DISABILITY DETERMINATIONS SERVICE
SSA
S09 Delaware DDS
SUITE 300
NEW CASTLE, DE 19720-1000
TEL: (800) 888-0000

DATE:	December 19, 2025
TO:	UNIVERSAL HLTH SVCS @ ROCKFORD
FAX NUMBER:	4109667352
RE:	DCPS Louis Anderson 1477239

NOTE: The information contained in this facsimile is intended only for the individual or organization named above and may contain confidential or privileged information. If you are not the intended recipient, any dissemination, distribution or copying of the communication is prohibited. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for the return of all documents transmitted.

DO NOT INCLUDE THIS PAGE WITH YOUR RESPONSE

PLEASE SHRED

DELAWARE DDS
920 WEST BASIN ROAD

SUITE 300
NEW CASTLE, DE 19720-1000
TEL: (800) 888-0000 Fax: (800) 888-0001

RQID:DCM257338 SITE:S09 DR:S
SSN:********* DOCTYPE:0001 RF:D CS:8542

CLAIMANT: DCPS Louis Anderson
CASE NUMBER: 1477239
REQUEST ID: DCM257338
Fiscal ID: 318930
December 19, 2025

PROVIDER:
UNIVERSAL HLTH SVCS @ ROCKFORD
100 ROCKFORD DR
NEWARK, DE 19713
Tax ID #: 788599976
Phone: 3029965480

PAYEE:
UNIVERSAL HLTH SVCS @ ROCKFORD
100 ROCKFORD DR
NEWARK, DE 19713
Tax ID #: 788599976

TO ENSURE PROPER PAYMENT, PLEASE VERIFY PAYEE AND TAX ID INFORMATION LISTED ABOVE AND THEN SIGN BELOW

Records can be Faxed to: (800) 888-0002

If you are sending by Fax, place this page ON TOP of medical evidence.
If you are also sending your own invoice, place your invoice directly behind this invoice.

When submitting your records using the **Electronic Records Express (ERE),** use the following: http://eme.ssa.gov. This method of submission requires an ERE account, ID, and password. Additional information on ERE is available at **www.ssa.gov/ere**.

TOTAL MAXIMUM CHARGE	SERVICE	TOTAL CHARGE
[$15.00]	**Medical Evidence of Record**	**$_____**

I certify that the above service has been provided. Service provided under this authorization is to be furnished without discrimination with regard to race, color, or national origin.

X_____ _____
SIGNATURE BY OR FOR PAYEE DATE

THIS IS AN INVOICE - PLEASE RETURN FOR PAYMENT.
***** INVOICE IS VOID AFTER 90 DAYS *****

FOR OFFICE USE ONLY

(Stephanie Schmidt)

FOR FISCAL DEPARTMENT USE ONLY
PAID DATE:_____
VOUCHER ID:_____

AUTHORIZED SIGNATURE _____

DISABILITY DETERMINATIONS SERVICE
SSA
S09 Delaware DDS
SUITE 300
NEW CASTLE, DE 19720-1000
TEL: (800) 888-0000

UNIVERSAL HLTH SVCS @ ROCKFORD
100 ROCKFORD DR
NEWARK DE 19713

Date: December 19, 2025
Case ID: 1477239
RE: DCPS Louis Anderson
AKA: Jacob Johnny Zimmermann Jr
Shahrukh Khan
DOB: November 24, 2000
Vendor Number: 2031

We are the office that makes disability decisions for the Social Security Administration. DCPS Louis Anderson is applying for or is receiving disability benefits due to the following conditions: Heart condition, arrhythmia, high blood pressure, headaches, and seizures. This is not an authorization to perform an examination.

What We Need From You

To help us evaluate this claim, please send records covering the period of: 06/19/2023 to Present.

Include the following information: medical history, psychiatric history, clinical findings, laboratory findings, imaging reports, treatment prescribed and the response, diagnosis, and prognosis.

Please respond by January 2, 2026. We are enclosing a signed HIPAA compliant authorization for the release of medical records and information.

