CONTINUING DISABILITY REVIEW REPORT SSA-454-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that reviews your medical condition(s) will use the information you provide in this report to 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, you may contact us at 1-800-772-1213 (TTY 1-800-325-0778). A Social Security Representative will assist you. Please have the information available from the bulleted items below when you call us. If you have a continuing disability review appointment, please have the information available, or the completed report ready when we contact you. **If you cannot speak or understand English, we will provide an interpreter free of charge.**

WHAT YOU NEED TO COMPLETE THIS REPORT

- Name, address, and phone number of a friend or relative (other than your doctors) we can contact who knows about your medical condition(s), and can help with your case, if needed.

- Name, address, and phone number of any health care providers you have seen **within the last 12 months.** (You may be able to get that information from the telephone book, Internet, online medical chart, medical bills, prescriptions, or prescription medicine containers.)

- Any prescription or non-prescription medicines you take or have taken **in the last 12 months**.

- Name of organization who we can contact that would have medical information about your condition(s) **in the last 12 months**. (Such as social services agencies, welfare agencies, attorneys, prisons, workers' compensation and insurance companies who have paid you disability benefits.)

- Information about any education since your last disability decision. (See top of **Page 3** for date of last decision.)

- Information about any vocational rehabilitation, employment, or other support services since your last disability decision. (See top of **Page 3** for date of last decision.)

- **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."**

- If you need more space to answer any question, please use **Section 9 - Remarks**, on the last page to finish your answer. Write the number of the question you are answering.

YOUR MEDICAL RECORDS

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS.
If you have consented to us obtaining medical records from your providers, we will request your records directly from them. 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), 221(i), 223(d), 1614(a), 1631(e), and 1633(c) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information to determine eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting Social Security Administration (SSA) in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and

- To private medical and vocational consultants for use in making preparation for, or evaluating the results of, consultative medical examinations or vocational assessments which they were engaged to perform by SSA or a State agency acting in accord with sections 221 or 1633 of the Act.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy.

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. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to****: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

SEND OR BRING THE COMPLETED REPORT TO YOUR LOCAL SOCIAL SECURITY OFFICE, OR 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.

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

CONTINUING DISABILITY REVIEW REPORT

For SSA Use Only - Do not write in this box.
Date of your last medical disability decision:

SECTION 1 - INFORMATION ABOUT YOU

When a question refers to "you" or "your" it refers to the person receiving disability benefits. If you are completing this report for someone else, please provide information about them.

1.A. NAME (First, Middle, Last, Suffix)	**1.B.** SOCIAL SECURITY NUMBER

1.C. In the last 12 months, have you used any other names on your medical or educational records? Examples include maiden name, other married names, other names, or nickname.

☐ YES

☐ NO

If YES, please list names used

1.D. MAILING ADDRESS (Street or PO Box) Include apartment number if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

1.E. Is your residence address the same as your mailing address? ☐ YES ☐ NO - Complete RESIDENT ADDRESS below

RESIDENT ADDRESS (Include apartment number if applicable.)

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

1.F. DAYTIME PHONE NUMBER(S) where we can call to speak with you, or leave a message, if needed. (Include area code, or IDD and country code if outside the USA or Canada.)

Primary: _____ Secondary: _____ *(If available)*

1.G. EMAIL ADDRESS

1.H. Can you speak and understand English? ☐ YES ☐ NO

If NO, what language do you prefer? _____

If you cannot speak and understand English, we will provide an interpreter free of charge.

1.I. Can you read and understand English? ☐ YES ☐ NO

1.J. Can you write more than your name in English? ☐ YES ☐ NO

SECTION 2 – SOMEONE WE CAN CONTACT

Please provide the name of someone (other than your doctors) we can contact who knows about your medical condition(s), and can help with your case and can help us reach you if you become unavailable. Examples include a family member, friend, or neighbor.

2.A. NAME (First, Middle Initial, Last)	**2.B.** Relationship to Person in **1.A.**

2.C. MAILING ADDRESS (Street or PO Box) Include apartment number if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

2.D. DAYTIME PHONE NUMBER (as described in **1.F.** above)

2.E. Can this person speak and understand English? ☐ YES ☐ NO

(If NO, what language is preferred?)

SECTION 3 - MEDICAL INFORMATION

Please provide us with general medical information to assist us with any records requests. We will use this information to see what additional questions or forms we may need to send you.

3.A. Separately list each physical and/or mental health condition that limits your ability to work. **If under age 18**, list the physical and/or mental health condition(s) that limit the child's ability to do the same things as other children the same age.

1.
2.
3.
4.
5.

If you need more space to list additional conditions go to Section 9 – Remarks

3.B. What is your height? _____ feet _____ inches OR _____ centimeters

3.C. What is your weight? _____ pounds OR _____ kilograms

3.D. Within the last 12 months, have you seen or received treatment from a health care provider (doctor, hospital, clinic, psychiatrists, nurse practitioners, therapists, physical therapists, or other medical professionals)?

