M. A.M.

CONTINUING DISABILITY REVIEW REPORT SSA-454-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that reviews your medical condition will use the information in this report. The information will help that office decide whether you are still disabled. Please complete as much of the report as you can.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. Please do **not** ask your health care provider to complete this report. If you cannot complete the report, a Social Security Representative will assist you. If you have an appointment, please have the completed report ready when we contact you.

Note: If you are assisting someone else with this report, please answer the questions as if that person were completing the report.

HOW TO COMPLETE THIS REPORT

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers including area code. If a phone number is outside the United States, also provide international direct dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may
 be able to get that information from the telephone book, Internet, medical bills,
 prescriptions, or prescription medicine containers.
- ANSWER EVERY QUESTION, unless the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- 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 question, please use Section 11 Remarks, on the last page to finish your answer. Write the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any of your medical records covering the last 12 months, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and the completed report with 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 request your records. The information that you give us on this report tells us where to request your medical and other records.

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to make a decision on the named claimant's claim. Your response is voluntary. However, failure to provide all or part of the requested information could prevent an accurate and timely decision on the named claimant's claim.

We rarely use this information provided on this form for any other purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

- 1. To enable a third party or an 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 from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs);
- 3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
- 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use this information you provided in computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Records Notice 60-0089. The notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security Office.

The Paperwork Reduction Act

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. 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 report.

SEND OR BRING THE COMPLETED REPORT TO YOUR LOCAL SOCIAL SECURITY OFFICE, THE NEAREST U.S EMBASSY OR CONSULATE OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778) for the address.

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

Social Security Administration			Form Approved OMB I	No. 0960-0072
	ING DISABI	LITY REVIE	W REPORT	
For SSA Use Only - Do not w				is needed.
Related SSN		Number Holder		ris dist
				2.75
Type(s) of Cases(s) Title II	DIB D	kan alikati daket	☐ FZ ☐ ESRD ☐] HIB
(Check all that apply.) Title XVI	ם וס ם	s DDC	□ BI □ BS	J BC
DATE OF THE LAST MEDICAL DI	SABILITY DECISION)N≯		
If you are filling out this report fo question refers to "you," "your," or the	ne "disabled person,	" it refers to the per	rson receiving disability be	
1. A Name (First, Middle Initial, Las	Carrows and the comment of the comme	ADOUT THE DISABLE	1. B Social Security N	umber
i. A Name (First, Middle Initial, Las	.,		1. B Social Secondy IV	umber
1. C Mailing Address (Street or P O	Box) Include apart	ment number if app	i olicable	
City	State/Province	ZIP/Postal Code	Country (if not USA)	
D Daytime Phone Number, included Canada. Phone number □ Check this box if you do not	have a phone or a r	 number where we c	an leave a message.	
1. E. Alternate Phone Number – and	other number where	we may reach you	ı, if any	
Alternate phone number			(\mathbf{y})	
1. F Can you speak and understand	d English? Ye	s No		***************************************
if no, what language do you pre	efer?			
If you cannot speak and unders	stand English, we w			
1. G Have you used any other name	-		rds in the last 12 months?	' Examples
are maiden name, other married na If yes, please list them here	me, or nickname.	Yes No		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Give the name of someone (other	CONTRACTOR OF THE PARTY OF THE	2 - Contacts	who knows about your me	edical
conditions, and can help you with y		s) we can contact	who knows about your mi	Sulcai
2. A Name (First, Middle Initial, Last)			2. B Relationship to Disa	bled Person
2 C Mailing Address (Street or D.O.	Pay) Include cont	l l	I a h l a	
2. C Mailing Address (Street or P O		ment number ii app	licable.	1 11 1 m 41 4 15 19 1
City	State/Province 2	ZIP/Postal Code	Country (if not USA)	and the second
2. D Daytime Phone Number (as de	escribed in 1.E abov	re)		
2. E Can this person speak and und	derstand English?	Yes No		1.1.1

- franklig

If no, what language is preferred?

