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**SOCIAL SECURITY FORMS**

## Duke Legal Project Materials



## Social Security Administration Forms

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# DISABILITY CASE STATUS SHEET

***Keep this sheet in the front of the disability case binder. Update as changes occur***

| | | | |
|---|---|---|---|
| Client's Name | | | |
| Social Security Number | | | |
| Date of Birth | | | |
| Place of Birth | | | |
| Mother's full name | | | |
| Case type | ☐ SSDI only ☐ SSI only ☐ Both SSI and SSDI ☐ Medicaid | | |
| Social Security/SSI Date of Application | | Alleged Onset Date | |
| Date Last Worked | | Date Last Insured | |
| **Case Progress** | | | |
| Date 1696 submitted | | | |
| Date of Initial Denial | | Date Reconsideration Requested | |
| Date of Reconsideration Denial | | Date of Request for Hearing* | |
| Date of OTR request | | Date of Hearing | |
| Date of ALJ Decision | | Nature of Decision | ☐ Fully Favorable<br>☐ Partially Favorable<br>☐ Denial |
| **Social Security Contacts** | | | |
| District Office Contact | | | |
| Initial Level: DDS Examiner (name & phone) | | | |
| Reconsideration: DDS Examiner (name & phone) | | | |
| Hearing Office Contact Information | | | |
| Name of ALJ | | | |

| **Social Security File** | | |
|---|---|---|
| **Date File Requested** | **Received** | **Level (e.g. initial, recon, hearing)** |
| | | |
| | | |
| **Date Bar Code Requested** | **Received** | **Level (e.g. initial, recon, hearing)** |
| | | |
| | | |

***If completed online, ALL forms (request for hearing, 1696, and 3441) must be submitted before appeal will be considered submitted**

**MEDICAL RECORDS REQUESTS**

| Health Care Provider/Facility and what requested | Dates of records requested | Request Sent and how (date) | Records Received (date) | Rec'd all requested? |
|---|---|---|---|---|
| Halifax Memorial – all outpatient care, including psychiatric and substance abuse | August 2011 – January 30, 2012 | 1/31/12, Via fax, confirmed | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Other records need to request: ☐ School records ☐ Work Records ☐ Vocational Rehab

☐ Other: _____

Status of requests

| Type of records requested, from whom | Dates of records requested | Request Sent and how (date) | Records Received (date) | Rec'd all requested? |
|---|---|---|---|---|
| Employee Attendance Records, ACME Inc | April 2014 January 30, 2015 | 6/03/15, Via US mail | | |
| Cumulative Student File Durham Public Schools, | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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## Social Security Disability/SSI Screening

Screener's name:_____ Date _____

Prospect name:_____ Referred by:_____

Date applied:_____ **Date last denied**_____

Has prospect already appealed? Yes_____ No_____ Date appealed_____

Reason for denial: disability_____ other (specify) _____

**Current stage in proceedings:**
**initial application** ____ **reconsideration** _____ **ALJ appeal** _____ **post ALJ** _____

Does prospect already have an attorney? Yes___ No___ Who? _____

Where does prospect get medical care?_____

Primary doctor_____ Does doctor support? _____

Date diagnosed:_____ CD4: latest _____ highest_____lowest_____

Date prospect became unable to work (i.e. became disabled) _____

**Main impairments & symptoms:**

Prospect's age_____ Education:_____

When/where did prospect last work? _____

What type of work?_____

Is prospect able to do any kind of work now? Yes _____ No_____

Why or why not? _____

Health insurance? Private____ Medicaid____ VA _____ ADAP _____uninsured_____

Has prospect applied for Medicaid? Yes _____ No_____

If denied Medicaid, date of denial_____. Appealed? Yes _____ No_____

Mother's Full name (needed to get info from SSA): _____

Other pertinent information (substance use, hospitalizations, etc.):

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# DISABILITY INTERVIEW
# Part 1 – Medical/Functional Information

Client's Name:_____

Interviewer::_____Date: _____

## I. INFORMATION ABOUT CLAIM

**Present claim**: _____SSI _____ Social Security Disability _____Private Disability

What date does client think his/her disability began?_____

Is this the date client listed on the disability application? _____Yes _____No

If not, what has changed? _____

When did client apply? _____

Was client denied after initial application? _____Yes _____No When? _____

Have denial letter? (If so, get copy) _____Yes _____No

Did client appeal that denial and ask for reconsideration? _____Yes _____No When? _____

Has client been denied after reconsideration? _____Yes _____No When? _____

Have denial letter? (if so, get copy) _____Yes _____No

Has client asked for a hearing? _____Yes _____No When?_____

Has a date been set? _____Yes _____No If so, what date? _____

Client's place of birth? _____Mother's name: _____

### Prior applications

Has client applied for disability in the past, before this application? Yes_____ No ____

If so, when, where, and what was the outcome: _____

**Representation:** Has client consulted with another attorney in this or a previous claim?

Yes_____ No ____

If yes, get name, location, status of relationship

## II. FAMILY

Is Client married? _____Yes _____No

Spouse's Name:_____Age:_____

Spouse's Occupation:_____ SSN:_____

Separated from present spouse? _____ If so, for how long and why? _____

_____

Number of former marriages: _____ Dates/duration_____

Number of former spouses:_____ Does client have children? _____Yes _____No

Names & ages: _____

_____

Which, if any, of the children live with client? _____

_____

Parents alive? Mother _____ Father_____

Cause of death of parents: _____

## III. MEDICAL HISTORY:

### Current Illnesses:

1. **HIV/Cancer (circle which)**

   When diagnosed? _____ Doctor/Clinic?_____

   Current CD4 (T-cell) count/Viral Load: _____ Lowest: _____

   Name and address of current doctors:

   _____

   _____

   _____

What treatment/medications received for HIV or Cancer? Current medications with dosage & frequency?

_____

_____

_____

_____

Side effects from medications:_____

_____

_____

_____

_____

### HIV-Symptomatic illnesses/Cancer-related illnesses/symptoms:

(For HIV, ask about infections, malignancies, skin conditions, blood abnormalities, neurological abnormalities, weight loss, diarrhea, kidney dysfunction, cardiac abnormality. For cancer, make sure to get thorough picture of symptoms from cancer as well as all treatment and side effects)

### 1. Condition/illness:

Description: _____

_____

When did symptoms begin? _____

When end? _____

Describe course of illness: _____

_____

How often recurred? _____

What treatment was prescribed? If a medication, list the name, dosage and frequency taken. Was treatment effective?

_____

_____

Treatment side effects: _____

_____

Doctor who treated (if different from above):

Name:_____

Address: _____

_____

## 2. Condition/illness:

Description: _____

_____

When did symptoms begin? _____

When end? _____

Describe course of illness: _____

_____

_____

How often recurred? _____

What treatment was prescribed? If a medication, list the name, dosage and frequency taken. Was treatment effective?

_____

_____

Treatment side effects: _____

_____

Doctor who treated (if different from above):

Name:_____

Address: _____

_____

## 3. Condition/illness:

Description: _____

_____

When did symptoms begin? _____

When end? _____

Describe course of illness: _____

_____

_____

How often recurred? _____

What treatment was prescribed? If a medication, list the name, dosage and frequency taken. Was treatment effective?

_____

_____

Treatment side effects: _____

_____

Doctor who treated (if different from above):

Name:_____

Address: _____

_____

## 4. Condition/illness:

Description: _____

_____

When did symptoms begin? _____

When end? _____

Describe course of illness: _____
_____

_____

How often recurred? _____

What treatment was prescribed? If a medication, list the name, dosage and frequency taken. Was treatment effective?
_____

_____

Treatment side effects: _____

_____

Doctor who treated (if different from above):

Name:_____

Address: _____

_____

## 5. Condition/illness:

Description: _____

_____

When did symptoms begin? _____

When end? _____

Describe course of illness: _____

_____

_____

How often recurred? _____

What treatment was prescribed? If a medication, list the name, dosage and frequency taken. Was treatment effective?

_____

_____

Treatment side effects: _____

_____

Doctor who treated (if different from above):

Name:_____

Address: _____

_____

## Other Medical Conditions:

**1. Condition/illness**:_____

Onset date: _____

Symptoms: _____

_____

What treatment was prescribed? If a medication, list the name, dosage and frequency taken. Was treatment effective?

_____

_____

Doctor and Address: _____

_____

**2. Condition/Illness:**_____

Onset date: _____

Symptoms: _____

_____

What treatment was prescribed? If a medication, list the name, dosage and frequency taken. Was treatment effective?

_____

_____

Doctor and Address: _____

_____

_____

**3. Condition/illness**_____

Onset date: _____

Symptoms: _____

_____

What treatment was prescribed? If a medication, list the name, dosage and frequency taken. Was treatment effective?

