

**DISABILITY REPORT  
ADULT**

**For SSA Use Only- Do not write in this box.  
Related SSN  
Number Holder**

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

**SECTION 1 - INFORMATION ABOUT YOU**

When a question refers to "you" or "your," it refers to the person who is applying for disability benefits. **If you are completing this report for someone else**, provide information about them.

**1.A. NAME** (First, Middle Initial, Last, Suffix)  
William I. Hamilton

**1.B. SOCIAL SECURITY NUMBER**  
999-99-9999

**1.C.** Have you used any other names on your medical or educational records? Examples include maiden name, other married names, other names, or nickname.  YES  NO  
If YES, please list names used:

**1.D. MAILING ADDRESS** (Street or PO Box) Include apartment number, if applicable.  
P.O. Box 94407

<b>CITY</b> Chicago	<b>STATE/Province</b> IL	<b>ZIP/Postal Code</b> 60681	<b>COUNTRY</b> (if not USA)
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**1.E. EMAIL ADDRESS**  
BillHam@aol.com

**1.F. DAYTIME PHONE NUMBER(S)** where we can call to speak with you or leave a message, if needed. Include area code or IDD and country code if outside the USA or Canada.  
Primary: 312-123-4567 Secondary: (if available) 312-187-6542

**1.G.** Can you speak and understand English?  YES  NO  
If NO, what language do you prefer?

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

**1.H.** Can you read and understand English?  YES  NO

**1.I.** Can you write more than your name in English?  YES  NO

**SECTION 2 - CONTACTS**

Is there someone we can contact who can help with your claim, if needed? Examples include a family member, friend, or neighbor.

**YES** Please provide the names of two people (**other than your doctors**) we can contact who know about your medical condition(s) and can help you with your claim and can help us reach you if you become unavailable.

**NO** **We recommend that you provide at least one contact, if available.** Providing the name of someone who knows you may help us to make a decision on your claim.

**2.A. NAME** (First, Middle Initial, Last)  
Mildred Q. Payne

**2.B. Relationship to the Person in 1.A.**  
Daughter

**2.C. MAILING ADDRESS** (Street or PO Box) Include apartment number, if applicable.  
445 Center St., Apt #304

<b>CITY</b> Chicago	<b>STATE/Province</b> IL	<b>ZIP/Postal Code</b> 60683	<b>COUNTRY</b> (if not USA)
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**2.D. DAYTIME PHONE NUMBER** (as described in 1.F. above)  
312-090-9820

**SECTION 2 - CONTACTS (continued)**

**2.E.** Can this person speak and understand English?  YES  NO  
If NO, what language is preferred?

**2.F.** NAME (First, Middle Initial, Last) **2.G.** Relationship to the Person in **1.A.**  
Zoraya M. Hamidi Friend

**2.H.** MAILING ADDRESS (Street or PO Box) Include apartment number, if applicable.  
93 Main St., Apt. 2

CITY Chicago STATE/Province IL ZIP/Postal Code 60601 COUNTRY (if not USA)

**2.I.** DAYTIME PHONE NUMBER (as described in **1.F.** above)  
312-011-0110

**2.J.** Can this person speak and understand English?  YES  NO  
If NO, what language is preferred?

**SECTION 3 - MEDICAL INFORMATION**

**3.A.** Separately list each physical and/or mental condition that limits your ability to work. If you have cancer, please include the type and stage.

- 1. Arthritis, right shoulder
- 2. Cataracts
- 3. Depression
- 4. Back pain
- 5.

**If you need more space, go to Section 11**

**3.B.** What is your height? 5 10 OR           
feet inches centimeters

**3.C.** What is your weight? 175 OR           
pounds kilograms

**SECTION 4 - WORK ACTIVITY**

**4.A.** Are you currently working?  
 NO, I have never worked (Go to question **4.B.**)  
 NO, I have stopped working (Go to question **4.C.**)  
 YES, I am currently working (Go to question **4.F.**)

**IF YOU HAVE NEVER WORKED:**

**4.B.** When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)?(MM/DD/YYYY) \_\_\_\_\_ (Go to **Section 5**)

**IF YOU HAVE STOPPED WORKING:**

**4.C.** When did you stop working?(MM/DD/YYYY) 10/12/2025  
Why did you stop working?

- Because of my condition(s).
- Because of other reasons.

Please explain why you stopped working. Examples include laid off, early retirement, seasonal work ended, or business closed.

