Internet 3368 Screenshots





Prepared By: Lockheed Martin June 25, 2009

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1. Pages

1.1. Welcome

1.1.1. Not From iClaim



Welcome to the Social Security Adult Disability Report

Form Approved: OMB No. xxxx-xxxx Expires xx/xx/xxxx

Thank you for using our online Disability report.

Before you begin...

Before you start this report, you should read Using This Report in order to understand the information and documents that may be needed.

You may also want to review the following related links:

Information About This Internet Report

- Special Instructions For Blind Users
 Other Ways To Complete The Disability Report

Disability Information

- * Social Security's Definition of Disability
- * How the Disability Application Process Works
- * Information about Social Security's Disability Programs

Legal and Official Information

- * Internet Security Policy
- * Website Policies & Other Important Information
- * Social Security Accessibility Policy





We estimate that it will take approximately 90 minutes to read the instructions, gather the facts, and answer the questions, but this will depend on the number of questions you need to answer. For more information about estimates, go to the Paperwork Reduction Act.

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1.1.2. From iClaim



Adult Disability Report

Welcome to the Social Security Adult Disability Report

Form Approved: OMB No. xxxx-xxxx Expires xx/xx/xxxx

Thank you for completing part of your online application for Social Security benefits. If you are applying for disability benefits, we will need additional information about your personal, medical, work, and education history. To protect your privacy, we will ask you to repeat some information you already entered in the form that you already completed.

Before you begin...

Before you start this report, you should read Using this report in order to understand the information and documents that may be needed.

You may also want to review the following related links:

Information About This Internet Report

- * <u>Special Instructions For Blind Users</u> * <u>Other Ways To Complete The Disability Report</u>

Disability Information

- Social Security's Definition of Disability
 How the Disability Application Process Works
- * Information about Social Security's Disability Programs

Legal and Official Information

- * Internet Security Policy

 * Website Policies & Other Important Information
- Social Security Accessibility Policy



We estimate that it will take approximately 90 minutes to read the instructions, gather the facts, and answer the questions, but this will depend on the number of questions you need to answer. For more information about estimates, go to the Paperwork Reduction Act.

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1.2. Reentry

Once a user receives a Reentry Number, the user can log out of the report and come back at a later time. This is the screen the user sees if user goes to the web site that is given when user gets reentry number (on Reentry Number page).



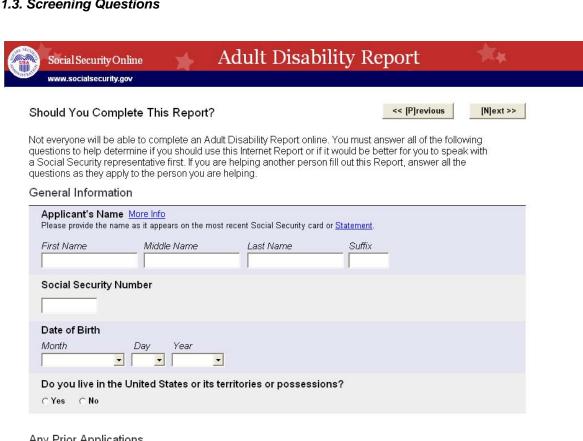
Welcome Back

Enter your Social Security Number and Reentry Number to return to the report.

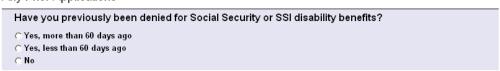
Review <u>Using this Report</u> to understand how to navigate and work with the Disability Report.

Social Security Number		
Reentry Number Beginning with a D, this number was provided to	you when you began your Disab	ility Report. <u>More Info</u>
	Go Back	Continue Report

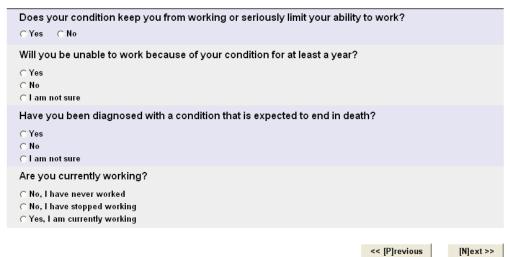
1.3. Screening Questions



Any Prior Applications



Your Condition



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[N]ext >>

1.4. Overview

1.4.1. Not From iClaim



This Disability Report is one step in the disability claim process described below. After you submit this report electronically, we will give you the opportunity to complete the application for Social Security benefits online.

Steps in the Disability Claim Process:

- · Disability Report you provide us with your medical and work history
- . Medical Release Form with Cover Sheet you allow us to get information from your doctors
- . Disability Application you provide us with information regarding your eligibility for payment

Note: Print and review this checklist so you know what information you need to begin the Disability Report.

If you have not already done so, refer to Using This Report to understand how to navigate and work with the Disability Report.



1.4.2. From iClaim



C 1 51 1 1 5 11

This Disability Report is one step in the disability claim process described below. You have already completed the Disability Application.

Steps in the Disability Claim Process:

- . Disability Application you provide us with information regarding your eligibility for payment
- . Disability Report you provide us with your medical and work history
- Medical Release Form with Cover Sheet you allow us to get information from your doctors

Note: Print and review this checklist so you know what information you need to begin the Disability Report.

If you have not already done so, refer to Using This Report to understand how to navigate and work with the Disability Report.



1.5. Report Completer

1.5.1. Completing report for myself

If user selects the first radio button, the next step is to click the Next button

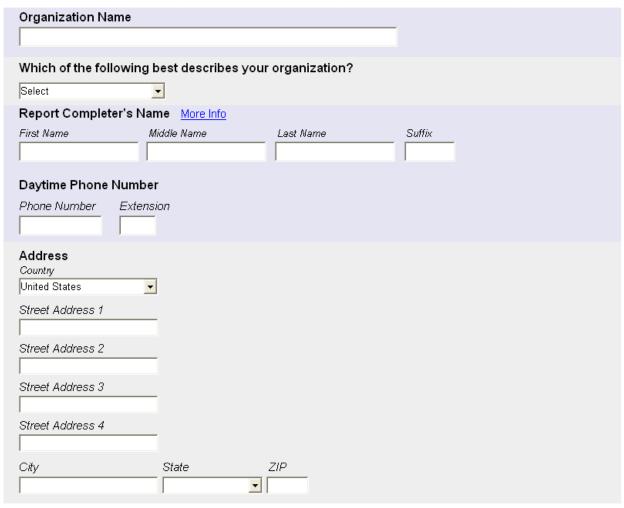


1.5.2. I represent an organization helping someone complete the report

If user selects the second radio button, the following fields appear.

Report Completer Information

The information entered on this page refers to the person completing the report, not the person applying for benefits.



