



IAPPEALS MEDICAL SCREEN SHOTS

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Section: Entry, Restart, and Exit Pages

Welcome page (Wlcm001)



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Getting Ready

What you need to know before you begin:

1. You are only required to submit new or updated medical information since your last filing (unless noted otherwise).
2. [View or print this checklist](#) of information you will need to have on hand before beginning your online appeal.
3. At the end of your session, you will be provided with a cover sheet and instructions on how to send any additional [Supporting documents](#) via US mail if needed.
4. When entering large blocks of text, be sure to click the "Save" or "Next" button to avoid timing out after 30 minutes of typing or inactivity.
5. This appeal may take 60 minutes or longer to complete. Your answers will be saved automatically as you move from screen to screen. You will be able to return to your saved appeal by using the [Re-entry Number](#) that will be provided to you.

Being prepared will help you spend less time to complete your disability appeal online.

More Information

- [About This Application](#)
- [Other Ways to Complete a Disability Appeal](#)
- [The Appeals Process](#)
- [Hours of Operation](#)

Your privacy is important.

For details about our use of your information, we encourage you to read our [Privacy Act Statement](#).

Submit an Appeal

Completing your appeal online may take 40 to 60 minutes. Your answers will be saved automatically so you can take a break at any time before submitting your appeal.

[Start a New Appeal](#)

or

[Return to a Saved Appeal](#)

Follow Up

After you are finished, we will contact you with any updates or questions we may have about your information. The claimant can log into their [my Social Security](#) account, or register for an account, to check the status of their appeal.



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Electronic Appeals Terms of Service

You are able to request a reconsideration or hearing with an Administrative Law Judge electronically by using this application and agreeing to the terms of service.

Note: A third party can provide this request on behalf of the claimant, but the third party must still agree to the terms below.

The Social Security Administration needs the following information to complete an electronic appeal request:

Claimant's Information

- Date on the Notice with the initial or reconsideration determination that you are appealing,
- Name,
- Social Security number,
- Date of birth,
- Mailing address, and
- Phone number.

Third Party Information, if applicable

- Representative's name,
- Address, and
- Phone number.

Medical/Other Information, if applicable (You may want to refer to your medical records and have your medicine containers available)

- Name, address, and phone number of a friend or relative who knows about your medical condition.
- Description of any change to your medical condition and any new medical conditions.
- Name, address, phone number, and visit dates of all health care providers, type of treatments, and tests since you last gave us medical evidence.
- Name of any medicine (prescription or over-the-counter) you are currently taking, why you are taking it, any side effects, and the name of the doctor who recommended or prescribed the medicine.
- Description of any change in your daily activities, work, and education.

If you do not wish to complete your appeal electronically, or you are unable to provide all of the information required for an electronic appeal within the 60-day appeal period, you may file your appeal request by mail or by visiting your local Social Security Office within this same appeal period. Visit www.ssa.gov/hlp/appeals/other-ways.htm to learn other ways to complete your disability appeal.

I Acknowledge:

- I have 60 days to request an appeal of the determination on my claim. My 60 days starts 5 days after the date on my Notice of Disapproved Claim or Notice of Reconsideration. I can file my appeal request online, by mail, or by visiting the local Social Security office. I can visit www.ssa.gov/benefits/disability/appeal.html to find additional information about the appeal process.
- I must inform the Social Security Administration about or submit all evidence known to me that relates

statements from medical sources about what I can still do despite my impairment(s).

- If I wish to submit evidence after I have submitted my appeal request, I can use www.ssa.gov/locator to find my local Social Security office and its business hours. I understand that in order for the Social Security Administration to consider my evidence, I must submit the evidence before the Social Security Administration makes a determination or decision on my appeal request.
- Appeal Level
 - Request for Reconsideration - I understand that if I have evidence to submit, but I am not able to submit it at the time I submit my appeal request, I should write, 'I have additional evidence to submit that is not electronic' in the 'I do not agree with the determination made on the above claim and request reconsideration. My reasons are:' section.
 - If the Social Security Administration sends me a notice that requests the evidence, I understand that I have 15 days to submit it before the Social Security Administration will start to process my request for reconsideration. I understand that once the 15 days expires, I still must inform the Social Security Administration about or submit any additional evidence.
 - Request for Hearing by Administrative Law Judge - I understand that if I have additional evidence to submit, but I am not able to submit it at the time I submit my appeal request, I can indicate on my appeal request that I have more evidence and can provide the name and sources of the additional evidence. I understand that I must inform the Social Security Administration about or submit any additional evidence no later than 5 business days before the date of my hearing.
- I must select the 'Submit' button within the Submit tab to file my appeal request with the Social Security Administration. **If I exit the application before selecting the "Submit" button, my appeal request will not be completed or processed.**
- Once I submit my appeal request electronically:
 - I will receive an on-screen confirmation that my appeal request has been submitted. I will also receive an email confirmation if an email address was provided.
 - The Social Security Administration will provide a cover sheet, which I can print and use to submit any evidence that I want the Social Security Administration to include with my appeal request.
 - If I indicated in my appeal request that I have additional evidence or the Social Security Administration needs additional information, a Social Security representative may contact me by email, phone, or mail.
- I can re-enter this application if:
 - I received a Re-entry number;
 - I do not submit my current appeal request; and
 - My appeal period has not expired.
- I cannot re-enter this application if:
 - I do not receive a re-entry number;
 - The appeal period has expired; or
 - I already submitted an appeal request on the determination or that I am attempting to appeal.
- If I want to add additional information to or change submitted information, I will mail, fax, or deliver paper copies of my evidence to my local Social Security office.
- I can obtain a receipt for my appeal request by accessing my Social Security account at www.socialsecurity.gov/myaccount, or by contacting my local Social Security office.

I understand that I may be subject to criminal or civil penalties, or both, if I provide false or misleading statements, engage in unauthorized use of this system, or otherwise misuse this system.

☐ I agree to the Terms of Service.

Next

Exit

Screening: Information about the Applicant (Scrn001)

Text SizeAccessibility Help



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Information about the Applicant

The information collected here refers to the adult or child whose disability decision is being appealed.

Name:

--

First

Middle

Last

Suffix

Social Security Number (SSN):

Date of Birth:

--

Month

Day

Year

Next

Previous

Who is entering this appeal (Entr001)

Text SizeAccessibility Help



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Who Is Entering This Appeal?

Are you John Public or are you entering this appeal on his/her behalf?

☒ I am John Public.

☐ I am entering this appeal for John Public.

Next



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Who Is Entering This Appeal?

Are you John Public or are you entering this appeal on his/her behalf?

- ☐ I am John Public.
☒ I am entering this appeal for John Public.

What is your relationship to John Public?

--

Appointed Representative (Attorney) or Staff
Appointed Representative (Non-Attorney) or Staff
Family Member
Friend/Neighbor
Government Agency
Health Service Agency/Hospital
Non-Profit Organization/Legal Aid Group
Nursing Care Facility
Social Worker
Other

Return to Saved appeal (Rtrn001)



Social Security

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Disability Appeal

Return to a Saved Appeal

Please enter the Re-entry Number and the Social Security Number to continue where you left off.

If you lose or forget your Re-entry Number, you will need to start a new appeal or the claimant can log into their [my Social Security](#) account, or create a new account, to check the status of their appeal and view their Re-entry Number.