AMAZ CO.	ection 2 – Contacts (co	itmu ed)	
2. F Who is completing this report? ☐ The disabled person listed in	1 Δ		
☐ The person listed in 2.A	•		
Someone else (Complete the	rest of Section 2 below)	2 U Poletionship	to Disabled Person
2. G Name (First, Middle Initial, Last)		Z. H Relationship	to Disabled Person
2. I Daytime Phone Number			
2. J Mailing Address (Street or P O Box)	Include apartment numbe	er if applicable.	
City	State/Province	ZIP/Postal Code	Country (if not USA)
ii s	ection 3 – Medical Cond	lition(s)	
3. A If you are an adult (age 18 or older	r), list the physical and/or	mental condition(s	
learning problems) that limit your ability to list the physical and/or mental condition(s do the same things as other children of th) (including emotional or	learning problems)	that limit the child's ability to
1.			
2.			
3.	***************************************		
4.	***************************************		*
5.		20)	
If you need more	space, go to Section 1	I – Remarks on pa	ge 12
3. B What is your height without shoes?	feet inches	ORcentimeters	(if outside USA)
3. C What is your weight without shoes?	pounds	OR kilograms (if	outside USA)
4. Since the date of your last medical of	Section 4 - Work plete only if you are age disability decision have	14 or older	date at top of Page 1)
☐ Yes (If yes, we may contact you for	or additional information)		、一分・エル代表はA. 関係・パ
□No			A MAN
Within the last 12 months, have you see	Section 5 – Medical Tre en a doctor or other healt		or received treatment at a
hospital or clinic, or do you have a future			
5. A For any physical condition(s)			
☐ Yes			
□ No			
5. B For any mental condition(s) (includ	ling emotional or learni	ng problems)	
☐ Yes			
□ No			1441

If you answered "No" to both 5. A and 5. B go to Section 6 Other Medical Information on page 9

. 5 – Med		

5. C Tell us who may have medical records covering the last 12 months about any of your physical or mental condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

nave one scheduled.	
Name of Facility or Office	Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	ikrakon miliku maga erre erre erre erre erre erre erre e	Patient ID# (if	known)					
Mailing Address	aghayaghir rayyayayaaaaaaaaaaaaaaaaaaaaaaaaaaaaa							
City	State/Province	ZIP/Postal Code	Country (if not U	JSA)				
Dates of Treatment (within the last 12	! months)		hby					
1. Office, Clinic or Outpatient visits	2. Emergency		3. Overnight hos	spital stays				
First Visit	List the most re		A. Date in	Date out				
Last Visit	В		B. Date in					
Next scheduled appointment	C		C. Date in	Date out				
(if any)								
What medical conditions were treate	ed or evaluated	?						
			\sim					
				1				
What treatment did you receive for t	he above condi	tions? (Do not de	scribe medicines or	tests in this box.)				
		NO .						
Check the boxes below for any tests the scheduled you to take. Please give the								
11 - Remarks on the last page.			you need to list mor	c toolo, doo ocollon				
☐ Check this box if no tests by this	s provider or at	this facility.		·				
Kind of Test	Dates of Tests	King	l of Test	Dates of Tests				
☐ EKG (heart test)	Dates of Tests	☐ EEG (brain		Dates of Tools				
☐ Treadmill (exercise test)		☐ HIV Test		350000000000000000000000000000000000000				
☐ Cardiac Catheterization		☐ Blood Test	(not HIV)					
☐ Biopsy (list body part)		☐ X-Ray (list	body part)	17.44.00				
		THE LIGHT OF	(P-1111)	1.3.7				
☐ Hearing Test		│	an (list body part)					
□ Speech/Language Test				***				
☐ Vision Test		☐ Other (plea	se describe)					
☐ Breathing Test								

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 9.

823	822	822	833	800	200	333	198	982	800	2.8	5.77.2.2.50	322	720	983	210	220	77	922	m	2011		833	88		m	222	888	ಜಜ	***	***	****		333	200		322	300	ssa
3.9	72	42	30	2.35	323	973	999	200	ж.	- XX	ł	10	210	V.	93	7000	$m_{\rm c}$	884	Sa:		w_{ij}	emin.	2.5	i de la comp	100	888	989	ęς		9000	9000	966	ęα	689	ulla	893	Sec.	Αŭ.
Sώ	a.		о.	10.	2.5	f as	3.4	5883		german.	880		- 5	*	88	20.0	-	200	un e	m	40	200	23	3 8	αŝ	٠.		2.3	858	133	6 86	18	6.5	-81	3.4	22.5		28
gē.	×	ж.		100	2 %	5 20	8.8	1222	ur.	mms	88 S	1 %	-		86	200	-	8.8	200	88 1	6.2	14.4		:8:	23	. * 3	8.8.	2.3	C 8880	6. T.	8.70	2.65.	SO.	20	8.8	200	600	80