Relationship dropdown options

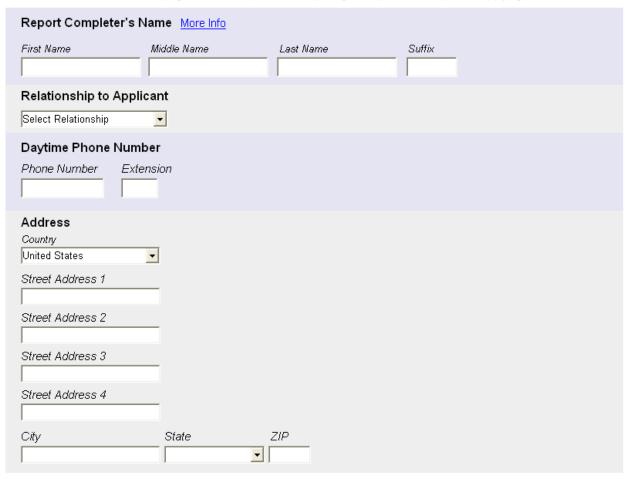
Select
Government Agency
Law Firm/Attorney
Non-attorney Representative
Not-for-Profit Social Agency
Health Services Agency/Hospital
Insurance Company
For Profit Organization
Nursing care facility
Homeless shelter

1.5.3. I am an individual helping someone complete report

If user selects the third radio button, the following fields appear.

Report Completer Information

The information entered on this page refers to the person completing the report, not the person applying for benefits.



Relationship dropdown options:

Select Relationship

Husband or Wife

Father

Mother

Child

Brother

Sister

Other Family Member (e.g. aunt)

Friend

Social Service Agency Worker

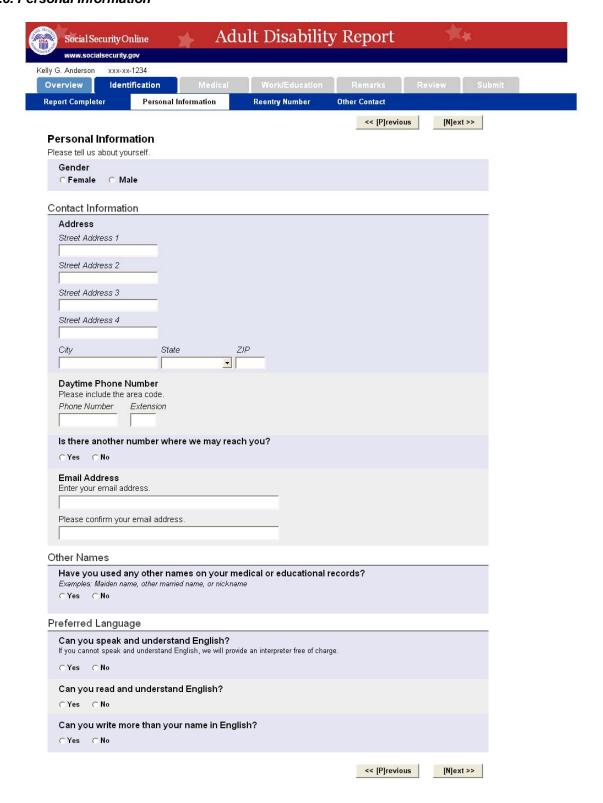
Legal Representative or Attorney

Other

1.5.3.1. If "Other" option is chosen If user selects the "Other" option, the following field appears below the Relationship dropdown.

You selected "Other", please explain:

1.6. Personal Information



1.6.1. If user has another phone number

If user says there is another number where user can be reached, the following fields appear below the question.

Phone Number Extension	Please include the a	area code.		
	Phone Number Extension			

1.6.2. If user has other names

If user says he has other names, the following fields appear below the question.

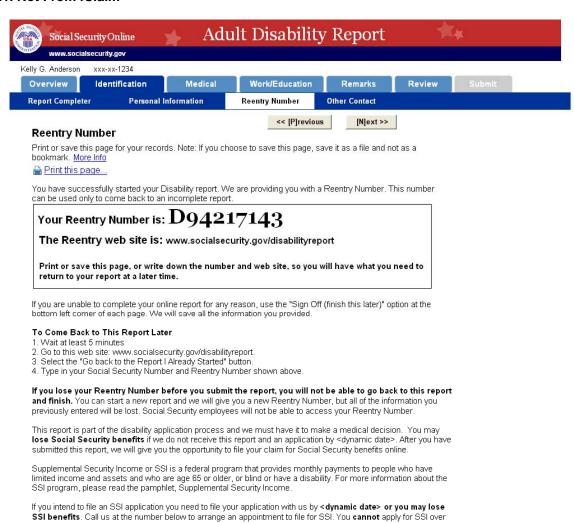
First Name Middle Name Last Name Suffix
1.
First Name Middle Name Last Name Suffix
2.
First Name Middle Name Last Name Suffix
3.

1.6.3. If user prefers another language

user says he prefers another language, the following field appears below the question.	
I prefer this language:	

1.7. Reentry Number

1.7.1. Not From iClaim



If you need assistance, please call us at 1-800-772-1213 (TTY number, 1-800-325-0778. Representatives are

available Monday through Friday from 7 a.m. to 7 p.m.

Print this page...

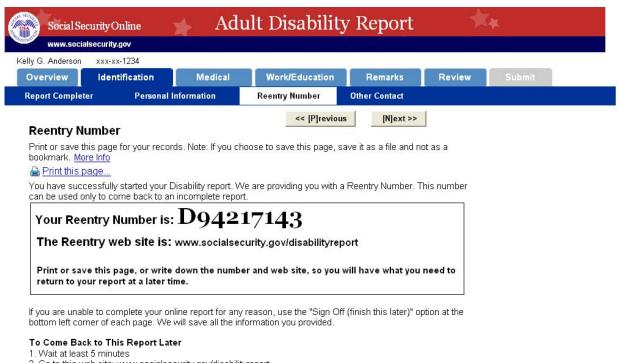
[S]ign Off (finish later)

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<< [P]revious

[N]ext >>

1.7.2. From iClaim



- 2. Go to this web site: www.socialsecurity.gov/disabilityreport.
- 3. Select the "Go back to the Report I Already Started" button.
- 4. Type in your Social Security Number and Reentry Number shown above.

If you lose your Reentry Number before you submit the report, you will not be able to go back to this report and finish. You can start a new report and we will give you a new Reentry Number, but all of the information you previously entered will be lost. Social Security employees will not be able to access your Reentry Number.

Supplemental Security Income or SSI is a federal program that provides monthly payments to people who have limited income and assets and who are age 65 or older, or blind or have a disability. For more information about the SSI program, please read the pamphlet, Supplemental Security Income.

