DCPS ELZA GLEICHNER
5170 WALKER OVERPASS
ERNESTINEFURT NM  86456

DEMO ENVIRONMENT

CONFIDENTIALITY NOTICE: The accompanying material contains sensitive information. This information may be privileged and confidential, and intended for the use of the recipient named in this correspondence. If you have received this information in error, please contact us immediately.

**DISABILITY DETERMINATIONS SERVICE**
**SSA**
**S09 Delaware DDS**
**SUITE 300**
**NEW CASTLE, DE 19720-1000**
**TEL: (555) 555-5555**

Date: Mar 8, 2022
Case ID: 21665

DCPS ELZA GLEICHNER
5170 WALKER OVERPASS
ERNESTINEFURT NM 86456

We are the office that makes disability decisions for the Social Security Administration. We are writing about your disability claim because we need more information about your condition, daily activities, or work history.

**What You Need To Do**

**Complete these form(s) with black or blue ink.** We realize that some of the questions may not seem relevant to the case, but please answer all of the questions to the best of your ability.

**Return the completed form(s) by March 18, 2022.** If you do not return the form(s), we may decide the case based on the information we already have on file. This means that we could find that you are not disabled based on our rules or that your disability has ended if you are already getting benefits.

**How To Return The Form(s)**

You may use the enclosed return envelope or fax your completed form(s) to us at (123) 456-7945. Please note the return address may be to a scanning center who works with us. **The completed form(s) must include the barcode page on top of the form(s).**

**If You Have Any Questions**

If you have any questions or wish to provide more information, please call us at the number(s) shown below Monday - Friday between 11:30 am and 7:30 pm. When you call or leave a message, please provide the Case ID: 21665, your name, and a call back number.

Thank you for your help.

S. Schmidt
(301) 555-1212
(987) 654-3210 (FAX)

cc: Alternate1 M. ContactLastname1, Sr

Enclosure(s):
Cardiac Questionnaire
Privacy Act and Paper Reduction Act Statement
Return Envelope

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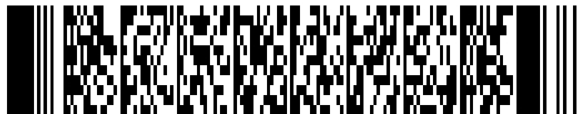
Form Approved
OMB No. 0960-0555

Date: Mar 8, 2022
Case ID: 21665
Claimant Name: DCPS Elza Gleichner



RQID:DCM12507 SITE:S09 DR:S
SSN:********* DOCTYPE:0221 RF:D CS:a5c8

**PLEASE COMPLETE AND RETURN BY MARCH 18, 2022**

**CARDIAC QUESTIONNAIRE**

If you need more space, please attach additional page(s).

1) Do you have any chest discomfort? ☐ Yes ☐ No

a) How often does it occur? ____________________

____________________

b) What brings on your chest discomfort? ____________________

____________________

c) What does it feel like? ____________________

____________________

d) How long do episodes last? ____________________

e) What relieves it? ____________________

____________________

f) Does it radiate? If so, where? ____________________

g) Does it occur at rest? ____________________

h) Does it awaken you from sleep? ____________________

2) Do you have shortness of breath? ☐ Yes ☐ No

a) When does it occur? ____________________

b) What brings it on? ____________________

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c) What relieves it? ____________________

d) How far can you walk without stopping to rest? ____________________

e) How many flights of stairs can you climb without stopping to rest? ____________________

3) Do you have additional symptoms (for example, fatigue, weakness, lightheadedness)? ☐ Yes ☐ No
If yes, describe.

____________________

____________________

____________________

4) List current cardiac medication(s).

| MEDICATION, DOSAGE, AND FREQUENCY | DATE STARTED | IF PRESCRIBED, NAME OF HEALTH CARE PROFESSIONAL | SIDE EFFECT(S) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

5) Describe any activities you have stopped due to shortness of breath or chest discomfort.

____________________

____________________

____________________

6) If you have seen any health care professionals for your cardiac condition since you filed your claim, complete the chart below.

DEMO ENVIRONMENT

| NAME OF HEALTH CARE PROFESSIONAL | ADDRESS AND PHONE NUMBER | DATE OF LAST VISIT AND NEXT SCHEDULED APPOINTMENT (IF ANY) |
|---|---|---|
| | | |
| | | |
| | | |

Name of person completing this form (Please print) | Date | Phone

Address | City | State | ZIP

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# Privacy Act Statement
# Collection and Use of Personal Information

Sections 205(a), 223(d) and 1631(d) and (e) 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 regarding your ability to perform work-related activities. 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 examination 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; and
2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We will disclose information under this routine use only in situations in which SSA may enter into a contractual or similar 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 Notices (SORN) 60-0044, entitled National Disability Determination Services File System and 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.

**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 20 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.*

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ALTERNATE1 MIDDLENAME1 CONTACTLASTNAME1 SR
3792 AUFDERHAR GROVE
STREET ADDRESS LINE 2
STREET ADDRESS LINE 3
STREET ADDRESS LINE 4
JANIEMOUTH IA  27903

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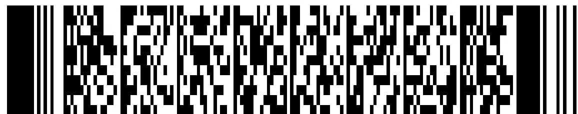

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