iClaim-i3368 Marriage (1st Party): Screen Package 0.5

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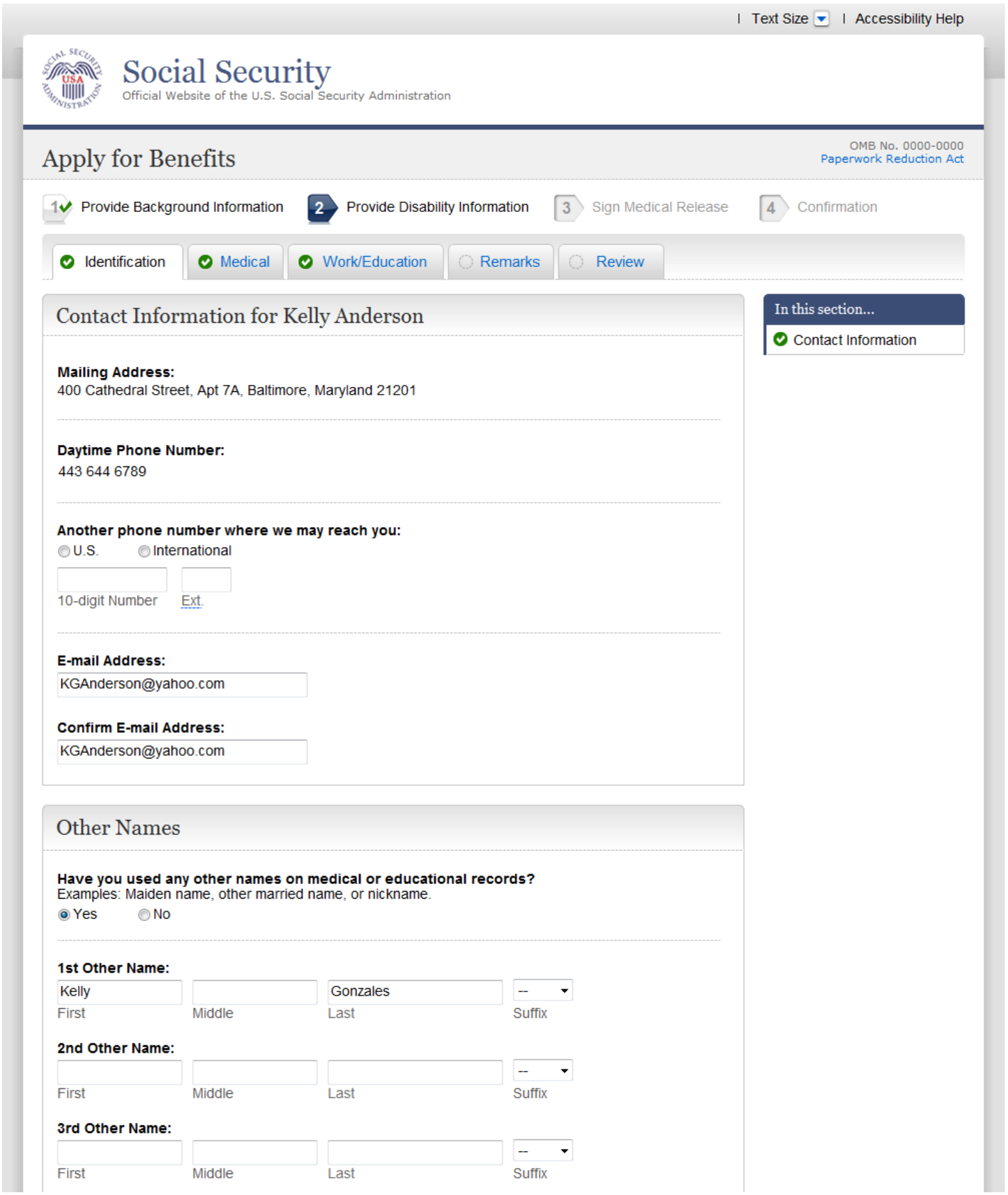
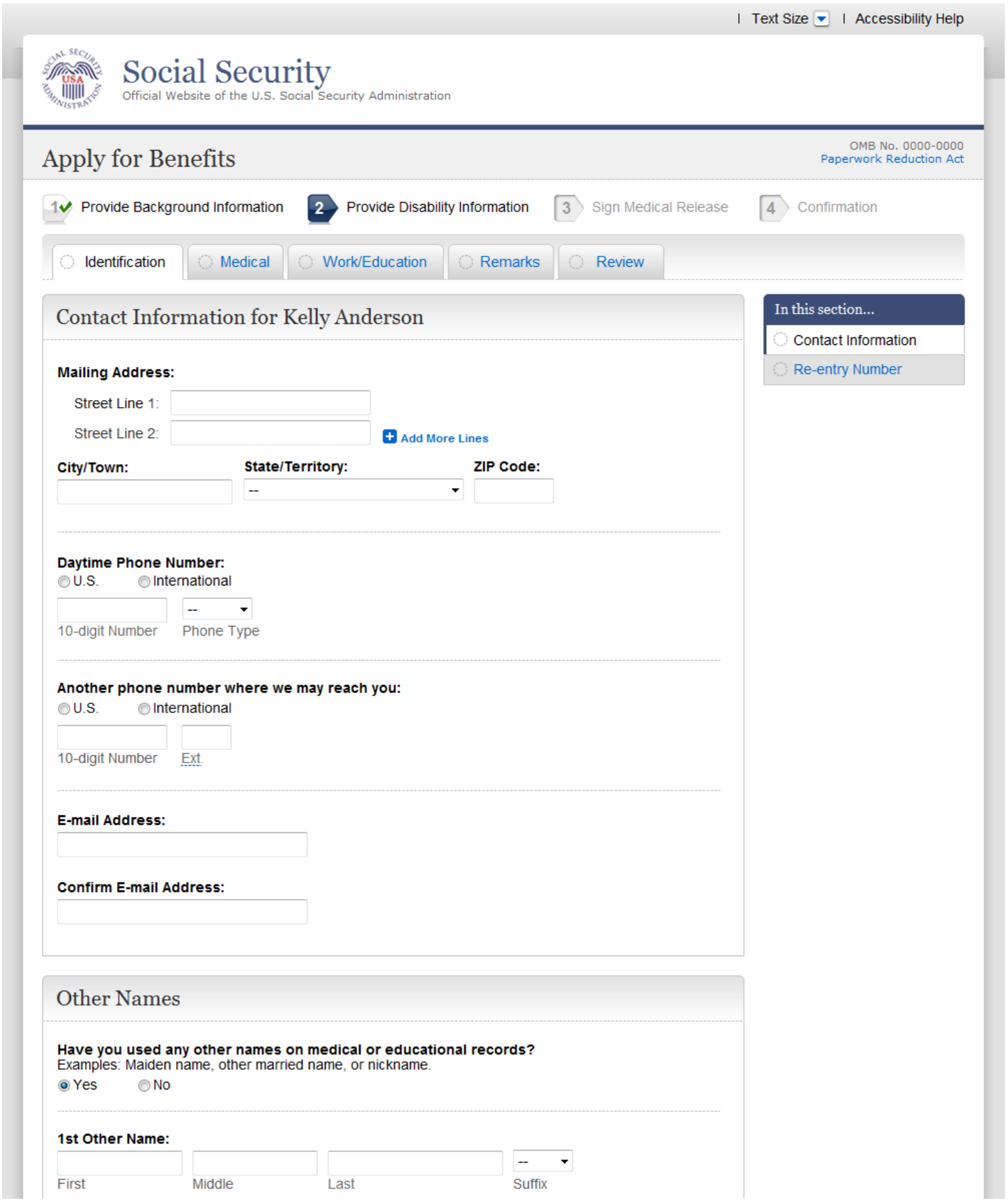

Text Size
Accessibility Help
Social Security
Official Website of the U.S. Social Security Administration
Apply for Benefits
OMB No. 0000-0000
Paperwork Reduction Act
1 Provide Background Information
2 Provide Disability Information
3 Sign Medical Release
4 Confirmation
Identification
Medical
Work/Education
Remarks
Review
Contact Information for Kelly Anderson
In this section...
Contact Information
Mailing Address:
400 Cathedral Street, Apt 7A, Baltimore, Maryland 21201
Daytime Phone Number:
443 644 6789
Another phone number where we may reach you:
U.S.
International
10-digit Number
Ext.
E-mail Address:
KGAnderson@yahoo.com
Confirm E-mail Address:
KGAnderson@yahoo.com
Other Names
Have you used any other names on medical or educational records?
Examples: Maiden name, other married name, or nickname.
Yes
No
1st Other Name:
Kelly
Gonzales
First
Middle
Last
Suffix
2nd Other Name:
3rd Other Name:

Next Save & Exit


Text Size
Accessibility Help
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Official Website of the U.S. Social Security Administration
Apply for Benefits
OMB No. 0000-0000
Paperwork Reduction Act
1 Provide Background Information
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3 Sign Medical Release
4 Confirmation
Identification
Medical
Work/Education
Remarks
Review
Contact Information for Kelly Anderson
In this section...
Contact Information
Re-entry Number
Mailing 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
Phone Type
Another phone number where we may reach you:
U.S.
International
10-digit Number
Ext.
E-mail Address:
Confirm E-mail Address:
Other Names
Have you 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:

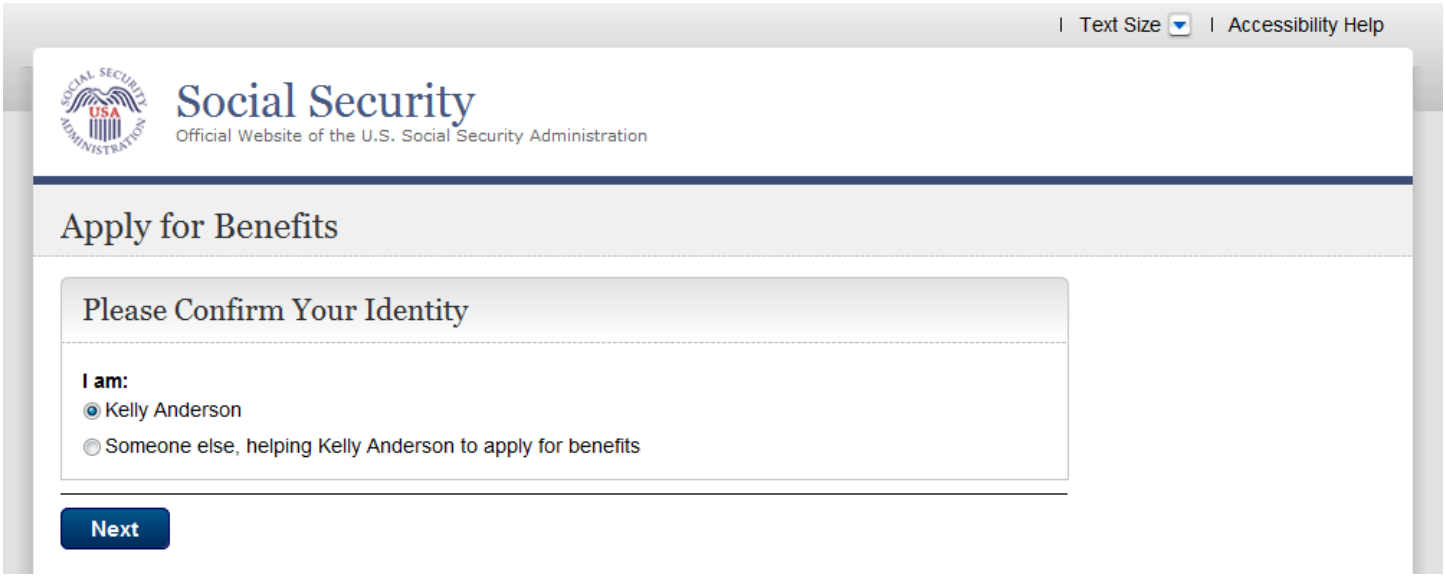
First | Middle | Last | -- Suffix

5th Other Name:

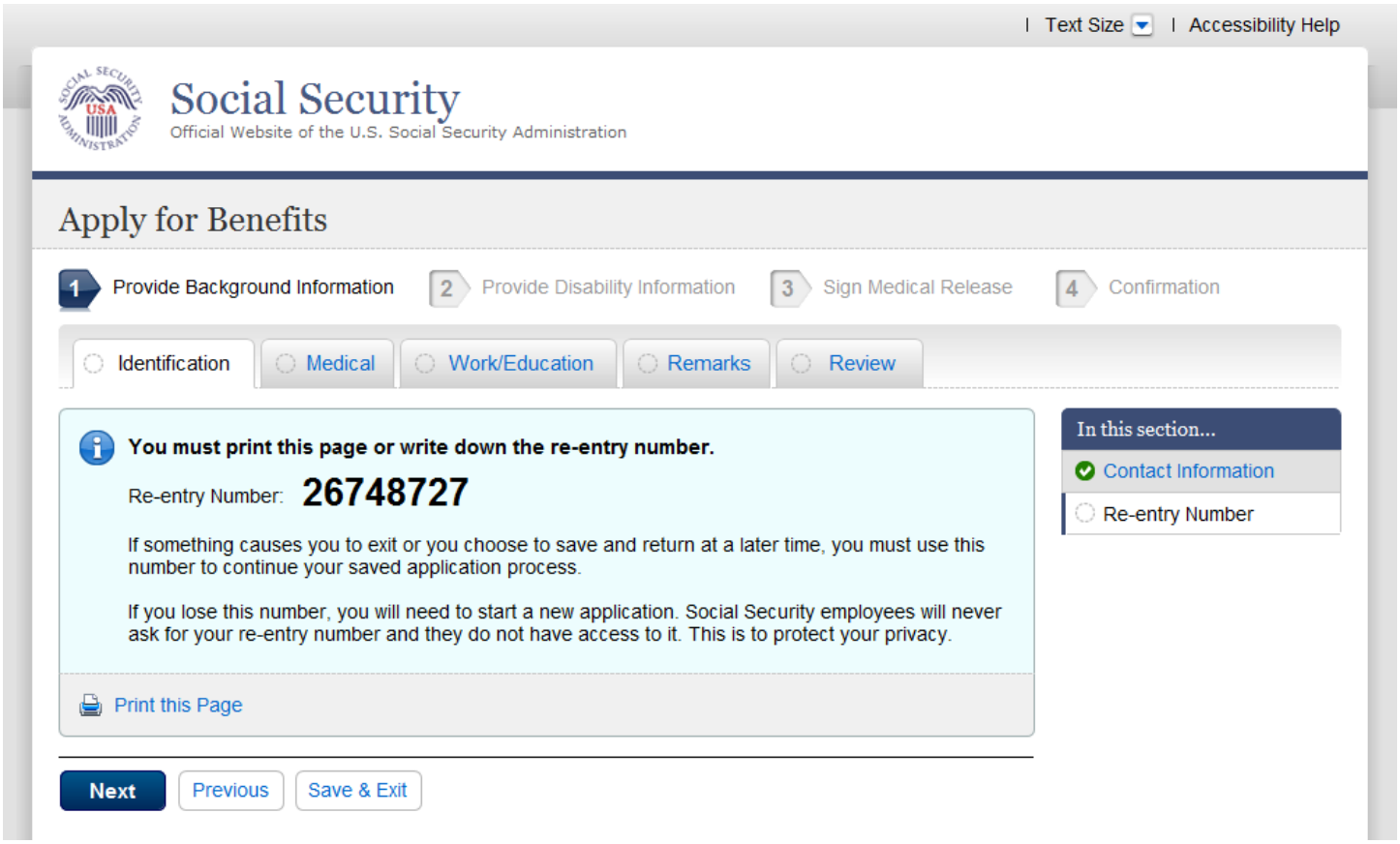
First | Middle | Last | -- Suffix

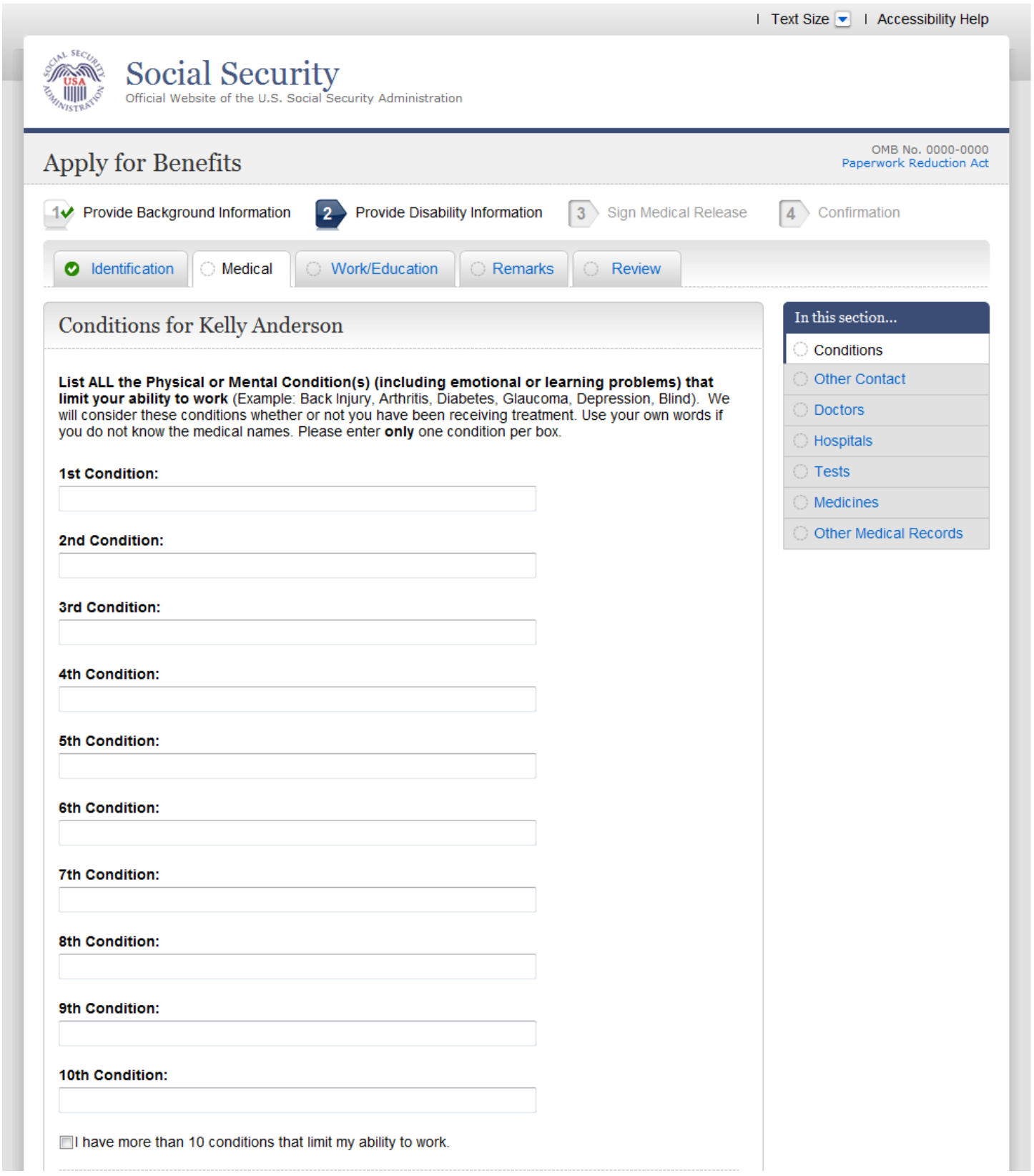
Next | Save & Exit

37.Confirm Your Identity On Re-entry (1st party to 1st party)



38.Re-entry Number (i3368 only)

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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 your ability to work (Example: Back Injury, Arthritis, Diabetes, Glaucoma, Depression, Blind). We will consider these conditions whether or not you have 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:
I have more than 10 conditions that limit my ability to work.
In this section...
Conditions
Other Contact
Doctors
Hospitals
Tests
Medicines
Other Medical Records

What is your height without shoes?

