

Disability Related Development

Civil Action Number: 1:10-CV-12345

Claimant: Lucky Phylla

Account Number: 987-65-4321

Exhibits

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DATE: May 11, 2010

The documents and exhibits contained in this administrative record are the best copies obtainable.

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

(3367) ID/Prior Filings

Identifying Information

1. Name of Person whose Social Security Record this Claim is being filed:

His or Her Social Security Number:

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Male**

Date Of Birth:

2. Claimant's Alleged Onset Date: **12/28/1999**

3. Potential Onset Date (if different from above):

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

6. Protective Filing Date: **10052007**

Date Last Insured (DIB/Freeze case):

Beginning of Prescribed Period (DWB):

End of Prescribed Period:

Controlling Date:

Closed Period Case: **No**

Prior Filing Information

7. Prior Filing(s): **No**

If Yes, and you are not sending the prior folder, enter the following:

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no PD on this case.

(3367) Observations

9. Observations/Perceptions:

How was the Interview Conducted? **Teleclaim with claimant**

If the claimant had difficulty with the following, explain in Observations, or show "No" or "Not observed/perceived." (Explain any "No" answers that you think would assist the DDS in making a decision):

Hearing: **No**

Reading: **Not observed/perceived**

Breathing: **No**

Understanding: **No**

Coherency: **No**

Concentrating: **No**

Talking: **No**

Answering: **No**

Other (specify):

Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

(3367) Development

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? No

12. Is DDS capability development needed? No

Remarks:

Name of Interviewer: **R. Wacaster**

Phone Number: **501-525-2476 ext. 3015**

Name of Person Completing Form: **R. Wacaster**

Date: **10/16/2007**

Form SSA-3367 EDCS

DISABILITY REPORT - ADULT - Form SSA-3368

(3368) Section 1 - Information About the Disabled Person

A. Name:

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.):

or number

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

Name:

Relationship:

Address:

Daytime Phone:

E. What is your height without shoes? **6'**

F. What is your weight without shoes? **160 lbs.**

G. Do you have a medical assistance card? **No**

If "YES", show the number here:

H. Can you speak and understand English? **Yes**

If "NO", what is your preferred language?

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

If you cannot speak and understand English, is there someone we may contact who speaks and understands English and will give you messages?

(If "YES", is this the same person as in "D" above? If it is, show "SAME" below, if not complete below.)

I. Can you read and understand English? **Yes**

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

(3368) Section 2 - Your Illnesses, Injuries, or Conditions and How They Affect You

A. What are the illnesses, injuries, or conditions that limit your ability to work?

Scoliosis

B. How do your illnesses, injuries, or conditions limit your ability to work?

i am unable to lift over 50 lbs. i have trouble turning my head.

C. Do your illnesses, injuries, or conditions cause you pain or other symptoms? **Yes**

D. When did your illnesses, injuries, or conditions first interfere with your ability to work? **12/28/1999**

E. When did you become unable to work because of your illnesses, injuries, or conditions?

12/28/1999

F. Have you ever worked? **No**

G. Did you work at any time after the date your illnesses, injuries, or conditions first interfered with your ability to work?

H. If "Yes," did your illnesses, injuries, or conditions cause you to:

work fewer hours?

change your job duties?

make any job-related changes such as your attendance, help needed, or employers?

Explain:

I. Are you working now?

If "NO," when did you stop working?

J. Why did you stop working?

(3368) Section 3 - Information About Your Work

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

* = Longest Job Held

Longest Job Held	Job Title	Type of Business	Dates Worked (From-To)	Hours Per Day	Days Per Week	Rate of Pay/Per
------------------	-----------	------------------	------------------------	---------------	---------------	-----------------

B. Which job did you do the longest?

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.):

D. In this job, did you:

Use machines, tools, or equipment?

Use technical knowledge or skills?

Do any writing, complete reports, or perform duties like this?

E. In this job, how many total hours each day did you:

Walk?

Stand?

Sit?

Climb?

Stoop? (Bend down & forward at waist.):

Kneel? (Bend legs to rest on knees.):

Crouch? (Bend legs & back down & forward.):

Crawl? (Move on hands & knees.):

Handle, grab or grasp big objects?

Reach?

