

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

1. A. SOCIAL SECURITY NUMBER

- -

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 93-233.

1. B. TYPE CLAIM (DI, DS, DC, BI, BS, BC), 1. C. OTHER ENTITLEMENT (TITLE II), 2. A. NAME OF PAYEE, B. NAME OF DISABLED OR BLIND INDIVIDUAL, 4. DATE OF BIRTH, 5. DATE DISABILITY BEGAN, 3. ADDRESS, 6. DO ADDRESS, 7. DO CODE, DDS CODE, 8. INITIAL, RECON, DHU, ALJ HEARING, APPEALS COUNCIL, U.S. DISTRICT COURT, REOPENING, 9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED: DISABILITY

A. CONTINUES (DA AND A DOES/DOES NOT CONTRIBUTE TO FINDING), B. CEASED (STATE PLAN LAST MET), C. ELIGIBILITY TERMINATED AT THE CLOSE OF THE LAST DAY OF

I. 301 CASE, J. BLINDNESS (1)CONTINUES, BEGAN, (2)CEASED, (3)CEASED, OTHER IMPAIRMENT BEGAN

10. BASIS FOR DETERMINATION (A. MEDICAL/MEDICAL VOC., B. WORK - NO IRWE, C. WORK - IRWE INVOLVED, D. OTHER)

11. REASON FOR CESSATION (CODE), 12. REASON FOR CONTINUANCE (CODE), MEDICAL LIST NO., 13. CHECK IF ATTACHING A CONTINUATION SHEET., 14. CHECK IF VOCATIONAL RULE MET., CITE RULE, 15. VOCATIONAL BACKGROUND, 16. OCC. YEARS, 17. EDUC. YEARS, 18. SPECIAL USE

19. VR ACTION (A. SC IN, B. SC OUT, C. PREV. REF., D. RE-REF), 20. WHY REVIEW WAS MADE - CODE:

21. PRIMARY DIAGNOSIS (BODY SYSTEM, CODE NO.), 22. SECONDARY DIAGNOSIS (CODE NO.), 23. DIARY (A. TYPE, B. MONTH, YEAR, C. REASON)

24. REMARKS (MULTIPLE IMPAIRMENTS CONSIDERED, 24.A. COMBINED MULTIPLE NONSEVERE-SEVERE, 24.B. COMBINED MULTIPLE NONSEVERE-NONSEVERE)

25. DISABILITY EXAMINER/CLAIMS REP., 26. DATE, 27. PHYSICIAN OR MEDICAL SPEC. SIGNATURE, 28. DATE

29. LETTER/PARAGRAPH NUMBER, 30. PHYSICIAN OR MEDICAL SPEC. NAME (STAMP, PRINT, OR TY), 30.A. SPEC. CODE, 31. SSA REPRESENTATIVE, 32. SSA CODE, 33. DATE

34. LIST NUMBER (A-F), 35. FOLDER SENT TO

PRIVACY ACT/PAPERWORK ACT NOTICE

We are authorized to collect the information under Sections 221(a) and (b) of the Social Security Act and Section 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 claimant's 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 30 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*