Even though you stopped working for other reasons, when do you believe your condition(s) became severe enough to keep you from working? (MM/DD/YYYY) \_\_\_\_\_





**SECTION 6 - WORK HISTORY (continued)****Check the box below that applies to you.**

**I had more than one job.** (If you had more than one job, we may contact you for more information. **Do not** answer the questions in **Section 6.B** through **6.D**. Goto **Section 7**.)

**I had only one job.** (If you had only one job, complete the questions in **6.B** through **6.D**.)

**6.B. Information about your work**

**6.B.1.** For the job you listed in **6.A**., describe in detail the tasks you did in a typical workday. Examples of tasks include stocking shelves, greeting customers, scheduling appointments, or maintaining records.

Assisted in the installation of electric power equipment, transformer repair, and underground cable replacement.

**6.B.2.** If any of the tasks listed above involved writing or completing reports, describe the type of report you wrote or completed and how much time you spent on it per workday or workweek.

About one hour every week was spend on spreadsheets that documented our time on the previous week's work.

**6.B.3.** If any of the tasks listed above involved supervising others, describe who or what you supervised and what supervisory duties you had. Examples of supervisory duties include evaluating employee job performance, making schedules, or maintaining time records.

I did not do any supervising activities. I reported to the managing electrician to make schedules and performance reviews.

**6.B.4.** List the machines, tools, and equipment you used regularly when doing this job and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.

Voltage testers, cable pullers, hydraulic punch drivers, rotary hammer drills, portable generators, bucket trucks (to reach overhead wires)

**6.B.5.** Did this job require you to interact with coworkers, the general public, or anyone else?

**YES**    **NO**

If **YES**, **describe** who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek. Examples include answering customer questions on the telephone for 5 hours per day or showing clients sale properties in person for 4 hours per day.

Every day I worked in a team with three others, rarely ever alone, in order to ensure safety, so about 7 hours out of an 8 hour day. I also frequently had to interact with the public when entering residential homes and spaces.

**SECTION 6 - WORK HISTORY (continued)**

**6.C. Physical and environmental requirements of your work**

Tell us how much time you spent doing the following physical activities in a typical workday. The total hours/minutes for standing, walking, and sitting should equal the Hours per Day reported in **6.A**. The example below shows an 8-hour workday with 2 hours standing and walking and 6 hours sitting (8 hours total).

Activity	How much of your workday? (Hours/Minutes)	Example:
Standing and walking (combined)	6-8	2 hours
Sitting	0-1	6 hours
Stooping (i.e., bending down & forward at waist)	3	15 minutes
Kneeling (i.e., bending legs to rest on knees)	2-3	15 minutes
Crouching (i.e., bending legs & back down & forward)	2-3	None
Crawling (i.e., moving on hands and knees)	1-2	None
Using fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt): <input type="checkbox"/> One Hand <input checked="" type="checkbox"/> Both Hands	3-4	2 hours (both hands)
Using hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a hammer, or water bottle): <input type="checkbox"/> One Hand <input checked="" type="checkbox"/> Both Hands	4-5	1 hour (both hands)
Reaching at or below the shoulder: <input type="checkbox"/> One Arm <input checked="" type="checkbox"/> Both Arms	4-5	1 hour (both arms)
Reaching overhead (above the shoulder): <input type="checkbox"/> One Arm <input checked="" type="checkbox"/> Both Arms	2-3	None
Climbing stairs or ramps	1-2	None
Climbing ladders, ropes, or scaffolds	1-2	None

If you need more space, use **Section 11**

Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.

Heavy machine parts, electrical cable, rigged scaffolding and hoists. Carried them anywhere from 50-500 feet during the day

Select the **heaviest** weight lifted:

- Less than 1 lb.   
  Less than 10 lbs.   
  10 lbs.   
  20 lbs.  
 50 lbs.   
 100 lbs. or more   
 Other \_\_\_\_\_

Select the weight **frequently** lifted (i.e., 1/3 to 2/3 of the workday):

- Less than 1 lb.   
  Less than 10 lbs.   
  10 lbs.   
 25 lbs.  
 50 lbs. or more   
 Other \_\_\_\_\_

Did this job expose you to any of the following? Check all that apply.

- Outdoors   
 Extreme heat (non-weather related)   
 Extreme cold (non-weather related)  
 Wetness   
 Humidity   
 Hazardous substances  
 Moving mechanical parts   
 High, exposed places   
 Heavy vibrations  
 Loud noise   
 Other \_\_\_\_\_

If one or more boxes are checked, tell us about the exposure(s) and how often you were exposed.

Worked outdoors (in Chicago summers & winters) on scaffolding about once per month.