Write, type or handle small objects?

F. Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.):

G. Heaviest weight lifted:

H. Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday.):

I. Did you supervise other people in this job?

How many people did you supervise?

What part of your time was spent supervising people?

Did you hire and fire employees?

J. Were you a lead worker?

A. Have you been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries, or conditions that limit your ability to work?

Yes

B. Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work?

No

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

Tell us who may have medical records or other information about your illnesses, injuries, or conditions.

D. List each Doctor/HMO/Therapist. Include your next appointment:

E. List each Hospital/Clinic. Include your next appointment:

Name:	ARKANSAS CHILDREN'S HOSPITAL		
Address:	ATTENTION: MEDICAL RECORDS 800 MARSHALL STREET LITTLE ROCK, AR 72202		
Phone:	501-364-1152		
Inpatient Date In 1:	2001	Inpatient Date Out 1:	2001
Inpatient Date In 2:		Inpatient Date Out 2:	
Inpatient Date In 3:		Inpatient Date Out 3:	
Outpatient Date First Visit:		Outpatient Date Last Visit:	
Emergency Room Dates of Visits:			
Next Appointment:			
Your Hospital/Clinic Number:			
Reasons for Visits:	scoliosis		
What treatment did you receive?	surgery		
What doctors do you see at this hospital/clinic on a regular basis?			

F. 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?

No

(3368) Section 5 - Medications

Do you currently take any medications for your illnesses, injuries, or conditions? No

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

Name of Medicine	Prescribed By (Name of Doctor)	Reason For Medicine	Side Effects You Have
------------------	-----------------------------------	---------------------	-----------------------

(3368) Section 6 - Tests

Have you had, or will you have, any medical tests for your illnesses, injuries, or conditions?

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	Who Sent You For This Test
--------------	--	------------	----------------------------

(3368) Section 7 - Education/Training Information

A. Highest grade of school completed: **12th grade**

Approximate date completed: **2004**

B. Did you attend special education classes? Yes

If "YES",

Name of School: LAKE HAMILTON HIGH SCHOOL	
Address: ATTENTION: PRINCIPAL 280 WOLF STREET PEARCY, AR 71964	
Dates Attended: 1994	To: 2004
Type of Program: i was unable to keep up in regular classes i had problems reading	

C. Have you completed any type of special job training, trade or vocational school?

No

If "YES", what type?

Approximate date completed:

(3368) Section 8 - Vocational Rehabilitation, Employment, or Other Support Services Information

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services, or other support services to help you go to work?

Yes

Name of Organization: HOT SPRINGS REHABILITATION CENTER	
Name of Counselor:	
Address: ATTN: MEDICAL RECORDS P. O. BOX 1358 HOT SPRINGS, AR 71902	
Daytime Phone Number: 501-624-4411	
Dates Seen: 2005	To: 08/31/2007
Types of Services or Tests Performed: i was studying food service	

(3368) Section 9 - Remarks

Use this section for any additional information you did not show in earlier parts of this form. When you are done 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.

Name of person completing this form:	Date Form Completed (Month, day, year):
Address (Number and street, City, State, Zip Code): ----- ----- -----	
e-mail address (optional): ----- -----	

Form SSA-3368 EDCS

DISABILITY DETERMINATION FOR SOCIAL SECURITY

EXHIBIT NO. 3E
PAGE: 1 OF 2

070710260001615

PAIN AND OTHER SYMPTOMS

RE: _____ SSN: _____ CASE#: 0831108

BARBARA COBB/409



RQID: J-000011KAP000 SITE: S04 DR: S
SSN: _____ DCTYPE: 0220 RF: D CS: 182f

1. Do you suffer from unusual fatigue? NO YES _____ (If YES, date you first noticed it? _____)

Do you require naps or rest? NO YES _____

If YES, how often? _____ Once a day (How long? _____)

_____ Twice or more a day (How long? _____)

_____ Can only get out of bed for medical appointments, etc.

2. Describe your pain or other symptoms: pain when moving head side to side/Back pain from rods in back

3. Does the pain interfere with your sleep? NO YES _____

4. Where is your pain located? lower neck

5. How long does the pain usually last? Only when moving head side to side

6. How often do you have the pain or other symptoms? 2 or 3 Daily

7. What activities or circumstances cause the pain or other symptoms? Driving, or when I try to move my head side to side

