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

We are 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. We will use the information you provide on this form to make a decision on your claim or case. Your response to this request is voluntary. However, failure to provide all or part of the information could prevent us from making an accurate and timely decision on your claim or case.

We rarely use the information you supply for any purpose other than for determining your living arrangements. 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 an agency to assist Social Security in establishing rights to Special Veterans Benefits; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to 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 www.socialsecurity.gov 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 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 ___ – ___ – ___

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**

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.)*

___ ___ ☐ Your Number ☐ Message Number ☐ None

Area Code *Number*

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	**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	**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			☐ **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 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			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**