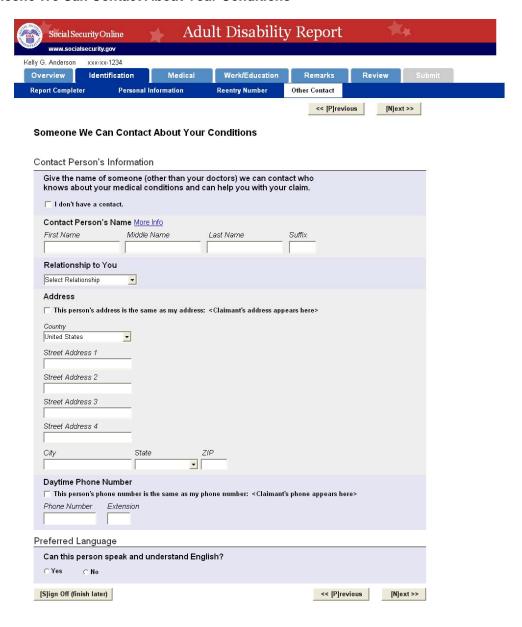
If you intend to file an SSI application you need to file your application with us by < dynamic date> or you may lose SSI benefits. Call us at the number below to arrange an appointment to file for SSI. You cannot apply for SSI over the Internet.

If you need assistance, please call us at 1-800-772-1213 (TTY number, 1-800-325-0778. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.

Print this page		
[S]ign Off (finish later)	<< [P]revious	[N]ext >>

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1.8. Someone We Can Contact About Your Conditions



Relationship dropdown options

Select Relationship

Husband or Wife

Father

Mother

Child

Brother

Sister

Other Family Member (e.g. aunt)

Friend

Social Service Agency Worker

Legal Representative or Attorney

Other

1.8.1. If no other contact checkbox is selected



Please provide a contact person. We may need to talk with someone who knows you and knows about your conditions. Doctors and hospitals may not have a complete picture of how your conditions may affect your daily life and your work.

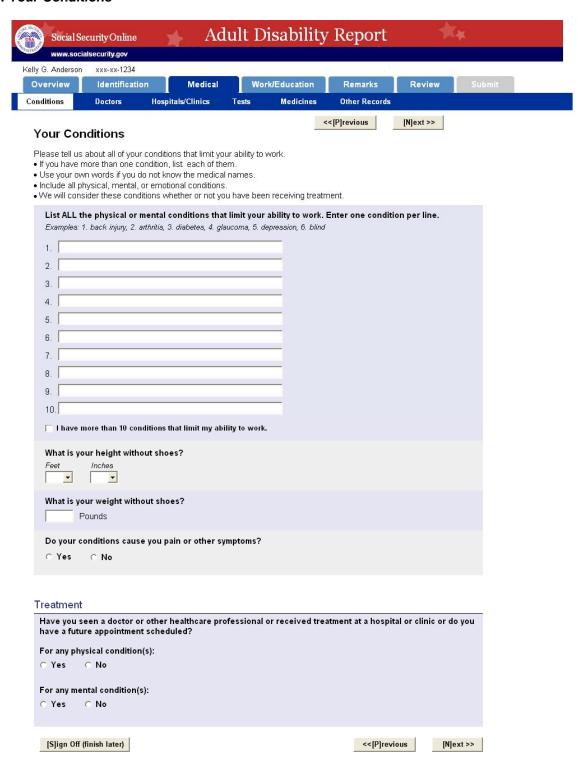
1.8.2. If "other" relationship is selected

1.8.3. If contact person prefers another language

If user prefers another language, the following field appears below the question.



1.9. Your Conditions



1.10. Doctors

This screenshot shows the screen with all the "yes" radio buttons answered to show all the possible entry fields that appear when "yes" is selected.

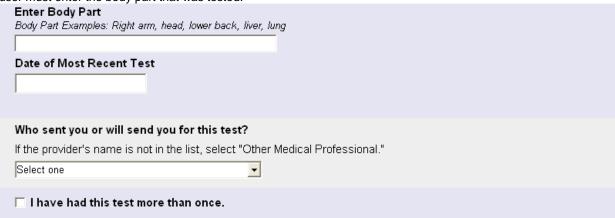
Social Se	curity Online	Ad	ult Disability	Report	* *	
www.socia	lsecurity.gov					
Kelly G. Anderson	ххх-хх-1234					
Overview	Identificatio	n Medical	Work/Education	Remarks	Review	Submit
Conditions	Doctors	Hospitals/Clinics	Tests Medicines	Other Records		
_				<<[P]rev	ious [N]ext >	>>
		Healthcare Prof				
		nesemble of the control of the contr	essionals to enter, click the			
 Include only t 	he people who h		clinic, do not list staff doctor conditions related to your d		out the in fater	
Doctor/Hea	althcare Profes	ssional details			Remove This Doo	etor
	octor/Healthcal First Name	re Professional: More Last Name	Suffix			
Office Nan	ne or Clinic, if a	applicable:				
Address:						
Country:						
United State	es of America 💌					
Street Addr	ress 1					
Street Addr	ress 2					
Street Addr	ress 3					
Street Addr	ress 4					

City	State ZIP Select
	Professional Phone Number: Extension
Patient ID Number,	if known:
Treatment Dates with	h this Doctor/Healthcare Professional <u>More Info</u>
First visit: Last visit: Next visit: Leave blank if no app	
l ests Ordered by this	s Doctor/Healthcare Professional
OYes ○No Please provide inform You will be able to ent	ealthcare professional ordered any tests for you? nation about up to two tests this doctor/healthcare professional ordered for you. ter more tests later.
Kind of Test Select one	
When was this test	most recently done? thcare professional ordered this test for me more than once.

	Kind of Test	
	Select one	
	When was this test most recently done?	
	☐ This doctor/healthcare professional ordered this test for me more than once.	
	This doctormeanticare professional ordered this test for life more than once.	
Me	edicines Recommended or Prescribed by this Doctor/Healthcare Professional	
	Has this doctor/healthcare professional prescribed any medicines for you?	
	⊙Yes ○No	
	List the name of the medicine you are currently taking and the reason why you are taking it.	
	List only one medicine at a time. Look at the medicine container if necessary.	
	You will be able to enter more medicines later.	
	1. Reason:	
	2. Reason:	
	3. Reason:	
	,	
Μa	edical 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.	
	900 character maximum. This is about 18 lines of typing. If you need more space, continue in the Remarks section at the end of this report.	
	If you need more space, continue in the Normania section at the end of this report.	
	w	
	Check Spelling	
	eatment from this Doctor/Healthcare Professional What treatment did you receive for the above conditions from this doctor/healthcare professional?	
	You DO NOT need to enter the information that you have already told us.	
	Examples: physical therapy, chemotherapy, counseling, heat treatments, massage. 1000 characters maximum. This is about 20 lines of typing.	
	If you need more space, continue in the Remarks section at the end of this report.	
	Check Spelling	
I	Sjign Off (finish later)	
13	Spign on funion rater) Done with this Doctor	8

1.10.1. Tests

If user selects a test that requires specifying a body part, an extra field appears named "Enter Body Part" in which the user must enter the body part that was tested.



1.10.2. If user selects "Other" test

User will be asked to describe the test and the body part.

