

[Date]

Social Security Administration

[Local Office Address]

[City, State, Zip Code]

RE: [Patient Full Name]

Date of Birth: [Patient DOB]

SSN: [Patient Social Security Number]

To Whom It May Concern:

I am writing this letter in my capacity as the Patient Care Coordinator for [Patient Name]. I have been coordinating [Patient Name]'s medical care and treatment plan since [Date].

The patient has been diagnosed with the following medical conditions:

- [Condition 1]
- [Condition 2]
- [Condition 3]

In my role, I monitor the patient's adherence to treatment, manage specialist referrals, and track their functional limitations. Based on clinical observations and medical records, these conditions significantly impact the patient's ability to perform activities of daily living and maintain gainful employment.

Specifically, the patient experiences the following limitations:

- [Detail physical limitations, e.g., inability to stand for more than 15 minutes]
- [Detail cognitive or mental limitations, e.g., severe memory impairment]
- [Detail side effects of medications or frequency of required treatments]

Despite following the prescribed treatment protocols, [Patient Name]'s symptoms persist and are expected to last for a continuous period of at least 12 months. It is my professional opinion that these impairments prevent the patient from sustaining any form of full-time work environment.

If you require further medical records or clarification regarding [Patient Name]'s care coordination, please contact our office at [Phone Number].

Sincerely,

[Signature]

[Printed Name]

Patient Care Coordinator

[Facility/Clinic Name]