DISABILITY REPORT - APPEAL

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

This report is used to update your information for your disability appeal. Completing this report accurately helps us process your claim. Please complete as much of this report as you can.

IF YOU NEED HELP

Please do **not** ask your health care provider to complete this report. You can get help from other people, such as a friend or family member. If you cannot complete this report, a Social Security representative can assist you. If you make an appointment with us, please complete as much of this report as you can and have it with you for your appointment.

HOW TO COMPLETE THIS REPORT

If you have Internet access, you may be able to complete this report online at www.ssa.gov/disability/appeal.

If you complete this report on paper:

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers, including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION**, unless the report indicates otherwise. You can write "don't know," or "none," or "does not apply" if you need to.
- If you need more space to answer any question, please use the **REMARKS** section on the last page, SECTION 10. Include the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any medical records that you have not given to us, send or bring them to our office with this completed report. Please tell us if you want us to return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and this completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

HOW TO SUBMIT THIS REPORT

Send or bring this completed report to your local Social Security office. If you have Internet access, you can locate your nearest Social Security office by ZIP code at www.socialsecurity.gov/locator. Our 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).

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), and 1631 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 reconsider and review an initial disability determination; review a continuing disability; and evaluate a request for a hearing. 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 the Social Security Administration 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 Federal, State, or local agencies (or agents on their behalf) for administering cash or non-cash income maintenance or health maintenance programs (including programs under 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, is 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 (OMB) control number. We estimate that it will take about 50 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

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

DISABILITY REPORT - APPEAL

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

Related SSN Number Holder

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you", "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle, Last, Suffix)	**1.B.** Social Security Number
Jamie Lynn Davis	506-11-9325

1.C. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada) 605-209-8418

☐ Check this box if you do not have a phone number where we can leave a message

1.D. Alternate Phone Number, another number where we may reach you, if any

1.E. Email address (Optional) jamiedavis_83@yahoo.com

SECTION 2 - CONTACTS

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim (e.g., friend or relative)

2.A. Name (First, Middle, Last)	**2.B.** Relationship to Disabled Person
Kimberly Joan Davis	Mother

2.C. Mailing Address (Street or PO Box), include apartment number or unit if applicable
713 Wright Court

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Rapid City	SD	57701	USA

2.D. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada) 605-391-2658

2.E. Can this person speak and understand English? ☒ Yes ☐ No

If no, what language does the contact person prefer?

2.F. Who is completing this form?

☒ The person who is applying for disability. (**Go to Section 3 - MEDICAL CONDITIONS**)

☐ The person listed in 2.A. (**Go to Section 3 - MEDICAL CONDITIONS**)

☐ Someone else (Please complete the information below)

2.G. Name (First, Middle, Last)	**2.H.** Relationship to Disabled Person

2.I. Mailing Address (Street or PO Box), include apartment number or unit if applicable

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

2.J. Daytime Phone Number, including area code (include IDD and country codes if outside the U.S. or Canada)

SECTION 3 - MEDICAL CONDITIONS

3.A. Since you last told us about your medical conditions, has there been any **CHANGE** (for better or worse) in your previously described physical or mental conditions?

☒ Yes, approximate date change occurred: Currently ☐ No

If yes, please describe in detail:

Both knees gives out when standing/bending cannot kneel on either knee. Cannot get surgery due to weight and age. Lower back has bulging discs/arthritis and cannot get surgery due to same resons. Miangioma in the skull radiation causes headaches & vision changes. Arthritis in feet,depression,anxiety, fibromyalgia, PCOS, ADHD,PVC,and carpel tunnel.

3.B. Since you last told us about your medical conditions, do you have any **NEW** physical or mental conditions?

☒ Yes, approximate date of new conditions: ☐ No

If yes, please describe in detail:

Severe depression, anxiety, and constant panic attacks. Continuous blood pressure issues that are hard to control. Currently it hurts to swallow due to issues with my throat.

