



# IAPPEALS REVITALIZATION 2013

## SCREEN PACKAGE VERSION 2.2



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## 1. Screen Package Version Information

The first release of this Screen Package as a project deliverable is numbered 1.0. The second release is 2.0.

<b>Version Number</b>	<b>Date</b>	<b>Content Revisions</b>	<b>Page #</b>	<b>Revised by</b>
0.1 (Draft)	09/24/2013			
1.0	10/28/2013	UXG final recommendations based on research, testing	Multiple	
2.0	02/06/2014	Updated language based on Sponsor Language Change Requests (LCRs)	Multiple	
2.1	02/07/2014	Removed the Attachment Utility screens, and made appropriate modifications to pages affected by the removal of attachment utility screens	Multiple	
2.2	02/11/2014	Addressed any omissions due to multiple screens or dynamic panel edits	Multiple	

## 2. About this Screen Package

This screen package is intended to provide snapshots of the various possible states of the iAppeals screens.

There are some global changes for the prototype which are not reflected in this document.

1. There has been a change to the instructional text for dates. The UXG recommendation:  
 “Enter the closest date [you] can remember. Examples: 6/2/2013; June 2013; Summer 2013.”

will be changed in production to:

“If the exact date is unknown, enter an approximate date. Examples: 6/2/2013; June 2013; Summer 2013.”

2. There has been a change to the field label and instructional text for side effects (for medicines). The UXG recommendation:

**Describe any side effects Sarah Jones experienced while taking this medicine:**

will be changed in production to:

**Describe any side effects Sarah Jones has while taking this medicine:**

If none, enter "None"

There are some additional minor inconsistencies (typographical errors) in the prototype that are incidental and immaterial to the OMB approval process. The work effort of correcting the inconsistencies within the prototype is prohibitively great, but these errors will be corrected in the production version of the application.

### 3. Third Party Screen Designs

#### 3.1. Welcome Page

The screenshot shows the top of a web page for the Social Security Administration. At the top left is the SSA logo, followed by the text "Social Security" and "Official Website of the U.S. Social Security Administration". Below this is a horizontal line, and then the heading "Disability Appeal". The main content area is divided into three columns. The left column has a section titled "Getting Ready" with a paragraph of introductory text and a bulleted list of items to gather. The middle column has a section titled "Submit an Appeal" with a paragraph of text and two buttons: "Start a New Appeal" and "Return to a Saved Appeal", separated by the word "or". The right column has a section titled "More Information" with four links: "About this Application", "Other Ways to Complete a Disability Appeal", "The Appeals Process", and "Hours of Operation". Below this is a section titled "Your privacy is important." with a paragraph of text and a link to the "Privacy Act Statement". At the bottom of the page is a footer with links for "Privacy Policy", "Website Policies & Other Important Information", "About Us", and "Site Map", followed by the text "Last reviewed or modified January 1, 2010 12:00 PM".

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

## Disability Appeal

### Getting Ready

Before you start your appeal, you should gather the [information you need](#) to complete your disability appeal, including:

- Doctors, hospitals, medical treatments, and tests since you last gave us medical information
- Medicines you are currently taking
- Changes in your medical conditions, daily activities, work, and education
- [Supporting documents](#) including forms, medical reports, and written statements

Being prepared will help you spend less time to complete your disability appeal online.

### Submit an Appeal

Completing your appeal online may take 40 to 60 minutes. Your answers will be saved automatically so you can take a break at any time.

[Start a New Appeal](#) or [Return to a Saved Appeal](#)

### More Information

- [About this Application](#)
- [Other Ways to Complete a Disability Appeal](#)
- [The Appeals Process](#)
- [Hours of Operation](#)


### Your privacy is important.

For details about our use of your information, we encourage you to read our [Privacy Act Statement](#).

[Privacy Policy](#) | [Website Policies & Other Important Information](#) | [About Us](#) | [Site Map](#)  
Last reviewed or modified January 1, 2010 12:00 PM



### 3.2. Screening



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

---

## Disability Appeal

### Information about the Applicant

The information collected here refers to the adult or child whose disability decision is being appealed.

**Name:**

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

**Social Security Number (SSN):**


**Date of Birth:**

-- ▾	<input type="text"/>	<input type="text"/>
Month	Day	Year

[Next](#) [Previous](#)

### 3.3. Screening: Lives in US

If state or territory is selected here, it is propagated to Applicant Detail page.



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

---

## Disability Appeal

### Information about the Applicant

The information collected here refers to the adult or child whose disability decision is being appealed.

**Name:**


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

**Social Security Number (SSN):**

**Date of Birth:**

-- ▾	<input type="text"/>	<input type="text"/>
Month	Day	Year

### 3.4. Who is Entering Appeal



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

---

## Disability Appeal

### Who Is Entering This Appeal?

**Are you Sarah Jones or are you entering this appeal on his/her behalf?**

I am Sarah Jones.

I am entering this appeal for Sarah Jones.

---

[Next](#) [Previous](#)

### 3.5. Who is Entering Appeal: Entering for Sarah Jones

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

## Disability Appeal

**Who Is Entering This Appeal?**

**Are you Sarah Jones or are you entering this appeal on his/her behalf?**

I am Sarah Jones.

I am entering this appeal for Sarah Jones.

**What is your relationship to Sarah Jones?**

--

**What is your name?**

First Middle Last Suffix

[Next](#) [Previous](#)

Contents of relationship drop list:

- 
- Appointed Representative (Attorney) or Staff
- Appointed Representative (Non-Attorney) or Staff
- Family Member
- Friend/Neighbor
- Government Agency
- Health Service Agency/Hospital
- Non-Profit Organization/Legal Aid Group
- Nursing Care Facility
- Social Worker
- Other

### 3.6. Who is Entering Appeal: Representative Selected



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

---

## Disability Appeal

### Who Is Entering This Appeal?

**Are you Sarah Jones or are you entering this appeal on his/her behalf?**

I am Sarah Jones.

I am entering this appeal for Sarah Jones.

**What is your relationship to Sarah Jones?**

Appointed Representative (Attorney) or Staff

**Representative's Name:**

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

[Next](#) [Previous](#)

### 3.7. Who is Entering Appeal: Other Selected



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

---

## Disability Appeal

### Who Is Entering This Appeal?

**Are you Sarah Jones or are you entering this appeal on his/her behalf?**

I am Sarah Jones.

I am entering this appeal for Sarah Jones.

**What is your relationship to Sarah Jones?**

Other

**Please specify your relationship:**

**What is your name?**


First Middle Last Suffix

---

[Next](#) [Previous](#)

### 3.8. Reentry Number – 3<sup>rd</sup> Party

Option to enter email address is not provided if the user navigates back to this page and already provided an email address.

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

## Disability Appeal

Identification   **Medical**   Activities/Training   Review

**i Please print this page or write down the reentry number.**


Reentry Number: **37649726**

Website: [www.socialsecurity.gov/disability/appeal](http://www.socialsecurity.gov/disability/appeal)

Select **Return to a Saved Appeal**

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue your saved appeal later.

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy.

 [Print this Page](#)

**Would you like us to email you this reentry number?**  
Please note, only the reentry number will be sent.

Yes    No


**Next**   Save & Exit

In this section...

- Reentry Number**
- [Preparer](#)
- [Applicant Information](#)
- [Representative](#)
- [Request for Hearing](#)

### 3.9. Reentry Number – 3<sup>rd</sup> Party: Email Selected

Option to enter email address is not provided if the user navigates back to this page and already provided an email address.



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

## Disability Appeal

Identification   **Medical**   Activities/Training   Review

**Please print this page or write down the reentry number.**


Reentry Number: **37649726**

Website: [www.socialsecurity.gov/disability/appeal](http://www.socialsecurity.gov/disability/appeal)

Select **Return to a Saved Appeal**

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue your saved appeal later.

