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## Social Security Administration Disability Update Report Information and Completion Instructions

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**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 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 Act Statement Collection and Use of Personal Information**

Sections 205(a), 221(i), 223(d), 1614(a)(4), 1631(e)(1), and 1633(a) and (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 us from making an accurate and timely decision on any claim filed.

We will use the information to make a determination of continued eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. 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 the Social Security Administration (SSA) or a State agency acting in accord with sections 221 or 1633 of the Act; and
2. To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs. We contemplate disclosing information under this routine use only in situations in which SSA may enter a contractual agreement with a third party to assist in accomplishing an agency function relating to this system of records.

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 Notice (SORN) 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at [www.socialsecurity.gov/foia/bluebook](http://www.socialsecurity.gov/foia/bluebook).

**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
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- 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**

0	1	,	5	4	0
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- 6. **DATES:** Put a number in each box. For example, show September 9, 2003, like this:

<b>Month</b>		<b>Year</b>	
0	9	0	3

- 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 1.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.

**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 1.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.

**Date and Telephone Sections** Please date the report form. Please provide a telephone number where you can be reached during the day.

# Disability Update Report

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

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		WORK ENDED		MONTHLY EARNINGS		
	Month	Year	Month	Year	Dollars Only, No Cents		
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>	<input type="text"/>

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):

<input type="checkbox"/> my doctor and I have not discussed whether I can work.	<input type="checkbox"/> my doctor told me I cannot work.	<input type="checkbox"/> my doctor told me I can work.
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4. Place an "X" in only one box which best describes your health now as compared to

<input type="checkbox"/>	<input type="checkbox"/> BETT	<input type="checkbox"/> ER
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