Re-entry Number:

Applicant's Social Security Number (SSN):

[Next](#)[Previous](#)

Confirm your identity (Cfid001)

[Text Size](#) | [Accessibility Help](#)



Social Security

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Disability Appeal

Please Confirm Your Identity

I am:

- ☒ John Public
- ☐ Jimmy Formcompleter
- ☐ Jack Representative
- ☐ Jonah Contact
- ☐ Someone else, helping John Public to appeal

Next

[Text Size](#) | [Accessibility Help](#)



Social Security

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Disability Appeal

Please Confirm Your Identity

I am:

- ☐ John Public
- ☒ Jimmy Formcompleter
- ☐ Jack Representative
- ☐ Jonah Contact
- ☐ Someone else, helping John Public to appeal

Next



Social Security

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Disability Appeal

Please Confirm Your Identity

I am:

- ☐ John Public
- ☐ Jimmy Formcompleter
- ☒ Jack Representative
- ☐ Jonah Contact
- ☐ Someone else, helping John Public to appeal

Please confirm your name:

Jack Representative -- 
First Middle Last Suffix

Next



Social Security

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Disability Appeal

Please Confirm Your Identity

I am:

- ☐ John Public
- ☐ Jimmy Formcompleter
- ☐ Jack Representative
- ☒ Jonah Contact
- ☐ Someone else, helping John Public to appeal

Please confirm your relationship to John Public:

Family Member 
--
Family Member
Friend/Neighbor
Government Agency
Health Service Agency/Hospital
Non-Profit Organization/Legal Aid Group
Nursing Care Facility
Social Worker
Other

Contact -- 
Last Suffix



Social Security

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Disability Appeal

Please Confirm Your Identity

I am:

- ☐ John Public
- ☐ Jimmy Formcompleter
- ☐ Jack Representative
- ☐ Jonah Contact
- ☒ Someone else, helping John Public to appeal

What is your relationship to John Public?

-- 

-
- Appointed Representative (Attorney) or Staff
- Appointed Representative (Non-Attorney) or Staff
- Family Member
- Friend/Neighbor
- Government Agency
- Health Service Agency/Hospital
- Non-Profit Organization/Legal Aid Group
- Nursing Care Facility
- Social Worker
- Other

First Name Last Name Suffix

[+ Add Line](#)

ZIP Code:

Your Daytime Phone Number:

- ☒ U.S. ☐ International

10-digit Number Ext 

Next

1st Party: Exiting the Application (Exit001-1)

Text Size Accessibility Help

 **Social Security**
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Disability Appeal

i Are you sure you want to exit? Your appeal has not been submitted and it will not be processed at this time.

"Yes, I Want to Exit" saves the information you have entered for your appeal request and allows you to complete and submit your appeal request later.

i Before you select "Yes, I Want to Exit" below, be sure you have the following information so you will be able to continue your appeal later.

Re-entry Number: 84338499

Website: www.ssa.gov/disability/appeal

Select "Return to a Saved Appeal"

If you lose or forget your Re-entry number, you can log into your [my Social Security](#) account, or register for an account, to check the status of your appeal and view your Re-entry Number. Social Security employees will never ask for your Re-entry Number, nor will they have access to it. This is to protect your privacy.

 [Print this page](#)

3rd Party: Exiting the Application (Exit001-3)

Text Size Accessibility Help

 **Social Security**
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Disability Appeal

i Are you sure you want to exit? Your appeal request has not been submitted and it will not be processed at this time.

"Yes, I Want to Exit" saves the information you have entered for your appeal request and allows you to complete and submit your appeal request later.

i Before you select "Yes, I Want to Exit" below, be sure you have the following information so you will be able to continue the appeal for John Public later.

Re-entry Number: 95623111

Website: www.socialsecurity.gov/disability/appeal

Select **Return to a Saved Appeal**.

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for John Public's Re-entry number, nor will they have access to it. This is to protect John Public's privacy.

 [Print this page](#)

Section: Identification Pages

1st Party: Re-entry Number (Rnty001-1)

Text Size | Accessibility Help



Social Security
The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification

Re-entry Number

You will need the following Re-entry Number if something causes you to exit the application or you choose to save and return to your appeal at a later time.

In this section...

Re-entry Number

[Your Information](#)

 Please print this page, write down the Re-entry Number, or enter your email address below.

Re-entry Number: 98958889

Website: www.socialsecurity.gov/disability/appeal

Select "Return to a Saved Appeal".

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue your saved appeal.

If you lose or forget your Re-entry Number, you can log into your [my Social Security](#) account, or register for an account, to check the status of your appeal and view your Re-entry Number. Social Security employees will never ask for your Re-entry Number, nor will they have access to it. This is to protect your privacy.

 [Print this page](#)

Would you like us to email you this Re-entry Number?
Please note, only the Re-entry Number will be sent.

☒ Yes ☐ No

Email Address:

Confirm Email Address:

Next

[Save & Exit](#)



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification

Re-entry Number

You will need the following Re-entry Number if something causes you to exit the application or you choose to save and return to your appeal at a later time.

In this section...

Re-entry Number

[Preparer](#)

[Applicant Information](#)

 Please print this page, write down the Re-entry Number, or enter your email address below.

Re-entry Number: 39862723

Website: www.socialsecurity.gov/disability/appeal

Select "Return to a Saved Appeal".

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue the saved appeal for John Public.

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for John Public's Re-entry Number, nor will they have access to it. This is to protect John Public's privacy.

 [Print this page](#)

Would you like us to email you this Re-entry Number?

Please note, only the Re-entry Number will be sent.

☒ Yes ☐ No

Email Address:

Confirm Email Address:

Next

[Save & Exit](#)

3rd Party: Form Completer: Preparer's Info (Frnc001)

Text SizeAccessibility Help



Social Security

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Disability Appeal

Identification

Information about Jonny B Corky

Your Mailing Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2:

+ Add Line

City/Town:State/Territory:

--

ZIP Code:

Your Daytime Phone Number:

☒ U.S. ☐ International

10-digit Number

Ext

Next

Previous

Save & Exit

In this section...

✓ Re-entry Number

Preparer

Applicant Information

1st Party: Applicant Information (Appd001-1)

Text Size

Accessibility Help



Social Security
The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification

Information about You

Name:

John

G

Public

--

First

Middle

Last

Suffix

Sex:

We only use this information to customize how we ask the questions for this appeal.

☐ Male ☐ Female

Mailing Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2:

+ Add Line

City/Town:

State/Territory:

ZIP Code:

Do you live at the above address?

☐ Yes ☐ No

Daytime Phone Number:

☒ U.S. ☐ International

10-digit Number

Ext

Alternative Phone Number, if any:

Please provide another phone number where we can reach you.

☒ U.S. ☐ International

10-digit Number

Ext

Email Address:

Confirm Email Address:

Next

Previous

Save & Exit

In this section...

☒ Re-entry Number

Your Information



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Identification

Information about John Public

Name:

John G Public --
First Middle Last Suffix

Sex:

We only use this information to customize how we ask the questions for this appeal.

☐ Male ☐ Female

Mailing Address:

Country:

United States or U.S. Territory ▼

Street Address:

Street Line 1: Street Line 2: [+ Add Line](#)

City/Town:

State/Territory:

-- ▼

ZIP Code:

Does John Public live at the above address?

☐ Yes ☐ No

Daytime Phone Number:

☒ U.S. ☐ International

10-digit Number Ext

Alternative Phone Number, if any:

Please provide another phone number where we can reach John Public.

☒ U.S. ☐ International

10-digit Number Ext

Email Address for John Public:

Confirm Email Address:

In this section...

[✓ Re-entry Number](#)[✓ Preparer](#)[Applicant Information](#)[Next](#)[Previous](#)[Save & Exit](#)

1st Party: Representative Info (Rpn001-1)

[Text Size](#) [Accessibility Help](#)

 **Social Security**
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Disability Appeal

[Identification](#) [Medical](#) [Activities/Training](#) [Review](#) [Submit](#)

Representative for John Public

Do you currently have an appointed representative? [More Info](#)

☐ Yes ☒ No

[Next](#) [Previous](#) [Save & Exit](#)

In this section...

- ✓ [Re-entry Number](#)
- ✓ [Your Information](#)
- Representative**
- [Appeal Request](#)

[Text Size](#) [Accessibility Help](#)

 **Social Security**
The Official Website of the U.S. Social Security Administration

Disability Appeal

[Identification](#) [Medical](#) [Activities/Training](#) [Review](#) [Submit](#)

Representative for John Public

Do you currently have an appointed representative? [More Info](#)

☒ Yes ☐ No

Representative's Name:

First Middle Last Suffix

Is the representative an attorney?

