iAppeals Revitalization

EDCS 3441
Screen Mock-ups

Version 4.0

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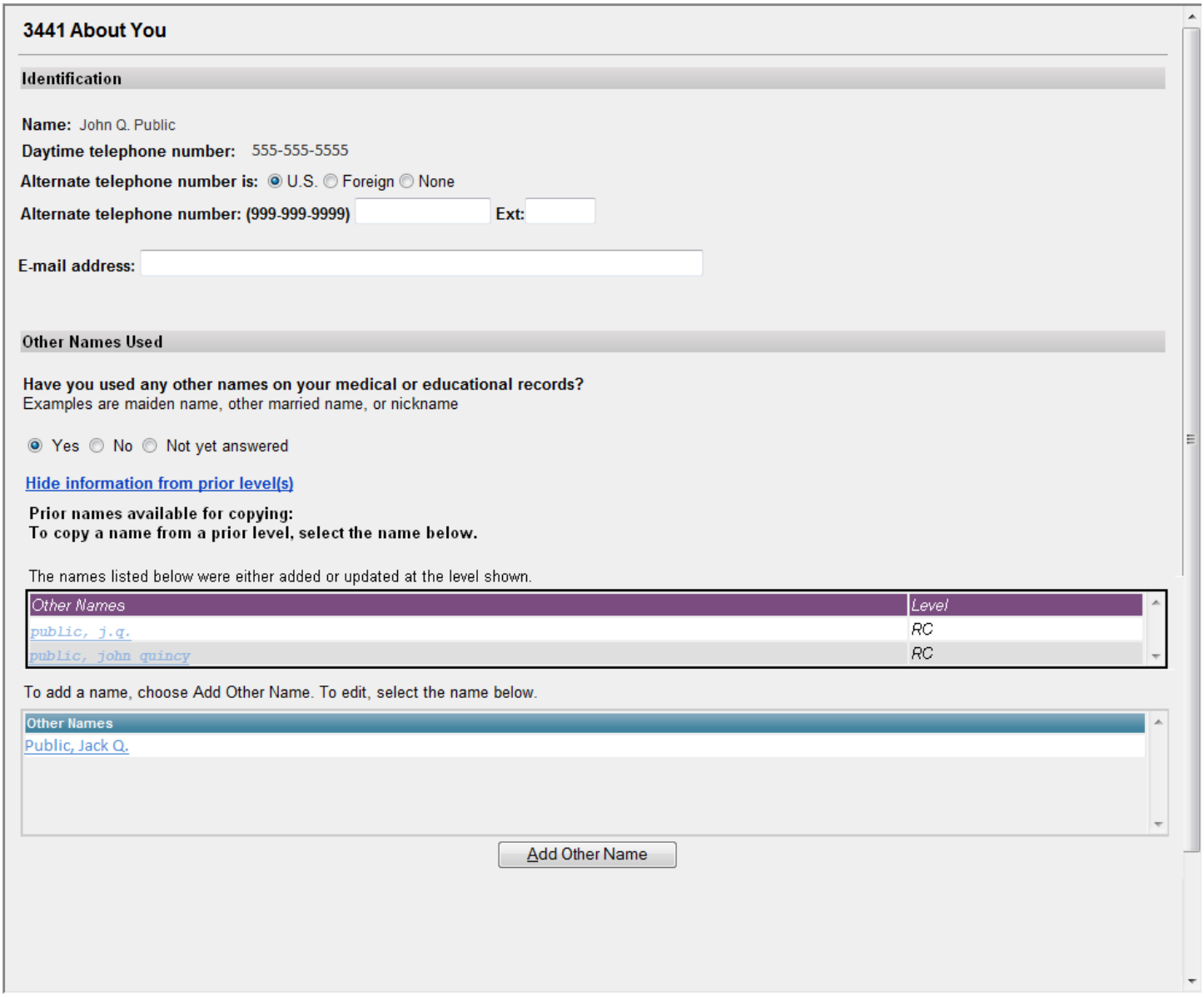
1. Screen Designs

1.1. 3441 About You



1.2. 3441 Contacts

3441 Contacts

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

[Copy from Prior]

Name of Alternate Contact

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

Relationship to disabled person: [...]

Address for Alternate Contact

Address is: (•) U.S. ( ) Foreign [Copy Address]

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City: State: ZIP Code:

Telephone for Alternate Contact

Telephone number is: (•) U.S. ( ) Foreign ( ) None

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

Preferred Language for Alternate Contact

Can this person speak and understand English?

( ) Yes (•) No ( ) Not yet answered

If "NO", what language is preferred?

Person Completing the Report

*Who is providing information?

( ) John Q. Public

( ) Alternate Contact listed above

(•) Someone else

[Copy from Prior]

Name of Person Completing This Report

First name: | Middle name: | Last name: | Suffix:

Agency name:

Relationship to disabled person: [...]

Address for Person Completing This Report

Address is: (•) U.S. ( ) Foreign [Copy Address]

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:

1.3. 3441 Medical Conditions

3441 Medical Conditions

Date of last disability report (MM/DD/YYYY): 05/06/2011

Medical Conditions

When you filed your claim you told us that your physical or mental conditions included:
Severe depression and anxity take medication daily for it; ANXIETY;

***Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your physical or mental conditions?**
(•) Yes ( ) No ( ) Not yet answered

Please describe in detail:
Examples of changes in conditions

Anxiety is more frequent.