8. About how long can you do the following before the pain occurs?

Stand/walk 2 hours Sit 2 hours

9. What makes the pain or other symptoms worse? Standing for long period
Lifting Bending to pick something up

10. What helps the pain or other symptoms besides medication? rest, take it easy

11. Please list the medications you are now taking for your pain and/or other symptoms:

NAME OF MEDICINE	DOSAGE AND HOW OFTEN TAKEN	SIDE EFFECTS
Ibuprofen	Depends on pain	none

12. Have you had to discontinue a medication for your disability because of side effects?
 If so, what is the name of that medication? no

13. Have you ever been prescribed a special treatment that didn't work (such as a TENS Unit or an ESI Stimulator)? NO YES
 If YES, what was the treatment? _____

14. Is there anything else about your pain and/or symptoms we should know?

I have pain when I stand or walk for long periods. Solesiosis in back had operation. Rods put in.

15. [Signature] 10/22/07
 (Signature of Claimant) (Date)

If this form was completed by someone other than the disability claimant, please give that person's name, relationship to claimant and daytime phone number.

 (Name) (Relationship) (Date)

PAIN

Social Security Administration
0831108/409

070710260001616 Form Approved: OMB No. 0960-0681



RQID: 1000011KA0000 SITE: S04 DR: S
SSN: TYPE: 0075 RF: D CS: 9fe4

FUNCTION REPORT - ADULT
BARBARA COBB/409

How your illnesses, injuries, or conditions limit your activities

SECTION A - GENERAL INFORMATION

1. NAME OF DISABLED PERSON

2. SOCIAL SECURITY NUMBER

3. 10/22/07
Date

4. **YOUR DAYTIME TELEPHONE NUMBER** (If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you)

Area Code Phone Number

Check if this is: Your Number
 Message Number
 None

5. a. Where do you live? (Check one.)

House Apartment Boarding House Nursing Home
 Shelter Group Home Other (What?) Mobile home

b. With whom do you live? (Check one.)

Alone With Family With Friends Other (Describe relationship)

SECTION B - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed. Eat Breakfast, watch TV, look for work, Eat lunch, Playstation 2, and Eat Supper

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? Yes No

If YES, for whom do you care, and what do you do for them?

8. Do you take care of pets or other animals? Yes 0716260001616 No

If YES, what do you do for them? *feed dog and cat*

9. Does anyone help you care for other people or animals? ___ Yes No

If YES, who helps and what do they do to help?

10. What were you able to do before your illnesses, injuries, or conditions that you CANNOT do now?

run, stand for long periods, hiking, some Amusement rides, lifting objects

11. Do the illnesses, injuries, or conditions affect your sleep? Yes ___ No

If YES, how? *headaches*

12. PERSONAL CARE (Check here ___ if NO PROBLEM with personal care.)

a. Explain how your illnesses, injuries, or condition affect your ability to:

Dress *can't bend in stand positions when putting*
on shoes.

Bathe *can't bend in stand positions when washing*
feet.

Care for hair *none*

Shave *none*

Feed self *none*

Use the toilet *none*

Other? *none*

- 070710260001616
b. Do you need any special reminders to take care of personal needs and grooming? ___ Yes No

If YES, what type of help or reminders are needed?

- c. Do you need help or reminders taking medicine? ___ Yes No

If YES, what kind of help is needed?

13. MEALS

- a. Do you prepare your own meals? Yes ___ No
If yes, what kind of food is prepared (for example, sandwiches, frozen dinners, or complete meals with several courses)? *Sandwiches, Frozen dinners*

How often do you prepare food or meals? (For example, daily, weekly, monthly.) *Daily*

How long does it take you? *Depend on type of food*

Any changes in cooking habits since the illness, injuries, or conditions began? *NO*

- b. If NO, explain why you cannot or do not prepare meals.

