Social Security Administration
Disability Update Report
Information and Completion Instructions

Why We Are Writing To You Now

The Social Security Administration must regularly review the cases of people getting disability benefits to make sure they are still disabled under our rules. It is time for us to review this case. Enclosed is a **Disability Update Report** for you to answer to update us about you (or the person for whom you are the representative payee), your health and medical conditions, any recent work activity, or any recent training.

What To Do First

Please read the following information, **and** the instructions for completing the report form, **before** you answer the questions.

When to Respond

Please complete the report, **sign it** and send it to us in the enclosed envelope within **30 days**. If there is no return envelope with the report, please send the signed report to us at:

Social Security Administration
P.O. Box 4550
Wilkes-Barre, PA 18767-4550

What We Do With Your Answers

We consider the information you give us together with the information in your claim record to decide if we need to do a full medical review. After we receive the completed report, we will notify you whether or not we need to do a full medical review.

If You Need Help To Answer The Report

It is important that information you give us is accurate. We have tried to make report questions easy to understand and answer. But, if you find that you do not understand a question or questions, please contact us, your authorized representative, a social service agency, your doctor or clinic, or some other person you trust.

If You Need To Contact Us

If you need to contact us, please call us toll-free at **1-800-772-1213** or TTY for the hearing impaired at **1-800-325-0778.** We can answer most questions over the telephone. If you prefer to visit or call one of our offices, please use the 800 number to get the local office address and telephone number. Please have the Disability Update Report with you if you call or visit an office. It will help us answer your questions. Also, if you plan to visit an office, you should call ahead to make an appointment. This will help us serve you.

We May Need To Contact You

Sometimes, we may need more information from you. If so, we will try to call you. If you do not have a telephone, please give us a number where we can leave a message for you. Please print the telephone number in the section provided on the back of the report form.

If We Don't Hear From You

If you do not complete and return the report promptly, or tell us why you cannot respond, we may stop sending payments to you. If it is necessary to stop your payments, we will send you another letter telling you what we plan to do.

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If We Do A Full Medical Review

If we decide to do a full medical review of your case, you can give us any information which you believe shows that you are still disabled, such as medical reports and letters from your doctors about your health. Then, we look at all your information in your case, including the new information you give us, and decide whether you continue to be disabled under our rules.

Appeals And Continued Benefits

When we review your case, we may find that you are no longer disabled under our rules, and your payments may stop. If your payments stop, you can appeal our decision or you can ask us to continue to make payments while you appeal.

If You Want To Work

Do you want to work, but worry about losing your payments or Medicare before you can support yourself? We want to help you go to work when you are ready. But, work and earnings **may** affect your benefits. Your local Social Security office can tell you more about work incentives, and how work and earnings can affect your benefits.

The Privacy And Paperwork Reduction Acts

Privacy Statement Collection and Use of Personal Information – Sections 205(a) and 1631(e)(1)(A) and (B) of the Social Security Act, as amended, and Social Security regulations at 20 C.F.R. 404.1589 and 416.989 authorize us to collect this information. We will use the information you provide to further document your claim and permit a determination about continuing disability.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than for the reasons explained above. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs);
2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act Systems of Records Notices entitled, Claims Folders Systems (60-0089) and the Master Beneficiary Record (60-0090). Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement – This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. The OMB control number for this collection is 0960-0511. We estimate that it will take 15 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

GENERAL INSTRUCTIONS - HOW TO COMPLETE "SCANNABLE" FORMS

The Disability Update Report is a scannable form which can be "read" electronically. To help us process your report, **please follow these instructions when you answer the questions on the report form:**

1. **USE BLACK INK OR A #2 PENCIL.**
2. **KEEP YOUR NUMBERS, LETTERS, AND "X'S" INSIDE THE BOXES.**
3. **NUMBERS:** Try to make your numbers look like these:

   0 1 2 3 4 5 6 7 8 9

4. **LETTERS:** Print in **CAPITALS.** Try to make your letters look like these:

   A B C D E F G H I J K L M
   N O P Q R S T U V W X Y Z

5. **MONEY AMOUNTS:** Show dollars only. Do not use dollar signs ($), and do not show cents. For example, show $1,540.30 like this:

   Dollars Only, No Cents

   01 , 540

6. **DATES:** Put a number in each box. For example, show September 9, 2003, like this:

   Month 09 **Year** 03

7. **THE REPORT PERIOD:** The "report period" is the period of time for which we need information. It is described at the top of the report form to the right of your name, and again in questions 1 through 6. Usually, the report period is the last 24 months, but it may be less. **It is important that you keep the report period in mind when answering the questions.**

HOW TO FILL OUT THE REPORT FORM

QUESTION 1.a. - Have You Worked?

If you have not worked during the report period, place an "X" in the box below "NO", and go on to question 2. If you have worked, mark the box below "YES", and answer question l.b.

QUESTION 1.b. - When You Worked And Your Monthly Earnings

Describe your most recent work activity first. Print the months and years you began and ended working in the boxes under "Work Began" and "Work Ended." **If you are working now**, print the current month and year in the first set of boxes under "Work Ended." Print your gross monthly earnings for the periods you worked in the boxes.

QUESTION 2 - School Or Work Training

Place an "X" in the box below "YES" if you have attended school and/or a training program during the report period; otherwise, mark the box below "NO". This could include high school equivalency programs, college courses, vocational evaluation or retraining programs, but generally would not include group therapy or hobbies.

Continued on the Reverse →

QUESTION 3 - Can You Work?

Tell us if you have discussed with your doctor whether you can return to any kind of work, and if so, whether the doctor told you that you can return to work, even if the work permitted is less physically demanding and/or less stressful than your usual work. **Place an "X" in only 1 box.**

QUESTION 4 - How Is Your Health?

