Form Approved
OMB NO. 0960-0440

# DISABILITY HEARING OFFICER'S REPORT OF DISABILITY HEARING

**DHU Code Number**

**Paperwork/Privacy Act Notice:** The Social Security Administration is authorized to collect the information on this form under Section 205(a), 1631 (e)(1)(A) and (B), and 1872 of the Social Security Act, as amended (42 U.S.C. 405, 1383, and 1395ii). Giving us this information is mandatory.

The information on this form will aid Disability Hearings Officers in conducting hearings and in preparing disability decisions. It will be made a part of the claims folder and be subject to its rules concerning disclosure.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. 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.

See Revised PRA, Attached

**Paperwork Reduction Act Statement** - 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 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213.** Send **only** comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

## I. IDENTIFYING INFORMATION

1. CLAIMANT'S NAME (Enter any changes in address/telephone number)

2. NUMBER HOLDER'S NAME (If different from claimant)

3. NUMBER HOLDER'S SOCIAL SECURITY NUMBER
___ __ ____

## II. BACKGROUND INFORMATION

1. FILE REVIEWED BY CLAIMANT/REPRESENTATIVE ☐ Yes ☐ No
(If no, explain) _____

2. HEARING PLACE

3. HEARING DATE/TIME HEARING BEGAN

4. PRESENT AT HEARING WERE:

5. MONTH/YEAR OF CESSATION

6. REASON FOR DETERMINATION UNDER APPEAL

7. DATE OF COMPARISON POINT DECISION (CPD) _____

8. BASIS FOR CPD

9. CLAIMANT'S BIRTHDATE _____ AGE _____ HEIGHT _____ WEIGHT _____ EDUCATION _____

10. TYPE OF CLAIM(S)
**TITLE II** ☐ DIB ☐ DWB ☐ CDB **TITLE XVI** ☐ Disability ☐ Blind

11. ABILITY TO READ/WRITE/SPEAK/UNDERSTAND ENGLISH ☐ Yes ☐ No (If no, explain)

## III. ISSUES

The basic issue to be determined is whether the claimant is disabled/blind under the definition of disability/blindness contained in sections 223 (d) and 1614 (a) of the Social Security Act, taking into account, when applicable, the standard of review for termination of disability benefits contained in sections 223 (f) and 1614 (a)(4) of the Social Security Act.

1. Other issues (new claim, EPE, 301 etc.): _____

2. Additional evidence submitted: _____

3. Identify CPD impairment(s) and describe any changes, including new impairments:

4. Impairment(s) which prevents claimant from working. Describe limitations:

## CLAIMANT'S STATEMENTS OF MEDICAL INFORMATION

**(Review sources/treatment/impairment with claimant)**

5. Claimant's comments on previously submitted medical evidence:

6. List any other doctors' reports, hospitalizations, and surgeries (performed and/or recommended) not contained in the claims file and which relate to the claimant's alleged disability; include claimant's explanation (if any) of why this evidence indicates no improvement and/or current disability:

7. Claimant's medication (type, prescribed dosage, reason for usage, frequency of use): Explain any changes in medication since the CPD: Effects/results of medication (including side effects, if any):

8. Other prescribed treatments/restrictions (therapy, inhalants, diet, elastic stockings, bed rest, bypass surgery, prosthesis, etc.) since the CPD: Effects/results of other treatments (including side effects, if any):

## CLAIMANT'S STATEMENT OF PAIN OR OTHER SYMPTOMS
**(complete only if symptoms are an issue)**

9. Describe location of pain; activity causing pain; type (sharp, dull); day/night; frequency and duration; radiation; relieved by. Explain any changes relating to pain or other symptoms since the CPD:

## CLAIMANT'S STATEMENT OF DAILY ACTIVITIES

10. Describe living arrangements (i.e., lives alone, type of housing, etc.)
Describe any changes since the CPD:

11. How does the claimant spend his/ her time during a typical day/week (household responsibilities, hobbies, social activities, exercises, etc.)? Describe any changes since the CPD.

