

iClaim-i3368 Marriage (3rd Party): Screen Package 0.2

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Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Preparer's Contact Information

The information collected on this page refers to you, the person helping Kelly Anderson.

Preparer's Name:

John [] Representative --
First Middle Last Suffix

Relationship to Applicant:

Legal Representative or Attorney

Organization Name:

Law Offices of John Representative

Address:

Street Line 1: 123 Charles St
Street Line 2: Suite [Add More Lines](#)

City/Town: Baltimore State/Territory: Maryland ZIP Code: 21043

Daytime Phone Number:

U.S. International
4102861234 []
10-digit Number Ext.


In this section...


- Preparer's Information
- Contact Information
- Re-entry Number

Next

Save & Exit

37.Rcm001-3_Preparer's Contact Information (i3368 only)

| Text Size  | Accessibility Help



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1 ✓ Provide Background Information**2** Provide Disability Information**3** Sign Medical Release**4** Confirmation

Identification Medical Work/Education Remarks Review

Preparer's Contact Information

The information collected on this page refers to you, the person helping Kelly Anderson.

Preparer's Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="--"/>
First	Middle	Last	Suffix

Relationship to Applicant:

Organization Name:

Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/[Territory]:** **ZIP Code:**

Daytime Phone Number:

U.S. International

<input type="text"/>	<input type="text"/>
10-digit Number	Ext.

NextSave & Exit

- In this section...
- Preparer's Information
 - Contact Information
 - Re-entry Number

38.Pin001-3_Contact Information



Apply for Benefits

OMB No. 0000-0000 Paperwork Reduction Act

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Contact Information for Kelly Anderson

Mailing Address:

400 Cathedral Street, Apt 7A, Baltimore, Maryland 21201

Daytime Phone Number:

443 644 6789

Another phone number where we may reach Kelly Anderson:

U.S. International

10-digit Number Ext.

E-mail Address:

KGAnderson@yahoo.com

Confirm E-mail Address:

KGAnderson@yahoo.com

In this section...

- Preparer's Information
- Contact Information
- Re-entry Number

Other Names

Have Kelly Andeson used any other names on medical or educational records?

Examples: Maiden name, other married name, or nickname.

Yes No

1st Other Name:

First Middle Last Suffix

2nd Other Name:

First Middle Last Suffix

3rd Other Name:

First Middle Last Suffix

4th Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

5th Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

Next

Previous

Save & Exit



Apply for Benefits

OMB No. 0000-0000
Paperwork Reduction Act

- 1 Provide Background Information
- 2 Provide Disability Information**
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Contact Information for Kelly Anderson

Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/[Territory]:** **ZIP Code:**

Daytime Phone Number:

10-digit Number [Ext.](#)

Another phone number where we may reach Kelly Anderson:

10-digit Number [Ext.](#)

E-mail Address:

Confirm E-mail Address:

In this section...

- Preparer's Information
- Contact Information
- Re-entry Number

Other Names

Has Kelly Anderson used any other names on medical or educational records?

Examples: Maiden name, other married name, or nickname.

- Yes No

1st Other Name:

First Middle Last Suffix

2nd Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

3rd Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

4th Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

5th Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

Next

Previous

Save & Exit

40.Re-entry Number

| Text Size  | Accessibility Help



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Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification Medical Work/Education Remarks Review

 **You must print this page or write down the re-entry number.**

Re-entry Number: **26748727**

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue Kelly Anderson's saved application process.

If you lose this number, you will need to start a new application. Social Security employees will never ask for Kelly Anderson's re-entry number and they do not have access to it. This is to protect Kelly Anderson's privacy.

In this section...

-  [Preparer's Information](#)
-  [Contact Information](#)
-  [Re-entry Number](#)

 [Print this Page](#)

NextPreviousSave & Exit

41.Re-entry Number (i3368 only)

Text Size | Accessibility Help

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Apply for Benefits

1 Provide Background Information 2 Provide Disability Information 3 Sign Medical Release 4 Confirmation

Identification Medical Work/Education Remarks Review

i You must print this page or write down the re-entry number.