_____

_____

Doctor and Address: _____

_____

_____

## Additional Medications:

Any medications being taken that have not been mentioned? (Name, dosage, frequency and doctor who prescribed:

_____

_____

_____

_____

_____

_____

_____

## Hospitals visited in the last 10 years:

1. Name/Location of Hospital: _____

   _____Emergency Room _____Admitted to hospital (inpatient)

   Reason: _____

   Dates: _____

2. Name/Location of Hospital: _____

   _____Emergency Room _____Admitted to hospital (inpatient)

   Reason: _____

   Dates: _____

3. Name/Location of Hospital: _____

   _____Emergency Room _____Admitted to hospital (inpatient)

   Reason: _____

   Dates: _____

4. Name/Location of Hospital: _____

   _____Emergency Room _____Admitted to hospital (inpatient)

   Reason: _____

   Dates: _____

**Pain --** Does the client experience pain? Yes_____ No_____.

**Location of pain #1**:_____

When did it start? _____ How often? _____

Intensity (on a scale of 1-10) _____ How long does it last? _____

What makes it better? _____ Worse? _____

What does client think is the condition causing the pain? _____

Has the client seen a doctor for the pain? Yes_____ No_____ Who? _____

What tests have been done (e.g. MRI, nerve conduction study)? _____

Treatment: _____

How does the pain affect the client's functioning, activities? _____

_____

**Location of pain #2**:_____

When did it start? _____ How often? _____

Intensity (on a scale of 1-10) _____ How long does it last? _____

What makes it better? _____ Worse? _____

What does client think is the condition causing the pain? _____

Has the client seen a doctor for the pain? Yes_____ No_____ Who? _____

What tests have been done (e.g. MRI, nerve conduction study)? _____

Treatment: _____

How does the pain affect the client's functioning, activities? _____

_____

**Location of pain #3**:_____

When did it start? _____ How often? _____

Intensity (on a scale of 1-10) _____ How long does it last? _____

What makes it better? _____ Worse? _____

What does client think is the condition causing the pain? _____

Has the client seen a doctor for the pain? Yes_____ No_____ Who? _____

What tests have been done (e.g. MRI, nerve conduction study)? _____

Treatment: _____

How does the pain affect the client's functioning, activities? _____

_____

## Mental Health/Substance Use Treatment

Ever been treated by a psychologist or psychiatrist? Yes_____ No_____

When: _____ For how long?_____

For what condition: _____

Name and address of doctor: _____

_____

Mental Health, community clinics or outpatient clinics visited: _____

_____

_____

In-Patient Psychiatric Treatment:

When:_____

Where: _____

## Drugs/Alcohol:

How much **alcohol** consumed per day (present)?_____

How much alcohol consumed daily in the past? _____

When stopped?_____

Currently use any **illegal drugs** (i.e. heroin, cocaine, crack, etc.)? Yes_____ No_____

Drugs used/frequency: _____

_____

Formerly use any illegal drugs? Yes_____ No_____

Drugs used/frequency: _____

_____

**Drug/Alcohol Treatment:** Describe any treatment received for substance abuse (dates, names of clinic or rehabilitation facility, whether inpatient or outpatient):

_____

_____

_____

_____

_____

## Smoking:

Smoking: Yes_____ No_____ _____packs/day

Former smoking of _____packs/day

## V. FUNCTIONAL ABILITIES:

### Basic Physical Activities:

| **Physical Demand** | | **Details/reasons** |
|---|---|---|
| **Sitting** | Maximum in one position | |
| | Maximum in one work-day (8 hour period) | |
| | Limitations | |
| | Pain? | |
| | Need to alternate sitting/standing/walking? How frequently? | |
| **Standing** | Maximum at one time | |

| | | |
|---|---|---|
| | | |
| | Maximum in one work-day (8 hour period) | |
| | Limitations | |
| | Pain? | |
| **Walking** | Maximum time/distance at one time | |
| | Maximum time in one work-day (8 hour period) | |
| | Limitations | |
| | Pain? | |
| **Lifting** | Heaviest object/weight claimant can lift occasionally (note: a gallon of milk weights about 10 pounds) | |
| | Heaviest object/weight claimant can lift frequently | |
| | Limitations | |
| | Pain? | |
| **Carrying** | Heaviest object/weight claimant can carry (note: a gallon of milk weights about 10 pounds) occasionally | |
| | Heaviest object/weight claimant can carry frequently (about 6 hours during the day) | |
| | Limitations | |
| | Pain? | |

## Other Physical Activities:

| **Physical Demand** | **Any problems?** |
|---|---|
| **Climbing** (ladders, stairs, scaffolding, etc) | |
| **Balancing** (to prevent fall from hazardous places) | |
| **Stooping** (bending) spine at the waist | |
| **Kneeling** (coming to rest on the knees) | |
| **Crouching** (Bending the legs and spine) | |
| **Crawling** (moving about on hands & knees) | |
| **Reaching** with hands/arms in any direction | |
| **Handling** by seizing, holding, grasping or turning | |
| **Fingering** by picking or pinching with finger(s) | |
| **Feeling** for size, shape, temperature or texture | |
| **Talking** to exchange ideas or information with others | |
| **Hearing** | |
| **Tasting/Smelling** | |
| **Near Acuity** (vision at 20 inches or less) | |
| **Far Acuity** (vision at 20 feet or more) | |
| **Depth perception** (to judge distances) | |
| **Accommodation** (quick near-point visual refocus) | |
| **Color Vision** | |
| **Fields of Vision** around the periphery of a fixed point | |

## Mental Abilities/Stamina

| **Mental Demand** | **Any problems?** |
|---|---|
| Memory | |
| Concentration | |

| | |
|---|---|
| Paying Attention | |
| Getting along with other people | |
| Going out in public | |
| Dealing with changes in routine | |
| Completing tasks on time | |

## Living arrangement:

House _____ Apt: _____ Room:_____

If Apt. or room, it is on the _____floor. Elevator available? _____

Bedroom on what floor? _____ Bathroom on what floor? _____

Kitchen on what floor? _____

How often does client climb stairs each day: _____

## Daily Activities:

What time does client get up? _____ Eat breakfast? _____

Need assistance with personal hygiene?_____

## Household tasks:

| **Task** | **Can client do it?** | | | **Who does it? If client does the task, describe any limitations, assistance** |
|---|---|---|---|---|
| | **Yes** | **No** | **At slower pace** | |
| Fix meals | | | | |
| Wash dishes | | | | |

| Task | Can client do it? | | | Who does it? |
|---|---|---|---|---|
| | | | | |
| Light housework | | | | |
| Heavy cleaning | | | | |
| | **Yes** | **No** | **At Slower pace** | |
| Vacuuming | | | | |
| Laundry | | | | |
| Yard work | | | | |
| Grocery shopping | | | | |
| Other shopping | | | | |
| Pay bills | | | | |

Does client do ***any*** work around the house?_____

Describe usual daily/weekly activities. _____

_____

_____

_____

Does client take naps/rests? _____

How often and for how long?_____

_____

Read? ____yes ____no What? _____

How often? _____ How long at one time? _____

Pay bills? ____yes ____no If no, who pays bills? _____

Watch TV? _____

Use computer? ____yes ____no How often? _____

How long at one time? _____

What does client do on the computer? ____ school work _____ personal business

_____ word processing ____ e-mail _____ internet _____social networking

_____Facebook/My Space _____ other – specify _____

Go anywhere? (how far and how often)_____

_____

Involved with friends? _____

Participate in religious activities?_____

Participate in any organizations? _____

Have a driver's license? _____ Currently driving? _____

Any limitations on driving? _____

If no longer driving, when and why did driving stop?_____

_____

_____

Last time drove and how far? _____

_____

Last long trip of any sort that client went on_____

_____

Does client use public transportation? _____ Need assistance? _____
Describe _____

_____

What assistance if any does client get from friends, relatives, case managers, etc. in personal care, daily activities, keeping track of bills, medications, etc.? Who provides the assistance?

_____

_____

_____

Third parties (relatives, friends, case manager, etc.) who can testify to client's disability from personal knowledge:

_____

_____

_____

## Other Details:

Current weight: _____ Usual weight:_____ Height: _____

Dominant hand: Right _____ Left _____

Restricted diet?_____

_____

Wear glasses? _____ Best corrected vision in each eye: Right_____ Left: _____

False teeth: _____ Hearing aid: _____

Allergies?_____

Have a breathing problem that restricts the work atmosphere?_____

How?_____

Serious childhood diseases and defects: _____

_____

## EDUCATION/WORK HIGHLIGHTS:

Highest level of education:_____

Date last worked: _____ Part-time or full-time? _____

Last job (job title) _____

Other types of work done by claimant in past 15 years: _____

_____

Has claimant ever been incarcerated? ____yes ____ no

If yes, where and when? _____

**Ability to Work:**

**Does client think he/she could do any work at present?** Yes _____ No ____

If yes, what type of work? _____

For how many hours a day? _____ For how many days a week?_____

If no, why not? _____

_____

Does client think he/she will be able to work in future? Yes_____ No _____

Why or why not? _____

_____

**INTERVIEWER'S IMPRESSIONS**

Does client seem credible? _____ If not, why not?

Does client have any difficulty communicating? If so, explain.

Overall impression of client:

**Remember to get client to sign any necessary paperwork!!**

- **Releases**
- **1696 (Appointment of Representative Form)**
- **Appeal paperwork**

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# DISABILITY INTERVIEW
# PART 2: Education and Work History

**Client**: _____

**Interviewer:** _____ **Date:** _____

## EDUCATION:

Age when left school: _____ Highest grade completed: _____

High School diploma?_____ GED? _____

College degree? _____ What field? _____

Vocational or business schools? _____ What field? _____

Reason left school :_____

Last school attended: _____

Any trouble writing and being understood? _____

Any trouble reading and understanding?

Newspapers _____ Directions _____

Letters from government agencies, insurance companies, etc. _____

_____

Have ability to do:

addition _____ count change _____

subtraction _____ multiplication _____

division _____

Describe vocational skills: (i.e., what kinds of work activities does client have skills for, even if doesn't have current ability to carry out.)

_____

_____

_____

## EMPLOYMENT (for the last 15 years):

**Current or most recent job** (Job title): _____

Employer: _____

Address: _____

Dates: _____

Describe what client did at this job (physical & mental activities):_____

_____

_____

| Physical Demand | Requirements of Past Job | Details/reasons |
|---|---|---|
| **Sitting** | How long did client sit in one position at one time? | |
| | How long -- total -- did client sit during the entire work day | |
| | Any problems with sitting requirements on this job? | |
| | Was client able to alternate sitting and standing? If so, how frequently? | |
| **Standing** | How long did client have to stand at one time? | |
| | How long – total -- did client have to stand in the entire work day? | |
| | Any problems with standing requirements on this job? | |
| **Walking** | How long did client have to walk at one time? | |
| | How long – total -- did client have to walk in the entire work day? | |
| | Any problems with walking requirements on this job? | |

| Physical Demand | Requirements of Past Job | Details/reasons |
|---|---|---|
| **Lifting** | What was the heaviest object/weight claimant had to lift on the job? | |
| | How often? | |
| | What object/weight did claimant lift frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with lifting requirements of this job? | |
| **Carrying** | What was the heaviest object/weight claimant had to carry on the job? | |
| | How often? | |
| | What object/weight did claimant carry frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with the carrying requirements of this job? | |

**Check any of the following required in the past job & include details:**

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Climbing** (ladders, stairs, scaffolding, etc) | | | |
| **Balancing** (to prevent fall from hazardous places) | | | |
| **Stooping** (bending) spine at the waist | | | |
| **Kneeling** (coming to rest on the knees) | | | |

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Crouching** (Bending the legs and spine) | | | |
| **Crawling** (moving about on hands & knees) | | | |
| **Reaching** with hands/arms in any direction | | | |
| **Handling** by seizing, holding, grasping or turning | | | |
| **Fingering** by picking or pinching with finger(s) | | | |
| **Feeling** for size, shape, temperature or texture | | | |
| **Talking** to exchange ideas or information with others | | | |
| **Hearing** | | | |
| **Tasting/Smelling** | | | |
| **Near Acuity** (vision at 20 inches or less) | | | |
| **Far Acuity** (vision at 20 feet or more) | | | |
| **Depth perception** (to judge distances) | | | |
| **Accommodation** (quick near-point visual refocus) | | | |
| **Color Vision** | | | |
| **Fields of Vision** around the periphery of a fixed point | | | |

Machines operated: _____

Fine motor tasks: _____

Interaction with co-workers, supervisors, public? _____

_____

How often were rest periods allowed? _____

Attendance requirements/accommodations?_____

Any special **environmental** characteristic of this job?

