DISABILITY REPORT - APPEAL

For SSA Use Only - Do not write in this box.

Related SSN Number Holder

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

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle, Last, Suffix)	**1.B.** Social Security Number
Anne Brown	555-55-5555

1.C. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada) 303-555-5534

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

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

1.E. Email address (Optional) Brown11@yahoo.com

SECTION 2 - CONTACTS

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim (e.g., friend or relative)

2.A. Name (First, Middle, Last)	**2.B.** Relationship to Disabled Person
Sam Brown	Husband

2.C. Mailing Address (Street or PO Box), include apartment number or unit if applicable
472 11th Street

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Montrose	CO	80299	

2.D. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada) 303-555-5534

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

If no, what language does the contact person prefer?

2.F. Who is completing this form?

☐ The person who is applying for disability. (**Go to Section 3 - MEDICAL CONDITIONS**)

☒ The person listed in 2.A. (**Go to Section 3 - MEDICAL CONDITIONS**)

☐ Someone else (Please complete the information below)

2.G. Name (First, Middle, Last)	**2.H.** Relationship to Disabled Person

2.I. Mailing Address (Street or PO Box), include apartment number or unit if applicable

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

2.J. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

SECTION 3 - MEDICAL CONDITIONS

3.A. Since you last told us about your medical conditions, has there been any **CHANGE** (for better or worse) in your previously described physical or mental conditions?

☒ Yes, approximate date change occurred: A month ago ☐ 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 She is more withdrawn and seems to be more out of touch with reality.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 had to increase her Clozaril.

3.B. Since you last told us about your medical conditions, do you have any **NEW** physical or mental conditions?

☒ Yes, approximate date of new conditions: 10-11-21 ☐ No

If yes, please describe in detail:
Anne developed a new heart condition--an abnormal heart rhythm that affects her ability to lift and carry. (See Section 10, Remarks)

If you need more space, use SECTION 10 - Remarks on the last page

SECTION 4 - MEDICAL TREATMENT

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname.

☐ Yes ☒ No

If yes, please list the other names used:

4.B. Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or **do you have a future appointment scheduled**?

☒ Yes ☐ No (Go to SECTION 6 - MEDICINES)

4.C. What type(s) of condition(s) were you treated for, or will you be seen for?

☒ Physical ☒ Mental (including emotional or learning problems)

If you answered "Yes" to 4.B., please tell us who may have **NEW** medical records about any of your physical or mental conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider**. If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities

Only list the providers you have seen since you last told us about your medical treatment.

SECTION 4 - MEDICAL TREATMENT (Continued)
Provider 1

4.D. Name of facility or office	Name of health care provider who treated you
The Mental Health Group	Dr. Claude Edwards

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

Phone Number	Patient ID# (if known)
303-123-4567	

Address
10001 Forest View Drive

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Denver	CO	80255	

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	**Emergency Room Visits at this facility**	**Overnight Hospital Stays at this facility**	
First visit Jan. 3, 2020	Date	Date in	Date out
Last visit Dec. 1, 2021	Date	Date in	Date out
Next scheduled appointment (if any) March 2022	Date	Date in	Date out
	☒ None	☒ None	

What new or updated medical conditions were treated or evaluated?
Schizophrenia.

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)
Medication and psychotherapy.

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☒ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	DATES OF TEST(S)	KIND OF TEST	DATES OF TEST(S)
☐ Biopsy (list body part)		☐ MRI/CT Scan (list body part)	
☒ Blood Test (not HIV)	10/21	☐ Speech/Language Test	
☐ Breathing test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-Ray (list body part)	
☐ EKG (heart test)			
☐ Hearing test		☐ Other (please describe)	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe, go to SECTION 5 - OTHER MEDICAL INFORMATION on page 8.

SECTION 4 - MEDICAL TREATMENT (Continued)
Provider 2

4.D. Name of facility or office	Name of health care provider who treated you
Cardiology Associates	Dr. Howard Stuckey

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

Phone Number	Patient ID# (if known)
303-555-2222	

Address
Suite 200, 1201 Canyon Blvd.

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Denver	CO	80302	

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	**Emergency Room Visits at this facility**	**Overnight Hospital Stays at this facility**	
First visit August 2021	Date	Date in	Date out
Last visit October 2021	Date	Date in	Date out
Next scheduled appointment (if any) Jan. 2022	Date	Date in	Date out
	☒ None	☒ None	

What new or updated medical conditions were treated or evaluated?
Heart rhythm problem: atrial fibrillation.

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)
Shock to restore normal rhythm.