☐ NO (**Go to 3.F.**)

☐ YES (**Complete the following section below.)**

You may find this information on medical bills or the internet. If you don't have the full street address, give as much as you can. **Example:** "On Main St next to the Courthouse."

1. NAME OF FACILITY OR OFFICE	NAME OF HEALTH CARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE LAST SEEN (IF KNOWN)	MM / YYYY

STREET ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

2. NAME OF FACILITY OR OFFICE	NAME OF HEALTH CARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE LAST SEEN (IF KNOWN)	MM / YYYY

STREET ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

3. NAME OF FACILITY OR OFFICE	NAME OF HEALTH CARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE LAST SEEN (IF KNOWN)	MM / YYYY

STREET ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

4. NAME OF FACILITY OR OFFICE	NAME OF HEALTH CARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE LAST SEEN (IF KNOWN)	MM / YYYY

STREET ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

5. NAME OF FACILITY OR OFFICE	NAME OF HEALTH CARE PROVIDER THAT TREATED YOU

What medical conditions were treated or evaluated?

PHONE NUMBER	DATE LAST SEEN (IF KNOWN)	MM / YYYY

STREET ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

If you need to list more facilities or doctors, use **Section 9 – Remarks**.

3.E. Within the last 12 months, did any of the providers listed in **3.D.** order any medical tests for you? (Include tests already performed and those scheduled in the future, and the healthcare provider that scheduled them.)

☐ NO (**Go to 3.F.**)

☐ YES (**Complete the following section below.**) – If you need more space, use **Section 9 – Remarks.**

TEST	NAME OF HEALTHCARE PROVIDER
Blood test (not HIV)	
Breathing test	
Cardiac catheterization	
EEG (brain wave test)	
EKG (heart test)	
Hearing test	
HIV test	
Speech/language test	
Treadmill (exercise test)	
Vision test	
Psychological/IQ test	
Biopsy (list body part):	
MRI/CT scan (list body part):	
X-ray (list body part):	
Other – please specify:	

3.F. Within the last 12 months, have you taken or are you now taking any prescription or non-prescription medicines?

☐ NO (**Go to 3.G.**)

☐ YES (**Complete the following section below.**) – Look at your medicine containers, if necessary. If you need more space, use **Section 9 – Remarks**.

NAME OF MEDICINE	IF PRESCRIBED, GIVE DOCTOR NAME	REASON FOR MEDICINE (IF KNOWN)
1.		
2.		
3.		
4.		
5.		
6.		

3.G. Do you use an assistive device?

☐ NO (**Go to Section 4**)

☐ YES (**Complete the following section below.**) If you need more space, use **Section 9 – Remarks**.

DEVICE	FREQUENCY OF USE		NAME OF HEALTH CARE PROVIDER, IF PRESCRIBED
☐ Braces	☐ Always	☐ Sometimes	
☐ Canes	☐ Always	☐ Sometimes	
☐ Crutches	☐ Always	☐ Sometimes	
☐ Eyeglasses	☐ Always	☐ Sometimes	
☐ Hearing aid	☐ Always	☐ Sometimes	
☐ Screen reader	☐ Always	☐ Sometimes	
☐ Walker	☐ Always	☐ Sometimes	
☐ Wheelchair	☐ Always	☐ Sometimes	
☐ Other:	☐ Always	☐ Sometimes	

3.H. Is the person receiving disability benefits listed in **1.A.** under age 14?

☐ NO (**Go to Section 4**)

☐ YES (**Go to Section 10**)

SECTION 4 – WORK INFORMATION
Complete only if you are age 14 years old or older

Please tell us if you have worked since the date of your last medical disability decision. If we have any additional questions about your work, we may contact you.

4.A. Since the date of your last medical disability decision have you worked? (See date on top of **Page 3.**)

☐ NO (**Go to 4.B.**)

☐ YES (**Complete following section below.**)

Are you currently working?

☐ No

☐ Yes

Select all types of work you had since your last medical disability decision:

☐ Wages from employer

☐ Self-employment

4.B. Is the person receiving disability benefits listed in **1.A.** under age 18?

☐ NO (**Go to Section 5**)

☐ YES (**Go to Section 10**)

SECTION 5 – SUPPORT SERVICES
Complete only if you are age 18 years or older

Please provide the information about your participation in support services. Examples of support services can include:

- **An Individualized Education Program (IEP) through a school (if a student age 18-21)**
- **An individualized work plan with an employment network under the Ticket to Work Program**
- **A Plan to Achieve Self-Support (PASS)**
- **An individualized plan for employment with a vocational rehabilitation agency or any other organization.**

5.A. Since the date of your last medical disability decision, have you participated or are you participating in any support services mentioned above or any other vocational rehabilitation, employment services, or other support services to help you return to work? (See date on top of **Page 3.**)

☐ NO (**Go to Section 6**)

☐ YES (**Complete the following section below.**)

FACILITY OR ORGANIZATION NAME	PHONE NUMBER

COUNSELOR, INSTRUCTOR, OR JOB COACH NAME

MAILING ADDRESS (Street or PO Box) (Include Suite, Building, etc.)

