«SSN»

«FOAddr1»
«FOAddr2»
«FOAddr3»
«FOCity», «FOState» «FOZIP»
Telephone: «EePhone»
TDD: «FOTDD»
Fax: «FOFax»
Office Hours: «FOHours»

July 16, 2009

«PNA1»
«PNA2»
«PNA3»
«PNA4»
«PNA5»
«City», «Stn» «ZIP»

Important Notice: You must complete and return this form or «YourBenys» «TitleText» benefits may stop.

«Salut»:

We must review the cases of people getting disability benefits to make sure they are still disabled under our rules. We may also review cases at other times.

We are writing to let you know that we are starting to review «YourBenys» disability case. We have enclosed a pamphlet that will tell you more about the review.

What You Need To Do Now

We would like you to **complete the enclosed forms** and return them to us **before «15daysDate»**. If you have no questions, and if the forms are complete, please **return them by mail**.

The Information We Will Need

In most cases, a Social Security representative will contact you to ask additional questions after you have mailed this form to us. We ask you to complete and mail the form before we call to save time. If we call, we may ask for more information about:

- Hospital stays and surgeries within the last 12 months, including the dates, reasons, and complete addresses
- Visits to doctors and clinics within the last 12 months, including the dates, reasons, and complete addresses
- Counseling and therapy
- Schools and special classes or tutoring
- Teachers and counselors who have knowledge of «YourBenys» condition
- Name(s) and dosage of any medicine(s) «Beny» use

- Each employer's name and address, the dates worked, and the amount earned if «YouHave» worked since we last reviewed «YourHis» case

How We Decide If You Are Disabled

Doctors and other trained staff will decide for us if «YourBeny's» condition has improved, and if «you are Beny is» still disabled under our rules.

When we decide, we will write and let you know our decision. Our letter will tell you whether «you are/ BenyIs» still disabled under our rules.

We may find that «you are/Beny is» no longer disabled under our rules and «YourHis» payments and Medicare coverage could stop. If this happens, you can appeal our decision. If you appeal our decision, you can also choose to have us to continue to pay you until we decide the appeal.

If We Do Not Hear From You

We may stop «YourBenys» «TitleText» benefits if you do not answer this letter by «15 daysDate» or contact us by this date to tell us why we have not heard from you. Before we stop «YourHis» benefits, we will send you another letter to explain our decision. The letter will also explain your right to appeal the decision and how to continue getting payments during the appeal.

Information About Medical Assistance

If «YourHis» SSI stops, any medical assistance «YouHave» that is based on SSI may also stop. If this happens, your medical assistance agency should contact you, or you can call them to see if «Beny» qualify for continued medical assistance.

If You Want An Interpreter To Help You

If you need an interpreter to conduct Social Security business, we will supply one on request, free of charge. If you want us to supply the interpreter, please call before you come to the office and tell us what language you prefer to speak.

If You Have Any Questions

Please visit our internet web site at www.socialsecurity.gov for general information about Social Security. You may call us toll-free at 1-800-772-1213, if you have any specific questions. We can answer most questions over the phone. You may call our TTY number at 1-800-325-0778 if you are deaf or hard of hearing. Please have this letter with you if you call or visit an office. It will help us answer your questions. You may also call ahead to make an appointment if you plan to visit an office. This will help us provide faster service when you arrive.

Enclosures:
Continuing Disability Review Report – Adult (SSA 454 ICR)

CONTINUING DISABILITY REVIEW REPORT - ADULT

SSA will use this form to review your medical condition(s) since the date of your last medical disability decision.

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

Selection date: MM/DD/YYYY

Claim Number: XXX-XX-2469A

WBDOC: Exc ☐ 2 ☐ 3 ☐

Date of your last medical disability decision: MM/DD/YYYY

IMPORTANT

Are you currently participating in the Ticket to Work Program or working under a plan with a private or State Vocational Rehabilitation Agency?	☐ No Continue with **1.A.**
	☐ Yes **STOP!!** Call the Social Security office at 410-555-2181

SECTION 1 – INFORMATION ABOUT THE DISABLED PERSON

1.A. Social Security Number, Name, and Address of Disabled Person

XXX-XX-2469
SEBASTIAN Q PETTIFOGGER
38 FOGGY BOTTOM RD
INDIANAPOLIS IN 31212-0987

If your Name and Address are correct, skip to **1.C.** If your Name or Address is not correct as shown, write an "X" in this box and enter corrections below:

▼ ☐

1.B. Enter Name or Address Corrections Here (Go to 1.C. if the above information is correct)

Full Name (First, Middle Initial, Last)

Mailing Address (number, street, apartment, PO box, rural route):

City: State: Zip Code: -

1.C. DAYTIME PHONE NUMBER (If you do not have a phone number where we can reach you, give us a daytime phone number where we can leave a message.)

Telephone Number: - -
(area code) (phone number)

☐ None - check here if we cannot contact you by phone.

1.D. ALTERNATE PHONE NUMBER

Telephone Number: - -
(area code) (phone number)

☐ None - check here if we cannot contact you by phone.

1.E. In the last 12 months, have you used any other names on your medical or educational records? ☐ Yes ☐ No

SECTION 2 - MEDICAL CONDITIONS

2.A. **If you are an adult (age 18 or older)**, list all of the physical and/or mental conditions that limit your ability to work. **If you are completing this form for a child (under age 18),** list all of the physical and/or mental conditions that limit the child's ability to do the same things as other children of the same age. **List each physical and/or mental condition (including emotional or learning problems) separately.**

1.

2.

3.