☐ Yes ☐ No

Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2: [Add Line](#)

City/Town: **State/Territory:** **ZIP Code:**

Daytime Phone Number:

☒ U.S. ☐ International

10-digit Number [Ext.](#)

Fax Number, if any:

☒ U.S. ☐ International

10-digit Number

[Next](#) [Previous](#) [Save & Exit](#)

In this section...

- ✓ [Re-entry Number](#)
- ✓ [Your Information](#)
- Representative**
- [Appeal Request](#)

**Social Security**

The Official Website of the U.S. Social Security Administration

Disability Appeal

[Identification](#) [Medical](#) [Activities/Training](#) [Review](#) [Submit](#)

Representative for John Public

Does John Public currently have an appointed representative? [More Info](#)☐ Yes ☐ No

Representative's Name:

First

Middle

Last

Suffix

Is the representative an attorney?

☐ Yes ☐ No

Address:

Country:

Street Address:

Street Line 1: Street Line 2: Street Line 3: Street Line 4:

If you selected "United States or U.S. Territory":

City/Town:

State/Territory:

ZIP Code:

If you did not select "United States or U.S. Territory":

City/Town:

State/Province/Region:

Postal Code:

Daytime Phone Number:

☐ U.S. ☐ International

If you selected U.S.:

10-digit Number

Ext

If you selected International:

Country Code + Number

Ext

Fax Number, if any:

☐ U.S. ☐ International

If you selected U.S.:

10-digit Number

If you selected International:

Country Code + Number

In this section...

[Re-entry Number](#)[Preparer](#)[Applicant Information](#)**Representative**[Appeal Request](#)[Next](#)[Previous](#)[Save & Exit](#)

1st Party: Request for Hearing (Appl001hr-1)

Need Larger Text? Accessibility Help

 **Social Security**
The Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0960-0269
Paperwork Reduction Act

Identification Medical Activities/Training Review Submit

Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" you received? [Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

I request a hearing before an Administrative Law Judge. I disagree with the determination made on my claim because: [What details to include](#)

Enter a brief reason for your appeal. (200 characters maximum)

Do you wish to appear at a hearing? [More info about appearing](#)

☐ I wish to appear at a hearing

☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. [\(Complete Waiver Form HA-4608\)](#)

[Next](#) [Previous](#) [Save & Exit](#)

In this section...

- ✓ Re-entry Number
- ✓ Your Information
- ✓ Representative
- Appeal Request

3rd Party: Request for Hearing (Appl001hr-3)

Need Larger Text? Accessibility Help

 **Social Security**
The Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0960-0269
Paperwork Reduction Act

Identification Medical Activities/Training Review Submit

Request for Hearing by Administrative Law Judge for John Public

What is the date on the "Notice of Decision" John Public received? [Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

John Public requests a hearing before an Administrative Law Judge. He disagrees with the determination made on his claim because: [What details to include](#)

Enter a brief reason for his appeal. (200 characters maximum)

Does John Public wish to appear at a hearing? [More info about appearing](#)

☐ John Public wishes to appear at a hearing

☐ John Public does not wish to appear at a hearing and requests that a decision be made based on the evidence in his case. [\(Complete Waiver Form HA-4608\)](#)

[Next](#) [Previous](#) [Save & Exit](#)

In this section...

- ✓ Re-entry Number
- ✓ Preparer
- ✓ Applicant Information
- ✓ Representative
- Appeal Request

1st Party: Request for Reconsideration (Appl001rec-1)

 **Social Security**
The Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0960-0622
Paperwork Reduction Act

⚠ IdentificationMedicalActivities/TrainingReview⚠ Submit

Request for Reconsideration

What is the date on the "Notice of Decision" you received? [Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

I do not agree with the determination made on the above claim and request reconsideration. My reasons are: [What details to include](#)
Enter a brief reason for your appeal. (200 characters maximum)

NextPreviousSave & Exit

In this section...

- ✓ Re-entry Number
- ✓ Your Information
- ✓ Representative
- Appeal Request

3rd Party: Request for Reconsideration (Appl001rec-3)

 **Social Security**
The Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0960-0622
Paperwork Reduction Act

⚠ IdentificationMedicalActivities/TrainingReview⚠ Submit

Request for Reconsideration for John Public

What is the date on the "Notice of Decision" John Public received? [Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

John Public disagrees with the determination made on his claim and requests reconsideration because: [What details to include](#)
Enter a brief reason for his appeal. (200 characters maximum)

NextPreviousSave & Exit

In this section...

- ✓ Re-entry Number
- ✓ Preparer
- ✓ Applicant Information
- ✓ Representative
- Appeal Request

Section: Medical Pages

1st Party: Contact Information (Cnti001-1)

Text Size | Accessibility Help

 **Social Security**
The Official Website of the U.S. Social Security Administration

Disability Appeal

OMB No. 0960-0144
[Paperwork Reduction Act](#)

Identification Medical Activities/Training Review Submit

Someone We Can Contact about John Public's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about your medical conditions and can help you with this appeal.

☐ I don't have a contact.

Name:

--

▼

FirstMiddleLastSuffix

Relationship to you:

--

▼

Does this person live with you?

☐ Yes

☐ No

Does this person have the same daytime phone number as you?

☐ Yes

☐ No

Can this person speak and understand English?

☐ Yes

☐ No

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Save & Exit

In this section...

Someone We Can Contact

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3rd Party: Contact Information (Cnti001-3)

Text Size | Accessibility Help

 **Social Security**
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Disability Appeal

OMB No. 0960-0144
[Paperwork Reduction Act](#)

Identification Medical Activities/Training Review Submit

Someone We Can Contact about John Public's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about John Public's medical conditions and can help him with this appeal.

Who can help us with this appeal?

☐ Jonny B Corky

☐ Someone Else

☐ No one

Next

Previous

Save & Exit

In this section...

Someone We Can Contact

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1st Party: Change in Medical Conditions (Cicd001-1)

Text SizeAccessibility Help

 **Social Security**
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Disability Appeal

IdentificationMedicalActivities/TrainingReviewSubmit

Change in Conditions for John Public

Since you last told us about your medical conditions, has there been any **CHANGE (for better or worse)** in your previously described physical or mental conditions? [What are changes in conditions?](#)

☐ Yes ☐ No

New Conditions

Since you last told us about your medical conditions, do you have any **NEW** physical or mental conditions? [What are new conditions?](#)

☐ Yes ☐ No

NextPreviousSave & Exit

In this section...

Someone We Can Contact

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3rd Party: Change in Medical Conditions (Cicd001-3)

Text SizeAccessibility Help

 **Social Security**
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Disability Appeal

IdentificationMedicalActivities/TrainingReviewSubmit

Change in Conditions for John Public

Since John Public last told us about his medical conditions, has there been any **CHANGE (for better or worse)** in his previously described physical or mental conditions? [What are changes in conditions?](#)

☐ Yes ☐ No

New Conditions

Since John Public last told us about his medical conditions, does he have any **NEW** physical or mental conditions? [What are new conditions?](#)

☐ Yes ☐ No

NextPreviousSave & Exit

In this section...

Someone We Can Contact

Medical Conditions

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1st Party: Medical Treatment (Nmed001-1)

Text Size Accessibility Help

 **Social Security**
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Disability Appeal

Identification Medical Activities/Training Review Submit

Other Names for John Public

Have you used any other names on your medical or educational records?
For example, maiden name, other married name, or nickname.

☐ Yes ☐ No

Medical Treatment

Since you last told us about your medical treatment, have you seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled?

☐ Yes ☐ No

Next Previous Save & Exit

In this section...

Someone We Can Contact

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3rd Party: Medical Treatment (Nmed001-3)

Text Size Accessibility Help

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Disability Appeal

Identification Medical Activities/Training Review Submit

Other Names for John Public

Has John Public used any other names on his medical or educational records?
For example, maiden name, other married name, or nickname.