Re-entry Number: **36548727**

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue Kelly Anderson's saved application process.

If you lose this number, you will need to start a new application. Social Security employees will never ask for Kelly Anderson's re-entry number and they do not have access to it. This is to protect Kelly Anderson's privacy.

 [Print this Page](#)

In this section...

- Preparer's Information
- Contact Information
- Re-entry Number

Next Previous Save & Exit

42. Confirm Your Identity On Re-entry (1st party to 3rd party)



Apply for Benefits

Please Confirm Your Identity

I am:

- Kelly Anderson
- Someone else, helping Kelly Anderson to apply for benefits

Is Kelly Anderson with you?

- Yes
- No

Preparer's Contact Information

The information collected on this page refers to you, the person helping Kelly Anderson.

Preparer's Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="--"/>
First	Middle	Last	Suffix

Relationship to Applicant:

Organization Name:

Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town:

State/[Territory]:

ZIP Code:

Daytime Phone Number:


- U.S.
- International

<input type="text"/>	<input type="text"/>
10-digit Number	Ext.

[Next](#)

43. Confirm Your Identity On Re-entry (3rd party to a different 3rd party)

| Text Size ▾ | Accessibility Help



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Apply for Benefits

Please Confirm Your Identity

I am:

- Kelly Anderson
- John Representative, helping Kelly Anderson to apply for benefits
- Someone else, helping Kelly Anderson to apply for benefits

Preparer's Contact Information

The information collected on this page refers to you, the person helping Kelly Anderson.

Preparer's Name:

First Middle Last Suffix

Relationship to Applicant:

Organization Name:

Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/[Territory]:** **ZIP Code:**

Daytime Phone Number:

U.S. International

10-digit Number [Ext.](#)

Next

44.Alg001-3_Conditions



Apply for Benefits

OMB No. 0000-0000 Paperwork Reduction Act

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Conditions for Kelly Anderson

List ALL the Physical or Mental Condition(s) (including emotional or learning problems) that limit her ability to work. (Example: Back Injury, Arthritis, Diabetes, Glaucoma, Depression, Blind) We will consider these conditions whether or not she has been receiving treatment. Use your own words if you do not know the medical names. Please enter **only** one condition per box.

1st Condition:

2nd Condition:

3rd Condition:

4th Condition:

5th Condition:

6th Condition:

7th Condition:

8th Condition:

9th Condition:

10th Condition:

Kelly Anderson has more than 10 conditions that limit her ability to work.

What is her height without shoes?

Feet Inches

- In this section...
- Conditions
 - Other Contact
 - Doctors
 - Hospitals
 - Tests
 - Medicines
 - Other Medical Records

What is her weight without shoes?

lbs

Does her condition cause her pain or other symptoms?

Yes No

Treatment

Has she seen a doctor or other healthcare professional or received treatment at a hospital or clinic or does she have a future appointment scheduled?

For any physical condition(s):

Yes No

For any mental condition(s):

Yes No

Next

Previous

Save & Exit



Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information**
- 3 Sign Medical Release
- 4 Confirmation

- Identification**
- Medical
- Work/Education
- Remarks
- Review

Someone Who Knows About Kelly Anderson's Conditions

Give the name of someone we can contact who knows about her medical conditions and can help her with her claim. This may be a family member or friend who knows about her daily life. Do not include her doctor.

Does Kelly Anderson know someone we can contact about her condition?

- Yes
- No

Name:

First Middle Last Suffix

Relationship to her:

What is the address of this person?

- Same as Kelly Anderson's address: 400 Cathedral St, Apt 7A, Baltimore, MD 21201
- Enter a different address:

Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: State/Territory: ZIP Code:

What is the daytime phone number of this person?

- Same as Kelly Anderson's phone number: 443-644-6789
- Enter a different daytime phone number:

Daytime Phone Number:

U.S. International

10-digit Number Ext.

In this section...

- Conditions
- Other Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

Preferred Language


Can this person speak and understand English?