**SECTION 6 - WORK HISTORY (continued)**

**6.D.** Explain how your medical conditions would affect your ability to do this job..

Arthritis in my right (dominant) shoulder means that I have trouble lifting more than a gallon of milk, much less heavy cables and machines. With my cataracts I have trouble reading voltage meters, which can be very dangerous in my line of work. My back pain makes it difficult to bend down, crawl, or climb ladders. Depression makes it hard for me to concentrate on any complex instructions anymore, and I've become more irritable with my coworkers, who I worked with very closely.

**SECTION 7 - MEDICINES**

**7.** Are you currently taking any prescription medicine(s)?

**NO** (Go to **Section 8**)

**YES** (Complete the information below. You may need to look at your medicine containers.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE DOCTOR NAME (IF KNOWN)	REASON FOR MEDICINE (IF KNOWN)
Diclofenac	Dr. Mohan	Arthritis
Prednisone	Dr. Javadi	Arthritis
Cyclobenzaprine	Dr. Walsh	Back pain
Celexa	Dr. Santos	Depression

If you need to list more medicines, use **Section 11**.

**SECTION 8 - MEDICAL TREATMENT**

**8.A.** Have you seen or received treatment from a health care provider(doctor, hospital, clinic, psychiatrist, nurse practitioner, therapist,physical therapist,or other medical professional), or **do you have a future appointment scheduled?**

- NO (Goto **Section 9**)
- YES (Complete the chart(s) below)

You may find this information on medical bills, online medical chart, or the Internet.

<b>8.A.1</b> NAME OF FACILITY OR OFFICE Midwest Orthopedics	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU Dr. Samira Mohan
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What medical conditions were treated or evaluated?  
 Arthritis and back pain

PHONE NUMBER 312-100-6649	DATE FIRST SEEN: <u>10/2020</u> MM/YYYY	DATE LAST SEEN: <u>05/2026</u> MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) <u>08/2026</u> MM/YYYY
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ADDRESS  
 8 Waters St., Suite 105

CITY Chicago	STATE/Province IL	ZIP/Postal Code 60608	COUNTRY (if not USA)
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<b>8.A.2</b> NAME OF FACILITY OR OFFICE Chicago Pain Clinic	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU Dr. Victoria Javadi
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What medical conditions were treated or evaluated?  
 Arthritis and back pain

PHONE NUMBER 312-022-5555	DATE FIRST SEEN: <u>05/2023</u> MM/YYYY	DATE LAST SEEN: <u>01/2026</u> MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) <u>                    </u> MM/YYYY
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ADDRESS  
 1001 West Illini Ave.

CITY Chicago	STATE/Province IL	ZIP/Postal Code 60606	COUNTRY (if not USA)
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<b>8.A.3</b> NAME OF FACILITY OR OFFICE South Side Spinal Specialists	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU Dr. Emery Walsh
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What medical conditions were treated or evaluated?  
 Back pain (disc degeneration)

PHONE NUMBER 312-101-0101	DATE FIRST SEEN: <u>12/2023</u> MM/YYYY	DATE LAST SEEN: <u>03/2026</u> MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) <u>09/2026</u> MM/YYYY
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ADDRESS  
 2000 Roosevelt Road, Suite 5

CITY Chicago	STATE/Province IL	ZIP/Postal Code 60619	COUNTRY (if not USA)
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**SECTION 8 - MEDICAL TREATMENT (continued)**

**8.A.4**

NAME OF FACILITY OR OFFICE Lake Michigan Mental Health Services	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU Dr. Trinity Santos
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What medical conditions were treated or evaluated?  
Depression

PHONE NUMBER 847-099-1414	DATE FIRST SEEN: <u>01/2024</u> MM/YYYY	DATE LAST SEEN: <u>04/2026</u> MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) <u>06/2026</u> MM/YYYY
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ADDRESS  
33 State St. # 4

CITY Schaumburg	STATE/Province IL	ZIP/Postal Code 60918	COUNTRY (if not USA)
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**8.A.5**

NAME OF FACILITY OR OFFICE Sacred Heart Hospital	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU Dr. Kareem Griswold
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What medical conditions were treated or evaluated?  
Back surgery–fusion at lumbar spine

PHONE NUMBER 847-003-4444	DATE FIRST SEEN: <u>11/2024</u> MM/YYYY	DATE LAST SEEN: <u>1/2025</u> MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) _____ MM/YYYY
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ADDRESS  
58 Yankovich St.

