AGENCY LETTERHEAD

Date: _____

Case ID: [Fill-in]

Addressee Name
Address Line 1
Address Line 2
City, State, ZIP Code

AGREEMENT TO ATTEND A TELEHEALTH CONSULTATIVE EXAMINATION

IMPORTANT: Please complete, sign, date, and mail this form as soon as possible using the pre-addressed envelope provided.

We are contacting you because we need more medical information for [your/name of claimant's] disability claim with the Social Security Administration (SSA). We are asking [you/name of claimant] to attend a [mental or speech and language] consultative examination so that we can obtain that information.

[You have/Name of claimant has] the option to attend a telehealth consultative examination. A telehealth consultative examination is conducted over the internet using video technology that would allow [you/name of claimant] and the provider to see and talk with each other. A telehealth consultative examination would allow [you/name of claimant] to attend the appointment from [your/name of claimant's] home or other private location.

If [you attend/name of claimant attends] a telehealth consultative examination, [you/name of claimant] will need to use a smartphone, tablet, laptop, or desktop computer that has a camera, microphone, and reliable internet connection. (For a speech and language examination: [you/name of claimant] will need to use a laptop, desktop computer, or tablet with diagonal screen display of at least 9.7 inches that has a camera, microphone, and reliable internet connection.) If [you do/name of claimant does] not want to attend a telehealth consultative examination, we will schedule a consultative examination in person.

Before you decide whether you agree to attend (have [name of claimant] attend) a telehealth consultative examination, we want to make sure you know that the information technology used for your (name of claimant's) exam will not be owned by SSA. Also, while the providers who perform consultative examinations for us are required to use online services that meet certain privacy and security requirements, there are privacy or security risks that may be associated with use of online services.

If you agree to [attend/have [name of claimant] attend] a telehealth consultative examination, we will tell you before the examination which video technology will be used for [your/name of claimant's] examination. We will also provide instructions on how to access the technology. [You/name of claimant] may be asked to agree to third-party terms and privacy policies of the video technology provider. Neither the State Disability Determination

Services (DDS) nor SSA control the terms of service or privacy policies of third-party video technology providers. [You/name of claimant] can decide not to attend a telehealth examination at any time before the examination.

When attending a telehealth consultative examination, [you/name of claimant] must present a valid, government-issued photo identification (ID) over the video connection. [You/name of claimant] may present ID documents, such as a United States (U.S.) State-issued driver's license, U.S. State-issued ID card, U.S. passport, U.S. military ID, or U.S. tribal ID. For a child who does not have a government-issued photo ID, you may present an original government-issued non-photo ID document, such as a birth certificate, or a nongovernment-issued photo ID, such as a student ID.

Please answer the questions below about how you would like to proceed with the consultative exam:

1. Do you agree to [attend/have [name of claimant] attend] a telehealth consultative examination voluntarily?

□ **Yes**
□ **No** (If you select "No," we will schedule an in-person consultative examination)

2. If you agree [to attend/have [name of claimant] attend] a telehealth consultative examination, [do you/does [name of claimant]] have the following:

A. Access to a private, indoor, quiet location where [you/name of claimant] can attend the examination?

□ **Yes**
□ **No**

B. Access to a reliable internet connection [you/name of claimant] could use for the examination?

□ **Yes**
□ **No**

C. Access to a device with a camera and microphone, such as a smartphone, tablet, laptop, or desktop computer that [you/name of claimant] could use for the examination? (For speech and language examination: Access to a device with a camera and microphone, such tablet, laptop, or desktop computer that [you/name of claimant] could use for the examination?)

□ **Yes**
□ **No**

3. Do you understand that you may change your mind about [attending/having [name of claimant] attend] a telehealth consultative examination at any time before the examination?

□ **Yes**
□ **No**

If you agree to attend a telehealth consultative examination and then change your mind, please call the number below so that we can schedule an in-person examination. We will also include a telephone number in your appointment notice that you can use to contact us.

By signing below, I am indicating that I have read and understand this form.

_____ _____
(Claimant/Parent or Legal Guardian Signature) (Date)

_____
(Printed Name)

If the examination is for a claimant who is a child aged 12 or older, they must also agree to attend the examination.

_____ _____
(Child's Signature) (Date)

_____
(Printed Name)

4. If you agree to [attend/have [name of claimant attend]], some of the appointment information may be sent by email. Please provide the email address where you wish to receive the appointment information:

_____
Email Address

If you have any questions about this letter or need to contact us, call Monday through Friday between 8:00 a.m. and 4:00 p.m. at the phone number below.

Thank you,

(DDS Signature Information) _____
DDS PHONE NUMBER Fill-in
DDS TTY/TRS Fill-in

Privacy Act Statement
Collection and Use of Personal Information

Sections 221 and 1633 of the Social Security Act, as amended, allow us to collect this information, which we will use to schedule a consultative examination either in person or by telehealth, depending on whether you agree to a telehealth examination. Providing this information is voluntary; not providing all or part of the information may delay, but will not negatively affect the determination we make on your claim for benefits. As law permits, we may use and share the information you submit, including with private medical and vocational consultants, other Federal agencies, contractors, and others, as outlined in the routine uses within System of Records Notice(s) 60-0044 and 60-0320, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs to establish or verify eligibility for Federal benefit programs and to recoup 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. We estimate that it will take about 5 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.*