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

- June 11, 2002
- October 2000
- Summer 1999

***Since you last told us about your medical conditions, do you have any NEW physical or mental conditions?**
Include:

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

(•) Yes ( ) No ( ) Not yet answered

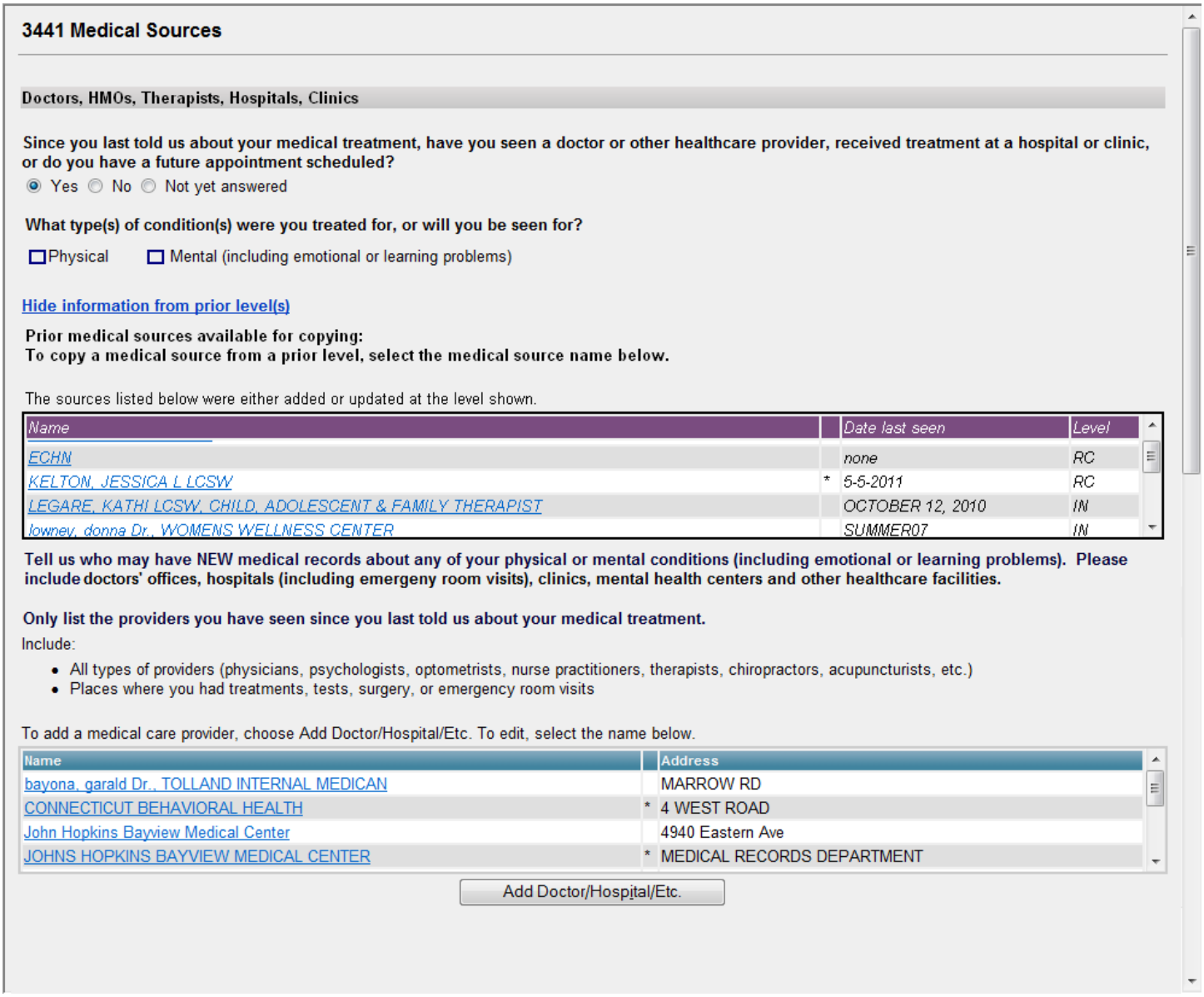
Please describe in detail:
Examples of new conditions

Difficulty in getting enough sleep.

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

- June 11, 2002
- October 2000
- Summer 1999

1.4. 3441 Medical Sources



3441 Medical Sources

Doctors, HMOs, Therapists, Hospitals, Clinics

Since you last told us about your medical treatment, have you seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled?

(•) Yes ( ) No ( ) Not yet answered

What type(s) of condition(s) were you treated for, or will you be seen for?

☐ Physical ☐ Mental (including emotional or learning problems)

Hide information from prior level(s)

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

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

Name		Date last seen	Level
ECHN		none	RC
KELTON, JESSICA L LCSW	*	5-5-2011	RC
LEGARE, KATHI LCSW, CHILD, ADOLESCENT & FAMILY THERAPIST		OCTOBER 12, 2010	IN
lowney, donna Dr., WOMENS WELLNESS CENTER		SUMMER07	IN

Tell us who may have NEW medical records about any of your physical or mental conditions (including emotional or learning problems). Please include doctors' offices, hospitals (including emergeny room visits), clinics, mental health centers and other healthcare facilities.

Only list the providers you have seen since you last told us about your medical treatment.

Include:

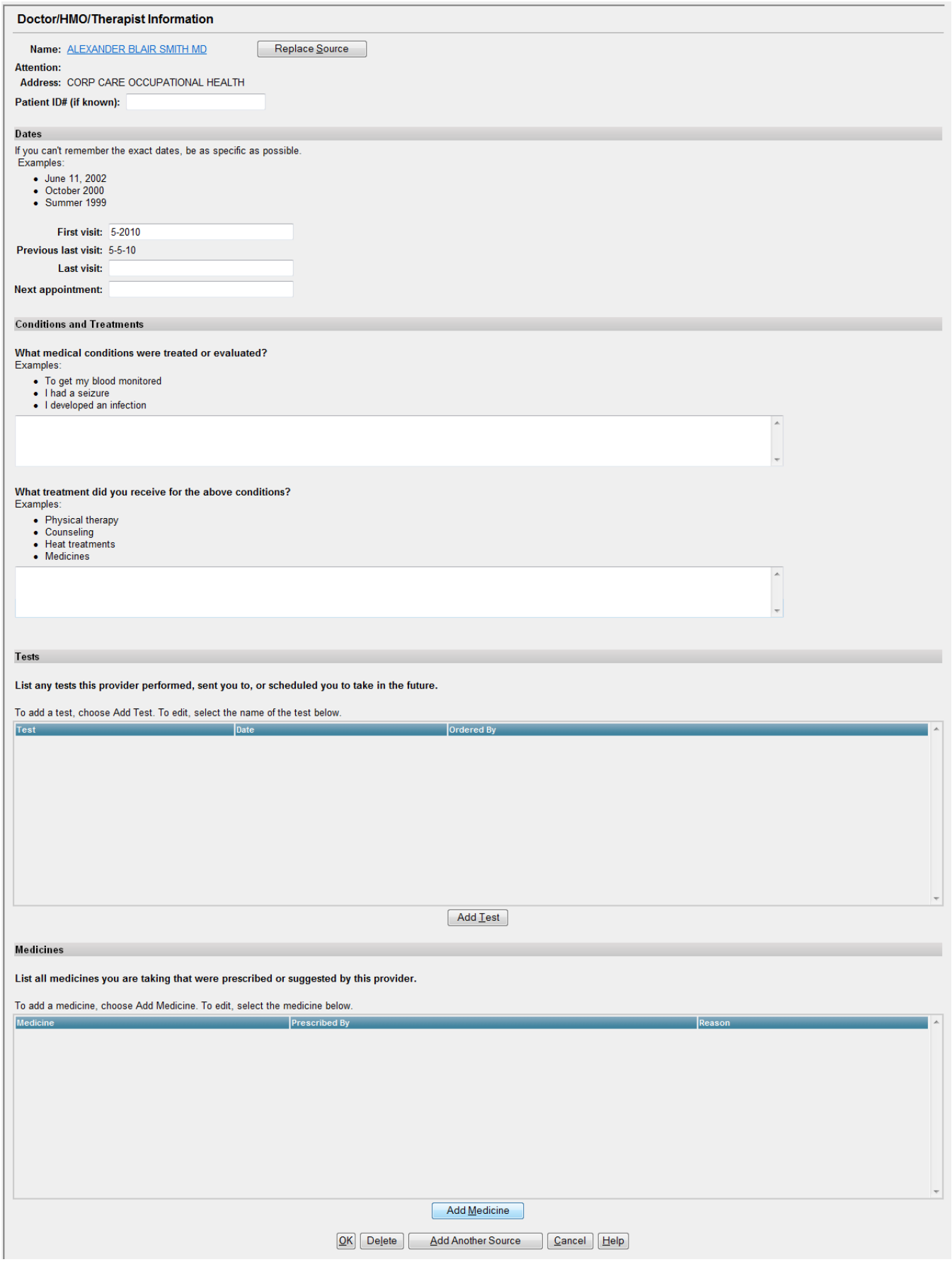
- All types of providers (physicians, psychologists, optometrists, nurse practitioners, therapists, chiropractors, acupuncturists, etc.)
- Places where you had treatments, tests, surgery, or emergency room visits

