestation each time to meet the definition of repeated manifestations; but, all manifestations used to meet the requirement must have occurred in the same 1-year period. (See attached instructions for the definition of repeated manifestations.)

If you need more space, please use section E.

MANIFESTATIONS:	NO. OF EPISODES IN THE SAME 1 YEAR PERIOD;	DURATION OF EACH EPISODE:
EXAMPLE: Diarrhea	3	1 month each

AND

b. **ANY OF THE FOLLOWING:**

☐ Marked restriction of **ACTIVITIES OF DAILY LIVING**; or

☐ Marked difficulties in maintaining **SOCIAL FUNCTIONING**; or

☐ Marked difficulties in completing tasks in a timely manner due to deficiencies in **CONCENTRATION, PERSISTENCE, OR PACE.**

E. REMARKS: ***(Please use this space if you lack sufficient room in section D or to provide any other comments you wish about your patient.)***

F. MEDICAL SOURCE'S NAME AND ADDRESS ***(Print or type)***

TELEPHONE NUMBER (Area Code)

DATE

KNOWING THAT ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW, I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.

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

FOR OFFICIAL USE ONLY

☐ FIELD OFFICE DISPOSITION:

☐ DISABILITY DETERMINATION SERVICES DISPOSITION:

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 must be **IN WRITING**, a telephone call to SSA is not sufficient.

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 $940 per month in 2008, 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.

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.

14.08 ***Human immunodeficiency virus (HIV) infection.*** With documentation as described in 14.00F and one of the following:

A. Bacterial infections:

1. Mycobacterial infection (for example, caused by *M. avium-intracellulare, M. kansasii*, or *M. tuberculosis*) at a site other than the lungs, skin, or cervical or hilar lymph nodes, or pulmonary tuberculosis resistant to treatment; or

2. Nocardiosis; or

3. *Salmonella* bacteremia, recurrent non-typhoid; or

4. Multiple or recurrent bacterial infections, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in a 12-month period.

OR

B. Fungal infections:

1. Aspergillosis; or

2. Candidiasis involving the esophagus, trachea, bronchi, or lungs, or at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or

3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or

4. Cryptococcosis, at a site other than the lungs (for example, cryptococcal meningitis); or

5. Histoplasmosis, at a site other than the lungs or lymph nodes; or

6. Mucormycosis; or

7. *Pneumocystis* pneumonia or extrapulmonary *Pneumocystis* infection.

OR

C. Protozoan or helminthic infections:

1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or

2. Strongyloidiasis, extra-intestinal; or

3. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

OR

D. Viral infections:

1. *Cytomegalovirus* disease (documented as described in 14.00F3b(ii)) at a site other than the liver, spleen or lymph nodes; or

2. Herpes simplex virus causing:

a. Mucocutaneous infection (for example, oral, genital, perianal) lasting for 1 month or longer; or

b. Infection at a site other than the skin or mucous membranes (for example, bronchitis, pneumonitis, esophagitis, or encephalitis); or

c. Disseminated infection; or

3. Herpes zoster:

a. Disseminated; or

b. With multidermatomal eruptions that are resistant to treatment; or

4. Progressive multifocal leukoencephalopathy.

OR

E. Malignant neoplasms:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or

2. Kaposi's sarcoma with:

a. Extensive oral lesions; or

b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or

3. Lymphoma (for example, primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease); or

4. Squamous cell carcinoma of the anal canal or anal margin.

OR

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3, above), with extensive fungating or ulcerating lesions not responding to treatment (for example, dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal *Candida*,

condyloma caused by human *Papillomavirus*, genital ulcerative disease).

OR

G. HIV encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses.

OR

H. HIV wasting syndrome, characterized by involuntary weight loss of 10 percent or more of baseline (computed based on pounds, kilograms, or body mass index (BMI)) or other significant involuntary weight loss as described in 14.00F5, and in the absence of a concurrent illness that could explain the findings. With either:

1. Chronic diarrhea with two or more loose stools daily lasting for 1 month or longer; or

2. Chronic weakness and documented fever greater than 38oC (100.4oF) for the majority of 1 month or longer.

OR

I. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

OR

J. One or more of the following infections (other than described in A-I, above). The infection(s) must either be resistant to treatment or require hospitalization or intravenous treatment three or more times in a 12-month period.