Yes No

Next

Previous

Save & Exit

| Text Size  | Accessibility Help



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Apply for Benefits

1 Provide Background Information 2 Provide Disability Information 3 Sign Medical Release 4 Confirmation


Identification Medical Work/Education Remarks Review

Someone Who Knows About Kelly Anderson's Conditions

Give the name of someone we can contact who knows about her medical conditions and can help her with her claim. This may be a family member or friend who knows about her daily life. Do not include her doctor.

Does Kelly Anderson know someone we can contact about her condition?

Yes No

 **We recommend that you provide a contact, if available.**

Having the name of someone who knows you may help us make a quicker decision on your claim. Doctors and hospitals may not have a complete picture of how your conditions affect your daily life and your work.

Please select "Yes" above if you want to change your answer.

In this section...

- Conditions
- Other Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

Next

Previous

Save & Exit

46.Doc001-3_Doctors and Healthcare Professionals

Text Size | Accessibility Help



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Apply for Benefits

1 Provide Background Information 2 Provide Disability Information 3 Sign Medical Release 4 Confirmation

Identification Medical Work/Education Remarks Review

Doctors and Other Healthcare Professionals for Kelly Anderson

If she does not have any more **doctors/healthcare professionals** to enter, click the Next button.

- If she was an inpatient or outpatient at a hospital or clinic, do not list staff doctors. We will ask about them later.
- Include only the people who have treated her for the conditions related to her disability.
- Give each person's first and last name if possible.

	Doctors/Healthcare Professionals	City	Phone	Actions
<input checked="" type="checkbox"/>	Dr. Samantha Gupta	Baltimore, MD	(410) 496-9643	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	Dr. Elijah Saunders	Baltimore, MD	(410) 328-4266	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- Conditions
- Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

47.Doc002-3_Doctors and Healthcare Professionals Details



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Apply for Benefits

Doctor/Healthcare Professional Details

Name of Doctor/Healthcare Professional: [? More info](#)

Prefix First Last Suffix

Office Name or Clinic, if applicable:

Doctor/Healthcare Professional's Address:

If you don't have the full street address, give us as much as you can.
 Example: "On Main St next to the Courthouse"

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town:

State/[Territory]:

ZIP Code:

Doctor/Healthcare Professional's Phone Number:

U.S. International

10-digit Number [Ext.](#)

Patient ID Number, if known:

Treatment Dates with this Doctor/Healthcare Professional

Please give us the closest date(s) she can remember. [? More info](#)

First visit:

Last visit:

Next visit:

Leave blank if no appointment scheduled.

Tests Ordered by this Doctor/Healthcare Professional

[? More info](#)

Has this doctor/healthcare professional ordered any tests for her?

This includes any medical tests she has had or will have.

Yes No

Details about Test 1:

Kind of Test:

Date of Test: [? More info](#)

This doctor/healthcare professional ordered this test for her more than once.

Details about Test 2:

Kind of Test:

Date of Test: [? More info](#)

This doctor/healthcare professional ordered this test for her more than once.

If she has more tests, we will ask for them later in the process.

Medicines Recommended or Prescribed by this Doctor/Healthcare Professional

Has this doctor/healthcare professional recommended or prescribed any medicines for her?

Yes No

List any medicines she is taking and the reasons she is taking them.

List only one medicine at a time. Look at the medicine container if necessary.

Medicine 1:

Reason 1:

Medicine 2:

Reason 2:

Medicine 3:

Reason 3:

If she has more medicines, we will ask for them later in the process.

Medical Conditions Treated by this Doctor/Healthcare Professional

What medical conditions were treated or evaluated by this doctor/healthcare professional?

Examples: back injury, arthritis, diabetes, depression, blind. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

Treatment from this Doctor/Healthcare Professional

What treatment did she receive from this doctor/healthcare professional?

You DO NOT need to repeat any information that you have already told us about medicines and tests.
Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

Save

Cancel

48.Hos001-3_Hospitals and Clinics

| Text Size ▼ | Accessibility Help



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Apply for Benefits

1 Provide Background Information2 Provide Disability Information3 Sign Medical Release4 Confirmation

Identification Medical Work/Education Remarks Review

Hospitals and Clinics for Kelly Anderson

If she does not have any more **hospitals/clinics** to enter, click the Next button.