_____Dangerous machinery _____Chemicals? _____Dust _____Noise _____ Heights

_____Extreme cold _____ Extreme heat _____ Other:_____

Explain: _____

_____

Why no longer working? _____

_____

What if any difficulties did client have on this job?

Physical:_____

_____

Mental (e.g. paying attention, processing information, getting along with other people):

_____

_____

Did client have any special help, accommodations, or conditions that were not given to other employees? (e.g. extra breaks, not required to do all duties, etc.)?

_____

_____

Is there any person at this last job who would have knowledge of ability/inability to do work? Name, address, phone, possible testimony:

_____

_____

Pay rate when job ended: _____ Hours per week: _____

If left because disabled, was any private disability insurance available? _____

Made claim?: _____ What results? _____

Worker's compensation? _____

Have you applied for or received unemployment compensation at any time after the date you became disabled? Yes_____ No_____.

If yes, give details, including dates:_____

**JOB # 2:** (Job title) _____

Employer: _____

Address: _____

Dates: _____

Describe what client did at this job (physical & mental activities):_____

_____

_____

| Physical Demand | Requirements of Past Job | Details/reasons |
|---|---|---|
| **Sitting** | How long did client sit in one position at one time? | |
| | How long -- total -- did client sit during the entire work day | |
| | Any problems with sitting requirements on this job? | |
| | Was client able to alternate sitting and standing? If so, how frequently? | |
| **Standing** | How long did client have to stand at one time? | |
| | How long – total -- did client have to stand in the entire work day? | |
| | Any problems with standing requirements on this job? | |
| **Walking** | How long did client have to walk at one time? | |
| | How long – total -- did client have to walk in the entire work day? | |
| | Any problems with walking requirements on this job? | |

| Physical Demand | Requirements of Past Job | Details/reasons |
|---|---|---|
| **Lifting** | What was the heaviest object/weight claimant had to lift on the job? | |
| | How often? | |
| | What object/weight did claimant lift frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with lifting requirements of this job? | |
| **Carrying** | What was the heaviest object/weight claimant had to carry on the job? | |
| | How often? | |
| | What object/weight did claimant carry frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with the carrying requirements of this job? | |

**Check any of the following required in the past job & include details:**

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Climbing** (ladders, stairs, scaffolding, etc) | | | |
| **Balancing** (to prevent fall from hazardous places) | | | |
| **Stooping** (bending) spine at the waist | | | |
| **Kneeling** (coming to rest on the knees) | | | |

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Crouching** (Bending the legs and spine) | | | |
| **Crawling** (moving about on hands & knees) | | | |
| **Reaching** with hands/arms in any direction | | | |
| **Handling** by seizing, holding, grasping or turning | | | |
| **Fingering** by picking or pinching with finger(s) | | | |
| **Feeling** for size, shape, temperature or texture | | | |
| **Talking** to exchange ideas or information with others | | | |
| **Hearing** | | | |
| **Tasting/Smelling** | | | |
| **Near Acuity** (vision at 20 inches or less) | | | |
| **Far Acuity** (vision at 20 feet or more) | | | |
| **Depth perception** (to judge distances) | | | |
| **Accommodation** (quick near-point visual refocus) | | | |
| **Color Vision** | | | |
| **Fields of Vision** around the periphery of a fixed point | | | |

Machines operated: _____

Fine motor tasks: _____

Interaction with co-workers, supervisors, public? _____

_____

How often were rest periods allowed? _____

Attendance requirements/accommodations?_____

Any special **environmental** characteristic of this job?

_____Dangerous machinery _____Chemicals? _____Dust _____Noise _____ Heights

_____Extreme cold _____ Extreme heat _____ Other:_____

Explain: _____

_____

Why no longer working? _____

_____

What if any difficulties did client have on this job?

Physical:_____

_____

Mental (e.g. paying attention, processing information, getting along with other people):

_____

_____

Did client have any special help, accommodations, or conditions that were not given to other employees? (e.g. extra breaks, not required to do all duties, etc.)?

_____

_____

Is there any person at this last job who would have knowledge of ability/inability to do work? Name, address, phone, possible testimony:

_____

_____

Pay rate when job ended: _____ Hours per week: _____

**JOB # 3:** (Job title) _____

Employer: _____

Address: _____

Dates: _____

Describe what client did at this job (physical & mental activities):_____

_____

_____

| Physical Demand | Requirements of Past Job | Details/reasons |
|---|---|---|
| **Sitting** | How long did client sit in one position at one time? | |
| | How long -- total -- did client sit during the entire work day | |
| | Any problems with sitting requirements on this job? | |
| | Was client able to alternate sitting and standing? If so, how frequently? | |
| **Standing** | How long did client have to stand at one time? | |
| | How long – total -- did client have to stand in the entire work day? | |
| | Any problems with standing requirements on this job? | |
| **Walking** | How long did client have to walk at one time? | |
| | How long – total -- did client have to walk in the entire work day? | |
| | Any problems with walking requirements on this job? | |

| Physical Demand | Requirements of Past Job | Details/reasons |
|---|---|---|
| **Lifting** | What was the heaviest object/weight claimant had to lift on the job? | |
| | How often? | |
| | What object/weight did claimant lift frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with lifting requirements of this job? | |
| **Carrying** | What was the heaviest object/weight claimant had to carry on the job? | |
| | How often? | |
| | What object/weight did claimant carry frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with the carrying requirements of this job? | |

**Check any of the following required in the past job & include details**

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Climbing** (ladders, stairs, scaffolding, etc) | | | |
| **Balancing** (to prevent fall from hazardous places) | | | |
| **Stooping** (bending) spine at the waist | | | |
| **Kneeling** (coming to rest on the knees) | | | |

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Crouching** (Bending the legs and spine) | | | |
| **Crawling** (moving about on hands & knees) | | | |
| **Reaching** with hands/arms in any direction | | | |
| **Handling** by seizing, holding, grasping or turning | | | |
| **Fingering** by picking or pinching with finger(s) | | | |
| **Feeling** for size, shape, temperature or texture | | | |
| **Talking** to exchange ideas or information with others | | | |
| **Hearing** | | | |
| **Tasting/Smelling** | | | |
| **Near Acuity** (vision at 20 inches or less) | | | |
| **Far Acuity** (vision at 20 feet or more) | | | |
| **Depth perception** (to judge distances) | | | |
| **Accommodation** (quick near-point visual refocus) | | | |
| **Color Vision** | | | |
| **Fields of Vision** around the periphery of a fixed point | | | |

Machines operated: _____

Fine motor tasks: _____

Interaction with co-workers, supervisors, public? _____

_____

How often were rest periods allowed? _____

Attendance requirements/accommodations?_____

Any special **environmental** characteristic of this job?

_____Dangerous machinery _____Chemicals? _____Dust _____Noise _____ Heights

_____Extreme cold _____ Extreme heat _____ Other:_____

Explain: _____

_____

Why no longer working? _____

_____

What if any difficulties did client have on this job?

Physical:_____

_____

Mental (e.g. paying attention, processing information, getting along with other people):

_____

_____

Did client have any special help, accommodations, or conditions that were not given to other employees? (e.g. extra breaks, not required to do all duties, etc.)?

_____

_____

Is there any person at this last job who would have knowledge of ability/inability to do work? Name, address, phone, possible testimony:

_____

_____

Pay rate when job ended: _____ Hours per week: _____

**JOB # 4:** (Job title) _____

Employer: _____

Address: _____

Dates: _____

Describe what client did at this job (physical & mental activities):_____

_____

_____

| Physical Demand | Requirements of Past Job | Details/reasons |
|---|---|---|
| **Sitting** | How long did client sit in one position at one time? | |
| | How long -- total -- did client sit during the entire work day | |
| | Any problems with sitting requirements on this job? | |
| | Was client able to alternate sitting and standing? If so, how frequently? | |
| **Standing** | How long did client have to stand at one time? | |
| | How long – total -- did client have to stand in the entire work day? | |
| | Any problems with standing requirements on this job? | |
| **Walking** | How long did client have to walk at one time? | |
| | How long – total -- did client have to walk in the entire work day? | |
| | Any problems with walking requirements on this job? | |

| Physical Demand | Requirements of Past Job | Details/reasons |
|---|---|---|
| **Lifting** | What was the heaviest object/weight claimant had to lift on the job? | |
| | How often? | |
| | What object/weight did claimant lift frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with lifting requirements of this job? | |
| **Carrying** | What was the heaviest object/weight claimant had to carry on the job? | |
| | How often? | |
| | What object/weight did claimant carry frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with the carrying requirements of this job? | |

**Check any of the following required in the past job & include details:**

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Climbing** (ladders, stairs, scaffolding, etc) | | | |
| **Balancing** (to prevent fall from hazardous places) | | | |
| **Stooping** (bending) spine at the waist | | | |
| **Kneeling** (coming to rest on the knees) | | | |

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Crouching** (Bending the legs and spine) | | | |
| **Crawling** (moving about on hands & knees) | | | |
| **Reaching** with hands/arms in any direction | | | |
| **Handling** by seizing, holding, grasping or turning | | | |
| **Fingering** by picking or pinching with finger(s) | | | |
| **Feeling** for size, shape, temperature or texture | | | |
| **Talking** to exchange ideas or information with others | | | |
| **Hearing** | | | |
| **Tasting/Smelling** | | | |
| **Near Acuity** (vision at 20 inches or less) | | | |
| **Far Acuity** (vision at 20 feet or more) | | | |
| **Depth perception** (to judge distances) | | | |
| **Accommodation** (quick near-point visual refocus) | | | |
| **Color Vision** | | | |
| **Fields of Vision** around the periphery of a fixed point | | | |

Machines operated: _____

Fine motor tasks: _____

Interaction with co-workers, supervisors, public? _____

_____

How often were rest periods allowed? _____

Attendance requirements/accommodations?_____

Any special **environmental** characteristic of this job?

