Social Security Administration

TITLE II Form Approved OMB No. 0960-0442

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

1. A. SOCIAL SECURITY NUMBER BIC

– –

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 ☐ DIB ☐ FZ ☐ DWB ☐ CDB ☐ ESRD ☐ HIB

1. C. OTHER ENTITLEMENT ☐ TITLE II ☐ TITLE XVI

2. A. NAME OF PAYEE (*IF ANY*)

3. WE'S NAME (IF CDB OR DWB CLAIM)

B. NAME OF DISABLED OR BLIND INDIVIDUAL

4. DATE OF BIRTH

5. DATE DISABILITY BEGAN

C. ADDRESS

6. DO ADDRESS

7.DO CODE DDS CODE

8. A. ☐ INITIAL B. ☐ RECON C. ☐ RECON DHU D. ☐ ALJ HEARING E. ☐ APPEALS COUNCIL F. ☐ U.S. DISTRICT COURT G. ☐ REOPENING

9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED: ☐ DISABILITY ☐ IMPAIRMENT SEVERITY (EPE MEDICAL REVIEW ONLY)

	A. CONTINUES	MONTH, DAY, YEAR
	B. CEASED	
	C. PERIOD OF DISABILITY TERMINATED AT THE CLOSE OF THE LAST DAY OF	
	D. EPE BEGIN MONTH	
	E. EPE REINSTATEMENT ALLOWED	
	F. EPE REINSTATEMENT DENIED	
	G. EPE SUSP. AFTER REINSTATEMENT	
	H. EPE BENEFIT TERMINATION MONTH	

	I. 301 CASE	
	J. BLINDNESS	
	(1)CONTINUES	MONTH, DAY, YEAR
	BEGAN	
	(a)DISABLED FOR CASH PURPOSES	
	(b)NOT DISABLED FOR CASH BENEFITS PURPOSES SINCE	
	(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 (Explain in item 24.)

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	B. 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 TYPE)

30.A. SPEC. CODE

31. SSA REPRESENTATIVE

32. SSA CODE

33. DATE

34. LIST NUMBER	A.	B.	C.	D.	E.	F.	35. FOLDER SENT TO

FORM **SSA-833-C3/U3** (5-1989) ef (3-2005) 3 Copies: (Folder, VR, State Agency/Data)

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 416.1615(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.

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 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401.***

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

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. **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 (TTY 1-800-325-0778).** *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.***