Include all hospitals and clinics where she has been treated for the condition(s) related to her disability.

	Hospitals and Clinics	City	Phone	Actions
<input checked="" type="checkbox"/>	Vancouver General Hospital	Vancouver, BC	(604) 875-4111	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- Conditions
- Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

49.Hos002-3_Hospitals and Clinics Details



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Apply for Benefits

Hospital/Clinic Details

Name of Hospital/Clinic:

Name of Healthcare Professional who treated you, if known:

Address:

If you don't have the full street address, give us as much as you can.
Example: "On Main St next to the Courthouse"

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town:

State/Territory:

ZIP Code:

Hospital/Clinic Phone Number:

U.S. International

10-digit Number [Ext.](#)

Hospital/Clinic Record Number, if known:

Treatment Dates at this Hospital/Clinic

[? More info](#)

Did she have any emergency room (ER) visits at this hospital/clinic?

ER Visit means she went to the ER and then went home.

Yes No

Dates of Emergency Room visits to this hospital/clinic.

Please give the dates of her most recent Emergency Room visits.

Details about Test 2:

Kind of Test:

Date of Test: [? More info](#)

The doctor(s) at this hospital ordered this test for her more than once.

If she has more tests, we will ask for them later in the process.

Medicines Recommended or Prescribed by this Hospital/Clinic

Have any of the doctors at this hospital/clinic recommended or prescribed any medicines for her?

Yes No

List any medicines she is taking and the reasons she is taking them.

List only one medicine at a time. Look at the medicine container if necessary.

Medicine 1:

Reason 1:

Medicine 2:

Reason 2:

Medicine 3:

Reason 3:

If she has more medicines, we will ask for them later in the process.

Medical Conditions Treated by this Hospital/Clinic

What medical conditions were treated or evaluated by this hospital/clinic?

Examples: back injury, arthritis, diabetes, depression, blind. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

Treatment from this Hospital/Clinic

What treatment did she receive for the above at this hospital/clinic?

You DO NOT need to repeat any information that you have already told us about medicines and tests.
Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

Save

Cancel

50.Tst001-3_Medical Tests



Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Medical Tests for Kelly Anderson


If she does not have any more **medical tests** to enter, click the **Next** button.


	Name of the Test	Test ordered by	Actions
<input checked="" type="checkbox"/>	EKG (Heart Test)	Doctor(s) at Vancouver General Hospital	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	X-ray (Body part)	Doctor(s) at Vancouver General Hospital	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

- In this section...
- [Conditions](#)
 - [Contact](#)
 - [Doctors](#)
 - [Hospitals](#)
 - [Tests](#)
 - [Medicines](#)
 - [Other Medical Records](#)

- Next**
- Previous
- Save & Exit

51.Tst002-3_Medical Test Details

| Text Size  | Accessibility Help



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Apply for Benefits

Test Details

Kind of Test:

Date of Test: [? More info](#)

Who sent her or will send her for this test?
If the provider's name is not in the list, select "Other Medical Professional."

This provider ordered this test more than once.



Apply for Benefits

Test Details

Kind of Test:

Date of Test: [? More info](#)

Who sent her or will send her for this test?

If the provider's name is not in the list, select "Other Medical Professional."

Add Doctor/Healthcare Professional

Add Hospital/Clinic

This provider ordered this test more than once.

Save


Cancel

Note: When user selects "Other Medical Professional" in the dropdown for "Who sent you...", the buttons "Add Doctor/Healthcare Professional" and "Add Hospital/Clinic" are displayed on the screen. It is mandatory for the user to select either of the buttons in order to continue.