5. D Tell us who may have medical records covering the last 12 months about any of your physical or mental condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

Name of Facility or Office	Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number		Patient ID# (if	known)	ya							
Mailing Address				A A A A A A A A A A A A A A A A A A A							
-											
City	State/Province	ZIP/Postal Code	Country (if not l	JSA)							
Dates of Treatment (within the last 12	? months)										
1. Office, Clinic or Outpatient visits	2. Emergency	Room visits	3. Overnight hos	pital stays							
First Visit	List the most re		A. Date in	Data out							
Last Visit	A B		B. Date in								
Next scheduled appointment	C		C Date in	Date out							
(if any)	O	***	C. Date in	Date out							
What medical conditions were treate	ed or evaluated?	•									
			O								
and the second of the second o											
What treatment did you receive for t	the above condi	tions? (Do not de	scribe medicines or	tests in this box.)							
Check the boxes below for any tests the scheduled you to take. Please give the											
11 - Remarks on the last page.			,								
☐ Check this box if no tests by thi											
Kind of Test	Dates of Tests		d of Test	Dates of Tests							
☐ EKG (heart test)		☐ EEG (brain	wave test)								
☐ Treadmill (exercise test)		☐ HIV Test									
☐ Cardiac Catheterization		☐ Blood Test	(not HIV)								
☐ Biopsy (list body part)		☐ X-Ray (list	body part)	edus (Called Andrews)							
☐ Hearing Test		☐ MRI/CT Sc	an (list body part)								
☐ Speech/Language Test											
☐ Vision Test		☐ Other (plea	se describe)								
☐ Breathing Test											

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 9.

	15— A				

5. E Tell us who may have medical records covering the last 12 months about any of your physical or mental condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

nave one sorication.	
Name of Facility or Office	Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

				manna dikiran ka na mangga na kakanan na manga na ka na
Phone Number		Patient ID# (if	known)	,
Mailing Address				
City	State/Province	ZIP/Postal Code	Country (if not	USA)
Dates of Treatment (within the last 12	2 months)			
1. Office, Clinic or Outpatient visits	2. Emergency		3. Overnight hos	pital stays
First Visit	List the most re		A. Date in	Date out
Last Visit	В.			_ Date out
Next scheduled appointment	C			Date out
(if any)	<u> </u>			- Togath
What medical conditions were treat	ed or evaluated?)		The second of th
			O_{I}	
				e Biren Vince
What treatment did you receive for	the above condi	tions? (Do not de	scribe medicines or	tests in this box.)
Check the boxes below for any tests the scheduled you to take. Please give the				
11 - Remarks on the last page.			you need to list mo	re lesis, use section
☐ Check this box if no tests by thi	s provider or at	this facility.		`#
Kind of Test	Dates of Tests		of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain	wave test)	
☐ Treadmill (exercise test)		☐ HIV Test		
☐ Cardiac Catheterization		☐ Blood Test	(not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list	body part)	* * * * * * * * * * * * * * * * * * *
☐ Hearing Test		I MADI/CT Co	an (list body part)	Say Subject Stand in the Stand
☐ Speech/Language Test		U WIKI/CI SC	an (list body part)	
Ţ Ţ Ţ	100000000000000000000000000000000000000			
☐ Vision Test		☐ Other (plea	ise describe)	
☐ Breathing Test				

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 9.

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Section 5 - I		

5. F Tell us who may have medical records covering the last 12 months about any of your physical or mental condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

