CONTINUING DISABILITY REVIEW REPORT
FORM SSA-454-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

We will use the information that you give us on this form to do your continuing disability review. We will use the form to update your disability information **since the date of your last medical disability decision**. Please complete as much of the form as you can. If you need help, your interviewer will help you finish it. If you have an appointment for an interview by telephone, have the form ready to discuss with us when we call you. If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.

Reminder: If you are filling out the form for someone else, please provide the information about him or her. When a question refers to "you," "your," or the "Disabled Person," it refers to the person who is receiving disability benefits.

HOW TO COMPLETE THIS FORM

- Print or write clearly.
- Unless otherwise indicated, **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 3, PUT INFORMATION FOR ONLY ONE DOCTOR/HMO/THERAPIST/OTHER/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THIS FORM.** However, you can get help from other people, like a friend or family member.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions, please use **SECTION 10 - REMARKS**, on Page 14, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records or copies of prescriptions at home, send them to our office with your completed form or, if you are having an interview in our office, bring them and any medicine containers with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information that we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of your medical sources, you may be able to get that information from the telephone book, medical bills, prescriptions, or prescription containers.

The Privacy Act

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d), and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your case. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your case. Although the information you furnish is almost never used for any purpose other than making a determination about your disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information about Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use information that 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.

The 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. 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 Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

AFTER COMPLETING THIS FORM, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0072

CONTINUING DISABILITY REVIEW REPORT

SSA will use this form to review your illnesses, injuries, or conditions since the date of your last medical disability decision.

For SSA Use Only
Do not write in this box.
Date of your last medical disability decision: _____

Related SSN _____ - _____ - _____ Number Holder _____

Type(s) of Case(s): (Check all that apply.)

TITLE II	☐ DIB	☐ DWB	☐ CDB	☐ FZ	☐ ESRD	☐ HIB
TITLE XVI	☐ DI	☐ DS	☐ DC	☐ BI	☐ BS	☐ BC

If you are <u>currently</u> participating in the Ticket to Work Program or working under a plan with a private or State Vocational Rehabilitation Agency, contact the Social Security Administration before completing this form.

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

1.A. NAME (first, middle, last)

1.B. SOCIAL SECURITY NUMBER
_____ - _____ - _____

1.C. DAYTIME PHONE NUMBER (If you do not have a phone number where we can reach you, give us a daytime phone number where we can leave a message.)

(_____) _____ - _____
(area code) (phone number)

☐ Your number
☐ Message number
☐ None

1.D. E-MAIL ADDRESS (optional)

1.E. Give the name of a friend or relative (other than your doctors) that we can contact who knows about your illnesses, injuries, or conditions, and can help you with your case.

NAME

RELATIONSHIP

ADDRESS (number, street, apt., PO Box, rural route)

CITY STATE ZIP _____ - _____

DAYTIME PHONE NUMBER
(_____) _____ - _____
(area code) (phone number)

1.F. Can you speak and understand English? ☐ YES ☐ NO

If "no," what is your preferred language? _____

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

If you cannot speak and understand English, is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO

If "yes," and this is the same person as in "1.E." above, write "SAME" below. If "yes," but this is a different person, complete the information below.)

NAME

RELATIONSHIP

ADDRESS (number, street, apt., PO Box, rural route)

CITY STATE ZIP _____ - _____

DAYTIME PHONE NUMBER
(_____) _____ - _____
(area code) (phone number)

1.G. If you are age 18 or older, can you read and understand English? ☐ YES ☐ NO

1.H. If you are age 18 or older, can you write more than your name in English? ☐ YES ☐ NO

1.I. What is your height without shoes?

1.J. What is your weight without shoes?

SECTION 2- INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

2.A. If you are an adult (age 18 or older), what are the disabling illnesses, injuries, or conditions that limit your ability to work? **If you are a child (under age 18)**, what are the disabling illnesses, injuries, or conditions that limit your ability to do the same things as other children of the same age?