When user selects either of the buttons, he is taken to Doctor or Hospital details page. Any action on the Doctor or Hospital details page should navigate them to the Tests page (Tst001-3_Medical tests)

52.Med001-3_Medicines

| Text Size ▾ | Accessibility Help



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Apply for Benefits

1 Provide Background Information2 Provide Disability Information3 Sign Medical Release4 Confirmation

Identification Medical Work/Education Remarks Review

Medicines for Kelly Anderson


If she does not have any more **medicines** to enter, click **Next** button. Please make sure to include all the prescription and over the counter medicines that she is taking.


	Name of Medicine	Reason	Prescribed/ Recommended by	Actions
<input checked="" type="checkbox"/>	Metformin	Diabetes	Dr. Samantha Gupta	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	Avandia	Diabetes	Dr. Samantha Gupta	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	Cymbalta	Depression	Dr. Elijah Saunders	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- Conditions
- Other Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

53.Med002-3_Medicine Details

| Text Size  | Accessibility Help



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Apply for Benefits

Medicine Details

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

What is the reason she is taking this medicine?

Who recommended or prescribed this medicine?
If this doctor's name is not in the list, select "Other Medical Professional."



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Apply for Benefits

Medicine Details

Enter name of the medicine:

Enter only one medicine at a time. Look at the medicine container if necessary.

What is the reason she is taking this medicine?

Who recommended or prescribed this medicine?

If this doctor's name is not in the list, select "Other Medical Professional."

Add Doctor/Healthcare Professional

Add Hospital/Clinic

Save

Cancel

Note: When user selects "Other Medical Professional" in the dropdown for "Who recommended...", the buttons "Add Doctor/Healthcare Professional" and "Add Hospital/Clinic" are displayed on the screen. It is mandatory for the user to select either of the buttons in order to continue.

When user selects either of the buttons, he is taken to Doctor or Hospital details page. Any action on the Doctor or Hospital details page should navigate them to the Medicines page (Med001-3_Medicines)

54.Msc001-3_Other Medical Records



Apply for Benefits

- 1 Provide Background Information
2 Provide Disability Information
3 Sign Medical Release
4 Confirmation

- Identification
 Medical
 Work/Education
 Remarks
 Review

Other Medical Records for Kelly Anderson

Although this does not apply to everyone, some people may have relevant Medical records in other places. These other medical records may be available from:

- vocational rehabilitation services
- worker's compensation
- public welfare
- doctors in a prison or jail
- records held by an attorney or lawyer or
- medical records at another place

These other records may contain important information that we need to consider in evaluating the disability application.

Note: You do not need to list any organization that she has already mentioned.

If she does not have any more sources of **other medical records**, please click the **Next** button.

Name of Organization/Office	City	Phone	Actions
No Organization/Office information has been added.			

- In this section...
- Conditions
 - Contact
 - Doctors
 - Hospitals
 - Tests
 - Medicines
 - Other Medical Records

-

55.Msc002-3_Other Medical Record Details



Social Security

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Apply for Benefits

Other Medical Records Details

Name of Place:

Name of Contact:

First

Last

Address:

If you don't have the full street address, give us as much as you can.
Example: "On Main St next to the Courthouse"

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town:

State/[Territory]:

ZIP Code:

Daytime Phone Number:

U.S. International

10-digit Number

Ext.

First visit:

Please give us the closest date she can remember.

Last visit:

Please give us the closest date she can remember.

Next visit:

Leave blank if no appointment scheduled.

Case Number, if any:

Reasons for Visits or Services:

If you need more space, continue in the Remarks tab. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling





Save

Cancel

56.



Apply for Benefits

- 1  Provide Background Information
- 2  Provide Disability Information
- 3  Sign Medical Release
- 4  Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Work Status for Kelly Anderson

In determining whether Kelly Anderson meets the requirements for receiving disability benefits, we must consider her work experience and job skills. [More info](#)

This section of the report asks for information about:

- when her condition(s) began to affect her ability to work;
- her 5 most recent jobs; and
- her education and training.

Please give as much information as you can. We will contact you later if we need more information.

Is Kelly Anderson currently working?

- No, she has never worked
- No, she has stopped working
- Yes, she is currently working

In this section...

