

Social Security Administration

Notice of Continuing Disability Review

SOCIAL SECURITY
12249 PEMBROKE RD
PEMBROKE PINES, FL 33025

Date: February 23, 2024
BNC#: 24QR161F20111

JOHN REED FOR
JOHN REED
1070 CORKWOOD ST
HOLLYWOOD, FL 33019

Dear JOHN REED:

We must regularly review the cases of people getting disability benefits to make sure they are still disabled under our rules. We may also review cases at other times. We are writing to let you know that we are starting to review JOHN REED's disability case. We have enclosed a pamphlet that will tell you more about the review.

How We Start The Review

We need current medical information to complete the disability review that we are required to conduct. Please fill out the enclosed forms following the instructions that are provided. The information on these forms is needed to complete the disability review. Please sign and date the enclosed forms and return them in the enclosed envelope as soon as possible. Please contact us at the telephone number shown below if you have any questions or need assistance completing these forms.

We're writing to ask you to send us the following information:

- Continuing Disability Review Report (SSA-454-BK)
- Authorization To Disclose Information To The Social Security Administration (SSA-827)

How We Decide If JOHN REED Is still Disabled

Doctors and other trained staff will decide for us if JOHN REED is still disabled under our rules. They work for your State but use our rules to make their decisions.

We Will Let You Know What We Decide

When we finish the review, we will write you and let you know what we have decided. Our letter will tell you whether JOHN REED is still disabled under our rules.

See Next Page

We may find that JOHN REED is no longer disabled under our rules and JOHN REED's payments will stop. If this happens, you can appeal our decision. You can also ask us to continue to pay benefits while you appeal.

If We Do Not Hear From You

We may stop JOHN REED's benefits if you don't respond to this request or contact us by March 24, 2024 to tell us why. If we stop his benefits, he could also lose any Medicare and/or Medicaid he has now.

Before we stop JOHN REED's benefits, we will send you another letter to explain our decision. The letter will also explain your right to appeal the decision and how to continue getting benefits during the appeal.

Suspect Social Security Fraud?

Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

For general information about Social Security we invite you to visit our website at www.socialsecurity.gov on the Internet. For general questions and specific questions about JOHN REED's case, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 866-613-3962 and ask for any representative. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY/TDD number 800-325-0778. If you do call or visit an office, please have this letter with you. It will help us answer your questions.

Social Security Administration

Unit: KAPCDR

Whose Records to be Disclosed	
NAME (First, Middle, Last, Suffix)	
JOHN REED	
SSN 225713968	Birthday (MM/DD/YYYY) 11/21/1993

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:
include
 - 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 Signature

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

March 7, 2024

Street Address

1070 CORKWOOD ST

Phone Number (with area code)

(202) 780-7177 / 954-559-8884

City

HOLLYWOOD

State

FL

ZIP

33019

WITNESS

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

Signature

JL - (Mom)

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

Phone Number (or Address)

954-632-0644

Phone Number (or Address)

1070 Corkwood St, Hollywood FL 33019

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

**Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(a), 223(d), and 1631(d) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on your claim that could result in a denial or loss of benefits.

We will use the information you provide to determine your eligibility or continuing eligibility for benefits, and your ability to manage any benefits that you currently receive.

We may also share your information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations;
2. To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and
3. To Federal, State or local agencies for administering cash or non-cash income maintenance or health maintenance programs.

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

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions.

SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

CONTINUING DISABILITY REVIEW REPORT SSA-454-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that reviews your medical condition(s) will use the information you provide in this report to decide whether you are still disabled. Please complete as much of the report as you can.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. **Please do not ask your health care provider to complete this report.** If you cannot complete the report, you may contact us at 1-800-772-1213 (TTY 1-800-325-0778). A Social Security Representative will assist you. Please have the information available from the bulleted items below when you call us. If you have a continuing disability review appointment, please have the information available, or the completed report ready when we contact you. **If you cannot speak or understand English, we will provide an interpreter free of charge.**

YOUR MEDICAL RECORDS

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS.

If you have consented to us obtaining medical records from your providers, we will request your records directly from them. The information that you give us on this report tells us where to request your medical and other records.

