

All EDCS 3441 Pages (in the order one sees them in the application.)

Section 1	2
<i>About You</i>	2
<i>Contact Information</i>	2
Section 2	3
<i>About Your Condition</i>	3
Section 3	4
<i>Medical Sources</i>	4
<i>Other Names</i>	5
<i>Doctor/HMO/ Therapist Information</i>	5
<i>Hospital Clinic Information</i>	6
<i>Other Source Information</i>	7
Section 4	7
<i>Medications</i>	7
<i>Medication Information</i>	8
Section 5	9
<i>Tests</i>	9
<i>Test Information</i>	10
<i>Copy Test Info</i>	10
Section 6 & 7	11
<i>Work Activities</i>	11
Section 8	12
<i>Education</i>	12
Section 9	13
<i>Voc Rehab</i>	13
<i>Voc Rehab Info</i>	14
Section 10	15
<i>Remarks</i>	15

Section 1


About You

Disability Case Process 733 03 9006 Richard Jose Omer Windows Internet Explorer

3441 About You - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

Forms

- 3441
- About You
- About Your Condition
- Med Sources
- Medications
- Tests
- Work/Activities
- Education
- Voc Rehab
- 3441 Remarks
- 3367
- Authorized Rep
- Flags/Messages



version 18.0
Build 59
Build Date 01/11/2010 05:04 PM

3441 About You

Identification

Name: Richard Jose Omer
Daytime telephone number: 410-555-1212
Your number: Message number
E-mail address:

Contacts

Hide information from prior level(s)

Prior contacts available for copying:
To copy a contact from a prior level, select the contact below.

The contacts listed below were either added or updated at the level shown.

Level	Name	Phone Number	State
3441	Strel, Georos	410-444-5565	IN

Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help with your claim.
To add a contact, choose Add Contact. To edit, select the contact's name below.

Contact Information

Disability Case Process 733 03 9006 Richard Jose Omer Windows Internet Explorer

Contact Information - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

Contact Information

First name: Middle name: Last name: Suffix:

Relationship to you:

Address Information

Address is: U.S. Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City: State: ZIP Code:

Telephone Information

Telephone number is: U.S. Foreign None

Type: Voice Fax TTY

Daytime telephone number: (999-999-9999) Ext.

Section 2

About Your Condition

3441 About Your Condition - AN: 733-03-9006 DS: N CEF: NYA Open in eView Hide Instructions

3441 About Your Condition

Date of last disability report (MM/DD/YYYY): 11/04/2009

About Your Condition

When you filed your claim you told us that your illnesses, injuries, or conditions included:
Cancer stage 2 Arthritis

*Has there been any change (for better or worse) in your illnesses, injuries, or conditions since you last completed a disability report?
 Yes No Not yet answered

Please describe in detail:
Examples of changes in conditions
blah

Approximate date the change(s) occurred:
If you can't remember the exact dates be as specific as possible
Examples

- June 11, 2002
- October 2000
- Summer 1999

*Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions since you last completed a disability report?
 Yes No Not yet answered

Please describe in detail:
Examples of new limitations

Approximate beginning date:
If you can't remember the exact dates be as specific as possible
Examples

- June 11, 2002
- October 2000
- Summer 1999

*Do you have any new illnesses, injuries, or conditions since you last completed a disability report?
Include

- New impairments that started since you filed your claim
- Impairments you forgot to tell us about when you applied

Yes No Not yet answered

Please describe in detail:
Examples of new conditions

Approximate beginning date:
If you can't remember the exact dates be as specific as possible
Examples

- June 11, 2002
- October 2000
- Summer 1999

Version 18.0
Build 59
Build Date: 01/11/2010 09:04 PM


Section 3

Medical Sources

3441 Medical Sources - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

Forms

- 3441
- About You
- About Your Condition
- Med Sources
- Medications
- Tests
- Work/Activities
- Education
- Voc Rehab
- 3441 Remarks
- 3367
- Authorized Rep
- Flags/Messages