1. Sepsis; or

2. Meningitis; or

3. Pneumonia; or

4. Septic arthritis; or

5. Endocarditis; or

6. Sinusitis documented by appropriate medically acceptable imaging.

OR

K. Repeated (as defined in 14.00I3) manifestations of HIV infection, including those listed in 14.08A-J, but without the requisite findings for those listings (for example, carcinoma of the

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.

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.

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.

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 sever 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?________

I can bend: Frequently Occasionally Never

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

I can lift the above indicated weight:

Constantly Frequently Occasionally Never

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

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?

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. A hearing will then be scheduled before and Administrative Law Judge.

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 a disability advocate:

Empire Justice Center
1 West Main Street, Suite 200
Rochester, NY 14614
Phone: 585-454-4060
Fax: 585-454-4019
Intake hours: Tuesday and Thursday's from 10:00 am to 1:00 pm

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.

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.

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **signed 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)*

See Privacy Act Notice

1. CLAIMANT NAME	CLAIMANT SSN – –	2. WAGE EARNER NAME, IF DIFFERENT
3. CLAIMANT CLAIM NUMBER, IF DIFFERENT – –	4. SPOUSE'S NAME, IF NOT WAGE EARNER	SPOUSE'S CLAIM NUMBER OR SSN – –

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the 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.

6. I have additional evidence to submit. ☐ Yes ☐ No

Name and address of source of additional evidence:

(Please submit it to the hearing office within 10 days. Your servicing Social Security Office will provide the address. Attach an additional sheet if you need more space.)

7. Do not complete if the appeal is a Medicare issue.
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)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.
Regardless of the issue you are appealing, you should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc., in No. 9.

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.

8. (CLAIMANT'S SIGNATURE) (DATE)			9. (REPRESENTATIVE'S SIGNATURE/NAME) (DATE)		
ADDRESS			(ADDRESS) ☐ ATTORNEY; ☐ NON ATTORNEY;		
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

10. Request received for the Social Security Administration on ____________ (Date) by: ____________ (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

11. Was the request for hearing received within 65 days of the reconsidered determination? ☐ YES ☐ NO
If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.

12. Claimant is represented ☐ Yes ☐ No
☐ List of legal referral and service organizations provided

13. Interpreter needed ☐ Yes ☐ No
Language (including sign language): ____________

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

16. HO COPY SENT TO: ____________ HO on ____________

☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII;
☐ Title II CF held in FO ☐ Electronic Folder
☐ CF requested ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII
(Copy of email or phone report attached)

17. CF COPY SENT TO: ____________ HO on ____________

☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title XVIII
☐ Other Attached: ____________

15. Check all claim types that apply:

☐ RSI only	(RSI)
☐ Title II Disablility-worker or child only	(DIWC)
☐ Title II Disability-Widow(er) only	(DIWW)
☐ SSI Aged only	(SSIA)
☐ SSI Blind only	(SSIB)
☐ SSI Disability only	(SSID)
☐ SSI Aged/Title II	(SSAC)
☐ SSI Blind/Title II	(SSBC)
☐ SSI Disability/Title II	(SSDC)
☐ Title XVIII	(HI/SMI)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify: ____________	

Form **HA-501-U5** (5-2007) ef (3-2008)
Destroy Prior Editions

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

PAPERWORK/PRIVACY ACT NOTICE

The Social Security Act (sections 205(a), 702, 1631(e)(1)(a) and (b), and 1869(b)(1) and (c), and Public Law 106-169 (Section 809(a)(1) of Sections 251(a)) and Section 1839(i) of the Act (P.L. 108-173) as appropriate) authorizes the collection of information on this form. We need the information to continue processing your claim. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out the information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration. We explain, in the Federal Register, these and other reasons why we may use or give out information about you. If you would like more information, get in touch with any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

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

DISABILITY REPORT - APPEAL - Form SSA-3441-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN
COMPLETING THIS FORM

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

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

HOW TO COMPLETE THIS FORM

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

ABOUT YOUR MEDICAL RECORDS

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

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

The Privacy Act

The Social Security Administration is authorized to collect the information on this form under sections 205(a) and (b), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your claim or case. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim or case. Although the information you furnish is almost never used for any purpose other than making a determination about your disability or continuing disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or 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 the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the 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 give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The Paperwork Reduction Act

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 45 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

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

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT - APPEAL

For SSA Use Only
Do not write in this box.