2.B. Has there been a change (for better or worse) in your illnesses, injuries, or conditions listed in SECTION 2.A., **since the date of your last medical disability decision** (see date on top right side of Page 1)?

☐ YES (Describe specific changes below and give dates when these changes started.)

☐ NO

If you need more space, use SECTION 10 - REMARKS.

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS

3.A. Within the last 12 months, have you seen a doctor/hospital/clinic or anyone else for your illnesses, injuries, or conditions?

☐ YES ☐ NO

Do you have a **future appointment** with a doctor/hospital/clinic or anyone else for your illnesses, injuries, or conditions?

☐ YES ☐ NO

3.B. Within the last 12 months, have you seen a doctor/hospital/clinic or anyone else for emotional or mental problems?

☐ YES ☐ NO

Do you have a **future appointment** with a doctor/hospital/clinic or anyone else for emotional or mental problems?

☐ YES ☐ NO

If you answered "No" to both 3.A. and 3.B., do not complete the rest of SECTION 3; skip to SECTION 4.

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

3.C. List other names, if any, that you have used on your medical records **within the last 12 months**.

3.D. List each **DOCTOR/HMO/THERAPIST/OTHER PERSON** who has treated you **within the last 12 months.** Also, provide this information for any future appointment(s).

1. NAME			**DATES**
ADDRESS			First Visit **(within last 12 months)**
CITY	STATE	ZIP -	Last Visit
PHONE ( ) - (area code) (phone number)	PATIENT ID# (if known)		Next Appointment
Reasons for visits	What treatment was received?		

2. NAME			**DATES**
ADDRESS			First Visit **(within last 12 months)**
CITY	STATE	ZIP -	Last Visit
PHONE ( ) - (area code) (phone number)	PATIENT ID# (if known)		Next Appointment
Reasons for visits	What treatment was received?		

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

DOCTOR/HMO/THERAPIST/OTHER

3. NAME			**DATES**
ADDRESS			First Visit **(within last 12 months)**
CITY	STATE	ZIP -	Last Visit
PHONE ( ) - (area code) (phone number)	PATIENT ID# (if known)		Next Appointment
Reasons for visits	What treatment was received?		

If you need more space, use SECTION 10 - REMARKS.

3.E. List each **HOSPITAL/CLINIC** where you received treatment **within the last 12 months**. Also, provide this information for any future appointment(s).

1. NAME			PHONE ( ) - (area code) (phone number)	
ADDRESS			PATIENT ID # (if known)	NEXT APPOINTMENT
CITY	STATE	ZIP -	What doctor(s) do you regularly see here?	

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

HOSPITAL/CLINIC

2. NAME			PHONE ( ) - (area code) (phone number)
ADDRESS			PATIENT ID # (if known) / NEXT APPOINTMENT
CITY	STATE	ZIP -	What doctor(s) do you regularly see here?

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

3. NAME			PHONE ( ) - (area code) (phone number)
ADDRESS			PATIENT ID # (if known) / NEXT APPOINTMENT
CITY	STATE	ZIP -	What doctor(s) do you regularly see here?

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

If you need more space, use SECTION 10 - REMARKS.

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

If you are under age 18, do not complete question 3.F. or SECTION 4; skip to SECTION 5 - TESTS.

3.F. Does anyone else (for example, Workers' Compensation, insurance company, prisons, attorneys, or welfare agency) have medical records or information about your illnesses, injuries, or conditions, **within the last 12 months**? Also, provide this information if you are scheduled to see anyone in the future.

☐ YES (Complete the following information.) ☐ NO (Skip to SECTION 4.)

NAME			**DATES**
ADDRESS			FIRST VISIT **(within the last 12 months)**
CITY	STATE	ZIP -	LAST VISIT
PHONE ( ) - (area code) (phone number)			NEXT APPOINTMENT
CLAIM NUMBER (if any)			NAME OF CONTACT PERSON
REASONS FOR VISITS			

If you need more space, use SECTION 10 - REMARKS.

