#### CONTINUING DISABILITY REVIEW REPORT SSA-454-BK

#### PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that reviews your medical condition will use the information in this report. The information will help that office decide whether you are still disabled. Please complete as much of the report as you can.

### IF YOU NEED HELP

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

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

### HOW TO COMPLETE THIS REPORT

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers, including area code. If a phone number is outside the United States, provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- ANSWER EVERY QUESTION, unless the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- Be sure to explain an answer if the question asks for an explanation or if you want to give additional information.
- If you need more space to answer any question, please use **Section 11 Remarks**, on the last page to finish your answer. Write the number of the question you are answering.

## YOUR MEDICAL RECORDS

If you have any of your medical records covering the last 12 months, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you have a scheduled appointment for an interview, bring your medical records, your prescription medicine containers (if available), and the completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

## The Privacy Act

Sections 205(a), 223(d), and 1631(e) (1) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to make a decision on the named claimant's claim. While giving us the information on this report 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. We generally use the information you supply for the purpose of making decisions regarding claims. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (1) to enable a third party or 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 about Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and, (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at <u>www.socialsecurity.gov</u> or at any local 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 <u>Paperwork Reduction Act of 1995</u>. 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. You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. **Send <u>only</u> comments relating to our time estimate to this address, not the completed report.** 

SEND OR BRING THE COMPLETED REPORT TO YOUR LOCAL SOCIAL SECURITY OFFICE, THE NEAREST U.S EMBASSY OR CONSULATE OFFICE. Office addresses are listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778) for the address.

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

SOCIAL SECURITY ADMINISTRA	TION					Form Approved OMB No. 0960-0072
CC		SABILITY I	REVIEW	REPORT	i i	
For SSA Use Only - Do not writ	te in this box. Dat	e of your last	medical di	sability deci	sion:	
Claim Number: Type(s) of Case(s): TITLE II (Check all that apply.) TITLE X	DIB VI DI	Number	Holder _ CDB	FZ	ESRD	
If you are filling out this report for the disabled person, please provide information about him or her. When a question refers to "you", "your", or the "disabled person", it refers to the person receiving disability benefits.						
SECTION 1	- INFORMATIC	ON ABOUT	THE DI	SABLED	PERSON	
<b>1.A.</b> NAME (first, middle initial,	last)		<b>1.B.</b> S	OCIAL SEC	URITY NUN	/BER
1.C. MAILING ADDRESS (Stre	eet or PO Box) Incl	ude apartmer	nt number	if applicable		
CITY	STATE/Province		ZIP/Posta	al Code	COUNTRY	(if not USA)
<b>1.D.</b> DAYTIME PHONE NUMB USA or Canada.	ER including area	code, and the	e IDD and	country code	es if you live	outside the
Phone number						
Check this box if you have a p	hone or a number w	here we can le	eave a mes	sage		
<b>1.E.</b> Alternate Phone Number, may reach you, if any	including area cod	e where we				
Alternate phone number						
1.F. Can you speak and understand English?						
If no, what language do you prefer?						
<b>1.G.</b> Have you used any other names on your medical or educational records in the last 12 months? Examples are maiden name, other married names, or nickname.						
If yes, please list them here						

SECTION 2 - CONTACTS							
Give the name of a friend or relative (other than your doctors) we can contact who knows about your medical conditions, and can help you with your case.							
<b>2.A.</b> NAME (first, middle initial,	<b>2.A.</b> NAME (first, middle initial, last) <b>2.B.</b> Relationship to Disabled Person						
2.C. MAILING ADDRESS (Street or PO Box ) Include apartment number if applicable							
CITY	STATE/Province	ZI	COUNTRY (if not USA)				
2.D. DAYTIME PHONE NUMBER (as described in 1.D. above)							
<b>2.E.</b> Can this person speak and understand English? If no, what language is preferred? YES □ NO							
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SECTION 2 - CONTACTS (continued)								
<b>2.F.</b> Who is completing this report?								
☐ The disabled person listed in 1.A (Go	to Section 3 - Medical Conditions)							
The person listed in 2.A (Go to Section	on 3 - Medical Conditions)							
☐ Someone else (Complete the rest of S	ection 2 below)							
<b>2.G.</b> NAME (first, middle initial, last) <b>2.H.</b> Relationship to Disabled Person								
2.I. DAYTIME PHONE NUMBER (as describe	2.I. DAYTIME PHONE NUMBER (as described in 1.D. above)							
2.J. MAILING ADDRESS (Street or PO Box) Include apartment number if applicable								
CITY STATE/Provir	nce ZIP/Postal Code COUNTRY (if not USA)							