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy.

 [Print this Page](#)

**Would you like us to email you this reentry number?**  
Please note, only the reentry number will be sent.

Yes    No

**Email Address:**

  
**Confirm Email Address:**


**Next**   Save & Exit

In this section...

- Reentry Number**
- [Preparer](#)
- [Applicant Information](#)
- [Representative](#)
- [Request for Hearing](#)




### 3.10. Are You Sure You Want to Exit – 3<sup>rd</sup> Party



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

---

## Disability Appeal

 **Are you sure you want to exit?**

Before you select "Yes, I Want to Exit" below, be sure you have the following information so you will be able to continue the appeal for Sarah Jones later.


Reentry Number: **37649726**

Website: [www.socialsecurity.gov/disability/appeal](http://www.socialsecurity.gov/disability/appeal)

Select **Return to a Saved Appeal**


If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy.

---

 [Print this Page](#)

---

### 3.11. Return to a Saved Appeal – 3<sup>rd</sup> Party



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

---

## Disability Appeal

### Return to a Saved Appeal

Please enter the Reentry Number and Social Security Number to continue where you left off. If you don't have a Reentry Number, you will need to start a new appeal.

---

**Reentry Number:**

---

**Applicant's Social Security Number (SSN):**

---

[Next](#) [Previous](#)

### 3.12. Who are You – 3<sup>rd</sup> Party

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

## Disability Appeal

Please Confirm Your Identity

**I am:**

- Sarah Jones
- Terry Halpern
- Pat Graham
- Jamie Gonzales
- Someone else, helping Sarah Jones to appeal


**Next**

The possibilities for the radio list are determined based on data already provided in the claim. The names shown would correspond to the roles, which should be shown in the following order:

1. claimant (always appears)
2. third party preparer, if any
3. person listed on "Someone we can contact" page, if any
4. representative, if any, if different from preparer
5. someone else, helping <claimant name> to appeal (always appears)

If option 5 is selected and completed, the data entered replaces any preparer information previously provided.

### 3.13. Who are You – 3<sup>rd</sup> Party: Someone Else



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

---

## Disability Appeal

### Please Confirm Your Identity

**I am:**

- Sarah Jones
- Terry Halpern
- Pat Graham
- Jamie Gonzales
- Someone else, helping Sarah Jones to appeal

**What is your relationship to Sarah Jones?**

**Your Name:**

First Middle Last Suffix

---

**Your Mailing Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

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

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

---

**Your Daytime Phone Number:**

U.S.  International


10-digit Number [Ext.](#)

Contents of relationship drop list:

--

- Appointed Representative (Attorney) or Staff
- Appointed Representative (Non-Attorney) or Staff
- Family Member
- Friend/Neighbor
- Government Agency
- Health Service Agency/Hospital
- Non-Profit Organization/Legal Aid Group
- Nursing Care Facility
- Social Worker
- Other

### 3.14. Who are You – 3rd Party: Other Selected



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

---

## Disability Appeal

---

### Please Confirm Your Identity

**I am:**

- Sarah Jones
- Terry Halpern
- Pat Graham
- Jamie Gonzales
- Someone else, helping Sarah Jones to appeal

**What is your relationship to Sarah Jones?**

Other

**Please specify:**

**Your Name:**

First Middle Last Suffix

---

**Your Mailing Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

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

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

---

**Your Daytime Phone Number:**

U.S.  International

10-digit Number Ext.

[Next](#)

### 3.15. Preparer – 3rd Party



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

---

## Disability Appeal

Identification   **Medical**   Activities/Training   Review

### Information about Terry Halpern

**Your Mailing Address:**

**Country:**

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add Line](#)

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

**Your Daytime Phone Number:**  
 U.S.    International

10-digit Number   Ext.


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

In this section...

- [Reentry Number](#)
- Preparer**
- [Applicant Information](#)
- [Representative](#)
- [Request for Hearing](#)

### 3.16. Rep Information – 3<sup>rd</sup> Party Professional Rep

Note: the right-hand secondary navigation adjusts based on selections made in the screening stages. In this example, the representative is completing the appeal.



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

## Disability Appeal

Identification   **Medical**   Activities/Training   Review

### Information about Pat Graham

**Your Mailing Address:**

**Country:**  
United States or U.S. Territory

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add Line](#)

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

**Daytime Phone Number:**  
 U.S.    International  
   
10-digit Number   Ext.

**FAX Number, if any:**  
 U.S.    International  
  
10-digit Number

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


In this section...

- Reentry Number
- Representative**
- Applicant Information
- Request for Hearing



### 3.17. Applicant Info – 3<sup>rd</sup> Party

State is prefilled based on selection on screening page, if applicable. Gender is only asked of third parties.



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

---

## Disability Appeal

Identification Medical Activities/Training Review

### Information about Sarah Jones

**Name:**  
Sarah Ann Jones --  
First Middle Last Suffix

**Gender:**  
We only use this information to customize how we ask the questions for this appeal.  
 Male  Female

**Mailing Address:**  
**Country:**  
United States or U.S. Territory

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add Line](#)

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

**Does Sarah Jones live at the above address?**  
 Yes  No

**Daytime Phone Number:**  
 U.S.  International  
   
10-digit Number Ext.

**Alternative Phone Number, if any:**  
Please provide another phone number where we can reach Sarah Jones.  
 U.S.  International  
   
10-digit Number Ext.

In this section...

- Reentry Number
- Preparer
- Applicant Information**
- Representative
- Request for Hearing

**Email Address for Sarah Jones:**

**Confirm Email Address:**

---


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

### 3.18. Rep – 3<sup>rd</sup> Party

This version of the Representative page would be shown only if a representative has not already been identified.

The screenshot shows the Social Security Administration's 'Disability Appeal' interface. At the top left is the Social Security Administration logo and the text 'Social Security Official Website of the U.S. Social Security Administration'. Below this is a navigation bar with four tabs: 'Identification', 'Medical', 'Activities/Training', and 'Review'. The 'Medical' tab is currently selected. The main content area is titled 'Disability Appeal' and contains a section for 'Representative for Sarah Jones'. This section includes a question: 'Does Sarah Jones currently have an appointed representative?' with radio button options for 'Yes' and 'No'. Below the question are three buttons: 'Next', 'Previous', and 'Save & Exit'. On the right side of the page, there is a sidebar titled 'In this section...' with a list of items: 'Reentry Number', 'Preparer', 'Applicant Information', 'Representative', and 'Request for Hearing'. The 'Representative' item is highlighted with a dark blue background.

### 3.19. Rep – 3<sup>rd</sup> Party: Yes Selected



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

---

## Disability Appeal

Identification   **Medical**   Activities/Training   Review

### Representative for Sarah Jones

**Does Sarah Jones currently have an appointed representative?**  
 Yes    No

**Representative's Name:**

First:  Middle:  Last:  Suffix:

**Is the representative an attorney?**  
 Yes    No

**Address:**

**Country:**

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add Line](#)

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

**Daytime Phone Number:**  
 U.S.    International  
   
10-digit Number   Ext.


