Disability Report - Appeal

How the online Appeal Disability Report works

OMB No. 0960-0144

You are now starting the online Appeal Disability Report, which is Part 2 of the Internet Appeal process. The Appeal Disability Report (SSA-3441) on the following pages will ask you to describe any changes that have occurred since you last completed a disability report. This will include information about your condition, medical sources and treatments, work activities and education. If you need to find a ZIP code for an address, use the ZIP Code Lookup.

Completing and Saving the Appeal Disability Report:

- The report does not have to be done all at once. After you complete the next page, we will give you a Reentry Number. You will be able to stop working on the report whenever you want and then use this Reentry Number to come back to the section where you left off.
- We estimate you will need 15 to 45 minutes, with an average of 30 minutes, to complete this Appeal Disability Report. If you want more information, use this link to read about the Paperwork Reduction Act.
- In each section of the report you will be asked to enter information. We will give you instructions and examples to guide you.
- At the end of each section, you will have a chance to review your answers and add or change information.
- After you complete a page, some answers are protected and cannot be changed by going back to that page. If you need to make changes to a protected answer on a completed page, continue with the report. You will be able to change your answer from the summary page at the end of the section.
- When you have completed the report, you will see a full summary of the information you entered. You can make any necessary changes and then print or save a copy of this summary for your records. If you want to keep a copy of the entire report for your records, you will need to print or save each page using your browser's print command.
- If you do not have enough room to enter all the information you want to give us on the report, including the Remarks block in the Review and Send section, please write the information on a separate sheet of paper and send it to us at the address we will give you after you've completed this report.

How to Move Around in the Report

- To move forward page by page in order in the report, use the Continue button at the bottom of the page.
- To move from section to section in the report, use the Tabs at the top of the page. Using a Tab takes you to that section. If the Tabs are not "dimmed," you can use them to go to any section at any time.
- If you are navigating using only the keyboard or using an assistive device and need help, visit our instructional page for alternative views and navigation. **Note:** If you select this link, you will leave this secure site and go to a new browser window. You will automatically return to this page when you close the new browser window.
- Once you have reached a Summary page in a section, you may return to it by using the Return to Summary button at the bottom of a page in that section.
- Additional buttons, other than Continue and Previous, may appear at the bottom of a page. These buttons allow you to take an action, such as deleting a page or returning to the summary.
- Additional information may appear in a new browser window. Close that window to return to the appeal process.

IMPORTANT

- **Do NOT use the Enter key to move around in the report or to select from the drop-down lists.**
- To move backward page by page in order in the report, select the Previous button at the bottom of the page. **Do NOT use the "Back" button on your browser to move backward.**
- **You will receive a time-limit warning if you stay more than 25 minutes on any one page. Then you can extend your time on that page. After the third warning on a page, you must move to another page or your time will run out and all your work on that page will be lost.** (**Note:** If you have turned JavaScript off in your browser, you will not receive these warnings and, after 30 minutes on a page, you must go to another page or your disability report session will end, and your work on the last page will be lost.)

Privacy Information

The Social Security Administration has access to the information you provide on this report and is authorized to keep even partially completed reports. This is for the purpose of helping you complete the appeals process or update your information.

Special Instructions for Blind Users

Continue

Social Security Online

Disability Report - Appeal

www.socialsecurity.gov

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

About you: general information

If you are completing the Appeal Disability Report for someone other than yourself, please remember that when we ask things "About You", we mean the disabled adult or child whose disability decision is being appealed (the "claimant").

Items marked with an asterisk (*) are required.

The name, address and phone number were entered on the Appeal Request.

Name: (First, Middle, Last)	**Kristophe J Kringle**
Address:	
* **(Street Address 1)**	**1 North Pole**
(Street Address 2)	
(Street Address 3)	
(Street Address 4)	
***(City, State, Zip Code)**	**Baltimore MD 21223**
Telephone Number: We need to know how to contact or leave a message for the claimant.	410-555-1212 **Extension:** [ ] (•) **This is the claimant's phone number.** ( ) **The claimant does not have a phone, but you can leave a message at this number.**
Email Address: (Optional):	kristophe.j.kringle@northpoleinc.com

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Social Security Online

Disability Report - Appeal

www.socialsecurity.gov

Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Print your reentry number

Before going any further, we are giving you a Reentry Number. If you get disconnected, or if you decide to work on the report again later, you will need this number. It will allow you to come back to this report and continue where you left off without losing any information you entered.

Please print this page (using the Print command in the browser)
or write down this Reentry Number 47741847

If you lose or forget your Reentry Number, you will have to begin this Appeal Disability Report over again and you will lose all the information you already entered.

Information about your Reentry Number

- **Remember to guard your Reentry Number carefully** because it is the key to reentering the application. **Do not put it where an unauthorized person can see it.**
- Social Security employees will never ask for a Reentry Number and they cannot look up a Reentry Number for you. This is to protect privacy.

To continue with this application later

1. Wait at least 5 minutes
2. Go to www.socialsecurity.gov/disability/appeal
3. Select 'Go Back to the Report I Already Started'
4. Enter the Claimant's Social Security Number and the Reentry Number shown above
   Result: We will bring you back to this report.

If you have any questions, you may contact us:

- By phone at our toll-free number, **1-800-772-1213**. If you are deaf or hard of hearing, call our toll-free "TTY" number, **1-800-325-0778**. Representatives are available Monday through Friday 7 AM to 7 PM.
- In person at your local Social Security Office.

Continue

Contact Us | How to Move Around This Report

Social Security Online

Disability Report - Appeal

www.socialsecurity.gov

Sign Off | About You | Medical History | Review and Send

Name: Kristophe Kringle
SSN: xxx-xx-6036

About you: someone we can contact about your conditions

Please tell us about someone else, other than your doctor or health care provider, whom we can contact to help with your appeal if necessary. Doctors and hospitals may not have a complete picture of how your conditions affect your daily life and your work. We may need to talk with someone who knows you and knows about your conditions.

If you are completing this for a child, please give us your name and address or that of the person who is giving you the information.

Items marked with an asterisk (*) are required.

*** Contact Person's Name:** Ingrit S Kringle **Suffix (if any)**

(First, Middle Initial, Last)

Relationship to You:

- (●) **Husband or Wife**
- ( ) **Mother**
- ( ) **Father**
- ( ) **Sister**
- ( ) **Brother**
- ( ) **Grandparent**
- ( ) **Child**
- ( ) **Aunt**
- ( ) **Uncle**
- ( ) **Cousin**
- ( ) **Stepmother**
- ( ) **Stepfather**
- ( ) **Neighbor**
- ( ) **Friend**
- ( ) **Significant Other**
- ( ) **Other (such as Social Worker, Attorney, Legal Representative)** :

*** Address:**

Please provide this contact's complete address, including apartment number if applicable. Please do NOT use punctuation; for example, no periods or commas. Example: 528 Dawn St Apt 101

☑ **Check if same as Kristophe Kringle's address**

*** (Street Address 1)**

(Street Address 2)

(Street Address 3)

*** (City, State, ZIP)**

Daytime Phone Number: ☑ **Check if same as Kristophe Kringle's phone number**

We need to be able to contact this person during the day.