-- --

Feet Inches

What is your weight without shoes?

lbs

Does your condition cause you pain or other symptoms?

Yes No

Treatment

Have you seen a doctor or other healthcare professional or received treatment at a hospital or clinic or do you have a future appointment scheduled?

For any physical condition(s):

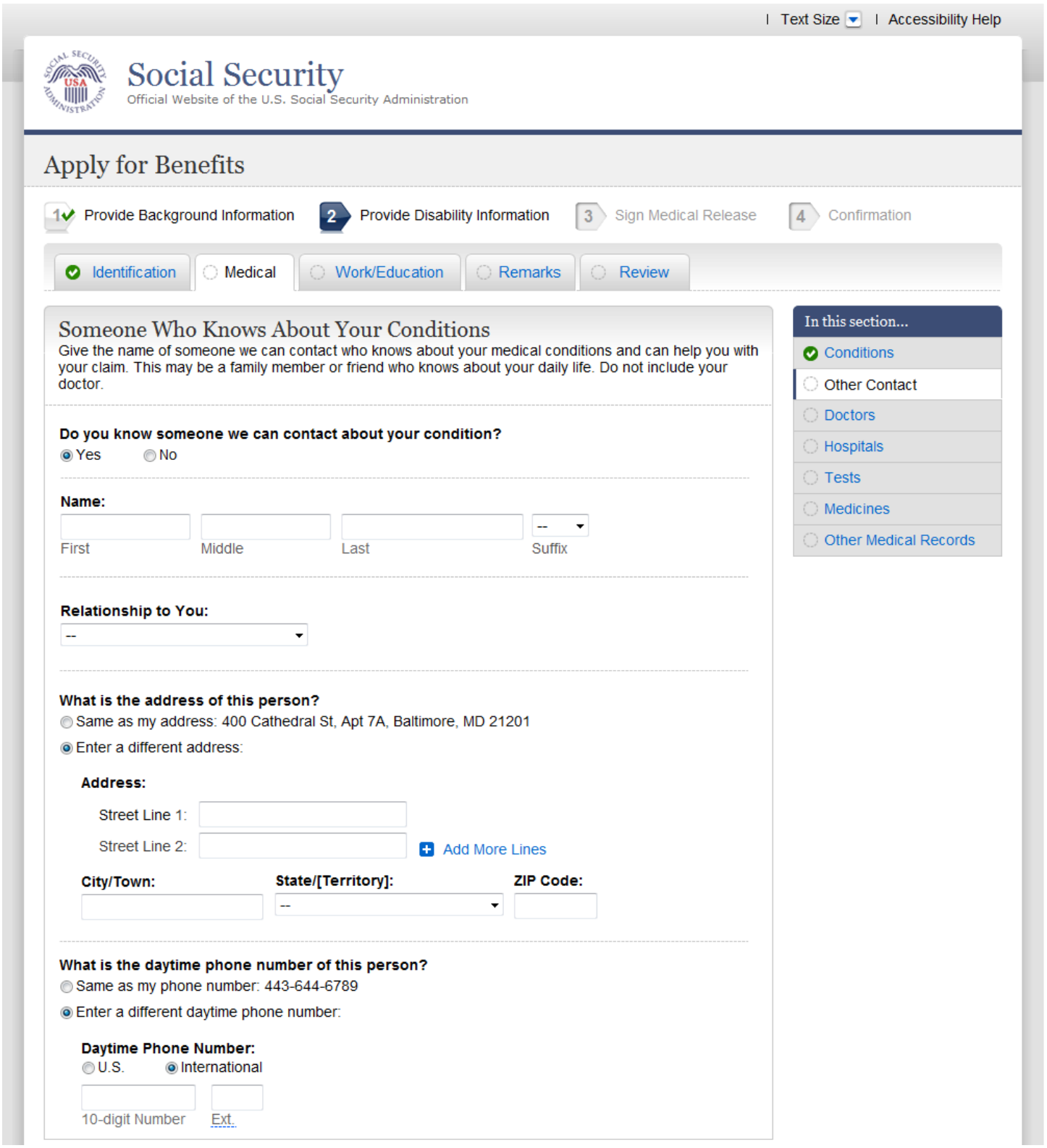
Yes No

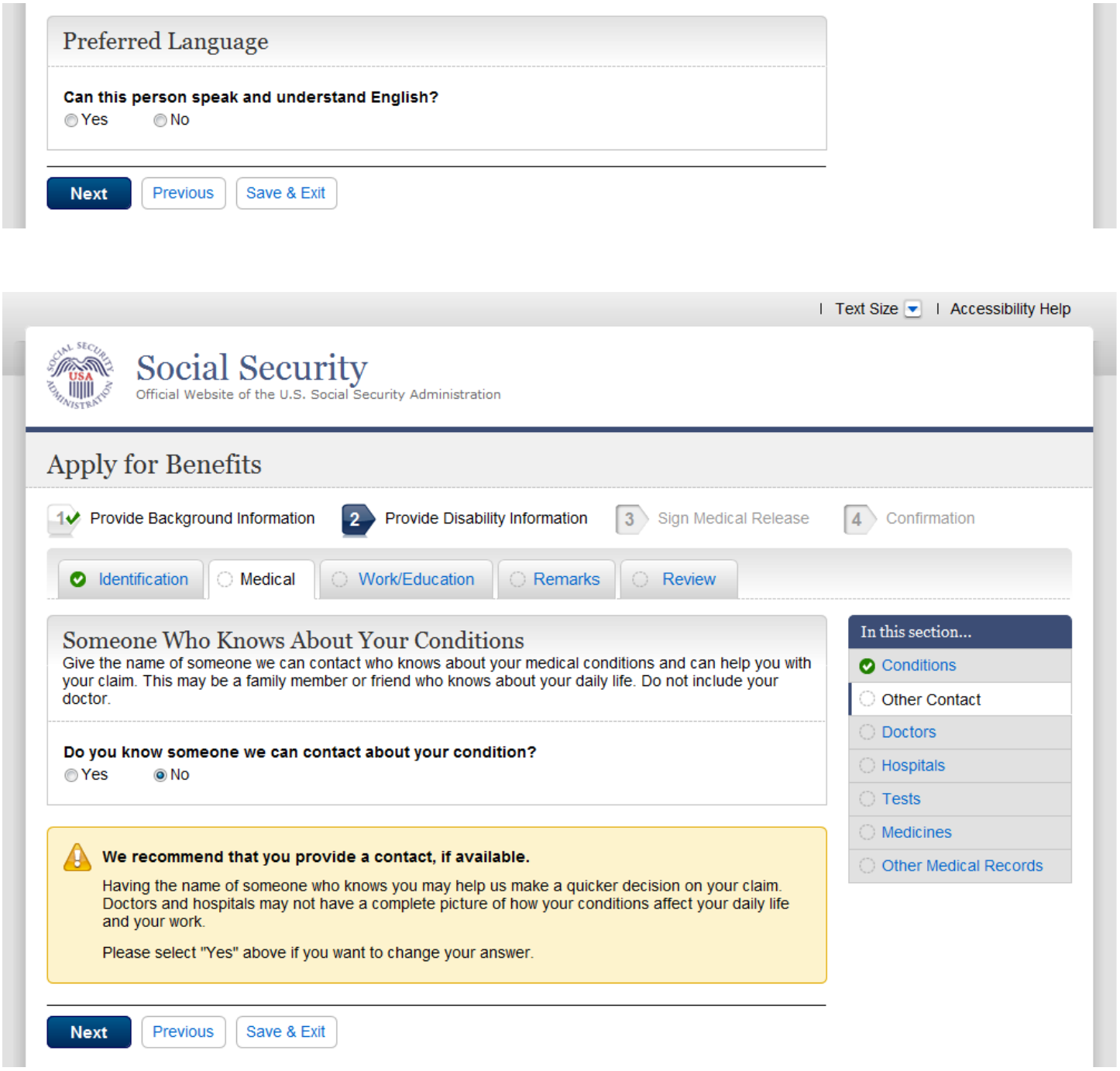
For any mental condition(s):

Yes No

Next Save & Exit

40.Con001-1_Someone Who Knows About Your Condition




Preferred Language
Can this person speak and understand English?
Yes
No
Next
Previous
Save & Exit
Text Size
Accessibility Help
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3 Sign Medical Release
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Identification
Medical
Work/Education
Remarks
Review
Someone Who Knows About Your Conditions
Give the name of someone we can contact who knows about your medical conditions and can help you with your claim. This may be a family member or friend who knows about your daily life. Do not include your doctor.
Do you know someone we can contact about your 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

41.Doc001-1_Doctors and healthcare professionals

42.Doc002-1_Doctors and healthcare professionals details

Social Security
Official Website of the U.S. Social Security Administration

Apply for Benefits

Doctor/Healthcare Professional Details

Name of Doctor/Healthcare Professional: More info

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:
United States or U.S. Territory

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) you 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 you?
This includes any medical tests you have 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 me more than once.

Details about Test 2:

Kind of Test:

--

Date of Test: More info

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

If you have 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 you?

