CONTINUING DISABILITY REVIEW REPORT
SSA-454-ICR

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 this report as you can. We will contact you if we need more information.

HOW TO COMPLETE THIS REPORT

- Print your answers with a black ink pen.
- If you are assisting someone else, please answer the questions as if that person were completing the report.
- Print only one letter or number in each box. Leave an empty box between words.
  Example:

C	O	N	T	I	N	U	I	N	G		D	I	S	A	B	I	L	I	T	Y		R	E	P	O	R	T

- Print dates like this: Month/Day/Year. For example, you would print November 10, 2010, like this: 11/10/2010

1	1	/	1	0	/	2	0	1	0

- Answer "Yes" or "No" questions by marking an "X" inside the "Yes" or "No" boxes.

  Example: Yes [X] Yes
  [ ] No

- Provide complete phone numbers including area code.
  Example: 410 - 555 - 1212

4	1	0	-	5	5	5	-	1	2	1	2

- If you cannot remember the names of your health care providers, you may be able to get that information from appointment reminders, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION,** unless the report indicates otherwise. If you need more space to answer any question, please use Section 8 - Remarks, on the last page to finish your answer. Write the number of the question you are answering.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS. The information you give us on this report tells us where to request your medical and other records. With your permission, we will request your records.

See Revised Privacy Act Attached

The Privacy Act

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. While giving us the information on this report is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. We generally use the information you supply for the purpose of making decisions regarding claims. 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 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); (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 the information you provide 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 or administered benefit programs and for repayment of payments or delinquent debts under these programs.

See Revised PRA Attached

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.***

MAIL THE COMPLETED REPORT IN THE ENCLOSED ENVELOPE OR TAKE IT TO YOUR LOCAL SOCIAL SECURITY OFFICE, THE NEAREST U.S EMBASSY OR CONSULATE OFFICE. Office addresses are 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.


Social Security Administration

Form Approved
OMB No. 0960-0072

CONTINUING DISABILITY REVIEW REPORT

SSA will use this form to review your medical condition(s) since the date of your last medical disability decision.

For SSA Use Only - Do not write in this box. WBDOC: Exc 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Name: _____ Own SSN: _____

Claim Number: _____ Selection date: _____

Date of your last medical disability decision: _____

0001023703043705060708000102370304370506070810101010600 12
1011121301234567890123456789001234567890123456789200901 01
2010202801232828103745437181227200909 17

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Are you **currently** participating in the Ticket to Work Program or working under a plan with a private or state vocational rehabilitation agency?

☐ Yes - **STOP** - Call the Social Security office at _____ ☐ No

1.B. **Current Mailing Address (disabled person or representative payee)**

1.C. Has the mailing address changed? ☐ Yes, add corrections below. ☐ No, go to **1.D.**

Mailing Address (number, street, apartment, P.O. box, rural route, city, state, ZIP code):

1.D. **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.)

Telephone Number:

☐☐☐ - ☐☐☐ - ☐☐☐☐ ☐ None, go to **1.F.**

(area code) (phone number)

1.E. **ALTERNATE PHONE NUMBER**

Telephone Number:

☐☐☐ - ☐☐☐ - ☐☐☐☐

(area code) (phone number)

1.F. Has your name changed or have you used any other names in the **last 12 months** on your medical or education records? ☐ Yes ☐ No

If yes, add other names used to **Section 8 - Remarks**

SECTION 2 - MEDICAL CONDITIONS

2.A. **If you are an adult (age 18 or older)**, list all of the physical and/or mental conditions that limit your ability to work. **If you are completing this form for a child (under age 18),** list all of the physical and/or mental conditions that limit the child's ability to do the same things as other children of the same age. **List each physical and/or mental condition (including emotional or learning problems) separately.**

1.

2.

3.

4.

5.

6.

7.

2.B. Do you have more than 7 medical conditions? ☐ Yes ☐ No

If yes, add the additional conditions to **Section 8 - Remarks**

SECTION 3 - MEDICAL RECORDS

3.A. Have you seen a doctor or other health care professional or received treatment at a hospital or clinic in the **last 12 months**, or do you have a future appointment scheduled for:

Any **physical** condition(s)? ☐ Yes ☐ No

Any **mental** condition(s) (including emotional or learning problems)? ☐ Yes ☐ No

If you answered **"No"** to both questions in **3.A,** go to **3.D.**

3.B. Tell us who may have medical records covering the **last 12 months** about any of your physical or mental condition(s). This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities.