14. HOUSE AND YARD WORK

- a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.) *Laundry, Dishing, cleaning*

- b. How much time does it take you, and how often do you do each of these things? *Depend on chore*

- c. Do you need help or encouragement doing these things? Yes ___ No

If YES, what help is needed? *reminders*

d. If you don't do house or yard work, explain why not. ^{07071 0260001616}

15. **GETTING AROUND**

a. How often do you go outside? Daily

If you don't go out at all, explain why not.

b. When going out, how do you travel? (Check all that apply.)

Walk Drive a car Ride in a car Ride a bicycle
 Use public transportation Other (Explain)

c. When going out, can you go out alone? Yes No
If NO, explain why you can't go out alone.

d. Do you drive? Yes No
If you don't drive, explain why not.

16. **SHOPPING**

a. If you do any shopping, do you shop: (Check all that apply.)
 In stores By phone By mail By computer

b. Describe what you shop for. Depend what I want

c. How often do you shop and how long does it take? one time a month

17. **MONEY**

a. Are you able to:

Pay bills	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Count Change	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Handle a savings account	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Use a checkbook/money orders	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Explain all "NO" answers.

No Experence

- b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? YES NO

If YES, explain how the ability to handle money has changed.

18. **HOBBIES AND INTERESTS**

- a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.) Watching TV, Playing Playstation 2, friends, smiw

- b. How often and how well do you do these things? Weekly

- c. Describe any changes in these activities since the illnesses, injuries, or conditions began. Not being able to stand long periods

19. **SOCIAL ACTIVITIES**

- a. Do you spend time with others? (In person, on the phone, on the computer, etc.) Yes No

If YES, describe the kinds of things you do with others. ride in car, watch TV, Play play station 2

How often do you do these things? 2 time a month

- b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.) None

Do you need to be reminded to go places? Yes No

How often do you go and how much do you take part?

Do you need someone to accompany you? Yes No

c. Do you have any problems getting along with family, friends, neighbors, or others? ___ Yes No

If YES, explain.

d. Describe any changes in social activities since the illnesses, injuries, or conditions began:

None

SECTION C – INFORMATION ABOUT ABILITIES

20. a. Circle any of the following items that your illnesses, injuries, or conditions affect:

- | | | | |
|--|--|---|------------------|
| <input checked="" type="checkbox"/> Lifting | <input checked="" type="checkbox"/> Standing | <input checked="" type="checkbox"/> Walking | Sitting |
| <input checked="" type="checkbox"/> Stair Climbing | <input checked="" type="checkbox"/> Kneeling | Squatting | Reaching |
| Using hands | Seeing | Hearing | Talking |
| <input checked="" type="checkbox"/> Bending | Memory | Concentration | Completing Tasks |
| Understanding | Following Instructions | Getting Along with Others | |

Please explain how your illness, injuries or conditions affect each of the items you circled. (For example, you can only lift: how many pounds, or you can only walk: how far).

b. Are you right-handed? ___ left-handed?

c. How far can you walk before needing to stop and rest? 20 min.
If you have to rest, how long before you can resume walking? 10 min.

d. For how long can you pay attention? 20 min.

e. Do you finish what you start? (For example: a conversation, chores, reading, watching a movie) Yes ___ No

f. How well do you follow written instructions? (For example, as a recipe)
pretty good

g. How well do you follow spoken instructions? Sometimes I forget I suppose to do

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers) good

i. Have you ever been fired or laid off from a job because of problems getting along with other people? Yes No

If YES, explain.

j. If YES, give name of employer.

How well do you handle stress?
Sometime well

k. How well do you handle changes in routine?
good

l. Have you noticed any unusual behavior or fears? Yes No

If YES, explain. riding public Transportation

21. Do you use any of the following?
(Please check all that apply.)

Crutches

Walker

Wheelchair

Other (Explain)

Cane

Brace/Splint

Artificial Limb

Hearing Aid

Glasses/Contact Lenses

Artificial Voice Box

Which of these was prescribed by a doctor?

glasses

When was it prescribed? 3 years

When do you need to use these aids?

