

Kevin Smith
108 Mulberry St
Inman, S.C. 29349

September 21, 2015

The Honorable Nikki R. Haley
Office of the Governor
1205 Pendleton Street
Columbia, SC 29201

Dear Governor Haley:

My name is Kevin Smith I am 37 years old and I had stroke in May of this year. I am writing because I need help getting my disability claim expedited. The system is flawed. It seems as if the people who need to get help have to wait and the ones who don't need it get help fast. I feel as if I am being penalized for something out of my control. I didn't ask for this stroke or the damage to my heart but I'm being penalized for it. I have not worked since I had my stroke. When I had my stroke I had damage done to my heart also and at this point I do not feel that I can go back to work. It takes a lot out of me just for everyday activities. I have worked since the age of 16 to provide my own way. I'm not used to being this dependent on others. My friends and family have helped me all they can and everybody is going through a hard time and I understand that. I have exhausted contacts given to me by people that have gone through this, the health program, and other services but there's no money left to help. I've contacted companies directly to tell them about my situation and I asked for help or any kind of services they can provide to get me through until my disability is started with no avail. I'm at the end of my rope and at this point I have no other options. I am asking that you would please oversee my case and expedite my disability claim. I have no money coming in and I have depleted all my savings. I am several months behind on my house payment. I worked hard for this house and now they're talking about foreclosure. I've tried speaking to them about the situation and they don't give me many options except for to buy my loan out which means I still lose my house. I have no more money for utilities. Their payments will be due next month and again I can't pay them. I feel as if I'm to the point of losing it all and I have worked so hard to get to where I am today. If I could get my disability started I feel I could catch up on all of these issues and be able to actually maintain my life here. Please help me. I have had to swallow pride so many times in these months to ask for help. I'm not used to asking for help but I have no other option. I am including copies of the paperwork I was required to complete to get the process started. This will contain all information needed to address my situation. I appreciate you taking the time out of your busy schedule to read this letter.

Sincerely

Kevin Smith

A handwritten signature in black ink that reads "Kevin Smith". The signature is written in a cursive, flowing style with a large initial "K" and a stylized "S".



DISABILITY DETERMINATION SERVICES
SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT

Providing quality disability determination services to South Carolinians in a responsive, timely and cost-effective manner.

Barbara G. Hollis, Commissioner

Greenville Regional Office • P.O. Box 3090 • Greenville, SC 29602 • (864) 282-4000
Toll-free: (800) 868-1950 • Medical Information Fax: (866) 868-7952

July 07, 2015

KEVIN JEREMY SMITH
108 MULBERRY ST
INMAN SC 29349

Ref. No: Q26610

Dear KEVIN JEREMY SMITH:

This refers to your application for disability benefits. The Social Security Administration has requested us to help determine if your impairment is severe enough to prevent gainful work. You are required by law to provide necessary information related to your application.

Before we can complete processing of your claim, we need additional information about your vision.

Please complete the enclosed form. Read the instructions carefully and answer all questions to the best of your ability. Please sign or print your name on the last page of the form and return it to this office in the enclosed envelope immediately.

It is very important that you complete the attached form and return it to us in the enclosed envelope within 10 days. If you do not return the form within 10 days, we may decide your case based on the information we already have. This means that we could find that you are not disabled or that your disability has ended if you are already getting benefits. If you have any questions or need help completing this form, please call this office at the above number. If calling long distance, use the toll free 1-800 number.

Sincerely,

A. Cain, Disability Examiner

ACA/458
Claim No: Q26610

Enclosures: Questionnaire
Envelope

cc: BRIAN M RICCI

MADL (4/15, mdp)
DMA: Y
SNO:

TDN: 0098107301

*Paperwork filled out 7/13
mailed 7/13 - put in mailbox
at Inman Post Office on way
home 7/13*

Request sent to:

KEVIN JEREMY SMITH
108 MULBERRY ST
INMAN SC 29349

RE:KEVIN JEREMY SMITH
Ref. No: Q26610

THIS PAGE MUST BE ON TOP OF THE QUESTIONNAIRE

RETURN ***THIS*** COVERSHEET AND THE ENCLOSED FORM.

