

Disability Case Selection

SSA Disability Claims System - Microsoft Internet Explorer provided by IE6.0 sP1>Alpha CI

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Disability Case Selection

[Enable JAWS Mode](#)

Search Criteria

Client SSN:

Client Name. Last: **First:**

Search Results

	Client Name	DSI	CEF	DOB	Estab Date	Level	Claim Type	Office Code	Office Type	Claim Status
<input type="radio"/>	Ovard, Joshua	N	Y	06/01/1983	07/31/2005	Reconsideration	DI	X33	FO	Closed
<input type="radio"/>	Ovard, Joshua Q.	N	Y	06/01/1983	01/15/2005	Initial	DI	C65	FO	Closed

Select Case Level

Select Case Level -- Web Page Dialog

No EDCS case found. Please select the adjudicative level at which you want the case to be established.

Initial Classification:

- Initial
- Reconsideration
- Hearing
- Appeals Council
- Federal Court

MCS Exclusion Claim

CDR Classification:

- CDR Initial
- CDR Reconsideration
- CDR Hearing

OK Cancel


Confirm Case Creation

Confirm Case Creation -- Web Page Dialog X

Client Name: Joshua Ovard
Date of Birth: 06/01/1983

The client's information will be collected as:

An Adult
 A Child
 An Age 18

***Comparison Point Decision (CPD) Date (mm/dd/yyyy):** 

***Have you worked since the CPD date?** Yes No Not Yet Answered

***Are you using a Ticket to Work?** Yes No Not Yet Answered

Do you wish to create a case for this person?

Form Selection

Disability Case Process 999-99-9999 Joshua Ovard - Microsoft Internet Explorer provided by IE6.0 SP1 > AlphaCI

Form(s) Selection - AN: 999-99-9999 CDR CEF: Y CPD CEF: NYA [Open in eView](#) [Hide Instructions](#)

Form(s) Selection

* Form SSA-454-BK Continuing Disability Review Report : Key Paper Not Yet Answered

* Do you have an appointed representative? Yes No Not Yet Answered

Link Folder

Disability Case Process 999-99-9999 Joshua Ovard - Microsoft Internet Explorer provided by IE6.0 SP1 > AlphaCI

Link Folder - AN: 999-99-9999 CDR CEF: Y CPD CEF: NYA [Open in eView](#) [Hide Instructions](#)

Link Folder

Below is the most recent certified electronic folder (CEF) with a favorable disability decision recorded in the electronic folder.

Name: Joshua Ovard
Level: Initial

Claim: DI
Filing date: 01/15/2005
Decision type: Allowance
Decision date: 10/16/2008
Claim number: 999-99-9999

Note: It is possible that not all filings relevant to CDRs were recorded in the Electronic Folder. Some folders were recorded in the Electronic Folder, but were not certified electronic. Some folders do not have allowances recorded.

* Is this the folder that contains the medical evidence for the last favorable disability determination? (If this folder contains an adopted decision, does the folder contain the necessary medical evidence?)

Yes No Not Yet Answered

CDR Information, Part 1 of 2

User has indicated claimant used other names, but has not entered any

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CDR Information

Client Identification

Name: Joshua Ovard
Date of birth: 06/01/1983
Mailing address: 608 W. 100 STREET
PROVO, UT 84601
Residence address: 608 W. 100 STREET
PROVO, UT 84601
Daytime telephone number: 801-377-1373

Please enter an alternate phone number or a phone number where a message can be left, if available.

Alternate Telephone Number is: U.S. Foreign None
Alternate telephone number:

Other Names Used

Have you used any other names on your medical or educational records in the last 12 months?
Examples are maiden name, other married name, or nickname.
 Yes No Not Yet Answered

CDR Information, Part 2 of 2

Other Names = Yes, but no other names entered

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Yes No Not Yet Answered

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

Other Names

Add

Your Language Information

Can you speak and understand English? Yes No Not Yet Answered

Case Information

* CDR type: []

* Comparison Point Decision (CPD) date (MM/DD/YYYY): 10/16/2008

Is DDS capability development needed? Yes No Not Yet Answered

Contact Information


* CR unit code: 123

* First name: Claims * Last name: Representative

* Telephone number: 801-377-1234 Ext. 5678

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Other Names Used

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Other Names Used [Open in eView](#) [Hide Instructions](#)

Add each name that might appear on your medical or educational records.