Version: 18.0
Build: 09
Build Date: 01/11/2010 05:04 PM

3441 Medical Sources

Doctors, HMOs, Therapists, Hospitals, Clinics

Since you last completed a disability report, have you seen or will you see a doctor, hospital, clinic, or anyone else for the illnesses, injuries, or conditions that limit your ability to work?
 Yes No Not yet answered

Since you last completed a disability report, have you seen or will you see a doctor, hospital, clinic, or anyone else for emotional or mental problems that limit your ability to work?
 Yes No Not yet answered

Hide information from prior level(s)

Prior medical sources available for copying:
 To copy a medical source from a prior level, select the medical source name below.

The sources listed below were either added or updated at the level shown.

Source Name	Date of Change	Level
Flint Water	09/00	IN

List the medical care providers and each hospital or clinic where you have been seen since you last completed a disability report. Include:

- All types of providers (physicians, psychologists, optometrists, nurse practitioners, therapists, chiropractors, acupuncturists, etc.)
- Places where you had treatments, tests, surgery, or emergency room visits

To add a medical care provider, choose Add Doctor/Hospital/Etc. To edit, select the name below.

Other Names Used

There is no information of this type in prior level(s)

List any other name(s) you may have been using when you received medical treatment for your condition since you last completed a disability report. Include:

- Maiden name
- Previous married name
- Nickname

To add a name, choose Add Other Name. To edit, select the name below.

Other Medical Sources

Since you last completed a disability report, does anyone else have medical records or information about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agencies) or are you scheduled to see anyone else?
 Yes No Not yet answered

There is no information of this type in prior level(s)

List any other people or places that may have your medical information or records since you last completed a disability report.
 To add a medical source, choose Add Other Source. To edit, select the name below.

Other Names

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Other Names Used - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

Other Names Used

Add each name that might appear on your medical records

*First name: |

Middle name:

*Last name:

Suffix: ✓

Doctor/HMO/ Therapist Information

Doctor/HMO/Therapist Information - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

Doctor/HMO/Therapist Information

Name: SINAL COMMUNITY CARE

Attention:

Address: ADMINISTRATIVE OFFICES

Your chart/HMO number, if known:

Dates

If you can't remember the exact dates be as specific as possible

Examples

- June 11, 2002
- October 2000
- Summer 1999

First visit:

Last visit:

Next appointment:

Conditions and Treatments

For what illnesses, injuries, or conditions have you been seeing this doctor?

Examples

- To get my blood monitored
- I had a seizure
- I developed an infection

What treatments did you receive?

Examples

- Physical therapy
- Counseling
- Heat treatments
- Medicines

Hospital/Clinic Information

Hospital/Clinic Information - AN: 733-03-9006 DSI: N CEF: NYA Open in a View [Hide Instructions](#)

Hospital/Clinic Information

Name: UNION MEMORIAL HOSPITAL

Attention:
Address: 201 E UNIVERSITY PKWY RM 103

Your hospital/clinic number, if known:
What doctor(s) do you see at this hospital/clinic on a regular basis?

Conditions and Treatments

Why did you go to the hospital?
Examples

- To get my blood monitored
- I had a seizure
- I fell off a ladder at work

What treatments did you receive?
(For outpatient care, include the location within the hospital if possible.)
Examples

- Physical therapy at the Rehab Clinic
- Blood transfusion
- Surgery
- Chemotherapy at the Oncology Clinic
- Stitches

Dates

Enter dates for all types of visits that apply
If you can't remember the exact dates, be as specific as possible. Dates must include a year.
Examples

- June 11 2002
- October 2000
- Summer 1999

Did you have inpatient stays in this facility? Yes No Not yet answered
If more than three, give the most recent ones.

ICD-9-CM	Date out

Did you have outpatient visits in this facility? Yes No Not yet answered

ICD-9-CM	Date out

Did you have emergency room visits in this facility? Yes No Not yet answered

ICD-9-CM	Date out

When is your next appointment at this facility (if applicable)?