**FAX Number, if any:**  
  
10-digit Number

**Next**   Previous   Save & Exit

**In this section...**

- Reentry Number
- Preparer
- Applicant Information
- Representative**
- Request for Hearing

### 3.20. Request for Reconsideration – 3rd Party



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

Disability Appeal OMB No. 0000-0000  
Paperwork Reduction Act

Identification | **Medical** | Activities/Training | Review

#### Request for Reconsideration for Sarah Jones

**What is the date on the "Notice of Decision" Sarah Jones received?** [Where to find this date](#)

mm/dd/yyyy

**Claim Number, if different from SSN:** [Where to find the claim number](#)

**Sarah Jones disagrees with the determination made on her claim and requests reconsideration because:** [What details to include](#)

Enter a brief reason for her appeal. (200 characters maximum)


Characters remaining: 200

**In this section...**

- ✓ Reentry Number
- ✓ Preparer
- ✓ Applicant Information
- ✓ Representative
- Request for Reconsideration**

**Next** | Previous | Save & Exit

### 3.21. Request for Hearing – 3<sup>rd</sup> Party



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

---

## Disability Appeal

OMB No. 0000-0000  
Paperwork Reduction Act

Identification   **Medical**   Activities/Training   Review

### Request for Hearing for Sarah Jones

**What is the date on the "Notice of Decision" Sarah Jones received?** [Where to find this date](#)

mm/dd/yyyy

**Claim Number, if different from SSN:** [Where to find the claim number](#)

**Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the determination made on her claim because:** [What details to include](#)  
Enter a brief reason for her appeal. (200 characters maximum)

Characters remaining: 200

**Does Sarah Jones wish to appear at a hearing?** [More info about appearing](#)

Sarah Jones wishes to appear at a hearing.


Sarah Jones does not wish to appear at a hearing and requests that a decision be made based on the evidence in her case. ([Complete Waiver Form HA-4608](#))

**In this section...**

- ✓ Reentry Number
- ✓ Representative
- ✓ Applicant Information
- Request for Hearing**

**Next**   Previous   Save & Exit

### 3.22. Someone We Can Contact – 3rd Party



# Social Security

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---

## Disability Appeal

OMB No. 0000-0000  
Paperwork Reduction Act

Identification    Medical    Activities/Training    Review

### Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

**Who can help us with this appeal?**


Terry Halpern  
 Someone else  
 No one

**Next**    Previous    Save & Exit

**In this section...**

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

### 3.23. Someone We Can Contact – 3rd Party: No one selected



# Social Security

Official Website of the U.S. Social Security Administration

---

## Disability Appeal

OMB No. 0000-0000  
Paperwork Reduction Act

Identification    Medical    Activities/Training    Review

### Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

**Who can help us with this appeal?**

Terry Halpern  
 Someone else  
 No one

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

Having the name of someone who knows Sarah Jones may help us make a decision on her appeal. Doctors and hospitals may not have a complete picture of how her conditions affect her daily life and work.

You can change the selection above to provide the contact information of someone who knows Sarah Jones.

**Next**    Previous    Save & Exit

**In this section...**

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information




### 3.24. Someone We Can Contact – 3rd Party: Someone else selected

Contents of relationship drop list:

- 
- Family Member
- Friend/Neighbor
- Government Agency
- Health Service Agency/Hospital
- Non-Profit Organization/Legal Aid Group
- Nursing Care Facility
- Social Worker
- Other

### 3.25. Someone We Can Contact – 3rd Party: Follow up questions



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## Disability Appeal

OMB No. 0000-0000  
Paperwork Reduction Act

[Identification](#) | [Medical](#) | [Activities/Training](#) | [Review](#)

### Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

**Who can help us with this appeal?**

Terry Halpern  
 Someone else  
 No one

**Name:**

First:  Middle:  Last:  Suffix:

**Relationship to Sarah Jones:**

**Does this person live with Sarah Jones?**

Yes  No

**Address:**

**Country:**

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add Line](#)

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

**In this section...**

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

**Does this person live with Sarah Jones?**  
 Yes  No

**Address:**

**Country:**  
United States or U.S. Territory ▼

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add Line](#)

**City/Town:**  **State/Territory:** -- ▼ **ZIP Code:**

---

**Does this person have the same daytime phone number as Sarah Jones?**  
 Yes  No

**Daytime Phone Number:**  
We need to be able to contact this person during the day.  
 U.S.  International

10-digit Number Ext.


---

**Can this person speak and understand English?**  
 Yes  No

**What language does the contact person prefer?**  
-- ▼

**Next** Previous Save & Exit

### 3.26. Someone We Can Contact – 3rd Party: Terry Halpern selected



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Official Website of the U.S. Social Security Administration

---

## Disability Appeal

OMB No. 0000-0000  
[Paperwork Reduction Act](#)

Identification    Medical    [Activities/Training](#)    [Review](#)

### Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

**Who can help us with this appeal?**

Terry Halpern  
 Someone else  
 No one

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

**In this section...**

- Someone We Can Contact**
- [Medical Conditions](#)
- [Medical Treatment](#)
- [Doctors and Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.27. Someone We Can Contact – 3rd Party: Professional Rep

# Social Security

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## Disability Appeal

OMB No. 0000-0000  
Paperwork Reduction Act

Identification     Medical     Activities/Training     Review

### Someone We Can Contact about Sarah Jones's Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about Sarah Jones's medical conditions and can help her with this appeal.

Sarah Jones doesn't have a contact.

**Name:**

First                      Middle                      Last                      Suffix

**Relationship to Sarah Jones:**

**Does this person live with Sarah Jones?**

Yes     No

**Does this person have the same daytime phone number as Sarah Jones?**

Yes     No

**Can this person speak and understand English?**

Yes     No

In this section...

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

### 3.28. Section3: Medical Conditions – 3rd Party

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

## Disability Appeal

Identification **Medical** Activities/Training Review

### Change in Conditions for Sarah Jones

Since Sarah Jones last told us about her medical conditions, has there been any **CHANGE** (for better or worse) in her physical or mental conditions? [? What are changes in conditions?](#)

Yes  No

### New Conditions

Since Sarah Jones last told us about her medical conditions, does she have any **NEW** physical or mental conditions? [? What are new conditions?](#)

Yes  No

**Next** Previous Save & Exit


**In this section...**

- Someone We Can Contact
- Medical Conditions**
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

1

<sup>1</sup> Note: the language for these questions has been changed per stakeholders. It does not reflect the recommendation of the User Experience Group.

### 3.29. Section3: Medical Conditions – 3rd Party: Follow up questions



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## Disability Appeal

Identification     Medical     Activities/Training     Review

### Change in Conditions for Sarah Jones

**Since Sarah Jones last told us about her medical conditions, has there been any CHANGE (for better or worse) in her physical or mental conditions?**    [? What are changes in conditions?](#)

Yes     No

**Date the change(s) occurred:**  
Enter the closest date you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Please describe the change(s) to Sarah Jones's condition(s) in detail:**  
(1000 characters maximum)

Characters remaining: 1000

If you need more space, continue in [Remarks](#).

### New Conditions

**Since Sarah Jones last told us about her medical conditions, does she have any NEW physical or mental conditions?**    [? What are new conditions?](#)

Yes     No

**Date when the new condition(s) began:**  
Enter the closest date you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Please describe Sarah Jones's new condition(s) in detail:**  
(1000 characters maximum)

Characters remaining: 1000

If you need more space, continue in [Remarks](#).

#### In this section...

- Someone We Can Contact
- Medical Conditions**
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

### 3.30. Section3: Medical Conditions – 3rd Party: Remarks Pop Up

#### Remarks


**Please provide any additional information:**  
Identify the question(s) these remarks apply to. You will be able to review and edit your remarks before you submit this appeal. (2000 characters maximum for your appeal)

Characters remaining: 2000

**See Sarah Jones's new condition(s) in detail:**  
(maximum)



### 3.31. Section4: Medical Treatment – 3rd Party



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---

## Disability Appeal

Identification    Medical    **Activities/Training**    Review

### Other Names for Sarah Jones

**Has Sarah Jones used any other names on her medical or educational records?**  
For example, maiden name, other married name, or nickname.