Related SSN ______ – ______ – ______

Number Holder ______________________

Individual is filing:

☐ **Reconsideration**

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

Date of Last Disability Report ______________________

☐ **Reconsideration for Disability Cessation**

☐ **Request for ALJ Hearing**

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

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

B. SOCIAL SECURITY NUMBER
______ – ______ – ______

C. DAYTIME TELEPHONE NUMBER *(If you do not have a number where we can reach you, give us a daytime number where we can leave a message.)*

(______) ______ – ______
Area Code *Number*

☐ Your Number ☐ Message Number ☐ None

D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help you with your claim or case.

NAME ______________________ RELATIONSHIP ______________________

ADDRESS ______________________
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

______________________ ______ ______ – ______ DAYTIME PHONE (______) ______ – ______
City *State* *ZIP* *Area Code* *Number*

SECTION 2 - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

A. Has there been any change (for better or worse) in your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

____

____

____

Approximate date the changes occurred:

Month	Day	Year

B. Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

____

____

____

Approximate date the changes occurred:

Month	Day	Year

C. Do you have any new illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

____

____

____

Approximate date the changes occurred:

Month	Day	Year

If you need more space, use Section 10 - REMARKS.

SECTION 3 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Since you last completed a disability report, have you seen or will you see a **doctor/hospital/clinic** or anyone else for the illnesses, injuries, or conditions that limit your ability to work? ☐ YES ☐ NO

B. Since you last completed a disability report, have you seen or will you see a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

C. List **other names** you have used on your medical records.

____

____

____

If you answered "NO" to both A and B, go to Section 4 - MEDICATIONS.

Tell us who may have medical records or other information about your illnesses, injuries, or conditions **since you last completed a disability report.**

D. List each DOCTOR/HMO/THERAPIST/OTHER. Include your **next appointment.**

1.

NAME				**DATES**
STREET ADDRESS				**FIRST** VISIT
CITY	**STATE**	**ZIP** –		**LAST** VISIT
PHONE ( ) – *Area Code* *Phone Number*		**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS				
WHAT **TREATMENT** DID YOU RECEIVE?				

2.

NAME				**DATES**
STREET ADDRESS				**FIRST** VISIT
CITY	**STATE**	**ZIP** –		**LAST** VISIT
PHONE ( ) – *Area Code* *Phone Number*		**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS				
WHAT **TREATMENT** DID YOU RECEIVE?				

If you need more space, use Section 10 - REMARKS.

E. List each HOSPITAL/CLINIC. Include your **next appointment.**

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP –	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE ( ) – *Area Code* *Phone Number*			☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS	

Next **appointment** ____________ Your hospital/clinic **number** ____________

Reasons for visits ____________

What **treatment** did you receive? ____________

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

If you need more space, use Section 10 - REMARKS.

F. Since you last completed a disability report, does **anyone else have medical records or information** about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else? ☐ YES ☐ NO

If "**YES**," complete information below:

NAME			**DATES**
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP** –	**LAST** VISIT
PHONE ( ) – *Area Code* *Phone Number*			NEXT **APPOINTMENT**
CLAIM NUMBER (if any)			
REASONS FOR VISITS			

If you need more space, use Section 10 - REMARKS.

SECTION 4 - MEDICATIONS

Are you currently taking any **medications** for your illnesses, injuries or conditions? ☐ YES ☐ NO

If "**YES**," please tell us the following: (*Look at your medicine containers, if necessary.*)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Section 10 - REMARKS.