Name of Facility or Office

Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number		Patient ID# (if	known)						
Mailing Address			tunillihubakaa aanaa aanaa ha						
City	State/Province	ZIP/Postal Code	Country (if not	USA)					
Dates of Treatment (within the last	12 months)	<u></u>							
1. Office, Clinic or Outpatient visits			3. Overnight hos	spital stays					
First Visit	List the most re		A. Date in Date out						
Last Visit	A B			_ Date out					
Next scheduled appointment	C		}	_ Date out					
(if any)	<u> </u>		o. Date iii	Dato odje <u></u>					
What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.) Check the boxes below for any tests this provider performed or sent you to within the last 12 months, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.									
Kind of Test	Dates of Tests	Kind	of Test	Dates of Tests					
☐ EKG (heart test)		☐ EEG (brain	wave test)						
☐ Treadmill (exercise test)		☐ HIV Test							
□ Cardiac Catheterization		☐ Blood Test	(not HIV)						
☐ Biopsy (list body part)		□ X-Ray (list	body part)						
☐ Hearing Test	411111111	☐ MRI/CT So	an (list body part)						
☐ Speech/Language Test									
☐ Vision Test		☐ Other (plea	se describe)						
☐ Breathing Test				Acceptable					

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 9.

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	C																			

5. G Tell us who may have medical records covering the last 12 months about any of your physical or mental condition(s) (including emotional or learning problems) that. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

Name of Facility or Office

Name of healthcare professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARD PROVIDER ABOVE.

Phone Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Patient ID# (if	known)	A STATE OF THE STA					
Mailing Address	AND THE PROPERTY OF THE PROPER								
City	State/Province	ZIP/Postal Code	Country (if not	USA)					
Dates of Treatment (within the last 12	2 months)								
1. Office, Clinic or Outpatient visits	2. Emergency		3. Overnight ho	espital stays					
First Visit	List the most re		A. Date in	_ Date out					
Last Visit	В			Date out					
Next scheduled appointment	C			Date out					
(if any)	<u> </u>			rei or mental					
Check the boxes below for any tests this provider performed or sent you to within the last 12 months, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page. Check this box if no tests by this provider or at this facility.									
Kind of Test	Dates of Tests	Kind	d of Test	Dates of Tests					
☐ EKG (heart test)		☐ EEG (brain	wave test)						
☐ Treadmill (exercise test)		☐ HIV Test							
☐ Cardiac Catheterization		☐ Blood Test	(not HIV)						
☐ Biopsy (list body part)		□ X-Ray (list	body part)						
☐ Hearing Test		☐ MRI/CT So	an (list body part)						
☐ Speech/Language Test				+ 2 + 1775 + 1781 + 2 + 1781 + 1881					
□ Vision Test	•	☐ Other (plea	ase describe)						
☐ Breathing Test	111111111111111111111111111111111111111			المنابع ويرش					

If you have been treated by more than five doctors or hospitals, use Section 11 – Remarks on the last page and give the same detailed information as above for each healthcare provider.

If you are UNDER AGE 18, skip to Section 12 – Additional Information

		Medical Information u are age 18 or olde	
6. Does anyone else have medical in and learning problems) covering the include places such as workers' comp disability benefits, prisons, attorneys,	formation about you last 12 months, o bensation, vocation	our physical or mental or are you scheduled al rehabilitation, insul	condition(s) (including emotional to see anyone else? (This may
☐ Yes (Please complete	e information belov	w.)	
□ No (Go to Section 7	7)		
Name of Organization		Phone Num	ber
Mailing Address			
City	State/Province	ZIP/Postal Code	Country (if not USA)
Name of Contact Person	1	Claim or ID Numbe	er (if any)
Date First Contact (in last 12 months)	Date Last Contac	et (in last 12 months)	Date Next Contact (if any)
Reasons for Contacts	The state of the s		,
If you need to list other people or same deta		e Section 11 – Rema s above for each on	
7. Are you now taking, or have you ta medicines?	v (4) (1) (1)	– Medicines months, any prescrip	otion or non-prescription
U Van (Cananiata tha fall			
Li Yes (Complete the foil	owing information.	Look at your medicing	ne containers, if necessary.)
☐ No (Go to Section 8)			ne containers, if necessary.)
		Look at your medicing	ne containers, if necessary.) Reason for medicine
☐ No (Go to Section 8)			
☐ No (Go to Section 8)			
☐ No (Go to Section 8)			
☐ No (Go to Section 8)			
☐ No (Go to Section 8)			
☐ No (Go to Section 8)			
☐ No (Go to Section 8)			
☐ No (Go to Section 8)			