Enter Body Part

Body Part Examples: Right arm, head, lower back, liver, lung
Describe Other
Date of Most Recent Test
Who sent you or will send you for this test?
If the provider's name is not in the list, select "Other Medical Professional."
Select one
□ I have had this test more than once.

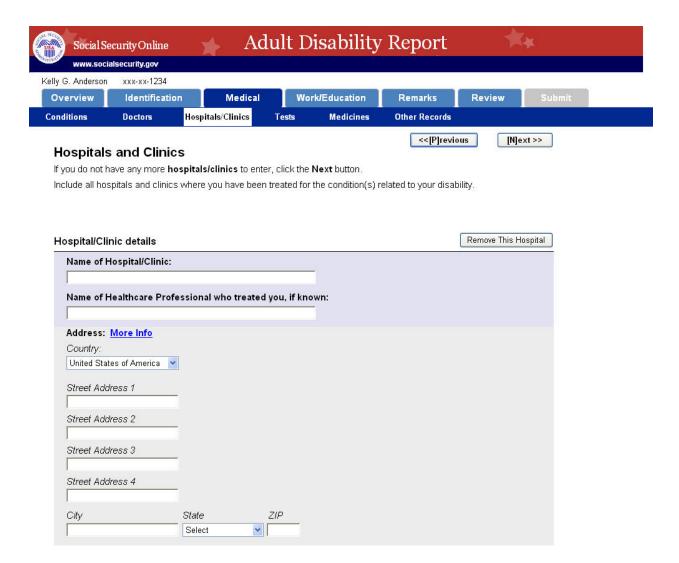
1.10.3. After user selects Done with this Doctor button

A table is shown with the entered data. User can add another doctor by selecting the Add Doctor button below the table.



1.11. Hospitals

This screenshot shows the Hospitals page when all of the radio button questions are answered "yes" to show all the possible entry fields that appear when "yes" is selected.



Phone Number Exte	Nation				
Hospital/Clinic Record	Number (if any):				
reatment Dates at this I	Hospital/Clinic More Info				
	ency room (ER) visit at this hospital/clinic? to the ER and then went home.				
⊙Yes ○No					
Dates of Emergency Ro	oom visits to this Hospital or clinic				
	of three most recent Emergency Room visits you can remember.				
Examples: June 2001; 6/2/0	Examples: June 2001; 6/2/01; June 2, 2001; Dec 2, 2001; summer 2001; 6/??/02, etc.				
	n. This is about 2 lines of typing. continue in the Remarks section at the end of this report.				
	ent stay at this hospital/clinic? have stayed at least one night.				
⊙Yes ○No					
Give us the dates of your	three most recent stays.				
Admission Date 1:	Discharge Date 1:				
Admission Date 2:	Discharge Date 2:				
Admission Date 3:	Discharge Date 3:				





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Medicines Recommended or Prescribed by this Hospital/Clinic Has the doctor(s) from this hospital/clinic ordered any medicines for you? ⊙Yes ○No List the name of the medicine you are currently taking and the reason why you are taking it. List only one medicine at a time. Look at the medicine container if necessary. You will be able to enter more medicines later. 1. Reason: 2. Reason: 3. Reason: 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 900 character maximum. This is about 18 lines of typing If you need more space, continue in the Remarks section at the end of this report. Check Spelling Treatment from this Hospital/Clinic What treatment did you receive for the above conditions at this hospital/clinic? You DO NOT need to enter the information that you have already told us. Examples: physical therapy, chemotherapy, counseling, heat treatments, massage. 1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section at the end of this report. Check Spelling [S]ign Off (finish later) Done with this Hospital

1.11.1. If user selects a test that requires a body part description

Refer to "Tests" section under the Doctors screens

1.11.2. If user selects "Other" test

Refer to "Tests" section under the Doctors screens

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1.11.3. Hospital Table

After clicking the Done with this Hospital button, the user will see a table that lists all the hospitals and clinics that the user has entered so far.



1.12. Tests

[S]ign Off (finish later)

If user did enter tests on the previous pages, the Tests tab will appear with a table listing the information that was previously entered. To add another test to the list, click the Add Test button.



<<[P]revious

[N]ext >>

If a user did not enter tests on the previous pages, the Tests tab will appear like the following screen. Once a user selects Done with this Test button, the user sees the Tests screen with the filled in table.



1.12.1. Test Details

1.12.1.1. Enter Body Part

Refer to "Tests" section under the Doctors screens

1.12.1.2. Other Test

Refer to "Tests" section under the Doctors screens

1.12.1.3. If "Other" doctor sent user for the test

If user selects "other" option under the "Who sent you or will send you for this test" question, user sees the following buttons that allow user to take user back to Doctor or Hospital page and add an additional doctor or hospital that user may have forgotten to enter.

Add Doctor/Healthcare Professional Add Hospital/Clinic

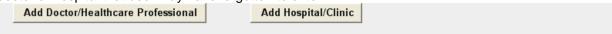
1.13. Medicines

If user did not enter any medicines on previous pages, the Medicines tab looks like this.



1.13.1. If user enters "Other Doctor"

If user selects "other" option under the "Who prescribed or suggested this medicine" question, user sees the following buttons that allow user to take user back to Doctor or Hospital page and add an additional doctor or hospital that user may have forgotten to enter.

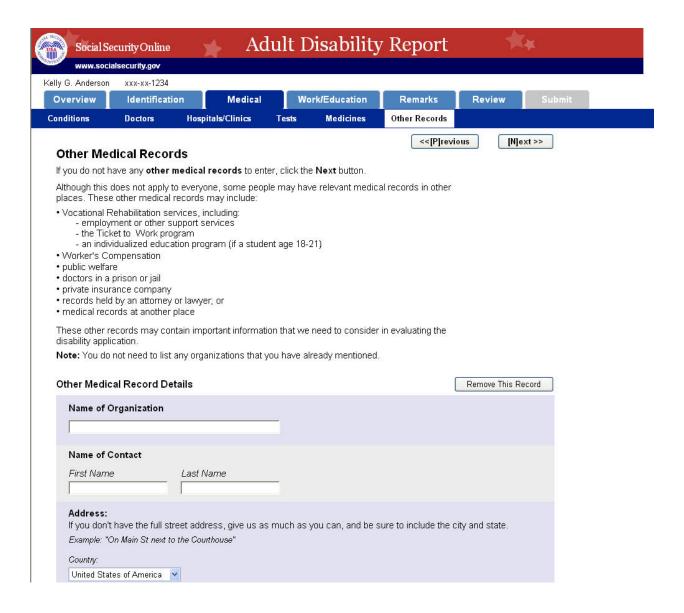


1.13.2. Medicines Table

If user did enter medicines on previous pages, the Medicines tab will appear with a table listing the information that was previously entered. To add another medicine to the list, click the Add Medicine button.