Yes     No

### Medical Treatment

**Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled?**


Yes     No

**In this section...**

- Someone We Can Contact
- Medical Conditions
- Medical Treatment**
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

**Next**    Previous    Save & Exit

### 3.32. Section4: Medical Treatment – 3rd Party: Follow up questions



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---

## Disability Appeal

Identification    **Medical**    [Activities/Training](#)    [Review](#)

### Other Names for Sarah Jones

**Has Sarah Jones used any other names on her medical or educational records?**  
For example, maiden name, other married name, or nickname.

Yes     No

**Other Name 1:**

           --   

First                      Middle                      Last                      Suffix

### Medical Treatment

**Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled?**

Yes     No

**What type(s) of condition(s) was Sarah Jones treated for, or will she be seen for?**

Physical     Mental (including emotional or learning problems)

**In this section...**

- [Someone We Can Contact](#)
- [Medical Conditions](#)
- Medical Treatment**
- [Doctors and Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.33. Doctors & Hospitals – 3rd Party



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---

## Disability Appeal

Identification    Medical    **Activities/Training**    Review

### Doctors and Hospitals for Sarah Jones

Please tell us about anyone who has **new** medical records about any of Sarah Jones's physical or mental conditions (including emotional or learning problems).

#### Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
Click Add Doctor to add a doctor or healthcare provider.			

---


#### Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
Click Add Hospital or Clinic to add a hospital or clinic.			

**In this section...**

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals**
- Tests
- Medicines
- Other Medical Information

### 3.34. Add New Doctors – 3rd Party



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---

## Disability Appeal

### Doctor or Healthcare Provider Details

---

**Name of Doctor or Healthcare Provider:**

-- Title First Last -- Suffix

---

**Name of Practice or Medical Group:**

---

**Phone Number:**

U.S.  International

10-digit Number Ext.

---

**Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

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

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

---

**Patient ID Number, if known:**

### Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**First Visit:**

**Last Visit:**

**Next Scheduled Appointment, if any:**

**Medical Conditions Treated by this Doctor or Healthcare Provider**

**What medical conditions were treated or evaluated?**

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

Characters remaining: 1000

**Treatment from this Doctor or Healthcare Provider**

**What treatment did Sarah Jones receive for the above conditions?**

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

**Tests Ordered by this Doctor or Healthcare Provider**

Please add any tests this doctor or healthcare provider ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

**Medicines Recommended or Prescribed by this Doctor or Healthcare**

### Provider

Please add **all prescription and non-prescription** medicines Sara Jones is **currently** taking that this doctor or healthcare provider recommended or prescribed.

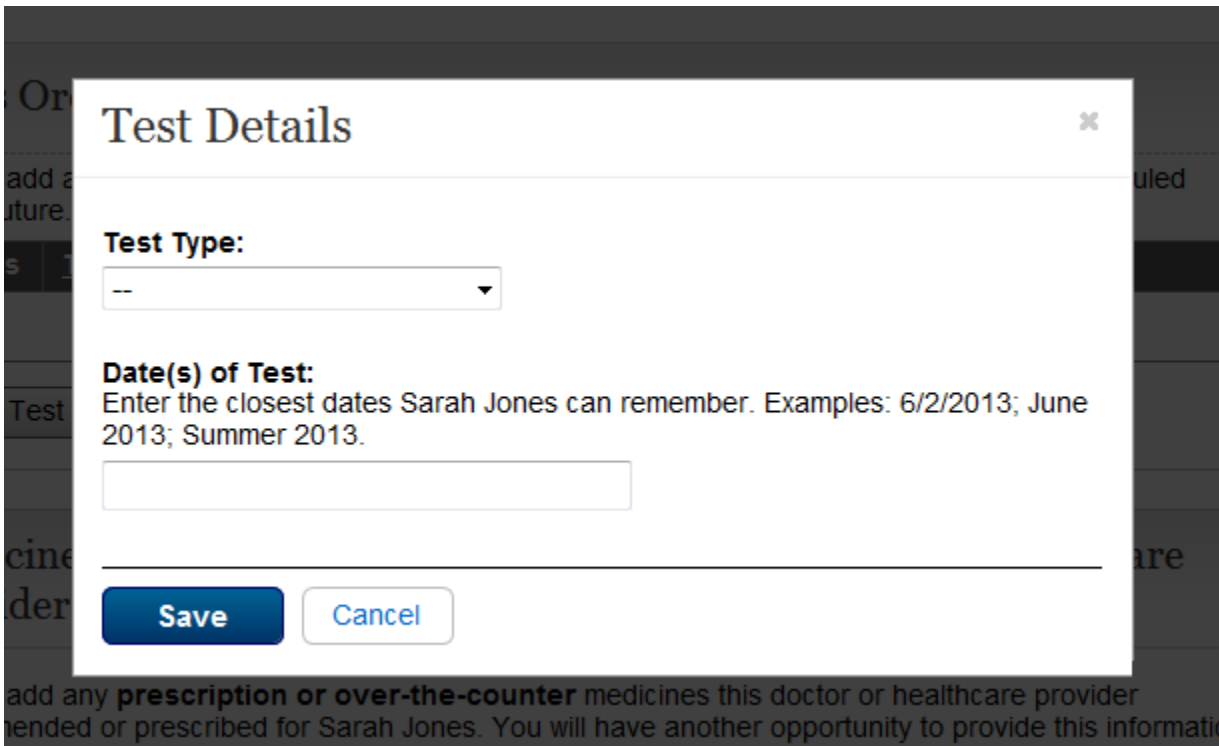
Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

### 3.35. Add New Doctors – 3rd Party: Test Popup



Contents of "Test Type" drop list:

- 
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

Of these Test Types, selection of the following items will dynamically display a Body Part:

- Biopsy
- X-Ray
- Other

Selecting "Other" will also dynamically display a "Please specify test type" text field.

### 3.36. Add New Doctors – 3rd Party: Test Popup with follow up question

The image shows a 'Test Details' popup window overlaid on a dark background. The popup has a title bar with 'Test Details' and a close button (X). It contains three main sections: 'Test Type' with a dropdown menu showing 'Biopsy', 'Body Part' with an empty text input field, and 'Date(s) of Test' with a text input field and a descriptive instruction: 'Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.' At the bottom of the popup are two buttons: 'Save' (blue) and 'Cancel' (white with blue border). The background shows a table with columns for 'Medicine', 'Reason', and 'Actions'.



### 3.37. Add New Doctors – 3rd Party: Medicine Popup

**Medicine Details** [Close]

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

**What is the reason Sarah Jones is taking this medicine?**

**Describe any side effects Sarah Jones experienced while taking this medicine:**

Characters remaining: 1000

**Save** **Cancel**

### 3.38. Doctors & Hospitals 1 Row Filled – 3rd Party



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---

## Disability Appeal

Identification  Medical  Activities/Training  Review

### Doctors and Hospitals for Sarah Jones

Please tell us about anyone who has **new** medical records about any of Sarah Jones's physical or mental conditions (including emotional or learning problems).

#### Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
<input checked="" type="checkbox"/>	Dr. Samantha Gupta	Baltimore	<input type="button" value="Edit"/> <input type="button" value="Delete"/>


#### Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
Click Add Hospital or Clinic to add a hospital or clinic.			

#### In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals**
- Tests
- Medicines
- Other Medical Information

### 3.39. Add New Hospitals – 3rd Party



**Social Security**  
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---

## Disability Appeal

### Hospital or Clinic Details

**Name of Hospital or Clinic:**

---

**Name of Healthcare Provider who treated Sarah Jones, if known:**

---

**Phone Number:**  
 U.S.     International

10-digit Number    Ext.

