DCPS TIMOTHY BRUEN
477 MICHEL LOCK
WILMINGTON DE 19891

This correspondence was formatted for mailing in an envelope without folding the pages.

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

Date: December 19, 2025
Case ID: 93807

DCPS TIMOTHY BRUEN
477 MICHEL LOCK
WILMINGTON DE 19891

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 about your disability claim because we need more information about your condition, daily activities, or work history.

What You Need To Do

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

Return the completed form(s) by January 3, 2026. If you do not return the form(s), we may decide the case based on the information we already have on file. This means that we could find that you are not disabled based on our rules or that your disability has ended if you are already getting benefits.

How To Return The Form(s)

You may use the enclosed return envelope or fax your completed form(s) to us at (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: 93807, your name, and a call back number.

Thank you for your help.

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

Enclosure(s):
Headache Questionnaire
Privacy Act and Paperwork Reduction Act Statement
Return Envelope

Form Approved
OMB No. 0960-0555

Date: December 19, 2025
Case ID: 93807
Claimant Name: DCPS Timothy Bruen

RQID:DCM257326 SITE:S09 DR:S
SSN:********** DOCTYPE:0235 RF:D CS:b692

PLEASE COMPLETE AND RETURN BY JANUARY 3, 2026

HEADACHE QUESTIONNAIRE

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

1) When did you start having headaches? (Approximate date) _____

2) When was your last headache? _____

3) What causes your headaches? _____

4) Describe a typical headache:

a) Type (for example, migraine, sinus, cluster) _____

b) Location (for example, front, temple, middle, side, back) _____

c) Symptoms (for example, nausea, vomiting, blurred vision) _____

5) How often do you get headaches? (for example, daily, weekly, monthly) _____

6) How long does a typical headache last? _____

7) Describe any limitations in your activities during a typical headache and how long these limitations last (for example, darkened room, lying without moving, sleep disturbance).

8) List current headache medication(s).

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

9) Have you visited an emergency room for treatment to relieve a headache? If so, when and where? _____

10) Do you use any other treatments to relieve your headaches? if so, describe. _____

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

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

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

Address

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*.