

RECONSIDERATION REPORT FOR DISABILITY CESSATION

OFFICE

DATE

REPORT MADE

IN PERSON TELEPHONE

PLACE OF REPORT

FO CONTACT STATION
 HOME OTHER

WAGE EARNER'S NAME

SOCIAL SECURITY NUMBER

BENEFICIARY'S NAME IF NOT WAGE EARNER

SOCIAL SECURITY NUMBER

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PERSON REPORTING

BENEFICIARY OTHER PERSON (Show name, address, relationship, and why beneficiary is not reporting.)

NAME

RELATIONSHIP

ADDRESS (Number and Street, City, State and ZIP Code)

WHY BENEFICIARY IS NOT REPORTING

TYPE OF
BENEFIT

DISABILITY

WORKER WIDOW CHILD

SSI

DISABILITY BLIND CHILD

Paperwork/Privacy Act Notice: The Social Security Administration is authorized to collect the information on this form under section 205(a), 1631(e)(A) and (B), and 1872 of the Social Security Act as amended (42 U.S.C. 405, 1383 and 1395ii). Giving us the information on this form is voluntary. However, if you do not respond, we will make a decision based on the evidence in your file.

The Social Security Administration will use the information on this form to fully evaluate your claim for disability benefits. We may routinely give out the information on this form without your consent if:

1. We need to get more information to decide if you are eligible for benefits.
2. An agency needs this information to decide if you are eligible for a health or income program such as SSI State supplementary payments, food stamps, Medicaid, energy assistance, Veterans benefits, or Basic Education Opportunity Grants;
3. A Federal law requires that we give out this information;
4. Your Congressman or the President's Office needs this information to answer questions you ask them.
5. Someone needs this information to do statistical research or audit reports for us related to the Social Security programs, or;

6. The Department of Justice needs the information to represent the Federal Government in a court suit related to SSA administered programs.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 30 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

PLEASE USE THIS FORM TO PROVIDE INFORMATION ABOUT YOUR DISABLING CONDITION THAT YOU DID NOT GIVE US ON YOUR LAST REPORT OF CONTINUING DISABILITY INTERVIEW (SSA-454-BK). NOTE: All information must reflect the beneficiary's (or his/her representative's) statements regarding the disabling condition since the last interview; i.e., the continuing disability interview. Changes in the condition and other new information as well as any corrections/additions to information previously provided should be included. This report will be one source of information used to reconsider the determination that disability has ceased.

PART I - INFORMATION ABOUT YOUR CONDITION

1. a. What is your disabling condition? (Briefly summarize all injuries or illnesses and tell how they prevent you from working?)

b. Has there been any change (for better or worse) in your disabling condition since your last disability interview? Yes No

If "yes," describe any changes.

c. Do you have any new injuries or illnesses? Yes No

If "yes," describe any changes.

2. a. Do you feel you are able to return to work?
If "yes," explain and describe any limitations in Part VI which were not previously provided.
If "no," explain in Part VI if you have not already told us why. Yes No

2. Cont.	b. Has your doctor told you that you are able to return to work? If "yes," answer items c, d and e.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did Not Say
	c. List the name and address of the doctor(s) who told you to return to work		
NAME		d. What date did your doctor tell you that you could return to work? →	MONTH-DAY-YEAR
ADDRESS (Number and Street, City, State and ZIP Code)		e. Did the doctor restrict you to limited or part-time work? → (If "yes," explain in Part VI.	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS

NOTE: When completing Part II, provide a summary of medical examinations and treatments not provided previously. If you have not seen a doctor, check here. →

3. List the name, address and telephone number of any doctor(s) you have seen			
a. NAME		TELEPHONE NUMBER (Include area code)	
ADDRESS (Number and Street, City, State and ZIP Code)			
How often do you see this doctor?	Date you first saw this doctor (Month, Day, Year)	Date you last saw this doctor (Month, Day, Year)	
Reasons for visits (show illness or injury for which you had an examination or treatment)			
Type of treatment received or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicine show "NONE").			
b. NAME		TELEPHONE NUMBER (INCLUDE AREA CODE)	
ADDRESS (Number and Street, City, State and ZIP Code)			
How often do you see this doctor?	Date you first saw this doctor (Month, Day, Year)	Date you last saw this doctor (Month, Day, Year)	
Reasons for visits (show illness or injury for which you had an examination or treatment)			
Type of treatment received or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicine show "none").			

4. List any hospitalizations or treatments at a clinic for your disabling condition		
NAME OF HOSPITAL OR CLINIC		PATIENT OR CLINIC NUMBER
ADDRESS (Number and Street, City, State and ZIP Code)		
Were you an inpatient (i.e., stayed at least overnight)? If "yes," show below. <input type="checkbox"/> Yes <input type="checkbox"/> No		Were you an outpatient? If "yes," show below. <input type="checkbox"/> Yes <input type="checkbox"/> No
DATES OF ADMISSIONS	DATES OF DISCHARGES	DATES OF VISITS

4. Reason for hospitalization or clinic visits (show illness or injury for which you had an examination or treatment)

Cont.

Type of treatment or medicine received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE").

5. List other agencies which have seen you for your injury or illness. (VA, Worker's Compensation, Vocational Rehabilitation, Public Assistance)

NAME OF AGENCY		YOUR CLAIM NUMBER
ADDRESS (Number and Street, City, State and ZIP Code)		TELEPHONE NUMBER (Include area code)
DATES OF VISITS (Month, Day, Year)	TYPES OF TREATMENTS OR EXAMINATION RECEIVED	

If more space is needed, list in Part VI the other agencies, their addresses, your claim numbers, dates, and treatment received.