SECTION 3 - MEDICAL CONDITION(S)						
<b>3.A. If you are an adult (age 18 or older)</b> , list the physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work. <b>If you are completing this report for a child (under age 18)</b> , list the physical and/or mental condition(s) (including emotional and learning problems) that limit the child's ability to do the same things as other children the same age. <b>List each physical and/or mental condition separately</b> .						
1.						
2.						
3.						
4.						
If you need more space go to Section 11 - Remarks on last page						
<b>3.B.</b> What is your height without shoes?			OR			
		nches		centimeters (if outside USA)		
<b>3.C.</b> What is your weight without shoes?			OR			
	pounds			kilograms (if outside USA)		

SECTION 4 - WORK Complete only if you are age 14 years old or older						
<b>4. Since the date of your last medical disability decision</b> have you worked? (see date at top of Page 1)						
SECTION 5 - MEDICAL TREATMENT						
Within the last 12 months, have you seen a doctor or other health care professional or received treatment at a						

hospital or clinic, or do you have a future appointment scheduled:
5.A. For any physical conditions?
YES NO
5.B. For any mental condition(s) (including emotional or learning problems)
YES NO
If you answered "No" to both 5.A. and 5.B., go to Section 6 - Other Medical Information on page 8

SEC	TION	5 - MEDICA		REATMEN	NT (con	tinued	d)
<b>5.C.</b> Tell us who may have meet condition(s) <b>(including emotio</b> emergency room visits), clinics, one scheduled.	nal or	learning proble	ems	). This incluc lities. Tell us	les docto about yo	ors' offic our next	es, hospitals (including appointment, if you have
Name of facility or office				Name of h	nealth car	e profe	ssional that treated you
ALL OF THE QUESTIONS	ON TH	IIS PAGE REFE	RT	O THE HEA	LTH CAI	RE PRC	FESSIONAL ABOVE.
PHONE () -	PHONE ( ) - PATIENT ID# (if known)						
MAILING ADDRESS				-			
CITY	(	STATE/Province		ZIP/Postal	Code	COUN	ITRY (if not USA)
Dates of Treatment (within the	e last	12 months)					
1. Office, Clinic or Outpatient vis	sits	2. Emergency R List the most rece			3. Overi	night Ho	spitals Stays
First Visit			Sint u		A Data	in	Data out
Last Visit		A			A. Date	III	Date out
		В.			B. Date	in	Date out
Next Scheduled Appointment (if a	ny)						
		C			C. Date	in	Date out
What medical conditions were to							
What treatment did you receive			-				
Check the boxes below for any scheduled you to take. Please Section 11 - Remarks on the la Check this box if no tests	give th ast pa	e dates for past ge.	and	future tests.			
KIND OF TEST	DAT	ES OF TESTs		KIND O	F TEST		DATES OF TESTs
EKG (heart test)				EEG (brain	wave tes	st)	
Treadmill (exercise test)				HIV Test			
Cardiac Catheterization			Blood Test (not HIV)				
Biopsy (list body part)			Ш	X-Ray (list	body par	()	
Hearing Test				MRI/CT Sca	n (list boo	ly part)	
Speech/Language Test	1		1				
Vision Test				Other (pleas	se describ	e)	
Breathing Test							
If you do not have ar	-	re doctors or ho	ospi	tals to desc	ribe, go	to Sect	ion 6 on page 8.
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# SECTION 5 - MEDICAL TREATMENT (continued)