---

**Address:**

**Country:**

**Street Address:**

Street Line 1:

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

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

---

**Patient ID Number, if known:**

### Treatment Dates at this Hospital or Clinic

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Did Sarah Jones have any outpatient visits at this hospital or clinic, or does she have any scheduled?**  
Outpatient visit means she went home the same day. This does not include emergency room visits.

Yes     No

---

**Did Sarah Jones have any emergency room (ER) visits at this hospital or clinic?**

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

Yes  No

**Did Sarah Jones have any overnight stays at this hospital or clinic?**

Yes  No

### Medical Conditions Treated by this Hospital or Clinic

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

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

Characters remaining: 1000

### Treatment from this Hospital or Clinic

**What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?**

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

### Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

### Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines Sara Jones is **currently** taking that this hospital or clinic recommended or prescribed.

Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

### 3.40. Add New Hospitals – 3rd Party: Yes to Treatment Dates

#### Disability Appeal

##### Hospital or Clinic Details

**Name of Hospital or Clinic:**

**Name of Healthcare Provider who treated Sarah Jones, if known:**

**Phone Number:**  
 U.S.     International

     
10-digit Number    [Ext.](#)

**Address:**

**Country:**  
United States or U.S. Territory ▾

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add More Lines](#)

**City/Town:**     **State/Territory:**  ▾    **ZIP Code:**

**Patient ID Number, if known:**

##### Treatment Dates at this Hospital or Clinic

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**Did Sarah Jones have any outpatient visits at this hospital or clinic, or does she have any scheduled?**  
Outpatient visit means she went home the same day. This does not include emergency room visits.  
 Yes     No

**First outpatient visit:**

**Last outpatient visit:**

**Next scheduled outpatient visit (if any):**

**Did Sarah Jones have any emergency room (ER) visits at this hospital or clinic?**

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

Yes     No

Please give the dates of Sarah Jones's most recent emergency room visits.

**Emergency Room Visit 1:**

**Emergency Room Visit 2:**

**Emergency Room Visit 3:**

**Did Sarah Jones have any overnight stays at this hospital or clinic?**

Yes     No

Give us the dates of Sarah Jones's three most recent stays.

**Visit 1:**

Date In

Date Out

**Visit 2:**

Date In

Date Out

**Visit 3:**

Date In

Date Out

**Medical Conditions Treated by this Hospital or Clinic**

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

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

Characters remaining: 1000

**Treatment from this Hospital or Clinic**

**What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?**

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

### Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

### Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines Sara Jones is **currently** taking that this hospital or clinic recommended or prescribed.

Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel



### 3.41. Doctors & Hospitals 2 Rows Filled – 3rd Party



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## Disability Appeal

[Identification](#) [Medical](#) [Activities/Training](#) [Review](#)

### Doctors and Hospitals for Sarah Jones

Please tell us about anyone who has **new** medical records about any of Sarah Jones's physical or mental conditions (including emotional or learning problems).

#### Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
<input checked="" type="checkbox"/>	Dr. Samantha Gupta	Baltimore	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

---

#### Hospitals and Clinics


Status	Hospital or Clinic	City	Actions
<input checked="" type="checkbox"/>	Vancouver General Hospital	Vancouver	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- [Someone We Can Contact](#)
- [Medical Conditions](#)
- [Medical Treatment](#)
- Doctors and Hospitals**
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.42. Tests – 3rd Party

Table will be prefilled with what was entered in doctors/hospitals pages



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## Disability Appeal

Identification **Medical** Activities/Training Review

### Tests for Sarah Jones

Please tell us about any medical tests Sarah Jones had or will have related to her disability.

Status	Name of Test	Test Ordered by	Actions
✓	EKG (Heart Test)	Dr. Samantha Gupta	Edit Delete
✓	X-Ray	Doctor(s) at Vancouver General Hospital	Edit Delete

Add Test

**Next** Previous Save & Exit

In this section...

- ✓ Someone We Can Contact
- ✓ Medical Conditions
- ✓ Medical Treatment
- ✓ Doctors and Hospitals
- Tests**
- Medicines
- Other Medical Information

### 3.43. Add New Test – 3rd Party

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Text Size | Accessibility Help

## Disability Appeal

### Test Details

**Test Type:**  
--

**Date(s) of Test:**  
Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.  
[Text Input Field]

**Who ordered this test for Sarah Jones?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."  
--

**Save** **Cancel**

Contents of Test Type drop list:

- 
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

Of these Test Types, selection of the following items will dynamically display a Body Part field:

- Biopsy
- X-Ray
- Other

Selecting "Other" will also dynamically display the "Please specify test type" question.

Contents of "Who recommended..." drop list:

--

*(All doctors previously entered)*

*(All hospitals previously entered)*


Other Doctor or Healthcare Provider


Other Hospital or Clinic

No one recommended or prescribed this medicine

I don't know

### 3.44. Add New Test – 3rd Party: Follow up question and Other Doctor

| Text Size  | Accessibility Help



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## Disability Appeal

### Test Details

**Test Type:**

**Body Part:**


**Date(s) of Test:**  
Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.


---

**Who ordered this test for Sarah Jones?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

**Has Sarah Jones seen this doctor or healthcare provider since she last sent us medical information?** [? Why we ask this](#)  
 Yes  No

### 3.45. Add New Test – 3rd Party: Have not seen the doctor

| Text Size  | Accessibility Help



## Social Security

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---

## Disability Appeal

### Test Details

**Test Type:**

**Body Part:**

**Date(s) of Test:**  
Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Who ordered this test for Sarah Jones?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

**Has Sarah Jones seen this doctor or healthcare provider since she last sent us medical information?** [Why we ask this](#)  
 Yes  No

### Doctor or Healthcare Provider Details

**Name of Doctor or Healthcare Provider who ordered this test for Sarah Jones:**


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

**Country:**

**City/Town:**

**State/Territory:**

### 3.46. Add New Test – 3rd Party: Have seen the doctor



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---

## Disability Appeal

### Test Details

**Test Type:**  
--

**Date(s) of Test:**  
Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.  
[ ]

**Who ordered this test for Sarah Jones?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."  
Other Doctor or Healthcare Provider

**Has Sarah Jones seen this doctor or healthcare provider since she last gave us medical information?** [Why we ask this](#)  
 Yes  No

### Doctor or Healthcare Provider Details

**Name of Doctor or Healthcare Provider who ordered this test for Sarah Jones:**  
-- [ ] [ ] --  
Title First Last Suffix

**Name of Practice or Medical Group:**  
[ ]

**Doctor or Healthcare Provider's Address:**  
**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 or Healthcare Provider's Phone Number:**  
 U.S.  International  
[ ] [ ]  
10-digit Number [Ext.](#)

**Patient ID Number, if known:**  
[ ]

### Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**First Visit:**

**Last Visit:**

**Next Scheduled Appointment, if any:**

**Medical Conditions Treated by this Doctor or Healthcare Provider**

**What medical conditions were treated or evaluated?**  
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

**Treatment from this Doctor or Healthcare Provider**

**What treatment did Sarah Jones receive for the above conditions?**  
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: 1000


**Medicines Recommended or Prescribed by this Doctor or Healthcare Provider**

Please add **any prescription or over-the-counter** medicines this doctor or healthcare provider recommended or prescribed for Sarah Jones. You will have another opportunity to provide this information.

Status	Medicine	Actions
Click Add Medicine to add a medicine.		



