SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT - APPEAL

For SSA Use Only
Do not write in this box.

Related SSN ___ – ___

Individual is filing:

Number Holder

☐ **Reconsideration**

Date of Last Disability Report

☐ **Request for Review by Federal Reviewing Official** ☐ **Reconsideration for Disability Cessation** ☐ **Request for ALJ Hearing**

❶ SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

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

Anne Brown

B. SOCIAL SECURITY NUMBER

555-55-5555

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.)*

(303) 555-5534
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 Sam Brown RELATIONSHIP Husband

ADDRESS 472 11th Street
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

Denver, CO 80299 – DAYTIME PHONE (303) 555-5534
City *State* *ZIP* *Area Code* *Number*

❷ 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:

My wife has chronic schizophrenia. She is more withdrawn and seems to be more out of touch with reality. Her auditory hallucinations came back. Her psychiatrist has had to increase her dose of Clozaril.

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:

Anne is now less able to perform daily chores like cooking a meal and cleaning. She has to be told when to bathe and is less willing to socialize with family members or guests. She needs more supervision than before.

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: Anne has developed a new heart condition—an abnormal heart rhythm that affects her ability to lift and carry. (See Section 10, Remarks)

Approximate date the changes occurred:

Month	Day	Year

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

❸

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.

none

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 Dr. Claudia Edwards			**DATES**
STREET ADDRESS 10001 Forest View Drive			**FIRST** VISIT 1989
CITY Denver	**STATE** CO	**ZIP** 80255_	**LAST** VISIT March 13, 2011
PHONE (303) 123 4567 *Area Code* *Phone Number*	**PATIENT ID #** (If known)		NEXT **APPOINTMENT** September 3, 2011
REASONS FOR VISITS Dr. Edwards is a psychiatrist who treats Anne's schizophrenia.			
WHAT **TREATMENT** DID YOU RECEIVE? Medication. Mental checkups and blood tests.			

2.

NAME	DATES
Dr. Howard Stuckey	
STREET ADDRESS Cardiology Associates, Suite 200, 1201 Canyon Blvd.	**FIRST** VISIT April 23, 2011
CITY: Denver; **STATE**: CO; **ZIP**: 80302-	**LAST** VISIT May 12, 2011
PHONE (303) 555-2222 (Area Code / Phone Number); **PATIENT ID #** (If known)	NEXT **APPOINTMENT** August 13, 2011
REASONS FOR VISITS: Diagnosis and treatment of cardiac arrhythmia.	
WHAT **TREATMENT** DID YOU RECEIVE? Medication for irregular heart beat. Dr. Stuckey states she may need a pacemaker if the medication does not control the abnormality.	

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: Denver General Hospital STREET ADDRESS: 2301 West Colfax Avenue CITY: Denver; STATE: CO; ZIP: 80204- PHONE: ( ) don't know (Area Code / Phone Number)	☑ **INPATIENT** STAYS (Stayed at least overnight)	DATE IN: April 23, 2011; DATE OUT: May 1, 2011
	☐ **OUTPATIENT** VISITS (Sent home same day)	DATE FIRST VISIT; DATE LAST VISIT
	☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS

Next **appointment** none

Your hospital/clinic **number** don't know

Reasons for visits Irregular heartbeat.

What **treatment** did you receive? Dr. Stuckey diagnosed Anne's heart condition and started treatment.

What **doctors** do you see at this hospital/clinic on a regular basis? None at hospital. She goes to Dr. Stuckey's clinic for follow-ups.

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.

❹

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
Clozaril	Dr. Edwards	schizophrenia	dizzy
Digoxin	Dr. Stuckey	irregular heart	feels weak
Aspirin	Dr. Stuckey	irregular heart	none

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

❺ 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)	April 23, 2011	Denver General Hospital	Dr. Stuckey
TREADMILL (EXERCISE TEST)	No		
CARDIAC CATHETERIZATION	No		
BIOPSY -- Name of body part	No		
HEARING TEST	No		
SPEECH/LANGUAGE TEST	No		
VISION TEST	No		
IQ TESTING	No		
EEG (BRAIN WAVE TEST)	No		
HIV TEST	No		
BLOOD TEST (NOT HIV)	April 2011	Denver General Hospital	Drs. Stuckey, Edwards
BREATHING TEST	No		
X-RAY -- Name of body part chest	Chest x-ray	Denver General Hospital	Dr. Stuckey
MRI/CT SCAN -- Name of body part	No		

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

❻ 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.

❼ SECTION 7 - INFORMATION ABOUT YOUR ACTIVITIES

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

Anne must be reminded to bathe and wears her clothes in a bizarre way. She is uninterested in her appearance or social activities. She spends most days watching TV. (See Section 10, Remarks)

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

If none, show "**NONE**." Dr. Edwards said Anne must be closely supervised and must avoid mental stress. Her symptoms worsened in 2006 and 2008 after she tried to return to work, and she had to be hospitalized. (See Section 10, Remarks)

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

8 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: _____

9 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.)

⑩ **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.

Anne has a severe chronic mental disorder. She can function minimally under the supervision and support of our family. Contrary to what the DDS stated when they terminated her benefits, Anne's mental condition has not significantly improved and is even worse. Her benefits were continued multiple times in past reviews. The DDS now says she's improved and can work. This is wrong, as shown by medical records and Dr. Edwards's opinion.

Anne's heart condition limits her physically now, in addition to her mental condition. She had an echocardiogram in the hospital which Dr. Stucky says showed an abnormal heart valve.

From Section 2.C: She also states the new heart medication makes her feel weaker. The doctor said she should not try to lift over 20 lbs. because of her heart condition.

From Section 7.A: Anne can sometimes do simple things (make a sandwich or do a little dusting, but our daughters do most of the cooking and cleaning). She often refuses to help, saying "I'm just not interested."

From Section 7.B: Dr. Edwards emphasized we must provide a highly supportive home for Anne or she will relapse. I think she is worse.

SECTION 10 - REMARKS

Name of person completing this form if other than the disabled person *(Please print)*	**Date Form Completed** *(Month, day, year)*
11 Samuel Brown	July 13, 2011

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

samuelbrown@coldmail.com

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**
472 11th Street	Denver,	CO	80299