Other Source Information

Other Source Information - AN: 733-83-9006 DSI: N CEF: NYA Open in a View Hide Instructions

Other Source Information

Name: HOME HEALTH CORP OF AMERICA

Attention:
Address: 100A BATEMAN ST
Your case/claim number, if known:

Dates
If you can't remember the exact dates be as specific as possible
Examples

- June 11 2002
- October 2000
- Summer 1999

First visit:
Last visit:
Next appointment:

Reasons for Visits
Why have you been seeing this organization?

Section 4


Medications

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3441 Medications - AN: 733-83-9006 DSI: N CEF: NYA Open in a View Hide Instructions

Forms

- 3441
 - About You
 - About Your Condition
 - Med Sources
 - Medications
 - Tests
 - Work/Activities
 - Education
 - Voc Rehab
 - 441 Remarks
- 3367
- Authorized Rep
- Flags/Messages


Version: 18.0
Build: 85
Build Date: 01/11/2010 05:04 PM

3441 Medications

Do you currently take any prescription or non-prescription medicines for your condition?
 Yes No Not yet answered

Hide information from prior level(s)
Prior medicines available for copying:
To copy a medicine from a prior level, select the medicine below.

The medicine(s) listed below were either added or updated at the level shown.

Acetaminophen	Waher Platt	makes me happy	IN
---------------	-------------	----------------	----

List all prescription and non-prescription medicines that you are currently taking for your condition.

To add a medicine, choose Add Medication. To edit, select the medicine listed below

Medication Information

Medication Information - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

Medication Information

Name of medicine:

Who prescribed this medicine (if prescription)?
Flatt Waite

If the doctor is not in this list choose Add Source to add the doctor

Reason for medicine:
Examples

- Slows down my heart rate
- Regulates my blood sugar
- Stops the pain

makes me happ:

What side effects have you experienced?
Include physical and mental effects and/or allergic reactions that may affect your ability to work
Examples

- Makes me so tired I can't do anything
- Makes me sick to my stomach
- Causes diarrhea

Section 5


Tests

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3441 Tests - AN: 733-03-9006 DSH: N CEF: NYA Open in eViewg Hide Instructions

Forms

- 3441
 - About You
 - About Your Condition
 - Med Sources
 - Medications
 - Tests
 - Work/Activities
 - Education
 - Voc Rehab
 - 3441 Remarks
- 3367
- Authorized Rep
- Flags/Messages



Version 18.0
Build 04
Build Date: 01/15/2010 04:00 PM

3441 Tests

Since you last completed a disability report, have you had any medical tests for illnesses, injuries, or conditions or do you have any such tests scheduled?

Yes No Not yet answered

Hide information from prior levels

Prior tests available for copying:
To copy a test from a prior level, select the test below.

The tests listed below were either added or updated at the level shown.

Test Name	Date	Source	Level
Blood test (Not HIV)	09/09	"No Source"	IN

List all tests that you had or are scheduled to have since you last completed a disability report.
To add a test, choose Add Test. To edit, select the name of the test below.

Bloody (left breast)	December 2009	Flatt Walter	"Unknown"
EKG (Heart test)			

Test Information

Test Information - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

Test information

Name of test:
Description of tests
Biopsy

What part of your body was covered or will be covered by this test?
Examples
• Right knee
• Lower back
This information is required if you select Biopsy MR/CT Scan or X-ray. It may be applicable if you typed another kind of test.
Left breast

When was/will test be done?
If you can't remember the exact dates, be as specific as possible.
Examples
• 10/13/2002
• June 2001
December 2009

Where was this test done or where will it be done?
AMERICAN RADIOLOGY ASSOC PA
If the place is not in the list, choose Add Source

Who sent you for this test?
Flat Water
If the medical care provider is not in the list, choose Add Source

Copy Test Info

Copy Test Info - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

Copy Test info

To copy a test, select the test from the list of available tests below.

