FSM SOCIAL SECURITY ADMINISTRATION

REPORT OF CONTINUING DISABILITY INTERVIEW	OFFICE	DATE
	REPORT MADE ☐ in person ☐ telephone	PLACE OF REPORT ☐ DO ☐ Contact Station ☐ Home ☐ Other

SS NUMBER	WAGE EARNER	NAME IF NOT WAGE EARNER

Person reporting ☐ Beneficiary ☐ Other person (Show name, address, relationship and why beneficiary is not report.)

Name and Relationship	Address	Why beneficiary is not reporting

Type(s) of Entitlement
(Check all that apply)

PRIVACY ACT/PAPERWORK ACT NOTICE: The information requested on this form is authorized by the Social Security Act, Section 205 (a) and 1631(e)(A) and (B), and Title 20 CFR 404.1589 and 416.989. The information provided will be used to further document your claim and permit a determination about your continuing disability. Information requested on this form is voluntary. However, if you do not provide the required information, a decision based on evidence in your file can result in a determination that your period of disability is ceased. While the information you furnish on this form would almost never be used for any purpose other than making a determination about your disability, such information may be disclosed by SSA for the following purposes: (1) To assist SSA in determining the right to Social Security benefits for yourself or another person; (2) To facilitate statistical research and audit activities necessary to assure the integrity and improvement of programs administered by the Social Security Administration, and (3) to comply with laws and regulations requiring the exchange of information between the Social Security Administration and another agency. These and other reasons why information about you may be used or given out are explained in the Federal Register. If you would like more information about this, get in touch with any Social Security office.

PART I - INFORMATION ABOUT YOUR CONDITION

1. a. What is the disability condition(s) for which you are receiving disability benefits?

b. Has there been any change (for better or worse) in your disabling condition since you last reported such information to us?

☐ **Yes** (If "yes", describe any changes below) ☐ **No**

c. Do you have any new injuries or illnesses?

☐ **Yes** (If "yes", describe any changes below) ☐ **No**

2. a. Do you feel you are able to return to work?

☐ **Yes** (If "yes", explain and describe any limitations in Part VI.) ☐ **No** (If "no", please explain in Part VI how your injuries prevent you from working.)

b. Has your doctor told you that you are able to return to work?

☐ **Yes** (If "yes", answer items c, d, and e.) ☐ **No** ☐ **Did not say**

2. c. List the name and address of the doctor(s) who told you to return to work.

NAME

ADDRESS

d. What date did your doctor tell you that you could return to work? (mo., day, yr.)	c. Do you have any new injuries or illnesses? ☐ **Yes** (If "yes", explain in Part VI.) ☐ **No**

PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS

3. List the name, address and telephone number of the doctor who has your latest medical records.

e. If you have not seen a doctor, check here ☐

NAME	ADDRESS	
TELEPHONE NUMBER (Include area code)		
How often do you see this doctor?	Date you first saw this doctor (mo., day, yr.)	Date you last saw this doctor (mo., day, yr.)

Reasons for visits (show illness or injury for which you had an examination or treatment)

Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")

a. Have you seen any doctors? ☐ **Yes** (If "yes", show the following) ☐ **No**

NAME	ADDRESS	
TELEPHONE NUMBER (Include area code)		
How often do you see this doctor?	Date you first saw this doctor (mo., day, yr.)	Date you last saw this doctor (mo., day, yr.)

Reasons for visits (show illness or injury for which you had an examination or treatment)

Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")

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Reasons for visits (show illness or injury for which you had an examination or treatment)

Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")

3. NAME

TELEPHONE NUMBER (Include area code)

ADDRESS

How often do you see this doctor?

Date you first saw this doctor (mo., day, yr.)

Date you last saw this doctor (mo., day, yr.)