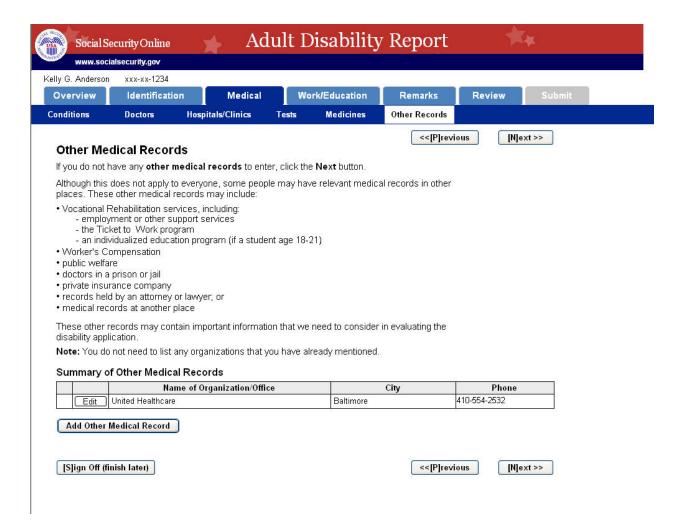


1.14. Other Medical Records



Street Address 1					
Street Address 2					
Officer Address 2					
Street Address 3					
Street Address 4					
City	State	ZIP			
	Select				
Phone Number Be sure to give us the area of	code.				
First Visit: Please give us the closest date you can remember.					
Last Visit: Please give us the closest d	late you can rememb	er.			
Next visit: Leave blank if no appointme	nt scheduled.				
Case Number, if any					
Reasons for Visits or Services 1000 characters maximum. This is about 20 lines of typing. If you need more space, continue in the Remarks section at the end of this report.					
			×		
Check Spelling					
[S]ign Off (fin	ish later)		Done with this Record		

1.14.1. Other Medical Records table



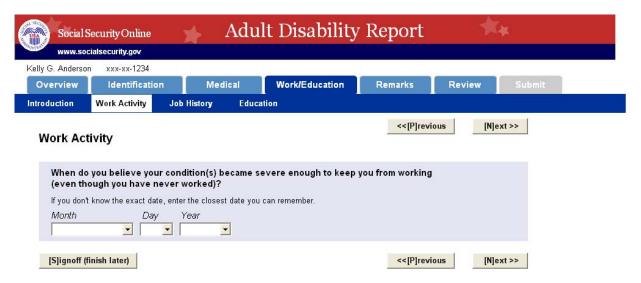
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1.15. Work/Education Introduction



1.16. Work Activity

1.16.1. Work Activity if user never worked



1.16.2. Work Activity if user stopped working



1.16.2.1. Other reasons

If user selects last two radio button options under "Why did you stop working" they will see this:

Please explain why you stopped working.

Examples: I'm a teacher and school was over for the year. By the end of the summer I was too sick to go back to work. I stopped work to raise my children.

900 characters maximum. This is about 18 lines of typing.

If you need more space, continue in the Remarks section at the end of this report.

Check spelling

Even though you stopped for other reasons, when do you believe that your condition(s) became severe enough to keep you from working?

Month

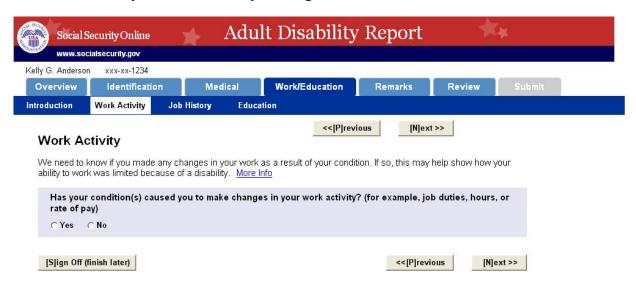
Day Year

1.16.2.2. Changes in work activity

If user says condition caused changes in work activity, user is asked

When did you make changes? If you don't know the exact date, enter the closest date you can remember. Month Day Year T

1.16.3. Work Activity if user is currently working



1.16.3.1. If user says conditions did cause changes to work activity:

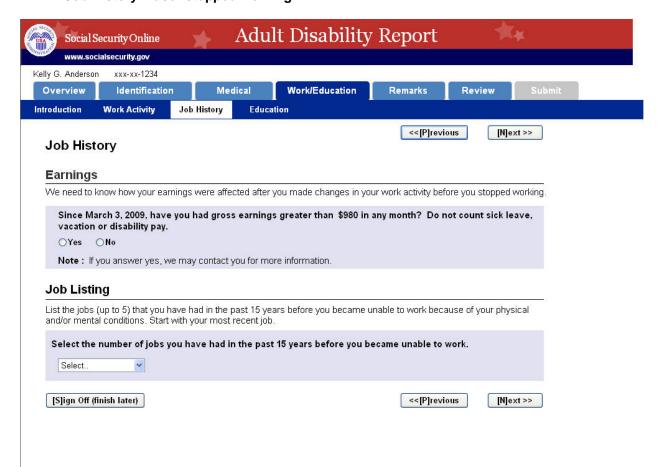
When did you co	ondition(s) f	first start bothering you?
If you don't know the	exact date, en	ter the closest date you can remember.
Month	Day •	Year 🔽
When did you m	ake change	es?
If you don't know the	exact date, en	ter the closest date you can remember.
Month	Day ▼ ▼	Year

1.17. Job History

1.17.1. Job History if user never worked

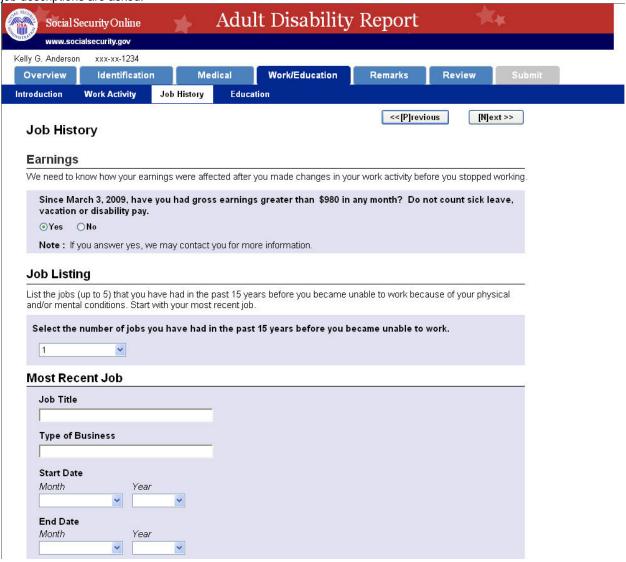


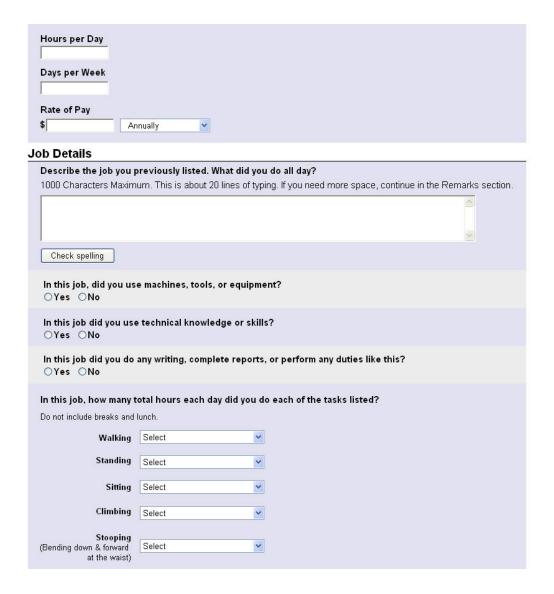
1.17.2. Job History if user stopped working

