COMPLETE THIS FORM IF YOU HAVE BEEN DENIED BENEFITS

Please complete this form and bring it with you to your appointment. You MUST complete this form prior to meeting with the attorney.

BRING YOUR DENIAL LETTER TO YOUR APPOINTMENT!

Name: _____
Appointment Date: _____ Time:_____

Palmyra Office Hannibal Office

1) When was the last day you worked? _____/_____/_____

2) Where were you working and why did you quit?
_____
_____
_____

3) Have you worked five out of the last ten years? Yes or No

4) What date did you provide Social Security Administration as the date you became disabled? _____/_____/_____

5) Do you have health insurance? Yes or No
Do you have Medicaid? Yes or No

6) What are the illnesses, injuries, or conditions that limit your ability to work?
_____
_____
_____
_____

7) How do your illnesses, injuries, or conditions limit your ability to work?
_____
_____
_____

8) Do you have health insurance? Yes or No
Do you have Medicaid? Yes or No

9) Your Height: _____ Your Weight: _____

10) **Please list the healthcare providers (mental and physical) you have seen SINCE you applied for benefits.**

Name of Healthcare Provider #1: _____
Complete mailing address: Street or P.O. Box _____
City: _____State:_____ Zip Code:_____
Telephone Number: _____
Approximate Date you **first** saw this healthcare provider: _____
Approximate Date you **last** saw this healthcare provider: _____
Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____
What was the reason for your last visit to this healthcare provider? _____
_____
What treatment was received? _____

Name of Healthcare Provider #2: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____
Telephone Number: _____
Approximate Date you **first** saw this healthcare provider: _____
Approximate Date you **last** saw this healthcare provider: _____
Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____
What was the reason for your last visit to this healthcare provider? _____
_____
What treatment was received? _____

Name of Healthcare Provider #3: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____
Telephone Number: _____
Approximate Date you **first** saw this healthcare provider: _____
Approximate Date you **last** saw this healthcare provider: _____
Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____
What was the reason for your last visit to this healthcare provider? _____
_____
What treatment was received? _____

If you need more space to list additional Healthcare Providers please use a separate sheet of paper and list the same information that is requested above.

11) **Please list any hospitals where you have been a patient (inpatient or outpatient) SINCE you applied for benefits.**

Name of Hospital #1: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____
Telephone Number: _____

Inpatient Stays: Date admitted: _____ Date released: _____
Reason for Inpatient Stay: _____
Treatment received at Inpatient stay: _____
Outpatient Visits: Dates _____
Reason for Outpatient Visit: _____
Treatment received at Outpatient Visit: _____
Emergency Room Visits: Dates _____
Reason for ER Visit: _____
Treatment received at ER Visit: _____

Name of Hospital #2: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____
Telephone Number: _____
Inpatient Stays: Date admitted: _____ Date released: _____
Reason for Inpatient Stay: _____
Treatment received at Inpatient stay: _____
Outpatient Visits: Dates _____
Reason for Outpatient Visit: _____
Treatment received at Outpatient Visit: _____
Emergency Room Visits: Dates _____
Reason for ER Visit: _____
Treatment received at ER Visit: _____

Name of Hospital #3: _____
Complete mailing address: Street or P.O. Box _____
City: _____State: _____ Zip Code:_____
Telephone Number: _____
Inpatient Stays: Date admitted: _____ Date released: _____
Reason for Inpatient Stay: _____
Treatment received at Inpatient stay: _____
Outpatient Visits: Dates _____
Reason for Outpatient Visit: _____
Treatment received at Outpatient Visit: _____
Emergency Room Visits: Dates _____
Reason for ER Visit: _____
Treatment received at ER Visit: _____

If you need additional space to list more Hospitals please use a separate sheet of paper and list the same information as requested above.

12) **Please list ALL the medications you take (also include any over-the-counter medications). If you need additional space please use a separate sheet of paper.**
Name of Medicine #1: _____
If prescribed, give name of doctor: _____
Reason for Medicine: _____

Side effects you have: _____

Name of Medicine #2: _____
If prescribed, give name of doctor: _____
Reason for Medicine: _____
Side effects you have: _____

Name of Medicine #3: _____
If prescribed, give name of doctor: _____
Reason for Medicine: _____
Side effects you have: _____

Name of Medicine #4: _____
If prescribed, give name of doctor: _____
Reason for Medicine: _____
Side effects you have: _____

13) How many years of education do you have? (High School = 12 years. If you have any college credit, indicate number of years and degree. If you have a GED, please include highest grade you completed before dropping out.)

14) Please name the last school you attended identifying town and state where it is located.

15) Were you in special education classes? Yes or No

16) Have you served in the military? If so, please identify the branch of service and what type of discharge you have.

17) Have you ever been convicted of a felony? If so please state the year and sentence for each offense.

18) Have any of your physicians or counselors suggested you have a problem with drugs or alcohol?

19) Do you have children under the age of 18? If so, list for each

Name	Age	Social Security Number
1.		
2.		
3.		
4.		
5.		

20) What was the city and state of your birth? (Required to communicate with social security)

21) What is your mother's maiden name? (Required to communicate with social security)

22) Have you ever applied for social security benefits *before*? If so, please state the year and whether or not you went to a hearing before a judge.

23) Are you married? Yes or No

If yes, does your spouse work? Yes or No
If yes, does your spouse work full-time or part-time?
If part-time, how many hours per week does your spouse work and at what rate of pay? _____ hours at $ _____/hour.

24) Do you have a pending workers compensation claim? Yes or No

25) **Work History**

Please list every job you have had in the past 15 years. Use more space if you need it.

A. Employer: Job Title:
Years worked: _____/_____/_____ through _____/_____/_____
Job Description:
Amount of weight routinely lifted:
How much time standing:
How much time sitting:

B. Employer: Job Title:
Years worked: _____/_____/_____ through _____/_____/_____
Job Description:
Amount of weight routinely lifted:
How much time standing:
How much time sitting:

C. Employer: Job Title:
Years worked: _____/_____/_____ through _____/_____/_____
Job Description:
Amount of weight routinely lifted:
How much time standing:
How much time sitting:

If you need additional space to list all your employers for the last 15 years please use a separate sheet of paper and list the same information as requested above.

26) Please list 2 people who know your condition(s) other than healthcare providers:

1) Name: Relationship to you:
Address: Phone #:

2) Name Relationship to you:
Address: Phone #:

27) Please list two people (who do not live with you or with each other) who will be able to help us find you, if we lose contact with you:

1) Name Relationship to you:
Address: Phone #:

2) Name Relationship to you:
Address: Phone#:

It is very important that you fill out this form completely!

If you do not know the exact dates of your visits/hospital stays, please at least estimate the month and year. This information is required to complete the application. ***DO NOT*** *get your medical records from your healthcare providers. Social Security will order all records from the information we provide them.*

Thank you.