RETURN RECORDS BY FAX TO SCDDS AT (866) 868-7952

OR

IF RETURNING BY MAIL, FOLLOW DIRECTIONS BELOW
USING THE RETURN ENVELOPE PROVIDED:

MAIL INSTRUCTIONS

Insert this page into the window envelope with the address showing.
THIS PAGE MUST BE ON TOP OF YOUR RESPONSE.

- Mail response to address in box at right.



THIS IS PAGE ONE OF YOUR RESPONSE.

SSA
S87 SC DDS GREENVILLE
P.O. BOX 8706
LONDON, KY 40742-8706



ACA/458
Claim No.: Q26610

RQID:0098107301Q26610 SITE:S87 DR:S
SSN:***** DOCTYPE:0050 RF:D CS:27f4
TDN: 0098107301

DMA: Y
FAXAD (mdp, 7/13)
SNO:

VISION Questionnaire

Name: KEVIN J SMITH
Ref. No: Q26610

Date: July 07, 2015

INSTRUCTIONS: The answers to these questions will help us determine whether your condition is disabling within the meaning to the law. Please print, type, or write clearly. Answer all items to the best of your ability in the space provided. Please give specific examples where possible. If you need more space, use the "Additional Comments" section.

General Questions:

1. When/where was your last eye examination? Did you get new glasses? If no, why not?

lens crafter Laurens Rd Greenville SC prior to 2011 NO glasses
do not wear glasses or contacts

2. What does your vision keep you from doing?

diagnosed since childhood legally blind in my left eye
this condition has not required glasses or contacts and I
have never had restrictions because of vision.

3. Do you manage your own money – write checks and pay bills?

Yes ☒ No

4. Are you able to count change?

Yes ☒ No

5. Is your vision corrected with glasses/lenses?

Yes No ☒

6. Do you drive?

Yes ☒ No

7. Can you use the stove/microwave?

Yes ☒ No

8. Can you read the newspaper/books?

Yes ☒ No

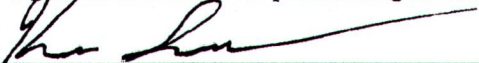
9. Are you able to watch television?

Yes ☒ No

Additional Comments: This section for additional information

I am willing to go to eye doctor if needed.

Signature of claimant or person filing on claimant's behalf (parent, guardian)



Date (Month, Day, Yr)

7.13.15

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)

FOR OFFICE USE ONLY: DO NOT WRITE BELOW THIS LINE.

ACA/458

Claim No: Q26610

VIS01 (6/13, mdp)

DMA: Y

TDN: 0098107301



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July 07, 2015

KEVIN JEREMY SMITH
108 MULBERRY ST
INMAN SC 29349

Ref. No: Q26610

Dear KEVIN JEREMY SMITH:

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Please complete the enclosed form. Read the instructions carefully and answer all questions to the best of your ability. Please sign or print your name on the last page of the form and return it to this office in the enclosed envelope immediately.

It is very important that you complete the attached form and return it to us in the enclosed envelope within 10 days. If you do not return the form within 10 days, we may decide your case based on the information we already have. This means that we could find that you are not disabled or that your disability has ended if you are already getting benefits. If you have any questions or need help completing this form, please call this office at the above number. If calling long distance, use the toll free 1-800 number.

Sincerely,

A. Cain, Disability Examiner

ACA/458
Claim No: Q26610

Enclosure: ADL Questionnaire
Envelope

cc: BRIAN M RICCI

*Filed 7/10/15
mailed 7/10/15*

ML56 (4/15, mdp)
DMA: Y
SNO:

TDN: 0098107139

Privacy Act and Paperwork Reduction Act Statements

Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. We generally use the information you supply for the purpose of making decisions regarding claims. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs. We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT.** If you do not have that address, you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. *Send only comments relating to our time estimate to this address, not the completed form.*

**PLEASE REMOVE THIS SHEET BEFORE RETURNING
THE COMPLETED FORM.**

Request sent to: KEVIN JEREMY SMITH
108 MULBERRY ST
INMAN SC 29349

RE:KEVIN JEREMY SMITH
Ref. No: Q26610

RETURN ***THIS*** COVERSHEET AND THE ENCLOSED FORM IN THE RETURN ENVELOPE.