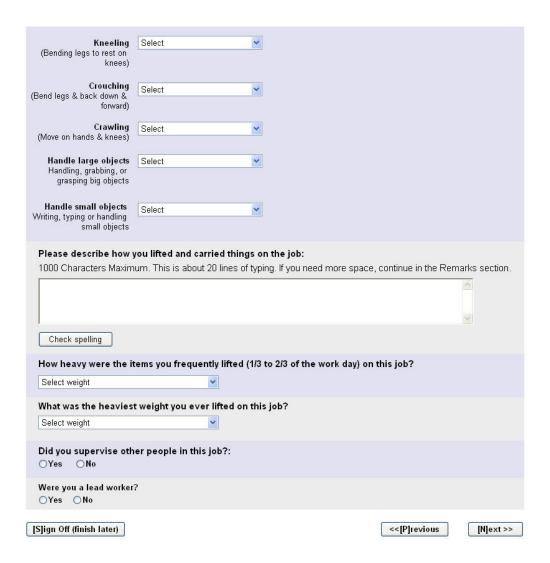


1.17.2.1. User selects 1 job

Only when a user selects one job does the report ask for job details. When other job amounts are selected, only brief job descriptions are asked.







1.17.2.2. If user selected "Other" for weight lifted amounts

Describe 'Other':			
,			

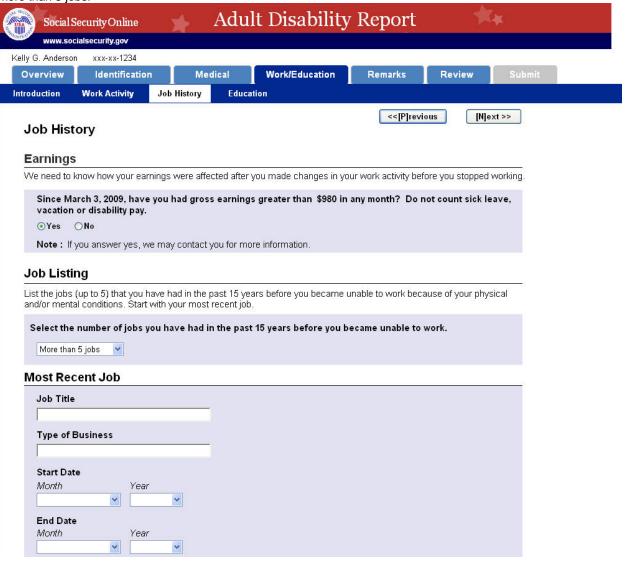
1.17.	2.3. If user Supervised People
Н	low many people did you supervise?
V	Vhat part of your time did you spend supervising people?
D	id you hire and fire employees?
-	Yes C No
	165 (100

1.17.2.4. If user selects 2-5 jobs

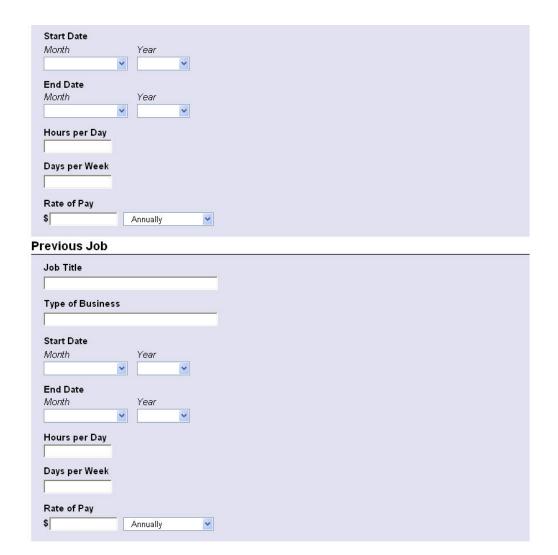
User is asked to enter information based upon the number of jobs selected. If two jobs are selected, two areas appear to enter brief descriptions of those jobs.

1.17.2.5. If a user selects "more than 5" jobs

User sees 5 areas to enter job descriptions as well as a confirmation at the bottom of the screen that user has had more than 5 jobs.



Hours per Day		
Days per Week		
Days per meen		
Rate of Pay		
\$	Annually 💌	
revious Job		
Job Title		
1		
Type of Business		
Start Date		
Month	Year	
·		
End Date Month	Year	
Workii		
St.		
Hours per Day		
Days per Week		
Rate of Pay		
\$	Annually	
revious Job		
TEVIOUS JOD		
Job Title		
Type of Business		
I VDA OT BUSIDASS		



Previous Job Job Title Type of Business Start Date Month Year **End Date** Month Year Hours per Day Days per Week Rate of Pay Annually I acknowledge that I have had more than 5 jobs in the last 15 years before I became unable of work. [S]ign Off (finish later) [N]ext >> <<[P]revious

1.17.3. Job History currently working

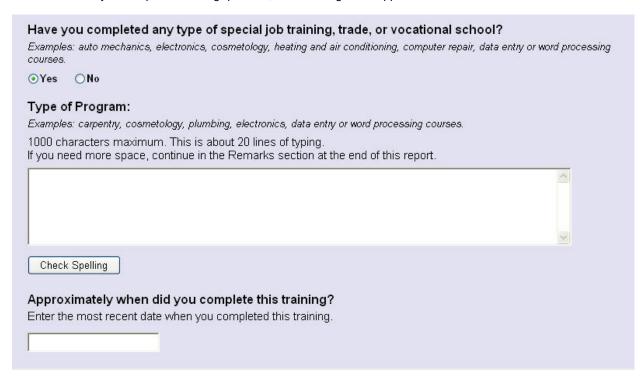
Refer to Job History stopped working for screenshots.