Extension:

Add Another Contact | Previous | **Continue**

Contact Us | How to Move Around This Report

Disability Report - Appeal

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

About you: updated information

Please tell us about changes in your illnesses, injuries, or conditions **since you last completed a Disability Report**. Look at the medical decision notice you received in the mail if you are not sure what you already told us. If you previously filed an Internet report, please refer to any pages you saved or printed.

You must answer all of the questions on this page before you can continue. We will ask you to explain some of your "yes" answers.

Items marked with an asterisk (*) are required.

Your Conditions Since You Last Completed a Disability Report:

* **Has there been any change (for better or worse) in any of your conditions?** ◉ Yes ○ No

Examples: blood pressure has gotten higher, asthma is worse

* **Do you have any new physical or mental limitations as a result of your conditions?** ○ Yes ◉ No

Examples: can't walk without a walker now; can't take gym class

* **Do you have any new illnesses, injuries, or conditions?** ○ Yes ◉ No

Examples: had a stroke, developed glaucoma, diagnosed with ADHD

Your Work and Training Since You Last Completed a Disability Report

* **Have you worked?** ○ Yes ◉ No

If yes, we will contact you for more information.

* **Have you completed any type of special job training, trade or vocational school?** ○ Yes ◉ No

Examples: Auto mechanics, cosmetology, computer courses

* **Have you received Vocational Rehabilitation, employment or other support services or participated in the Ticket-to-Work program, or an individualized education program through an educational institution (if a student age 18-21)?** ○ Yes ◉ No

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

About you: describe changes in your conditions

You said earlier that there has been a change, for better or worse, in your conditions. If this is not correct, you can [Change Your Answer]

Please give us a detailed description of all **changes** to your conditions. For adults, tell us about any new symptoms that limit your ability to work. For children, tell us about any new symptoms that affect their daily lives.

- Don't assume that your conditions are self-explanatory. Different people with the same conditions have different symptoms and complications. Make sure you tell us about all your impairments and symptoms.
- Include all physical, mental, and emotional conditions, including learning disabilities and behavioral problems.
- No one knows better than you how these conditions affect you.
- Please do not repeat what you told us before. Use this space only to tell us new information. If you are not sure what kinds of things to tell us, you can review the examples.

Describe in detail the changes to your conditions since you last completed a Disability Report.

1000 characters maximum. This is about 20 lines of typing.

[Count Characters] You have entered 0 characters

Vixen had run away, poor girl, and I was very worried. This caused a drastic rise in my blood pressure, which then led to the two heart attacks which have occurred since I filed my claim.

Examples

When did these changes begin?

Enter the closest date you can remember. Examples: 06/02/2003; 06/03; June 2003; Summer 2003.

2/2/2010

[Previous] [Continue]

Contact Us | How to Move Around This Report

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

About you: about your activities

Please tell how your conditions affect your ability to care for yourself and any changes you have made in your daily activities **since you last completed a Disability Report**. You may include how often you do activities and if you need assistance in doing activities, such as:

- Walking, standing, moving your arms, using your hands and fingers, climbing steps, lifting objects.
- Cooking, cleaning, vacuuming, making beds, shopping, and odd jobs around the house.
- Watching TV, listening to the radio, reading books and newspapers, sports, hobbies.
- Visiting with friends and relatives, going to religious services, attending social clubs.
- Driving a car or motorcycle, riding the bus or subway.

How have your daily activities changed since you last completed a Disability Report?

If there has been no change, please enter "no change."

1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section at the end of this report.

Count Characters You have entered 0 characters

I have had to get my Chief of Elven Services to go purchase my groceries and help out with most other chores that my wife or I cannot do.

How do your conditions affect your ability to care for your personal needs since you last completed a Disability Report?

If there has been no effect, please enter "no effect." Include such activities as: dressing, bathing, tying shoes, buttoning buttons, combing hair, and fixing meals.

1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section at the end of this report.

Count Characters You have entered 0 characters

My dear wife must bathe me and help me to dress every day. I am dealing with constant pain and tiredness.

Examples

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Social Security Online **Disability Report - Appeal**

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

About you: summary

Please review the information that you gave us earlier and make sure it is correct. To go back to any item to make changes or corrections, select the Edit button. If you would like to make an addition, select the Add button.

This page will print in a printer friendly format.

Note: Because of space limitations, this summary will show only the first 100 characters of the typed descriptions you gave us. However, everything you told us will be included in the report that you submit to Social Security.

Information About You

General Information

Edit Kristophe J Kringle — 1 North Pole, Baltimore, MD 21223

People We Can Contact About Your Condition

Edit Ingrit S Kringle — 1 North Pole, Baltimore, MD 21223

Add Another Contact

About Your Conditions Since You Last Completed a Disability Report

Changes in Your Conditions

Edit These changes began 2/2/2010
Description of changes to your condition: Vixen had run away, poor girl, and I was very worried. This caused a drastic rise in my blood press ...

New Physical or Mental Limitations

Edit You said that you don't have any new physical or mental limitations as a result of your condition(s).

New Conditions

Edit You said that you don't have any new conditions.

About Your Activities

Edit Description of changes to daily activities: I have had to get my Chief of Elven Services to go purchase my groceries and help out with most othe ...
Description of ability to care for personal needs: My dear wife must bathe me and help me to dress every day. I am dealing with constant pain and tire ...

Work and Training Since You Last Completed a Disability Report

Work History

Edit You said that you have not worked.

Special Job Training, Trade or Vocational School

Edit You said that you have not had any type of special job training, trade or vocational school.

Vocational Rehabilitation or Ticket-to-Work Program

Edit You said that you have not received Vocational Rehabilitation services or participated in a Ticket-to-Work program.