SECTION 4 - MEDICATIONS

Are you taking any medications for your illnesses, injuries, or conditions?

☐ YES (Complete the following information. Look at your medicine containers, if necessary.)

☐ NO (Skip to SECTION 5.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	ANY SIDE EFFECTS YOU HAVE

If you need more space, use SECTION 10 - REMARKS.

SECTION 5 - TESTS

Within the last 12 months, have you had any of the following tests for your illnesses, injuries, or conditions? Also, provide this information if you are scheduled for tests in the future.

☐ YES (Complete the following information, give approximate dates, if necessary.)

☐ NO (Skip to SECTION 6.)

KIND OF TEST	WHEN WAS/ WILL TEST BE DONE? (month, day, year)	WHERE DONE? (name of facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY - Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY -- Name of body part _____			
MRI/CT SCAN -- Name of body part _____			

If you need more space, use SECTION 10 - REMARKS.

SECTION 6 - EDUCATION/TRAINING INFORMATION

Complete SECTION 6 if you are age 18 years old or older.

6.A. Check the highest grade of school completed.

School:

None ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐

College:

1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Approximate date completed: _____

6.B. Since the date of your last medical disability decision (see date on top right side of Page 1), have you completed or will you complete any type of special job training, trade or vocational school?

☐ YES (Complete the following information.) ☐ NO

NAME OF SCHOOL

ADDRESS			PHONE
CITY	STATE	ZIP -	( ) - (area code) (phone number)

TYPE OF PROGRAM

APPROXIMATE DATE COMPLETED (or will complete)

If you need more space, use SECTION 10 - REMARKS.

SECTION 7 - UPDATED WORK INFORMATION

If you are under age 14, skip to SECTION 10 - REMARKS.

If you are age 14 or older, complete SECTION 7.A., and as appropriate, B., C., and D. only. Then skip to SECTION 10 - REMARKS.

If you are age 16 or older, complete all of SECTION 7.

7.A. ARE YOU WORKING NOW?

- ☐ **Full-time** (Skip to Question 7.D.)
- ☐ **Part-time** (Skip to Question 7.D.)
- ☐ **Not working now** (Continue to Question 7.B.)

7.B. If you are not working now, did you work **since the date of your last medical disability decision** (see date on top right side of Page 1).

- ☐ YES (Go to Question 7.C.)
- ☐ NO (Skip to Question 7.E.)

7.C. If you are not working now, do you believe that your medical condition has improved?

- ☐ YES
- ☐ NO

7.D. If you have worked at any time **since the date of your last medical disability decision** (see date on top right side of Page 1), complete the following information for each job you have done. List the most recent job first.

		JOB 1	JOB 2	JOB 3
JOB TITLE (example: cook)				
TYPE OF BUSINESS (example: restaurant)				
JOB DESCRIPTION				
DATES WORKED (month and year)	FROM:			
	TO:			
HOURS PER DAY				
DAYS PER WEEK				
RATE OF PAY (per hour, day, week, month, or year)				
REASON YOU STOPPED WORK				

If you need more space, use SECTION 10 - REMARKS.

SECTION 7 - UPDATED WORK INFORMATION, continued

7.E. If you are not working, do you believe that you are able to work?

- ☐ No, I don't believe that I am able to work at this time.
- ☐ Yes, and I believe that I do **not** have limitations or restrictions on my ability to work.
- ☐ Yes, but I believe that I have limitations or restrictions on my ability to work. (Please explain.)

7.F. Has your doctor(s) told you that you are able to work?

- ☐ No (Skip to Section 8.)
- ☐ Did not say (Skip to Section 8.)
- ☐ Yes, and my doctor(s) did **not** place limitations or restrictions on my ability to work.
- ☐ Yes, but my doctor(s) placed limitations or restrictions on my ability to work. (Please explain. If the same as 7.E., write "same" here.)