We want to know how your overall health now compares to what it was at the beginning of the report period. You may feel that your health has gotten worse, has improved, or you may feel that your health is about the same and has not gotten better or worse. **Place an "X" in only 1 box.**

QUESTION 5 - Treatment By A Doctor Or Clinic

A "doctor or clinic" can include treatment such as evaluations, checkups, counseling, providing prescriptions or medicine by a doctor, visiting nurse, family health center, psychologist, licensed counseling service, physical therapist, a chiropractor or other licensed health provider. Treatment may be provided in person or by telephone or other contact.

How To Answer Question 5.a.

If you have not been treated by a doctor or clinic during the report period, place an "X" in the box below "NO", and go on to question 6. If you have gone to a doctor or clinic during the report period, mark the box below "YES", and answer question 5.b.

Question 5.b. - Reason For The Visit

Please start with the most recent visit and then work backwards in time. Print as much information as will fit, but keep a space between each word. Try to use the most important or key word(s), such as **ARTHRITIS** or **BAD BACK**, or **HYPERTENSION** or **HIGH BLOOD**. Your medical bills or doctor can provide a short, accurate description.

Date of Visit

Print the month and year you were treated. Complete all 4 boxes. For example, print September 10, 2003, as **09 03**.

NOTE: If needed, use the "REMARKS" section on side 2 of the form.

QUESTION 6.a - Have You Been Hospitalized Or Had Surgery?

Place an "X" in the box below "NO" if you have not been hospitalized or not had surgery during the report period. If you have been hospitalized or had surgery during the report period, then place an "X" in the box below "YES" and answer question 6.b.

Question 6.b. - Reason For Treatment

Please report your most recent treatment first and then work backwards in time. Try to provide the most important information. Keep a space between each word. Your medical bills or doctor can provide short, accurate words.

Date of Treatment

Print the month and year you were hospitalized or had surgery. Be sure to use all four spaces. **If you were hospitalized more than one month,** print last month you were hospitalized.

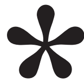
NOTE: If needed, use the "REMARKS" section on side 2 of the form.

Remarks Section

If you need more room to answer questions l.b., 5.b. and/or 6.b., or there are any other facts or statements you want us to consider, place an "X" in the box and write in this section. If necessary, use an extra piece of paper.

Signature, Date and Telephone Sections

Please sign the report form as you usually sign your name. Please provide a telephone number where you can be reached during the day.



DATE:

Disability Update Report

Social Security Administration, P.O. Box , Wilkes-Barre. PA 18767-

FORM APPROVED
OMB NO. 0960-0511

PAYEE'S NAME AND ADDRESS	REPORT PERIOD From: To The Present	
	BENEFICIARY	
PSC:	TELEPHONE NUMBER	CLAIM NUMBER

Please be sure to **use black ink or a #2 pencil to print your answers.** Also, **read the enclosed instructions** before completing the form. Finally, remember that when answering the questions, **the "REPORT PERIOD" for which we need information about you is from to the present**. If you have any questions, call 1-800-772-1213 or TTY for the hearing impaired at 1-800-325-0778.

1. a. Since have you worked for someone or been self-employed? → YES ☐ NO ☐

b. If you answered "YES" to 1.a., please complete the information below.

Most Recent Work	WORK BEGAN Month	WORK BEGAN Year	WORK ENDED Month	WORK ENDED Year	MONTHLY EARNINGS Dollars Only, No Cents
1.					$,
2.					$,
3.					$,

2. Have you attended any school or work training program(s) since ? YES ☐ NO ☐

3. Since to the present...*(Please place an 'X' in one box only):*

☐ my doctor and I have not discussed whether I can work.
☐ my doctor told me I cannot work.
☐ my doctor told me I can work.

4. Place an "X" in only one box which best describes your health now as compared to .

☐ BETTER ☐ SAME ☐ WORSE

Form SSA-455-OCR-SM (10-2013)

Continued on the Reverse →

FOR SSA USE ONLY
AC? ☐☐☐

5. a. Have you gone to a doctor or clinic for treatment (including evaluations, checkups, counseling, prescriptions, or medicine) since ? → YES ☐ NO ☐

b. If you answered "YES" to 5.a., please list:

		Reason For Visit:	Month	Year
Most Recent Visit	1.			
	2.			
	3.			

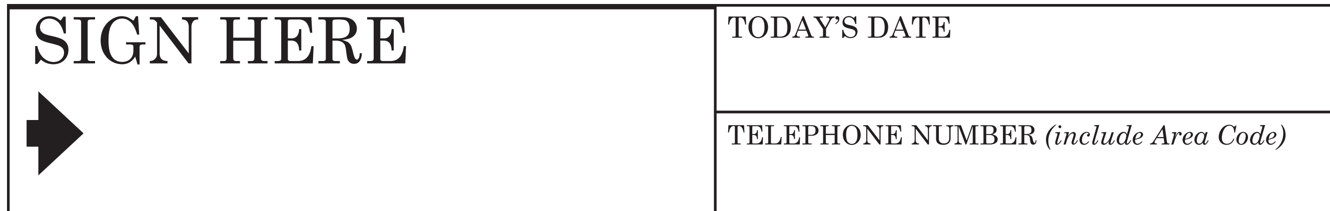
6. a. Have you been hospitalized or had surgery since ? → YES ☐ NO ☐

b. If you answered "YES" to 6.a., please list:

		Reason For Hospitalization or Surgery:	Month	Year
Most Recent	1.			
	2.			
	3.			

REMARKS: If you use this space to further answer questions 1. through 6., place an "X" in the box to the right and print on the lines below. ☐

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.



SIGN HERE	TODAY'S DATE
	TELEPHONE NUMBER *(include Area Code)*