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Sign Off
About You
Medical History
Review and Send
Name: Kristophe Kringle
SSN: xxx-xx-6036
About you: end of part 1
You have now completed the first section of the report.
If you want to add to or change this information later, you can select the "About You" tab at the top to come back to it.
If You Want to Continue
The next section of the report will ask about your medical history, including your doctors, hospitals, medications, and medical tests.
If You Want to Stop
If you want to stop and come back to this later, you can do so at any time by choosing "Sign Off" at the top left corner of the page. Signing off makes sure that the information you have entered has been saved and protects your confidentiality by requiring that you sign on again with your reentry number when you are ready to continue. When you come back, we will take you back to where you left off.
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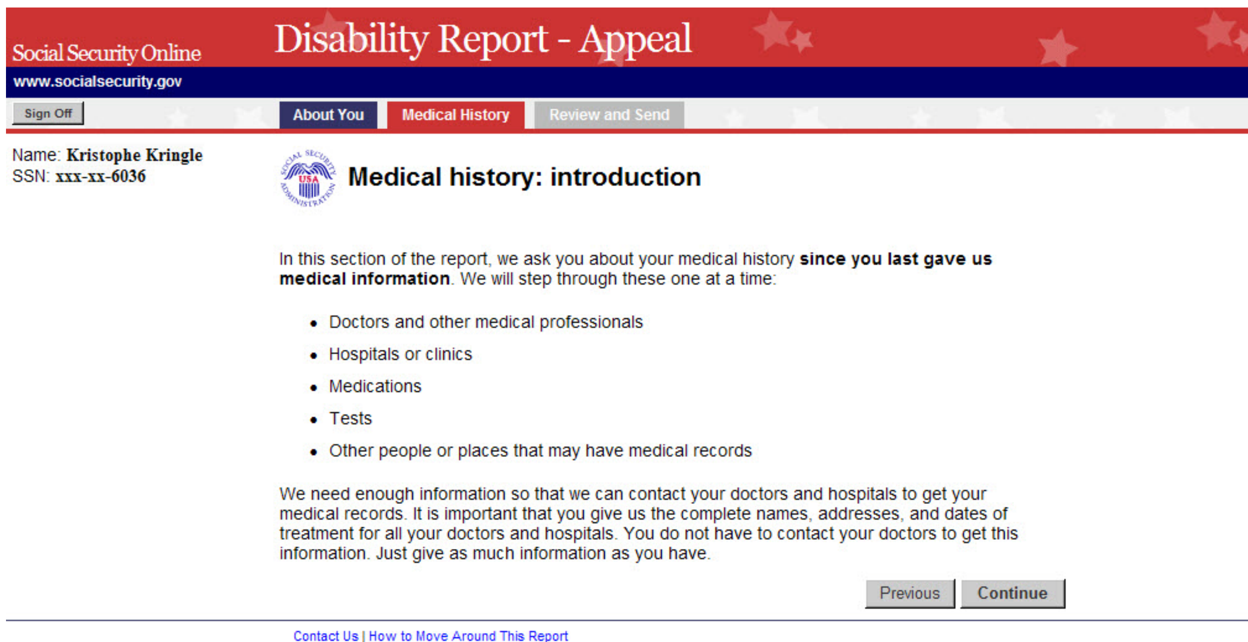
Social Security Online
Disability Report - Appeal
www.socialsecurity.gov
Sign Off
About You
Medical History
Review and Send
Name: Kristophe Kringle
SSN: xxx-xx-6036
Medical history: introduction
In this section of the report, we ask you about your medical history since you last gave us medical information. We will step through these one at a time:
Doctors and other medical professionals
Hospitals or clinics
Medications
Tests
Other people or places that may have medical records
We need enough information so that we can contact your doctors and hospitals to get your medical records. It is important that you give us the complete names, addresses, and dates of treatment for all your doctors and hospitals. You do not have to contact your doctors to get this information. Just give as much information as you have.
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Disability Report - Appeal

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: treatments and medicines

Please tell us about hospital visits, doctor visits, medicines, and tests **since you last gave us medical information**. If you are not sure what information you've already given us, look at the medical decision notice you received in the mail. If you previously filed an Internet report, please refer to any summary pages you printed.

Items marked with an asterisk (*) are required.

Treatments and Tests Since You Last Gave Us Medical Information:

Be sure to include any doctors who prescribed medicines that you are currently taking as well as those who sent you for tests.

* **Have you seen or will you see a doctor, hospital, clinic, or anyone else for your conditions?**	(●) Yes ( ) No
* **Have you seen or will you see a doctor, hospital, clinic, or anyone else for mental or emotional problems?**	( ) Yes (●) No
* **Have you had any medical tests, or do you have any tests scheduled for your conditions?**	( ) Yes (●) No

Current medicines:

* **Are you taking any prescription or over-the-counter medicines for your conditions?**	(●) Yes ( ) No

Other Names:

* **Are there other names you may have been using at the time you received medical treatment for your conditions?**	( ) Yes (●) No

This information helps us to get all your medical records promptly.
Examples:
Maiden name, previous married name, nickname

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Contact Us | How to Move Around This Report

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: about your doctors and other medical professionals

- Include the people who have treated you for the conditions related to your disability **since you last gave us medical information.**
- Include any people who have treated you for your conditions and whom you may not have told us about before.
- Include any doctors who have prescribed medications that you are currently taking.
- Give each person's first and last name if possible.
- If you were an inpatient or outpatient at a hospital or clinic, do not list staff doctors. We will ask about them later.
- If you have seen several doctors, list each of them on a separate line.

We will ask you for more information about each of these people. We use this information to get copies of your medical records that will help us make a decision on your appeal.

After you leave this page, the information you entered will be locked. If you need to correct the information you gave us, you will be able to make changes on following pages where we ask you for more details. Or, you can make changes from the summary page at the end of each section, or at the end of this report.

List all the doctors or medical professionals described above:

(First Name, Last Name)

Include physicians, psychologists, optometrists, nurse practitioners, therapists, chiropractors, acupuncturists, etc. You can check current medicine bottles for doctors' names.

Examples:
Dr. Patrick Coll, Ms. Donna Swam

#	Title	First Name	Last Name
1.	Dr.	Hans	Kvack
2.	Dr.		
3.	Dr.		
4.	Dr.		
5.	Dr.		
6.	Dr.		
7.	Dr.		
8.	Dr.		
9.	Dr.		
10.	Dr.		