Driving

SECTION D - REMARKS 001616

Use this section for any **added information** that you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), **be sure to complete the fields at the bottom of this page.**

10/22/07

Date (Month, Day, Year)

email address (optional)

City, State, and Zip

FUNCTION

Form SSA-3373-BK (9-2004) ef (10-2004)

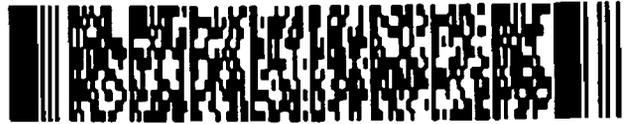
070710260001617

To whom it may concern-

my name is [redacted]
I've been helping [redacted] with understanding
Some of these questions on his forms.
His Mother and I feel like [redacted]
needs to have a mental evaluation
done. We feel like [redacted] has other
disabilities other than his SKoleoses.
We do not know how to go about getting
this information. If you could help us
we would greatly appreciate this. Thank you
very much for you time.

Social Security Administration
0831108/409

070710260001617 Form Approved: OMB No. 0960-0578



RQID: L000011KAN000 SITE: S04 DR: S
SSN: ICTYPE: 1080 RF: D CS: 7498

WORK HISTORY REPORT
BARBARA COBB/409

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last)

B. SOCIAL SECURITY NUMBER

S

C. YOUR DAYTIME TELEPHONE NUMBER (If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)

Check if this is: Your Number
 Message Number
 None

Area Code Phone Number

SECTION 2 - INFORMATION ABOUT YOUR WORK

List all of the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

	Job Title	Type of Business	Dates Worked From	Dates Worked To
1.	None			
2.				
3.				
4.				
5.				
6.				
7.				
8.				

070710760001617

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1			
Rate of Pay	Per (Check One)		Hours per day
\$ ___ Hour ___ Day ___ Week ___ Month ___ Year			Days per week

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this?)

Check the **heaviest** weight lifted:

___ Less than 10 lbs ___ 10 lbs ___ 20 lbs ___ 50 lbs ___ 100 lbs. or more ___ Other ___

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

___ Less than 10 lbs ___ 10 lbs ___ 25 lbs ___ 50 lbs. or more ___ Other ___

Did you supervise other people in this job? ___ YES (Complete items below) ___ NO (Skip to next page)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ___ YES ___ NO

Were you a lead worker? ___ YES ___ NO

070710260001617
Give us more information about Job No. 2 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 2					
Rate of Pay	Per (Check One)			Hours per day	Days per week
\$ _____	Hour	Day	Week	Month	Year

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use Machines, tools or equipment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Use Technical Knowledge or skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do any writing, complete reports or perform duties like this?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this?)

Check the heaviest weight lifted:

Less than 10 lbs 10 lbs 20 lbs 50 lbs 100 lbs. or more Other _____

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

Less than 10 lbs 10 lbs 25 lbs 50 lbs. or more Other _____

Did you supervise other people in this job? YES (Complete items below) NO (Skip to next page)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

Were you a lead worker? YES NO

070710260001517
Give us more information about Job No. 3 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 3					
Rate of Pay	Per (Check One)			Hours per day	Days per week
\$ ___ Hour ___ Day ___ Week ___ Month ___ Year					

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this?)

Check the heaviest weight lifted:

___ Less than 10 lbs ___ 10 lbs ___ 20 lbs ___ 50 lbs ___ 100 lbs. or more ___ Other ___

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

___ Less than 10 lbs ___ 10 lbs ___ 25 lbs ___ 50 lbs. or more ___ Other ___

Did you supervise other people in this job? ___ YES (Complete items below) ___ NO (Skip to next page)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ___ YES ___ NO

Were you a lead worker? ___ YES ___ NO

070710260001617

Give us more information about Job No. 4 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 4

Rate of Pay	Per (Check One)	Hours per day	Days per week
\$ _____	Hour _____ Day _____ Week _____ Month _____ Year _____		

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this?)

Check the heaviest weight lifted:

___ Less than 10 lbs ___ 10 lbs ___ 20 lbs ___ 50 lbs ___ 100 lbs. or more ___ Other ___

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

___ Less than 10 lbs ___ 10 lbs ___ 25 lbs ___ 50 lbs. or more ___ Other ___

Did you supervise other people in this job? ___ YES (Complete items below) ___ NO (Skip to next page)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ___ YES ___ NO

Were you a lead worker? ___ YES ___ NO

070710760001617

Give us more information about Job No. 5 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 5			
Rate of Pay	Per (Check One)		Hours per day
\$ ___ Hour ___ Day ___ Week ___ Month ___ Year			Days per week

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this?)