☐ Yes ☐ No

Medical Treatment

Since John Public last told us about his medical treatment, has he seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or does he have a future appointment scheduled?

☐ Yes ☐ No

Next Previous Save & Exit

In this section...

Someone We Can Contact

Medical Conditions

Medical Treatment

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Other Medical Information

1st Party: List of Doctors and Hospitals (Doho001-1)

Text SizeAccessibility Help

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Disability Appeal

IdentificationMedicalActivities/TrainingReviewSubmit

Doctors and Hospitals for You

Please tell us about anyone who has **new or updated** medical records about any of your physical or mental conditions (including emotional or learning problems).

Status	Doctor or Healthcare Provider	City	Actions
	Johnny Walker	Baltimore	EditDelete

Add Doctor

Status	Hospital or Clinic	City	Actions
	First Hospital	Baltimore	EditDelete

Add Hospital or Clinic

NextPreviousSave & Exit

In this section...

Someone We Can Contact

Medical Conditions

Medical Treatment

Doctors and Hospitals

Tests

Medicines

Other Medical Information

3rd Party: List of Doctors and Hospitals (Doho001-3)

Text SizeAccessibility Help

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Disability Appeal

IdentificationMedicalActivities/TrainingReviewSubmit

Doctors and Hospitals for John Public

Please tell us about anyone who has **new or updated** medical records about any of his physical or mental conditions (including emotional or learning problems).

Status	Doctor or Healthcare Provider	City	Actions
	Johnny Walker	Baltimore	EditDelete

Add Doctor

Status	Hospital or Clinic	City	Actions
	First Hospital	Baltimore	EditDelete

Add Hospital or Clinic

NextPreviousSave & Exit

In this section...

Someone We Can Contact

Medical Conditions

Medical Treatment

Doctors and Hospitals

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Other Medical Information

1st Party: Specific Doctor Detailed Information (Doct002-1)

Text Size  Accessibility Help



Social Security

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Disability Appeal

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

-- ▾			-- ▾
Title	First	Last	Suffix

Name of Practice or Medical Group:

Phone Number:

☒ U.S. ☐ International

10-digit Number	Ext

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town:

State/Territory:

ZIP Code:

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Since you last told us about your last medical treatment, has there been any new or updated treatment?
Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What new or updated treatment did you receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click "Add Test" to add a test.		

Add Test

Medicines Recommended or Prescribed by this Doctor or Healthcare Provider

Please add **ALL prescription and non-prescription medicines** that you are currently taking that this doctor or healthcare provider recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click "Add Medicine" to add a medicine.			

Add Medicine

Save

Cancel

3rd Party: Specific Doctor Detailed Information (Doct002-3)

Text Size Accessibility Help



Social Security

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Disability Appeal

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

-- ▾			-- ▾
Title	First	Last	Suffix

Name of Practice or Medical Group:

Phone Number:

☒ U.S. ☐ International

--	--

10-digit Number

[Ext](#)

Address:

Country:

United States or U.S. Territory ▾

Street Address:

Street Line 1:

Street Line 2:

[+ Add Line](#)

City/Town:

State/Territory:

-- ▾

ZIP Code:

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Since John Public last told us about his last medical treatment, has there been any new or updated treatment? Enter the closest date(s) John Public can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What new or updated treatment did John Public receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for John Public, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click "Add Test" to add a test.		

Add Test

Medicines Recommended or Prescribed by this Doctor or Healthcare Provider

Please add **ALL prescription and non-prescription medicines** that John Public is currently taking that this doctor or healthcare provider recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click "Add Medicine" to add a medicine.			

Add Medicine

Save Cancel

1st Party: Specific Hospital Detailed Information (Hosp002-1)

Text Size | Accessibility Help



Social Security

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Disability Appeal

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated you, if known:

Phone Number:

☒ U.S. ☐ International

10-digit Number

Ext

Address:

Country:

United States or U.S. Territory ▼

Street Address:

Street Line 1:

Street Line 2:

[+ Add Line](#)

City/Town:

State/Territory:

ZIP Code:

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?

Outpatient visit means you went home the same day. This does not include emergency room visits.

☐ Yes ☐ No

Did you have any emergency room (ER) visits at this hospital or clinic?

ER visit means you went to the ER and then went home.

☐ Yes ☐ No

Did you have an overnight stay at this hospital or clinic?

☐ Yes ☐ No

Medical Conditions Treated by this Hospital or Clinic

What new or updated medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What new or updated treatment did you receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click "Add Test" to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **ALL prescription and non-prescription medicines** that you are currently taking that this hospital or clinic recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click "Add Medicine" to add a medicine.			

Add Medicine

Save

Cancel

3rd Party: Specific Hospital Detailed Information (Hosp002-3)

Text Size  Accessibility Help



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated John Public, if known:

Phone Number:

☒ U.S. ☐ International

10-digit Number

Ext Area

Address:

Country:

United States or U.S. Territory 

Street Address:

Street Line 1:

Street Line 2:

[+ Add Line](#)

City/Town:

State/Territory:

-- 

ZIP Code:

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) John Public can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Did John Public have any outpatient visits at this hospital or clinic, or does he have any scheduled?

Outpatient visit means he went home the same day. This does not include emergency room visits.

☐ Yes ☐ No

Did John Public have any emergency room (ER) visits at this hospital or clinic?

ER visit means he went to the ER and then went home.

☐ Yes ☐ No

Did John Public have an overnight stay at this hospital or clinic?

☐ Yes ☐ No

Medical Conditions Treated by this Hospital or Clinic

What new or updated medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What new or updated treatment did John Public receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for John Public, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click "Add Test" to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **ALL prescription and non-prescription medicines** that John Public is currently taking that this hospital or clinic recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click "Add Medicine" to add a medicine.			

Add Medicine

Save

Cancel

1st Party: List of Tests (Test001-1)

Text SizeAccessibility Help



Social Security

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Disability Appeal

IdentificationMedicalActivities/TrainingReviewSubmit

Tests for John Public

Since you last told us about your disability, please tell us about any medical tests you had or will have related to your disability.

Status	Name of Test	Test Ordered by	Actions
	Blood Test (Not HIV)	I don't know	EditDelete

Add Test

In this section...

Someone We Can Contact

Medical Conditions

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NextPreviousSave & Exit

3rd Party: List of Tests (Test001-3)

Text SizeAccessibility Help



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Disability Appeal

IdentificationMedicalActivities/TrainingReviewSubmit

Tests for John Public

Since you last told us about your disability, please tell us about any medical tests John Public had or will have related to his disability.

Status	Name of Test	Test Ordered by	Actions
	Blood Test (Not HIV)	I don't know	EditDelete

Add Test

In this section...

Someone We Can Contact

Medical Conditions

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NextPreviousSave & Exit

1st Party: Specific Test Detailed Information (Test002-1)

Text Size  | Accessibility Help



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Disability Appeal

Test Details

Test Type:

Other 

Body Part:

Please specify test type:

Date(s) of Test:

Enter the closest date you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

6/2/2015

Who ordered this test for you?

If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Other Doctor/Healthcare Provider 

Have you seen this doctor or healthcare provider since you last gave us medical information?

 [Why we ask this](#)

☒ Yes ☐ No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider who ordered this test for you:

-- 

Title

First

Last

-- 

Suffix

Name of Practice or Medical Group:

Phone Number:

☒ U.S. ☐ International

10-digit Number

[Ext](#)

Address:

Country:

United States or U.S. Territory 

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town:

State/Territory:

-- 

ZIP Code:

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Since you last told us about your last medical treatment, has there been any new or updated treatment? Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What new or updated treatment did you receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Save

Cancel

3rd Party: Specific Test Detailed Information (Test002-3)

Text Size  | [Accessibility Help](#)



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Disability Appeal

Test Details

Test Type:

Date(s) of Test:

Enter the closest date you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Who ordered this test for John Public?