### 3.47. Add New Test – 3rd Party: Other Hospital



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## Disability Appeal

#### Test Details

**Test Type:**  
--

**Date(s) of Test:**  
Enter the closest dates Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.  
[Text Input]

**Who ordered this test for Sarah Jones?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."  
Other Hospital or Clinic

#### Hospital or Clinic Details

**Name of Hospital or Clinic:**  
[Text Input]

**Name of Healthcare Provider who treated Sarah Jones, if known:**  
[Text Input]

**Phone Number:**  
 U.S.    International  
[Text Input] [Text Input]  
10-digit Number   Ext.

**Address:**  
**Country:**  
United States or U.S. Territory

**Street Address:**  
Street Line 1: [Text Input]  
Street Line 2: [Text Input] [+ Add More Lines](#)

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

**Patient ID Number, if known:**  
[Text Input]

#### Treatment Dates at this Hospital or Clinic

Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**Did Sarah Jones have any outpatient visits at this hospital or clinic, or have one scheduled?**  
Outpatient visit means she went home the same day. This does not include emergency room visits.

**Did Sarah Jones have any outpatient visits at this hospital or clinic, or have one scheduled?**

Outpatient visit means she went home the same day. This does not include emergency room visits.

Yes  No

**Did Sarah Jones have any emergency room (ER) visits at this hospital or clinic?**

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

Yes  No

**Did Sarah Jones have any overnight stays at this hospital or clinic?**

Yes  No

**Medical Conditions Treated by this Hospital or Clinic**

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

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

Characters remaining: 1000

**Treatment from this Hospital or Clinic**

**What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?**

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

**Medicines Recommended or Prescribed by this Hospital or Clinic**


Please add **all prescription and non-prescription** medicines Sara Jones is **currently** taking that this hospital or clinic recommended or prescribed.

Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save Cancel

### 3.48. Tests 3 Rows Filled – 3rd Party



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## Disability Appeal

[Identification](#) [Medical](#) [Activities/Training](#) [Review](#)

### Tests for Sarah Jones

Please tell us about any medical tests Sarah Jones had or will have related to her disability.

Status	Name of Test	Test Ordered by	Actions
✓	EKG (Heart Test)	Dr. Samantha Gupta	<a href="#">Edit</a> <a href="#">Delete</a>
✓	Breathing Test	Dr. Samantha Gupta	<a href="#">Edit</a> <a href="#">Delete</a>
✓	X-Ray	Doctor(s) at Vancouver General Hospital	<a href="#">Edit</a> <a href="#">Delete</a>

[Add Test](#)

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

In this section...

- ✓ [Someone We Can Contact](#)
- ✓ [Medical Conditions](#)
- ✓ [Medical Treatment](#)
- ✓ [Doctors and Hospitals](#)
- Tests**
- [Medicines](#)
- [Other Medical Information](#)

### 3.49. Medicines – 3rd Party

Table will be prefilled with information that was entered in doctors/hospitals pages. No medicines have been provided yet in this example.

The screenshot displays the Social Security Administration's 'Disability Appeal' web interface. At the top left is the SSA logo and the text 'Social Security Official Website of the U.S. Social Security Administration'. The main heading is 'Disability Appeal'. Below this is a navigation bar with four tabs: 'Identification' (selected with a green checkmark), 'Medical', 'Activities/Training', and 'Review'. The main content area is titled 'Medicines for Sarah Jones' and contains the instruction: 'Please tell us about all prescription and non-prescription medicines that Sarah Jones is currently taking for the conditions related to her disability.' Below this instruction is a table with the following structure:

Status	Name of Medicine	Prescribed by	Actions
Click Add Medicine to add a medicine.			

Below the table is an 'Add Medicine' button. To the right of the main content is a sidebar titled 'In this section...' with a list of navigation items: 'Someone We Can Contact', 'Medical Conditions', 'Medical Treatment', 'Doctors and Hospitals', 'Tests', 'Medicines' (highlighted), and 'Other Medical Information'. At the bottom of the page are three buttons: 'Next' (highlighted), 'Previous', and 'Save & Exit'.

### 3.50. Add New Medicine – 3rd Party

The screenshot shows the Social Security Administration's 'Disability Appeal' interface. At the top right, there are links for 'Text Size' and 'Accessibility Help'. The Social Security Administration logo and name are at the top left. The main heading is 'Disability Appeal'. Below this is a 'Medicine Details' section with the following fields:


- Enter name of the medicine:** Enter only one medicine at a time. Look at the medicine container if necessary. (Text input field)
- Why is Sarah Jones taking this medicine?** (Text input field)
- Describe any side effects Sarah Jones experienced while taking this medicine:** Include physical or mental effects and allergic reactions. (1000 characters maximum) (Text area)
- Who recommended or prescribed this medicine?** If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic." (Dropdown menu)

At the bottom of the form, there are 'Save' and 'Cancel' buttons. A character count shows 'Characters remaining: 1000'.

Contents of "Who recommended..." drop list:

- 
- (All doctors previously entered)*
- (All hospitals previously entered)*
- Other Doctor or Healthcare Provider
- Other Hospital or Clinic
- No one recommended or prescribed this medicine
- I don't know

### 3.51. Add New Medicine – 3rd Party: Other doctor



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## Disability Appeal

### Medicine Details

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

**Why is Sarah Jones taking this medicine?**

**Describe any side effects Sarah Jones experienced while taking this medicine:**  
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000


**Who recommended or prescribed this medicine?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Other Doctor or Healthcare Provider

**Has Sarah Jones seen this doctor or healthcare provider since she last gave us medical information?** [? Why we ask this](#)

Yes  No

### 3.52. Add New Medicine – 3rd Party: Have not seen the doctor



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---

#### Disability Appeal

---

#### Medicine Details

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

**Why is Sarah Jones taking this medicine?**

**Describe any side effects Sarah Jones experienced while taking this medicine:**  
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

**Who recommended or prescribed this medicine?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."


Other Doctor or Healthcare Provider

**Has Sarah Jones seen this doctor or healthcare provider since she last gave us medical information?** [? Why we ask this](#)

Yes  No

#### Doctor or Healthcare Provider Details

### 3.53. Add New Medicine – 3rd Party: Have seen the doctor



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## Disability Appeal

### Medicine Details

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

**Why is Sarah Jones taking this medicine?**

**Describe any side effects Sarah Jones experienced while taking this medicine:**  
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

**Who recommended or prescribed this medicine?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Other Doctor or Healthcare Provider

**Has Sarah Jones seen this doctor or healthcare provider since she last gave us medical information?** [Why we ask this](#)

Yes  No

### Doctor or Healthcare Provider Details

**Name of Doctor or Healthcare Provider who prescribed this medicine:**

-- Title -- First Last Suffix

**Name of the Practice or Medical Group:**

**Phone Number:**

U.S.  International

10-digit Number Ext.

**Address:**

**Country:**

United States or U.S. Territory



**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add More Lines](#)  
**City/Town:**  **State/Territory:**  **ZIP Code:**

---

**Patient ID Number, if known:**

**Treatment Dates with this Doctor or Healthcare Provider**  
Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**First Visit:**

**Last Visit:**

**Next Scheduled Appointment, if any:**

**Medical Conditions Treated by this Doctor or Healthcare Provider**

**What medical conditions were treated or evaluated?**  
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

**Treatment from this Doctor or Healthcare Provider**

**What treatment did Sarah Jones receive for the above conditions?**  
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)


Characters remaining: 1000


### Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

### 3.54. Add New Medicine – 3rd Party: Other Hospital

| Text Size  | Accessibility Help



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### Disability Appeal

#### Medicine Details


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

**Why is Sarah Jones taking this medicine?**

**Describe any side effects Sarah Jones experienced while taking this medicine:**  
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

**Who recommended or prescribed this medicine?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Other Hospital or Clinic 

#### Hospital or Clinic Details

**Name of Hospital or Clinic where this medicine was prescribed or recommended:**

**Name of Healthcare Provider who treated Sarah Jones, if known:**

**Phone Number:**

U.S.     International

U.S.     International

10-digit Number    Ext.