* **First name:**

Middle name:

* **Last name:**

Suffix

CDR Information, Part 2 of 2

Other Names = Yes, with another name entered

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Other Names Used

Have you used any other names on your medical or educational records in the last 12 months?
Examples are maiden name, other married name, or nickname.

Yes No Not Yet Answered

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

Other Names

[Ovard, Josh](#)

Your Language Information

Can you speak and understand English? Yes No Not Yet Answered

Case Information

* CDR type:

* Comparison Point Decision (CPD) date (MM/DD/YYYY):

Is DDS capability development needed? Yes No Not Yet Answered

| |

CDR Representatives

Appointed Representative = No

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CDR Representatives

Representative Payee Information

This following table displays all representative payee information found on the MBR/SSR. If more than one is listed, delete all except the correct payee prior to transfer.

To add a representative payee, choose Add Rep Payee. To edit or delete, select the representative payee's name below.

Name	Address	Claim Type

Appointed Representative Information

Does this person have an appointed representative?

Yes No Not Yet Answered

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CDR Representatives, Part 1 of 2

Appointed Representative = Yes

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CDR Representatives

Representative Payee Information

This following table displays all representative payee information found on the MBR/SSR. If more than one is listed, delete all except the correct payee prior to transfer.

To add a representative payee, choose Add Rep Payee. To edit or delete, select the representative payee's name below.

Name	Address	Claim Type

Appointed Representative Information

Does this person have an appointed representative?

Yes No Not Yet Answered

*First name: Middle name: *Last name: Suffix:

Appointed Representative Address Information

| | |

CDR Representatives, Part 2 of 2

Appointed Representative = Yes

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Appointed Representative Information

Does this person have an appointed representative?
 Yes No Not Yet Answered

*First name: Middle name: *Last name: Suffix:

Appointed Representative 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:

Appointed Representative Telephone Information

Telephone Number is: U.S. Foreign None
Type: Voice Fax TTY
Daytime telephone number: (999-999-9999) Ext:

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CDR Claims

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CDR Claims

Select a claim type to view CDR claim information:

Claim Type	Claim Number	BIC
CDBR	999-99-9991	C1
DI	999-99-9992	

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Contacts, Part 1 of 3

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Alternate Contact Information

Is there someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your case?

Yes No Not Yet Answered

Name of Alternate Contact

First name: Middle Name: Last name: Suffix:

Relationship to Disabled Person:

Address for Alternate Contact

Mailing address is: U.S. Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

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Contacts, Part 2 of 3

Person Completing Report = Claimant

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Street address line 4:

City: State: -- Zip Code:

Telephone for Alternate Contact

Please enter an alternate phone number or a phone number where a message can be left, if available.

Telephone Number is: U.S. Foreign None

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

Preferred Language of Alternate Contact

Can this person speak and understand English? Yes No Not Yet Answered

Person Completing the Report

Who is providing information?

- Joshua Ovard
- Alternate Contact listed above
- Someone else

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Contacts, Part 3 of 3

Person Completing Report = Someone Else

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Someone else

*First name: Middle Name: *Last name: Suffix:

Relationship to Disabled Person:

Address for Person Completing This Report

Mailing 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 for Person Completing This Report

Telephone Number is: U.S. Foreign None

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

Medical Conditions, Part 1 of 2

Medical Conditions Propagated from mainframe, no new conditions entered

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454 Medical Conditions

Physical and Mental Conditions

* List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

Enter one condition **on each line**. You will be given additional lines as needed.

1.

2.

Height and Weight

What is your height without shoes? feet: inches:

What is your weight without shoes? pounds:

Assistive Devices

Do you use an assistive device?

[Examples](#)

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Medical Conditions, Part 2 of 2

Medical Conditions Propagated from mainframe, no new conditions entered

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*** List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.**
Enter one condition **on each line**. You will be given additional lines as needed.

1.

2.

Height and Weight

What is your height without shoes? feet: inches:

What is your weight without shoes? pounds:

Assistive Devices

Do you use an assistive device?
[Examples](#)

Always Sometimes Never Not Yet Answered

| | |

Medical Conditions, Part 1 of 2

Medical Conditions Propagated from mainframe, plus one new conditions entered
User has indicated claimant uses an assistive device

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454 Medical Conditions

Physical and Mental Conditions

* List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

Enter one condition on each line. You will be given additional lines as needed.

1.

2.

3.