(•) Yes ( ) No

List any medicines you are taking and the reasons you are 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 you have 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

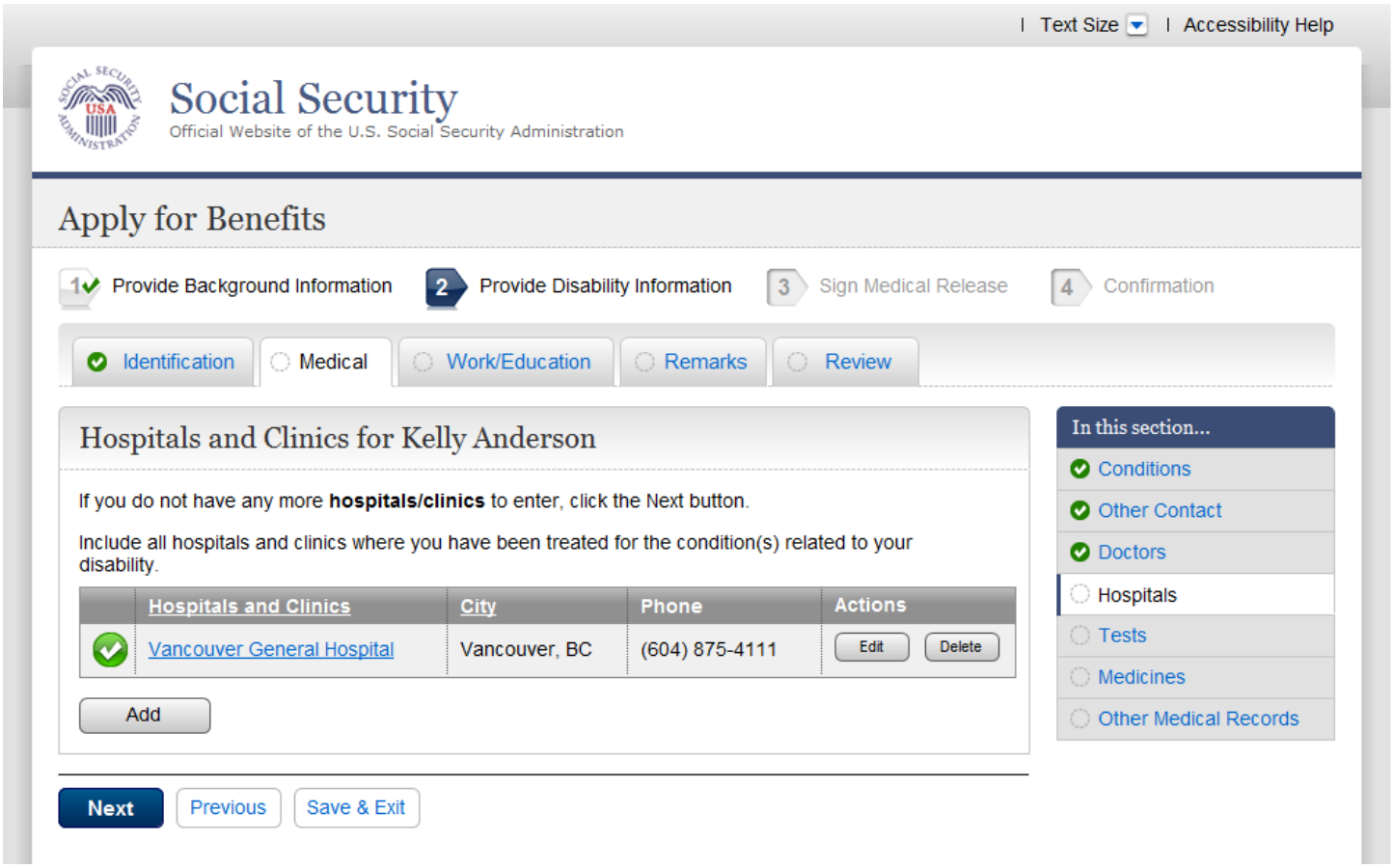
What treatment did you receive from this doctor/healthcare professional?
You DO NOT need to repeat any information that you have already told us about medicines and tests. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

Save Cancel

43.Hos001-1_Hospitals and Clinics



44.Hos002-1_Hospital and Clinic Details

Social Security
Official Website of the U.S. Social Security Administration

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:
United States or U.S. Territory

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.

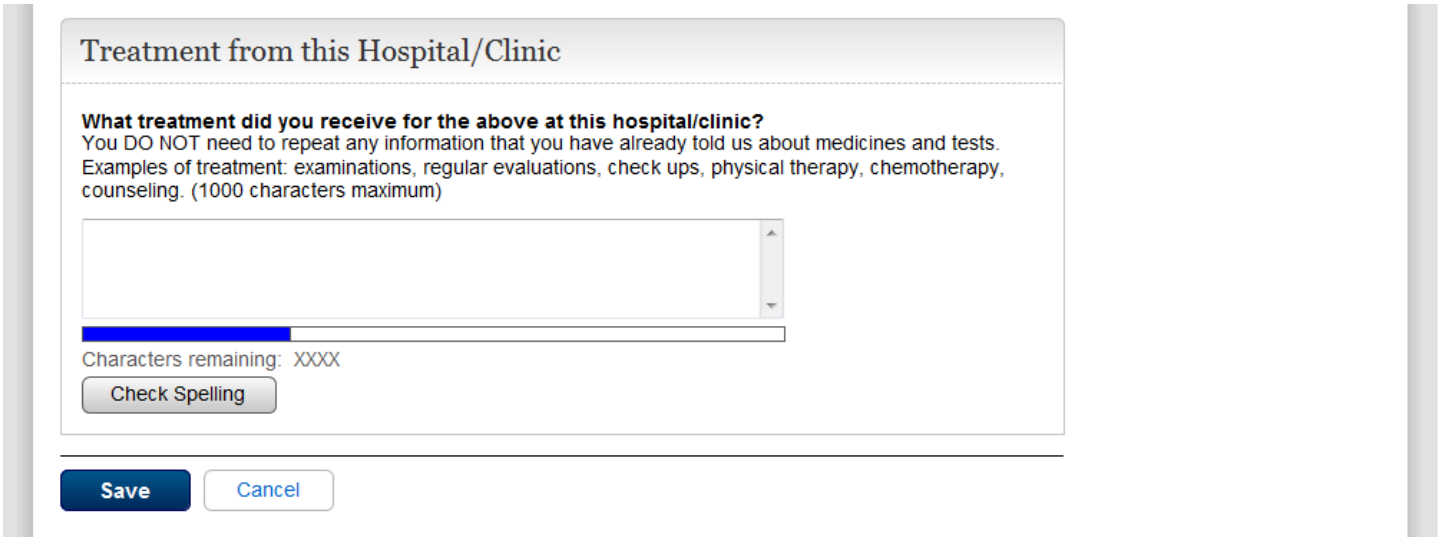
Hospital/Clinic Record Number, if known:

Treatment Dates at this Hospital/Clinic

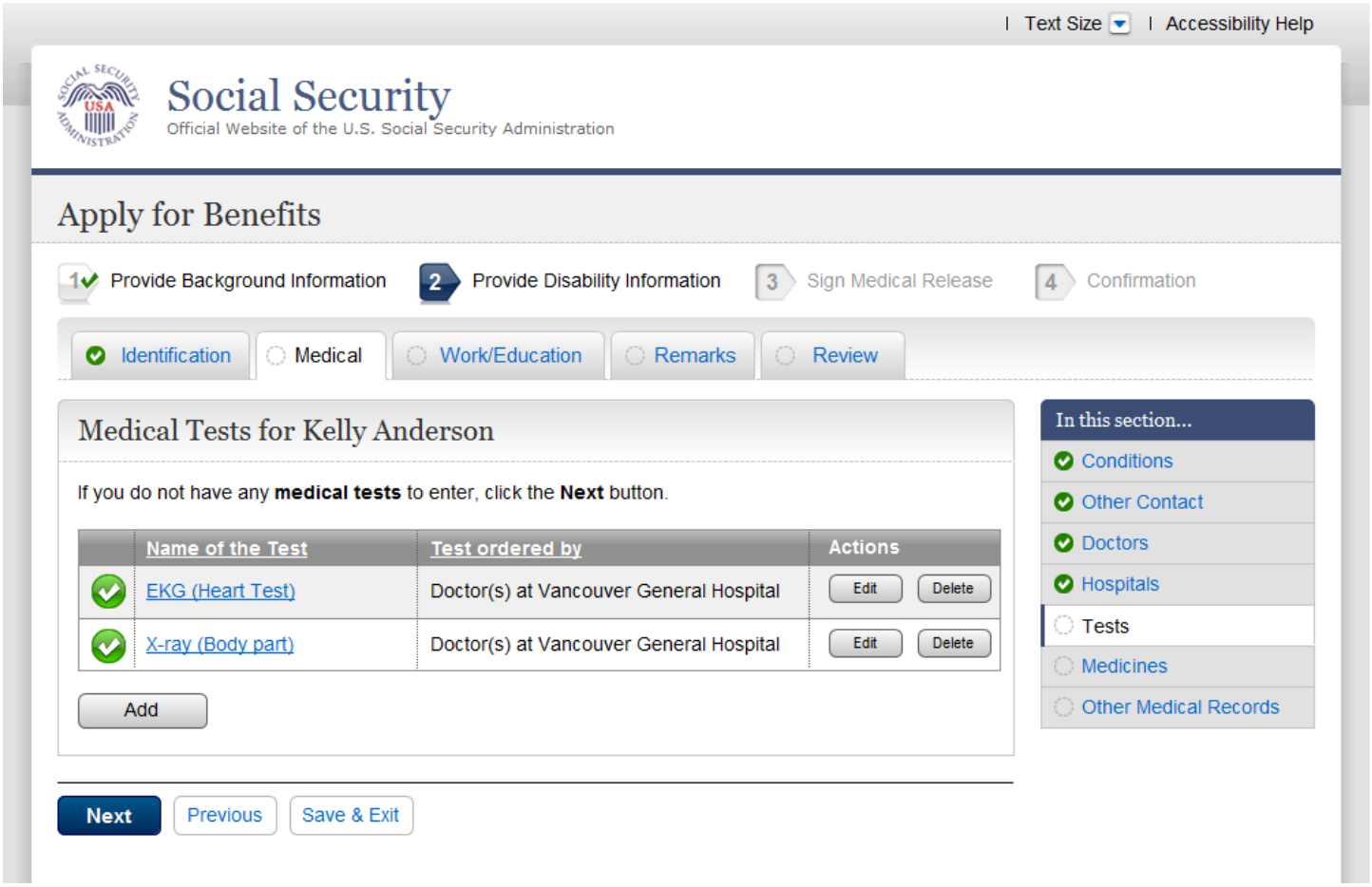
More info

Did you have any emergency room (ER) visits at this hospital/clinic?
ER Visit means you went to the ER and then went home.