If you need more space, use SECTION 10 - Remarks on the last page

SECTION 4 - MEDICAL TREATMENT

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname.

☐ Yes ☒ No

If yes, please list the other names used:

4.B. Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or **do you have a future appointment scheduled**?

☒ Yes ☐ No (Go to SECTION 6 - MEDICINES)

4.C. What type(s) of condition(s) were you treated for, or will you be seen for?

☒ Physical ☒ Mental (including emotional or learning problems)

If you answered "Yes" to 4.B., please tell us who may have **NEW** medical records about any of your physical or mental conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider**. If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities

Only list the providers you have seen since you last told us about your medical treatment.

SECTION 4 - MEDICAL TREATMENT (Continued)
Provider 1

4.D. Name of facility or office	Name of health care provider who treated you
Oyate IHS	Dr.Mauricio Ehlert-Birriel

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)
605-355-2500	

Address
3200 Canyon Lake Drive,

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Rapid City	SD	57702	

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	**Emergency Room Visits at this facility**	**Overnight Hospital Stays at this facility**	
First visit	Date	Date in	Date out
Last visit Clinic	Date 3/24/24	Date in	Date out
Next scheduled appointment (if any) To be determined	Date	Date in	Date out
	☐ None	☐ None	

What new or updated medical conditions were treated or evaluated?
Depression, infection, throat issues.

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)
Antibiotics, steroids, ENT referral for throat.

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☒ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	DATES OF TEST(S)	KIND OF TEST	DATES OF TEST(S)
☐ Biopsy (list body part)		☒ MRI/CT Scan (list body part)	03/24/24
☒ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-Ray (list body part)	
☐ EKG (heart test)			
☐ Hearing test		☐ Other (please describe)	
☐ HIV Test		MRI	
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe, go to SECTION 5 - OTHER MEDICAL INFORMATION on page 8.

SECTION 4 - MEDICAL TREATMENT (Continued)
Provider 2

4.D. Name of facility or office	Name of health care provider who treated you
Oyate - IHS	Amber Genise - Mental Health Provider

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)
605-355-2500	

Address
3200 Canyon Lake Drive

City	State/Province	ZIP/Postal Code	Country (if not U.S.)
Rapid City	SD	57702	

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	**Emergency Room Visits at this facility**	**Overnight Hospital Stays at this facility**	
First visit March	Date	Date in	Date out
Last visit March	Date	Date in	Date out
Next scheduled appointment (if any) Ongoing/Monthly	Date	Date in	Date out
	☒ None	☒ None	

What new or updated medical conditions were treated or evaluated?
Evaluate mental health for depession, anxiety, and panic attacks along with med refills.

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☒ No (Go to the next page.)

KIND OF TEST	**DATES OF TEST(S)**	**KIND OF TEST**	**DATES OF TEST(S)**
☐ Biopsy (list body part)		☐ MRI/CT Scan (list body part)	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-Ray (list body part)	
☐ EKG (heart test)			
☐ Hearing test		☐ Other (please describe)	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you do not have any more providers to describe, go to SECTION 5 - OTHER MEDICAL INFORMATION on page 8.

SECTION 4 - MEDICAL TREATMENT (Continued)
Provider 3

4.D. Name of facility or office	Name of health care provider who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Dates of Treatment (approximate date, if exact date is unknown)

Office, Clinic, or Outpatient visits at this facility	**Emergency Room Visits at this facility**	**Overnight Hospital Stays at this facility**	
First visit	Date	Date in	Date out
Last visit	Date	Date in	Date out
Next scheduled appointment (if any)	Date	Date in	Date out
	☐ None	☐ None	

What new or updated medical conditions were treated or evaluated?

What new or updated treatment did you receive for the above conditions? (Do not list medicines or tests in this box.)

Has this provider performed or sent you to any tests? Please include tests you are scheduled to have in the future. ☐ Yes (Please complete the information below.) ☐ No (Go to the next page.)