5.D. Tell us who may have mee condition(s) (including emotio					
				ur next appointment, if you have	
one scheduled.	,		,		
Name of facility or office	Name o	f health car	re professional that treated you		
ALL OF THE QUESTIONS	ON THIS PAGE REFE	R TO THE HE	ALTH CAF	RE PROFESSIONAL ABOVE.	
PHONE () -		PATIEN	T ID# (if kn	lown)	
MAILING ADDRESS					
CITY	STATE/Province	ZIP/Posta	al Code	COUNTRY (if not USA)	
Dates of Treatment (within the	e last 12 months)	•			
1. Office, Clinic or Outpatient vis	sits   2. Emergency F	Room Visits	3. Overn	ight Hospitals Stays	
First Visit	List the most rec	ent date first			
	— A		A. Date in	Date out	
Last Visit					
Next Scheduled Appointment (if a	<u> </u>		B. Date ir	Date out	
	C		C. Date in Date out		
What medical conditions were to	reated or evaluated?				
What treatment did you receive	for the above condition	s? (Do not des	cribe medic	ines or tests in the box.)	
		-			
Check the boxes below for any	tests this provider per	formed or sent	you to <b>with</b>	hin the last 12 months, or has	
scheduled you to take. Please		and future test	s. If you ne	ed to list more tests, use	
Section 11 - Remarks on the la					
☐ Check this box if no tests	s by this provider or a	t this facility.			
KIND OF TEST	DATES OF TESTs	KIND	OF TEST	DATES OF TESTs	
EKG (heart test)		EEG (brain	wave test	)	
Treadmill (exercise test)		HIV Test			
Cardiac Catheterization		Blood Test	(not HIV)		
Biopsy (list body part)		X-Ray (list	body part)		
Hearing Test		MRI/CT Sca	In (list body	part)	
Speech/Language Test		1	. ,		
Vision Test		Other (pleas	e describe)		
Breathing Test			- /		
If you do not have ar	ny more doctors or he	ospitals to des	scribe, go t	to Section 6 on page 8.	

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SEC	CTION 5 - MEDICA	L TREATMENT (cont	inued)			
5.E. Tell us who may have me condition(s) (including emotion			any of your physical or mental			
			ur next appointment, if you have			
one scheduled.		,				
Name of facility or office Name of health care professional that treated you						
ALL OF THE QUESTIONS	ON THIS PAGE REFE	R TO THE HEALTH CAR	E PROFESSIONAL ABOVE.			
PHONE () - PATIENT ID# (if known)						
MAILING ADDRESS						
CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)			
Dates of Treatment (within th	le last 12 months)					
1. Office, Clinic or Outpatient v First Visit			ght Hospitals Stays			
	— A	A. Date in	Date out			
Last Visit	— В.	B. Date in	Date out			
Next Scheduled Appointment (if a			2400000			
	C	C. Date in	Date out			
What treatment did you receive	e for the above condition	ns? (Do not describe medio	cines or tests in the box.)			
Check the boxes below for any	v tests this provider per	formed or sent you to <b>with</b>	in the last 12 months, or has			
scheduled you to take. Please	give the dates for past	and future tests. If you ne	ed to list more tests, use			
Section 11 - Remarks on the Check this box if no to		r at this facility.				
KIND OF TEST	DATES OF TESTs	KIND OF TEST	DATES OF TESTs			
EKG (heart test)		EEG (brain wave test)				
Treadmill (exercise test)		HIV Test				
Cardiac Catheterization		Blood Test (not HIV)				
Biopsy (list body part)		X-Ray (list body part)				
Hearing Test		MRI/CT Scan (list body	part)			
Speech/Language Test						
Vision Test		Other (please describe)				
Breathing Test						
-	-	ospitals to describe, go t	o Section 6 on page 8.			
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			• •			
5.F. Tell us who may have medi condition(s) (including emotion						
emergency room visits), clinics, one scheduled.						
Name of facility or office	Name of	Name of health care professional that treated you				
ALL OF THE QUESTIONS C	ON THIS PAGE REFE	ER TO THE HEA		E PROFESSIONAL ABOVE.		
PHONE () -		PATIENT	ID# (if kno	wn)		
MAILING ADDRESS						
CITY	STATE/Province	ZIP/Postal	Code C	COUNTRY (if not USA)		
Dates of Treatment (within the						
1. Office, Clinic or Outpatient visi First Visit	its 2. Emergency R List the most rec		3. Overnig	ht Hospitals Stays		
				Data aut		
Last Visit	— A		A. Date in	Date out		
	— В.		B. Date in	Date out		
Next Scheduled Appointment (if an	y)		-			
	C		C. Date in	Date out		
What medical conditions were tr	eated or evaluated?					
What treatment did you receive f	for the above conditio	ns? (Do not desc	ribe medici	ines or tests in the box.)		
Check the boxes below for any t	tests this provider per	formed or sent v	ou to <b>withi</b>	n the last 12 months, or has		
scheduled you to take. Please g	ive the dates for past	and future tests	. If you nee	ed to list more tests, use		
Section 11 - Remarks on the la						
☐ Check this box if no tests						
KIND OF TEST	DATES OF TESTs		OF TEST	DATES OF TESTS		
EKG (heart test)		EEG (brain v	wave test)			
Treadmill (exercise test)		HIV Test				
Cardiac Catheterization		Blood Test (	,			
Biopsy (list body part)		X-Ray (list b	ody part)			
Hearing Test		MRI/CT Scar	n (list body p	eart)		
Speech/Language Test			<b>`</b>			
Vision Test		Other (please	e describe)			
Breathing Test						
If you do not have any	y more doctors or he	ospitals to desc	cribe, go to	Section 6 on page 8.		