If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Save

[Cancel](#)

1st Party: List of Medicines (Medi001-1)

Text Size | Accessibility Help

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Disability Appeal

Identification Medical Activities/Training Review Submit

Medicines for John Public

Please tell us about **ALL prescription and non-prescription medicines** that you are currently taking for the conditions related to your disability.

Status	Name of Medicine	Prescribed by	Actions
	Aspirin	No one	Edit Delete

Add Medicine

In this section...

Someone We Can Contact

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Next Previous Save & Exit

3rd Party: List of Medicines (Medi001-3)

Text Size | Accessibility Help

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Disability Appeal

Identification Medical Activities/Training Review Submit

Medicines for John Public

Please tell us about **ALL prescription and non-prescription medicines** that John Public is currently taking for the conditions related to his disability.

Status	Name of Medicine	Prescribed by	Actions
Click "Add Medicine" to add a medicine.			

Add Medicine

In this section...

Someone We Can Contact

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Next Previous Save & Exit

1st Party: Specific Medicine Detailed Information (Medi002-1)

Text Size  | [Accessibility Help](#)



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Disability Appeal

Medicine Details

Enter name of the medicine:

Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:

Include physical or mental effects and allergic reactions. (1000 characters maximum)

Pian pain

Characters remaining: 991

Who recommended or prescribed this medicine?

If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated you, if known:

Phone Number:

☒ U.S. ☐ International

10-digit Number

[Ext](#)

Address:

Country:

Street Address:

Street Line 1:

Street Line 2:

[+ Add Line](#)

City/Town:

State/Territory:

ZIP Code:

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?

Outpatient visit means you went home the same day. This does not include emergency room visits.

☒ Yes ☐ No

First outpatient visit:

Last outpatient visit:

Next scheduled outpatient visit (if any):

Did you have any emergency room (ER) visits at this hospital or clinic?

ER visit means you went to the ER and then went home.

☒ Yes ☐ No

Please give the dates of your most recent emergency room visits.

Emergency Room Visit 1:

Emergency Room Visit 2:

Emergency Room Visit 3:

Did you have an overnight stay at this hospital or clinic?

☒ Yes ☐ No

Give us the dates of your three most recent stays.

Visit 1:

Date In

Date Out

Visit 2:

Date In

Date Out

Visit 3:

Date In

Date Out

Medical Conditions Treated by this Hospital or Clinic

What new or updated medical conditions were treated or evaluated?

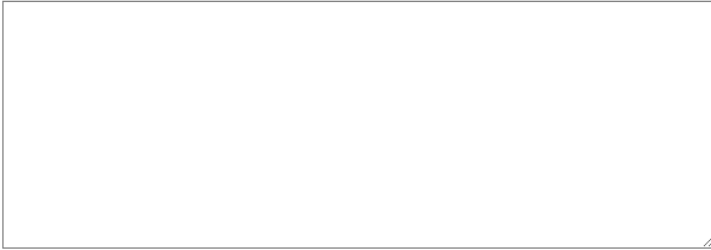
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What new or updated treatment did you receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)



Characters remaining: 1000

Save

Cancel



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Disability Appeal

Medicine Details

Enter name of the medicine:

Enter only one medicine at a time. Look at the medicine container if necessary.

Why is John Public taking this medicine?

Describe any side effects John Public experienced while taking this medicine:

Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

Who recommended or prescribed this medicine?

If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Save

Cancel

1st Party: Other Medical Records (Othr001-1)

Medical Information, Medical Information, Medical Information

sRe/Othr001-1.html

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Disability Appeal

✔ Identification

✔ Medical

Activities/Training

Review

⚠ Submit

Other Medical Information for John Public

We need to know if anyone else has medical information about any of your conditions or if you are scheduled to see anyone else.

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid your disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else?

☒ Yes ☐ No

Status	Medical Information Source	City	Phone	Actions
✔	Hialia	Baltimore	(410) 325-8779	EditDelete

Add Source

In this section...

✔ Someone We Can Contact

✔ Medical Conditions

✔ Medical Treatment

✔ Doctors and Hospitals

✔ Tests

✔ Medicines

✔ Other Medical Information

Next

Previous

Save & Exit



Disability Appeal

✔ Identification

✔ Medical

Activities/Training

Review

⚠ Submit

Other Medical Information for John Public

We need to know if anyone else has medical information about any of John Public's conditions or if he is scheduled to see anyone else.

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid John Public's disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since John Public last told us about his other medical information, does anyone have medical information about any of his physical or mental conditions (including emotional and learning problems) or is he scheduled to see anyone else?

☒ Yes ☐ No

Status	Medical Information Source	City	Phone	Actions
✔	Hialia	Baltimore	(410) 325-8779	EditDelete

Add Source

In this section...

✔ Someone We Can Contact

✔ Medical Conditions

✔ Medical Treatment

✔ Doctors and Hospitals

✔ Tests

✔ Medicines

✔ Other Medical Information

NextPreviousSave & Exit

1st Party: Details of Other Medical Information (Othr002-1)

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Social Security

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Disability Appeal

Medicine Details

Enter name of the medicine:

Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:

Include physical or mental effects and allergic reactions. (1000 characters maximum)

Pian pain

Characters remaining: 991

Who recommended or prescribed this medicine?

If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Other Doctor/Healthcare Provider

Have you seen this doctor or healthcare provider since you last gave us medical information?

[Why we ask this](#)

☒ Yes ☐ No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

-- -- -- --
Title First Last Suffix

Name of Practice or Medical Group:

Phone Number:

☒ U.S. ☐ International

10-digit Number Ext

Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2:

[Add Line](#)

City/Town:

State/Territory:

ZIP Code:

--

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Since you last told us about your last medical treatment, has there been any new or updated treatment?
Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What new or updated treatment did you receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Save

Cancel



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Details of Other Medical Information

Name of Organization:

Claim or ID Number, if any:

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

City/Town:

State/Territory:

ZIP Code:

Name of Contact Person:

First

Last

Phone Number:

☒ U.S. ☐ International

10-digit Number

Ext

Contacts with this Organization

Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor. Enter the closest date(s) John Public can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Date of First Contact:

Date of Last Contact:

Date of Next Contact, if any:

Reasons for Contact:

(1000 characters maximum)

Characters remaining: 1000

If you need more space, continue in [Remarks](#).

Save

Cancel

Section: Activities and Training Pages

1st Party: Activities (Actv001-1)

Text Size Accessibility Help



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Disability Appeal

Identification Medical Activities/Training Review Submit

Activities for John Public

Since you last told us about your activities, has there been any change (for better or for worse) in your daily activities due to your physical or mental conditions?
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

☐ Yes ☐ No

Next

Previous

Save & Exit

In this section...

Activities

Work and Education

Vocational Rehabilitation

3rd Party: Activities (Actv001-3)

Text Size Accessibility Help



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Disability Appeal

Identification Medical Activities/Training Review Submit

Activities for John Public

Since John Public last told us about his activities, has there been any change (for better or for worse) in his daily activities due to his physical or mental conditions?
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

☐ Yes ☐ No

Next

Previous

Save & Exit

In this section...

Activities

Work and Education

Vocational Rehabilitation

1st Party: Work, Education & Training (Wetr001-1)

Text Size ▾ Accessibility Help



Social Security

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Disability Appeal

☒ Identification

☒ Medical

Activities/Training

Review

 Submit

Work and Education for John Public

Since you last told us about your work, have you worked or has your work changed?

☐ Yes ☐ No

Since you last told us about your education, have you completed or are you enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes?

☐ Yes ☐ No

In this section...

☒ Activities

Work and Education

Vocational Rehabilitation

Next

Previous

Save & Exit

3rd Party: Work, Education & Training (Wetr001-3)

Text Size ▾ Accessibility Help



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

☒ Identification

☒ Medical

Activities/Training

Review

 Submit

Work and Education for John Public

Since John Public last told us about his work, has he worked or has his work changed?