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

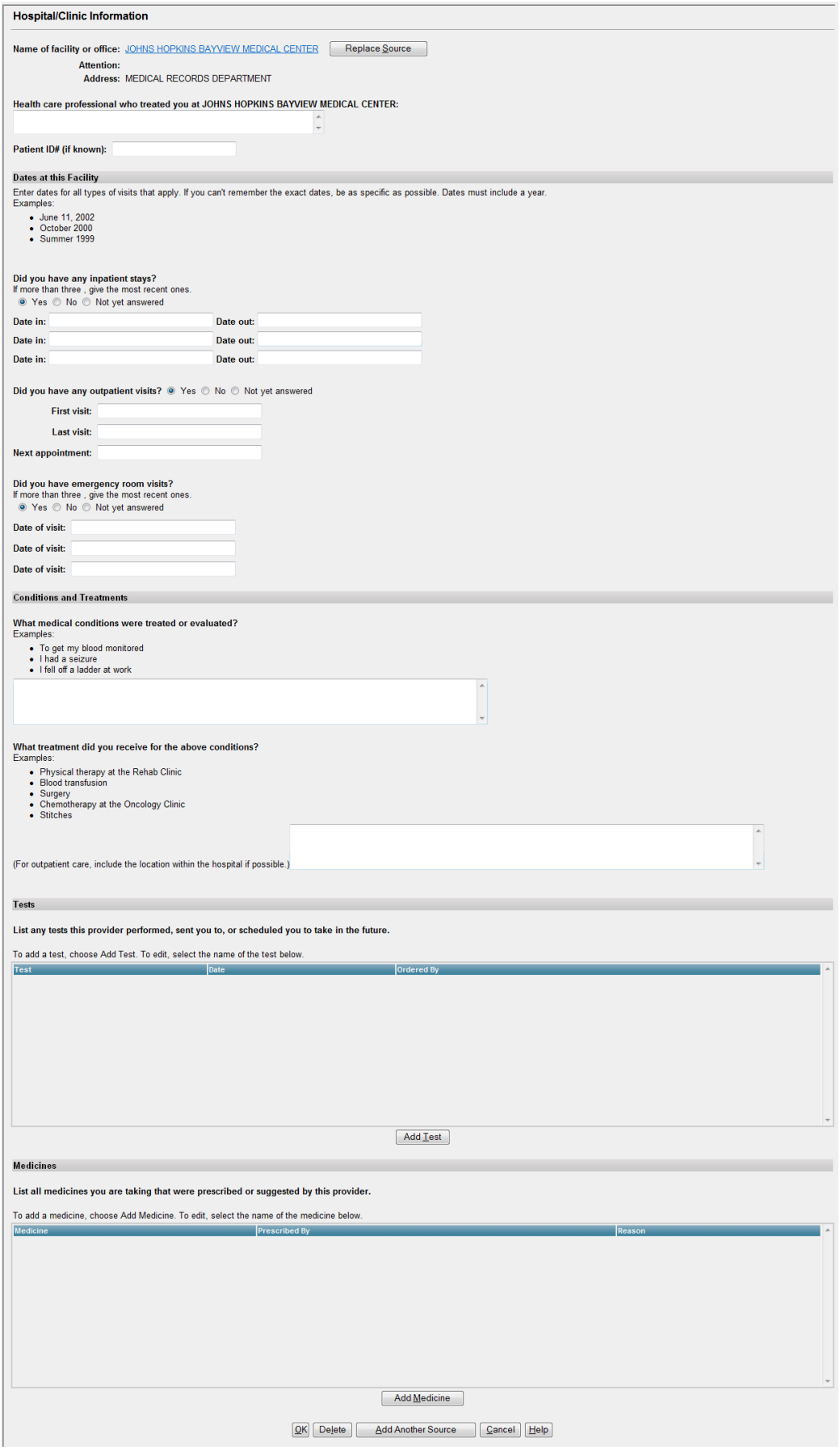
Name		Address
bayona, garald Dr., TOLLAND INTERNAL MEDICAN		MARROW RD
CONNECTICUT BEHAVIORAL HEALTH	*	4 WEST ROAD
John Hopkins Bayview Medical Center		4940 Eastern Ave
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	*	MEDICAL RECORDS DEPARTMENT

Add Doctor/Hospital/Etc.

1.5. Doctor/HMO/Therapist Information



1.6. Hospital/Clinic Information



Hospital/Clinic Information

Name of facility or office: JOHNS HOPKINS BAYVIEW MEDICAL CENTER Replace Source
Attention:
Address: MEDICAL RECORDS DEPARTMENT

Health care professional who treated you at JOHNS HOPKINS BAYVIEW MEDICAL CENTER:

Patient ID# (if known):

Dates at this Facility

Enter dates for all types of visits that apply. If you can't remember the exact dates, be as specific as possible. Dates must include a year.
Examples:
- June 11, 2002
- October 2000
- Summer 1999

Did you have any inpatient stays?
If more than three , give the most recent ones.
Yes No Not yet answered
Date in: Date out:
Date in: Date out:
Date in: Date out:

Did you have any outpatient visits? Yes No Not yet answered
First visit:
Last visit:
Next appointment:

Did you have emergency room visits?
If more than three , give the most recent ones.
Yes No Not yet answered
Date of visit:
Date of visit:
Date of visit:

Conditions and Treatments

What medical conditions were treated or evaluated?
Examples:
- To get my blood monitored
- I had a seizure
- I fell off a ladder at work

What treatment did you receive for the above conditions?
Examples:
- Physical therapy at the Rehab Clinic
- Blood transfusion
- Surgery
- Chemotherapy at the Oncology Clinic
- Stitches

(For outpatient care, include the location within the hospital if possible.)

Tests

List any tests this provider performed, sent you to, 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 taking that were 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

OK Delete Add Another Source Cancel Help

1.7. 3441 Other Medical Information

3441 Other Medical Information

Since you last told us about your other medical information, does anyone else have medical information about your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else?

Examples:

- Worker's Compensation
- Vocational rehabilitation services
- Insurance companies who have paid you disability benefits
- Prisons and correctional facilities
- Attorneys
- Social service agencies
- Welfare agencies
- School/education records