- Work Status
- Work Activity
- Job History
- Education

- Next**
- Previous
- Save & Exit

58.Wac001-3-sw_Work Activity



Apply for Benefits

- 1 Provide Background Information
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- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
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- Remarks
- Review

Work Activity for Kelly Anderson

We need to know more about Kelly Anderson's reasons for stopping work and whether she made any changes in her work as a result of her condition(s).

When did she stop working?

If she don't know the exact date, enter the closest date she can remember.

Month Day Year

Why did she stop working?

- Because of her condition
- Because of her condition AND other reasons
- Because of other reasons

Please explain the other reasons why she stopped working.

[More info](#)

Characters remaining: 1000

Even though she stopped for other reasons, when does she believe that her condition(s) became severe enough to keep her from working?

Month Day Year

Did her condition(s) cause her to make changes in her work activity before she stopped working? [More info](#)

- Yes
- No

When did she make changes?

If she don't know the exact date, enter the closest date she can remember.





Month Day Year



In this section...

- Work Status
- Work Activity
- Job History
- Education



Apply for Benefits

- 1  Provide Background Information
- 2  Provide Disability Information
- 3  Sign Medical Release
- 4  Confirmation

-  Identification
-  Medical
- Work/Education
- Remarks
- Review

Work Activity for Kelly Anderson




We need to know if Kelly Anderson made any changes in her work as a result of her condition. If so, this may help show how her ability to work was limited because of a disability. [? More info](#)

Has her condition(s) caused her to make changes to her work activity?


- Yes
- No

When did she make changes?

If she don't know the exact date, enter the closest date she can remember.


--  --  -- 
Month Day Year

In this section...

-  [Work Status](#)
- [Work Activity](#)
- [Job History](#)
- [Education](#)

- Next**
- Previous
- Save & Exit

60.Wac001-3-nw_Work Activity





| Text Size  | Accessibility Help



Social Security

Official Website of the U.S. Social Security Administration

Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification Medical Work/Education Remarks Review

Work Activity for Kelly Anderson

When does Kelly Anderson believe her condition(s) became severe enough to keep her from working (even though she have never worked)?
If she don't know the exact date, enter the closest date she can remember.

Month

Day

Year

[Next](#)[Previous](#)[Save & Exit](#)

In this section...

- [Work Status](#)
- [Work Activity](#)
- [Job History](#)
- [Education](#)

61.Job001-3-sw_Job History



Apply for Benefits

- 1 Provide Background Information
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- Review

Job History for Kelly Anderson

List the jobs (up to 5) that she has had in the past 15 years before she became unable to work because of her physical and/or mental conditions. Start with her most recent job.

Select the number of jobs she has had in the past 15 years before she became unable to work:

In this section...

- Work Status
- Work Activity
- Job History
- Education

Most Recent Job

Job Title:

Type of Business:

Start Date:

<input type="text" value="--"/>	<input type="text" value="--"/>
Month	Year

End Date:

<input type="text" value="--"/>	<input type="text" value="--"/>
Month	Year

Hours per Day:

Days per Week:

Rate of Pay:

\$ <input type="text"/>	<input type="text" value="--"/>
Amount	Frequency

Job Details

Please describe what she lifted, how far she carried things, and how often she was required to do so in her job:

If you need more space use the Remarks tab. (1000 characters maximum)

Characters remaining: 1000

Check Spelling

How heavy were the items she frequently lifted (1/3 to 2/3 of the work day) in this job?

What was the heaviest weight she ever lifted in this job?

Did she supervise other people in this job?

Yes No

How many people did she supervise?

What part of her time did she spend supervising people?

Did she hire and fire employees?

Yes No

Was she a lead worker?

Yes No

Next

Previous

Save & Exit

62.Job 001-3-cw_Job History



Apply for Benefits

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- Identification
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- Remarks
- Review

Job History for Kelly Anderson

Since May 2, 2005, have you had gross earnings greater than \$830 in any month? Do not count sick leave, vacation, or disability pay.

We may contact your for more information.

- Yes
- No

In this section...