7.G. What is the name(s) of the doctor(s) who said you were able to work?	**7.H.** According to your doctor, when were/are you able to begin work?
(Please make sure that this doctor(s) is listed in SECTION 3.)	

If you need more space, use SECTION 10 - REMARKS.

SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Complete SECTION 8 if you are age 18 years old or older.

8.A. Since the date of your last medical disability decision (see date on top right side of Page 1), have you participated, or are you participating, in the **Ticket to Work Program**, a plan with a private or State Vocational Rehabilitation Services, an employment network, or any other support services to help you go to work? ☐ YES (Complete the following information.) ☐ NO (Skip to SECTION 9.)

NAME OF ORGANIZATION

NAME OF COUNSELOR

ADDRESS			PHONE
CITY	STATE	ZIP -	( ) - (area code) (phone number)

8.B. When did you start participating in the plan?

8.C. Are you still participating in the plan?

☐ YES

☐ NO. I completed the plan _____
(date completed)

☐ NO. I stopped participating in the plan before completing it. (Please explain why you are no longer participating.)

8.D. Types of services or tests provided (for example: intelligence or psychological testing, vision, physicals, hearing, workshops, schools, colleges):

If you need more space, use SECTION 10 - REMARKS.

SECTION 9 - INFORMATION ABOUT YOUR DAILY ACTIVITIES

Complete SECTION 9 if you are age 18 years old or older.

9.A. Describe what you do in a typical day.

SECTION 9 - INFORMATION ABOUT YOUR DAILY ACTIVITIES, continued	
9.B. Do you have difficulty doing any of the following? (Please explain any "Yes" answers.)	
Dressing	☐ No ☐ Yes
Bathing	☐ No ☐ Yes
Caring for hair	☐ No ☐ Yes
Taking medicine	☐ No ☐ Yes
Preparing meals	☐ No ☐ Yes
Feeding self	☐ No ☐ Yes
Doing chores (inside/outside house)	☐ No ☐ Yes
Driving or using public transportation	☐ No ☐ Yes
Shopping	☐ No ☐ Yes
Managing money	☐ No ☐ Yes
Walking	☐ No ☐ Yes
Standing	☐ No ☐ Yes
Lifting objects	☐ No ☐ Yes
Using arms	☐ No ☐ Yes
Using hands or fingers	☐ No ☐ Yes
Sitting	☐ No ☐ Yes
Seeing, hearing, or speaking	☐ No ☐ Yes

SECTION 9 - INFORMATION ABOUT YOUR DAILY ACTIVITIES, continued

9.B. (continued) Do you have difficulty doing any of the following? (Please explain any "Yes" answers.)

Concentrating	☐ No	☐ Yes
Remembering	☐ No	☐ Yes
Understanding/following directions	☐ No	☐ Yes
Completing tasks	☐ No	☐ Yes
Getting along with people	☐ No	☐ Yes

9.C. Do you use an assistive device (for example: eye glasses, hearing aids, braces, canes, crutch(es), walker, wheelchair)?

☐ NO

☐ YES (Please describe what kind, when and how you use it.)

9.D. Do you have hobbies or interests?

☐ NO

☐ YES (Please describe what they are and how much time you spend doing them.)

If you need more space, use SECTION 10 - REMARKS.

SECTION 10 - REMARKS

Please provide any additional information you did not show in earlier parts of this form. You may also attach any medical records, copies of prescriptions, or any other records about your current illnesses, injuries, or conditions you have at home that you wish to give us. When you are finished, or if you don't have anything to add, be sure to complete the information below.

Date Form Completed (month, day, year)

If the person completing this form is NOT the disabled person, please complete the following information.

Name (please print)

Address (number and street)			**E-mail address** (optional)
City	**State**	**ZIP** -	**Relationship to disabled person**