Check the heaviest weight lifted:

___ Less than 10 lbs ___ 10 lbs ___ 20 lbs ___ 50 lbs ___ 100 lbs. or more ___ Other ___

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

___ Less than 10 lbs ___ 10 lbs ___ 25 lbs ___ 50 lbs. or more ___ Other ___

Did you supervise other people in this job? ___ YES (Complete items below) ___ NO (Skip to next page)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ___ YES ___ NO

Were you a lead worker? ___ YES ___ NO

Give us more information about Job No. 6 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 6			
Rate of Pay	Per (Check One)		Hours per day
\$ ___ Hour ___ Day ___ Week ___ Month ___ Year			Days per week

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this?)

Check the heaviest weight lifted:

___ Less than 10 lbs ___ 10 lbs ___ 20 lbs ___ 50 lbs ___ 100 lbs. or more ___ Other ___

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

___ Less than 10 lbs ___ 10 lbs ___ 25 lbs ___ 50 lbs. or more ___ Other ___

Did you supervise other people in this job? ___ YES (Complete items below) ___ NO (Skip to next page)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ___ YES ___ NO

Were you a lead worker? ___ YES ___ NO

DISABILITY REPORT - APPEAL - Form SSA-3441

(3441) Section 1 - Information About the Disabled Person

- A. Name: _____
- B. Social Security Number: _____
- C. What is your 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**
- 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 with your claim.

Name:	
Relationship:	
Address:	
Daytime Phone:	

(3441) Section 2 - Information About Your Illnesses, Injuries, or Conditions

Date of Last Disability Report: 10/16/2007

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

If "YES," please describe in detail:

Approximate date the change(s) occurred:

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? **No**

If "YES," please describe in detail:

Approximate beginning date:

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

If "YES," please describe in detail:

Approximate beginning date:

(3441) 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?

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?

No

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

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. Include your next appointment.

E. List each Hospital/Clinic. Include your next appointment.

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

Name:	Hot Springs Rehabilitation Center		
Address:	105 Reserve hot springs, AR 71901	Date First Visit:	about 2005
		Date Last Visit:	about 2007
Phone:		Next Appointment:	none
Claim Number:			
Reasons for Visits:	Went through training program for kitchen work.		

(3441) Section 4 - Medications

Are you currently taking any medications for your illnesses, injuries, or conditions? **Yes**

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
Ibuprofen		I have a lot of headaches. This helps.	none

(3441) Section 5 - Tests

Since you last completed a disability report, have you had any medical tests for your illnesses, injuries, or conditions or do you have any such tests scheduled?

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?
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(3441) Section 6 - Updated Work Information

A. Have you worked since you last completed a disability report?

No

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

(3441) Section 7 - Information About Your Activities

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

Scoliosis makes it hard to lift, bend or turn my head. I have trouble doing a lot of normal things because of this. I can't read well or understand what I read, so I have trouble doing things like filling out applications. I haven't passed my driving test yet.

B. What changes have occurred in your daily activities since you last completed a disability report? (If none, show "None")

none

(3441) Section 8 - Education/Training Information

Have you completed any special job training, trade or vocational school since you last completed a disability report?

No

If "YES," describe what type:

Approximate date completed:

(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services Information

Since you last completed a disability report, have you participated in the Ticket Program or another program of vocational rehabilitation services, employment services, or other support services to help you go to work?

No

If "Yes," complete the following information:

(3441) Section 10 - Remarks

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

I was dropped as a baby and had a skull fracture. I was in the hospital at Geneva General in Geneva, NY. I had back surgery in 2001 at Arkansas Children's Hospital. They put a rod in my back.* This report was completed on the Internet using i3441 (Public) by: Report Completer Name: [redacted] Report Completer Address: [redacted] Completer Phone Number: Report Completer Email Address: nuu Internet medical form submitted on: 01/09/2008

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.

I UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.