☐ **Check here if you want to add more doctors or medical professionals**

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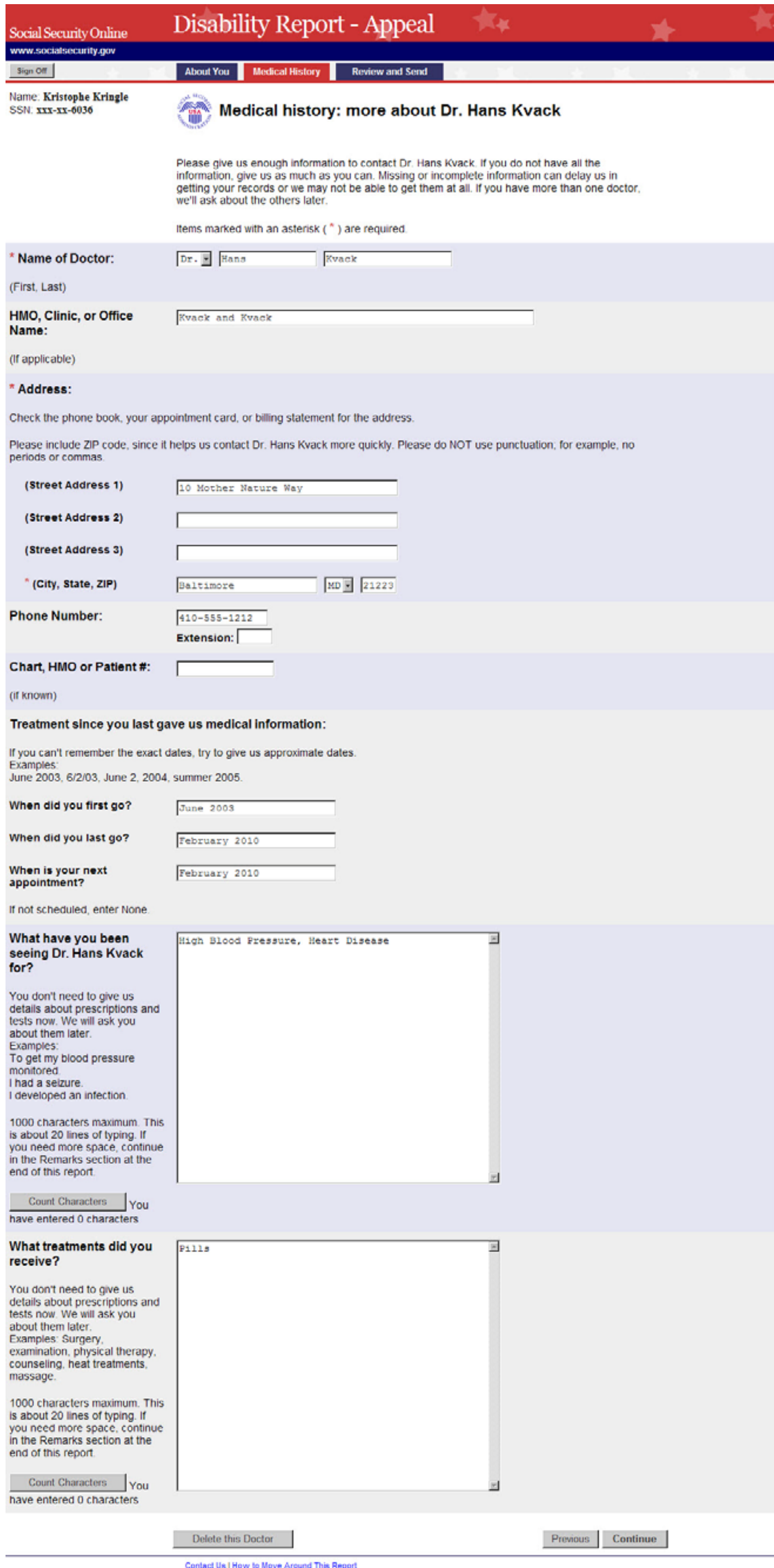
Contact Us | How to Move Around This Report



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Disability Report - Appeal

Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: more about Dr. Hans Kvack

Please give us enough information to contact Dr. Hans Kvack. If you do not have all the information, give us as much as you can. Missing or incomplete information can delay us in getting your records or we may not be able to get them at all. If you have more than one doctor, we'll ask about the others later.

Items marked with an asterisk (*) are required.

*** Name of Doctor:** Dr. | Hans | Kvack

(First, Last)

HMO, Clinic, or Office Name: Kvack and Kvack

(If applicable)

*** Address:**

Check the phone book, your appointment card, or billing statement for the address.

Please include ZIP code, since it helps us contact Dr. Hans Kvack more quickly. Please do NOT use punctuation; for example, no periods or commas.

(Street Address 1) 10 Mother Nature Way

(Street Address 2)

(Street Address 3)

*** (City, State, ZIP)** Baltimore | MD | 21223

Phone Number: 410-555-1212
Extension:

Chart, HMO or Patient #:

(if known)

Treatment since you last gave us medical information:

If you can't remember the exact dates, try to give us approximate dates.
Examples:
June 2003, 6/2/03, June 2, 2004, summer 2005.

When did you first go? June 2003

When did you last go? February 2010

When is your next appointment? February 2010

If not scheduled, enter None.

What have you been seeing Dr. Hans Kvack for?

High Blood Pressure, Heart Disease

You don't need to give us details about prescriptions and tests now. We will ask you about them later.
Examples:
To get my blood pressure monitored.
I had a seizure.
I developed an infection.

1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section at the end of this report.

Count Characters You have entered 0 characters

What treatments did you receive?

Pills

You don't need to give us details about prescriptions and tests now. We will ask you about them later.
Examples: Surgery, examination, physical therapy, counseling, heat treatments, massage.

1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section at the end of this report.

Count Characters You have entered 0 characters

Delete this Doctor | Previous | Continue

Contact Us | How to Move Around This Report

You have entered a new doctor

You have named as the person who . You did not list this person when we asked about doctors or medical professionals you have seen for your condition. We will ask you to give us details for this doctor on the next page.

Continue

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: about your hospitals or clinics

Include hospitals and clinics where you have been treated for the conditions related to your disability **since you last gave us medical information.**

Include any hospitals and clinics where you have been treated for your conditions and that you may not have told us about before.

If you were treated at several hospitals or clinics, list each of them on a separate line.

We will ask you for more information about each of these places. We use this information to get copies of your medical records that will help us make a decision on your appeal.

After you leave this page, the information you entered will be locked. If you need to correct the information you gave us, you will be able to make changes on following pages where we ask you for more details. Or, you can make changes from the summary page at the end of each section, or at the end of this report.

List all hospitals, clinics, or other places where you have been treated:

Include places other than doctors' offices where you went for treatments, tests, surgery, or emergency room visits.

Examples:
University Hospital, Mayo Clinic, Radiology Associates Inc.

1. U of Z Hospital
2.
3.
4.
5.
6.
7.
8.
9.
10.

☐ **Check here if you want to add more hospitals or clinics**

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Sign Off | About You | Medical History | Review and Send

Name: Kristophe Kringle
SSN: xxx-xx-6036

Medical history: about U of Z Hospital

Please fill in all the information you can about your visits to U of Z Hospital. We need full information so we can request your medical records.

Items marked with an asterisk (*) are required.

*** Hospital or Clinic Name:** U of Z Hospital

*** Address:**

Check the phone book, your appointment card, or your billing statement for the address. Please include the ZIP code, since this helps us to contact the hospital more quickly. Please do NOT use punctuation; for example, no periods or commas.

(Street Address 1) 10 Z Street

(Street Address 2)

(Street Address 3)

*** (City, State, ZIP)** Baltimore MD 21223

Phone Number: 410-555-1212
Extension:

Hospital/Clinic Record #:

(if known)
This is your patient number, not your billing number.

What doctors do you see on a regular basis in U of Z Hospital?