(1) Name of Hospital, Clinic, Doctor or other Health Care Professional:

Telephone Number: ___ - ___ - ____ (area code) (phone number)

City:

State:

(2) Name of Hospital, Clinic, Doctor or other Health Care Professional:

Telephone Number: ( ) - - City: State:

(area code) (phone number)

(3) Name of Hospital, Clinic, Doctor or other Health Care Professional:

Telephone Number: ( ) - - City: State:

(area code) (phone number)

(4) Name of Hospital, Clinic, Doctor or other Health Care Professional:

Telephone Number: ( ) - - City: State:

(area code) (phone number)

(5) Name of Hospital, Clinic, Doctor or other Health Care Professional:

Telephone Number: ( ) - - City: State:

(area code) (phone number)

3.C.	Have you seen more than 5 medical providers in the **last 12 months**? If yes, someone will contact you for the additional information.	☐ Yes	☐ No
3.D.	Does anyone else have medical information about your condition(s) covering the **last 12 months**, or are you scheduled to see anyone else? (This includes workers' compensation, insurance companies who have paid you disability benefits, prisons, attorneys, and welfare.) If yes, someone will contact you for the additional information.	☐ Yes	☐ No

SECTION 4 - WORK, EDUCATION AND TRAINING
Complete this section only if you are 18 or older

4.A.	Since have you worked?	☐ Yes	☐ No
4.B.	Since have you received any education?	☐ Yes, go to **4.C.**	☐ No, go to **4.D.**
4.C.	If you answered **Yes** in **4.B**, what year did you last attend any school? (for example: 2010)	Y Y Y Y	
4.D.	Since have you received any type of specialized job, trade or vocational training?	☐ Yes	☐ No

SECTION 5 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES
Complete this section only if you are 18 or older

5. Since , have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support (PASS);
- an Individualized Education Program (IEP) through an educational institution (if a student age18-21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work? ☐ Yes ☐ No

SECTION 6 - TESTS AND MEDICINES

6.A. Have you had any medical tests in the **last 12 months**, or do you have any tests scheduled for your condition? If yes, someone will contact you for the information. ☐ Yes ☐ No

6.B. Are you now taking, or have you taken in the **last 12 months**, any prescription or non-prescription medicines? ☐ Yes, go to **6.C.** ☐ No, go to **7.A.**

6.C. List your medicines below. Look at your medicine containers, if necessary.

1.

2.

3.

4.

5.

6.

7.

6.D. Are you taking more than 7 medicines?
If yes, add them to **Section 8 - Remarks** ☐ Yes ☐ No

SECTION 7 - DAILY ACTIVITIES

7.A. Describe what you do in a typical day (for example: I get up around 7 a.m., take a shower, eat breakfast, check emails)

Use **Section 8 - Remarks** if more space is needed


7.B.	Do you have difficulty doing any of the following?		Explain **"Yes"** answers here. ▼
Dressing	☐ Yes	☐ No	
Bathing	☐ Yes	☐ No	
Caring for hair	☐ Yes	☐ No	
Taking medicine	☐ 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	
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/following directions	☐ Yes	☐ No	
Completing tasks	☐ Yes	☐ No	
Getting along with people	☐ Yes	☐ No	

7.C.	Do you use an assistive device (for example: eye glasses, hearing aids, braces, canes, crutch(es), walker, wheelchair)?	☐ Always	☐ Sometimes	☐ Never

If **Always** or **Sometimes,** please describe what kind, when, and how you use it.

7.D.	Do you have hobbies or interests?	☐ Yes	☐ No

If **Yes,** please describe what they are and how much time you spend doing them.

SECTION 8 - REMARKS

Please provide any additional information you did not show in earlier sections of this form. You may also attach any medical records, copies of prescriptions, or any other records about your medical condition(s) 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 **Section 9 - Contacts**.

SECTION 9 - CONTACTS

9.A. Give the name of someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your case.

Full Name (First, Middle Initial, Last):

Daytime Telephone Number: ___ - ___ - ____ (area code) (phone number)

Relationship to Disabled Person:

9.B. Who completed this report?

- ☐ The disabled person (go to **9.D.**)
- ☐ The person listed in **9.A.** above (go to **9.D.**)
- ☐ Someone else (go to **9.C.**)

9.C. Give the name of the person who completed this report.

Full Name (First, Middle Initial, Last):

Daytime Telephone Number: ___ - ___ - ____

Relationship to Disabled Person:

9.D. When was this report completed (month / day / year)? MM / DD / YYYY

SSA will insert the following revised Privacy Act and PRA Statements into the form at its next scheduled reprinting:

The Privacy Act

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.

The information you furnish on this form is voluntary. However, failure to provide this requested information could prevent an accurate and timely decision on the named claimant's claim.

We rarely use the information you supply for any purpose other than for making a determination about your continuing entitlement to benefits. 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 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 and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide 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 or 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 our Systems of Records Notices entitled, Claims Folder Systems, 60-0089 and Master Beneficiary Record, 60-0090. These notices, 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 30 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 Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed report.***

MAIL THE COMPLETED REPORT IN THE ENCLOSED ENVELOPE OR TAKE IT 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 addresses are also 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).