RETURN RECORDS BY FAX TO SCDDS AT (866) 868-7952
If Faxing Records, Please Fax Both Sides of Double-Sided Forms

OR

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SSA
S87 SC DDS GREENVILLE
P.O. BOX 8706
LONDON, KY 40742-8706

THIS PAGE MUST BE ON TOP OF YOUR RESPONSE.

ACA/458
Claim No.: Q26610
DMA: Y
FAXNB (5/11)
SNO:

TDN: 0098107139

FUNCTION REPORT - ADULT - Form SSA-3373-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

It is important that you tell us about your activities and abilities.

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 8**

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activitiesRQID:0098107139Q26610 SITE:S87 DR:S
SSN:***** DOCTYPE:0075 RF:D CS:81F4For SSA Use Only
Do not write in this box.

Related SSN _____

Number Holder _____

SECTION A - GENERAL INFORMATION

1. NAME OF DISABLED PERSON (First, Middle Initial, Last)

KEVIN JEREMY SMITH

2. SOCIAL SECURITY NUMBER

249-71-6995

3. 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.)

(864) 915-9571
Area Code Phone Number☒ Your Number ☒ Message Number ☐ None

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

☒ House ☐ Apartment ☐ Boarding House ☐ Nursing Home
☐ Shelter ☐ Group Home ☐ Other (What?) _____

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

☒ Alone ☐ With Family ☐ With Friends
☐ Other (Describe relationship.) _____

SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

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

Since stroke I am easily confused, tired, dizzy and have limited function of my right hand. I have back issues that make it difficult to stand or sit for extended periods of time. I am easily exhausted and out of breath, from even walking to the mail box and back. I have heart damage as a result of the stroke. It's hard to keep things straight mentally. I even forgot my dogs name for about an hour one day, and I've had him for 6-7 years. It's hard to function. I am more irritable and easier to anger and easier frustrated.

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

Wake - walk dog, have breakfast, take meds, feed dog, go to shower,
go to appointments if necessary, lunch, small house chores, wash dishes, laundry,
watch tv or play games, shop if needed, run basic errands
have supper maybe out or cook. walk dog again go to bed.

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

☐ No

If "YES," what do you do for them?

walk, feed, bathe, play take to

vet as needed

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 can't do now?

multi task, walk distances and for long periods of time, being around people
handle stressful situations.

11. Do the illnesses, injuries, or conditions affect your sleep?

☒ Yes

☐ No

If "YES," how?

Its harder to go to sleep, and I find myself sleeping
in longer such as till 10-10:30. Before I would wake at latest on weekend,
a 8 am.

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

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

Dress not an issue

Bathe

Care for hair

Shave

Feed self

Use the toilet

Other

- 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? reminders to take meds, make appointments

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

If "YES," what kind of help do you need? set reminders on phone

13. MEALS

- a. Do you prepare your own meals? ☒ Yes ☐ No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.) sandwiches, microwaveable steamed veggies,

snack food veggies, apple sauce, canned items, heat and serve sometimes
grill.

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

daily

How long does it take you? 5-20 mins depending on method

Any changes in cooking habits since the illness, injuries, or conditions began?

yes - NO junk food, have to avoid fast food, on low sodium diet
fix fresh or frozen veggies, cook steaks or nonburger at home

- 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, washing

dishes, sweeping, trash, light dusting NO outside
chores

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

laundry twice week 1-2 hours, dishes once a week 1 hour, sweeping once
week, spread out over a few hours, sit and rest, trash gather 5-10 mins every 3rd day
or so. light dusting week + 2 weeks over an hour or so.

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

If "YES," what help is needed? NO

d. If you don't do house or yard work, explain why not. - I Can not do yard work. I do not have riding mower, and I cant stand or walk long enough to use push mower or leaf blower. Also the heat has been worse on me since the stroke. I get tired and weak faster.