12. Explain how condition affects claimant's ability to perform household or other activities. Describe any changes or modifications since the CPD:

13. Does claimant drive? If so, length and frequency of trips. If not, explain. If claimant uses other means of transportation, list type and frequency. Describe changes since the CPD:

14. How often does claimant shop, for what, alone or with help (is help required or just for company)? Describe and include any changes since the CPD:

15. Sleeping habits (Describe any changes since the CPD):

## CLAIMANT'S STATEMENTS OF LIMITATIONS

16.

| Limited in: | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Walking | ☐ | ☐ | Seeing | ☐ | ☐ |
| Standing | ☐ | ☐ | Hearing | ☐ | ☐ |
| Sitting | ☐ | ☐ | Speaking | ☐ | ☐ |
| Lifting/Carrying | ☐ | ☐ | Climbing | ☐ | ☐ |
| Bending | ☐ | ☐ | Balancing | ☐ | ☐ |
| Reaching | ☐ | ☐ | Stooping | ☐ | ☐ |
| | | | Kneeling | ☐ | ☐ |
| Feeling or Manipulation of Objects | ☐ | ☐ | Crouching | ☐ | ☐ |
| | | | Crawling | ☐ | ☐ |

If any of the above items are checked "Yes", describe the limitation(s) below:
Describe any changes since the CPD:

17. Note any problems with surroundings, e.g., dust, fumes, noise, stress inherent to job duties, and describe changes since the CPD:

## CLAIMANT'S STATEMENTS OF MENTAL LIMITATIONS

18. Briefly describe any difficulty understanding, remembering, concentrating, persisting at tasks and/or completing them timely, following instructions, relating to others, or tolerating increased stress and/or mental demands such as those which might be expected in a work situation or to complete household or other tasks. Explain any changes in these capacities since the CPD:

## SUPPLEMENTAL VOCATIONAL INFORMATION

19. Review and verify relevant vocational history and describe any inconsistencies:

20. Has claimant looked for work since the CPD? ☐ YES ☐ NO

Explain:

21. Claimant's explanation of why impairment(s) continues to prevent performance of past or other work:

22. Has claimant had any education, training or involvement with vocational rehabilitation (VR) since the CPD? ☐ YES ☐ NO

(Include any education, training or VR the claimant received, is receiving, or plans to receive.)

Explain:

## WITNESS STATEMENT

23. A.1. NAME | A.2. RELATIONSHIP TO CLAIMANT | A.3. Excluded ☐ (check)

A.4. Why does witness think the claimant hasn't improved since the CPD or can't work? Basis for this opinion is (personal observation, what claimant has said, etc.):

B.1. NAME | B.2. RELATIONSHIP TO CLAIMANT | B.3. Excluded ☐ (check)

B.4. Why does witness think the claimant hasn't improved since the CPD or can't work? Basis for this opinion is (personal observation, what claimant has said, etc.):

24. CLOSING STATEMENT (for additional space, use continuation sheet):

25. DISABILITY HEARING OFFICER'S OBSERVATION OF THE CLAIMANT AND NOTES

Check each item to indicate if any difficulty observed:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Breathing | ☐ | ☐ | Reading | ☐ | ☐ |
| Seeing | ☐ | ☐ | Comprehending | ☐ | ☐ |
| Speaking | ☐ | ☐ | Responding | ☐ | ☐ |
| Hearing | ☐ | ☐ | Concentrating | ☐ | ☐ |
| Sitting | ☐ | ☐ | Remembering | ☐ | ☐ |
| Walking | ☐ | ☐ | Relating to people | ☐ | ☐ |
| Standing | ☐ | ☐ | Unusual behavior | ☐ | ☐ |
| Use of hands or arms | ☐ | ☐ | Deformities | ☐ | ☐ |
| Writing | ☐ | ☐ | Other (specify) _____ | | |

If any of the above items are checked "yes," describe the exact difficulty involved:

Disability hearing Officer's Notes:

26.

| DISABILITY HEARING OFFICER'S SIGNATURE | DATE/TIME |
| --- | --- |
| | |

CONTINUATION SHEET

***The following revised PRA Statement will be inserted into the form at its next scheduled reprinting:***

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