



SOCIAL SECURITY ADMINISTRATION

Refer To:
[Claimant SSN]
[Claimant Name]

Office of Disability Adjudication and Review
Hearing Office
Hearing Office Address
City, State Zip Code
Telephone Number/ Fax Number

Date

School Administrator or Pupil Personnel Director
Facility Name
Facility Address
City, State Zip Code

The above-named individual has appealed a disability case to our office. We are asking you to provide information about the individual that will help us make a decision.

Please ask the person(s) who is most familiar with the individual's overall functioning to complete the enclosed questionnaire. This is usually the individual's regular or special education teacher. However, for some illnesses, injuries, or conditions, another person, like a counselor or therapist, may be better able to complete the questionnaire.

We have enclosed a completed SSA-827 signed by the individual or the person acting on his or her behalf, which authorizes you to provide the information we are requesting. For your convenience, we have enclosed a return envelope. Alternatively, you may use the enclosed barcode to fax the completed questionnaire to [FECS Toll Free number]. If you have any questions, please contact us at [Hearing Office telephone number].

Sincerely yours,

Hearing Office Employee Name
Hearing Office Employee Title

Enclosures:
(SSA-5665-BK, Teacher Questionnaire)
(SSA-827, Authorization To Disclose Information to the Social Security Administration)