15. GETTING AROUND

a. How often do you go outside? walk dog and get mail daily, go to appts as needed
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. groceries, necessities. Sometimes I go to rent a movie, or out with a friend to window shop.

c. How often do you shop and how long does it take? groceries every other week 2 hours, few mins at rental movies once a week, once a week out with friends at most, couple hours 1-3

17. MONEY

a. Are you able to:

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

Explain all "NO" answers. _____

- 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.)

playing games, watching tv, movies, going to historical places,
taking walks, bowling, playing pool, being around people

- b. How often and how well do you do these things? daily tv, play game video before

stroke would go every weekend / every other weekend to local historic site,
or for walks, go out with friends to places like wild wings, to see
local roads, eat out nightly. I was always going or doing something.

- c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

I don't have the energy to go on long walks or even to my mail box

Some days, I don't have the patience to be around a lot of people
at one time, I'm easily tired out, and frustrated by being tired.

I also don't have any income since being out of work since 5/12/15

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. on phone, text, in person

How often do you do these things?

- b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)

or once-twice a week phone daily, text daily, in person as needed
none other than doctor appointments, physical
therapy

Do you need to be reminded to go places?

☒ Yes

☐ No

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

set reminders in phone and
on calendar.

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.

Always fatigued, limited funds, easily frustrated, because of diet restrictions eating out is limited, mentally fatigued faster, feel dizzy, spacey so driving is limited out of caution

SECTION D - INFORMATION ABOUT ABILITIES

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

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

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far])

lifting less than 20 lbs, squatting bending standing reaching hurt back, walking down drive way around yard chest hurts and is exhausting, stairs rest between flights chest pains, memory concentration, understanding varies day to day based on resting and how fatigued I am. using hands, right hand still weak

b. Are you: ☒ Right Handed? ☐ Left Handed?

c. How far can you walk before needing to stop and rest?

to mail box and back, approx 50ft

If you have to rest, how long before you can resume walking? 5-10 mins

d. For how long can you pay attention?

20-30 mins (may pause movie and do something else then come back to it.)

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, a recipe.)

Good.

g. How well do you follow spoken instructions?

Good

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," please explain. _____

If "YES," please give name of employer. _____

j. How well do you handle stress? before stroke it was fine. I dealt with customers and even was customer relations manager, now I don't handle stress or pressure well. I am easily frustrated.

k. How well do you handle changes in routine? well, I can adjust and go with the flow

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

If "YES," please explain. fear of losing everything, fear of pushing too hard, fear of being alone in life. When frustrated I anger easily, fear of putting family and friends away.

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Brace/Splint | <input type="checkbox"/> Glasses/Contact Lenses |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Artificial Limb | <input type="checkbox"/> Artificial Voice Box |
| <input type="checkbox"/> Other (Explain) _____ | | |

Which of these were prescribed by a doctor? _____

When was it prescribed? _____

When do you need to use these aids? _____

22. Do you currently take any medicines for your illnesses, injuries, or conditions?

☐ Yes

☐ No

If "YES," do any of your medicines cause side effects?

☐ Yes

☒ No

If "YES," please explain. (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE	SIDE EFFECTS YOU HAVE

SECTION E - REMARKS

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

Due to my right hand still being weak my friend filled this out while I told her what to put. This is her information:

Chrystal Nodine

595 Nodine Rd

Campobello SC 29322

cell - 864-313-1591

Chrystal Nodine

Name of person completing this form (Please print)

Kevin J. Smith

Date (month, day, year)

7/15/15

Address (Number and Street)

108 Mulberry St

Email address (optional)

kertoga@yahoo.com

City

Indian

State

SC

Zip Code

29349



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SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT
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July 07, 2015

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INMAN SC 29349

Ref. No: Q26610

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Before we can complete processing of your claim, we need additional information about your work background. Please complete the enclosed form, answering all questions as completely and carefully as possible.

If there is not enough space to describe all of the different kinds of jobs you have had, please use **Section 3 - Remarks** to describe the additional jobs. Please remember to sign this form in the space provided.

It is very important that you complete this form and return it to us in the enclosed envelope within 10 days. **See the attached page for instructions on returning your report to the DDS (Please include that page as the TOP document with your report, with these pages underneath).** If you have any questions or need help completing this form, please call this office at the above number. If calling long distance, use the toll free 1-800-number.