Height and Weight

What is your height without shoes? feet: inches:

What is your weight without shoes? pounds:

Assistive Devices

Do you use an assistive device?

| | |

Medical Conditions, Part 2 of 2

Medical Conditions Propagated from mainframe, plus one new conditions entered
User has indicated claimant uses an assistive device

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Height and Weight

What is your height without shoes? feet: inches:

What is your weight without shoes? pounds:

Assistive Devices

Do you use an assistive device?

[Examples](#)

Always Sometimes Never Not Yet Answered

Please describe what kind, when, and how you use it.

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Medical Sources

Initial view

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454 Medical Sources

Doctors, Therapists, Hospital, Clinics

Within the last 12 months, have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:

* For any **physical** condition(s)

Yes No Not Yet Answered

* For any **mental** condition(s) (including emotional or learning problems)

Yes No Not Yet Answered

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Medical Sources

User has indicated claimant has medical sources, but has not entered any

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454 Medical Sources

Doctors, Therapists, Hospital, Clinics

Within the last 12 months, have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:

* For any **physical** condition(s)
 Yes No Not Yet Answered

* For any **mental** condition(s) (including emotional or learning problems)
 Yes No Not Yet Answered

Tell us who may have medical records covering **the last 12 months** about any of your **physical or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities.




Tell us about your **next appointment**, if you have one scheduled.

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

Name	Address

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Doctor/Therapist Information, Part 1 of 2

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Doctor/Therapist Information Source to Merge

Name: [John McKell](#)

Attention:

Address: 147 West 400 North

Patient ID# (if known):

Dates

First visit:

Last visit:

Next appointment:

Conditions and Treatments

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions?

Doctor/Therapist Information, Part 2 of 2

Tests

List any tests **this provider** performed or sent you to **within the last 12 months**, or scheduled you to take in the future.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By

Add Test

Medicines

List all medicines you are now taking, or have you taken **in the last 12 months**, prescribed or suggested **by this provider**.

To add a medicine, choose Add Medicine. To edit, select the name of the medicine below.

Medicine	Prescribed By	Reason

Add Medicine

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add a condition, choose Add Condition. To edit, select the name of the condition below.

Name
Fatigue, Fibromyalgia
Migraines

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

Help

Medical Sources

User has indicated claimant has medical sources and entered a doctor

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454 Medical Sources

Doctors, Therapists, Hospital, Clinics

Within the last 12 months, have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:

* For any **physical** condition(s)

Yes No Not Yet Answered

* For any **mental** condition(s) (including emotional or learning problems)

Yes No Not Yet Answered

Tell us who may have medical records covering **the last 12 months** about any of your **physical or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities.

Tell us about your **next appointment**, if you have one scheduled.

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

Name	Address
Dr. John McKell	147 West 400 North

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Hospital/Clinic Information, Part 1 of 3

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Hospital/Clinic Information

Name of facility or office: [Utah General Hospital](#)

Attention:

Address: 6701 Main Street

Health care professional who treated you at Utah General Hospital:

Patient ID# (if known):

Dates at this Facility

Did you have any inpatient stays? Yes No Not Yet Answered

Date In:	<input type="text"/>	Date Out:	<input type="text"/>
Date In:	<input type="text"/>	Date Out:	<input type="text"/>
Date In:	<input type="text"/>	Date Out:	<input type="text"/>

Did you have any outpatient visits? Yes No Not Yet Answered

First visit:

Last visit:

Next appointment:

Add Hospital/Clinic, Part 2 of 3

Did you have any emergency room visits?



Yes



No



Not Yet Answered

Date of visit:

Date of visit:

Date of visit:

Conditions and Treatments

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions?

Tests

List any tests **this provider** performed or sent you to **within the last 12 months**, or scheduled you to take in the future.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By

Add Test

Add Hospital/Clinic, Part 3 of 3

Medicines

List any prescription or non-prescription medicines you are now taking, or have you taken **in the last 12 months**, prescribed or suggested by **this provider**.

To add a medicine, choose Add Medicine. To edit, select the name of the medicine below.

Medicine	Prescribed By	Reason

Add Medicine

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add a condition, choose Add Condition. To edit, select the name of the condition below.

Name
Fatigue, Fibromyalgia
Migraines

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

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Tests Summary

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454 Tests Summary

Have you had any medical tests in the last 12 months, or do you have any tests scheduled for your condition?

Yes No Not Yet Answered

List all tests that you had or will have for your condition.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By
X-Ray	12/16/2008	Dr. John McKell

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Test Information

No body part involved or other explanation needed

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Test Information [Open in eView](#) [Hide Instructions](#)

***Name of Test:**

Date of Test:

Provider who performed, sent you to, or scheduled you to take this test.
If you need to add a medical source, you must return to MED SOURCES.