(•) Yes ( ) No ( ) Not yet answered

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

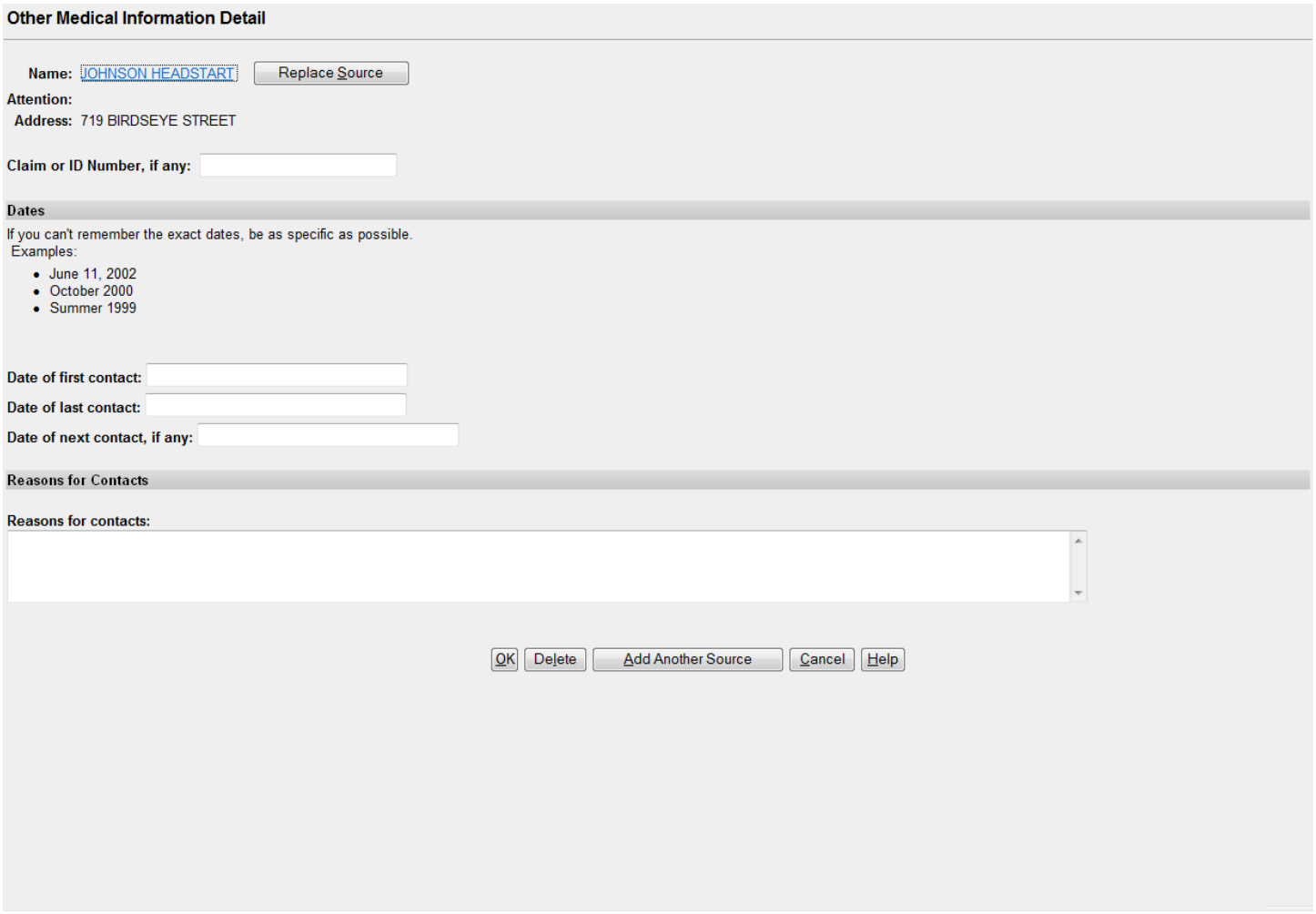
List any other people or places that may have your medical information or records since you last told us about your other medical information.

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

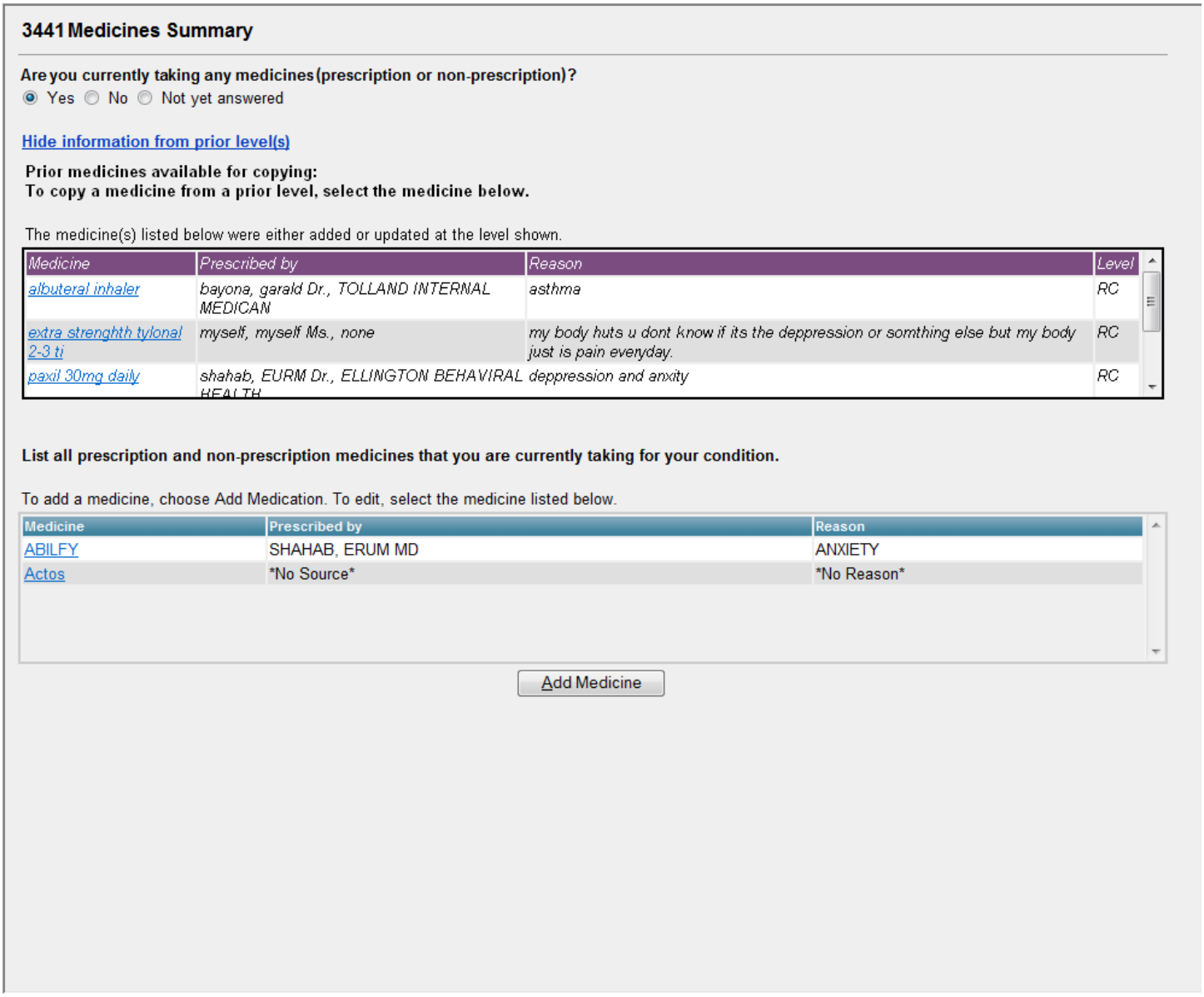
Name		Address

Add Source

1.8. Other Medical Information Detail



1.9. 3441 Medicines Summary



3441 Medicines Summary

Are you currently taking any medicines (prescription or non-prescription)?