WHAT YOU NEED TO COMPLETE THIS REPORT

- Name, address, and phone number of a friend or relative (other than your doctors) we can contact who knows about your medical condition(s), and can help with your case, if needed.
- Name, address, and phone number of any health care providers you have seen **within the last 12 months.** (You may be able to get that information from the telephone book, Internet, online medical chart, medical bills, prescriptions, or prescription medicine containers.)
- Any prescription or non-prescription medicines you take or have taken **in the last 12 months.**
- Name of organization who we can contact that would have medical information about your condition(s) **in the last 12 months.** (Such as social services agencies, welfare agencies, case workers, attorneys, prisons, workers' compensation and insurance companies who have paid you disability benefits.)
- Information about any education since your last disability decision. (See top of **Page 3** for date of last decision.)
- Information about any vocational rehabilitation, employment, or other support services since your last disability decision. (See top of **Page 3** for date of last decision.)
- **ANSWER EVERY QUESTION**, unless the report indicates otherwise. **If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."**
- If you need more space to answer any question, please use **Section 9 - Remarks**. Write the number of the question you are answering.

Privacy Act Statement Collection and Use of Personal Information

Sections 205(a), 221(i), 223(d), 1614(a), 1631(e), and 1633(c) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information to determine eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting Social Security Administration (SSA) in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and
- To private medical and vocational consultants for use in making preparation for, or evaluating the results of, consultative medical examinations or vocational assessments which they were engaged to perform by SSA or a State agency acting in accord with sections 221 or 1633 of the Act.

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

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784, and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 480 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments relating to our time estimate or other aspects of this collection to:** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

SEND OR BRING THE COMPLETED REPORT TO YOUR LOCAL FIELD OFFICE, OR THE NEAREST U.S. EMBASSY OR CONSULATE OFFICE. Office addresses are listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778) for the address.

**AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET
AND KEEP IT FOR YOUR RECORDS.**

CONTINUING DISABILITY REVIEW REPORT

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

Date of your last medical disability decision:

SECTION 1 - INFORMATION ABOUT YOU

When a question refers to "you" or "your" it refers to the person receiving disability benefits. If you are completing this report for someone else, please provide information about them.

1.A. NAME (First, Middle, Last, Suffix)

JOHN REED

1.B. SOCIAL SECURITY NUMBER

3968

1.C. In the last 12 months, have you used any other names on your medical or educational records?

Examples include maiden name, other married names, other names, or nickname.

YES

NO

If YES, please list names used

John Michael Reed

1.D. MAILING ADDRESS (Street or PO Box) Include apartment number if applicable.

1070 Corkwood St.

CITY

Hollywood

STATE/Province

FL

ZIP/Postal Code

33019

COUNTRY (if not USA)

1.E. Is your residence address the same as your mailing address? YES NO - Complete RESIDENT ADDRESS below

RESIDENT ADDRESS (Include apartment number if applicable.)

CITY

STATE/Province

ZIP/Postal Code

COUNTRY (if not USA)

1.F. DAYTIME PHONE NUMBER(S) where we can call to speak with you, or leave a message, if needed.

(Include area code, or IDD and country code if outside the USA or Canada.)

Primary: (202) 780-7177 (father)

Secondary:
(If available)

954-559-8884 (me, son)

1.G. EMAIL ADDRESS

JohnMichaelReedFAS@GMail.com

1.H. Can you speak and understand English?

YES

NO

If NO, what language do you prefer?

If you cannot speak and understand English, we will provide an interpreter free of charge.

1.I. Can you read and understand English?

YES

NO

1.J. Can you write more than your name in English?

YES

NO

SECTION 2 - SOMEONE WE CAN CONTACT

Please provide the name of someone (other than your doctors) we can contact who knows about your medical condition(s), and can help with your case and can help us reach you if you become unavailable. Examples include a family member, friend, or neighbor.

2.A. NAME (First, Middle, Last, Suffix)

Anna S. Reed

2.B. Relationship to Person in 1.A.

Mom

2.C. MAILING ADDRESS (Street or PO Box) Include apartment number if applicable.

1070 Corkwood St.

CITY <u>Hollywood</u>	STATE/Province <u>FL</u>	ZIP/Postal Code <u>33019</u>	COUNTRY (if not USA)
--------------------------	-----------------------------	---------------------------------	----------------------

2.D. DAYTIME PHONE NUMBER (as described in 1.F. above) 954-632-0644

2.E. Can this person speak and understand English? YES NO
(If NO, what language is preferred?)