_____Dangerous machinery _____Chemicals? _____Dust _____Noise _____ Heights

_____Extreme cold _____ Extreme heat _____ Other:_____

Explain: _____

_____

Why no longer working? _____

_____

What if any difficulties did client have on this job?

Physical:_____

_____

Mental (e.g. paying attention, processing information, getting along with other people):

_____

_____

Did client have any special help, accommodations, or conditions that were not given to other employees? (e.g. extra breaks, not required to do all duties, etc.)?

_____

_____

Is there any person at this last job who would have knowledge of ability/inability to do work? Name, address, phone, possible testimony:

_____

_____

Pay rate when job ended: _____ Hours per week: _____

**JOB # 5:** (Job title) _____

Employer: _____

Address: _____

Dates: _____

Describe what client did at this job (physical & mental activities):_____

_____

_____

| **Physical Demand** | **Requirements of Past Job** | **Details/reasons** |
|---|---|---|
| **Sitting** | How long did client sit in one position at one time? | |
| | How long -- total -- did client sit during the entire work day | |
| | Any problems with sitting requirements on this job? | |
| | Was client able to alternate sitting and standing? If so, how frequently? | |
| **Standing** | How long did client have to stand at one time? | |
| | How long – total -- did client have to stand in the entire work day? | |
| | Any problems with standing requirements on this job? | |
| **Walking** | How long did client have to walk at one time? | |
| | How long – total -- did client have to walk in the entire work day? | |
| | Any problems with walking requirements on this job? | |

| Physical Demand | Requirements of Past Job | Details/reasons |
|---|---|---|
| **Lifting** | What was the heaviest object/weight claimant had to lift on the job? | |
| | How often? | |
| | What object/weight did claimant lift frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with lifting requirements of this job? | |
| **Carrying** | What was the heaviest object/weight claimant had to carry on the job? | |
| | How often? | |
| | What object/weight did claimant carry frequently on the job (more than 2 hours) | |
| | How often? | |
| | Any problems with the carrying requirements of this job? | |

**Check any of the following required in the past job & include details:**

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Climbing** (ladders, stairs, scaffolding, etc) | | | |
| **Balancing** (to prevent fall from hazardous places) | | | |
| **Stooping** (bending) spine at the waist | | | |
| **Kneeling** (coming to rest on the knees) | | | |

| Physical Demand | Yes | No | Details/Problems meeting requirements |
|---|---|---|---|
| **Crouching** (Bending the legs and spine) | | | |
| **Crawling** (moving about on hands & knees) | | | |
| **Reaching** with hands/arms in any direction | | | |
| **Handling** by seizing, holding, grasping or turning | | | |
| **Fingering** by picking or pinching with finger(s) | | | |
| **Feeling** for size, shape, temperature or texture | | | |
| **Talking** to exchange ideas or information with others | | | |
| **Hearing** | | | |
| **Tasting/Smelling** | | | |
| **Near Acuity** (vision at 20 inches or less) | | | |
| **Far Acuity** (vision at 20 feet or more) | | | |
| **Depth perception** (to judge distances) | | | |
| **Accommodation** (quick near-point visual refocus) | | | |
| **Color Vision** | | | |
| **Fields of Vision** around the periphery of a fixed point | | | |

Machines operated: _____

Fine motor tasks: _____

Interaction with co-workers, supervisors, public? _____

_____

How often were rest periods allowed? _____

Attendance requirements/accommodations?_____

Any special **environmental** characteristic of this job?

_____Dangerous machinery _____Chemicals? _____Dust _____Noise _____ Heights

_____Extreme cold _____ Extreme heat _____ Other:_____

Explain: _____

_____

Why no longer working? _____

_____

What if any difficulties did client have on this job?

Physical:_____

_____

Mental (e.g. paying attention, processing information, getting along with other people):

_____

_____

Did client have any special help, accommodations, or conditions that were not given to other employees? (e.g. extra breaks, not required to do all duties, etc.)?

_____

_____

Is there any person at this last job who would have knowledge of ability/inability to do work? Name, address, phone, possible testimony:

_____

_____

Pay rate when job ended: _____ Hours per week: _____

***If there are more past jobs, add extra pages***

## Unsuccessful Work Attempts:

Any attempts to work that were unsuccessful? (i.e., tried to work and had to quit or reduce hours because of difficulties performing the job) If so, describe in detail.

_____

_____

## Rehabilitation Services:

Presently a Vocational Rehabilitation client? Yes_____ No _____

Counselor's name and phone number: _____

_____

What program/services are being provided? _____

_____

Previously a Vocational Rehabilitation client? Yes_____ No _____

Dates: _____ Location: _____

Services: _____

**CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION**

To: _____
Re: _____
Date of Birth: _____
Dates Requested: _____

I, _____, authorize you to disclose to the Health Justice Clinic of Duke University School of Law, any and all past, present, and future records, reports, or other information you have on file concerning my medical condition, specifically including records relating to HIV/AIDS, psychiatric or psychological reports, evaluations, and treatment records and any information relating to substance abuse, including drug and/or alcohol treatment records. The purpose of the release of information is legal representation.

I understand that, once disclosed, my medical information will no longer be protected by the Health Information Privacy Protection Act ("HIPPA") and may be subject to redisclosure by Duke Health Justice Clinic. I also understand that Duke Health Justice Clinic will not redisclose my medical information except to the extent necessary to provide legal representation.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law.

I understand my consent is revocable, except to the extent that action has already been taken; otherwise, this Consent remains in effect for one year from the date it was signed.

You are authorized and requested to accept this authorization, whether it bears an original or photostatic copy of my signature.

_____ _____
Date Client Name:

FORM
M3132
REV.
10/03

# AUTHORIZATION TO PROTECTED HEALTH INFORMATION AT DUKE UNIVERSITY MEDICAL CENTER*

50

If mailing this form, please send to:
Duke University Hospital
Health Information Management Department
Attn: Medical Information Release Unit
P.O. Box 3016 Durham, N.C. 27710

Patient Name: _____

Medical Record Number: _____

Date of Birth: _____

Phone Number: _____

Social Security Number: _____

I authorize and request Duke University*, Duke University Hospital* (a component of the Duke University Health System), and the Private Diagnostic Clinic, PLLC* to release the following noted protected health information from the medical records of the Patient listed above to:

Hannah Demeritt/Allison Rice, Duke Health Justice Clinic

(Person/Physician/Entity TO RECEIVE records-please be specific)

☐ To be mailed to: Duke Health Justice Clinic Box 90360, Durham, NC 27708-0360

(Address)

☐ By electronic access to medical and claims information

☐ Through oral communication with healthcare providers regarding treatment, care or payment.

The specific information for the following dates of service: _____

**INFORMATION TO BE DISCLOSED** (check the appropriate boxes and include other information where indicated):

☐ Summary Health Information
(Includes Discharge Summary, History and Physical, Radiology, Pathology, Laboratory, and Dictated notes)

☐ History and Physical (e.g., Doctor Visit)
☐ Discharge Summary
☐ Operative Report
☐ Immunization Records
☐ Comprehensive Record
☐ Laboratory Reports
☐ Radiology Reports
☐ Emergency Department Reports
☐ Physical Therapy/Occupational Therapy Notes
☐ Patient Discharge Instructions

☐ Other: _____

☐ Information contained in the Patient's medical record related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date.

☐ Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse.

**THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE:**

☐ Sharing with other health care providers as needed
☑ Legal reasons
☐ Other: _____
☐ Insurance processing
☐ Personal use

This Authorization shall cover actions by and for Duke University, Duke University Health System, and the Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates. This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the Health Information Management Department (see address above). Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal and/or state privacy laws may not protect the re-disclosure. I understand authorizing the disclosure of information identified above is voluntary, and this Authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

This authorization will expire on the following date or event: one year from date signed, or until revoked

**If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.**

| Date | Signature of Patient** or Legal Representative** | Signature of Witness |
|---|---|---|

****If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor-Patient's behalf.** By signing this form for someone else, you as the parent, guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

* Several components and sites of Duke University, the Duke University Health System, and the Private Diagnostic Clinic, PLLC maintain separate medical records (e.g., student health, primary care, community PDC practices, etc.) that are not electronically linked and therefore not covered by this Authorization. If applicable, please contact those components / sites for additional medical records.