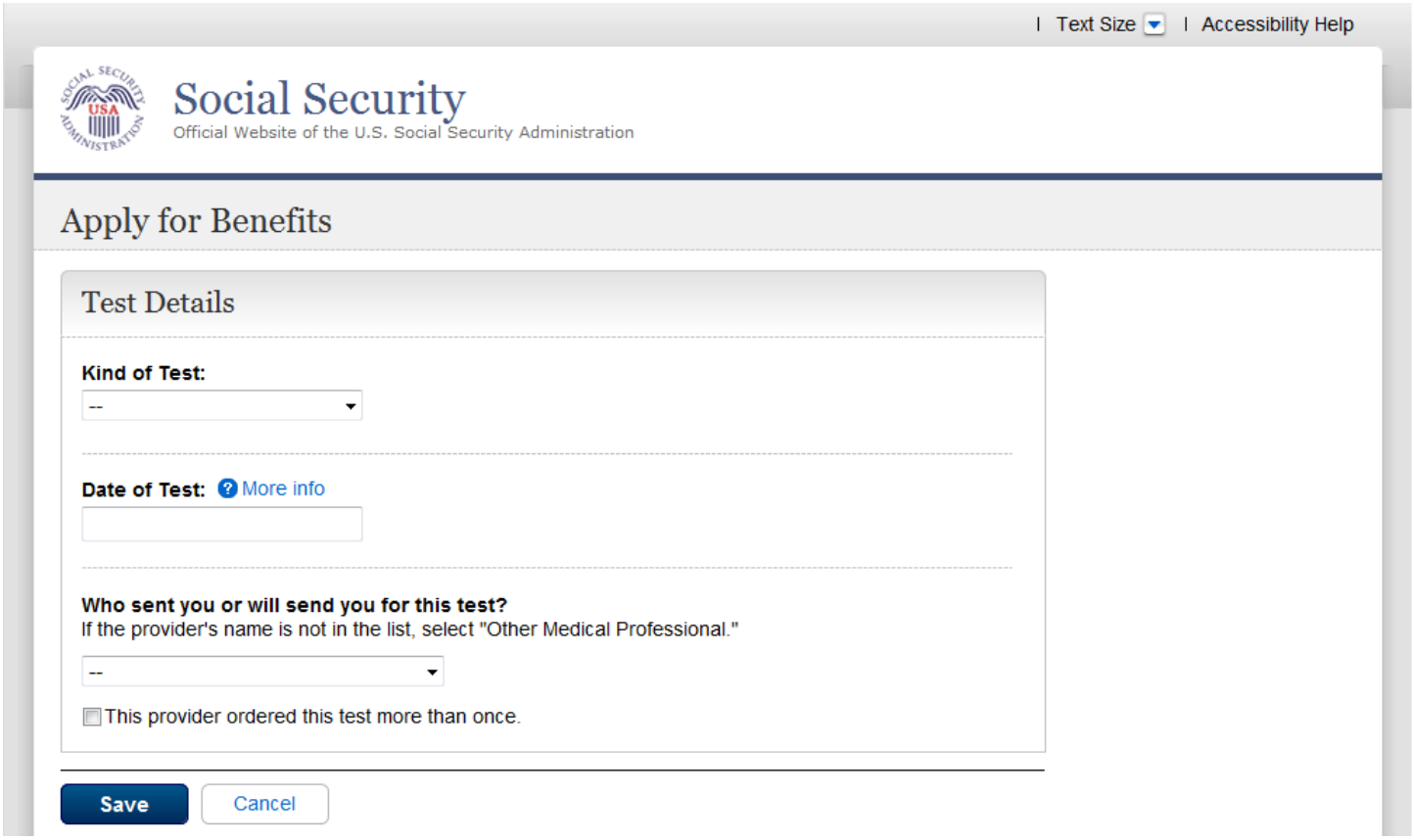
Yes No

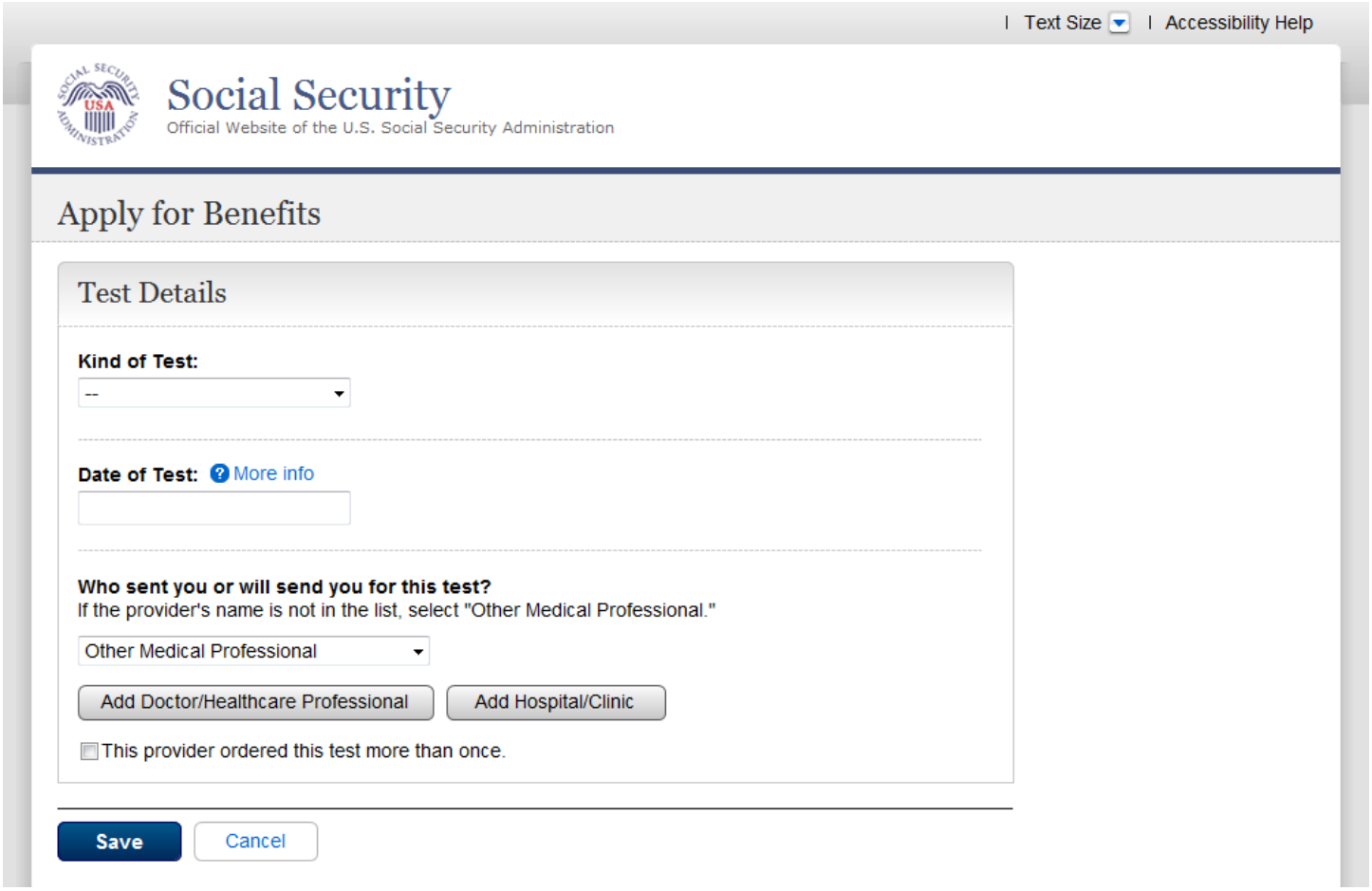

Treatment from this Hospital/Clinic
What treatment did you receive for the above at this hospital/clinic?
You DO NOT need to repeat any information that you have already told us about medicines and tests.
Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)
Characters remaining: XXXX
Check Spelling
Save
Cancel

45.Tst001-1_Medical tests


Text Size
Accessibility Help
Social Security
Official Website of the U.S. Social Security Administration
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 you do not have any medical tests to enter, click the Next button.
Name of the Test
Test ordered by
Actions
EKG (Heart Test)
Doctor(s) at Vancouver General Hospital
Edit
Delete
X-ray (Body part)
Doctor(s) at Vancouver General Hospital
Edit
Delete
Add
In this section...
Conditions
Other Contact
Doctors
Hospitals
Tests
Medicines
Other Medical Records
Next
Previous
Save & Exit