SECTION 3 - MEDICAL INFORMATION

Please provide us with general medical information to assist us with any records requests. We will use this information to see what additional questions or forms we may need to send you.

3.A. Separately list each physical and/or mental health condition that limits your ability to work. If under age 18, list the physical and/or mental health condition(s) that limit the child's ability to do the same things as other children the same age.

1. Bipolar Schizophrenia (with other weird symptoms like temporal lobe epilepsy)
2. Schizoaffective disorder, bipolar type
3. Non-24 Hour Sleep Wake Disorder (Non-24)
4. Grandiose Narcissistic/Sociopath/Psychopath Personality Disorder
5. (Also I can't safely drive, Sometimes I have pseudoseizures)-Abnormal movements

If you need more space to list additional conditions go to Section 9 – Remarks

3.B. What is your height? 5 10 OR
feet inches

centimeters

3.C. What is your weight? 155 OR
pounds kilograms

3.D. Within the last 12 months, have you seen or received treatment from a health care provider (doctor, hospital, clinic, psychiatrists, nurse practitioners, therapists, physical therapists, or other medical professionals)?

NO (Go to 3.F.)

YES (Complete the following section below.)

You may find this information on medical bills or the internet. If you don't have the full street address, give as much as you can remember. Example: "On Main St. next to the Courthouse."

1. NAME OF FACILITY OR OFFICE Memorial Outpatient Behavior NAME OF HEALTH CARE PROVIDER THAT TREATED YOU APRN Edgar Matamoros

What medical conditions were treated or evaluated?

-Bipolar, most recent episode manic

-Schizoaffective disorder, bipolar type

PHONE NUMBER <u>For records: 954-265-5947</u>	DATE LAST SEEN (IF KNOWN) <u>3/2024</u>
--------------------------------------------------	-----------------------------------------------

STREET ADDRESS <u>5595 S University Dr</u>	STATE/Province <u>FL</u>	ZIP/Postal Code <u>33328</u>	COUNTRY (if not USA)
-----------------------------------------------	-----------------------------	---------------------------------	----------------------

CITY <u>Davie</u>

2. NAME OF FACILITY OR OFFICE Dr. Byk's office	NAME OF HEALTH CARE PROVIDER THAT TREATED YOU Psy.D. Maria Karilshadt-Byk		
----------------------------------------------------------	-------------------------------------------------------------------------------------	--	--

What medical conditions were treated or evaluated?

Grandiose Narcissistic/Sociopath/Psychopath Personality Disorder.
-Please request psychotherapy notes, I authorize disclosure.

PHONE NUMBER Records fax: 954-820-6597	DATE LAST SEEN (IF KNOWN)	02, 2024 MM YYYY
--------------------------------------------------	------------------------------	---------------------

STREET ADDRESS
10400 Griffin Rd, Suite 109

CITY Cooper City	STATE/Province FL	ZIP/Postal Code 33328	COUNTRY (if not USA)
----------------------------	-----------------------------	---------------------------------	----------------------

3. NAME OF FACILITY OR OFFICE Memorial Division of- Dr. Boris Betancourt	NAME OF HEALTH CARE PROVIDER THAT TREATED YOU		
------------------------------------------------------------------------------------	-----------------------------------------------	--	--

What medical conditions were treated or evaluated?

- Non-24 hour sleep wake disorder** → Same thing.
- Circadian rhythm sleep-wake disorder, non-24**

PHONE NUMBER Records fax: 954-276-0602	Main number 954-276-1925	DATE LAST SEEN (IF KNOWN)	08, 2023 MM YYYY
--------------------------------------------------	------------------------------------	------------------------------	---------------------

STREET ADDRESS
7369 Sheridan St, Suite 302 Email: **records@MHS.net**

CITY Hollywood	STATE/Province FL	ZIP/Postal Code 33024	COUNTRY (if not USA)
--------------------------	-----------------------------	---------------------------------	----------------------

4. NAME OF FACILITY OR OFFICE Memorial Healthcare	NAME OF HEALTH CARE PROVIDER THAT TREATED YOU Dr. Tarek Zakaria		
-------------------------------------------------------------	---------------------------------------------------------------------------	--	--

What medical conditions were treated or evaluated?