List the first and last name of each doctor, if possible. Provide as much information as you can. Example: Dr. Linda Camp, Dr. Dave Bell, Dr. Bob Barnhart, and Dr. Newton

1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section at the end of this report.

Count Characters You have entered 0 characters

Did you have any of the following visits at U of Z Hospital?

*** Inpatient Stay:** (•) Yes ( ) No

Stayed over at least one night.

*** Outpatient Stay or Appointment:** ( ) Yes (•) No

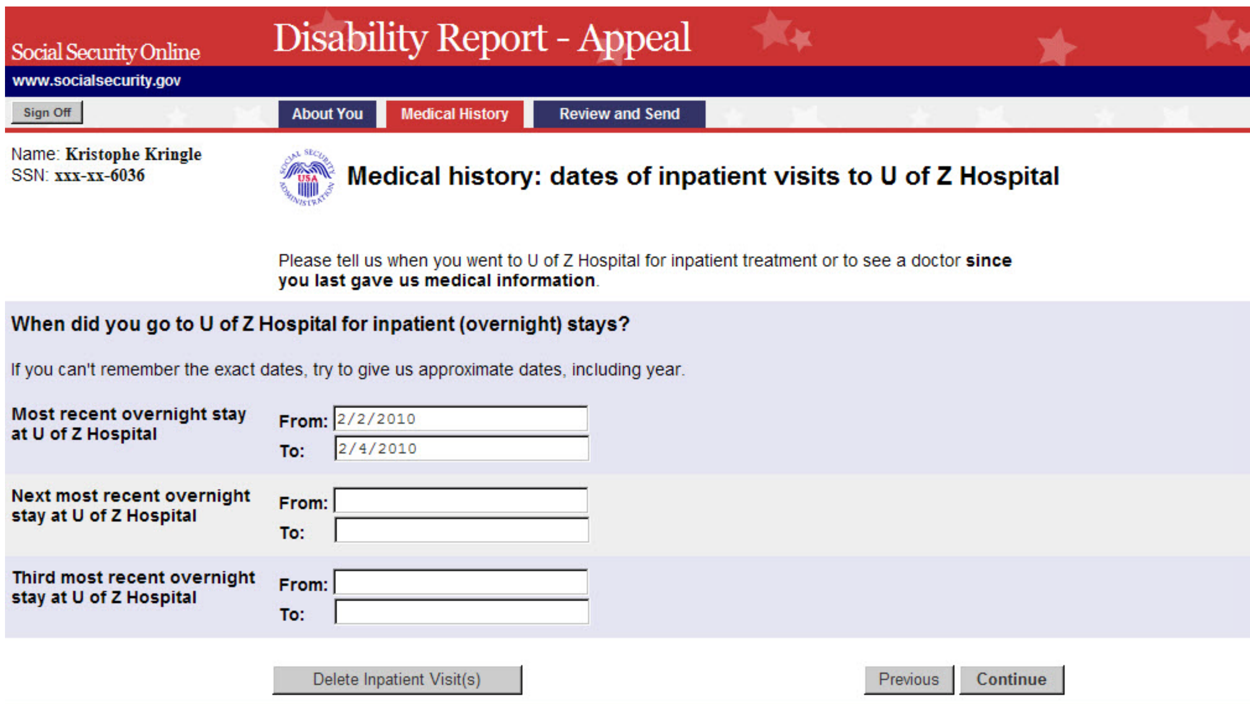
Went home the same day.

*** Emergency Room (ER):** (•) Yes ( ) No

Went to ER and then went home.

Delete this Hospital | Previous | Continue

Contact Us | How to Move Around This Report


Social Security Online
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www.socialsecurity.gov
Sign Off
About You
Medical History
Review and Send
Name: Kristophe Kringle
SSN: xxx-xx-6036
Medical history: dates of inpatient visits to U of Z Hospital
Please tell us when you went to U of Z Hospital for inpatient treatment or to see a doctor since you last gave us medical information.
When did you go to U of Z Hospital for inpatient (overnight) stays?
If you can't remember the exact dates, try to give us approximate dates, including year.
Most recent overnight stay at U of Z Hospital
From: 2/2/2010
To: 2/4/2010
Next most recent overnight stay at U of Z Hospital
From:
To:
Third most recent overnight stay at U of Z Hospital
From:
To:
Delete Inpatient Visit(s)
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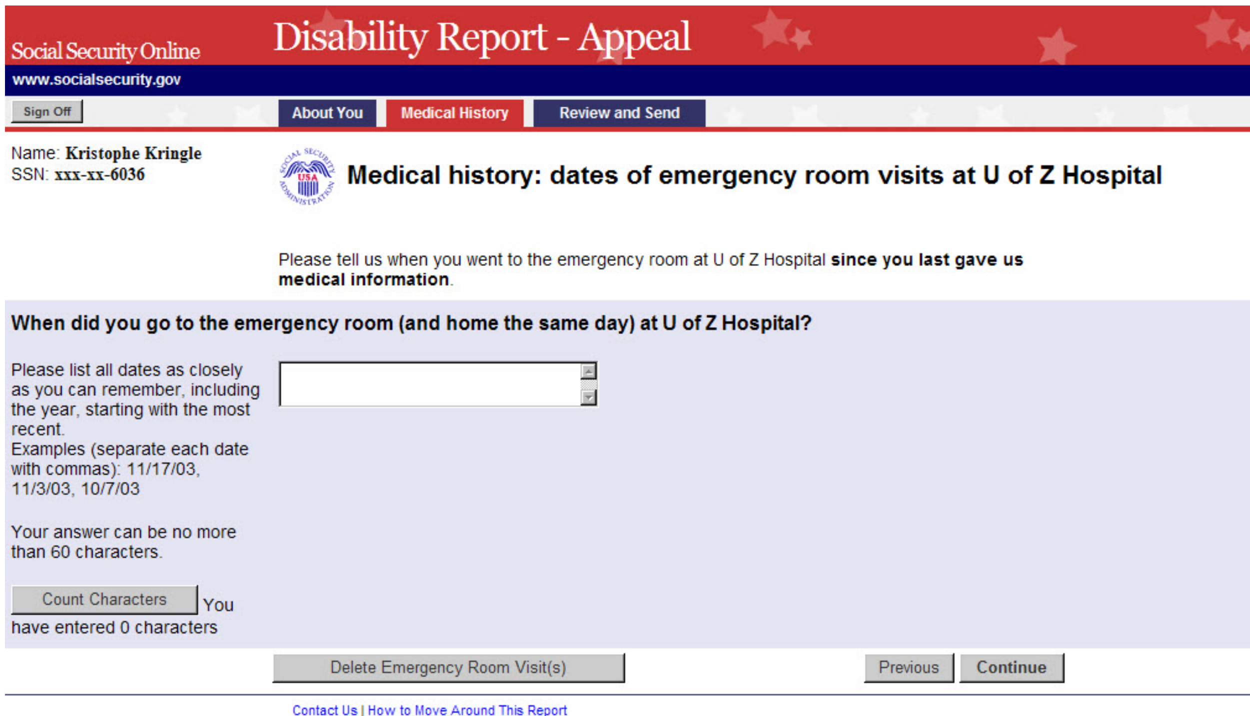
Contact Us | How to Move Around This Report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Sign Off
About You
Medical History
Review and Send
Name: Kristophe Kringle
SSN: xxx-xx-6036
Medical history: dates of emergency room visits at U of Z Hospital
Please tell us when you went to the emergency room at U of Z Hospital since you last gave us medical information.
When did you go to the emergency room (and home the same day) at U of Z Hospital?
Please list all dates as closely as you can remember, including the year, starting with the most recent.
Examples (separate each date with commas): 11/17/03, 11/3/03, 10/7/03
Your answer can be no more than 60 characters.
Count Characters
You have entered 0 characters
Delete Emergency Room Visit(s)
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Contact Us | How to Move Around This Report