☐ Yes ☐ No

Since John Public last told us about his education, has he completed or is he enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes?

☐ Yes ☐ No

In this section...

☒ Activities

Work and Education

Vocational Rehabilitation

Next

Previous

Save & Exit



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

[✔ Identification](#) [✔ Medical](#) [Activities/Training](#) [Review](#) [⚠ Submit](#)

Vocational Rehabilitation, Employment, or Other Support Services for John Public

We need to know about your participation in:

- an individual work plan with an employment network under the Ticket to Work Program
- an individualized plan for employment with a vocational rehabilitation agency or any other organization
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work
- a Plan to Achieve Self-Support (PASS)
- an individualized education program (IEP) through an educational institution (if a student age 18-21)

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs?

☐ Yes ☐ No

In this section...

- [✔ Activities](#)
- [✔ Work and Education](#)

Vocational Rehabilitation

Next

Previous

Save & Exit

Text Size

Accessibility Help



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

✔ Identification

✔ Medical

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Review

⚠ Submit

Vocational Rehabilitation, Employment, or Other Support Services for John Public

We need to know about John Public's participation in:

- an individual work plan with an employment network under the Ticket to Work Program
- an individualized plan for employment with a vocational rehabilitation agency or any other organization
- any program providing vocational rehabilitation, employment services, or other support services to help him go to work
- a Plan to Achieve Self-Support (PASS)
- an individualized education program (IEP) through an educational institution (if a student age 18-21)

Since John Public last told us about his vocational rehabilitation, has he participated, or is he participating, in one of these programs?

☐ Yes ☐ No

In this section...

✔ Activities

✔ Work and Education

Vocational Rehabilitation

Next

Previous

Save & Exit

Section: Review and Submit Pages

1st Party: Remarks (Rmks001-1)

Need Larger Text?Accessibility Help



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

✔ Identification

✔ Medical

✔ Activities/Training

Review

⚠ Submit

Additional Remarks for John Public

Please provide any additional information

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. (2000 characters maximum)

In this section...

Remarks

Medical Release

Summary

Next

Previous

Save & Exit



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

 Identification  Medical  Activities/Training Review  Submit

Additional Remarks for John Public

Please provide any additional information

Use this space to provide any information John Public could not show in earlier sections of this form or any additional information John Public feels we should know about. (2000 characters maximum)

Characters remaining: 2000

In this section...

Remarks

[Medical Release](#)

[Summary](#)

Next

Previous

Save & Exit

1st Party: Medical Release Form (Mdrf001-1)

[Need Larger Text?](#) | [Accessibility Help](#)



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

[✓ Identification](#) [✓ Medical](#) [✓ Activities/Training](#) [Review](#) [⚠ Submit](#)

Medical Release Form

In order to make a decision about your disability claim, we need to obtain your:

- Medical Records
- Education Records
- Other information related to your ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration [SSA-827]) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Please read the [Medical Release Form](#) and make a selection below.

I voluntarily authorize and request disclosure of all my medical records; also educational records and other information related to my ability to perform tasks. I agree to:

- ☐ **Electronically sign** the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)
- ☐ **Print, sign and mail a paper copy** of the Medical Release Form. I understand this may delay the processing of my disability claim.

In this section...

[✓ Remarks](#)

[Medical Release](#)

[Summary](#)

[Next](#)

[Previous](#)

[Save & Exit](#)

3rd Party: Medical Release Form (Mdrf001-3)

Text Size  Accessibility Help

**Social Security**
The Official Website of the U.S. Social Security Administration

Disability Appeal

✔ Identification

✔ Medical

✔ Activities/Training

⚠ Review

⚠ Submit

Medical Release Form for John Public

In order to make a decision about this disability claim, we need to obtain John Public's:

- Medical Records
- Education Records
- Other information related to his ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration [SSA-827]) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Is John Public with you and can he read Medical Release Form now?

☐ Yes ☐ No

In this section...

✔ Remarks

✔ Medical Release

Summary

Next

Previous

Save & Exit

1st Party: Summary (Revw001-1)

Need Larger Text? | Accessibility Help

 **Social Security**
The Official Website of the U.S. Social Security Administration

Disability Appeal

☒ Identification ☒ Medical ☒ Activities/Training ☒ Review ☐ Submit

i You have not submitted the appeal request for John Public.

Please review the information below before submitting the appeal on the "Submit tab".

You can Save and Exit and return later to complete your appeal request.

If you need to make any changes, please select the "EDIT" button to return to that page.

In this section...

☒ Home ☒ Medical Release ☒ Summary

Summary Review

If you need to make any changes, please select the **Edit** button to return to that page.

Identification

☒ Information about John Public

Name: **John G Public**
Mailing Address: **4500 Frederick Road, Baltimore, Maryland, 21228**
Do you live at the above address? **Yes**
Daytime Phone Number: **(410) 326-8778**
Alternative Phone Number:
Email Address:

☒ Representative

Has a representative: **Yes**
Representative's Name: **Mario F DiLuca**
Is the representative an attorney? **Yes**
Address: **45 North Charles Street, Baltimore, Maryland, 21202**
Daytime Phone Number: **(410) 333-7878**
Fax Number:

☒ Request for Hearing by Administrative Law Judge

Date Notice of Decision received: **08/10/2018**
Claim Number: **123456**
Reason for Appeal: **No remarks whatsoever! None, zipppp, nada!**
Do you wish to appear at a hearing? **I wish to appear at a hearing**

Medical

☒ Someone We Can Contact about John Public's Medical Conditions

I don't have a contact.

☒ Medical Conditions

Change in physical or mental conditions: **Yes**
Date change(s) occurred: **8/2/2018**
Description of change(s): **Some remarks go here...**
New physical or mental conditions: **Yes**
Date when new condition(s) began: **8/2/2018**
Description of new condition(s): **Some remarks go here...**

☒ Medical Treatment

Other Names Used: **Yes**
Other Name 1: **Johnny P Smith**
Other Name 2: **Doug H Twitt**
Other Name 3: **Mark J Swift**
Other Name 4: **Henry G Gugen**
Other Name 5: **Doodle N Noodle**
Seen a healthcare provider or received treatment, or have an appointment scheduled: **Yes**
Types of condition(s) treated for or will be seen for: **Physical**

Add **Doctors or Healthcare Providers**

Click the "Add" button if you need to enter information for a new doctor or healthcare provider.

Edit **Doctor 1**

Doctor or Healthcare Provider Details

Name of Doctor or Health Care Provider: **Johnny Walker**

Name of Practice or Medical Group: **Hypopotamus Clinic**

Phone Number: **(410) 888-3434**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Patient ID Number, if known:

Treatment Dates

First Visit: **June 2018**

Last Visit:

Next Scheduled Appointment:

Medical Conditions Treated

Medical conditions treated: **Here go some medical conditions...**

Treatment Received

Treatments Received: **Here go some received treatments for the medical conditions received as stated above...**

Add **Hospitals and Clinics**

Click the "Add" button if you need to enter information for a new hospital or clinic.

Edit **Hospital 1**

Hospital or Clinic Details

Name of Hospital or Clinic: **First Hospital**

Name of Healthcare Provider who treated you: **John Dostorov**

Phone Number: **(410) 888-3434**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Patient ID number: **123**

Treatment Dates

Outpatient Visits: **Yes**

First Visit: **June 2018**

Last Visit: **July 2018**

Next Visit: **July 2020**

Emergency Room Visits: **No**

Inpatient Stays: **No**

Medical Conditions Treated

Medical conditions treated: **Some remarks go here**

Treatment Received

Treatment Received: **Here go some received treatments**

Add **Tests**

Click the "Add" button if you need to enter information for a new test.

Edit **Test 1**

Test Type: **Blood Test (Not HIV)**

Date(s) of Test: **May 2018**

Who ordered this test? **I don't know**

Add **Medicines**

Click the "Add" button if you need to enter information for a new medicine.