1.18. Education



1.18.1. Special Training

If user answers "yes" to special training question, the following fields appear:

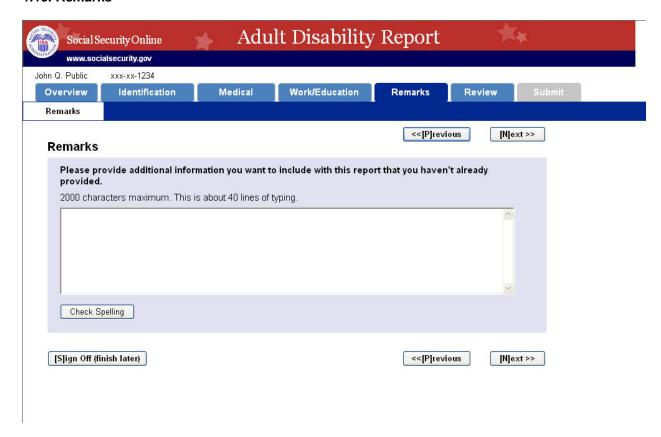


1.18.2. Special Education

If user answers "yes" to special education question, the following fields appear:

Please describe your	Special Education:
School Name:	
City	State, if in USA Select
Country, if not USA	
Dates Attended:	
Enter the dates when you give us approximate date	u attended this school. If you can't remember the exact dates, try to es.
From:	To:
Have you had specia	l education at more than one school?
○ Yes ○ No	

1.19. Remarks

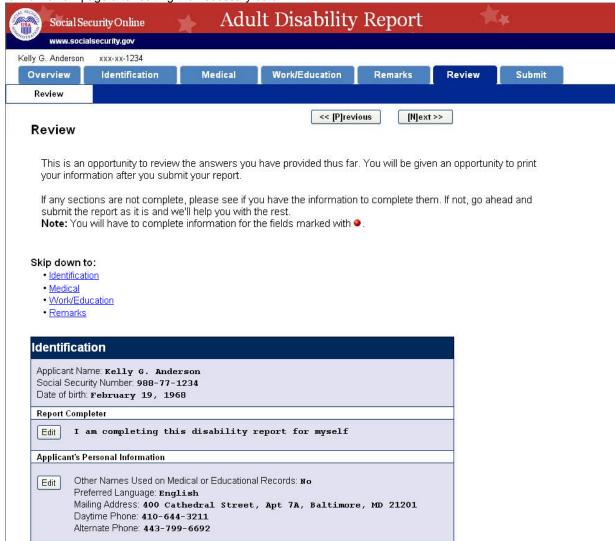


1.20. Review

Reentry Number

Reentry Number#: D94217143

The Review page shows all of the data that a user has entered in the following format. The edit buttons take the user back to the original page on which the user entered the information. If a user does click the Edit button on this page, a "Return to Review" button will appear on the bottom of the page that the user is editing so the user can easily return to the Review page after editing the necessary data.



Other Contact



Name: Chris Anderson

Relationship: Husband or Wife

Mailing Address: 400 Cathedral Street, Apt 7A, Baltimore, MD 21201

Daytime Phone: 866-867-5309 Preferred Language: English

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Medical

Introduction



Seen a healthcare provider or received treatment, or have an appointment scheduled: For physical conditions: Yes

For mental conditions: Yes

Conditions



List of physical and mental conditions:

1 type 2 diabetes

2 heart disease

3: COPD

4: depression

Height without shoes: 5 feet, 8 inches

Weight without shoes: 260 pounds

Doctors and Other Healthcare Professionals



Doctor/Professional #1: Dr. Samantha Gupta

Office Name: Physicians Associate Group

Address: 900 Caton Avenue, Suite 301, Catonsville, MD 21229

Phone: 410-496-9643

Reason for visits: diabetes, heart disease, COPD

Treatments received: blood pressure and breathing monitored

First visit: 1999

Last visit: 03/2009

Next scheduled appointment: None

Edit Doctor/Professional #2: Dr. Elijah Saunders

Address: 2200 Kernan Drive, Room 4611, Baltimore, MD 21207

Phone: **410-328-4266**

Reason for visits: depression, pain management

Treatments received: therapy

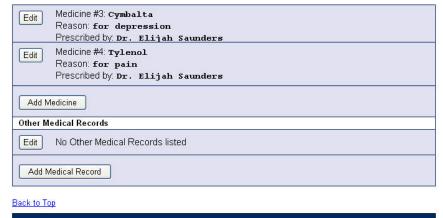
First visit: **11/2008**

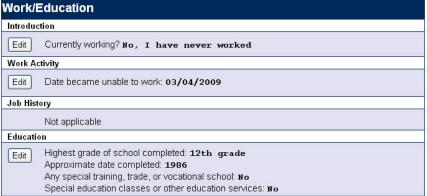
Last visit: 04/2009

Next scheduled appointment: 05/2009

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1.21. Printing Instructions



1.21.1. If user answers yes to printer question

The following text will appear below the question.

Directions

Print or save this page for your records. Note: If you choose to save this page, save it as a file and not as a bookmark. More Info



Your claim for disability benefits is very important to us. Help us start work on your claim as soon as possible by taking all the following steps. Even though this is an online report, there is still paperwork involved. More Info

What You Need To Do Next:

- 1. Print the Cover Sheet.
- **2.** Print, sign, and date the <u>Medical Release Form</u>. You must print and return BOTH pages. (The Medical Release form requires Adobe Reader to open and print it. More Info)
- **3.** Read the <u>instructions</u> for completing the medical release form. Note: All adults are required to sign and date the medical release forms for themselves, even if someone else is helping them with the application process. The only exceptions are when the disabled person has a legal guardian or is deceased.
- **4.** Mail or bring the Cover Sheet and Medical Release Form to your local Social Security office listed below. DO NOT take these forms to your doctor.

Your local Social Security office:

SOCIAL SECURITY ADMINISTRATION 1010 Park Ave Suite 200 Baltimore, MD 21201 (866) 931-9942

You can mail or bring these documents to a different Social Security office if you want. You can use the Office Locator to find another Social Security office.

If you already have copies of any medical records from your doctor, you can send or bring them to us. However, we do not recommend that you delay your case by requesting medical records yourself. We can do this for you.

If you have printing problems:

Please try again. If you still are unable to print, continue on. Contact Social Security at the address and phone number listed above to tell us that you could not print the medical release forms.



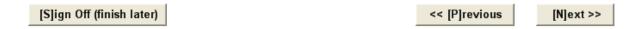
1.21.2. If user answers no

The following text will appear below the question.

Directions

Since you do not have a printer right now, you can do one of the following:

- You may continue on and submit this report. We will then contact you about your submitted information and send you documents to sign OR
- You can Sign Off then log back into this report when you do have access to a printer.
 Note: If you sign off you will need your SSN and Reentry Number, which is **D94217143**, to sign back in to www.socialsecurity.gov/disabilityreport.