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: about your visits at U of Z Hospital

Please explain why you went and what treatment(s) you received during **each visit** to U of Z Hospital **since you last gave us medical information**. We will ask about tests and medications later. Make sure to answer these questions for the following visits:

- Inpatient stays:
  - From: 2/2/2010 To: 2/4/2010
  - From: No Date Entered To: No Date Entered
  - From: No Date Entered To: No Date Entered
- Emergency room visits were on No Date Entered
- Any additional visits not listed here.

Each answer can be no more than 1000 characters. This is about 20 lines of typing. If you need more space, continue in the Remarks section at the end of this report.

For each visit, why did you go to U of Z Hospital?

Examples:

- Had 6 outpatient visits between October 2003 and the present for my cancer.
- Needed monthly blood transfusions as outpatient every month for the past four months.
- Had surgery on November 20, 2003, and stayed in the hospital for a week because I developed an infection.
- Went to ER on October 13, 2003, because I was nauseated, dizzy, and running a high fever.
- Spent the Summer of 2003 in the hospital for third degree burns.

Count Characters You have entered 0 characters

```
2/2/2010 - 2/4/2010

Heart attack, rising high blood pressure
```

For each visit to U of Z Hospital, what treatments did you receive?

Include the location within the hospital if possible.
Examples:

- Physical therapy at the Rehab Clinic from Sept.- Nov. 2003.
- Knee surgery on Sept. 29, 2003.
- Chemotherapy at the Oncology Clinic weekly since Oct. 2003.
- Needed 30 stitches on right arm on Sept. 14, 2003.

Count Characters You have entered 0 characters

```
pills, heart monitoring
```

When is your next appointment at U of Z Hospital?

If not scheduled, enter None. Please give us the exact date if known. If you don't know the exact date, give us the closest date you can remember.
Examples:
1-19-04, 1/19/2004, Jan. 2004

```
N/A
```

Deleting this page is not allowed because you gave us more information about this on another page.

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: about your medicines

You can list up to 30 prescription and over-the-counter medicines in this section. We will ask you for more information about each of these later.

After you leave this page, the information you entered will be locked. If you need to correct the information you gave us, you will be able to make changes on following pages where we ask you for more details. Or, you can make changes from the summary page at the end of each section, or at the end of this report.

List all prescription and over-the-counter medicines that you are currently taking:

Copy the name directly from the medicine container, if you have it.

Examples:

- Ritalin
- Albuterol
- Insulin
- Aspirin
- Melatonin
- Glucosamine

1. nitroglycerin
2. plavix
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

☐ **Check here if you want to add more medicines**

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Contact Us | How to Move Around This Report

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: more about nitroglycerin

Please tell us about this medicine. Try to give us enough information to understand your condition and how the medicine affects it. If you do not have all the information, give us as much as you can.

Items marked with an asterisk (*) are required.

*** Medicine Name:** nitroglycerin

Which doctor, if any, told you to take this medicine? Dr. Hans Kvack

Other: (First Name, Last Name) Dr.

(If a doctor did not tell you to take this medicine, leave this question blank.)
If the doctor's name is not in the list, type it in the space marked "other" below the list. If you are not sure which doctor told you to take it or do not remember the doctor's name, **leave the space blank**.

Reason for nitroglycerin: high blood pressure

Examples:
Slows down my heart rate.
Regulates my blood sugar.
Stops the pain.

1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section of this report.

Count Characters You have entered 0 characters

What side effects do you have, if any? dizziness

(If none, enter none) Include physical or mental effects and allergic reactions.

Examples:
Makes me so tired I can't do anything.
Makes me sick to my stomach.
Causes diarrhea.

1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section of this report.

Count Characters You have entered 0 characters

Delete this Medicine | Previous | Continue

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: more about plavix

Please tell us about this medicine. Try to give us enough information to understand your condition and how the medicine affects it. If you do not have all the information, give us as much as you can.

Items marked with an asterisk (*) are required.

*** Medicine Name:** plavix

Which doctor, if any, told you to take this medicine? Dr. Hans Kvack

Other: (First Name, Last Name) Dr.

(If a doctor did not tell you to take this medicine, leave this question blank.)
If the doctor's name is not in the list, type it in the space marked "other" below the list. If you are not sure which doctor told you to take it or do not remember the doctor's name, **leave the space blank**.

Reason for plavix: arterial plaque buildup

Examples:
Slows down my heart rate.
Regulates my blood sugar.
Stops the pain.

1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section of this report.

Count Characters You have entered 0 characters

What side effects do you have, if any? none

(If none, enter none) Include physical or mental effects and allergic reactions.

Examples:
Makes me so tired I can't do anything.
Makes me sick to my stomach.
Causes diarrhea.

1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section of this report.

Count Characters You have entered 0 characters

Delete this Medicine | Previous | Continue

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: other medical records

Although this does not apply to everyone, you may have relevant medical records in other places. These other records may contain important information that we need to consider in evaluating your condition.

Remember, this refers only to those contacts and services received **since you last gave us medical information.**

Note: Do not repeat any places that you already told us about in this report, for example, doctor's offices and hospitals.

After you leave this page, the information you entered will be locked. If you need to correct the information you gave us, you will be able to make changes on following pages where we ask you for more details. Or, you can make changes from the the summary page at the end of each section, or at the end of this report.

Have you received services from other organizations that would have your medical records?

○ **Yes** ◉ **No**

If "Yes", please select any of the following that might have medical records or information about your condition:

- ☐ **Workers' Compensation**
- ☐ **Public welfare office**
- ☐ **Prison or jail**
- ☐ **Private insurance company**
- ☐ **Attorney/lawyer**
- ☐ **Another place, not on this list**

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: summary

Please review the information that you gave us earlier and make sure it is correct. To go back to any item to make changes or corrections, select the Edit button. If you would like to make an addition, select the Add button.