Edit **Medicine 1**

Medicine Name: **Aspirin**

Reason: **Joint Pain**

Side Effects: **Nausea**

Prescribed by: **No one recommended or prescribed this medicine**

Add **Other Medical Information**

Click the "Add" button if you need to enter information for a new other medical information.

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else? **Yes**

Date(s) of Test: **May 2018**

Who ordered this test? **I don't know**

☒ **Medicines**

Click the "Add" button if you need to enter information for a new medicine.

☒ **Medicine 1**

Medicine Name: **Aspirin**

Reason: **Joint Pain**

Side Effects: **Nausea**

Prescribed by: **No one recommended or prescribed this medicine**

☒ **Other Medical Information**

Click the "Add" button if you need to enter information for a new other medical information.

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (Including emotional and learning problems) or are you scheduled to see anyone else? **Yes**

☒ **Other Medical Information 1**

Details of Other Medical Information

Name of Organization: **Halls**

Claim or ID Number: **12345**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Name of Contact Person: **Fred Elmo**

Phone Number: **(410) 326-3778**

Contacts with this Organization

Date of First Contact: **June 16, 2018**

Date of Last Contact: **June 16, 2018**

Date of Next Contact: **June 16, 2020**

Reason for Contacts: **Some Visit Reason remarks go in here...**

Activities/Training

☒ **Activities**

Changes in daily activities due to physical or mental conditions: **Yes**

Describe the changes in daily activities: **Here go some remarks...**

☒ **Work and Education**

Have you worked or has your work changed: **No**

Completed or enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes: **Yes**

Type of training: **Training type**

Date(s) attended: **Sept 2017-May 2020**

Degree(s) attained, if any: **Training degree**

Date of attainment: **May 2020**

☒ **Vocational Rehabilitation, Employment, or Other Support Services**

Participated in program: **Yes**

Name of Organization or School: **Some Vocational Rehab Name**

Name of Counselor, Instructor, or Job Coach: **Curt Cooshy**

Phone Number: **(410) 326-3778**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Date started participating: **10/12/2014**

Review

☒ **Remarks**

Remarks: **Some remarks go in here...**

☒ **Medical Release Form**

I voluntarily authorize and request disclosure of all of my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Agreed to electronically sign the medical release form.**

3rd Party: Summary (Revw001-3)

Need Larger Text? Accessibility Help

 **Social Security**
The Official Website of the U.S. Social Security Administration

Disability Appeal

☒ Identification ☒ Medical ☒ Activities/Training ☒ Review ☐ Submit

i You have not submitted the appeal request for John Public.

Please review the information below before submitting the appeal on the "Submit tab".

You can Save and Exit and return later to complete your appeal request.

If you need to make any changes, please select the "EDIT" button to return to that page.

In this section...

- ☒ Remarks
- ☒ Medical Release
- ☒ Summary

Summary Review

If you need to make any changes, please select the **Edit** button to return to that page.

Identification

☒ Information about Jonny B Corky

Relationship: **Family Member**
Mailing Address: **1234 First Street, Baltimore, Maryland, 21201**
Phone: **(410) 326-8778**

☒ Information about John Public

Name: **John Q Public**
Mailing Address: **4500 Frederick Road, Baltimore, Maryland, 21228**
Does John Public live at the above address? **Yes**
Daytime Phone Number: **(410) 326-8778**
Alternative Phone Number:
Email Address:

☒ Representative

Has a representative: **Yes**
Representative's Name: **Mario F DiLuca**
Is the representative an attorney? **Yes**
Address: **45 North Charles Street, Baltimore, Maryland, 21202**
Daytime Phone Number: **(410) 333-7878**
Fax Number:

☒ Request for Hearing by Administrative Law Judge

Date Notice of Decision received: **08/12/2018**
Claim Number: **123456**
Reason for Appeal: **No remarks whatsoever! None, zippo, nada!**
Does John Public wish to appear at a hearing? **John Public wishes to appear at a hearing**

Medical

☒ Someone We Can Contact about John Public's Medical Conditions

Who can help us with this appeal? **No one**

☒ Medical Conditions

Change in physical or mental conditions: **Yes**
Date change(s) occurred: **8/2/2018**
Description of change(s): **Some remarks go here...**
New physical or mental conditions: **Yes**
Date when new condition(s) began: **8/2/2018**
Description of new condition(s): **Some remarks go here...**

☒ Medical Treatment

Other Names Used: **Yes**
Other Name 1: **Johnny P Smith**
Other Name 2: **Doug H Twit**

Other Name 5: **Doodle N Noodle**

Seen a healthcare provider or received treatment, or have an appointment scheduled: **Yes**

Types of condition(s) treated for or will be seen for: **Phycloal**

Add

Doctors or Healthcare Providers

Click the "Add" button if you need to enter information for a new doctor or healthcare provider.

Edit

Doctor 1

Doctor or Healthcare Provider Details

Name of Doctor or Health Care Provider: **Johnny Walker**

Name of Practice or Medical Group: **Hypopotamus Clinic**

Phone Number: **(410) 898-3434**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Patient ID Number, if known:

Treatment Dates

First Visit: **June 2018**

Last Visit:

Next Scheduled Appointment:

Medical Conditions Treated

Medical conditions treated: **Here go some medical conditions...**

Treatment Received

Treatments Received: **Here go some received treatments for the medical conditions received as stated above...**

Add

Hospitals and Clinics

Click the "Add" button if you need to enter information for a new hospital or clinic.

Edit

Hospital 1

Hospital or Clinic Details

Name of Hospital or Clinic: **First Hospital**

Name of Healthcare Provider who treated you: **John Dootorov**

Phone Number: **(410) 898-3434**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Patient ID number: **123**

Treatment Dates

Outpatient Visits: **Yes**

First Visit: **June 2018**

Last Visit: **July 2018**

Next Visit: **July 2020**

Emergency Room Visits: **No**

Inpatient Stays: **No**

Medical Conditions Treated

Medical conditions treated: **Some remarks go here**

Treatment Received

Treatment Received: **Here go some received treatments**

Add

Tests

Click the "Add" button if you need to enter information for a new test.

Edit

Test 1

Test Type: **Blood Test (Not HIV)**

Date(s) of Test: **May 2018**

Who ordered this test? **I don't know**

Add

Medicines

Click the "Add" button if you need to enter information for a new medicine.

Edit

Medicine 1

Medicine Name: **Aspirin**

Reason: **Joint Pain**

Side Effects: **Nausea**

Prescribed by: **No one recommended or prescribed this medicine**

Add

Other Medical Information

Date(s) of Test: **May 2018**
Who ordered this test? **I don't know**

Add **Medicines**

Click the "Add" button if you need to enter information for a new medicine.

Edit **Medicine 1**

Medicine Name: **Aspirin**
Reason: **Joint Pain**
Side Effects: **Nausea**
Prescribed by: **No one recommended or prescribed this medicine**

Add **Other Medical Information**

Click the "Add" button if you need to enter information for a new other medical information.