- Work Status
- Work Activity
- Job History
- Education

Job Listing

List the jobs (up to 5) that you have had in the past 15 years. Start with your most recent job.

Select the number of jobs you have had in the past 15 years:

Most Recent Job

Job Title:

Type of Business:

Start Date:

Month

Year

End Date:

Month

Year

Hours per Day:

Days per Week:

Did she write, type or handle small objects?

Yes No

How many hours did she write, type or handle small objects?

3 hours

Did she reach?

Yes No

You answered she did not reach.

Please describe what she lifted, how far she carried things, and how often she was required to do so in her job:

If you need more space use the Remarks tab. (1000 characters maximum)

Characters remaining: 1000

Check Spelling

How heavy were the items she frequently lifted (1/3 to 2/3 of the work day) in this job?

What was the heaviest weight she ever lifted in this job?

Did she supervise other people in this job?

Yes No

How many people did she supervise?

What part of her time did she spend supervising people?

Did she hire and fire employees?

Yes No

Was she a lead worker?

Yes No


Next

Previous

Save & Exit

63.Job 001-3-nw_Job History

Text Size | Accessibility Help

 **Social Security**
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Apply for Benefits

1 Provide Background Information 2 Provide Disability Information 3 Sign Medical Release 4 Confirmation

Identification Medical Work/Education Remarks Review

Job History for Kelly Anderson

In an earlier question, you indicated that Kelly Anderson has never worked. If this is incorrect, please

Based upon your previous answer, you do not need to enter information on this page.

In this section...

- Work Status
- Work Activity
- Job History
- Education

64.Edu001-3_Education and Training



Social Security

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Education and Training for Kelly Anderson

Highest Grade Completed:

If Kelly Anderson did not complete the entire school year, select the previous year that she completed.

Date Completed:

Enter the date when she most recently completed a school year as close as she can remember.

Has she completed any type of special job training, trade or vocational school?

- Yes
- No

In this section...

- Work Status
- Work Activity
- Job History
- Education

Special Education

Did Kelly Anderson attend special education classes? [More Info](#)

- Yes
- No

Language

Can Kelly Anderson speak and understand English?

If she cannot speak and understand English, we will provide an interpreter free of charge.

- Yes
- No

Can Kelly Anderson read and understand English?

- Yes
- No

Can Kelly Anderson write more than her name in English?

- Yes
- No

- Next
- Previous
- Save & Exit



Apply for Benefits

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Remarks for Kelly Anderson

Please provide any additional information Kelly Anderson wants to include:

Characters remaining: 2000

In this section...

- Remarks



Apply for Benefits

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Review Information for Kelly Anderson

If you need to make any changes, please select the "Edit" button to return to that page.

Identification

[Edit](#) Personal Information

Personal Information

Name: **Kelly G. Anderson**
 Gender: **Female**
 Mailing Address: **400 Cathedral Street, Apt 7A, Baltimore, MD 21201**
 Daytime Phone: **443 644 6789**
 Extension:
 Alternate Phone: No
 E-Mail Address: **KGAnderson@yahoo.com**
 Other Names Used on Medical or Educational Records: **Yes**
 Other Name 1: **Kelly Gonzales**

[Edit](#) Preparer's Information

Preparer's Information

Preparer's Name: **Tyler Williams**
 Relationship to Julie Public: **Friend**
 Organization Name: --
 Address: **400 Cathedral Street Apt 10A, Baltimore MD 21201**
 Daytime Phone Number: **443-644-5151**
 Extension: --

Medical

[Edit](#) Conditions

List of physical and mental conditions:

- 1: **Type 2 diabetes**
- 2: **Chronic Shortness of Breath**
- 3: **Heart Disease**
- 4: **Depression**
- 5: **Pain**
- 6:

Remarks

[Edit](#)  Remarks

Remarks

Additional information:



You will not be able to change Kelly Anderson's information once you continue to Step 3.

When you select "Accept & Continue" below, you will have completed Step 2. Please make sure that everything you have provided is correct before you continue to Step 3.

[Accept & Continue](#)

[Previous](#)

[Save & Exit](#)