This page will print in a printer friendly format.

Note: Because of space limitations, this summary will show only the first 100 characters of the typed descriptions you gave us. However, everything you told us will be included in the report that you submit to Social Security.

About Your Doctors and Other Medical Professionals

About Dr. Hans Kvack

Edit
Kvack and Kvack
Reason for visit: High Blood Pressure, Heart Disease
Treatments received: Pills

10 Mother Nature Way
Baltimore, MD 21223

Add Another Doctor

About Your Hospitals/Clinics

About U of Z Hospital

Edit
You did not provide the medical record number for this hospital/clinic.
You did not enter any doctors whom you see on a regular basis at this hospital/clinic.
Visits Included: Inpatient visit, Emergency Room visit

10 Z Street
Baltimore, MD 21223

Edit
Inpatient Stays:
From: 2/2/2010 To: 2/4/2010

Edit
Emergency Room visits were on "No Date Entered"

Edit
Reasons for visits: 2/2/2010 - 2/4/2010 Heart attack, rising high blood pressure
Treatment received: pills, heart monitoring
Next Appointment is: N/A

Add Another Hospital/Clinic

About Your Medications

About nitroglycerin

Edit
Reasons for medicine: high blood pressure
Side effects: dizziness
Prescribed by: Dr. Hans Kvack

About plavix

Edit
Reasons for medicine: arterial plaque buildup
Side effects: none
Prescribed by: Dr. Hans Kvack

Add Another Medication

About Your Medical Tests

Edit
You said that you have not had or scheduled any medical tests for your condition since you last gave us medical information.

Other Names Used

Edit
You said that there are no other names on your medical records.

About Your Other Medical Records

Edit
You said that you have not received services from other organizations that would have your medical records since you last gave us medical information.

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Contact Us | How to Move Around This Report

Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Medical history: end of part 2

You have now reached the end of the second section of the report.

If you want to add to or change this information later, you can select the "Medical History" tab at the top to come back to it.

If You Want to Stop

If you want to stop and come back to this later, you can do so at any time by selecting "Sign Off" at the top left corner of the page. Signing Off makes sure that the information you have entered has been saved, and protects your confidentiality by requiring that you sign on again with your Reentry Number when you are ready to continue. When you come back, we will return you to the page where you signed off.

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Sign Off | About You | Medical History | Review and Send

Name: Kristophe Kringle
SSN: xxx-xx-6036

Review and send: summary

If you have filled out the report to this point, you are almost done! Now it's time to review your answers below. If any sections are not complete, please see if you have the information to complete them. If not, go ahead and send the report in as it is, and we'll help you with the rest.

You may want to print or save a copy of this summary for your records. You will not be able to print the entire Appeal Disability Report. If you want a copy of each page, you will need to go back through the report and print or save each page.

About You Summary

Information About You

General Information

Edit | Kristophe J Kringle | 1 North Pole, Baltimore, MD 21223

People We Can Contact About Your Condition

Edit | Ingrit S Kringle | 1 North Pole, Baltimore, MD 21223

Add Another Contact

About Your Conditions Since You Last Completed a Disability Report

Changes in Your Conditions

Edit | These changes began 2/2/2010
Description of changes to your condition: Vixen had run away, poor girl, and I was very worried. This caused a drastic rise in my blood press ...

New Physical or Mental Limitations

Edit | You said that you don't have any new physical or mental limitations as a result of your condition(s).

New Conditions

Edit | You said that you don't have any new conditions.

About Your Activities

Edit | Description of changes to daily activities: I have had to get my Chief of Elven Services to go purchase my groceries and help out with most othe ...
Description of ability to care for personal needs: My dear wife must bathe me and help me to dress every day. I am dealing with constant pain and tire ...

Work and Training Since You Last Completed a Disability Report

Work History

Edit | You said that you have not worked.

Special Job Training, Trade or Vocational School

Edit | You said that you have not had any type of special job training, trade or vocational school.

Vocational Rehabilitation or Ticket-to-Work Program

Edit | You said that you have not received Vocational Rehabilitation services or participated in a Ticket-to-Work program.

Medical History Summary

About Your Doctors and Other Medical Professionals

About Dr. Hans Kvack

Edit | Kvack and Kvack
Reason for visit: High Blood Pressure, Heart Disease
Treatments received: Pills | 10 Mother Nature Way, Baltimore, MD 21223

Add Another Doctor

About Your Hospitals/Clinics

About U of Z Hospital

Edit | You did not provide the medical record number for this hospital/clinic.
You did not enter any doctors whom you see on a regular basis at this hospital/clinic.
Visits Included: Inpatient visit, Emergency Room visit | 10 Z Street, Baltimore, MD 21223

Edit | Inpatient Stays:
From: 2/2/2010 To: 2/4/2010

Edit | Emergency Room visits were on "No Date Entered"

Edit | Reasons for visits: 2/2/2010 - 2/4/2010 Heart attack, rising high blood pressure
Treatment received: pills, heart monitoring
Next Appointment is: N/A

Add Another Hospital/Clinic

About Your Medications

About nitroglycerin

Edit | Reasons for medicine: high blood pressure
Side effects: dizziness
Prescribed by: Dr. Hans Kvack

About plavix

Edit | Reasons for medicine: arterial plaque buildup
Side effects: none
Prescribed by: Dr. Hans Kvack

Add Another Medication

About Your Medical Tests

Edit | You said that you have not had or scheduled any medical tests for your condition since you last gave us medical information.

Other Names Used

Edit | You said that there are no other names on your medical records.

About Your Other Medical Records

Edit | You said that you have not received services from other organizations that would have your medical records since you last gave us medical information.

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Review and send: additional remarks about your case

Before you send this report, please provide any additional comments or information that you think we should know.

Please include any doctors, hospitals, medicines, tests, etc., that you did not already tell us about. For example, if you checked a box anywhere on this report to show that you had more information than the space allowed, you may give us that information here. If you do not have enough room to enter all the information you want to give us, please write the information on a separate sheet of paper and send it to us at the address we will give you.

Items marked with an asterisk (*) are required.

Please enter any additional remarks:

2000 characters maximum. This is about 40 lines of typing or about 320 words.

Count Characters You have entered 0 characters

```
Please tell the kids I won't let the Heat Miser
or Snow Miser ruin things for us this year.
```

* **Information About the Person Completing this Report**

- (•) **Kristophe Kringle completed this report**
- ( ) **Ingrit Kringle completed this report**
- ( ) **Someone else completed this report**

If you completed this report for Kristophe Kringle and you are not Ingrit Kringle, please provide the information requested below. Skip this part if you completed the report for yourself.