(•) Yes ( ) No ( ) Not yet answered

Hide information from prior level(s)

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

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

Medicine	*Prescribed by*	*Reason*	*Level*
albuteral inhaler	*bayona, garald Dr., TOLLAND INTERNAL MEDICAN*	*asthma*	*RC*
extra strenghth tylonal 2-3 ti	*myself, myself Ms., none*	*my body huts u dont know if its the deppression or somthing else but my body just is pain everyday.*	*RC*
paxil 30mg daily	*shahab, EURM Dr., ELLINGTON BEHAVIRAL HEALTH*	*deppression and anxity*	*RC*

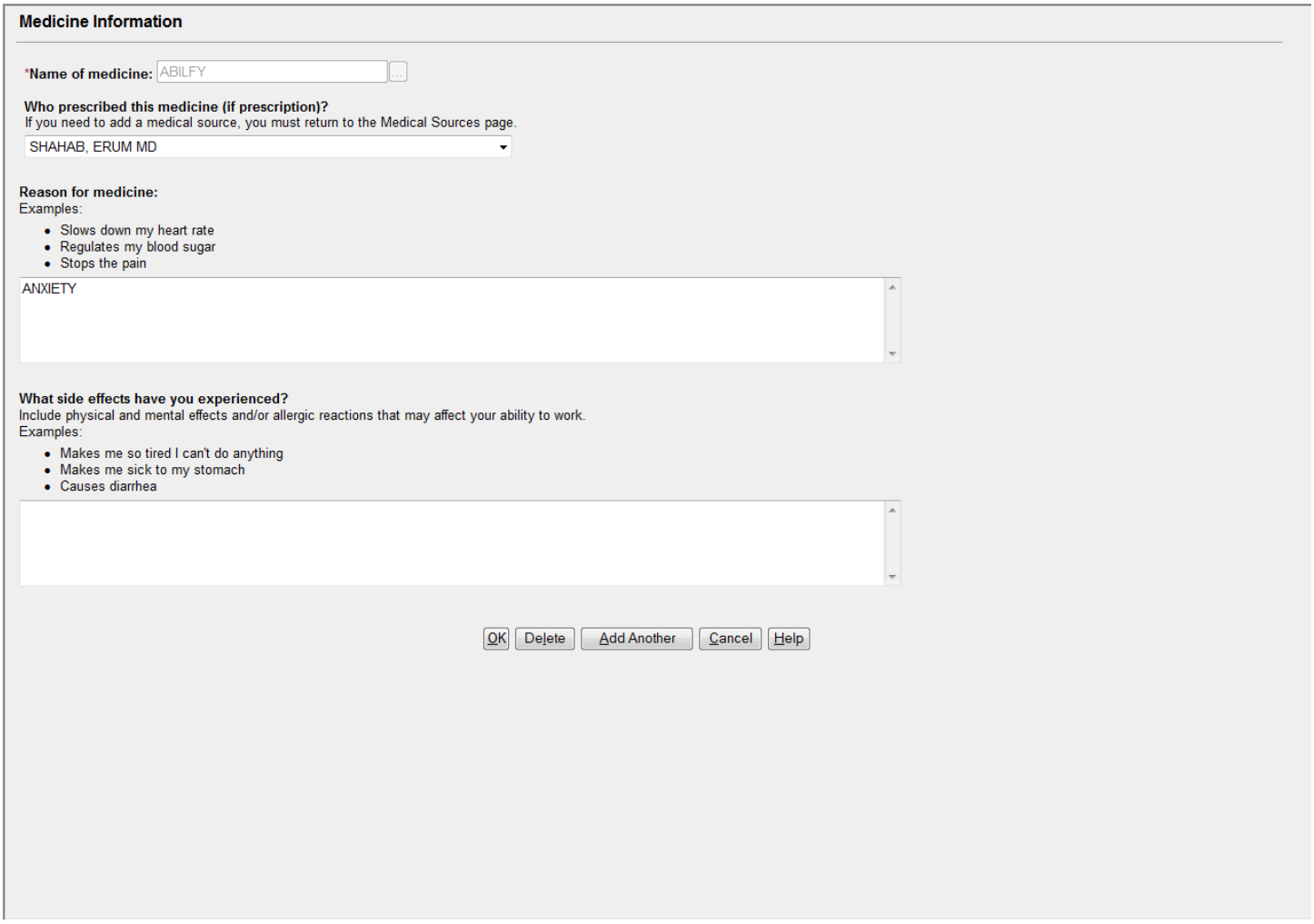
List all prescription and non-prescription medicines that you are currently taking for your condition.

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

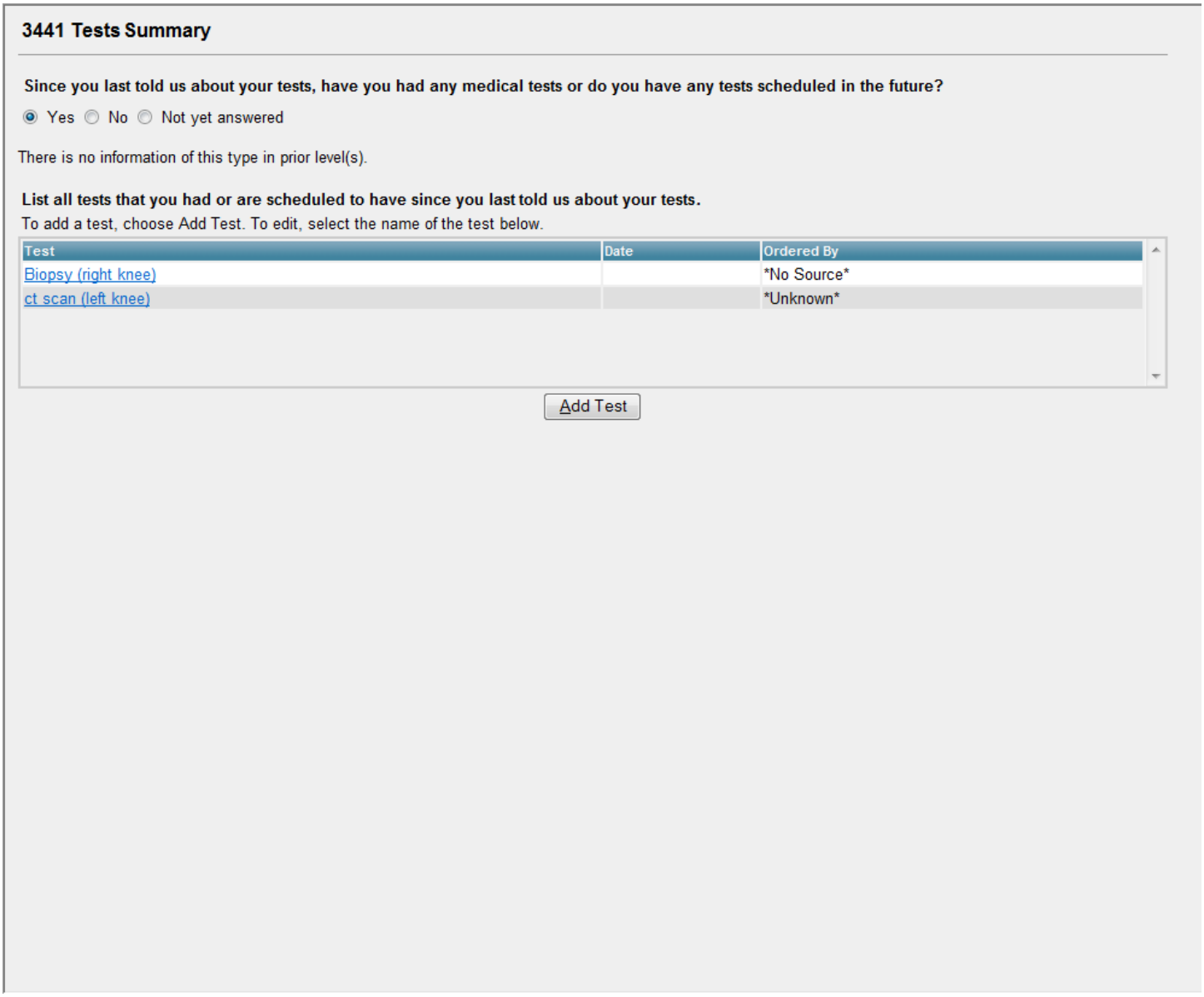
Medicine	Prescribed by	Reason
ABILFY	SHAHAB, ERUM MD	ANXIETY
Actos	*No Source*	*No Reason*

Add Medicine

1.10. Medicine Information



1.11. 3441 Tests Summary



1.12. 3441 Activities

3441 Activities

Information About Your Activities

Since you last told us about your activities, has there been any change (for better or worse) in your daily activities due to your physical or mental conditions?

