

CHRISTY TREMAINE RITCHIE V  
8741 WHITE ROW  
APT. 293  
TOWNSEND DE 19734

TEST ENVIRONMENT

*This correspondence was formatted for mailing in an envelope with the pages folded once.*

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

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

Date: December 19, 2025  
Case ID: 1477239

CHRISTY TREMAINE RITCHIE V  
8741 WHITE ROW  
APT. 293  
TOWNSEND DE 19734

This is a very important letter from Social Security. Please read it carefully. If you cannot read English, please take this letter to someone who can read it to you right away, or contact Social Security for free help.

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 Louis Anderson's condition, daily activities, or work history. DCPS Louis Anderson 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 January 3, 2026.

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

You may use the enclosed return envelope or fax your completed form(s) to us at (800) 888-0002. 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 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):  
Seizure Witness Questionnaire  
Privacy Act and Paperwork Reduction Act Statement  
Return Envelope

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



RQID:DCM257339 SITE:S09 DR:S  
SSN:\*\*\*\*\* DOCTYPE:0215 RF:D CS:a43e

**PLEASE COMPLETE AND RETURN BY JANUARY 3, 2026**

**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)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **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](http://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.***

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