Name: (First, Middle Initial, Last) **Suffix (if any)**

Address:

(Street Address 1)

(Street Address 2)

(Street Address 3)

(City, State, ZIP)

Email Address (Optional)

Relationship to Disabled Person

Daytime Telephone Number

Extension:

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Sign Off | About You | Medical History | Review and Send

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Review and send: send this report

You are ready to send this report electronically to Social Security. If you were not able to complete all parts of the report, don't worry. We will contact you if we need any more information.

IMPORTANT: After you send this report, you will not be able to come back to it online.

- If you want to make changes after sending the online Appeal Disability Report, you will have to contact your Social Security Office.
- If you want a copy of the summary page and you have not yet printed it, choose the "Previous Page" button to go back to the summary before using "Send." You can then return to this page and send the report to us.
- If you are ready to submit this report, use the "Send" button.

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Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Review and send: additional forms we need

Although you have sent the report to us online, we still need a few items from you. In the next few pages, we will guide you through the process of printing and sending these items to us.

What you need to do next:

1. Continue to the next page, which is the cover sheet.
2. Print a copy of the cover sheet (or two copies if you want to keep one).
3. Complete the "Name" block and date on the cover sheet.
4. Mark on the cover sheet what you are sending or bringing to Social Security.
5. Mail or bring the cover sheet and its attachments to Social Security at the address we will give you.

You may want to print an extra copy of each form to keep for your records.

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Disability Report - Appeal

Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Review and send: print cover sheet

Please print this page and mail or bring it to Social Security at the address shown below to submit medical release forms for Kristophe Kringle.

Kristophe Kringle's address is:

1 North Pole
Baltimore, MD 21223

Kristophe Kringle's daytime phone number is:

(410) 555-1212

Name and address of someone else Social Security can contact who knows about Kristophe Kringle's condition and can help with his or her appeal:

Ingrit S Kringle
1 North Pole
Baltimore, MD 21223
(410) 555-1212

I have attached the following items:

Check all that apply.

___Medical Release
___Medical Evidence
___Appointment of Representative Form
___Other (Please list below.)

____

Name of person completing this disability report: Kristophe Kringle

____

Date: February 26, 2010

____

Mail or bring to:

SOCIAL SECURITY ADMINISTRATION
315 N WASHINGTON ST
ROCKVILLE, MD 20850
(301) 413-0400

You can mail or bring these documents to a different Social Security Office. You can use the Office Locator to find another Social Security Office.

If you have printing problems:

Please try again. If you are still unable to print this page, please continue. Contact Social Security at the address and phone number we have provided to tell us that you could not print the Cover Sheet.

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Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Review and send: print your medical release form

You also need to print and sign a medical release form SSA-827 Authorization to Release Information to SSA. The law requires us to have your signed authorization form in order to get your medical records from your doctors or hospitals, and from other sources that you gave us.

What you need to do:

1. Use the link below to access the medical release form. The medical release form is in Portable Document Format (PDF) and requires Adobe Acrobat Reader to open it and print it. If you don't have Adobe Acrobat Reader on your computer you can download a free copy. Use this link to get a free copy of Adobe Reader.
2. **Print the medical release form. You must print BOTH sides, front and back.**
3. Sign and date the medical release form.

   Note: All adults are required to sign the medical release form for themselves, even if someone else is helping them with the appeal process. The exceptions are when the disabled person has a legal guardian or is deceased.

4. Mail or bring the signed and dated medical release form along with the cover sheet of this Appeal Disability Report and any other appeal forms you have printed to Social Security at the address we will give you. DO NOT take any forms to your doctor.
5. If you already have copies of medical records from your doctor, you can send or bring them to us. However, we do not recommend that you delay your case by requesting medical records yourself. We can do this for you.

Here are instructions for completing the medical release form.

Please print one copy.

Authorization to Disclose Information to SSA

If you have printing problems:

Please try again. If you are still unable to print the form, please continue. Contact Social Security at the address and phone number we will give you later to tell us that you could not print the medical release form.

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Name: **Kristophe Kringle**
SSN: **xxx-xx-6036**

Confirmation

Thank you.

We received your Appeal Disability Report on February 26, 2010 at 5:52:30 pm Eastern Time. We will process it at your local Social Security Office (see address below).

We recommend you read this entire page then **print or save** it for your records.

Important--Next Steps:

Mail or bring the following items to your local Social Security Office at the address below.

- **Signed and dated SSA-827, Authorization to Disclose Information to SSA,** and copies of any medical information you may already have on hand.
- **Completed and dated cover sheet** for this Appeal Disability Report with any other items identified on the cover sheet that you need to submit.

If you were unable to print the SSA-827 (Authorization to Disclose Information to SSA), please contact Social Security.

Your Local Social Security Office:

SOCIAL SECURITY ADMINISTRATION
315 N WASHINGTON ST
ROCKVILLE, MD 20850
(301) 413-0400

You can mail or bring these documents to a different Social Security Office. You can use the Office Locator to find another Social Security Office.

What to Expect:

- While we are processing your appeal, we may contact you for more information or to set up an interview. We may ask you to fill out additional forms.
- If we need more medical evidence, we may ask you to see a doctor for a special examination. We will pay for this.
- If you have copies of medical records that you have not given to us before, mail them to your local Social Security Office.
- Please contact Social Security, immediately, if you:
  - Go to a new doctor
  - Have a new medical test done
  - Have a change in your condition
  - Go to work
  - Change your address or phone number
- For more information on the disability process, go to How the Disability Appeal Process Works

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Feedback survey

Thank you for using our Internet Disability Report. We would like to know what you think of this service. Please take a minute to fill out our survey below. If you do not want to fill out the survey, you may leave this site by using the "Finished" button below.

1. How easy or hard was it for you to fill out the Disability Report? Please select one rating:

- (•) Very Easy (if selected, go to question 3)
- ( ) Somewhat Easy (if selected, go to question 3)
- ( ) Somewhat Hard
- ( ) Very Hard

2. If you felt that the Disability Report was hard to fill out, please select all the reasons from the list below that might apply:

- [ ] Did not understand what information I needed to give
- [ ] Too many questions to answer
- [ ] Problems of my own (couldn't find information needed; not feeling well; interrupted)
- [ ] Computer too slow
- [ ] Problems typing and/or changing information
- [ ] Problems moving from one place to another on the report or from one place to another on a page

3. Which section of the Disability Report was the hardest to fill out? Select one:

- ( ) About You (Identifying information, description of your medical condition)
- (•) Medical History (Doctors, hospitals, test, medications, etc.)

4. Did you have problems printing any of the forms?

- ( ) Yes
- (•) No

5. Did you fill out the Internet Disability Report because you are applying for disability benefits yourself or were you helping someone else?

- (•) Applying for benefits myself
- ( ) Helping someone else

6. Overall, how would you rate the Disability Report as an Internet service? Please select one rating:

- (•) Excellent
- ( ) Very Good
- ( ) Good
- ( ) Fair
- ( ) Poor
- ( ) Very Poor

[Finished]

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