	plete only if you	tion and Training are age 18 or olde dical disability decis		f Page 1.)		
☐ Yes,						
☐ No, go to question 8.	B below					
If Yes, What year did you last attend Please describe the education you re	any school?			-		
8. B Have you received any type of spec (See date at top of Page 1)	cialized job, trade	, or vocational traini	ng since your last disab	ility decision?		
☐ Yes,				Old Bright State Control		
☐ No, go to Section 9 b	elow			A A		
Name of Training Facility	***************************************	Phone				
Mailing Address		4	N. A. 1999 (M. A. 1941)			
City	State/Province	ZIP/Postal Code	Country (if not USA)		
Type of Program		Date Completed (or scheduled to be completed)				
Section 9 – Vocational I	Rehabilitation, Explete only if you cal disability december of the employment network of the employment with a voc (PASS); ogram (IEP) through all rehabilitation, or emation)	are age 18 or older isision (see date at to work under the Ticker ational rehabilitation agh a school (if a stu	ner Support Services op of page 1) have you et to Work Program; n agency or any other o dent age 18 – 21); or es, or other support serv	rganization;		
Mailing Address				in the state of th		
•						
City	State/Province	ZIP/Postal Code	Country (if not USA)			
9 C When did you start participating in t	h	m2				

Section 9 – Vocational Rehabilitation, Employment, or Other Support Services (Complete if you are age 18 or older	santinued)
9. D Are you still participating in the plan or program?	
☐ Yes. I am scheduled to complete the plan or program on:	
(Date to be Completed)	
□ No. I completed the plan or program on:	•
(Date Completed)	
☐ No. I stopped participating in the plan or program before completing it because:	
9. E What types of services, tests, or evaluations were provided (for example, intelligence or ps	sychological
testing, vision or hearing test, physical exam, work evaluations, or classes)?	
If you need to list another plan or program use Section 11 – Remarks on the last page a detailed information as above	and give the same
Section 10 - Daily Activities	
Complete only if you are age 18 or older 10. A Describe what you do in a typical day (for example: I get up around 7A.M., take a shower	r. eat breakfast.
etc.).	
	1
If you need more space, go to Section 11 – Remarks on the last page	200 000 000 000 000 000 000 000 000 000
10. B Do you use an assistive device (for example: eye glasses, hearing aids, braces, canes, owheelchair, service animal)?	crutch(es), walker,
☐ Always ☐ Sometimes ☐ Never	
If ALWAYS or SOMETIMES, please describe what kind, when, and how you use it.	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	i durie
	* . 47 . 1
If you need more space, use Section 11 – Remarks on the last page	
10. C Do you have hobbies or interests? ☐ Yes ☐ No	A CONTRACTOR OF THE CONTRACTOR
If YES, please describe what they are and how much time you spend doing them.	
If you need more space, use Section 11 – Remarks on the last page	

- **10** -

FORM SSA 454-BK Paper v 18 06/09/09

	S C	ection 10 omplete o	– Daily Activities, continued nly if you are age 18 or older
10. D Do you ever have dif Please explain any "\	ficulty doing	g any of th	e following? ▼
Dressing	☐ Yes	□ No	
Bathing	☐ Yes	[™] □ No	
Caring for hair	☐ Yes	□ No	
Taking medicines	☐ Yes	□No	
Preparing meals	☐ Yes	□ No	
Feeding self	☐ Yes	□ No	
Doing Chores (inside/outside house)	☐ Yes	□ No	
Driving or using public transportation	☐ Yes	□ No	
Shopping	☐ Yes	□ No	
Managing money	☐ Yes	□ No	
Walking	□ Yes	□ No	
Standing	☐ Yes	□ No	6
Lifting Objects	☐ Yes	□ No	
Using arms	☐ Yes	□No	
Using hands or fingers	☐ Yes	□ No	
Sitting	☐ Yes	□No	
Seeing, hearing, or speaking	☐ Yes	□No	
Concentrating	☐ Yes	□No	
Remembering	□ Yes	□ No	
Understanding or following directions	☐ Yes	□No	
Completing tasks	☐ Yes	□No	
Getting along with people	☐ Yes	□ No	

	1 – Remarks
Please write any additional information you did not give	in earlier parts of this report. If you did not have enough
space in the sections of this report to write the requeste	ed information, please use this space to tell us the
additional information requested in those sections. Be	sure to show the section to which you are referring.
)
На выполнение принципарного принципарного принципарного пределение выполнение выполнение выполнение выполнение	
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