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

5.B. Are you still participating in the plan or program? (Select answer below)

☐ YES - Date began: MM / YYYY	Expected completion date: MM / YYYY
☐ NO - Date began: MM / YYYY	Date stopped: MM / YYYY

Reason stopped:

5.C. What types of services, tests, or evaluation were provided?

Select all that apply:

☐ Vision test	☐ Psychological/IQ test	☐ Work classes	☐ Hearing test	☐ Work Evaluation

☐ Other - Please explain:

SECTION 6 - OTHER MEDICAL INFORMATION
Complete only if you are age 18 years or older

Please provide the contact information for anyone else or any other organization that may have medical information about your physical or mental health condition(s) that you did not list in Questions 3.D. or 5.A.

6. Within the last 12 months, does anyone else (other than your medical providers) have your medical information or are you scheduled to see anyone else? Examples include places like social services agencies, welfare agencies, attorneys, prisons, workers' compensation, insurance companies who have paid you disability benefits.

☐ NO (**Go to Section 7**)

☐ YES (**Complete the following section below.**)

NAME OR ORGANIZATION	PHONE NUMBER
MAILING ADDRESS	

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

NAME OF CONTACT PERSON	CLAIM NUMBER (if any)

Date of First Contact (in last 12 months)	Date of Last Contact (in last 12 months)	Date of Next Contact (if any)

Reason(s) for Contacts

If you need to list other people or organizations use Section 9 - Remarks and give the same detailed information as above for each one you list.

SECTION 7 – EDUCATION, TRAINING, AND LITERACY
Complete only if you are age 18 years or older

Please provide any information about your education, training, and literacy since your last disability decision.

7.A. Have you received any **education** since your last disability decision? (See date at the top of **Page 3.**)

☐ NO, (**Go to 7.B.**)

☐ YES (**Complete the following section below.**)

NAME OF SCHOOL	DATE(S) OF ATTENDANCE
	MM / YYYY to MM / YYYY

MAILING ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

TYPE OF PROGRAM/DEGREE	Date Completed (or scheduled to be completed)
	MM / YYYY

7.B. Have you received any type of **training** (specialized job, trade, or vocational training) since your last disability decision? (See date at top of **Page 3**.)

☐ NO (**Go to 7.C.**)

☐ YES (**Complete the following section below.**)

NAME OF TRAINING FACILITY	PHONE NUMBER
MAILING ADDRESS	

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

TYPE OF PROGRAM	Date Completed (or scheduled to be completed)
	MM / YYYY

7.C. What written language do you use every day in most situations (at home, work, school, in community, etc.)?

7.D. READING - In the language you identified in **7.C.**, can you **read** a simple message, such as a shopping list or short and simple notes? ☐ YES ☐ NO

7.E. WRITING - In the language you identified in **7.C.**, can you **write** a simple message, such as a shopping list or short simple notes? ☐ YES ☐ NO

If you need to list other education information or training facilities use Section 9 - Remarks and provide the same detailed information as above.

SECTION 8 - DAILY ACTIVITIES
Complete only if you are age 18 years or older.

Please tell us how your conditions affect your everyday life. This will help us further understand your medical condition(s).

8.A. Describe what you do in a typical day. Please focus on how your medical condition(s) affect your daily activities. If you need more space, use **Section 9 – Remarks**. **Claims Specialists will mention to respondents that this question is optional**

8.B. Do you have hobbies or interests? If you need more space, use **Section 9 – Remarks.**

☐ YES ☐ NO **Claims Specialists will mention to respondents that this question is optional**

If YES, please describe what they are and how much time you spend doing them **This Question is Optional**

8.C. Do your medical conditions cause you to have difficulties doing any of the following?

☐ YES ☐ NO

If YES, please select any tasks that you need help with or have difficulty doing.

☐ Dressing	☐ Taking medicine	☐ Doing chores (inside/outside of house)
☐ Bathing	☐ Preparing meals	☐ Driving or using public transportation
☐ Caring for hair	☐ Feeding self	☐ Understanding or following directions
☐ Walking	☐ Shopping	☐ Managing money
☐ Standing	☐ Lifting objects	☐ Getting along with people
☐ Sitting	☐ Using arms	☐ Using hands or fingers
☐ Concentrating	☐ Remembering	☐ Seeing, hearing, or speaking

Please explain anything you marked you need help with or have difficulty doing:

SECTION 9 - 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 requested information, please use this space to provide the additional information requested in those sections. Be sure to note the section (and question number) to which you are referring.

SECTION 10 – WHO IS COMPLETING THIS REPORT

Date Report Completed (month, day, year)

Who is completing this report?

- ☐ The person listed in **1.A.**
- ☐ The person listed in **2.A.**
- ☐ Someone else (Complete the following section below)

NAME (First, Middle Initial, Last)	Relationship to Person in **1.A.**

DAYTIME PHONE NUMBER where we may reach you or leave a message, if needed. (Include the area code, IDD and country codes if you live outside the USA or Canada.)

MAILING ADDRESS (Street or PO Box) Include apartment number if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)