46.Tst002-1_Medical Test Details



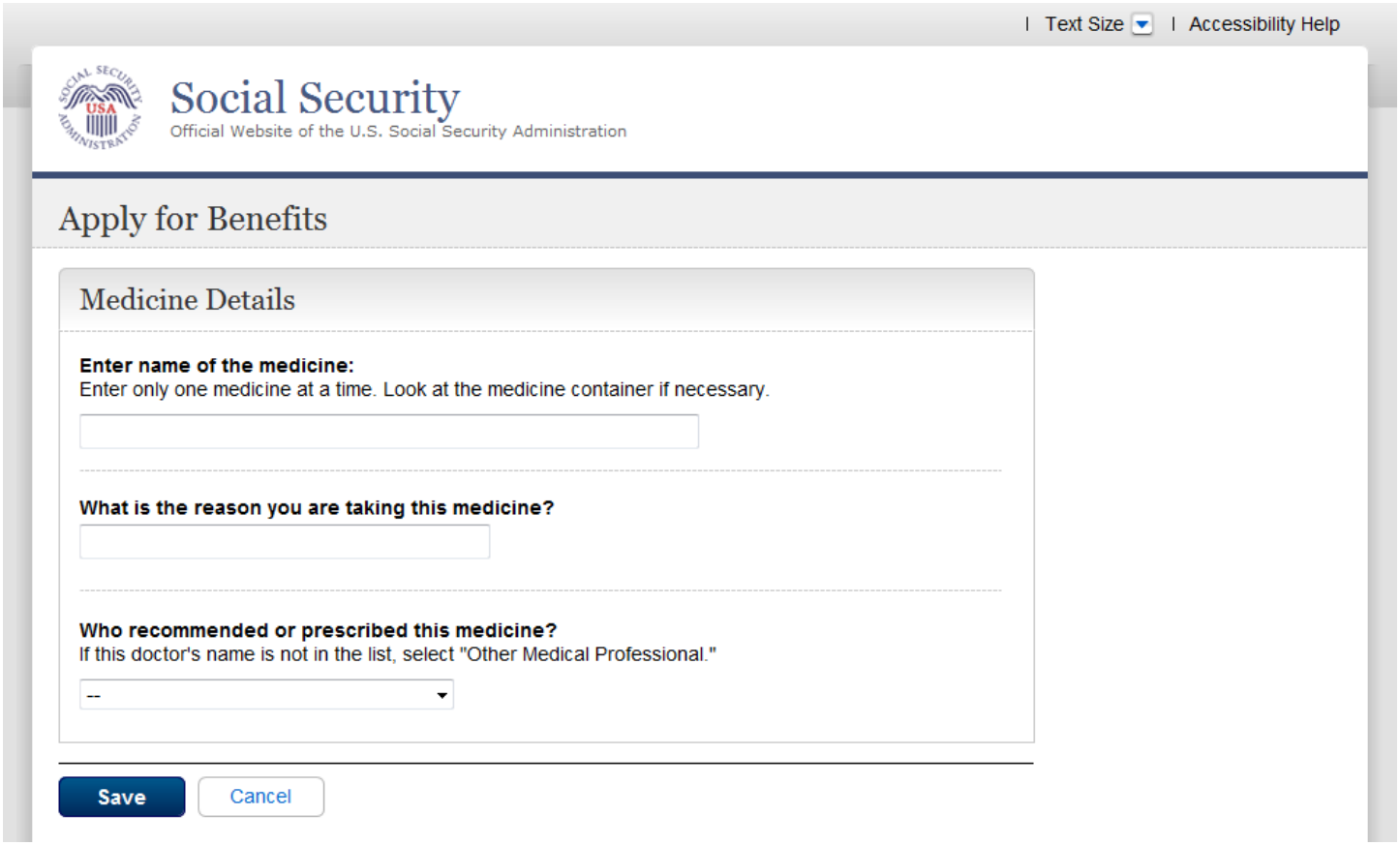


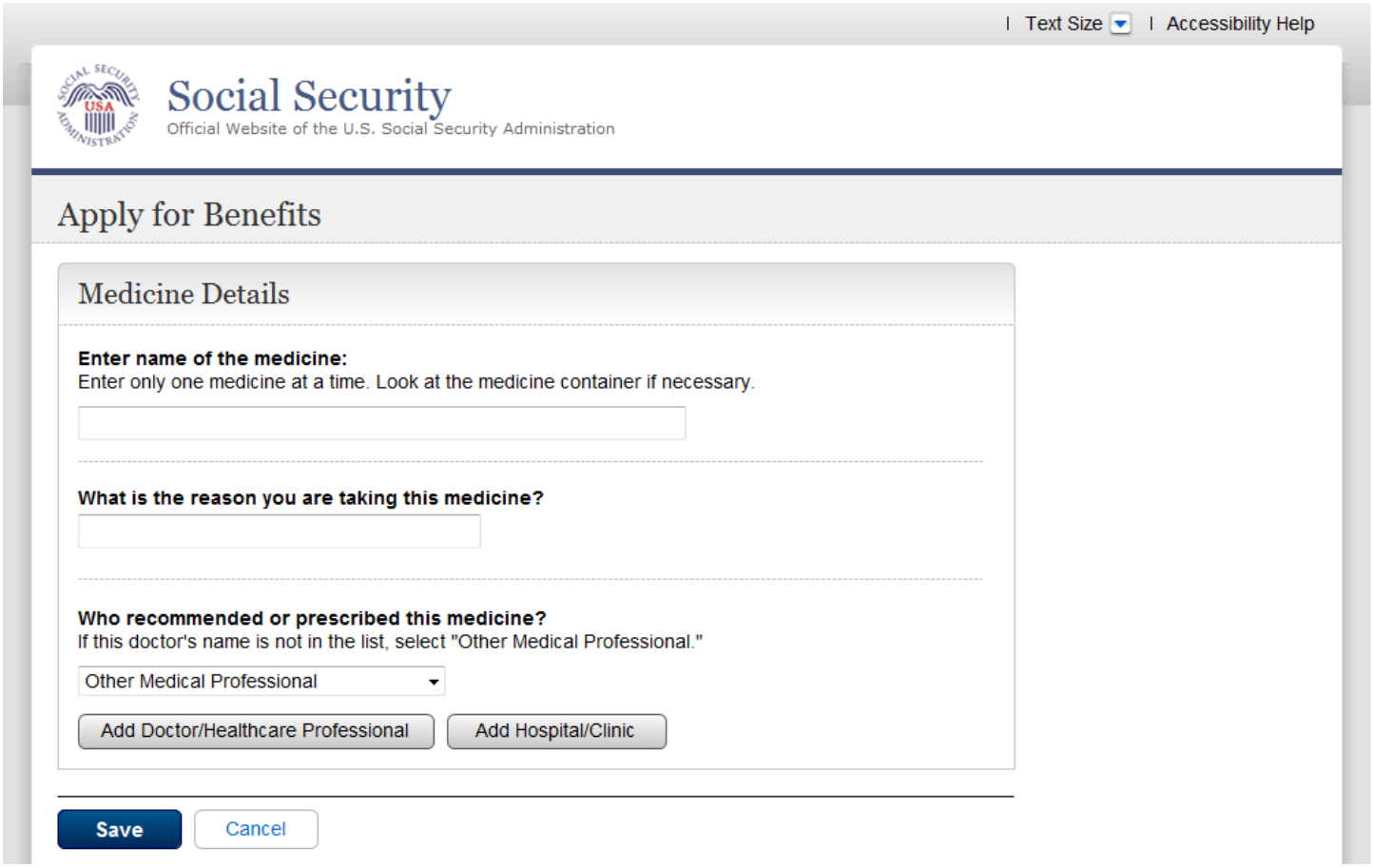
Note: When user selects “Other Medical Professional” in the dropdown for “Who sent you…”, the buttons “Add Doctor/Healthcare Professional” and “Add Hospital/Clinic” are displayed on the screen. It is mandatory for the user to select either of the buttons in order to continue.

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 (Tst001-1_Medical tests)

47.Med001-1_Medicines

48.Med002-1_Medicine Details




Text Size
Accessibility Help
Social Security
Official Website of the U.S. Social Security Administration
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 you are taking this medicine?
Who recommended or prescribed this medicine?
If this doctor's name is not in the list, select "Other Medical Professional."
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 (Med001-1_Medicines)

49.Msc001-1_Other medical records

Social Security
Official Website of the U.S. Social Security Administration

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 you have already mentioned.

If you do 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.			

Add

In this section...

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

Next | Previous | Save & Exit

50.Msc002-1_Other Medical Record Details

Social Security
Official Website of the U.S. Social Security Administration

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:
United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2: Add More Lines

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

Daytime Phone Number:
Include area code.

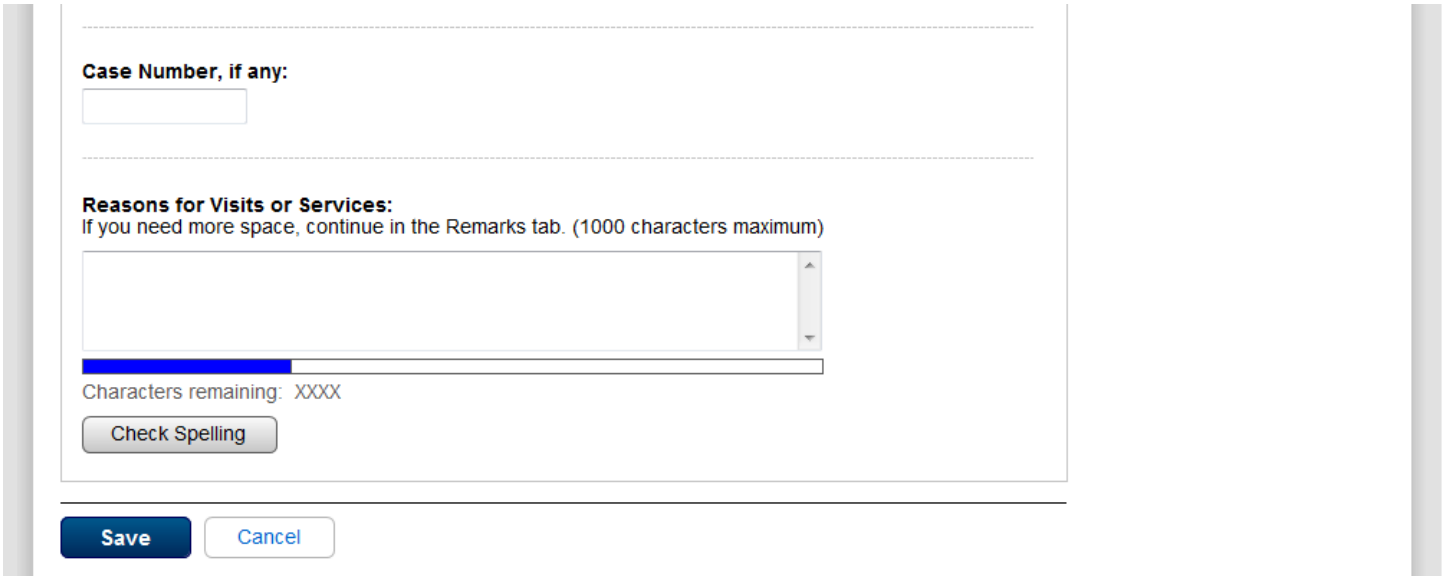
U.S. International

10-digit Number Ext.