SECTION 5 - TESTS

Since you last completed a disability report, have you had any **medical tests** for illnesses, injuries, or conditions or do you have any such tests scheduled? ☐ YES ☐ NO

If "**YES**," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN WAS/WILL TEST BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY -- Name of body part ______			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY -- Name of body part ______			
MRI/CT SCAN -- Name of body part ______			

If you need more space, use Section 10 - REMARKS.

SECTION 6 - UPDATED WORK INFORMATION

Have you worked **since you last completed a disability report?** ☐ YES ☐ NO

If "**YES,**" you will be asked to give details on a separate form.

SECTION 7 - INFORMATION ABOUT YOUR ACTIVITIES

A. How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?

____

____

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

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

If you need more space, use Section 10 - REMARKS.

SECTION 8 - EDUCATION/TRAINING INFORMATION

Have you completed any type of **special job training, trade or vocational school since you last completed a disability report?** ☐ YES ☐ NO

If "**YES**," describe what type:

Approximate date completed:

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OTHER SUPPORT SERVICES INFORMATION, OR INDIVIDUALIZED EDUCATION PROGRAM

Since you last completed a disability report, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support;
- an individualized education program through an educational institution (if a student age 18-21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES ☐ NO

If "**YES**," complete the following information:

NAME OF ORGANIZATION OR SCHOOL

NAME OF COUNSELOR OR INSTRUCTOR

ADDRESS

(Number, Street, Apt. No.(if any), P.O. Box, or Rural Route)

–

City *State* *ZIP*

DAYTIME PHONE NUMBER ( ) –

Area Code *Number*

DATES SEEN TO

TYPE OF SERVICES, TESTS, OR EVALUATIONS PERFORMED

(IQ, vision, physicals, hearing, workshops, classes, etc.)

SECTION 10 - REMARKS

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

SECTION 10 - REMARKS

Name of person completing this form if other than the disabled person *(Please print)*	**Date Form Completed** *(Month, day, year)*

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

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

Relationship to Disabled Person	**Daytime Telephone Number**
	( ) –

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

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.

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.

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

REQUEST FOR RECONSIDERATION

(Do not write in this space)

NAME OF CLAIMANT		NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from claimant.)*
CLAIMANT SSN – –	CLAIMANT CLAIM NUMBER (if different from SSN) – –	SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER – –
SPOUSE'S NAME *(Complete ONLY in SSI cases)*		SPOUSE'S SOCIAL SECURITY NUMBER *(Complete ONLY in SSI cases)* – –

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital /medical, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY

(See the three ways to appeal in the How To Appeal Your Supplemental Security Income (SSI) Or Special Veterans Benefit (SVB) Decision instructions.)

"I want to appeal your decision about my claim for Supplemental Security Income (SSI) or Special Veterans Benefits (SVB). I've read about the three ways to appeal. I've checked the box below."

☐ Case Review ☐ Informal Conference ☐ Formal Conference

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

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.

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY		
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

See list of initial determinations

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ YES ☐ NO
2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO
3. IS THIS REQUEST FILED TIMELY? ☐ YES ☐ NO
   (If "NO", attach claimant's explanation for delay and attach any pertinent letter, material, or information in Social Security office.)

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)

☐ NO FURTHER DEVELOPMENT REQUIRED (GN 03102.300)

☐ REQUIRED DEVELOPMENT ATTACHED

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

SOCIAL SECURITY OFFICE ADDRESS

ROUTING INSTRUCTIONS (CHECK ONE) →

☐ DISABILITY DETERMINATION SERVICES *(ROUTE WITH DISABILITY FOLDER)*
☐ ODO, BALTIMORE
☐ PROGRAM SERVICE CENTER
☐ OIO, BALTIMORE
☐ OEO, BALTIMORE
☐ DISTRICT OFFICE RECONSIDERATION
☐ CENTRAL PROCESSING SITE (SVB)

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

Form **SSA-561-U2** (9-2007) ef (7-2008) Prior Edition May Be Used Until Exhausted **Claims Folder**

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

There are three different ways to appeal. You can pick the appeal that fits your case. You can have a lawyer, friend, or someone else help you with your appeal.

