BOB SMITH
1234 ABC DR
ANYWHERE MD 21042

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

Date: Mar 8, 2022
Case ID: 21665

BOB SMITH
1234 ABC DR
ANYWHERE MD 21042

We are the office that makes disability decisions for the Social Security Administration. We are writing to you because we need more information about DCPS Elza Gleichner's condition, daily activities, or work history. He gave us your name as a person who would be able to provide us with this information.

What You Need To Do

Complete the enclosed form(s) to the best of your ability based on your knowledge. Please use black or blue ink and return the form(s) by March 18, 2022.

How To Return The Form(s)

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

If You Have Any Questions

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

Thank you for your help.

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

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

Form Approved
OMB No. 0960-0555

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

RQID:DCM12512 SITE:S09 DR:S
SSN:********* DOCTYPE:0215 RF:D CS:dccd

PLEASE COMPLETE AND RETURN BY MARCH 18, 2022

SEIZURE WITNESS QUESTIONNAIRE

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

1) What is your relationship to this individual? _____

2) How long have you known this individual? _____

3) How often do you see this individual? _____

4) How many times have you seen this individual have a seizure? _____

5) What is the approximate date of the last seizure you saw? _____

6) Were there any changes in the individual's behavior just before a seizure? ☐ Yes ☐ No

If yes, explain _____

_____

_____

7) Describe what happened to the individual during a seizure (for example, did the individual lose consciousness, fall down, stare into space, lose bowel or bladder control, bite tongue, have repeated body movements, suffer an injury)?

_____

_____

_____

_____

8) Describe any problems the individual had after a seizure (for example, confusion, tiredness, difficulty talking or walking) and how long the problems lasted.

9) Did the individual remember having a seizure? ☐ Yes ☐ No

10) How long does a seizure typically last? _____

11) In addition to seizures you have witnessed, do you know about any other seizures? ☐ Yes ☐ No

If yes, explain

Name of person completing this form (Please print)	Date	Phone	
Address	City	State	ZIP

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d) and 1631(d) and (e) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on any claim filed.

We will use the information to make a determination regarding your ability to perform work-related activities. We may also share your information for the following purposes, called routine uses:

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

2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We will disclose information under this routine use only in situations in which SSA may enter into a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records.

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

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0044, entitled National Disability Determination Services File System and 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*