Sincerely,

A. Cain, Disability Examiner

ACA/458
Claim No: Q26610

Enclosure: Vocational Report
Return Envelope

cc: BRIAN M RICCI

TDN: 0098107206

ML31NO (4/15, mdp)
DMA: Y
SNO:

Request sent to: KEVIN JEREMY SMITH
108 MULBERRY ST
INMAN SC 29349

RE:KEVIN JEREMY SMITH
Ref. No: Q26610

RETURN **THIS** COVERSHEET AND THE ENCLOSED FORM IN THE RETURN ENVELOPE.

RETURN RECORDS BY FAX TO SCDDS AT (866) 868-7952
If Faxing Records, Please Fax Both Sides of Double-Sided Forms

OR

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Insert this page into the window envelope with the address showing.
THIS PAGE MUST BE ON TOP OF YOUR RESPONSE.

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SSA
S87 SC DDS GREENVILLE
P.O. BOX 8706
LONDON, KY 40742-8706



ACA/458
Claim No.: Q26610

RQID:0098107206Q26610 SITE:S87 DR:S
SSN:***** DOCTYPE:1080 RF:D CS:5990
TDN: 0098107206

DMA: Y
FAXW (5/11)
SNO:

Form Approved OMB No. 0960-0578

WORK HISTORY REPORT - Form SSA-3369**(3369) Work History Report****Section 1 - Information About The Disabled Person**

A. Name (First, Middle Initial, Last)	B. Social Security Number
Kevin Jeremy Smith	249-71-6995

C. Daytime Telephone Number (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.):

864-915-9571 Primary**None Alternate****Section 2 - Information About Your Work**

A. List all the jobs that you have 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-To)
1. SERVICE ADVISOR	CAR DEALERSHIP	FEBRUARY 2012 - FEBRUARY 2015
2. SERVICE ADVISOR	CAR DEALERSHIP	MARCH 2015 - MAY 2015
3. SERVICE ADVISOR	CAR DEALERSHIP	MAY 1997 - DECEMBER 2010
4. _		-
5. _		-
6. _		-

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

Job Title No. 1:		SERVICE ADVISOR	
Rate of Pay:	\$2,100.00	Per:	Week bi-weekly
Hours Per Day:	8	Days Per Week:	5

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

got info off vehicles, put in computer, printed paperwork, discussed issues with customers, moved cars around lot, took vehicles to tech shop bay, made small repairs in drive thru such as wipers, light bulb replacements, filter ect. Called customers.

In this Job, did you:

Use machines, tools, or equipment? Computers, small tools,

Use technical knowledge or skills? technical svc - had to go to school to maintain service advisor excellence per toyota standards, also use specified programs on computer.

Do any writing, complete reports, or perform duties like this? yes daily writing, computer data entry

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

Walk? 0 constantly moving est. 6 hours

Stand? 0 - constantly

Sit? 0 maybe hour - up and down to enter info in computer, but also could enter

Climb? 0 ~~standing~~ sitting was frowned upon and could be an infraction.

not really any climbing

Stoop? (Bend down and forward at waist): 0 constantly to get info from vehicles also getting in and out of vehicles.

Kneel? (Bend legs to rest on knees): 0 not a lot

Crouch? (Bend legs & back down & forward): 0 some - again to retrieve info.

Crawl? (Move on hands & knees): 0 hardly ever

Handle, grab or grasp big objects? 0 daily - showing parts, replacing small items in drive

Reach? 0 yes daily, again to do small repairs.

Write, type or handle small objects? 0 yes. constantly, daily.

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

Not a lot of lifting or carrying occasionally tires

Heaviest weight you lifted: 50 lbs

Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday.): ~~200 lbs~~ 1-2 lbs

daily, parts mostly

Did you supervise other people in this job? NO

How many people did you supervise? N/A

What part of your time was spent supervising people? N/A

Did you hire and fire employees? NO

Were you a lead worker? NO

Give us more information about Job No. 2. Estimate hours and pay, if you need to.