---

**Address:**

**Country:**

**Street Address:**

Street Line 1:

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

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

---

**Patient ID Number, if known:**

---

**Treatment Dates at this Hospital or Clinic**  
Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Did Sarah Jones have any outpatient visits at this hospital or clinic, or have one scheduled?**  
Outpatient visit means she went home the same day. This does not include emergency room visits.

Yes     No

---

**Did Sarah Jones have any emergency room (ER) visits at this hospital or clinic?**  
ER visit means she went to the ER and then went home.

Yes     No

---

**Did Sarah Jones have any overnight stays at this hospital or clinic?**

Yes     No

---

**Medical Conditions Treated by this Hospital or Clinic**

---

**What medical conditions were treated or evaluated by this hospital or clinic?**  
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

---

**Treatment from this Hospital or Clinic**

**What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?**  
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

### Tests Ordered at this Hospital or Clinic


Please add any tests this hospital or clinic ordered for Sarah Jones, including scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Save Cancel

### 3.55. Medicines 3 Rows Filled – 3rd Party



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## Disability Appeal

Identification Medical Activities/Training Review

### Medicines for Sarah Jones

Please tell us about **all prescription and non-prescription medicines** that Sarah Jones is currently taking for the conditions related to her disability.

Status	Name of Medicine	Prescribed by	Actions
✓	Singulair	Dr. Samantha Gupta	Edit Delete
✓	Plavix	Doctors at Vancouver General Hospital	Edit Delete
✓	Cymbalta	Dr. Elijah Saunders	Edit Delete

Add Medicine

Next Previous Save & Exit

In this section...

- ✓ Someone We Can Contact
- ✓ Medical Conditions
- ✓ Medical Treatment
- ✓ Doctors and Hospitals
- ✓ Tests
- Medicines**
- Other Medical Information

### 3.56. Section5: Other Medical Info – 3rd Party



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## Disability Appeal

Identification    Medical    **Activities/Training**    Review

### Other Medical Information for Sarah Jones

We need to know if anyone else has medical information about any of Sarah Jones's conditions or if she is scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid Sarah Jones disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

**Since Sarah Jones last told us about her other medical information, does anyone have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else?**

Yes     No

**In this section...**

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information**

**Next**    Previous    Save & Exit

### 3.57. Section5: Other Medical Info – 3rd Party: Yes selected



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---

## Disability Appeal

✔ Identification

Medical

Activities/Training

Review

### Other Medical Information for Sarah Jones

---

We need to know if anyone else has medical information about any of Sarah Jones's conditions or if she is scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid Sarah Jones disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

**Since Sarah Jones last told us about her other medical information, does anyone have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else?**

Yes   
  No

Status	Medical Information Source	City	Phone	Actions
Click Add Source to add a medical information source.				

Next

Previous


Save & Exit

In this section...

- ✔ [Someone We Can Contact](#)
- ✔ [Medical Conditions](#)
- ✔ [Medical Treatment](#)
- ✔ [Doctors and Hospitals](#)
- ✔ [Tests](#)
- ✔ [Medicines](#)
- ✔ **Other Medical Information**



### 3.58. Add Other Medical Info – 3rd Party



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#### Disability Appeal

---

#### Details of Other Medical Information

---

**Name of Organization:**

**Claim or ID Number, if any:**

---

**Address:**

**Country:**

**Street Address:**

Street Line 1:

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

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

---

**Name of Contact Person:**

**Phone Number:**  
 U.S.     International

10-digit Number    [Ext.](#)

---

#### Contacts with this Organization

Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor.  
Enter the closest date(s) Sarah Jones can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Date of First Contact:**

**Date of Last Contact:**

**Date of Next Contact, if any:**

---

**Reasons for Contacts:**  
(1000 characters maximum) If you need more space, please continue in [Remarks](#).

Characters remaining: 1000

### 3.59. Added Other Medical Info – 3rd Party



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---

## Disability Appeal

Identification    Medical    **Activities/Training**    Review

### Other Medical Information for Sarah Jones

We need to know if anyone else has medical information about any of Sarah Jones's conditions or if she is scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid Sarah Jones disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

**Since Sarah Jones last told us about her other medical information, does anyone have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else?**

Yes     No


Status	Medical Information Source	City	Actions
<input checked="" type="checkbox"/>	Workers' Insurance, Inc.	Baltimore	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

**Next**    Previous    Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information**

### 3.60. Section7: Activities – 3rd Party



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## Disability Appeal

Identification    Medical   **Activities/Training**   Review

### Activities for Sarah Jones

**Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions?**  
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

Yes    No

**Next**   Previous   Save & Exit

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation

### 3.61. Section7: Activities – 3rd Party: Follow up question



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## Disability Appeal

Identification    Medical   **Activities/Training**   Review

### Activities for Sarah Jones

**Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions?**  
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

Yes    No

**Please describe the changes in her daily activities in detail:**  
(1000 characters maximum)


Characters remaining: 1000

**Next**   Previous   Save & Exit

**In this section...**

- Activities**
- Work and Education
- Vocational Rehabilitation

### 3.62. Section8: Work & Education – 3rd Party



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---

## Disability Appeal

Identification    Medical   **Activities/Training**   Review

### Work and Education for Sarah Jones

**Since Sarah Jones last told us about her work, has she worked or has her work changed?**  
 Yes    No


**Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school?**  
 Yes    No

**Next**   Previous   Save & Exit

In this section...

- Activities
- Work and Education**
- Vocational Rehabilitation

### 3.63. Section8: Work Education – 3rd Party: Follow up question



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---

## Disability Appeal

Identification    Medical   **Activities/Training**   Review

### Work and Education for Sarah Jones

**Since Sarah Jones last told us about her work, has she worked or has her work changed?**  
 Yes    No

**Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school?**  
 Yes    No

**What type of training?**  
Examples: carpentry, cosmetology, plumbing, electronics, data entry or word processing courses.

**Date(s) attended:**

If you need to enter more information, continue in [Remarks](#).

**In this section...**

- Activities
- Work and Education**
- [Vocational Rehabilitation](#)

**Next**   Previous   Save & Exit

### 3.64. Section9: Voc Rehab – 3rd Party: First follow up question



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## Disability Appeal

Identification    Medical   [Activities/Training](#)   [Review](#)

**In this section...**

- Activities
- Work and Education
- Vocational Rehabilitation**

### Vocational Rehabilitation, Employment, or Other Support Services

We need to know about Sarah Jones's participation 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)
- any program providing vocational rehabilitation, employment services, or other support services to help her go to work


**Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs?**

Yes    No

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



### 3.65. Section9: Voc Rehab – 3rd Party: Second follow up questions



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## Disability Appeal

Identification    Medical   **Activities/Training**   Review

In this section...

- Activities
- Work and Education
- Vocational Rehabilitation**

### Vocational Rehabilitation, Employment, or Other Support Services

We need to know about Sarah Jones's participation 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)
- any program providing vocational rehabilitation, employment services, or other support services to help her go to work

**Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs?**

Yes    No

**Name of Organization or School:**

**Name of Counselor, Instructor, or Job Coach:**

**Phone Number:**  
 U.S.    International  
  
10-digit Number

**Address:**  
**Country:**  
United States or U.S. Territory

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add Line](#)

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

**Date when Sarah Jones started participating in the plan or program:**

If you need to enter more information, continue in [Remarks](#).