Here are the three ways to appeal:

1. CASE REVIEW:

You can give us more facts to add to your file. Then we'll decide your case again. You don't meet with the person who decides your case.
You can pick this kind of appeal in all cases.

2. INFORMAL CONFERENCE:

You'll meet with the person who will decide your case. You can tell that person why you think you're right. You can give us more facts to help prove you're right. You can bring other people to help explain your case.

You can pick this kind of appeal in all SSI cases *except* two. You can't have it if we turned down your SSI application for medical reasons or because you're not blind. Also you can't have it if we're giving you SSI but you disagree with the date we said you became blind or disabled. In SVB cases, you can pick this kind of appeal only if we're stopping or lowering your SVB payment.

3. FORMAL CONFERENCE:

This is a meeting like an informal conference. Plus, we can make people come to help prove you're right. We can do this even if they don't want to help you. You can question these people at your meeting.

You can pick this kind of appeal only if we're stopping or lowering your SSI or SVB payment. You can't get it in any other case.

Now you know the three kinds of appeals. You can pick the one that fits your case. Then fill out this form. We'll help you fill it out.

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.

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 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.***

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **signed 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)*

See Privacy Act Notice

1. CLAIMANT NAME	CLAIMANT SSN – –	2. WAGE EARNER NAME, IF DIFFERENT
3. CLAIMANT CLAIM NUMBER, IF DIFFERENT – –	4. SPOUSE'S NAME, IF NOT WAGE EARNER	SPOUSE'S CLAIM NUMBER OR SSN – –

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the 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.

6. I have additional evidence to submit. ☐ Yes ☐ No

Name and address of source of additional evidence:

(Please submit it to the hearing office within 10 days. Your servicing Social Security Office will provide the address. Attach an additional sheet if you need more space.)

7. Do not complete if the appeal is a Medicare issue.
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)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.
Regardless of the issue you are appealing, you should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc., in No. 9.

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.

8. (CLAIMANT'S SIGNATURE) (DATE)			9. (REPRESENTATIVE'S SIGNATURE/NAME) (DATE)		
ADDRESS			(ADDRESS) ☐ ATTORNEY; ☐ NON ATTORNEY;		
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

10. Request received for the Social Security Administration on ____________ by: ____________
(Date) (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

11. Was the request for hearing received within 65 days of the reconsidered determination? ☐ YES ☐ NO
If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.

12. Claimant is represented ☐ Yes ☐ No
☐ List of legal referral and service organizations provided

13. Interpreter needed ☐ Yes ☐ No
Language (including sign language): ____________

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

16. HO COPY SENT TO: ____________ HO on ____________

☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII;
☐ Title II CF held in FO ☐ Electronic Folder
☐ CF requested ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII
(Copy of email or phone report attached)

17. CF COPY SENT TO: ____________ HO on ____________

☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title XVIII
☐ Other Attached: ____________

15. Check all claim types that apply:

☐ RSI only	(RSI)
☐ Title II Disablility-worker or child only	(DIWC)
☐ Title II Disability-Widow(er) only	(DIWW)
☐ SSI Aged only	(SSIA)
☐ SSI Blind only	(SSIB)
☐ SSI Disability only	(SSID)
☐ SSI Aged/Title II	(SSAC)
☐ SSI Blind/Title II	(SSBC)
☐ SSI Disability/Title II	(SSDC)
☐ Title XVIII	(HI/SMI)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify: ____________	

Form **HA-501-U5** (5-2007) ef (3-2008)
Destroy Prior Editions

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

PAPERWORK/PRIVACY ACT NOTICE

The Social Security Act (sections 205(a), 702, 1631(e)(1)(a) and (b), and 1869(b)(1) and (c), and Public Law 106-169 (Section 809(a)(1) of Sections 251(a)) and Section 1839(i) of the Act (P.L. 108-173) as appropriate) authorizes the collection of information on this form. We need the information to continue processing your claim. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out the information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration. We explain, in the Federal Register, these and other reasons why we may use or give out information about you. If you would like more information, get in touch with any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