Reasons for visits (show illness or injury for which you had an examination or treatment)

Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")

4. Have you been hospitalized or treated at a clinic for your disabling condition? ☐ **Yes** (If "yes", show the following) ☐ **No**

NAME OF HOSPITAL OR CLINIC

PATIENT OR CLINIC NUMBER

ADDRESS

Were you an inpatient (i.e., stayed at least overnight?) ☐ **Yes** (If "yes", fill in the dates below) ☐ **No**

Were you an outpatient? ☐ **Yes** (If "yes", fill in the dates below) ☐ **No**

DATES OF ADMISSIONS	DATES OF DISCHARGE	DATES OF VISITS

Reason for hospitalization or clinic visits (show illness or injury for which you had an examination or treatment)

Type of treatment or medicine received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")

NAME OF HOSPITAL OR CLINIC

PATIENT OR CLINIC NUMBER

ADDRESS

Were you an inpatient (i.e., stayed at least overnight?) ☐ **Yes** (If "yes", fill in the dates below) ☐ **No**

Were you an outpatient? ☐ **Yes** (If "yes", fill in the dates below) ☐ **No**

DATES OF ADMISSIONS	DATES OF DISCHARGE	DATES OF VISITS

Reason for hospitalization or clinic visits (show illness or injury for which you had an examination or treatment)

Type of treatment or medicine received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")

If you have seen other doctors or if you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI.

5. Have you ever been seen by other agencies for your injury or illness? (VA, worker's compensation, welfare, etc.) (List any other agencies and their addresses, your claim numbers, dates and treatment received in Part VI)

☐ **Yes** (If "yes", fill in the information below) ☐ **No**

NAME OF AGENCY	ADDRESS OF AGENCY
YOUR CLAIM NUMBER	
DATES OF VISITS (mo., day, yr.)	TYPES OF TREATMENTS OR EXAMINATION RECEIVED

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part VI.

6. Have you had any of the following tests?

	YES	NO	IF "YES" SHOW WHERE DONE	IF "YES" SHOW WHEN DONE
EKG - Resting	☐	☐		
EKG - Treadmill	☐	☐		
Chest x-ray	☐	☐		
Other x-ray (specify >)	☐	☐		
Breathing tests	☐	☐		
Blood tests	☐	☐		
Other (specify >)	☐	☐		
Other (specify >)	☐	☐		
Other (specify >)	☐	☐		
Other (specify >)	☐	☐		

PART III - INFORMATION ABOUT YOUR ACTIVITIES

7. Has any doctor told you to cut back or limit your activities in any way since the date shown on Page 1?

☐ **Yes** (If "yes", give the name of the doctor below and tell what he/she told you about cutting back or limiting your activities) ☐ **No**

NAME OF DOCTOR	EXPLANATION OF WHAT DOCTOR TOLD YOU

8. In the areas below, describe your daily activities and state what and how much you do of each; how often you do it; and any assistance you require.

PERSONAL MOBILITY (walking, moving about, exercising your legs, etc.)

PERSONAL NEEDS AND GROOMING (dressing, bathing, etc.)

8. HOUSEHOLD MAINTENANCE (cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities)

RECREATIONAL ACTIVITIES AND HOBBIES (TV, radio, newspapers, books, fishing, bowling, musical instruments, etc.)

SOCIAL CONTACTS (visits with friends, relatives, neighbors, church, social clubs)

OTHER (drive car, motorcycle, ride bus or subway, etc.)

9. Have you attended (trade, vocational or academic) school or had any other type of vocational training since you began receiving disability benefits?

☐ **Yes** (If "yes", explain below) ☐ **No**

10. Are you attending school? ☐ **Yes** (If "yes", show the following) ☐ **No**

NAME OF SCHOOL	ADDRESS OF SCHOOL
CURRENT GRADE	

PART IV - INFORMATION ABOUT THE WORK YOU DID

11. Since you became disabled, have you done any work? ☐ **Yes** (If "yes", show the following for each work attempt, no matter how short it was) ☐ **No**

JOB TITLE (Be sure to begin with your usual job)	TYPE OF BUSINESS	DATES WORKED (month/year)		DAYS PER WEEK	RATE OF PAY (per hour, day, week, month or year)
		FROM	TO		

12. Describe your basic duties (explain what you did and how you did it) below. Also, explain why you stopped working for each work attempt listed in item 11.