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# SECTION 5 - MEDICAL TREATMENT (continued)

<b>5.G.</b> Tell us who may have mer condition(s) <b>(including emotic</b> emergency room visits), clinics one scheduled.	onal or learning prob	lems). This inclue	des doctors' o	ffices, hospitals (including	
Name of facility or office			nealth care pro	ofessional that treated you	
ALL OF THE QUESTIONS	ON THIS PAGE REF	ER TO THE HEA	LTH CARE P	ROFESSIONAL ABOVE.	
PHONE () -		PATIENT	D# (if known	1)	
MAILING ADDRESS					
CITY	STATE/Province	e ZIP/Postal	Code CO	UNTRY (if not USA)	
Dates of Treatment (within the	e last 12 months)		I		
1. Office, Clinic or Outpatient vi First Visit	sits 2. Emergency I List the most red		3. Overnight	Hospitals Stays	
	— A		A. Date in	Date out	
Last Visit					
Next Scheduled Appointment (if a	B		B. Date in	Date out	
	C		C. Date in Date out _		
What medical conditions were What treatment did you receive		ons? (Do not desc	ribe medicine	s or tests in the box.)	
Check the boxes below for any scheduled you to take. Please Section 11 - Remarks on the Check this box if no test	give the dates for pas last page.	t and future tests			
KIND OF TEST	DATES OF TESTs		F TEST	DATES OF TESTs	
EKG (heart test)		EEG (brain v	wave test)		
Treadmill (exercise test)		HIV Test	· · ·		
Cardiac Catheterization		Blood Test (	not HIV)		
Biopsy (list body part)		🔲 X-Ray (list b	X-Ray (list body part)		
Hearing Test		MRI/CT Scar	n (list body part)		
Speech/Language Test				_	
Vision Test		Other (please	e describe)		
Breathing Test				_	
If you do not have a	ny more doctors or h	ospitals to desc	cribe, go to S	ection 6 on page 8.	

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If you are under age 18, Skip to Section 11 - Remarks on the last page.						
SECTION 6 - OTHER MEDICAL INFORMATION Complete only if you are age 18 years old or older						
<b>6.</b> Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems) <b>covering the last 12 months</b> , or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, atttorneys, social service agencies and welfare.)						
YES (Complete the follow	wing information.	.)	🗖 NO (G	o to S	ECTI	ION 7.)
NAME OF ORGANIZATION				PHO	NE N (	IUMBER ) -
MAILING ADDRESS						
CITY	STATE/Province	e	ZIP/Postal C	ode		COUNTRY (if not USA)
NAME OF CONTACT PERSON	L	CLA	AIM NUMBER	(if any	/)	1
Date First Contact (in last 12 months)	Date Last C	Conta	ct (in last 12 mo	onths)	Date	e Next Contact (if any)
Reasons for Contacts						
If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.						
SECTION 7 - MEDICINES						
7. Are you now taking, or have you	taken in the last	t 12 i	months , any	prescr	iptio	n or non-prescription

medicines?