UNC HEALTH CARE

500 Eastowne Drive
Chapel Hill, NC 27514

# AUTHORIZATION FORM – MIM #710-S

☐ Radiology Films please send:

ATTN: IMAGING SUPPORT
(919) 966-3280, Fax (919) 966-4990

☐ For all other record requests please send:

ATTN: RELEASE OF MEDICAL INFORMATION
(919) 966-2336, Fax (919) 966-6295
Email: relmedinfo@unch.unc.edu

**I authorize:**

| | | | | |
|---|---|---|---|---|
| ☐ | UNC Health Care System | OR | ☐ | Other facility: |

**To use or disclose to**:

| | | | |
|---|---|---|---|
| Name of Person or Facility: Health Justice Clinic, Duke Law School | | | |
| Address Box 90360 | City Durham | State NC | Zip 27705 |
| Phone: 919-613-7169 | Fax: 919-613-7262 | Email: demeritt@law.duke.edu | |

**The protected health information of:**

| | | | |
|---|---|---|---|
| Patient Name: | | Date of Birth: | SS# (last 4): |
| Address | City | State | Zip |
| Phone: | | UNC Medical Record # | |

Dates of Service: _____

**Put a CHECKMARK next to the specific documents that apply to your request:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Clinic notes (outpatient) | ☐ | Operative / Procedure notes | ☐ | Progress Notes (inpatient) |
| ☐ | Emergency Dept. notes | ☐ | Providers Orders | ☐ | Radiology reports |
| ☐ | Urgent Care Center notes | ☐ | Nursing notes | ☐ | Patient Billing records |
| ☐ | History and Physical | ☐ | Consultations | ☐ | Film / CD (Imaging support) |
| ☐ | Discharge Summary | ☐ | Laboratory reports | ☐ | All Medical Records |
| Other (describe) | | | | | |

***I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy notes requires a separate authorization.***

**Put a CHECKMARK next to the purpose of the request:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Attorney/ Legal | ☐ | Continued Patient Care | ☐ | Insurance |
| ☐ | Personal Use | ☐ | Social Services/ Disability | ☐ | Other: |

**Put a <u>CHECKMARK</u> next to how you would like to receive your request:**

| | |
|---|---|
| | Mail to address listed above. |
| | Review in Release department. |
| | Receive electronically at e-mail above |

| | |
|---|---|
| | Fax to # listed above **(Health care providers only; no personal faxes)** |
| | Review remotely **(employees only)** |

| | |
|---|---|
| | Pick up in Release Dept. |
| | Verbal release |

**I UNDERSTAND THAT:**

- I may revoke this Authorization at any time:
  - The revocation will not apply to information that has already been released in response to this Authorization.
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Medical Information Management Department.
- I may refuse to sign this Authorization:
  - My treatment, payment, enrollment in a health plan, or eligibility for benefits can not be conditioned upon my authorization of this disclosure.
  - A fee may be charged for providing the protected health information. Please contact Copy Service to obtain fee and rate information at 919-966-4521.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

**I have read and understand the information in this Authorization form.**

| | |
|---|---|
| Signature of Patient: | |
| Printed Name: | Date: |

Or

| | |
|---|---|
| Signature of Authorized Representative: | |
| Printed Name: | Date: |
| Please explain Representative's authority to act on the behalf of the Patient: | |

| **OFFICE USE ONLY** | |
|---|---|
| PROCESSED DATE: _____<br><br>PROCESSED BY:_____<br>ADDITIONAL NOTES: | STAMPS / ADDITIONAL NOTES: |

## CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, authorize Duke Health Justice Clinic to disclose to _____, any and all past, present, and future records, reports, or other information you have relating to the Clinic's representation of me. This includes authority to discuss my case and share confidential information with the person(s) named above.

I understand that I can revoke my consent, except to the extent that action has already been taken; otherwise, this Consent remains in effect for one year from the date it was signed.

You are authorized and requested to accept this authorization, whether it bears an original or photostatic copy of my signature.

_____ _____

Date Name

# CONSENT TO RELEASE CONFIDENTIAL INFORMATION

TO: _____

I, _____authorize you to disclose to the Duke Health Justice Clinic, any and all past, present, and future records, reports, or other information you have on file concerning:

_____

I understand my consent is revocable, except to the extent that action has already been taken; otherwise, this Consent remains in effect for one year from the date it was signed.

You are authorized and requested to accept this authorization, whether it bears an original or photostatic copy of my signature.

_____
Printed name:

_____
Date

# DISABILITY CASE CHECKLIST

Use this checklist as a guide as you work on your Social Security or SSI Disability case. Print out a copy and place it in your file and periodically scan into CLIO. These are the many steps needed to prepare the case. *They are not necessarily done in the sequence listed below,* but all the steps will usually be needed. You will need to be working on many of these tasks simultaneously. If steps have already been taken, but not checked of on list, please check them off, so that we make sure every step has been taken.

**New Client: Initial Paperwork:** At or prior to initial meeting with client –

- ❑ Complete 2-page intake form
- ❑ Get signed:
    - o Three general medical releases
    - o Provider-specific medical releases if needed (e.g. for Duke, UNC, Wake Med & other providers) (one per provider)
    - o General & Third Party Releases
    - o Social Security Consent to Release, SSA-3288 (to permit SSA to talk to us)
    - o Appointment of Representative Form (Form 1696)
- ❑ Print the Disability Information Form for the file and fill it in as the case progresses. (Keep the form updated throughout your representation)

**Initial Client Meeting**

- ❑ Interview client and complete the Disability Interview Form – Part I (allow up to 2 hours for the interview)
- ❑ Prepare a detailed Opening Memo for the file, summarizing and synthesizing the facts of the client's disability case
- ❑ Get any forms listed above signed, if they have not already been

**Appeal Paperwork:**

If case is ready to appeal, get the appropriate appeal forms signed

- Initial Denial: (Must appeal within 60 days of denial and ALL forms must be filled out online for appeal to be complete)
    - Request for Reconsideration (online)
    - Social Security Authorization to Release Confidential Information (Form 827)
    - Disability Report - Appeal, Form 3441 BK (online)
    - Submit 1696 if not already done
- Reconsideration Denial (Must appeal within 60 days of denial and ALL forms must be filled out online for appeal to be complete)
    - Request for Hearing (online)
    - Social Security Authorization to Release Confidential Information (Form 827)
    - Disability Report - Appeal, Form 3441 BK. (online)
    - Submit 1696 if not already done (online)

**Working the Case**

- Complete and send in appeal forms within 60 days of the denial letter (as above)
- Request Medical Records from all providers (with release enclosed). Follow up on requests after 2 weeks if not received.
- Request CD of Social Security file from local office if prior to denial at Recon
    - When received, have Hannah or Allison convert the CD to a pdf file.
    - Print SSA File review notes form. Review file and complete form. You can also annotate the PDF version with bookmarks, sticky notes, highlighter
    - Chart any medical records in the Social Security file, which we don't have, including reports of consultative examinations obtained by Social

Security (see charting, below)

- Interview client about education and past work (by phone is o.k.) and complete Disability Interview Form – Part II.

- Update the Opening Memo with the information obtained in the second interview (work & education)

**Case Planning:**

- Assess the need to request additional records, e.g.

    - School Records
    - Employment Records

- Assess the need to obtain information or affidavits from medical and non-medical people, e.g.

    - Treating Physician, Nurse Practitioner or Physician's Assistant
    - Case Manager, Social Worker
    - Mental Health Provider (therapist, psychiatrist, substance abuse counselor)
    - Friends or relatives who are familiar with the client's functioning
    - Former employers or co-workers

- Assess whether the case may be appropriate for seeking "Critical Case Status" based on dire financial need or terminal illness (which includes an AIDS diagnosis)

    - If appropriate, obtain documentation of dire need or terminal illness ("TERI").

    - Submit Request for Critical Case Status to Social Security

**Case Development and Investigation**

- Contact third parties and interview for affidavit

    - If parties are able to give useful information about client's functional limitations, draft affidavit for their consideration

    - After approval by supervising attorney, send affidavit to party for signature

- Do medical research to gain understanding of your client's particular mental and physical illnesses

- As medical records come in -

    - Note receipt of the record on the Disability Information Form

    - SCAN the records to pdf format and save to CLIO. Save as code "MEDR" (Medical Records). The file name should include provider or facility name and date range, in the following format: e.g., UNC 11132014-08072015 (note that this format needs to be followed exactly, no commas, etc.

    - Make note in CLIO that medical records have been received.

    - Three-hole-punch the records, organize them, and put in the file/binder, behind a tab for the particular provider. (Labels for the most common providers are available in the AIDS Clinic pod.)

    - Digest Medical Records in a chronological "medical chart"

    - Have Supervising Attorney review your first few chart entries

    - Use medical references in the office and online to help understand terminology and abbreviations

- Compare the Social Security file to our file and identify any records we have that Social Security lacks

- Make notes in CLIO about which records SSA is lacking and inform supervising attorney so she can upload to ERE.

**Analysis, Theory, and Development of Proof**

- Develop potential theories of the case (using the 5-step sequential evaluation used by Social Security

- Work to develop affidavit from treating medical providers

    - Write to the client's treating physician outlining possible theories and enclosing relevant Social Security listings for review by the physician

    - Consider discussing Residual Functional Capacity or other questionnaires with physicians and possibly having them fill out (discuss with supervisor)

- Call the physician about a week after sending the letter to discuss the physician's opinions about the case
- If the physician is willing to sign an affidavit attesting to your client's disability, draft an affidavit based on your conversation and the medical records for his/her consideration
- Mail or E-mail the affidavit for review and signature.

- Evaluate the client's past relevant work
  - Review Dictionary of Occupational Titles to locate the client's jobs
  - Review those jobs with the client to determine whether they match the client's actual past jobs

**Advocate with Social Security Administration**

- Submit medical records, affidavits, and other supporting materials to Social Security
  - If you don't already have a Bar Code from Social Security, get one.
- If at the Hearing Level
  - Determine whether the case is appropriate for requesting a decision on the record ("OTR")
  - Draft Legal Memorandum for Administrative Law Judge
  - If case is appropriate for OTR, or hearing is approaching, send the following to the Administrative Law Judge with a Request for a Favorable Decision on the Record
    - Legal Memorandum
    - Supporting affidavits from physicians
    - Third party affidavits
    - Medical Records not in Social Security file
  - If case is not appropriate for OTR, prepare for hearing, represent client at hearing.

