

DISABILITY DETERMINATION AND TRANSMITTAL

1. DESTINATION DDS ODO DPB DQB OIO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		2. DDS CODE	3. FILING DATE	4. SSN - -	BIC (if CDB or DWB CLAIM)
5. NAME AND ADDRESS OF CLAIMANT (include ZIP Code)				6. WE'S NAME (IF CDB OR DWB CLAIM)	
				7. TYPE CLAIM (Title II) DIB FZ DWB CDB-R CDB-D RD-R RD-D RD P-R P-D MQFE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
				8. TYPE CLAIM (Title XVI) <input type="checkbox"/> DI <input type="checkbox"/> DS <input type="checkbox"/> DC <input type="checkbox"/> BI <input type="checkbox"/> BS <input type="checkbox"/> BC	
9. DATE OF BIRTH		10. PRIOR ACTION <input type="checkbox"/> PD <input type="checkbox"/> PT		11. REMARKS	
12. DISTRICT-BRANCH OFFICE ADDRESS (include ZIP Code)			DO-BO CODE		
13. DO-BO REPRESENTATIVE			14. DATE	11A. <input type="checkbox"/> Presumptive Disability	11B. <input type="checkbox"/> Impairment

DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED

15. CLAIMANT DISABLED A. <input type="checkbox"/> Disability Began B. <input type="checkbox"/> Disability Ceased		16A. PRIMARY DIAGNOSIS BODY SYS. CODE NO.		16B. SECONDARY DIAGNOSIS CODE NO.	
17. DIARY TYPE	MO./YR.	REASON			
18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)(i)(216)(i) A. <input type="checkbox"/> Not Disab. for Cash Bene. Purp. B. <input type="checkbox"/> Disab. for Cash Benefit Purp. Beg.			19. CLAIMANT NOT DISABLED Through Date of A. <input type="checkbox"/> Current Determination B. <input type="checkbox"/> Through _____ C. <input type="checkbox"/> Before Age 22 (CDB only)		
20. VOCATIONAL BACKGROUND			OCC YRS.	ED YRS.	21. VR ACTION SC IN SC OUT Prev Ref A. <input type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/>
22. REG-BASIS CODE	23. MED LIST NO.	24. MOB CODE	25. REVISED DET <input type="checkbox"/>	25A. Initial Recon Recon DHU ALJ Hearing Appeals Council U.S. District Court A. <input type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/>	
26. LIST NO.	A.	B.	C.	D.	E. F.
27. RATIONALE <input type="checkbox"/> See Attached SSA-4268-U4/C4 <input type="checkbox"/> Check if Vocational Rule Met. Cite Rule					
28. A. <input type="checkbox"/> Period of Disability B. <input type="checkbox"/> Disability Period C. <input type="checkbox"/> Estab Beg _____ AND D. <input type="checkbox"/> Continues E. <input type="checkbox"/> Term _____					
29. LTR/PAR NO.	30. DISABILITY EXAMINER-DDS		31. DATE	32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE	
	32A. PHYSICIAN OR MEDICAL SPEC. NAME (Stamp, Print or Type)		33. DATE		
34. REMARKS					MULTIPLE IMPAIRMENTS CONSIDERED
					34A. COMBINED MULTIPLE NONSEVERE-SEVERE
					34B. COMBINED MULTIPLE NONSEVERE-NONSEVERE
35. BASIS CODE	36. REV. DET. CODES	37. SSA REPRESENTATIVE			SSA CODE
					38. DATE

PRIVACY ACT/PAPERWORK ACT NOTICE

We are authorized to collect this information under Sections 221 (a) and (b) of the Social Security Act and Sections 404.1615(d) and 416.1015 (d) of the Code of Federal Regulations. The information will be used to determine eligibility for benefits and for program evaluation and management. You are not required to complete this form, however, failure to do so could affect the claimants eligibility for benefits.

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.

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 15 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.** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. *Send only comments relating to our time estimate to this address, not the completed form.*