PART V - INFORMATION ABOUT REHABILITATION SERVICES

13. VOCATIONAL REHABILITATION

IMPORTANT: Even if it is determined that you are not disabled, you may be eligible for continued payments if you are in an approved State vocational rehabilitation program and meet other requirements of the law.

a. Are you receiving help, such as services, training or counseling from the state vocational rehabilitation agency?

☐ **Yes** (If "yes", complete the following) ☐ **No**

b. What kind of help have you been receiving?

c. Do you expect to receive any type of training?

☐ **Yes** (If "yes", when?) ☐ **No**

WHEN

d. What is the name, address and phone number of your VR counselor?

NAME

ADDRESS

TELEPHONE NO. (Include area code)

PART VI - REMARKS

14. Use this section for additional space to answer any previous questions. Also, use this space to give any additional information that you think will be helpful in the review of the continuing entitlement to Social Security disability benefits. (If you need more space, use the separate sheet of paper. Also, if you wish, you may attach any evidence that shows your current condition.

PART VI - REMARKS

14. **Remarks**

PART VII - AUTHORIZATION AND NOTIFICATION STATEMENTS

I understand that this report will be used to determine whether to continue or to stop my disability benefits. I also understand that if I am receiving Social Security disability benefits and Supplemental Security Income payments, this questionnaire is applicable to both claims.

- Copies of medical records may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- Results of any such independent examination may be provided to my personal physician.
- Medical information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
- The State Vocational Rehabilitation Agency may review any medical evidence for determining my eligibility for rehabilitative services.
- I agree to notify the Social Security Administration if my medical condition improves or I go to work.
- I know that anyone who makes a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law. I affirm the above statements are true.

SIGNATURE OF CLAIMANT OR PERSON FILING ON CLAIMANT'S BEHALF	DATE (Mo., Day, Yr.)	TELEPHONE NUMBER (Include area code)

MAILING ADDRESS (Number and Street, Apt. No., P.O. Box or Rural Route)

CITY AND STATE	ZIP CODE	NAME OF COUNTRY (In which you now live)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X) two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
1. ADDRESS (Number & street, city, state and zip code)	2. ADDRESS (Number & street, city, state and zip code)

PART VIII - FOR SSA USE ONLY - DO NOT WRITE BELOW THIS LINE

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER

15. a. Check each item to indicate if any difficulty was observed:

	YES	NO		YES	NO
Breathing	☐	☐	Use of hands and arms	☐	☐
Sight	☐	☐	Writing	☐	☐
Speaking	☐	☐	Reading	☐	☐
Hearing	☐	☐	Comprehending	☐	☐
Sitting	☐	☐	Responding	☐	☐
Walking	☐	☐	Relating to people	☐	☐
Standing	☐	☐	Other (specify)	☐	☐

b. If any of the above items were checked “yes”, describe the exact difficulty involved.

c. Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above). Indicate any other noticeable physical/mental limitations/impairments. Also, indicate any unusual circumstances surrounding the interview, e.g., how the claimant came to the DO/BO for the interview, lack of difficulty where it might be expected.

PART VIII - FOR FSMSSA USE ONLY - DO NOT WRITE BELOW THIS LINE

16. a. Does the claimant need assistance in processing his or her claim?

☐ **Yes** (If "yes", answer 16b) ☐ **No**

b. If "yes" show the following information regarding an interested party willing to assist the claimant.

NAME	ADDRESS
RELATIONSHIP	
TELEPHONE NUMBER (Include area code)	

17. a. Does the claimant speak English?

☐ **Yes** ☐ **No** (If "no", answer 17b)

b. What language does he/she speak?

18. Is work in the 15 years prior to this interview, in file?

☐ **Yes** ☐ **No** (If "no", secure SSA-3369-F6)

19. Is capability development by the DDS necessary?

☐ **Yes** ☐ **No**

20. a. Is development of work activity necessary?

☐ **Yes** (If "yes", answer 20b) ☐ **No**

b. If "yes", is an SSA-821-F4 in file?

☐ **Yes** ☐ **No** (If "no", answer 20c)

c. If "no", explain why

SIGNATURE OF DO or BO INTERVIEWER OR REVIEWER	DATE
TITLE	