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# MEDICAL CHART
**Client:**

| DATE | PROVIDER | SUBJECTIVE: COMPLAINTS HISTORY | OBJECTIVE: EXAM FINDINGS DIAGNOSIS | DRUGS TREATMENT PLAN |
|---|---|---|---|---|
| | | | | |
| | | | | |
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# Social Security File Review Chart

**Client:** _____

**Reviewer:** _____ **Date Reviewed:** _____

| Document | Look for | Notes |
|---|---|---|
| **INITIAL** | | |
| **SSA Form 3367** | Date completed | |
| Date: | DOB | |
| | Protective Filing Date | |
| | Alleged Onset | |
| | Date Last Insured | |
| | Date Last Worked | |
| | Prior Claims | Type claim<br>Date filed<br>Date of initial denial<br>Level of final decision<br>Date of final decision |
| | Limitations perceived at interview? | |
| **SSA Form 3368** | Third party contact | |
| Date: | Medical conditions | |
| | Limitations | |
| | Past Work | |
| | Providers listed | |
| | Medications | |
| | Tests | |
| | Education | |
| **Function Report** | Notable details | |
| **Consultative Exams** | Physical? | |
| | Mental? | |
| Mental RFC Date: | | |
| Psych Review Technique Date: | | |
| Physical RFC Date: | | |
| Decision Analysis Date: | | |
| **Disability Determination & Transmittal** | Grounds for denial. | Major/severe Impairments found. Listings considered and analysis. Notes from medical sources. Past relevant work and education info. RFC determination, if any. DOT jobs client can allegedly do. |
| | | |

| Document | Look for | Notes |
|---|---|---|
| **RECONSIDERATION** | | |
| **Reconsideration Paperwork** | Anything different from initial paperwork | |
| **Disability Report 3367** | Anything different from initial paperwork | |
| **Disability Report Appeal - 3441** | Anything different from initial paperwork | |
| **Consultative Exams** | Physical? | |
| | Mental? | |
| Mental RFC<br>Date: | | |
| Psychiatric Review Technique<br>Date: | | |
| Physical RFC<br>Date: | | |
| Decision Analysis<br>Date: | | |
| Case Development Sheet | | |
| **Disability Determination & Transmittal** | Grounds for denial. Anything new/different than original. | Major/severe Impairments found. Listings considered and analysis. Notes from medical sources. Past relevant work and education info. RFC determination, if any. DOT jobs client can allegedly do. |
| **HEARING** | | |
| Request for hearing | Date filed and reasons | |
| Disability Report Appeal – 3441 | Anything new or different | |
| 1696 in file? When submitted | | |
| **OTHER (work records, anything else pertinent** | | |
| **MEDICAL RECORDS** | | |
| Source | Dates – look at actual records in file – do not assume that the name given to the document accurately reflects its content. | |
| | | |

# CASE THEORY

| Client | Student Rep |
|---|---|
| Date | |

| Preliminary Matters | |
|---|---|
| Date of Application | |
| Protective Filing Date (SSI) | |
| Benefits applied for | |
| Date denied | |
| Stage in proceedings | |
| Date last worked | |
| Alleged onset date | |
| Date Last Insured | |
| Prior Applications? | |
| Medicaid? | |
| Step at which SSA denied the case & brief summary of SSA rationale | |
| **Sequential Evaluation** | |
| **Step 1**<br>**Work?** | |
| **Step 2**<br>**Severe Impairments?** | |
| **Step 3**<br>**Listings**: | |
| **Step 3.5**<br>**Residual Functional Capacity?** | **SSA Physical RFC:** |

| | |
|---|---|
| **Physical RFC?** Sedentary/Light/ Medium/Heavy | **Other RFC evidence:** |
| **Mental RFC** | **SSA Mental RFC**<br><br>**Other Mental RFC Evidence** |
| **Manipulative, Environmental, Postural Limitations?** | **Physical RFC** |
| **Other limitations?** (breaks, attendance, etc) | |
| **Step 4**<br>**Past Relevant Work (15 years before adjudication date)**<br>-performed at SGA?<br>-performed long enough to learn?<br>-"as performed" vs performed in national economy | |
| **Step 5**<br>**Any work existing in National Economy**<br><br>**RFC**<br><br>**Age**<br>-Younger – 18-44<br>-Younger – 45-49<br>-Approaching advanced age – 50-54<br>-Advanced age – 55 or over<br>-Closely approaching retirement age 60-64<br><br>**Education**<br><br>**Work experience** – skilled? Unskilled? Semi-skilled, skills transferrable | |
| **GRIDS** | |

| | |
|---|---|
| Off Grids | |

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***PHYSICAL MEDICAL SOURCE STATEMENT***

From:_____

Re: **[client name]** **DOB [client's DOB]**

Please answer the following questions concerning your patient's impairments. *Attach relevant treatment notes, radiologist reports, laboratory and test results as appropriate.*

1. Frequency and length of contact: _____

2. Diagnoses: _____

_____

3. Prognosis: _____

4. List your patient's ***symptoms***, including pain, dizziness, fatigue, etc:

_____

_____

_____

5. If your patient has pain, characterize the nature, location, frequency, precipitating factors, and severity of your patient's pain:

_____

_____

6. Identify the clinical findings and objective signs:

_____

_____

7. Describe the treatment and response including any side effects of medication that may have implications for working, *e.g.*, drowsiness, dizziness, nausea, etc:

_____

_____

8. Have your patient's impairments lasted or can they be expected to last at least twelve months?
☐ Yes ☐ No

9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?
☐ Yes ☐ No

10. Identify any psychological conditions affecting your patient's physical condition:

- ☐ Depression
- ☐ Somatoform disorder
- ☐ Psychological factors affecting physical condition
- ☐ Anxiety
- ☐ Personality disorder
- ☐ Other: _____

11. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a ***competitive work situation on a full-time basis (40 hours per week, 50 weeks per year)***.

a. How many city blocks can your patient walk without rest or severe pain? _____

b. Please circle the hours and/or minutes that your patient can sit ***at one time***, *e.g*., before needing to get up, *etc*.

**Sit:** 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

c. Please circle the hours and/or minutes that your patient can stand ***at one time***, *e.g*., before needing to sit down, walk around, *etc*.

**Stand:** 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

d. Please indicate how long your patient can sit and stand/walk ***total in an 8-hour working day*** (with normal breaks):

| Sit | Stand/walk | |
|---|---|---|
| ☐ | ☐ | less than 2 hours |
| ☐ | ☐ | about 2 hours |
| ☐ | ☐ | about 4 hours |
| ☐ | ☐ | at least 6 hours |

e. Does your patient need a job that permits shifting positions at will from sitting, standing or walking? ☐ Yes ☐ No

f. Does your patient need to include periods of walking around during an 8-hour working day?
☐ Yes ☐ No

If yes, how ***often*** must your patient walk?
1 5 10 15 20 30 45 60 90
Minutes

How ***long*** must your patient walk each time?
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Minutes

g. Will your patient sometimes need to take unscheduled breaks during a working day?
☐ Yes ☐ No

If yes, 1) how ***often*** do you think this will happen? _____

2) how ***long*** (on average) will your patient have to rest before returning to work? _____

3) what symptoms cause a need for breaks?

☐ Muscle weakness ☐ Pain/ paresthesias, numbness
☐ Chronic fatigue ☐ Adverse effects of medication
☐ Diarrhea ☐ Other: _____

h. With prolonged sitting, should your patient's leg(s) be elevated? ☐ Yes ☐ No

If yes, 1) how ***high*** should the leg(s) be elevated? _____

2) if your patient had a sedentary job***, what percentage of time*** during an 8-hour working day should the leg(s) be elevated? _____%

3) what symptoms cause a need to elevate leg(s)? _____

i. While engaging in occasional standing/walking, must your patient use a cane or other hand-held assistive device? ☐ Yes ☐ No

If yes, what symptoms cause the need for a cane?

☐ Imbalance ☐ Pain ☐ Weakness
☐ Insecurity ☐ Dizziness
☐ Other: _____

***For this and other questions on this form, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.***

j. How many pounds can your patient lift and carry in a competitive work situation?

| | **Never** | **Rarely** | **Occasionally** | **Frequently** |
|---|---|---|---|---|
| Less than 10 lbs. | | ☐ | ☐ | ☐ |
| 10 lbs. | ☐ | ☐ | ☐ | ☐ |
| 20 lbs. | ☐ | ☐ | ☐ | ☐ |
| 50 lbs. | ☐ | ☐ | ☐ | ☐ |

k. How often can your patient perform the following activities?

| | **Never** | **Rarely** | **Occasionally** | **Frequently** |
|---|---|---|---|---|
| Twist | ☐ | ☐ | ☐ | ☐ |
| Stoop (bend) | ☐ | ☐ | ☐ | ☐ |
| Crouch/ squat | ☐ | ☐ | ☐ | ☐ |
| Climb stairs | ☐ | ☐ | ☐ | ☐ |
| Climb ladders | ☐ | ☐ | ☐ | ☐ |

l. Does your patient have significant limitations with reaching, handling or fingering?

☐ Yes ☐ No

If yes, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

| | **HANDS: Grasp, Turn Twist Objects** | **FINGERS: Fine Manipulations** | **ARMS: Reaching In Front of Body** | **ARMS: Reaching Overhead** |
|---|---|---|---|---|
| **Right:** | **%** | **%** | **%** | **%** |
| **Left:** | **%** | **%** | **%** | **%** |

m. How much is your patient likely to be ***"off task"***? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

Please explain the reasons for your conclusion: _____

n. Is your patient likely to work at a ***reduced pace*** due to symptoms? That is, at how much slower a pace than average would your patient be able to work?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

Please explain the reasons for your conclusion: _____

o. To what degree can your patient tolerate work stress?

☐ Incapable of even "low stress" work
☐ Capable of low stress work
☐ Capable of moderate stress - normal work
☐ Capable of high stress work

Please explain the reasons for your conclusion: _____

p. Are your patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No

If yes, assuming your patient was trying to work full time, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

☐ Never
☐ About one day per month
☐ About two days per month
☐ About three days per month
☐ About four days per month
☐ More than four days per month

12. Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings and laboratory or test results ***reasonably consistent*** with the symptoms and functional limitations described above in this evaluation?

☐ Yes ☐ No

If no, please explain: _____

13. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

_____

14. What is the earliest date that the description of ***symptoms and limitations*** in this questionnaire applies? _____

_____ _____

*Date* *Signature*

*Printed/Typed Name:* _____

*Address:* _____

_____

_____

# MENTAL MEDICAL SOURCE STATEMENT

From: _____ Re: _____

SSN: _____

Please answer the following questions concerning your patient's impairments. *Attach relevant treatment notes and test results* as appropriate.