Please provide a statement based on your findings. Your statement should express your opinion about your patient's ability to do work-related physical and/or mental activities despite the limitations or restrictions imposed by DCPS Louis Anderson's medical condition(s). For physical impairments, these activities include sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical activities (including manipulative or postural activities, such as reaching, handling, stooping, or crouching); other activities, such as seeing, hearing, or using other senses; and ability to adapt to environmental conditions, such as temperature extremes or fumes. For mental impairments, these activities include understanding; remembering; maintaining concentration, persistence, or pace; carrying out instructions; and responding appropriately to supervision, coworkers, and work pressures.

If it is determined that we need additional information regarding your patient's impairments, would you be willing to perform an examination to provide additional findings? Please contact us if you would be willing to perform this examination. We will assume that you do not wish to perform the examination if you do not respond.

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 7:00 am and 5:00 pm. When you call or leave a message, please provide the Case ID: 1477239, your name, DCPS Louis Anderson's name, and a call back number.

Thank you for your help.

S. Schmidt
(301) 555-1212
(800) 888-0001 (FAX)

Enclosure(s):
Invoice
Epilepsy Questionnaire
Privacy Act and Paperwork Reduction Act Statement
SSA-827 Authorization to Disclose Information to the Social Security Administration (SSA)
Return Envelope

Form Approved
OMB No. 0960-0555

Date: December 19, 2025
Case ID: 1477239
Claimant Name: DCPS Louis Anderson

PLEASE COMPLETE AND RETURN BY JANUARY 2, 2026

EPILEPSY QUESTIONNAIRE

1) Date of most recent examination: _____

2) Diagnoses: _____

3) Indicate the type of seizures: ☐ Convulsive ☐ Non-Convulsive

4) Dates of last two seizures: _____ _____

5) Describe typical seizures (include all associated phenomena, such as aura, loss of consciousness, tonic or clonic movement, incontinence, alteration of awareness, unconventional behavior, duration, etc.).

_____

_____

_____

6) Describe postictal manifestations and duration. _____

_____

_____

7) If convulsive, when do episodes occur?

☐ Day (with loss of consciousness and convulsive seizures) ☐ Night

8) Seizures witnessed by physician or staff member? ☐ Yes ☐ No

If yes, describe. _____

_____

_____

9) Treatment:

MEDICATION	DOSAGE AND FREQUENCY	SIDE EFFECT(S)

10) Other treatment: _____

11) Are seizures controlled with medication? ☐ Yes ☐ No

If no, explain. _____

12) Frequency of seizures after prescribed treatment: _____

13) Serum levels:

DRUG	DATE	RESULT

14) If serum drug levels are therapeutically inadequate, explain further. _____

15) Describe any functional limitations resulting from the patient's condition (for example, driving, physical activity, hazardous conditions).

16) Describe any restrictions to work-related activities, if not previously provided (for example, walking, lifting, carrying).

NOTE: Please submit copies of any testing and laboratory results, if you have not provided them previously.

Physician's Signature	Date	Phone
Printed Name		Title

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), and 1631(d) of the Social Security Act, as amended, allow us to collect your information or the information you are submitting on behalf of another, which we will use to determine benefits eligibility. Providing the information is voluntary, but not providing all or part of the information may prevent an accurate and timely decision on any claim filed. As law permits, we may use and share the information you submit, including with other Federal agencies, private medical and vocational consultants, contractors, and others, as outlined in the routine uses within System of Records Notices (SORN) 60-0044, 60-0089, and 60-0320; available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs to establish or verify eligibility for Federal benefit programs and to recoup debts under these programs.

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

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*		
Carlton	Dupree	Cook

SSN	866-18-3319	Birthday *(mm/dd/yy)*	01/01/84

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:

UNIVERSAL HLTH SVCS @ ROCKFORD
100 ROCKFORD DR
NEWARK, DE 19713
06/19/2023 TO PRESENT

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

SIGN ▶ *Electronically signed by* **Carlton Dupree Cook**

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	Street Address		
02/27/24	**7653 Third St**		
Phone Number (with area code)	City	State	ZIP
213-598-1603	**HONOLULU**	**HI**	**96850**

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

SIGN ▶ *Attested by SSA or Designated State Agency Employee:* **T Foulke**

Phone Number (or Address): **866-964-0783 NEW YORK NY 10036-1436**

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

SIGN ▶

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.***