First visit:
Please give us the closest date you can remember.

Last visit:
Please give us the closest date you can remember.

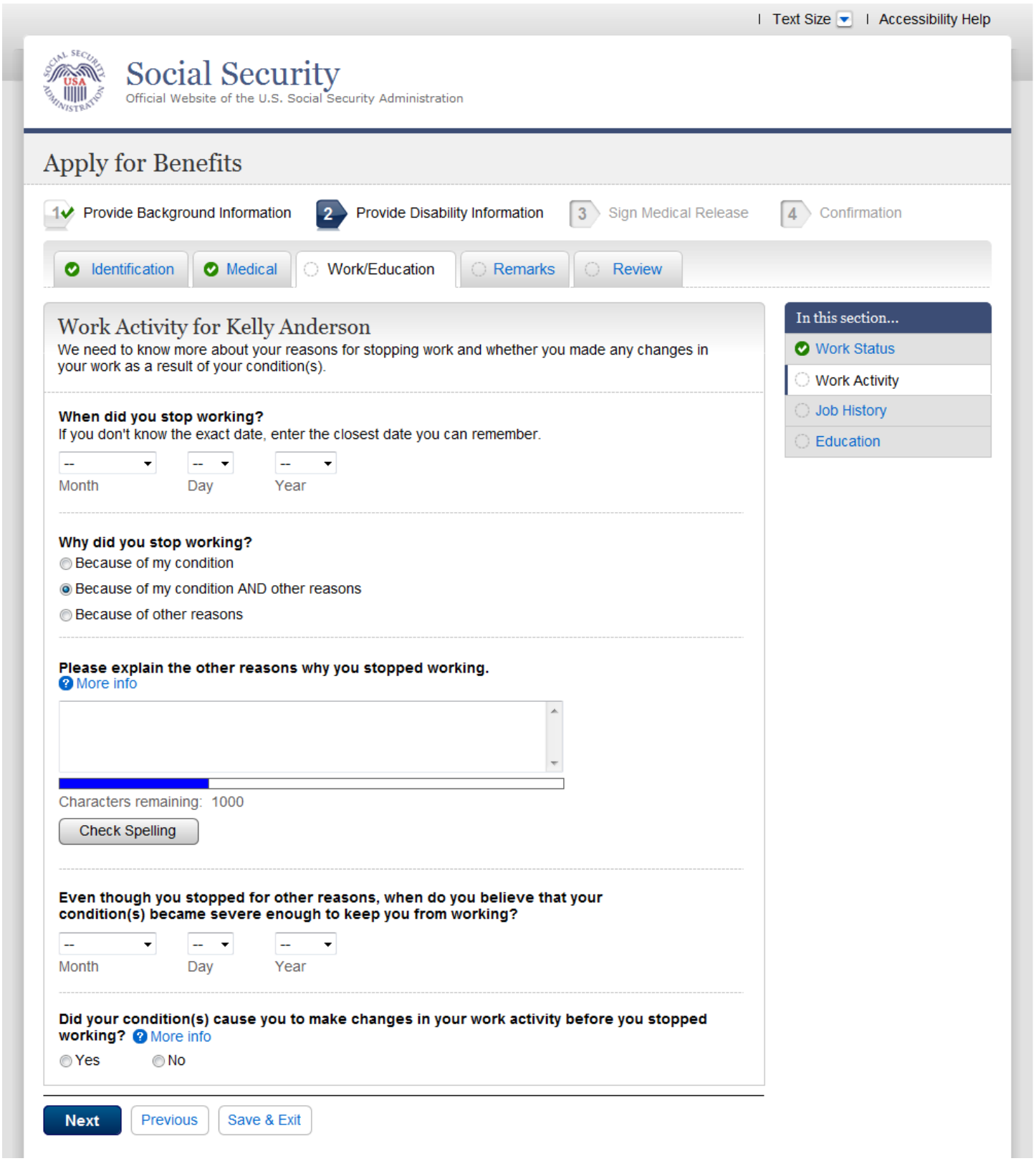
Next visit:
Leave blank if no appointment scheduled.


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

51.

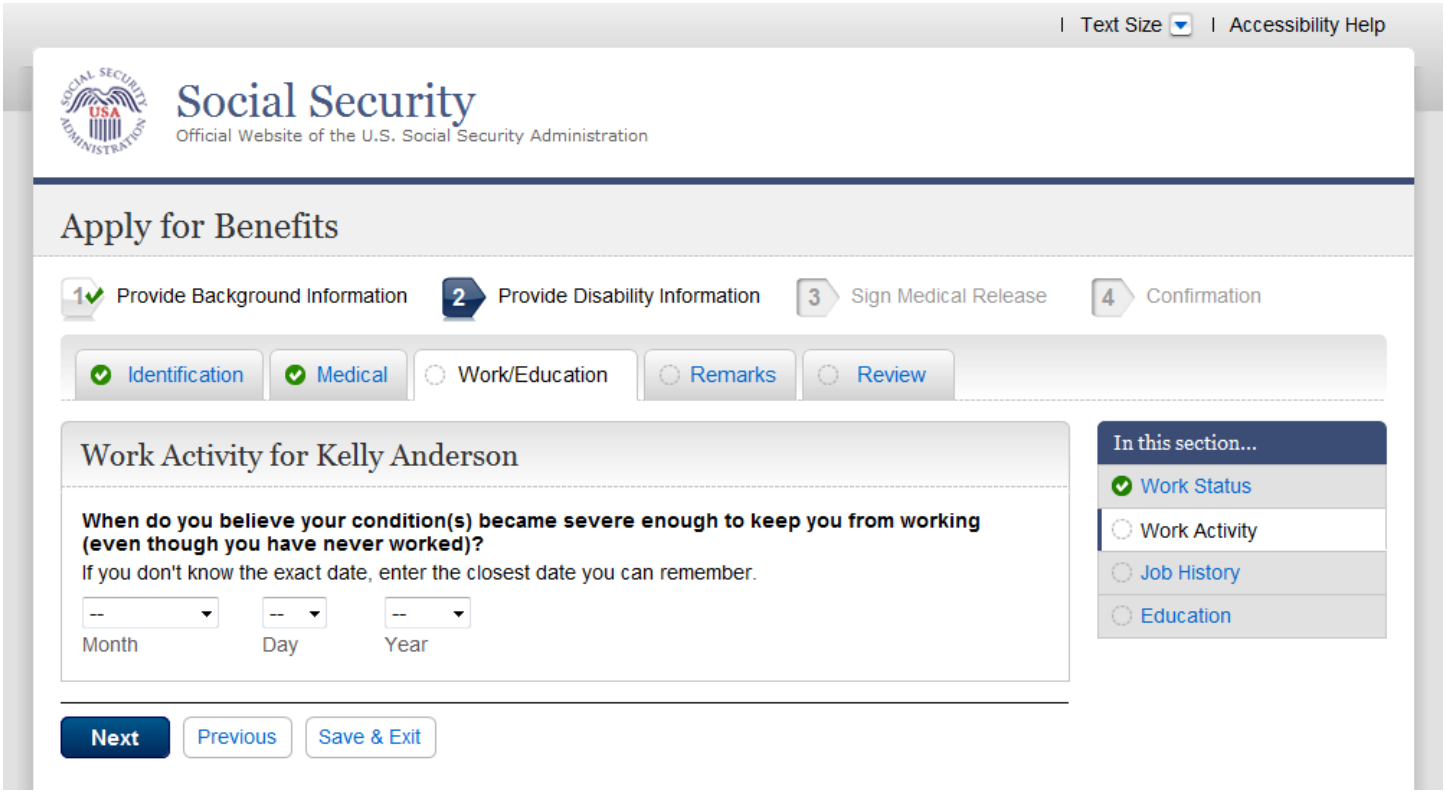
52.Win001-1_Work Status

53.Wac001-1-sw_Work Activity



54.Wac001-1-cw_Work Activity

55.Wac001-1-nw_Work Activity



56.Job001-1-sw_Job History

Social Security
Official Website of the U.S. Social Security Administration

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

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

Select the number of jobs you have had in the past 15 years before you became unable to work:
1

In this section...
- Work Status
- Work Activity
- Job History
- Education

Most Recent Job

Job Title:

Type of Business:

Start Date:
-- Month -- Year

End Date:
-- Month -- Year

Hours per Day:

Days per Week:

Rate of Pay:
$ Amount -- Frequency

Job Details

Describe this job, what did you do all day?
If you need more space use the Remarks tab. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

In this job, did you use machines, tools or equipment?
○ Yes ○ No

In this job, did you use technical knowledge or skills?
○ Yes ○ No

In this job, did you do any writing, complete reports, or perform any duties like this?
○ Yes ○ No

In this job, how many hours each day did you do each of the tasks listed below?
Do not include breaks and lunch.

Did you walk?
● Yes ○ No

How many hours did you walk?
0.5 hours

Did you stand?
○ Yes ● No

You answered you did not stand.