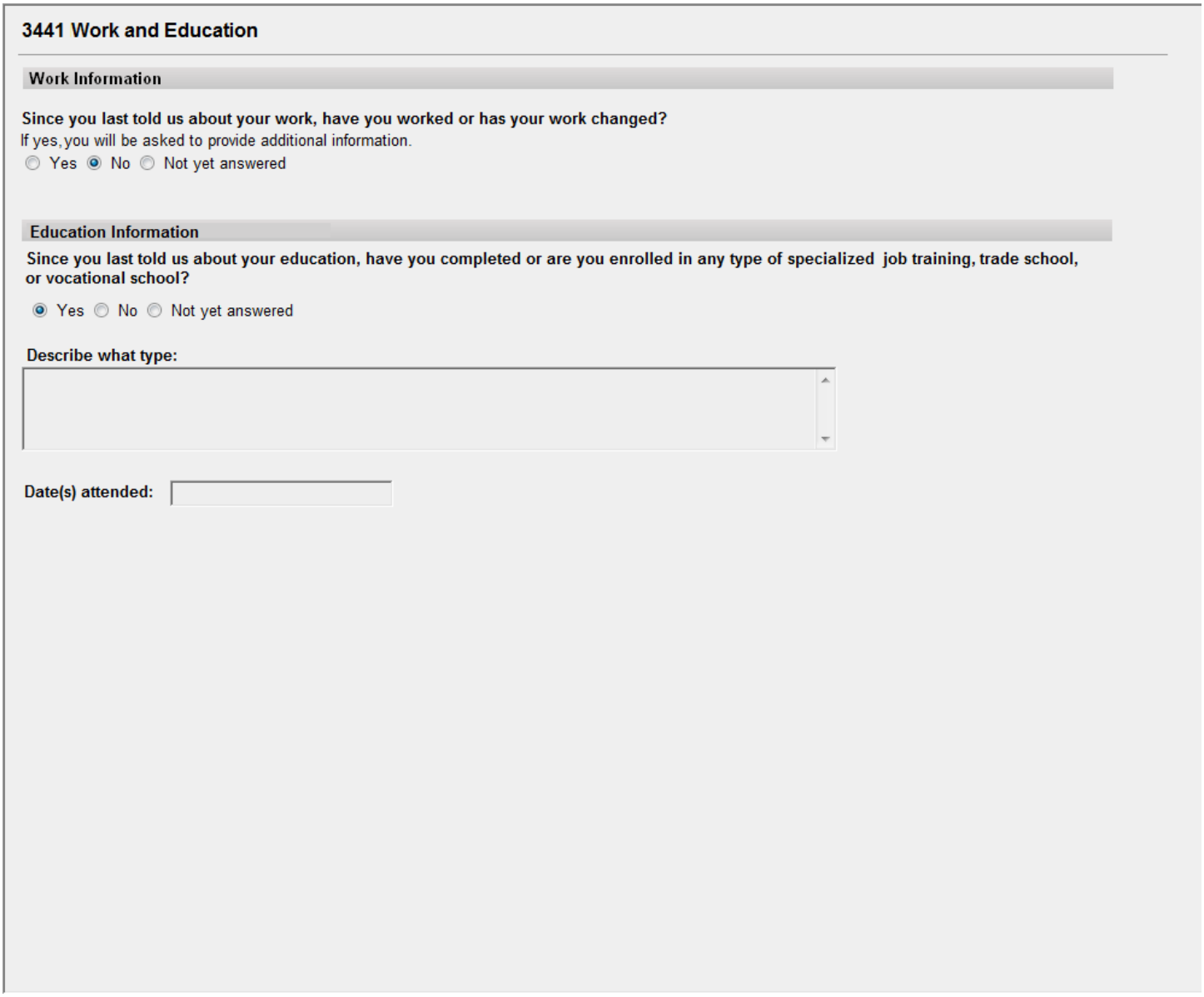
Examples:

- Household tasks
- Personal care
- Getting around
- Hobbies and interests
- Social activities

(•) Yes ( ) No ( ) Not yet answered

Describe in detail.

1.13. 3441 Work and Education



3441 Work and Education

Work Information

Since you last told us about your work, have you worked or has your work changed?
If yes, you will be asked to provide additional information.
○ Yes ◉ No ○ Not yet answered

Education Information

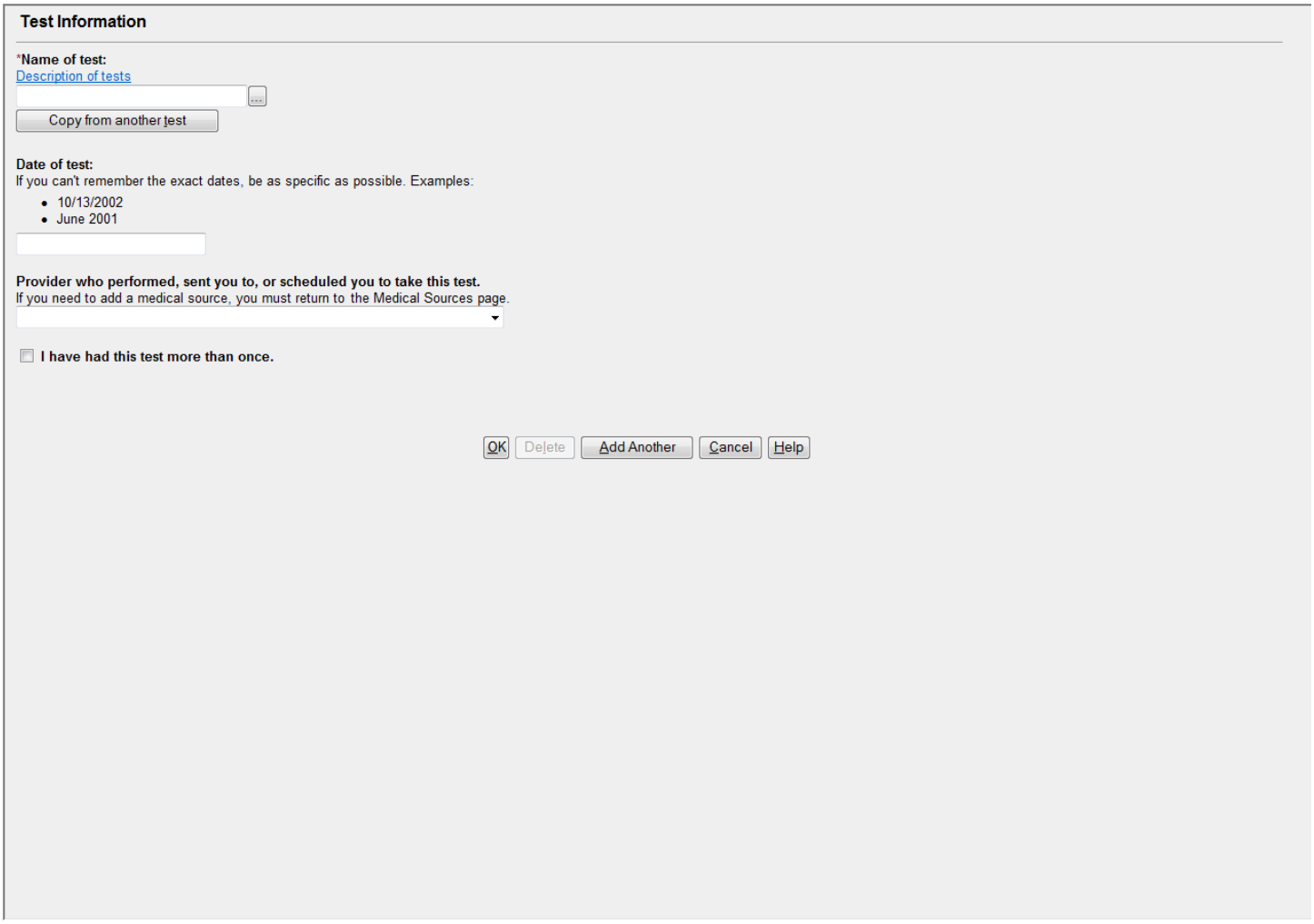
Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?