- Involuntary movements. - Weird hard to explain stuff from brain.**
- Pseudoseizures resembling temporal lobe epilepsy.**

PHONE NUMBER 954-265-9500	DATE LAST SEEN (IF KNOWN)	04, 2023 MM YYYY
-------------------------------------	------------------------------	---------------------

STREET ADDRESS
1150 N 35th Ave, Suite #590

CITY Hollywood	STATE/Province FL	ZIP/Postal Code 33021	COUNTRY (if not USA)
--------------------------	-----------------------------	---------------------------------	----------------------

5. NAME OF FACILITY OR OFFICE Memorial Midtown	NAME OF HEALTH CARE PROVIDER THAT TREATED YOU Dr. Howard Kreger		
----------------------------------------------------------	---------------------------------------------------------------------------	--	--

What medical conditions were treated or evaluated?

Went to neurologist for various hard to explain symptoms from brain. Some symptoms resembled temporal lobe epilepsy.

PHONE NUMBER 305-682-2900	DATE LAST SEEN (IF KNOWN)	MM, 2020 YYYY
-------------------------------------	------------------------------	------------------

STREET ADDRESS
2063 Biscayne Blvd, Suite #501

CITY Miami	STATE/Province FL	ZIP/Postal Code 33137	COUNTRY (if not USA)
----------------------	-----------------------------	---------------------------------	----------------------

If you need to list more facilities or doctors, use **Section 9 – Remarks**.

3.E. Within the last 12 months, did any of the providers listed in 3.D. order any medical tests for you? (Include tests already performed and those scheduled in the future, and the healthcare provider, or facility, that scheduled them.)

NO (Go to 3.F.)

YES (Complete the following section below.) – If you need more space, use **Section 9 – Remarks**.

TEST	NAME OF HEALTHCARE PROVIDER OR FACILITY
Blood test (not HIV)	
Breathing test	
Cardiac catheterization	
EEG (brain wave test)	
EKG (heart test)	
Hearing test	
HIV test	
Speech/language test	
Treadmill (exercise test)	
Vision test	
Psychological/IQ test	
Biopsy (list body part, if known):	
MRI/CT scan (list body part, if known):	
X-ray (list body part, if known):	
Other – please specify:	

3.F. Within the last 12 months, have you taken or are you now taking any prescription or non-prescription medicines? Please put any side-effects you may have in **Section 9 - Remarks**.

NO (Go to 3.G.)

YES (Complete the following section below.) – Look at your medicine containers, if necessary.
If you need more space, use **Section 9 – Remarks**.

NAME OF MEDICINE	IF PRESCRIBED, GIVE DOCTOR NAME (IF KNOWN)	REASON FOR MEDICINE (IF KNOWN)
1. <u>Invega (Paliperidone)</u>	<u>APRN Edgar Matamoros</u>	<u>Schizoaffective disorder</u>
2.		
3.		
4.		
5.		
6.		

3.G. Do you use an assistive device?

Note: Even if you do not always use an assistive device at home, if you always use it when outside your home, please select "always."

NO (Go to Section 3.H.)

YES (Complete the following section below.) If you need more space, use Section 9 – Remarks.

DEVICE	FREQUENCY OF USE		NAME OF HEALTH CARE PROVIDER, IF PRESCRIBED (IF KNOWN)
<input type="checkbox"/> Braces	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	
<input checked="" type="checkbox"/> Canes	<input type="checkbox"/> Always	<input checked="" type="checkbox"/> Sometimes	Parkinsonism (reason)
<input type="checkbox"/> Crutches	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	
<input checked="" type="checkbox"/> Eyeglasses	<input checked="" type="checkbox"/> Always	<input type="checkbox"/> Sometimes	
<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	
<input type="checkbox"/> Screen reader	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	
<input type="checkbox"/> Walker	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	
<input type="checkbox"/> Other:	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	

3.H. Is the person receiving disability benefits listed in 1.A. under age 14?

NO (Go to Section 4)

YES (Go to Section 10)

SECTION 4 – WORK INFORMATION

Complete only if you are age 14 years old or older

Please tell us if you have worked since the date of your last medical disability decision. If we have any additional questions about your work, we may contact you.