Signature of claimant or person filing on claimant's behalf (parent, guardian)	Date (Month, day, year)
Address (Number and street, city, state and ZIP code)	e-mail Address (optional)

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
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

Form SSA-3441 EDCS

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

(3367) ID/Prior Filings

Identifying Information

1. Name of Person whose Social Security Record this Claim is being filed:

His or Her Social Security Number: _____

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Male**

Date Of Birth: _____

2. Claimant's Alleged Onset Date:

3. Potential Onset Date (if different from above):

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

6. Protective Filing Date:

Date Last Insured (DIB/Freeze case): _____

Beginning of Prescribed Period (DWB):

End of Prescribed Period:

Controlling Date:

Closed Period Case:

Prior Filing Information

7. Prior Filing(s):

If Yes, and you are not sending the prior folder, enter the following:

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no PD on this case.

(3367) Observations

9. Observations/Perceptions:

How was the Interview Conducted? **No contact with claimant**

Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

(3367) Development

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed?

Remarks:

Name of Interviewer: **T. Hunter**

Phone Number: _____

Name of Person Completing Form: **T. Hunter**

Date: **01/28/2008**

Form SSA-3367 EDCS

DISABILITY REPORT - APPEAL - Form SSA-3441

(3441) Section 1 - Information About the Disabled Person

A. Name: _____

B. Social Security Number: _____

C. What is your 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.):

_____ir 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 with your claim.

Name:

Relationship:

Address:

Daytime Phone:

--	--

(3441) Section 2 - Information About Your Illnesses, Injuries, or Conditions

Date of Last Disability Report: **01/28/2008**

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

If "YES," please describe in detail:

Approximate date the change(s) occurred:

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? **No**

If "YES," please describe in detail:

Approximate beginning date:

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

If "YES," please describe in detail:

Approximate beginning date:

(3441) 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?

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?

No

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

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. Include your next appointment.

E. List each Hospital/Clinic. Include your next appointment.

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?

No

(3441) Section 4 - Medications

Are you currently taking any medications for your illnesses, injuries, or conditions? **Yes**

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
ibuprofen		headaches and back pain. I take a lot of it.	none

(3441) Section 5 - Tests

Since you last completed a disability report, have you had any medical tests for your illnesses, injuries, or conditions or do you have any such tests scheduled?

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?

(3441) Section 6 - Updated Work Information

A. Have you worked since you last completed a disability report?

No

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

(3441) Section 7 - Information About Your Activities

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

Can't read much. Limited in turning head and bending, so have trouble doing much physically. Have lots of headaches, so can't concentrate.

B. What changes have occurred in your daily activities since you last completed a disability report? (If none, show "None")

No change

(3441) Section 8 - Education/Training Information

Have you completed any special job training, trade or vocational school since you last completed a disability report?

No

If "YES," describe what type:

Approximate date completed:

(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services Information

Since you last completed a disability report, have you participated in the Ticket Program or another program of vocational rehabilitation services, employment services, or other support services to help you go to work?

No

If "Yes," complete the following information:

(3441) Section 10 - Remarks

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

null* This report was completed on the Internet using i3441 (Public) by: Report Completer Name: { _____ } Report Completer Address: _____ Report Completer Phone Number: Report Completer Email Address: null Internet medical form submitted on: 04/25/2008

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.

I UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.

Signature of claimant or person filing on claimant's behalf (parent, guardian)	Date (Month, day, year)
Address (Number and street, city, state and ZIP code)	e-mail Address (optional)

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
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

Form SSA-3441 EDCS

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

(3367) ID/Prior Filings

Identifying Information

1. Name of Person whose Social Security Record this Claim is being filed:

His or Her Social Security Number:

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Male**

Date Of Birth:

2. Claimant's Alleged Onset Date:

3. Potential Onset Date (if different from above):

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

6. Protective Filing Date: **10/05/2007**

Date Last Insured (DIB/Freeze case):

Beginning of Prescribed Period (DWB):

End of Prescribed Period:

Controlling Date:

Closed Period Case:

Prior Filing Information

7. Prior Filing(s):

If Yes, and you are not sending the prior folder, enter the following:

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no PD on this case.

(3367) Observations

9. Observations/Perceptions:

(3367) Development

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed? **No**

Remarks:

Name of Interviewer: **R. Longinotti**

Phone Number: **501-525-2476 ext. 3013**

Name of Person Completing Form:

Date:

Form SSA-3367 EDCS