◉ Yes ○ No ○ Not yet answered

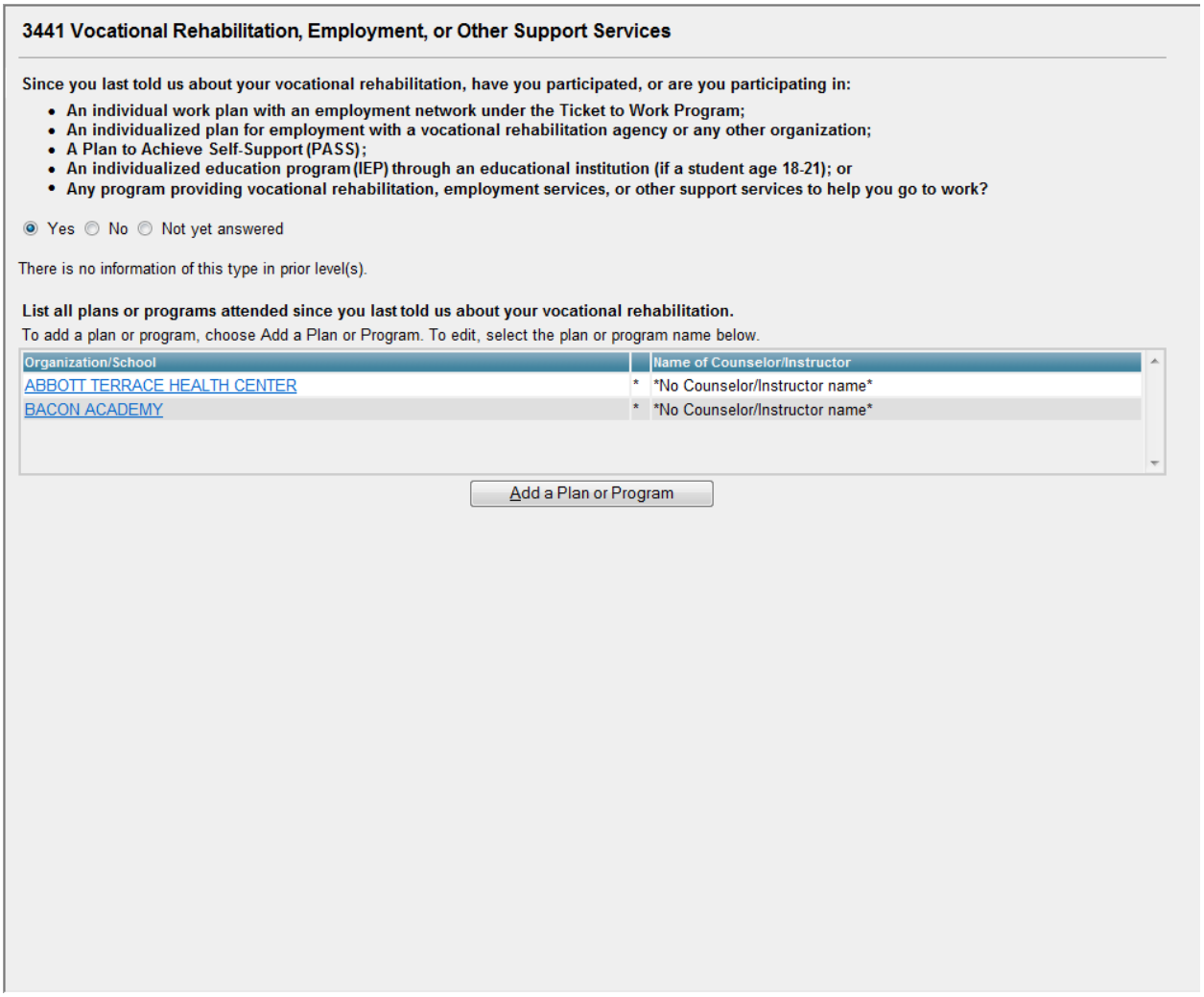
Describe what type:

Date(s) attended:

1.14. Test Information



1.15. 3441 Vocational Rehabilitation, Employment, or Other Support Services



3441 Vocational Rehabilitation, Employment, or Other Support Services

Since you last told us about your vocational rehabilitation, 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 an educational institution (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