4.A. Since the date of your last medical disability decision have you worked? (See date on top of Page 3.)

NO (Go to 4.B.)

YES (Complete following section below.)

Are you currently working?

No

Yes

Select all types of work you had since your last medical disability decision:

Wages from employer

Self-employment

4.B. Is the person receiving disability benefits listed in 1.A. under age 18?

NO (Go to Section 5)

YES (Go to Section 10)

SECTION 5 – SUPPORT SERVICES**Complete only if you are age 18 years or older**

Please provide the information about your participation in support services. Examples of support services can include:

- An Individualized Education Program (IEP) through a school (if a student age 18-21)
- An individualized work plan with an employment network under the Ticket to Work Program
- A Plan to Achieve Self-Support (PASS)
- An individualized plan for employment with a vocational rehabilitation agency or any other organization.

5.A. Since the date of your last medical disability decision, have you participated or are you participating in any support services mentioned above or any other vocational rehabilitation, employment services, or other support services to help you return to work? (See date on top of **Page 3**.)

NO (Go to Section 6)

YES (Complete the following section below.)

FACILITY OR ORGANIZATION NAME	PHONE NUMBER
-------------------------------	--------------

COUNSELOR, INSTRUCTOR, OR JOB COACH NAME

MAILING ADDRESS (Street or PO Box) (Include Suite, Building, etc.)

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
------	----------------	-----------------	----------------------

5.B. Are you still participating in the plan or program? (Select answer below. If date not known, use best estimate.)

YES - Date began: MM / YYYY Expected completion date: MM / YYYY

NO - Date began: MM / YYYY Date stopped: MM / YYYY

Reason stopped:

5.C. What types of services, tests, or evaluation were provided?

Select all that apply:

Vision test Psychological/IQ test Work classes Hearing test Work evaluation
 Other - Please explain:

SECTION 6 - OTHER MEDICAL INFORMATION**Complete only if you are age 18 years or older**

Please provide the contact information for anyone else or any other organization that may have medical information about your physical or mental health condition(s) that you did not list in Questions 3.D. or 5.A.

6. Within the last 12 months, does anyone else (other than your medical providers) have your medical information or are you scheduled to see anyone else? Examples include places like social services agencies, case workers, welfare agencies, attorneys, prisons, workers' compensation, insurance companies who have paid you disability benefits.

NO (Go to Section 7)

YES (Complete the following section below.)

NAME OR ORGANIZATION		PHONE NUMBER	
MAILING ADDRESS			
CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
NAME OF CONTACT PERSON		CLAIM NUMBER (if any)	
Date of Last Contact (in last 12 months, if known)		Date of Next Contact (if any)	
Reason(s) for Contacts			
If you need to list other people or organizations use Section 9 - Remarks and give the same detailed information as above for each one you list.			
SECTION 7 – EDUCATION, TRAINING, AND LITERACY			
Complete only if you are age 18 years or older			
Please provide any information about your education, training, and literacy since your last disability decision. Information about Individualized Education Plans (IEPs) or other support services should be recorded in "SECTION 5 - SUPPORT SERVICES".			
7.A. Have you received any education since your last disability decision? (See date at the top of Page 3.)			
<input checked="" type="checkbox"/> NO (Go to 7.B.) <input type="checkbox"/> YES (Complete the following section below.)			
NAME OF SCHOOL			
DATE(S) OF ATTENDANCE If date not known, use best estimate. / to / MM YYYY MM YYYY			
MAILING ADDRESS			
CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
TYPE OF PROGRAM/DEGREE			
Date Completed (or scheduled to be completed) If date not known, use best estimate. / MM YYYY			
7.B. Have you received any type of training (specialized job, trade, or vocational training) since your last disability decision? (See date at top of Page 3.)			
<input checked="" type="checkbox"/> NO (Go to 7.C.) <input type="checkbox"/> YES (Complete the following section below.)			
NAME OF TRAINING FACILITY		PHONE NUMBER	
MAILING ADDRESS			
CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
TYPE OF PROGRAM		Date Completed (or scheduled to be completed) If date not known, use best estimate. / MM YYYY	

7.C. What written language do you use every day in most situations (at home, work, school, in community, etc.)? English

7.D. READING - In the language you identified in 7.C., can you read a simple message, such as a shopping list or short simple notes? YES NO

7.E. WRITING - In the language you identified in 7.C., can you write a simple message, such as a shopping list or short simple notes? YES NO

If you need to list other education information or training facilities use Section 9 - Remarks and provide the same detailed information as above.