KIND OF TEST	**DATES OF TEST(S)**	**KIND OF TEST**	**DATES OF TEST(S)**
☐ Biopsy (list body part)		☐ MRI/CT Scan (list body part)	
☐ Blood Test (not HIV)		☐ Speech/Language Test	
☐ Breathing test		☐ Treadmill (exercise test)	
☐ Cardiac Catheterization		☐ Vision Test	
☐ EEG (brain wave test)		☐ X-Ray (list body part)	
☐ EKG (heart test)			
☐ Hearing test		☐ Other (please describe)	
☐ HIV Test			
☐ IQ Testing			

If you need to list more tests, use SECTION 10 - REMARKS on the last page.

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

SECTION 5 - OTHER MEDICAL INFORMATION

5. **Since you last told us about your other medical information**, does anyone else have medical information about any of your **physical or mental** conditions (including emotional and learning problems) or are you scheduled to see anyone else?

This may include:
- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

☐ YES (Please complete the information below.)

☒ NO (Go to SECTION 6 - MEDICINES.)

Name of Organization	Claim or ID Number (if any)

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Name of Contact Person	Phone Number

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

If you need to list more people or organizations, use SECTION 10 - REMARKS on the last page.

SECTION 6 - MEDICINES

6. Are you currently taking any medicines (prescription or non-prescription)?

☒ YES (Please complete the information below. You may need to look at your medicine containers.)

☐ NO (Go to SECTION 7 - ACTIVITIES.)

NAME OF MEDICINE	IF PRESCRIBED, NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
Fluoxitine	Amber Genise	Depression/Anxiety	None
Synthroid	Dr.Mauricio Ehlert Pinniel	Thyroid	None
Lisinopril	Dr.Mauricio Ehlert Pinniel	Blood Pressure	Shakes/nausea/
Montelukast	Dr.Mauricio Ehlert Pinniel	Asthma	None
Omeprazole	Dr.Mauricio Ehlert Pinniel	Reflux	None
Metroporol	Dr.Mauricio Ehlert Pinniel	PVC	Nausea/weak/tired
Bupropion	Amber Genise	Anxiety/Depression	None

If you need to list more medicines, use SECTION 10 - REMARKS on the last page.

SECTION 7 - ACTIVITIES

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your previously described daily activities due to your physical or mental conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

☒ Yes ☐ No

If yes, please describe in detail:

Difficulty sleeping, cannot sit/stand for very long, knee joints swell and am in excruciating pain 100% of the time. Cannot get in and out of cars, up stairs, or into the bathtub, etc. Continuously crying, isolating, no interest in socalizing, can't take care of my home and housework/cooking, due to depression. Extreme difficulty eating due to swallowing issues.

If you need more space, use SECTION 10 - REMARKS on the last page.

SECTION 8 - WORK AND EDUCATION

8.A. Since you last told us about your work, have you worked or has your work changed?

☐ Yes ☒ No

If yes, you will be asked to provide additional information.

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes?

☐ Yes ☒ No

If yes, what type?

Date(s) attended:

Degree(s) attained, if any:

Date of attainment (MM/YYYY):

If you need more space, use SECTION 10 - REMARKS on the last page.

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

9. **Since you last told us about your vocational rehabilitation**, 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 (PASS)?
- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ Yes (Please complete the information below.)

☒ No (Go to SECTION 10 - REMARKS.)

Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Address

City	State/Province	ZIP/Postal Code	Country (if not U.S.)

Date when you started participating in the plan or program:

If you need more space, use SECTION 10 - REMARKS on the last page.

SECTION 10 - REMARKS

Use this space to provide any information you could not show in earlier sections of this form or additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

Meds Continued:

Chlorthalidone	Heart	Shakey, uneasy
Amlodipine Besylate	Heart	Shakey, nausea
Tylenol	Arthritis	
Ibuprophen	Arthritis	
Arthritis creams	Arthritis	

My 12 year old daughter Kymberlyn passed away on March 12,2024 due to illness, which has severely aggrivated my already continuous mental and emotional health issues.