

DISABILITY DETERMINATION AND TRANSMITTAL

1. DESTINATION DDS <input type="checkbox"/> ODO <input type="checkbox"/> DPB <input type="checkbox"/> DQB <input type="checkbox"/> OIO <input type="checkbox"/>		2. DDS CODE	3. FILING DATE	4. SSN - -	BIC (if CDB or DWB CLAIM)
5. NAME AND ADDRESS OF CLAIMANT (include ZIP Code)			6. WE'S NAME (IF CDB OR DWB CLAIM)		
			7. TYPE CLAIM (Title II) DIB <input type="checkbox"/> FZ <input type="checkbox"/> DWB <input type="checkbox"/> CDB-R <input type="checkbox"/> CDB-D <input type="checkbox"/> RD-R <input type="checkbox"/> RD-D <input type="checkbox"/> RD <input type="checkbox"/> P-R <input type="checkbox"/> P-D <input type="checkbox"/> MQFE <input type="checkbox"/>		
			8. TYPE CLAIM (Title XVI) <input type="checkbox"/> DI <input type="checkbox"/> DS <input type="checkbox"/> DC <input type="checkbox"/> BI <input type="checkbox"/> BS <input type="checkbox"/> BC		
9. DATE OF BIRTH	10. PRIOR ACTION <input type="checkbox"/> PD <input type="checkbox"/> PT		11. REMARKS		
12. DISTRICT-BRANCH OFFICE ADDRESS (include ZIP Code)		DO-BO CODE			
13. DO-BO REPRESENTATIVE		14. DATE	11A. <input type="checkbox"/> Presumptive Disability		11B. <input type="checkbox"/> Impairment

DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED

15. CLAIMANT DISABLED A. <input type="checkbox"/> Disability Began B. <input type="checkbox"/> Disability Ceased		16A. PRIMARY DIAGNOSIS BODY SYS. CODE NO.		16B. SECONDARY DIAGNOSIS CODE NO.	
17. DIARY TYPE	MO./YR.	REASON			
18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)/(216)(i) A. <input type="checkbox"/> Not Disab. for Cash Bene. Purp. B. <input type="checkbox"/> Disab. for Cash Benefit Purp. Beg.		19. CLAIMANT NOT DISABLED Through Date of A. <input type="checkbox"/> Current Determination B. <input type="checkbox"/> Through _____ C. <input type="checkbox"/> Before Age 22 (CDB only)			
20. VOCATIONAL BACKGROUND		OCC YRS.	ED YRS.	21. VR ACTION SC IN A. <input type="checkbox"/> SC OUT B. <input type="checkbox"/> Prev Ref C. <input type="checkbox"/>	
22. REG-BASIS CODE	23. MED LIST NO.	24. MOB CODE	25. REVISED DET <input type="checkbox"/>	25A. Initial A. <input type="checkbox"/> Recon B. <input type="checkbox"/> Recon DHU C. <input type="checkbox"/>	ALJ Hearing D. <input type="checkbox"/> Appeals Council E. <input type="checkbox"/> U.S. District Court F. <input type="checkbox"/>
26. LIST NO.	A.	B.	C.	D.	E.
27. RATIONALE <input type="checkbox"/> See Attached SSA-4268-U4/C4 <input type="checkbox"/> Check if Vocational Rule Met. Cite Rule					

28. A. Period of Disability B. Disability Period C. Estab Beg _____ AND D. Continues E. Term _____

29. LTR/PAR NO.	30. DISABILITY EXAMINER-DDS	31. DATE	32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE	33. DATE
32A. PHYSICIAN OR MEDICAL SPEC. NAME (Stamp, Print or Type)				32B. SPEC. CODE
34. REMARKS			MULTIPLE IMPAIRMENTS CONSIDERED	
			34A. COMBINED MULTIPLE NONSEVERE-SEVERE	
			34B. COMBINED MULTIPLE NONSEVERE-NONSEVERE	
35. BASIS CODE	36. REV. DET. CODES	37. SSA REPRESENTATIVE		SSA CODE
				38. DATE

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We are authorized to collect this information under Sections 221 (a) and (b) of the Social Security Act and Sections 404.1615(d) and 416.1015 (d) of the Code of Federal Regulations. The information will be used to determine eligibility for benefits and for program evaluation and management. You are not required to complete this form, however, failure to do so could affect the claimants eligibility for benefits.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

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