Did you sit?
● Yes ○ No

How many hours did you sit?
3 hours

Did you climb?
○ Yes ● No

You answered you did not climb.

Did you stoop (bending down & forward at the waist)?
○ Yes ○ No

Did you kneel (bending legs to rest on knees)?
○ Yes ○ No

Did you crouch (bending legs & back down & forward)?
○ Yes ○ No

Did you crawl?
○ Yes ○ No

Did you handle large objects?
● Yes ○ No

How many hours did you handle large objects?
0.5 hours

Did you write, type or handle small objects?
● Yes ○ No

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

Did you reach? You answered you did not reach.

○ Yes ◉ No

Please describe what you lifted, how far you carried things, and how often you were required to do so in your job:
If you need more space use the Remarks tab. (1000 characters maximum)

Characters remaining: 1000

Check Spelling

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

--

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

--

Did you supervise other people in this job?

◉ Yes ○ No

How many people did you supervise?

What part of your time did you spend supervising people?

Did you hire and fire employees?

○ Yes ○ No

Were you a lead worker?

○ Yes ○ No

Next Previous Save & Exit

57.Job001-1-cw_Job History

Social Security
Official Website of the U.S. Social Security Administration

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

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:

1

Most Recent Job

Job Title:

Type of Business:

Start Date:

-- Month -- Year

End Date:

-- Month -- Year

Hours per Day:

Days per Week:

Did you write, type or handle small objects?

(•) Yes ( ) No

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

3 hours

Did you reach?

( ) Yes (•) No

You answered you did not reach.

Please describe what you lifted, how far you carried things, and how often you were required to do so in your job:
If you need more space use the Remarks tab. (1000 characters maximum)

Characters remaining: 1000

Check Spelling

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

--

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

--

Did you supervise other people in this job?

(•) Yes ( ) No

How many people did you supervise?

What part of your time did you spend supervising people?

Did you hire and fire employees?

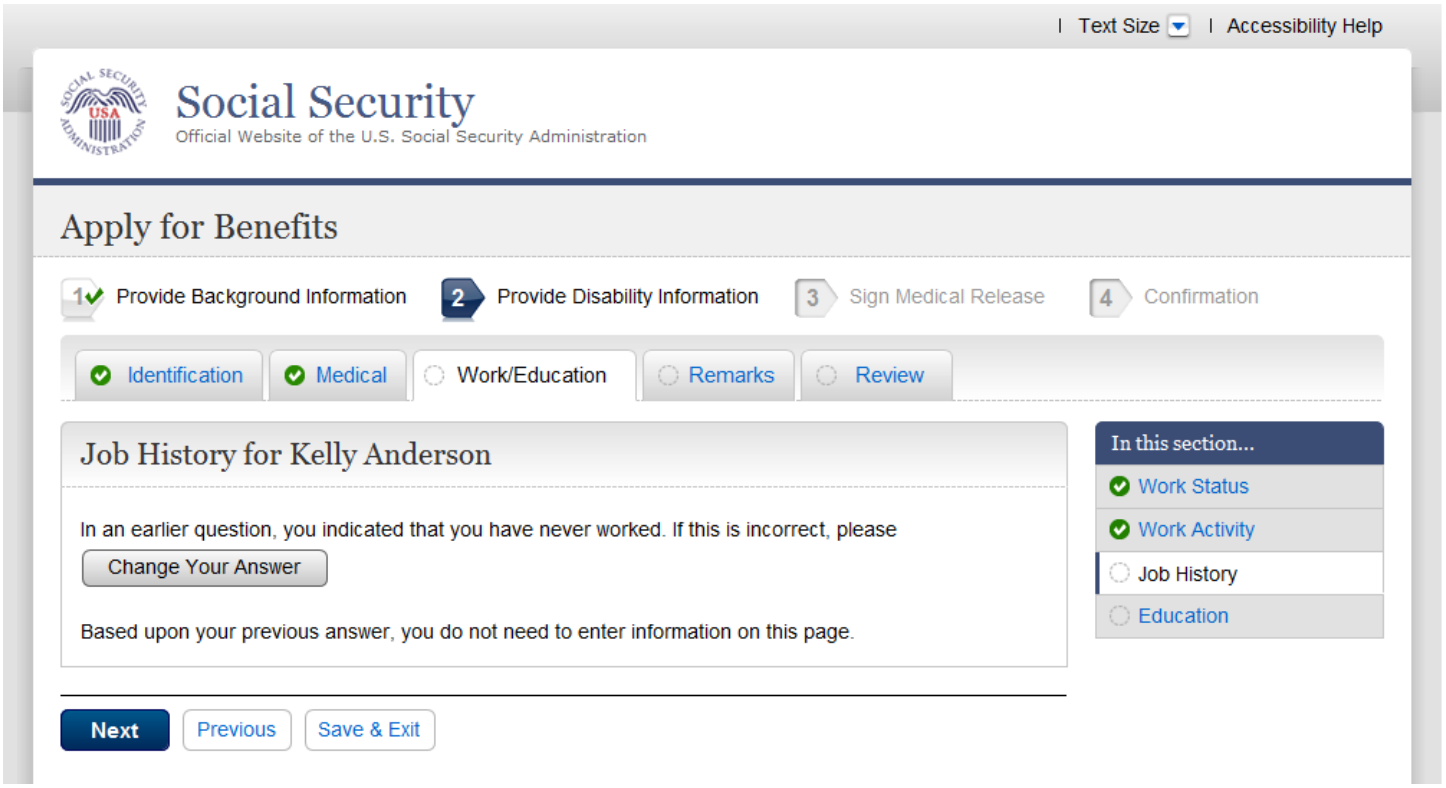
( ) Yes ( ) No

Were you a lead worker?

( ) Yes ( ) No

Next Previous Save & Exit

58.Job001-1-nw_Job History



59.Edu001-1_Education and Training

Social Security
Official Website of the U.S. Social Security Administration

Apply for Benefits

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

Identification | Medical | Work/Education | Remarks | Review

Education and Training for Kelly Anderson

Highest Grade Completed:
If you did not complete the entire school year, select the previous year that you completed.

--

Date Completed:
Enter the date when you most recently completed a school year as close as you can remember.

Have you completed any type of special job training, trade or vocational school?
Yes No

Special Education

Did you attend special education classes? More Info
Yes No

Language

Can you speak and understand English?
If you cannot speak and understand English, we will provide an interpreter free of charge.
Yes No

Can you read and understand English?
Yes No

Can you write more than your name in English?
Yes No

In this section...
- Work Status
- Work Activity
- Job History
- Education

Next | Previous | Save & Exit

60.Rmk001-1_Remarks

61.Rvw001-1_Review (i3368)

Social Security
Official Website of the U.S. Social Security Administration

Apply for Benefits

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

Identification | Medical | Work/Education | Remarks | Review

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**

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:
7:
8:
9:
10:

Height without shoes: **5' 8"**
Weight without shoes: **260 lbs**
Conditions cause pain or other symptoms: **Yes**

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

For mental conditions: **Yes**

Edit ✔ Someone who knows about your condition

Someone who knows about your conditions

Name: **Jamie Gonzales**
Relationship: **Sister**
Mailing Address: **210 Main Street, Baltimore, MD 21228**
Daytime Phone Number: **210-111-2342**
Extension:
Speak and Understand English: **Yes**

Edit ✔ Doctors and Other Healthcare Professionals

Doctor/Healthcare Professional 1
Name: **Dr. Samantha Gupta**
Address: **B900 Caton Avenue, Suite 301, Baltimore MD 21229**
Phone Number: **410-496-9643**
Extension:
First Visit: **Sometime in 1999**
Last Visit: **March 16, 2012**
Next Scheduled Appointment:
Medical conditions treated: **Diabetes, Heart Disease, COPD**
Treatments Received: **Singulair, Plavix**

Doctor/Healthcare Professional 2
Name: **Dr. Elijah Saunders**
Address: **2200 Kernan Drive, Rm 4611, Baltimore, MD 21207**
Phone Number: **410-328-4266**
Extension:
First Visit: **November 10, 2011**
Last Visit: **March 27, 2012**
Next Scheduled Appointment: **October 3, 2012**
Medical conditions treated: **Depression, Pain Management**
Treatments Received: **Cymbalta**

Edit ✔ Hospitals and Clinics

Hospital/Clinic 1
Name: **Vancouver General Hospital**
Address: **855 West 12th Avenue, Vancouver, BC V5Z 1M9**
Phone Number: **604-875-4111**
Extension:
Emergency Room Visits: **Yes**
Emergency Room Visit 1 : **October, 2008**
Inpatient Stays: **No**
Outpatient Visits: **No**
Medical conditions treated: **Heart attack**
Treatment Received:

Edit ✔ Tests

Hours per day: **12**
Days per week: **4**
Rate of pay: **90,000**
Frequency of pay: **Yearly**

Job Description: **--**
Equipment used: **No**
Technical knowledge used: **Yes**
Completed reports: **Yes**
Walking: **1 hour**
Standing: **4 hours**
Sitting: **1 hour**
Climbing: **0 hour (Never)**
Stooping: **0 hour (Never)**
Kneeling: **0 hour (Never)**
Crouching: **0 hour (Never)**
Crawling: **0 hour (Never)**
Handling large objects: **0 hour (Never)**
Writing, typing or handling small objects: **1 hour**
Reaching: **1 hour**
Description of lifting and carrying: **--**
Weight of frequently lifted items: **Less than 10 lbs**
Maximum weight lifted: **Less than 10 lbs**
Supervise others: **No**
Lead worker: **No**

Edit ✔ Education

Education and Training
Highest grade of school completed: **4 years of college**
Date completed: **1988**
Any special training, trade, or vocational school: **No**
Special education: **No**
Speak in English: **Yes**
Read in English: **Yes**
Write in English: **Yes**

Remarks

Edit ✔ Remarks

Remarks
Additional information:

You will not be able to change your 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