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else? **Yes**

Edit **Other Medical Information 1**

Details of Other Medical Information
Name of Organization: **Hiale**
Claim or ID Number: **12345**
Address: **1234 First Street, Baltimore, Maryland, 21201**
Name of Contact Person: **Fred Elmo**
Phone Number: **(410) 326-3778**
Contacts with this Organization
Date of First Contact: **June 15, 2018**
Date of Last Contact: **June 15, 2018**
Date of Next Contact: **June 15, 2020**
Reason for Contacts: **Some Visit Reason remarks go in here...**

Activities/Training

Edit **Activities**

Changes in daily activities due to physical or mental conditions: **Yes**
Describe the changes in daily activities: **Here go some remarks...**

Edit **Work and Education**

Have you worked or has your work changed: **No**
Completed or enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes: **Yes**
Type of training: **Training type**
Date(s) attended: **Sept 2017-May 2020**
Degree(s) attained, if any: **Training degree**
Date of attainment: **May 2020**

Edit **Vocational Rehabilitation, Employment, or Other Support Services**

Participated in program: **Yes**
Name of Organization or School: **Some Vocational Rehab Name**
Name of Counselor, Instructor, or Job Coach: **Curt Cooshy**
Phone Number: **(410) 326-3778**
Address: **1234 First Street, Baltimore, Maryland, 21201**
Date started participating: **10/12/2014**

Review

Edit **Remarks**

Remarks: **Some remarks go in here...**

Edit **Medical Release Form**

I voluntarily authorize and request disclosure of all of my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Agreed to electronically sign the medical release form.**

Next

Previous

Save & Exit

**Social Security**

The Official Website of the U.S. Social Security Administration

Disability Appeal

☒ Identification ☒ Medical ☒ Activities/Training ☒ Review ☐ **Submit**

Attach Files for John Public

If you have any additional electronic evidence that will help us obtain your medical records or review your appeal, please attach them here. If you have additional paper evidence to submit, a cover sheet and instructions will be provided.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

Click "Add File", then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

Your files will not be processed by Social Security until you click "Submit Appeal". If you click "Previous" or "Save & Exit", you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
-----------	---------------	-----------	--------------

Add File

! You have not submitted your appeal request. We will process your appeal request once you select the **Submit** button below.

To submit and complete your request at a later time, select the **Save and Exit** button to temporarily save the information you have entered.

In this section...

! [Attach Files](#)

Submit Appeal

[Previous](#)

[Save & Exit](#)



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

✓ Identification ✓ Medical ✓ Activities/Training ✓ Review ⚠ Submit

Attach Files for John Public

If you have any additional electronic evidence that will help us obtain John Public's medical records or review his appeal, please attach them here. If you have additional paper evidence to submit, a cover sheet and instructions will be provided.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

Click "Add File", then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

Your files will not be processed by Social Security until you click "Submit Appeal". If you click "Previous" or "Save & Exit", you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
Click "Add File" to attach a file.			

Add File



You have not submitted your appeal request. We will process your appeal request once you select the "Submit" button below.

To submit and complete your request at a later time, select the "Save and Exit" button to temporarily save the information you have entered.

Submit Appeal

Previous

Save & Exit

In this section...

⚠ Attach Files

1st Party: Application Submission Confirmation (Conf001-1)

Need Larger Text? Accessibility Help



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

 **You have successfully submitted your Disability Appeal on December 2, 2016 at 1:49:08 PM Eastern Time.**

You can log into your [my Social Security](#) account, or register for an account, to check the status of your appeal.

We highly recommend that you print or save a copy of each for your records.

- [Your Receipt](#)
- [Electronically Signed Medical Release Form](#)

Additional Information

You can use this [personalized cover sheet](#) if you have additional information to submit. [? If you are unable to print](#)

Done

3rd Party: Application Submission Confirmation (Conf001-3)

Text Size Accessibility Help



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

 **You have successfully submitted John Public's Disability Appeal on March 18, 2025 at 4:00:15 PM Eastern Time.**

We highly recommend that you print or save a copy of each for his records.

- [Your Receipt](#)
- [Electronically Signed Medical Release Form](#)

Additional Information

You can use this [personalized cover sheet](#) if you have additional information to submit. [? If you are unable to print](#)

Done



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal



You have successfully submitted John Rock's Disability Appeal on March 18, 2025 at 5:08:07 PM Eastern Time.

We highly recommend that you print or save a copy of the appeal for his records.

Print or Save

Additional Information

Although you have submitted John Rock's disability appeal online, we still need a few items from him. Please print and have him complete the following: [? If you are unable to print](#)

- [personalized cover sheet](#)
- [Medical Release Form \(Authorization to Disclose Information to the Social Security Administration \[SSA-827\]\)](#) [? Instructions for completing the Medical Release Form](#)
- [Form SSA-1696 \(Appointment of Representative\)](#)



Do you want to begin a new appeal?

We can copy your contact information into the appeal. You will have the opportunity to edit it later.

Start Another Appeal

Done

Receipt (Rcpt001)



You have successfully submitted your Disability Appeal on March 18, 2025 at 4:00:15 PM Eastern Time.

We may review John Public's case to determine if we can make a decision without a hearing. If we determine he needs a hearing, we will appoint an Administrative Law Judge to conduct the hearing. We will provide advance notice of the time and place of hearing. The hearing office assigned to this case will also send John Public more information regarding his appeal.

Information You Submitted for John Public

Identification

Information about Sam Washington

Relationship: **Family Member**

Mailing Address: **741 Main St, Baltimore, Maryland, 21117**

Phone:

Information about John Public

Name: **John Q Public**

Mailing Address: **741 Main St, Baltimore, Maryland, 21117**

Does John Public live at the above address? **Yes**

Daytime Phone Number:

Alternative Phone Number:

Email Address:

Representative

Has a representative: **No**

Request for Hearing by Administrative Law Judge

Date Notice of Decision received: **03/10/2025**

Claim Number:

Reason for Appeal: **because**

Does John Public wish to appear at a hearing? **John Public wishes to appear at a hearing**

Medical

Someone We Can Contact about John Public's Medical Conditions

Who can help us with this appeal? **Sam Washington**

Medical Conditions

Change in physical or mental conditions: **No**

New physical or mental conditions: **No**

Medical Treatment

Other Names Used: **No**

Seen a healthcare provider or received treatment, or have an appointment scheduled: **No**

Doctors or Healthcare Providers

No doctors or healthcare providers entered.

Hospitals and Clinics

No hospitals or clinics entered.

Tests

No tests entered.

Medicines

No medicines entered.

Other Medical Information

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else? **No**

Activities/Training

Activities

Changes in daily activities due to physical or mental conditions: **No**

Work and Education

Have you worked or has your work changed: **No**

Completed or enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes: **No**

Vocational Rehabilitation, Employment, or Other Support Services

Participated in program: **No**

Review

Remarks

Remarks:

Medical Release Form

I voluntarily authorize and request disclosure of all of my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Agreed to electronically sign the medical release form.**

Electronically Signed Medical Authorization (Form827)

Form **SSA-827** (03-2020)
Discontinue Prior Editions

Page 1 of 2
OMB No. 0960-0623

Whose Records to be Disclosed	
NAME (First, Middle, Last, Suffix) John Q Public	
SSN ***-**-7222	Birthday (MM/DD/YYYY) 05/25/1977

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
 - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed). Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM

The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am capable of managing benefits ONLY (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY INDIVIDUAL authorizing disclosure Signature

Electronically signed by:
John Q Public

IF not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian ☐ Other personal representative
(explain)

(Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed 03/19/2025
Street Address 741 Main St
Phone Number (with area code) City Baltimore
State MD ZIP 21117

WITNESS

I know the person signing this form or am satisfied of this person's identity:

Signature IF needed, second witness sign here (e.g., if signed with "X" above)

Phone Number (or Address) Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

**Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

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

Sections 205(a), 223(d), and 1631(d) 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 your claim that could result in a denial or loss of benefits.

We will use the information you provide to determine your eligibility or continuing eligibility for benefits, and your ability to manage any benefits that you currently receive.

We may also share your information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations;
2. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and
3. To Federal, State or local agencies for administering cash or non-cash income maintenance or health maintenance programs.

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 (SORNs) 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. 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 control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions.

SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Cover Sheet (Covr001)

Cover Sheet for John Public

BNC: 25VZ271B09375

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on John Public's claim for benefits.

John Public's address:

741 Main St
Baltimore, MD 21117

John Public's phone number:

Name and address of someone else Social Security can contact who knows about John Public's condition:

Sam Washington
741 Main St
Baltimore, MD 21117

I have attached the following items (check all that apply):

- ☐ Copies of Medical Records You Already Have
- ☐ Other (Please list below)

Mail or bring to:

SOCIAL SECURITY
315 N WASHINGTON ST
ROCKVILLE , MD 20850-1750