YES (Complete the following information. Look at your medicine containers, if

NO (Go to SECTION 8.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE
If you need to list other	medicines use Section 11 - Rema	rks on the last page

SECTION 8 - EDUCATION AND TRAINING Complete only if you are age 18 years old or older			
8.A. Have you received any education	tion since your last dis	sability decision? (See	date at top of Page 1.)
YES (Complete the information	on below.)	NO, go to question	8.B below
If Yes, what year did you last attend	I any school?		
Please describe the education you	received.		
8.B. Have you received any type or decision? (See date at top of Pa		e, or vocational training	since your last disability
YES (Complete the information	on below.)	NO NO	
NAME OF TRAINING FACILITY		PHONI (	= ) -
MAILING ADDRESS			
CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
TYPE OF PROGRAM	L	Date Completed (or	scheduled to be completed)
If you need to list other education information or training facilities use Section 11 - Remarks on the last page and give the same detailed information as above			
SECTION 9 - VOCATIONAL		ON, EMPLOYMEN	T, OR OTHER SUPPORT
SERVICES			
Complete only if you are age 18 years old or older			
9.A. Since the date of your last me participated, or are you participating	dical disability deci	sion (see date on top of I	<sup>p</sup> age 1), have you
an individualized work plan		network under the Ticke	et to Work Program;
		ational rehabilitation ag	ency or any other organization;
<ul> <li>a Plan to Achieve Self-Supp</li> <li>an Individualized Education</li> </ul>		h a school (if a studen	t age 18-21); or
any program providing voca			r other support services to help
you go to work?	below.)	NO (Go to Section 10	))

NAME OF ORGANIZATION OR SC	CHOOL			
NAME OF COUNSELOR, INSTRUCTOR, OR JOB COACH () -			NUMBER ) -	
MAILING ADDRESS				
CITY	STATE/Province	ZIP/Postal Co	de	COUNTRY (if not USA)
<b>9.B.</b> When did you start participating in the plan or program?				

## SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT **SERVICES** (continued)

## Complete if you are age 18 years old or older

9.C. Are you still participating in the plan or program?

YES, I am scheduled to complete the plan or program on:

**NO**, I completed the plan on:

(date to be completed)

(date completed)

NO, I stopped participating in the plan before completing it because:

9.D. What types of services, tests, or evaluations were provided (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluations, or classes?)

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

SECTION 10 - DAILY ACTIVITIES
Complete only if you are age 18 years old or older
<b>10.A.</b> Describe what you do in a typical day (for example: I get up around 7 A.M., take a shower, eat breakfast, etc.).
If you need more space, go to Section 11 - Remarks on the last page
<b>10.B.</b> Do you use an assistive device (for example: eye glasses, hearing aids, braces, canes, crutch(es), walker, wheelchair, service animal)? ☐ Always ☐ Sometimes ☐ Never
If ALWAYS OR SOMETIMES, please describe what kind, when, and how you use it.
If you need more space, use SECTION 11 - Remarks on the last page
10.C. Do you have hobbies or interests?
YES NO
If YES, please decribe what they are and how much time you spend doing them.
If you need more space, use Section 11 - Remarks on the last page
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		LY ACTIVITIES (continued)
Complete only if you are age 18 years old or older		
<b>10.D.</b> Do you ever have difficulty doing	any of the fo	ollowing? (Please explain any "Yes" answers.)
Dressing	Yes	No
Bathing	Yes	No No
Caring for hair	🗖 Yes	No No
Taking medicines	Yes	No
Preparing meals	Yes	No
Feeding self	Yes	No
Doing chores (inside/outside house)	Yes	No
Driving or using public transportation	Yes	No
Shopping	Yes	No
Managing money	Yes	No
Walking	Yes	No
Standing	🗖 Yes	No
Lifting objects	🗖 Yes	No
Using arms	Yes	No
Using hands or fingers	Yes	No
Sitting	Yes	No
Seeing, hearing, or speaking	Yes	No
Concentrating	Yes	No
Remembering	Yes	No
Understanding or following directions	Yes	No
Completing tasks	Yes	No
Getting along with people	Yes	No
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## **SECTION 11 - REMARKS**

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

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