1. Frequency and length of contact: _____

_____

2. DSM-IV Multiaxial Evaluation:

Axis I: _____ Axis IV: _____

Axis II: _____ Axis V: Current GAF: _____

Axis III: _____ Highest GAF Past year: _____

3. Treatment and response: _____

_____

_____

4. a. List of prescribed medications:

b. Describe any side effects of medications that may have implications for working. E.g., dizziness, drowsiness, fatigue, lethargy, stomach upset, etc.:

5. Describe the *clinical findings* including results of mental status examination that demonstrate the severity of your patient's mental impairment and symptoms:

_____

_____

_____

6. Prognosis: _____

7. Identify your patient's signs and symptoms:

| | | | |
|---|---|---|---|
| | Anhedonia or pervasive loss of interest in almost all activities | | Intense and unstable interpersonal relationships and impulsive and damaging behavior |
| | Appetite disturbance with weight change | | Disorientation to time and place |
| | Decreased energy | | Perceptual or thinking disturbances |
| | Thoughts of suicide | | Hallucinations or delusions |
| | Blunt, flat or inappropriate affect | | Hyperactivity |
| | Feelings of guilt or worthlessness | | Motor tension |
| | Impairment in impulse control | | Catatonic or other grossly disorganized behavior |
| | Poverty of content of speech | | Emotional lability |
| | Generalized persistent anxiety | | Flight of ideas |
| | Somatization unexplained by organic disturbance | | Manic syndrome |
| | Mood disturbance | | Deeply ingrained, maladaptive patterns of behavior |
| | Difficulty thinking or concentrating | | Inflated self-esteem |
| | Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress | | Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury |
| | Psychomotor agitation or retardation | | Loosening of associations |
| | Pathological dependence, passivity or agressivity | | Illogical thinking |
| | Persistent disturbances of mood or affect | | Vigilance and scanning |
| | Persistent nonorganic disturbance of vision, speech, hearing, use of a limb, movement and its control, or sensation | | Pathologically inappropriate suspiciousness or hostility |
| | Change in personality | | Pressures of speech |
| | Apprehensive expectation | | Easy distractibility |
| | Paranoid thinking or inappropriate suspiciousness | | Autonomic hyperactivity |
| | Recurrent obsessions or compulsions which are a source of marked distress | | Memory impairment – short, intermediate or long term |
| | Seclusiveness or autistic thinking | | Sleep disturbance |
| | Substance dependence | | Oddities of thought, perception, speech or behavior |
| | Incoherence | | Decreased need for sleep |
| | Emotional withdrawal or isolation | | Loss of intellectual ability of 15 IQ points or more |
| | Psychological or behavioral abnormalities associated with a dysfunction of the brain with a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities | | Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week |
| | Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes) | | A history of multiple physical symptoms (for which there are no organic findings) of several years duration beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly |
| | Persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity or situation | | Involvement in activities that have a high probability of painful consequences which are not recognized |

8. To determine your patient's ability to do *work-related activities on a day-to-day basis in a regular work setting,* please give us your opinion **based on your examination** of how your patient's mental/emotional capabilities are affected by the impairment(s). Consider the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not your patient's age, sex or work experience.

- *Seriously limited, but not precluded* means ability to function in this area is seriously limited and less than satisfactory, but not precluded in all circumstances.
- *Unable to meet competitive standards* means your patient cannot satisfactorily perform this activity independently, appropriately, effectively and on a sustained basis in a regular work setting.
- *No useful ability to function,* an extreme limitation, means your patient cannot perform this activity in a regular work setting.

| I. | MENTAL ABILITIES AND APTITUDES NEEDED TO DO UNSKILLED WORK | Unlimited or Very Good | Limited but satisfactory | **Seriously limited, but not precluded** | **Unable to meet competitive standards** | **No useful ability to function** |
|---|---|---|---|---|---|---|
| A. | Remember work-like procedures | | | | | |
| B. | Understand and remember very short and simple instructions | | | | | |
| C. | Carry out very short and simple instructions | | | | | |
| D. | Maintain attention for two hour segment | | | | | |
| E. | Maintain regular attendance and be punctual within customary, usually strict tolerances | | | | | |
| F. | Sustain an ordinary routine without special supervision | | | | | |
| G. | Work in coordination with or proximity to others without being unduly distracted | | | | | |
| H. | Make simple work-related decisions | | | | | |
| I. | Complete a normal workday and workweek without interruptions from psychologically based symptoms | | | | | |
| J. | Perform at a consistent pace without an unreasonable number and length of rest periods | | | | | |
| K. | Ask simple questions or request assistance | | | | | |
| L. | Accept instructions and respond appropriately to criticism from supervisors | | | | | |
| M. | Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes | | | | | |
| N. | Respond appropriately to changes in a routine work setting | | | | | |
| O. | Deal with normal work stress | | | | | |
| P. | Be aware of normal hazards and take appropriate precautions | | | | | |

(Q) Explain limitations falling in the three most limited categories (identified by **bold type)** and include the medical/clinical findings that support this assessment:

| II. | MENTAL ABILITIES AND APTITUDES NEEDED TO DO SEMISKILLED AND SKILLED WORK | Unlimited or Very Good | Limited but satisfactory | **Seriously limited, but not precluded** | **Unable to meet competitive standards** | **No useful ability to function** |
|---|---|---|---|---|---|---|
| A. | Understand and remember detailed instructions | | | | | |
| B. | Carry out detailed instructions | | | | | |
| C. | Set realistic goals or make plans independently of others | | | | | |
| D. | Deal with stress of semiskilled and skilled work | | | | | |

(E) Explain limitations falling in the three most limited categories (identified by **bold type)** and include the medical/clinical findings that support this assessment:

| III. | MENTAL ABILITIES AND APTITUDE NEEDED TO DO PARTICULAR TYPES OF JOBS | Unlimited or Very Good | Limited but satisfactory | **Seriously limited, but not precluded** | **Unable to meet competitive standards** | **No useful ability to function** |
|---|---|---|---|---|---|---|
| A. | Interact appropriately with the general public | | | | | |
| B. | Maintain socially appropriate behavior | | | | | |
| C. | Adhere to basic standards of neatness and cleanliness | | | | | |
| D. | Travel in unfamiliar place | | | | | |
| E. | Use public transportation | | | | | |

(F) Explain limitations falling in the three most limited categories (identified by **bold type)** and include the medical/clinical findings that support this assessment:

9. Does your patient have a low IQ or reduced intellectual functioning?
☐ Yes ☐ No

Please explain (with reference to specific test results):

10. Does the psychiatric condition exacerbate your patient's experience of pain or any other physical symptom? ☐ Yes ☐ No

If yes, please explain:

11. If stress tolerance is an issue, what demands of work does this patient find stressful?

- ☐ speed
- ☐ precision
- ☐ complexity
- ☐ deadlines
- ☐ working within a schedule
- ☐ making decisions
- ☐ exercising independent judgment
- ☐ completing tasks
- ☐ working with other people
- ☐ dealing with the public (strangers)
- ☐ dealing with supervisors
- ☐ being criticized by supervisors
- ☐ simply knowing that work is supervised
- ☐ getting to work regularly
- ☐ remaining at work for a full day
- ☐ fear of failure at work
- ☐ monotony of routine
- ☐ little latitude for decision-making
- ☐ lack of collaboration on the job
- ☐ no opportunity for learning new things
- ☐ underutilization of skills
- ☐ lack of meaningfulness of work

12. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

☐ Never ☐ About two days per month ☐ About four days per month
☐ About one day per month ☐ About three days per month ☐ More than four days per month

13. Has your patient's impairment lasted or can it be expected to last at least twelve months?
☐ Yes ☐ No

14. Are your patient's impairments reasonably consistent with the symptoms and functional limitations described in this evaluation? ☐ Yes ☐ No

If no, please explain:

15. Please describe any additional reasons not covered above why your patient would have difficulty working at a regular job on a sustained basis.

16. If your patient's impairments include alcohol or substance abuse, do alcohol or substance abuse contribute to any of your patient's limitations set forth above?

☐ Yes ☐ No

If Yes, a) please list the limitations affected:

b) please explain what changes you would make to your description of your patient's limitations if your patient were totally abstinent from alcohol or substance abuse:

17. Can your patient manage benefits in his or her own best interest? ☐ Yes ☐ No

_____ _____

Date Signature

Printed/Typed Name: _____

Address: _____

_____

245-9
7-66 8/09

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Social Security Administration

# Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*

**TO: Social Security Administration**

| ***My Full Name** | ***My Date of Birth (MM/DD/YYYY)** | ***My Social Security Number** |
|---|---|---|

I authorize the Social Security Administration to release information or records about me to:

| ***NAME OF PERSON OR ORGANIZATION:** | ***ADDRESS OF PERSON OR ORGANIZATION:** |
|---|---|
| Allison Rice | Duke Health Justice Clinic, Box 90360, Durham, NC 27708 |
| Hannah Demeritt | Duke Legal Project, Box 90360, Durham NC 27708 |

***I want this information released because:** Legal Representation

We may charge a fee to release information for non-program purposes.

The purpose of this request is to evaluate a Social Security claim or appeal, thus this request is FOR PROGRAM PURPOSES

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☑ Social Security Number
2. ☑ Current monthly Social Security benefit amount
3. ☑ Current monthly Supplemental Security Income payment amount
4. ☑ My benefit or payment amounts from date _____ to date _____
5. ☑ My Medicare entitlement from date _____ to date _____
6. ☑ Medical records from my claims folder(s) from date entire history to date entire history

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☑ Complete medical records from my claims folder(s)
8. ☑ Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

   All records in the possession of Social Security relating to my disability claim generated at a local office or DDS,

   including doctor or consultant reports, correspondence, record of contact with claimant or third party, entire application

**I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.**

***Signature:** _____ ***Date:** _____

***Address:** Duke Health Justice Clinic Box 90360, Durham, NC

**Relationship (if not the subject of the record):** _____ ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

| 1.Signature of witness | 2.Signature of witness |
|---|---|
| Address(Number and street,City,State, and Zip Code) | Address(Number and street,City,State, and Zip Code) |

Social Security Administration
**Please read the instructions before completing this form.**

82

Form Approved
OMB No. 0960-0527

| Name (Claimant) (Print or Type) | Social Security Number<br>– – |
|---|---|
| Wage Earner (If Different) | Social Security Number<br>– – |

## Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, S. Hannah Demeritt, Allison Rice, Duke Health Justice Clinic, Box 90360, Durham, NC 27708
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☑ Title II (RSDI) ☑ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☑ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☑ I appoint, or I now have, more than one representative. My main representative is Allison Rice
(Name of Principal Representative)

| Signature (Claimant) | Address Duke Health Justice Clinic Box 90360, Durham, NC 27708-0360 | |
|---|---|---|
| Telephone Number (with Area Code)<br>( ) – | Fax Number (with Area Code)<br>( ) – | Date |

## Part II ACCEPTANCE OF APPOINTMENT

I, _____ , hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☑ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.

☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☑ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☑ NO

**I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

| Signature (Representative) | Address<br>Duke Health Justice Clinic, Box 90360, Durham, NC 27708 | |
|---|---|---|
| Telephone Number (with Area Code)<br>(919 ) 613 – 7169 | Fax Number (with Area Code)<br>( 919 ) 613 – 7262 | Date |

## Part III FEE ARRANGEMENT

*(Select an option, sign and date this section.)*

☐ **Charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **Waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

| Signature (Representative) | Date |
|---|---|

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**WHOSE *Records to be Disclosed***

Form Approved
OMB No. 0960-0623

NAME *(First, Middle, Last)*
asdfasdf

SSN _ _ - _ - _

Birthday *(mm/dd/yy)*

# 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**

**SIGN ▶**

**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 | | |
|---|---|---|---|
| Phone Number (with area code ) | City | State | ZIP - |

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

**SIGN ▶**

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

| 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.*

Form Approved
OMB No. 0960-0144

# DISABILITY REPORT - APPEAL

**For SSA Use Only**
Do not write in this box.

Related SSN ___ – ___ – ____

**Individual is filing:**

Number Holder _____

☐ **Reconsideration**

**Date of Last Disability Report** _____

☐ **Request for Review by Federal Reviewing Official** ☐ **Reconsideration for Disability Cessation** ☐ **Request for ALJ Hearing**

## SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

**A. NAME** *(First, Middle Initial, Last)*

**B. SOCIAL SECURITY NUMBER**
___ – ___ – ____

**C. DAYTIME TELEPHONE NUMBER** *(If you do not have a number where we can reach you, give us a daytime number where we can leave a message.)*

( ) ___ – _____ ☐ Your Number ☐ Message Number ☐ None
*Area Code* *Number*

**D.** Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help you with your claim or case.

NAME _____ RELATIONSHIP _____

ADDRESS _____
*(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)*

_____ _____ _____ – _____ DAYTIME PHONE ( ) ___ – _____
*City* *State* *ZIP* *Area Code* *Number*

## SECTION 2 - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

**A.** Has there been any change (for better or worse) in your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

_____

_____

_____

**Approximate date the changes occurred:**

| Month | Day | Year |
|---|---|---|
| | | |

**B.** Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

_____

_____

_____

**Approximate date the changes occurred:**

| Month | Day | Year |
|---|---|---|
| | | |

**C.** Do you have any new illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

**Approximate date the changes occurred:**

| Month | Day | Year |
|---|---|---|
| | | |

**If you need more space, use Section 10 - REMARKS.**

## SECTION 3 - INFORMATION ABOUT YOUR MEDICAL RECORDS

**A.** **Since you last completed a disability report,** have you seen or will you see a **doctor/hospital/clinic** or anyone else for the illnesses, injuries, or conditions that limit your ability to work? ☐ YES ☐ NO

**B.** **Since you last completed a disability report,** have you seen or will you see a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

**C.** List **other names** you have used on your medical records.

**If you answered "NO" to both A and B, go to Section 4 - MEDICATIONS.**

Tell us who may have medical records or other information about your illnesses, injuries, or conditions **since you last completed a disability report.**

**D. List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment.**

1.

| **NAME** | | | **DATES** |
|---|---|---|---|
| **STREET ADDRESS** | | | **FIRST** VISIT |
| **CITY** | **STATE** | **ZIP** – | **LAST** VISIT |
| **PHONE** ( ) – *Area Code* *Phone Number* | **PATIENT ID #** (If known) | | NEXT **APPOINTMENT** |
| **REASONS** FOR VISITS | | | |
| WHAT **TREATMENT** DID YOU RECEIVE? | | | |

2.

| **NAME** | | | **DATES** |
|---|---|---|---|
| **STREET ADDRESS** | | | **FIRST** VISIT |
| **CITY** | **STATE** | **ZIP** – | **LAST** VISIT |
| **PHONE** ( ) – *Area Code* *Phone Number* | **PATIENT ID #** (If known) | | NEXT **APPOINTMENT** |
| **REASONS** FOR VISITS | | | |
| WHAT **TREATMENT** DID YOU RECEIVE? | | | |

**If you need more space, use Section 10 - REMARKS.**

**E. List each HOSPITAL/CLINIC.** Include your **next appointment.**

| HOSPITAL/CLINIC | | | TYPE OF VISIT | DATES | |
|---|---|---|---|---|---|
| NAME | | | ☐ **INPATIENT** STAYS *(Stayed at least overnight)* | DATE IN | DATE OUT |
| | | | | | |
| | | | | | |
| | | | | | |
| STREET ADDRESS | | | ☐ **OUTPATIENT** VISITS *(Sent home same day)* | DATE FIRST VISIT | DATE LAST VISIT |
| CITY | STATE | ZIP – | | | |
| PHONE ( ) – *Area Code* *Phone Number* | | | ☐ **EMERGENCY ROOM** VISITS | DATES OF VISITS | |
| | | | | | |

Next **appointment** _____ Your hospital/clinic **number** _____

**Reasons** for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

**If you need more space, use Section 10 - REMARKS.**

**F. Since you last completed a disability report,** does **anyone else have medical records or information** about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else? ☐ YES ☐ NO

If "**YES**," complete information below:

| **NAME** | | | **DATES** |
|---|---|---|---|
| **STREET ADDRESS** | | | **FIRST** VISIT |
| **CITY** | **STATE** | **ZIP** – | **LAST** VISIT |
| **PHONE** ( ) – *Area Code* *Phone Number* | | | NEXT **APPOINTMENT** |
| **CLAIM NUMBER** (if any) | | | |
| **REASONS** FOR VISITS | | | |

**If you need more space, use Section 10 - REMARKS.**

## SECTION 4 - MEDICATIONS

Are you currently taking any **medications** for your illnesses, injuries or conditions? ☐ YES ☐ NO

If "**YES**," please tell us the following: (*Look at your medicine containers, if necessary.*)

| NAME OF MEDICINE | IF PRESCRIBED, GIVE NAME OF DOCTOR | REASON FOR MEDICINE | SIDE EFFECTS YOU HAVE |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |

**If you need more space, use Section 10 - REMARKS.**

## SECTION 5 - TESTS

**Since you last completed a disability report,** have you had any **medical tests** for illnesses, injuries, or conditions or do you have any such tests scheduled? ☐ YES ☐ NO

If "**YES**," please tell us the following: *(Give approximate dates, if necessary.)*

| KIND OF TEST | WHEN WAS/WILL TEST BE DONE? (Month, day, year) | WHERE DONE? (Name of Facility) | WHO SENT YOU FOR THIS TEST? |
|---|---|---|---|
| EKG (HEART TEST) | | | |
| TREADMILL (EXERCISE TEST) | | | |
| CARDIAC CATHETERIZATION | | | |
| BIOPSY -- Name of body part _____ | | | |
| HEARING TEST | | | |
| SPEECH/LANGUAGE TEST | | | |
| VISION TEST | | | |
| IQ TESTING | | | |
| EEG (BRAIN WAVE TEST) | | | |
| HIV TEST | | | |
| BLOOD TEST (NOT HIV) | | | |
| BREATHING TEST | | | |
| X-RAY -- Name of body part _____ | | | |
| MRI/CT SCAN -- Name of body part _____ | | | |

**If you need more space, use Section 10 - REMARKS.**

## SECTION 6 - UPDATED WORK INFORMATION

Have you worked **since you last completed a disability report?** ☐ YES ☐ NO

If **"YES,"** you will be asked to give details on a separate form.

## SECTION 7 - INFORMATION ABOUT YOUR ACTIVITIES

**A.** How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?

**B.** What changes have occurred in your daily activities **since you last completed a disability report?**

If none, show "**NONE**."

**If you need more space, use Section 10 - REMARKS.**

## SECTION 8 - EDUCATION/TRAINING INFORMATION

Have you completed any type of **special job training, trade or vocational school since you last completed a disability report?** ☐ YES ☐ NO

If "**YES**," describe what type: _____

Approximate date completed: _____

## SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OTHER SUPPORT SERVICES INFORMATION, OR INDIVIDUALIZED EDUCATION PROGRAM

**Since you last completed a disability report, have you participated, or are you participating 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;
- a Plan to Achieve Self-Support;
- an individualized education program through an educational institution (if a student age 18-21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES ☐ NO

If "**YES**," complete the following information:

NAME OF ORGANIZATION OR SCHOOL _____

NAME OF COUNSELOR OR INSTRUCTOR _____

ADDRESS _____
*(Number, Street, Apt. No.(if any), P.O. Box, or Rural Route)*

_____ _____ _____
*City* *State* *ZIP*

DAYTIME PHONE NUMBER ( ) – _____
*Area Code* *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES, TESTS, OR EVALUATIONS PERFORMED _____
*(IQ, vision, physicals, hearing, workshops, classes, etc.)*

## SECTION 10 - REMARKS

**Use this section for any additional information you did not show in earlier parts of this form. When you are finished with this section (or if you don't have anything to add), be sure to go to the next page and complete the blocks there.**

## SECTION 10 REMARKS

| | |
|---|---|
| **Name** of person completing this form if other than the disabled person *(Please print)* | **Date Form Completed** *(Month, day, year)* |

**E-Mail Address** of person completing this form *(optional)*

*If the person completing this form is other than the disabled person or the person identified in Section 1. Item D., please complete the following information.*

| | |
|---|---|
| **Relationship to Disabled Person** | **Daytime Telephone Number** ( ) – |

**Address** *(Number and street)* **City** **State** **ZIP**

–