EKG (HR&L) (981)	Unknown
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Section 6 & 7

Work Activities

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3441 Work/Activities - AN: 733-03-9006 DSI: N CEF: NYA Open in aView Hide Instructions

- Forms
- 3441
 - About You
 - About Your Condition
 - Med Sources
 - Medications
 - Tests
 - Work/Activities
 - Education
 - Voc Rehab
 - 3441 Remarks
- 3367
- Authorized Rep
- Flags/Messages



Version 18.0
Build 29
Suite Date: 01/11/2010 06:04 PM

3441 Work/Activities

Update Work Information

Have you worked since you last completed a disability report?
If yes, you will be asked to give details on a separate form

Yes No Not yet answered

Information About Your Activities

How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?
Examples of how condition affects ability to care for self

What changes have occurred in your daily activities since you last completed a disability report?
(If none, show None)


Section 8

Education

Disability Case Process 733 01 9006 Harvard, Joe Oliver - Windows Internet Explorer

3441 Education/Training - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

- Forms
- 3441
 - [About You](#)
 - [About Your Condition](#)
 - [Med Sources](#)
 - [Medications](#)
 - [Tests](#)
 - [Work/Activities](#)
 - [Education](#)
 - [Voc Rehab](#)
 - [3441 Remarks](#)
- 3367
- Authorized Rep
- Flags/Messages



Version 18 C
Build 09
Build Date 01-11-2010 02:04 PM

3441 Education/Training

Have you completed any type of special job training, trade or vocational school since you last completed a disability report?
 Yes No Not yet answered

If "Yes", describe what type:
I went to school to learn how to be a bus driver

Approximate date completed: July 2009

Section 9

Voc Rehab

Disability Case Process / 110119006 Richard Love timer - Windows Internet Explorer

3441 Vocational Rehabilitation - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions


Forms

3441

- About You
- About Your Condition
- Med Sources
- Medications
- Tests
- Work/Activities
- Education
- Voc Rehab
- 3441 Remarks

3367

- Authorized Rep
- Flags/Messages



Version: 18.0
Build: 09
Build Date: 01/11/2010 05:04 PM

3441 Vocational Rehabilitation

(Vocational Rehabilitation, Employment Services, Other Support Services, and Individualized Education Programs)

Since you last completed a disability report, have you participated, or are you participating in any program providing vocational rehabilitation, employment services, or other support services to help you go to work or in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support; or
- An individualized education program through an educational institution (if a student age 18-21)?

Yes No Not yet answered

There is no information of this type in prior level(s).

List all plans or programs attended since you last completed a disability report.

To add a plan or program, choose Add a Plan or Program. To edit, select the plan or program name below.

HOLLANDER COUNSELING ASSOC	* No Counselor/Instructor name*
----------------------------	---------------------------------

[Add a Plan or Program](#)

Voc Rehab Info

Vocational Rehabilitation Information - AN: 733-03-9006 DSI: N CEF: NYA Open in eView Hide Instructions

Vocational Rehabilitation Information

Organization/School

Name: HOLLANDER COUNSELING ASSOC

Attention:

Address: SUITE 204B

Dates Seen

If you can't remember the exact dates be as specific as possible

Examples

- June 10 2001
- February 1998
- Summer 1995

When did you first go?

When did you last go?

Types of Services

What kind of services did you receive? What tests or evaluations were performed?

Examples

- Workshops
- Job coaching
- Job placement
- Tuition assistance
- Aptitude testing
- Classes


Section 10

Remarks

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3441 Remarks - AN: 733-03-9006 DSI: N CEF: NYA [Open in eView](#) [Hide Instructions](#)

- Forms
 - 3441
 - About You
 - About Your Condition
 - Med Sources
 - Medications
 - Tests
 - Work/Activities
 - Education
 - Voc Rehab
 - 3441 Remarks
 - 3367
 - Authorized Rep
 - Flags/Messages


Version 18.0
Build 09
Build Date: 01-11-2010 05:04 PM

3441 Remarks

Use this section for any additional information you did not show in earlier parts of this form.