4.

5.

2.B. Do you have more than 5 medical conditions? ☐ Yes ☐ No

SECTION 3 - MEDICAL RECORDS

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic within the last 12 months, or **do you have a future appointment scheduled?**

3.A. For any **physical** condition(s)? ☐ Yes ☐ No

3.B. For any **mental** condition(s) (including emotional or learning problems)? ☐ Yes ☐ No

If you answered "no" to both 3.A and 3.B, go to Section 4 - Work, Education and Training

3.C. Tell us who may have medical records covering **the last 12 months** about any of your **physical or mental** condition(s). This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities.

(1) Name of **Hospital, Clinic, Doctor** or other **Health Care Professional:**

Telephone Number: - -
(area code) (phone number)

City and **State** in which you saw this medical provider:

(2) Name of **Hospital, Clinic, Doctor** or other **Health Care Professional:**

Telephone Number: - - (area code) (phone number)

City and **State** in which you saw this medical provider:

(3) Name of **Hospital, Clinic, Doctor** or other **Health Care Professional:**

Telephone Number: - - (area code) (phone number)

City and **State** in which you saw this medical provider:

(4) Name of **Hospital, Clinic, Doctor** or other **Health Care Professional:**

Telephone Number: - - (area code) (phone number)

City and **State** in which you saw this medical provider:

(5) Name of **Hospital, Clinic, Doctor** or other **Health Care Professional:**

Telephone Number: - - (area code) (phone number)

City and **State** in which you saw this medical provider:

3.D. Have you seen other medical providers within the last 12 months? ☐ Yes ☐ No

3.E. Does **anyone else** have medical information about your condition(s) covering the last 12 months, or are you scheduled to see anyone else? (This includes workers' compensation, insurance companies who have paid you disability benefits, prisons, attorneys, and welfare.) ☐ Yes ☐ No

SECTION 4 - WORK, EDUCATION AND TRAINING
Complete this section only if you are 18 or older

4.A. Since **MM/DD/YYYY,** have you worked? ☐ Yes ☐ No

4.B. Since **MM/DD/YYYY,** have you received any education? ☐ Yes ☐ No

4.C. What year did you last attend any school? (for example 1982) Y Y Y Y

4.D. Since **MM/DD/YYYY,** have you received any type of specialized job, trade or vocational training? ☐ Yes ☐ No

SECTION 5 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES
Complete this section only if you are 18 or older

5.A. Since MM/DD/YYYY , 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 age18-21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ Yes ☐ No

SECTION 6 - MEDICINES

6.A. Are you now taking, or have you taken in the last 12 months, any prescription or non-prescription medicines? ☐ Yes ☐ No

6.B. If you answered yes, please list your medicines below. Look at your medicine containers, if necessary.

1.
2.
3.
4.
5.
6.
7.
8.
9.

SECTION 7 - DAILY ACTIVITIES

Use remarks section if more space is needed

7.A. Describe what you do in a typical day (for example: I get up around 7 a.m., take a shower, eat breakfast, check emails, etc.)

7.B. Do you have difficulty doing any of the following?					Please explain any "Yes" answers here. ▼
Dressing	☐	Yes	☐	No	
Bathing	☐	Yes	☐	No	
Caring for hair	☐	Yes	☐	No	
Taking medicine	☐	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/following directions	☐	Yes	☐	No	
Completing tasks	☐	Yes	☐	No	
Getting along with people	☐	Yes	☐	No	

7.C. Do you use an assistive device (for example: eye glasses, hearing aids, braces, canes, crutch(es), walker, wheelchair)? ☐ Always ☐ Sometimes ☐ Never

If ALWAYS or SOMETIMES, please describe what kind, when, and how you use it.

7.D. Do you have hobbies or interests? ☐ Yes ☐ No

If YES, please describe what they are and how much time you spend doing them.

SECTION 8 - REMARKS

Please provide any additional information you did not show in earlier parts of this form. You may also attach any medical records, copies of prescriptions, or any other records about your medical condition(s) you have at home that you wish to give us. When you are finished, or if you don't have anything to add, be sure to complete the information below.

SECTION 9 - CONTACTS

9.A. Give the name of someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your case.

Full Name (First, Middle Initial, Last):

Daytime Telephone Number: ___ - ___ - ____ (area code) (phone number)

Relationship to Disabled Person:

9.B. When was this report completed (month / day / year)? MM / DD / YYYY

9.C. Who completed this report?

- ☐ The disabled person
- ☐ The person named in 9.A. above
- ☐ Someone else (go to question 9.D.)

9.D. Give the name of the person who completed this report.

Full Name (First, Middle Initial, Last):

Daytime Telephone Number: ___ - ___ - ____

Relationship to Disabled Person:

Privacy Act Statement
Collection and Use of Personal Information

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. Your response is voluntary. However, failure to provide all or part of the requested information could prevent an accurate and timely decision on the named claimant's claim.

We rarely use this information provided on this form for any other purpose other than for the reasons explained above. 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 Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, 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;

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs; and,

5. To contractors for the purpose of assisting SSA in the efficient administration of the Ticket to Work and Self Sufficiency Program.

We may also use this information you provided 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 and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Records Notices 60-0089 and 60-0050. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your 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 30 minutes to read the instructions, gather the facts, and answer the questions. We estimate that it will take about 30 minutes for the follow up interview. **SEND OR BRING THE COMPLETED REPORT TO YOUR LOCAL SOCIAL SECURITY OFFICE, THE NEAREST U.S EMBASSY OR CONSULATE OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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.** *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 report.***

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