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	DATES OF TEST(S)	KIND OF TEST	DATES OF TEST(S)
☐ Biopsy (list body part)		☐ MRI/CT Scan (list body part)	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☒ X-Ray (list body part) Chest	
☒ EKG (heart test)	Jan. 2022		
☐ Hearing test		☒ Other (please describe) Echocardiogram	Jan. 2022
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe, go to SECTION 5 - OTHER MEDICAL INFORMATION on page 8.

SECTION 4 - MEDICAL TREATMENT (Continued)
Provider 3

4.D. Name of facility or office	Name of health care provider who treated you

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

Phone Number	Patient ID# (if known)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	**Emergency Room Visits at this facility**	**Overnight Hospital Stays at this facility**	
First visit	Date	Date in	Date out
Last visit	Date	Date in	Date out
Next scheduled appointment (if any)	Date	Date in	Date out
	☐ None	☐ None	

What new or updated medical conditions were treated or evaluated?

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

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	**DATES OF TEST(S)**	**KIND OF TEST**	**DATES OF TEST(S)**
☐ Biopsy (list body part)		☐ MRI/CT Scan (list body part)	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-Ray (list body part)	
☐ EKG (heart test)			
☐ Hearing test		☐ Other (please describe)	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

SECTION 5 - OTHER MEDICAL INFORMATION

5. **Since you last told us about your other medical information**, does anyone else have medical information about any of your **physical or mental** conditions (including emotional and learning problems) or are you scheduled to see anyone else?

This may include:
- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

☐ YES (Please complete the information below.)

☒ NO (Go to SECTION 6 - MEDICINES.)

Name of Organization	Claim or ID Number (if any)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Name of Contact Person	Phone Number

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

If you need to list more people or organizations, use SECTION 10 - REMARKS on the last page.

SECTION 6 - MEDICINES

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

☒ YES (Please complete the information below. You may need to look at your medicine containers.)

☐ NO (Go to SECTION 7 - ACTIVITIES.)

NAME OF MEDICINE	IF PRESCRIBED, NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
Clozaril	Dr.Claude Edwards	Treat schizophrenia	Sleepy, weak
Pradaxa	Dr. Stuckey	Anticoagulation	Bruise easilyQ
MULTAQ	Dr. Stuckey	Control heart rhythm	Tired

If you need to list more medicines, use SECTION 10 - REMARKS on the last page.

SECTION 7 - ACTIVITIES

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your previously described daily activities due to your physical or mental conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

☒ Yes ☐ No

If yes, please describe in detail:

Anne is now able to perform daily chores like cooking a simple meal and cleaning. But she also has to be told to bathe and is less willing to socialize with family members or guests.

If you need more space, use SECTION 10 - REMARKS on the last page.

SECTION 8 - WORK AND EDUCATION

8.A. Since you last told us about your work, have you worked or has your work changed?

☐ Yes ☒ No

If yes, you will be asked to provide additional information.

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes?

☐ Yes ☒ No

If yes, what type?

Date(s) attended:

Degree(s) attained, if any:

Date of attainment (MM/YYYY):

If you need more space, use SECTION 10 - REMARKS on the last page.

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

9. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

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

☐ Yes (Please complete the information below.)

☒ No (Go to SECTION 10 - REMARKS.)

Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Date when you started participating in the plan or program:

If you need more space, use SECTION 10 - REMARKS on the last page.

SECTION 10 - REMARKS

Use this space to provide any information you could not show in earlier sections of this form or additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

3A. Anne needs almost constant supervision, will wander off if I don't watch her, and is increasingly suspicious of other people's motives. She wears her clothes in bizarre ways. 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 denied her benefits, Anne's mental condition has not significantly improved and is even worse. Dr. Edwards emphasized we must provide a highly supportive home for Anne or she will decompensate even more. I think she is clearly worse and Dr. Edwards agrees. She's certainly not better, and her benefits should not have stopped. The DDS says she now can work. This is wrong as shown by medical records and Dr. Edwards' opinion. I wonder if a real medical specialist reviewed her records and why they didn't contact Dr. Edwards for a statement.

Anne's heart condition limits her physically now,in addition to her mental condition, and her medications make her lethargic. Dr. Stuckey says he can't completely control her rhythm and that she's at risk for stroke. Anne can sometimes do simple things like making a sandwich or doing a little dustingm, but our daughters do most of the dusting and cleaning. Anne often refuses to help, saying "I'm just not interested."

I forgot to mention that Anne has a narrowed heart valve that causes her rhythm problem and also decreases her ability to do physical chores; she tires very easily. She certainly has not been able to work since her benefits were denied, in my opinion. Please contact her treating doctors.