Physical and Mental Conditions




List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines

Test Information

Body part involved

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Test Information [Open in eView](#) [Hide Instructions](#)

*Name of Test:

What part of your body was covered or will be covered by this test?

Date of Test:

Provider who performed, sent you to, or scheduled you to take this test.
If you need to add a medical source, you must return to MED SOURCES.

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines

Physical and Mental Condition Information – Plan A

Claimant adds physical or mental condition while adding test

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Physical and Mental Condition Information [Open in eView](#) [Hide Instructions](#)

Enter one condition on each line. You will be given additional lines as needed.

1.

2.

3.

Physical and Mental Condition Information – Plan B

Claimant adds physical or mental condition while adding test

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Physical and Mental Condition Information [Open in eView](#) [Hide Instructions](#)

***Enter a physical and/or mental condition (including emotional or learning problems) that limits your ability to work.**

Check Spelling

Medicines Summary

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454 Medicines Summary

Are you now taking, or have you taken in the last 12 months, any prescription or non-prescription medicines?

Yes No Not Yet Answered

List all prescription and non-prescription medicines that you take for your condition.

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

Medicine	Prescribed By	Reason
Ambien	Dr. John McKell	Insomnia

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Medicine Information

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Medicine Information [Open in eView](#) [Hide Instructions](#)

***Name of Medicine:**

Who prescribed this medicine (if prescription):
If you need to add a medical source, you must return to MED SOURCES.

Reason for medicine:
Examples:
• Slows down my heart rate
• Regulates my blood sugar
• Stops the pain

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

Other Medical Information

Initial View

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454 Other Medical Information

Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems) covering the last 12 months, or are you scheduled to see anyone else?

Examples:

- Workers' Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency

Yes No Not Yet Answered

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Other Medical Information

User has indicated claimant has other medical source, but has not entered any

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454 Other Medical Information

Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems) covering the last 12 months, or are you scheduled to see anyone else?

Examples:

- Workers' Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency

Yes No Not Yet Answered

To add a medical source, choose Add Another. To edit, select the name below.

Name	Address

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Other Medical Information

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Other Medical Information [Open in eView](#) [Hide Instructions](#)

Name:
Attn:
Address:

Claim or ID Number, if any:

Dates

Date of first contact, in last 12 months:

Date of last contact:

Date of next contact, if any:

Reasons for Contacts

Reasons for contacts:

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

Other Medical Information

User has entered an other medical source

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454 Other Medical Information

Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems) covering the last 12 months, or are you scheduled to see anyone else?

Examples:

- Workers' Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency

Yes No Not Yet Answered

To add a medical source, choose Add Another. To edit, select the name below.

Name	Address
CoreSource	PO Box 2920, Clinton, IA

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Education and Training

Initial View

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454 Education and Training

Education

Have you received any education since 10/16/2008?

Yes No Not Yet Answered

Training

Have you received any type of specialized job, trade, or vocational training since 10/16/2008?

Yes No Not Yet Answered

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Education and Training, Part 1 of 2

User has indicated claimant received education and training

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Flags/Messages

454 Education and Training

Education

Have you received any education since 10/16/2008?

Yes No Not Yet Answered

Please describe the education received.

What year did you last attend any school?

Training

Have you received any type of specialized job, trade, or vocational training since 10/16/2008?

Yes No Not Yet Answered

Name of Training Facility:

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Education and Training, Part 2 of 2

User has indicated claimant received training

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Have you received any type of specialized job, trade, or vocational training since 10/16/2008?

Yes No Not Yet Answered

Name of Training Facility:

Telephone Number is: U.S. Foreign None

Telephone number: (999-999-9999) Ext:

Mailing 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:**

Type of Program:

Approximate Date Completed (or scheduled to be completed):

| | |

Vocational Rehabilitation, Employment, or Other Support Services Initial View

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454 Vocational Rehabilitation, Employment, or Other Support Services

Since the date of your last medical disability decision, have you participated, or are you participating 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 (PASS);
- An individualized education program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

Yes No Not Yet Answered

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Vocational Rehabilitation

User has indicated claimant received vocational rehabilitation, but has not entered any

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454 Vocational Rehabilitation, Employment, or Other Support Services

Since the date of your last medical disability decision, have you participated, or are you participating 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 (PASS);
- An individualized education program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

Yes No Not Yet Answered




List all plans or programs attended.