Job Title No. 2:		SERVICE ADVISOR	
Rate of Pay:	\$1,500.00	Per:	Bi-Weekly
Hours Per Day:	8 9	Days Per Week:	5 6 days

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

*Same as job 1 plus responsible for taking money, making appointments for all advisors, was back up for other advisors due to smaller staff, also was service lube manager which was a separate option for just oil change and small repairs we offered customers result a full service

In this Job, did you: Use machines, tools, or equipment? computers, tablets, small tools

Use technical knowledge or skills? Use different computer programs, had to learn and maintain Nissan standards, and customer service

Do any writing, complete reports, or perform duties like this? yes consistently and daily. writing, data entry on computer, tablet

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

Walk? 0 - Constantly moving est. 6 hrs

Stand? 0 - "

Sit? 0 - maybe 1-2 hours

Climb? 0 not really

Stoop? (Bend down and forward at waist): 0 - Constantly - gathering info, getting in and out of vehicles

Kneel? (Bend legs to rest on knees): 0 - Not a lot

Crouch? (Bend legs & back down & forward): 0 some - again to retrieve info or do small repairs

Crawl? (Move on hands & knees): 0 - hardly ever

Handle, grab or grasp big objects? 0 - some but not often and not daily

Reach? 0 yes, daily to do small repairs

Write, type or handle small objects? 0 - yes, constantly, daily

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

Same as Number 1 - occasional lifting or carrying tires not long distances

Heaviest weight you lifted: few feet.

50 lbs

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

Small parts and tablet

Did you supervise other people in this job? yes

How many people did you supervise? 2

What part of your time was spent supervising people? 60%

Did you hire and fire employees? NO

Were you a lead worker? yes

Give us more information about Job No. 3. Estimate hours and pay, if you need to.

Job Title No. 3:		SERVICE ADVISOR	
Rate of Pay:	\$2,200.00	Per:	Bi-Weekly
Hours Per Day:	8	Days Per Week:	5

6 day twice a month

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.):
 * Same as Job 1 + 2 - (Additional jobs) - used car svc manager, express lib manager, customer relation manager, service ~~manager~~ advisor, in this time period which gave me more duties and responsibilities.

In this Job, did you:

Use machines, tools, or equipment? yes. same as Job 1 and 2 - Computer, small tools

Use technical knowledge or skills? Customer svc relation, handled disgruntled upset customers, also had to maintain knowledge and certifications per Toyota standards, used multiple computer programs.
 Do any writing, complete reports, or perform duties like this? yes, data entry in computer, handled payroll for technicians, spread sheet for used cars.

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

Walk? 0 8 hours - due to being on salary many days were 10 hours or longer

Stand? 0 8 hours

Sit? 0 2 hours

Climb? 0 not really

Stoop? (Bend down and forward at waist): 0 constantly

Kneel? (Bend legs to rest on knees): 0 ~~constantly~~ not a lot

Crouch? (Bend legs & back down & forward): 0 yes constant - to get into, do inspections,

Crawl? (Move on hands & knees): 0 - small repairs.

Handle, grab or grasp big objects? 0 - Not a lot

Handle, grab or grasp big objects? 0 same - showing parts, delivering to techs, doing small repairs

Reach? 0 yes, daily - doing small repairs

Write, type or handle small objects? 0 constantly - taking info, data entry, small repairs, payroll, time cards, sheets, inspections, pulling info from computer

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

small objects, occasionally tires or parts to techs.

Heaviest weight you lifted: 50 lbs

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

small parts for minor repairs,

Did you supervise other people in this job? yes

How many people did you supervise? most at one time 8 techs, specialists, clean up

What part of your time was spent supervising people? 70%

Did you hire and fire employees? no

Were you a lead worker? yes

(3369) Section 3 - Remarks

It's difficult to quantify hours for specific functions, standing sitting ect. I explained to the best of my ability. There was always constant flow of customers and duties that had to be handled in timely manner. For Job 3 example some of my jobs stretched across multiple buildings and locations. I was always moving and dealing with customers and employees. I don't feel as if I can handle this stress or physical demand since my stroke. I am willing to go through any exams or testing or therapies in order to show my current state.

Thank you