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

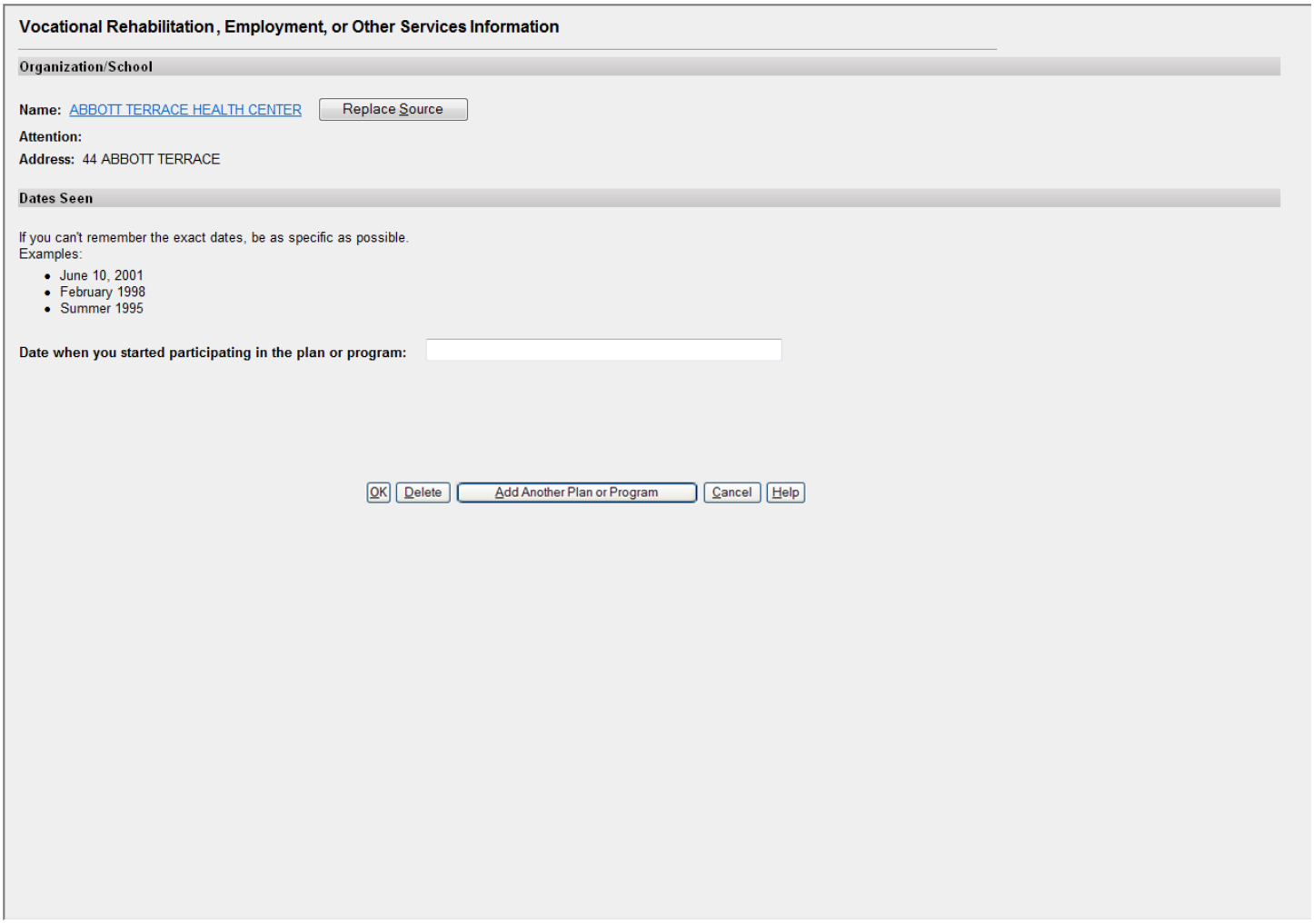
List all plans or programs attended since you last told us about your vocational rehabilitation.

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

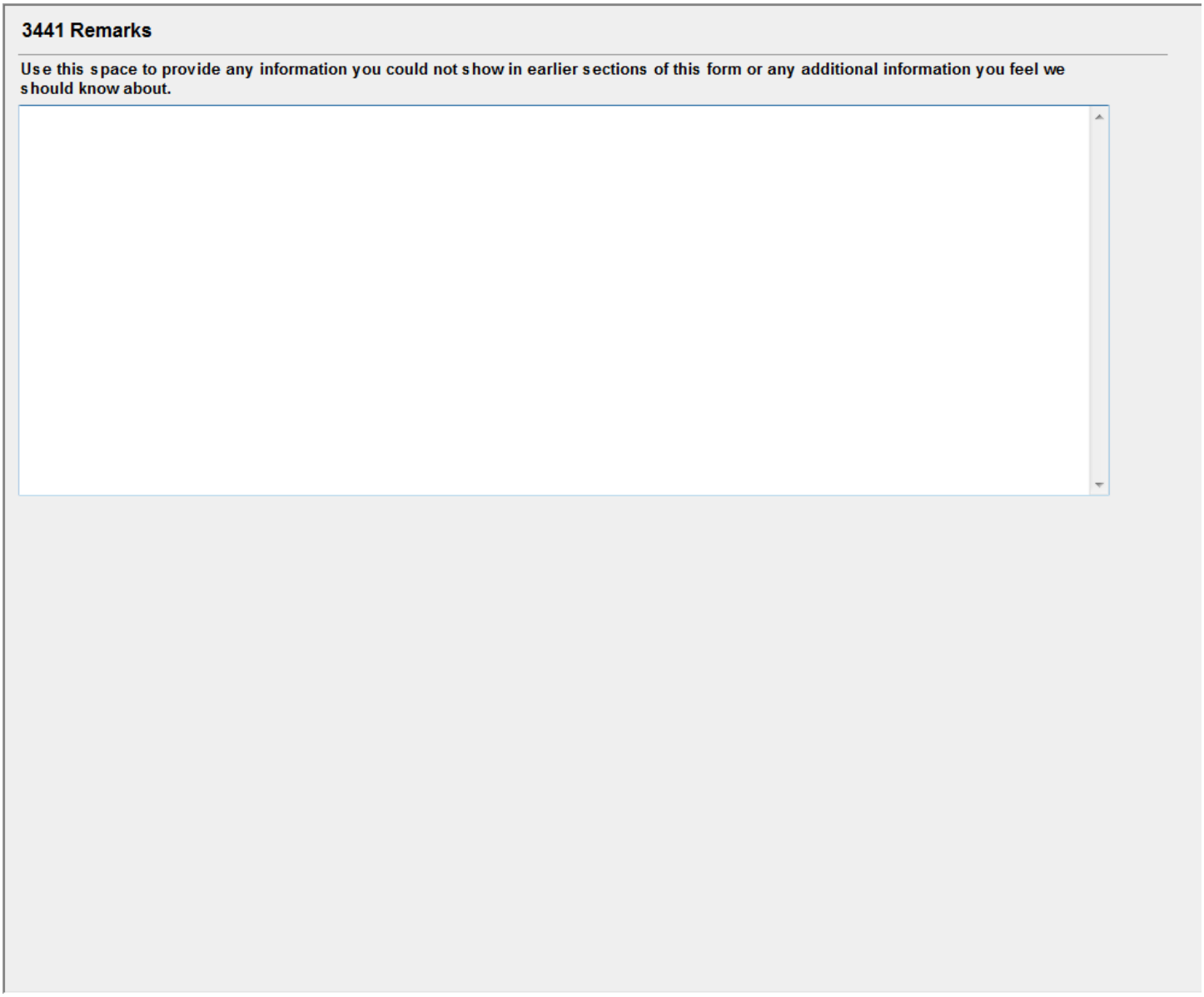
Organization/School		Name of Counselor/Instructor
ABBOTT TERRACE HEALTH CENTER	*	*No Counselor/Instructor name*
BACON ACADEMY	*	*No Counselor/Instructor name*

Add a Plan or Program

1.16. Vocational Rehabilitation, Employment, or Other Services Information



1.17. 3441 Remarks



1.18. Screen Mock-up Version Information

Version Number	*Date*	*Content Revisions*	*Page #*	*Revised by*
1.0	2/28/14	Version 1.0		Beth Candella
2.0	3/5/14	Updated Section 1.15 Vocational Rehabilitation screen mock-up	17	Beth Candella
3.0	3/25/14	Updated Section 1.13 Work and Education screen mock-up with new wording per ODP	15	Beth Candella
4.0	3/27/14	Updated Section 1.15 Vocation Rehabilitation to remove “COMPLETE THIS SECTION…”	17	Beth Candella