CITY Chicago	STATE/Province IL	ZIP/Postal Code 60606	COUNTRY (if not USA)
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**8.A.6**

NAME OF FACILITY OR OFFICE Proliance Physical Therapy	NAME OF HEALTHCARE PROVIDER THAT TREATED YOU Oscar Watanabe, PT
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What medical conditions were treated or evaluated?  
Back pain, arthritis in shoulder

PHONE NUMBER 847-105-2054	DATE FIRST SEEN: <u>2/2025</u> MM/YYYY	DATE LAST SEEN: <u>12/2025</u> MM/YYYY	DATE OF NEXT APPOINTMENT: (IF KNOWN) _____ MM/YYYY
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ADDRESS  
62 Wildrose Dr., Suite 105

CITY Aurora	STATE/Province IL	ZIP/Postal Code 61084	COUNTRY (if not USA)
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If you need to list more facilities or healthcare providers, use **Section 11**.

**SECTION 8 - MEDICAL TREATMENT (continued)**

**8.B.** Did any of the healthcare providers listed in **8.A.** order any medical tests for you? Include tests already performed and scheduled in the future.

NO (Go to **Section 9**)

YES (Select tests from the chart below)

TEST	NAME OF HEALTHCARE PROVIDER OR FACILITY	DATE OF TEST (MM/YYYY)
Blood test (not HIV)		
Breathing test		
Cardiac catheterization		
EEG (brain wave test)		
EKG (heart test)		
Hearing test		
HIV test		
Speech/language test		
Treadmill (exercise test)		
Vision test		
Psychological/IQ test	Dr. Trinity Santos	2/2024
Biopsy (list body part):		
MRI/CT scan (list body part): Spine	South Side Spinal Specialists	12/2023, 2/2026
X-ray (list body part): Right shoulder	Midwest Orthopedics	3/2021, 4/2024
Other - please specify:		

If you need to list more tests, use **Section 11**.

**SECTION 9 - OTHER MEDICAL INFORMATION**

9. Does anyone else (other than your healthcare providers) have your medical information? Examples include Department of Veterans Affairs, social service agencies, vocational rehabilitation agencies, welfare agencies, attorneys, prisons, workers' compensation, and insurance companies who have paid you disability benefits.

- NO (Go to **Section 10** if you are receiving Supplemental Security Income (SSI) and have been asked to complete this report; if not, go to **Section 11**.)
- YES (Complete the information below)

NAME OF ORGANIZATION Titanium Disability Insurance	PHONE NUMBER 302-001-0010
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ADDRESS  
900 E. 57<sup>th</sup> Ave, Suite 2002

CITY Boca Raton	STATE/Province FL	ZIP/Postal Code 23896	COUNTRY (if not USA)
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NAME OF CONTACT PERSON Libby Maroney	CLAIM NUMBER (if any) 91632-AG
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Date of First Contact 11/14/2025	Date of Last Contact 5/24/2026	Date of Next Contact (if any)
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Reasons for Contacts

Collecting and gathering medical records for a long-term disability insurance claim, which has been approved

If you need to list other people or organizations, use **Section 11**

**COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.**

**SECTION 10 - SUPPORT SERVICES**

Provide information about your participation in support services, if applicable. Examples of support services can include:

- An Individualized Education Program (IEP) through a school (if a student aged 18-21)
- An individual work plan with an employment network under the Ticket to Work Program
- A Plan to Achieve Self-Support (PASS)
- An individualized plan for employment with a vocational rehabilitation agency or any other organization

10.A. Have you participated or are you participating in any support services mentioned above or any other vocational rehabilitation, employment services, or other support services to help you to go to work?

- YES (Complete the information below)
- NO (Go to **Section 11**)

10.B. FACILITY OR ORGANIZATION NAME	PHONE NUMBER
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COUNSELOR, INSTRUCTOR, OR JOB COACH NAME

ADDRESS (Street or PO Box) Include Suite, Building, etc.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
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**SECTION 11 - Remarks (continued)**


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**SECTION 12 - WHO IS COMPLETING THIS REPORT**


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Date Report Completed (MM/DD/YYYY)

Who is completing this report?

- The person listed in **1.A.**
- The person listed in **2.A.**
- The person listed in **2.F.**
- Someone else (Complete the information below)

NAME (First, Middle Initial, Last)

Relationship to the Person in **1.A.**

MAILING ADDRESS (Street or PO Box) Include the apartment number, if applicable.

CITY

STATE/Province

ZIP/Postal Code

COUNTRY (if not USA)

DAYTIME PHONE NUMBER where we may reach you or leave a message, if needed. Include the area code or IDD and country code if outside the USA or Canada.

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