6. INDICATE ANY OF THE FOLLOWING TESTS YOU HAVE HAD	IF CHECKED SHOW	
	WHERE DONE	WHEN DONE
<input type="checkbox"/> EKG - Resting		
<input type="checkbox"/> EKG - Treadmill		
<input type="checkbox"/> Chest x-ray		
<input type="checkbox"/> Other x-ray (specify ►)		
<input type="checkbox"/> Breathing tests		
<input type="checkbox"/> Blood tests		
<input type="checkbox"/> Other (specify ►)		
<input type="checkbox"/> Other (specify ►)		
<input type="checkbox"/> Other (specify ►)		
<input type="checkbox"/> Other (specify ►)		

PART III - INFORMATION ABOUT YOUR ACTIVITIES

7. Describe any limitations your doctor placed on your activities not reported previously. Give the name of the doctor below and tell what he or she told you about limiting your activities:

8. Describe your daily activities in the following areas and state what and how much you do of each; how often you do it; and any assistance you require. Provide only information which differs from that reported previously.

PERSONAL MOBILITY (walking, moving about, exercising your legs, etc.)

PERSONAL NEEDS AND GROOMING (dressing, bathing, etc.):

HOUSEHOLD MAINTENANCE (cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

RECREATIONAL ACTIVITIES AND HOBBIES (TV, radio, newspapers, or books, fishing, bowling, musical instruments, etc.):

SOCIAL CONTACTS (visits with friends, relatives, neighbors, church, social clubs):

OTHER (drive car, motorcycle, ride bus or subway, etc.):

9. LIST ANY (TRADE, VOCATIONAL OR ACADEMIC) SCHOOL(S) OR ANY OTHER TYPE OF VOCATIONAL TRAINING YOU HAVE NOT ALREADY TOLD US ABOUT.

10. List any school you are now attending if not previously provided.

NAME OF SCHOOL	ADDRESS OF SCHOOL (Number and Street, City, State and ZIP Code)	CURRENT GRADE
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PART IV - INFORMATION ABOUT THE WORK YOU DID

WHEN COMPLETING PART IV PROVIDE INFORMATION SINCE DATE YOU BECAME DISABLED

11. Since you became disabled, have you done work that was not previously reported? Yes No

If "Yes," complete the following for each work attempt, no matter how short it was.

JOB TITLE (Be sure to begin with your usual job)	TYPE OF BUSINESS	DATES WORKED (month/year)		DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)
		FROM	TO		
					\$
					\$
					\$
					\$

12. Describe your basic duties (explain for each job listed above what you did and how you did it) below. Also, explain why you stopped working for each work attempt listed in item 11.

PART V - INFORMATION ABOUT REHABILITATION SERVICES

13. VOCATIONAL REHABILITATION IMPORTANT: Even if it is determined that you are not disabled, you may be eligible for continued payments if you are in an approved vocational rehabilitation program and meet other requirements of the law.

a. Describe any help you are receiving, such as services, training or counseling from a State vocational rehabilitation agency or other vocational rehabilitation program not provided previously.

b. List any type of training you expect to receive, if not provided previously.

13. c. Indicate the name, address and phone number of your VR counselor and the State VR agency or other VR service provider, if not provided previously.

Cont.







NAME	ADDRESS (Number and Street, City, State and ZIP Code)	TELEPHONE NUMBER (Include area code)
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PART VI - REMARKS

14. Use this section for additional space to answer any previous questions. Also, use space to give any additional information that you think will be helpful in the review of the continuing entitlement to Social Security disability benefits. (If you need more space, use a separate sheet of paper. Also, if you wish, you may attach any evidence that shows your current condition.)

PART VII - AUTHORIZATION AND NOTIFICATION STATEMENTS

I understand that this report will be used to determine whether to continue or to stop my disability benefits. I also understand that if I am receiving Social Security disability benefits and Supplemental Security Income payments, this questionnaire is applicable to both claims.

-  Copies of medical records may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
-  Results of any such independent examination may be provided to my personal physician.
-  Medical information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
-  The State Vocational Rehabilitation Agency may review any medical evidence for determining my eligibility for rehabilitative services.
-  I agree to notify the Social Security Administration if my medical condition improves or I go to work.
-  I know that anyone who makes a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law. I affirm that the above statements are true.

SIGNATURE OF CLAIMANT OR PERSON FILING ON THE CLAIMANT'S BEHALF SIGN HERE 	DATE (Mo., Day, Yr.)	TWO TELEPHONE NUMBERS WHERE CLAIMANT CAN BE REACHED (INCLUDE AREA CODE)
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MAILING ADDRESS (Number and Street, Apt., P.O. Box or Rural Route)	
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CITY AND STATE	ZIP CODE
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Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X) two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (Number and street, city, state and ZIP code)	ADDRESS (Number and street, city, state and ZIP code)

16. Does the claimant need assistance in processing his or her claim? If "yes" and not provided previously, show name, address, relationship, and telephone number of an interested party willing to assist the claimant.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
NAME	RELATIONSHIP		
ADDRESS (Number and Street, City, State and Zip Code)	TELEPHONE NUMBER (include area code)		
17. Does the claimant speak English? If "no," what language does he/she speak?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
18. Is all work in the past 15 years documented in file? If "no," secure SSA-3369-F6 for the undocumented work.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
19. Is capability development by the DDS necessary?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
20. Is development of work activity necessary?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If "yes," is an SSA-820-F4 or SSA-821-F4 in file? If "no," explain why below.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
SIGNATURE OF INTERVIEWER OR REVIEWER	TITLE	DATE	TELEPHONE NUMBER (including area code)