

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

1.A. SOCIAL SECURITY NUMBER BIC

xxx xx xxxx A

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 93-233.

1.B. TYPE CLAIM [X] DIB [] FZ [] DWB [] CDB [] ESRD [] HIB

1.C. OTHER ENTITLEMENT [] TITLE II [] TITLE XVI IF NEEDED

2.A. NAME OF PAYEE (IF ANY) If needed

3 WE'S NAME (IF CDB or DWB CLAIM)

B. NAME OF DISABLED OR BLIND INDIVIDUAL XXXX X XXXXX

4. DATE OF BIRTH

5. DATE DISABILITY BEGAN

C. ADDRESS xxxX Xxxxxx Xxxx xxxxxxxx xx xxxxx

6. DO ADDRESS xxxX Xxxxx XX xxxxxxx XX xxxxx

7. DO CODE xxx DDS CODE

8. A. [] INITIAL B. [] RECON C. [] RECON DHU D. [] ALJ HEARING E. [] APPEALS COUNCIL F. [] U.S.DISTRICT COURT G. [] REOPENING

9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED: [X] DISABILITY [] IMPAIRMENT SEVERITY (EPE MEDICAL REVIEW ONLY)

Table with columns: A. CONTINUES, B. CEASED, C. PERIOD OF DISABILITY TERMINATED AT THE CLOSE OF THE LAST DAY OF, D. EPE BEGIN MONTH, E. EPE REINSTATEMENT ALLOWED, F. EPE REINSTATEMENT DENIED, G. EPE SUSP. AFTER REINSTATEMENT, H. EPE BENEFIT TERMINATION MONTH. Includes handwritten 'IF NEEDED' and 'OR'.

Table with columns: I. 301 CASE, J. BLINDNESS, (1) CONTINUES, BEGAN, (a) DISABLED FOR CASH PURPOSES, (b) NOT DISABLED FOR CASH BENEFITS PURPOSES SINCE, (2) CEASED, (3) CEASED, OTHER IMPAIRMENT BEGAN. Includes handwritten 'X' marks.

10. BASIS FOR DETERMINATION A. [] MEDICAL/MEDICAL VOC. B. [X] WORK-NO IRWE OR C. [X] WORK-IRWE INVOLVED D. [] OTHER (Explain in item 24.)

11. REASON FOR CESSATION CODE: 12. REASON FOR CONTINUANCE CODE: 30 MEDICAL LIST NO. XXXX

13. [X] CHECK IF ATTACHING A CONTINUATION SHEET. 14. [] CHECK IF VOCATIONAL RULE MET. CITE RULE

15. VOCATIONAL BACKGROUND XX-XX 16. OCC. YEARS X 17. EDUC. YEARS X 18. SPECIAL USE

19. VR ACTION A. [] SC IN B. [] SC OUT C. [] PREV. REF D. [] RE-REF. 20. WHY REVIEW WAS MADE-CODE: 14 or 15

21. PRIMARY DIAGNOSIS BODY SYSTEM XX CODE NO. 0 22. SECONDARY DIAGNOSIS: CODE NO. XXXX 23. DIARY A. TYPE XXX B. MONTH xx YEAR xx C. REASON X

24. REMARKS IStat Blind Noncomparable SGA Stat Blind WK (mm/yy - on OR show each month and year of SGA See DI 41005.001V MULTIPLE IMPAIRMENTS CONSIDERED 24A. COMBINED MULTIPLE NONSEVERE--SEVERE 24B. COMBINED MULTIPLE NONSEVERE--NONSEVERE

25. DISABILITY EXAMINER/CLAIMS REP. 26. DATE 27. PHYSICIAN OR MEDICAL SPEC. SIGNATURE 28. DATE

29. LETTER/PARAGRAPH NUMBER SEE DI 41005.020B.3 30. PHYSICIAN OR MEDICAL SPEC. NAME (STAMP PRINT OR TYPE) 30.A SPEC. CODE

31. SSA REPRESENTATIVE XXXXXXXX X XXXXXXXX 32. SSA CODE XX 33. DATE FORM COMPLETED 10/05/12

34. LIST NUMBER A. B. C. D. E. F. 35. FOLDER SENT TO If external location, see DI 41005.001.Z.5, Internal, leave blank

SEE DI 41501.025B FOR DISABILITY LISTINGS CODES