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

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0349

REQUEST FOR RECONSIDERATION - DISABILITY CESSATION - RIGHT TO APPEAR

(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

FOR SOCIAL SECURITY OFFICE USE ONLY
(DO NOT WRITE IN THIS SPACE)

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from Claimant)	SOCIAL SECURITY NUMBER
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)	

☐ FO Code ______
☐ Benefit Continuation
☐ Foreign Language Notice ______

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ CHILD

I DO NOT AGREE WITH THE DETERMINATION TO STOP DISABILITY BENEFITS AND I REQUEST RECONSIDERATION. My reasons are (reasons should relate to the basis for stopping disability benefits and be as specific as possible):
NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice.

I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION (If "NONE" write "NONE") (Attach additional page if needed):

CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY **OR** CHECK BLOCK 2.

☐ 1. I (and/or my representative) wish to appear at a face-to-face disability hearing. The disability hearing will be with a person called a disability hearing officer and it will let me explain why I do not agree with the decision to stop benefits.

☐ I need an interpreter at the disability hearing - Language ______
(If you need an interpreter, SSA will provide one at no cost to you.)

OR

☐ 2. I do not wish to appear nor do I wish a representative to appear for me at the disability hearing. I have been advised of my right to have a disability hearing. I understand that a disability hearing will give me a chance to present witnesses. It will also let me explain to the disability hearing officer why my disability benefits should not end. I understand that this chance to be seen and heard could help the disability hearing officer learn about the facts in my case. The disability hearing officer would give me a chance to have people who know about my condition give information and explain how my condition keeps me from working and restricts my activities. I have been told about my right to representation at the disability hearing, including representation by an attorney or other person of my choice. Although the above has been explained to me, I do not want to appear at at disability hearing, or have someone represent me at a disability hearing. I prefer to have the disability hearing officer decide my case on the evidence in my file, plus any evidence that I submit or that may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a disability hearing prior to the writing of a decision in my case. In this case, I can make the request with any Social Security office.

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 or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE		
STREET ADDRESS.			REPRESENTATIVE'S ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	DATE		TELEPHONE NUMBER	DATE	

Witnesses are required ONLY if this form has been signed by mark (X). If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)	ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)

PRIVACY ACT AND PAPERWORK REDUCTION ACT NOTICE

The Privacy Act requires us to notify you that we are authorized to collect this information by sections 205(a), 1631(e)(1)(A) and (B) of the Social Security Act. You do not have to provide the information requested. However,we cannot act on your request unless you give us this information.

The Social Security Administration will use the information on this form to fully evaluate your claim for disability benefits. We may routinely give out the information on this form without your consent if:

1. We need to get more information to decide if you are eligible for benefits;
2. An agency needs this information to decide if you are eligible for a health or income program such as SSI State supplementary payments, food stamps, Medicaid, energy assistance, Veterans benefits, or Basic Educational Opportunity Grants;
3. A Federal law requires that we give out this information;
4. Your Congressman or the President's Office needs this information to answer your questions;
5. Someone needs this information to do statistical research or audit reports for us related to the Social Security programs, or,
6. The Department of Justice needs the information to represent the Federal Government in a court suit related to SSA administered programs.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any 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 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213 (TTY 1-800-325-0778).** Send **only** comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

Example

Sarah P. is a 45 year old single female who lives alone in a home she owns. The home is worth $150,000, there is no mortgage. She has $54.00 in a bank account. She owns a 2000 Chevy mini van worth $2500. She works part time at her church on the newsletter and earns $100 per month.

Does she meet the financial guidelines for SSI eligibility?

Is she working (substantial gainful activity)?

She was diagnosed with HIV in 2000 and with AIDS in 2003, due to a T cell count below 200. She previously worked as a taxidermist. She stopped working in January of 2004. She was hospitalized for four days with pneumonia in 2004. Current symptoms include fatigue, diarrhea, night sweats, occasional thrush.

What will you need in order to assist her in filing her application?

What evidence should you gather and provide to SSA to support the application?

Does she meet the disability criteria for Social Security Disability?

Does she meet a “listing”?