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

Organization/School	Name of Counselor/Instructor

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Vocational Rehabilitation, Employment, or Other Support Services Information, Part 1 of 2

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Vocational Rehabilitation, Employment, or Other Support Services Information [Open in eView](#) [Hide Instructions](#)

Name: Utah Vocational Rehabilitation
Attention:
Address: 125 N. Temple Street W.

Dates Seen

When did you start participating in the plan or program?

Are you still participating in the plan or program?

Yes. Scheduled to be completed on:

No. I completed the plan or program on:

No. I stopped participating in the plan or program before completing it because:

Not Yet Answered

Types of Services

What types of services, tests, or evaluations were provided?

[Examples](#)

Vocational Rehabilitation, Employment, or Other Support Services Information, Part 2 of 2

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

Daily Activities

Initial View

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454 Daily Activities

Typical Day

Describe what you do in a typical day:
For example: I get up around 7 A.M., take a shower, eat breakfast, etc.

Hobbies or Interests

Do you have hobbies or interests?

Yes No Not Yet Answered

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Daily Activities

User has indicated claimant has hobbies or interests

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454 Daily Activities

Typical Day

Describe what you do in a typical day:

For example: I get up around 7 A.M., take a shower, eat breakfast, etc.

Hobbies or Interests

Do you have hobbies or interests?

Yes No Not Yet Answered

Please describe what they are and how much time you spend doing them.

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Daily Activities, continued, Part 1 of 2

Initial View

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454 Daily Activities, continued

Do you ever have difficulty doing any of the following?

Dressing: Yes No Not Yet Answered

Bathing: Yes No Not Yet Answered

Caring for hair: Yes No Not Yet Answered

Taking medicines: Yes No Not Yet Answered

Preparing meals: Yes No Not Yet Answered

Feeding self: Yes No Not Yet Answered

Doing chores (inside/outside house): Yes No Not Yet Answered

Driving or using public transportation: Yes No Not Yet Answered

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Daily Activities, continued, Part 2 of 2

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Preparing meals: Yes No Not Yet Answered

Feeding self: Yes No Not Yet Answered

Doing chores (inside/outside house): Yes No Not Yet Answered

Driving or using public transportation: Yes No Not Yet Answered

Shopping: Yes No Not Yet Answered

Managing money: Yes No Not Yet Answered

Walking: Yes No Not Yet Answered

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Daily Activities, continued

User has indicated claimant has difficulty bathing

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454 Daily Activities, continued

Do you ever have difficulty doing any of the following?

Dressing: Yes No Not Yet Answered

Bathing: Yes No Not Yet Answered

Please explain:

Caring for hair: Yes No Not Yet Answered

Taking medicines: Yes No Not Yet Answered

Preparing meals: Yes No Not Yet Answered

Feeding self: Yes No Not Yet Answered

Doing chores (inside/outside house): Yes No Not Yet Answered

Driving or using Yes No Not Yet Answered

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454 Work

Has Joshua Ovard worked since 10/16/2008?

Yes No

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Daily Activities, cont 2, Part 1 of 2

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454 Daily Activities, continued

Do you ever have difficulty doing any of the following?

Standing: Yes No Not Yet Answered

Lifting objects: Yes No Not Yet Answered

Using arms: Yes No Not Yet Answered

Using hands or fingers: Yes No Not Yet Answered

Sitting: Yes No Not Yet Answered

Seeing, hearing, or speaking: Yes No Not Yet Answered

Concentrating: Yes No Not Yet Answered

Remembering: Yes No Not Yet Answered

Understanding or Yes No Not Yet Answered

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Daily Activities, cont 2, Part 2 of 2

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Concentrating: Yes No Not Yet Answered

Remembering: Yes No Not Yet Answered

Understanding or following directions: Yes No Not Yet Answered

Completing tasks: Yes No Not Yet Answered

Getting along with people: Yes No Not Yet Answered

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454 Remarks

Please provide any additional information you did not give in earlier parts of this report.

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SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting:

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a decision on the named claimant's claim. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent an accurate or timely decision on the named claimant's claim.

We rarely use the information you supply for any purpose other than to make a decision on the named claimant's claim. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs);
2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs. (e.g., to the Bureau of Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices entitled, Supplemental Security Income Record and Special Veterans Benefits (60-0103), Claims Folders System (60-0089), Master Beneficiary Record (60-0090), and Electronic Disability Claim File (60-0320). Additional information about this and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

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