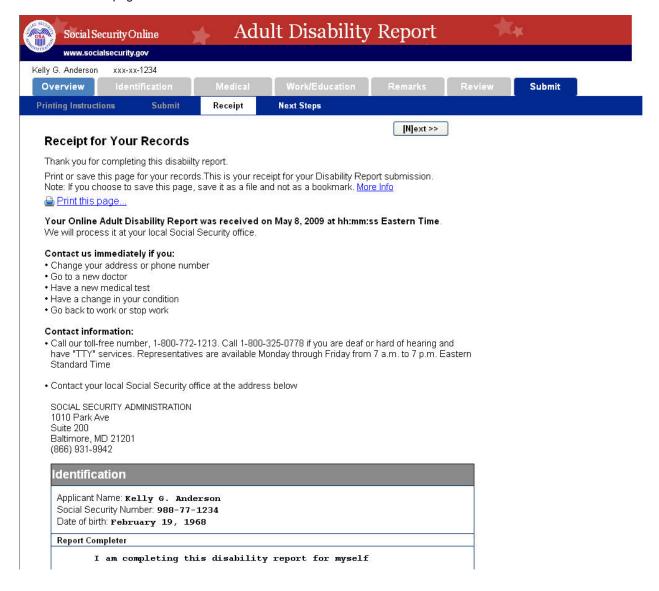
1.22. Submit

There is no Submit button at the top to encourage users to read the page.



1.23. Receipt

This page will be very similar to the Review page. Two exceptions are: the text at the top is only on the Receipt page, and this page is formatted differently for optimal printing. Users will see all the information that they have entered and submitted on this page.



Applicant's Personal Information

Other Names Used on Medical or Educational Records: No

Preferred Language: English

Mailing Address: 400 Cathedral Street, Apt 7A, Baltimore, MD 21201

Daytime Phone: **410-644-3211**Alternate Phone: **443-799-6692**

Other Contact

Name: Chris Anderson

Relationship: Husband or Wife

Mailing Address: 400 Cathedral Street, Apt 7A, Baltimore, MD 21201

Daytime Phone: **866-867-5309** Preferred Language: **English**

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Medical

Introduction

Seen a healthcare provider or received treatment, or have an appointment scheduled: For physical conditions: **Yes**

For mental conditions: Yes

Conditions

List of physical and mental conditions:

- 1 type 2 diabetes
- 2 heart disease
- 3: COPD
- 4: depression

Height without shoes: 5 feet, 8 inches

Weight without shoes: 260 pounds

Doctors and Other Healthcare Professionals

Doctor/Professional #1: Dr. Samantha Gupta

Office Name: Physicians Associate Group

Address: 900 Caton Avenue, Suite 301, Catonsville, MD 21229

Phone: **410-496-9643**

First visit: 1999

Last visit: 03/2009

Next scheduled appointment: None

Tests: None

Medicines: Plavix, Singulair

Reason for visits: diabetes, heart disease, COPD

Treatments received: blood pressure and breathing monitored

Doctor/Professional #2: Dr. Elijah Saunders

Address: 2200 Kernan Drive, Room 4611, Baltimore, MD 21207

Phone: 410-328-4266

Reason for visits: depression, pain management

Treatments received: therapy

First visit: **11/2008** Last visit: **04/2009**

Next scheduled appointment: 05/2009

Hospitals and Clinics

Hospital/Clinic #1: Union Memorial Hospital

Address: 201 East University Parkway, Suite 226, Baltimore, MD 21218

Phone: **410-554-2532** Inpatient Stays: Date In: **03/2009** Date Out: **03/2009**

Outpatient Visits: None

Emergency Room Visits: First visit: 2007 Last Visit: 2008

Reason for visits: heart surgery, couldn't breathe well

Treatments received: surgery

Hospital/Clinic #2: Vancouver General Hospital

Address: 855 West 12th Avenue, Vancouver, Canada V5Z 1M9

Phone: **604-875-4111** Inpatient Stays: **None** Outpatient Visits: **None**

Emergency Room Visits: 10/2008

Reason for visits: thought I was having a heart attack

Treatments received: observation

Tests

Test #1: EKG

Sent for test by: Doctor at Vancouver General Hospital

Date of test: 10/2008

Test #2: x-Ray

Test Description: chest

Sent for test by: Doctor at Vancouver General Hospital

Date of test: 10/2008

Medicines

Medicine #1: ${f Singulair}$

Reason: for breathing

Prescribed by: Dr. Samantha Gupta

Medicine #2: Plavix

Reason: a blood thinner

Prescribed by: Dr. Samantha Gupta

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Medicine #3: Cymbalta
Reason: for depression
Prescribed by: Dr. Elijah Saunders

Medicine #4: Tylenol
Reason: for pain
Prescribed by: Dr. Elijah Saunders

Other Medical Records

No Other Medical Records listed

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Work/Education Introduction Currently working? No, I have never worked Work Activity Date became unable to work: 03/04/2009 Job History Not applicable Education Highest grade of school completed: 12th grade Approximate date completed: 1986 Any special training, trade, or vocational school: No Special education classes or other education services: No

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Print this page...

[N]ext >>

1.24. Next Steps

1.24.1. Not From iClaim



What's Next



The disability report you just completed is one step in the Disability Application Process. You will need to complete the other two steps as well.

- · Complete the Disability Report.
- Sign and send the Medical Release Form with the Cover Sheet. If you do not have a printer, we will send the Medical Release Form and Cover Sheet to you.
- Complete the Disability Application by selecting the Go to Application button at the bottom of this
 page.

We do not start work on your claim until you complete all three of the above steps. For more information about the disability process, go to How the Disability Application Process Works.

If you do not want to file your application online, contact us :

- Call our toll-free number, 1-800-772-1213. If you are deaf or hard of hearing, call our toll-free "TTY" number, 1-800-325-0778. Representatives are available Monday through Friday from 7 a.m. to 7 p.m. Eastern Standard Time, or
- · Contact your local Social Security office at the address below.

SOCIAL SECURITY ADMINISTRATION 1010 Park Ave Suite 200 Baltimore, MD 21201 (866) 931-9942

What to Expect After Completing the Application For Disability Benefits

- It takes about 120 days to process applications for disability benefits. Every claim is different. We may take
 more or less time on your claim.
- · We may contact you for more information while we work on your claim.
- If we need more medical evidence, we may ask you to see a doctor for a special exam. We will pay for this.

Return to Receipt Go to Application

1.24.2. From iClaim



What's Next

The disability report you just completed is part 2 of a 3 step process to apply for disability benefits.

- · According to our records, you have also completed Step 1 and filed an application.
- Please make sure you follow through with Step 3 of this process: Printing, signing and mailing your Medical Release Form with the Cover Sheet. If you do not have a printer, we will send the Medical Release Form and Cover Sheet to you.

We do not start work on your claim until you complete all three of the above steps. For more information about the disability process, go to How the Disability Application Process Works.

To leave this page, select the Finished button at the bottom of this page.

If you have further questions regarding this process and would like to speak with a Social Security Representative:

- Call our toll-free number, 1-800-772-1213. If you are deaf or hard of hearing, call our toll-free "TTY" number, 1-800-325-0778. Representatives are available Monday through Friday from 7 a.m. to 7 p.m. Eastern Standard Time, or
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