SECTION 8 - DAILY ACTIVITIES

Complete only if you are age 18 years or older.

Please tell us how your conditions affect your everyday life. This will help us further understand your medical condition(s).

8. Do your medical conditions cause you to have difficulties doing any of the following? You should think about the difficulty you experience in performing these tasks alone and without assistance from other people or assistive devices. If other people or assistive devices help you perform a task or perform a task for you because it would be difficult for you to perform the task without the assistance, choose "Yes".

YES NO

If YES, please select any tasks that you need help with or have difficulty doing.

<input type="checkbox"/> Dressing	<input type="checkbox"/> Taking medicine	<input type="checkbox"/> Doing chores (inside/outside of house)
<input type="checkbox"/> Bathing	<input type="checkbox"/> Preparing meals	<input checked="" type="checkbox"/> Driving or using public transportation
<input type="checkbox"/> Caring for hair	<input type="checkbox"/> Feeding self	<input type="checkbox"/> Understanding or following directions
<input checked="" type="checkbox"/> Walking	<input type="checkbox"/> Shopping	<input type="checkbox"/> Managing money
<input checked="" type="checkbox"/> Standing	<input type="checkbox"/> Lifting objects	<input checked="" type="checkbox"/> Getting along with people 
<input checked="" type="checkbox"/> Sitting	<input type="checkbox"/> Using arms	<input type="checkbox"/> Using hands or fingers
<input checked="" type="checkbox"/> Concentrating	<input checked="" type="checkbox"/> Remembering	<input checked="" type="checkbox"/> Seeing, hearing, or speaking

Please explain anything you marked you need help with or have difficulty doing:

-Walking, standing straight, and sitting upright can be difficult for me due to Parkinsonism and Extrapyramidal Symptoms (EPS). I use a phone instead of a desk computer whenever possible and I walk with a cane. I can travel short distances without a cane.

-Some cognitive issues and ADHD from childhood.

-Can't safely drive. Pseudoseizures and Alice in Wonderland syndrome sometimes. -I have no sympathy/empathy/care for others.
-I have mild astigmatism and 1/4 inch thick glasses.

If you need more space, use Section 9 – Remarks.

SECTION 9 - REMARKS

Please provide any additional information you did not give in earlier parts of this report, that you think would help us understand your disability and how it affects you. If you did not have enough space in prior sections of this report to provide the requested information, please use this space here to provide the additional information requested in those sections. For example, if you experience any side effects from the medication listed in 3.F., please provide that information in this section. Be sure to note the name of the section (and question number) you are referring to.

- I misspelled "Narcissistic" in section 3.A. line 4.
 - Medication didn't fix me. Tried maybe 15 different pills. Generally didn't work. Transitioned from psychiatric treatment with APRN Edgar Matamoros to psychological treatment with Psy.D. Maria Karilstadt-Byk (Dr. Byk for short). Seeing Dr. Byk in Hollywood, FL.
 - Psychiatrically hospitalized at Memorial Regional Hospital from 12/10/2023 - 12/17/2023 for mania, delusions.
 - For a detailed personal account of my issues, see this essay on my GitHub at web browser URL:
https://github.com/JohnReedLOL/Essay_for_Disability
- URL/Link is not case sensitive.

SECTION 10 – WHO IS COMPLETING THIS REPORT

Date Report Completed (month, day, year)

March 8, 2024

Who is completing this report?

- The person listed in 1.A.
 The person listed in 2.A.
 Someone else (Complete the following section below)

NAME (First, Middle Initial, Last)

Relationship to Person in 1.A.

DAYTIME PHONE NUMBER where we may reach you or leave a message, if needed. (Include the area code, IDD and country codes if you live outside the USA or Canada.)

MAILING ADDRESS (Street or PO Box) Include apartment number if applicable.

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
------	----------------	-----------------	----------------------