**Next**   Previous   Save & Exit

### 3.66. Remarks – 3rd Party



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---

## Disability Appeal

✔ Identification    ✔ Medical    ✔ Activities/Training    Review

### Remarks for Sarah Jones

**Please provide any additional information:**  
Use this space to provide any information Sarah Jones could not show in earlier sections of this form or any additional information Sarah Jones feels we should know about. (2000 characters maximum)


Characters remaining: 2000

**In this section...**

- Remarks
- Medical Release
- Summary

**Next**    Previous    Save & Exit

### 3.67. Medical Release – 3rd Party



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---

## Disability Appeal

✔ Identification    ✔ Medical    ✔ Activities/Training    Review

### Medical Release Form for Sarah Jones

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

**Is Sarah Jones with you now and can she read the Medical Release form?**


Yes     No

**In this section...**

- ✔ Remarks
- Medical Release**
- Summary

**Next**    Previous    Save & Exit

### 3.68. Medical Release – 3<sup>rd</sup> Party: Applicant is Present



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---

## Disability Appeal

Identification    Medical    Activities/Training    Review

### Medical Release Form for Sarah Jones

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

**Is Sarah Jones with you now and can she read the Medical Release form?**

Yes    No

Please ask Sarah Jones to read the  [Medical Release Form](#) and make a selection below.

**I voluntarily authorize and request disclosure of all my medical records; also educational records and other information related to my ability to perform tasks. I agree to:**

**Electronically sign** the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)

**Print, sign and mail a paper copy** of the Medical Release Form. I understand this may delay the processing of my disability claim.

**In this section...**

- Remarks
- Medical Release**
- Summary

### 3.69. Medical Release – 3<sup>rd</sup> Party: Applicant is Not Present



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## Disability Appeal

✔ Identification    ✔ Medical    ✔ Activities/Training    Review

### Medical Release Form for Sarah Jones

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

**Is Sarah Jones with you now and can she read the Medical Release form?**

Yes     No

**i After submitting the appeal, you will:**


- Be presented with a link to the Medical Release form.
- Print the Medical Release form and have Sarah Jones sign it.
- Mail the signed paper copy.

**Next**    Previous    Save & Exit

In this section...

- ✔ Remarks
- Medical Release**
- Summary

### 3.70. Medical Release – 3<sup>rd</sup> Party Professional Rep



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

---

## Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

### Medical Release Form for Sarah Jones

**Do you have Sarah Jones's signed Medical Release form?**

Yes  No

**Next** Previous Save & Exit

In this section...

- ✔ Remarks
- Medical Release**
- Summary

### 3.71. Medical Release – 3<sup>rd</sup> Party Professional Rep: Has signed form



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

---

## Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

### Medical Release Form for Sarah Jones

**Do you have Sarah Jones's signed Medical Release form?**

Yes  No

**After submitting the appeal, you can either:**


- Mail her signed Medical Release form to Social Security; or
- Submit her signed Medical Release form to a local Social Security office.

**Next** Previous Save & Exit

In this section...

- ✔ Remarks
- Medical Release**
- Summary

### 3.72. Medical Release – 3<sup>rd</sup> Party Professional Rep: Does not have signed form



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

---

## Disability Appeal

Identification    Medical    Activities/Training   Review

### Medical Release Form for Sarah Jones

**Do you have Sarah Jones's signed Medical Release form?**

Yes    No

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

**Is Sarah Jones with you and can she read the Medical Release form now?**

Yes    No

**Next**   Previous   Save & Exit

In this section...

- Remarks
- Medical Release**
- Summary



### 3.73. Medical Release – 3<sup>rd</sup> Party Professional Rep: Applicant is Present



# Social Security

Official Website of the U.S. Social Security Administration

## Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

### Medical Release Form for Sarah Jones

**Do you have Sarah Jones's signed Medical Release form?**

Yes  No

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

**Is Sarah Jones with you and can she read the Medical Release form now?**

Yes  No

Please ask Sarah Jones to read the  [Medical Release Form](#) and make a selection below.

**I voluntarily authorize and request disclosure of all my medical records; also educational records and other information related to my ability to perform tasks. I agree to:**

**Electronically sign** the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)


**Print, sign and mail a paper copy** of the Medical Release Form. I understand this may delay the processing of my disability claim.

Next Previous Save & Exit

In this section...

- ✔ Remarks
- Medical Release
- Summary

### 3.74. Medical Release – 3<sup>rd</sup> Party Professional Rep: Applicant is Not Present



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

---

## Disability Appeal

Identification    Medical    Activities/Training    Review

### Medical Release Form for Sarah Jones

**Do you have Sarah Jones's signed Medical Release form?**

Yes    No

In order to make a decision about this disability claim, we need to obtain Sarah Jones's:

- Medical Records
- Educational Records
- Other information related to her ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

**Is Sarah Jones with you and can she read the Medical Release form now?**

Yes    No

**After submitting the appeal, you will:**

- Be presented with a link to the Medical Release form.
- Print the Medical Release form and have Sarah Jones sign it.
- Mail the signed paper copy.


**Next**   Previous   Save & Exit

**In this section...**

- Remarks
- Medical Release**
- Summary

### 3.75. Overall Summary – 3<sup>rd</sup> Party Public

**Please note:** If a Yes/No question is answered No, any conditional fields below are not displayed.



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

---

## Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

### Overall Summary for Sarah Jones

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

#### Identification

Edit ✔ Information about Terry Halpern

Relationship: **Friend/Neighbor**  
Mailing Address: [REDACTED]  
Daytime Phone Number: [REDACTED]

Edit ✔ Information about Sarah Jones

Name: **Sarah Ann Jones**  
Mailing Address: [REDACTED]  
Does Sarah Jones live at the above address? **Yes**  
Daytime Phone Number: [REDACTED]  
Alternative Phone Number: [REDACTED]  
FAX Number: [REDACTED]  
Email Address: [REDACTED]

Edit ✔ Representative

Does Sarah Jones currently have an appointed representative? **Yes**  
Representative's Name: **Pat Graham**  
Is the representative an attorney? **Yes**  
Address: [REDACTED]  
Daytime Phone Number: [REDACTED]  
FAX Number, if any: [REDACTED]

Edit ✔ Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" Sarah Jones received: **June 30, 2013**  
Claim Number, if different from SSN:  
Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the determination made on her claim because: **Her condition has become worse and she can't sit upright or stand for long periods of time.**  
Does Sarah Jones have additional evidence to submit? **Yes**

In this section...

- ✔ Remarks
- ✔ Medical Release
- Summary**

Does Sarah Jones wish to appear at a hearing? **Yes**

**Medical**

**Someone We Can Contact**

Name: **Jamie Gonzales**

Relationship to Sarah Jones: **Family Member**

Address: [Redacted]

Daytime Phone Number: [Redacted]

Can this person speak and understand English? **Yes**

**Medical Conditions**

Have there been any CHANGES (for better for worse) in the physical or mental conditions that Sarah Jones HAS already reported? **Yes**

Date the change occurred: **early January 2013**

Please describe in detail: **Her condition is worse and she can't or stand for long periods of time. She gets dizzy. When she has difficulty breathing, she has to use her nebulizer.**

Are there any NEW physical or mental conditions that Sarah Jones has NOT already reported? **Yes**

Date the change occurred: **June**

Please describe in detail: **She is being treated for a heart condition. When she has difficulty breathing, she has to use her nebulizer.**

**Medical Treatment**

Has Sarah Jones used any other names on her medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled? **Yes**

What type(s) of condition(s) was Sarah Jones treated for, or will Sarah Jones be seen for? **Physical, Mental (including emotional or learning problems)**

**Doctors and Hospitals**

**Doctor or Healthcare Provider 1**

Name of Doctor or Health Care Provider: **Dr. Samantha Gupta**

Name of Practice of Medical Group: **Gupta & Associates**

Phone Number: [Redacted]

Address: [Redacted]

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Patient ID Number, if known:

Next Scheduled Appointment: **August 1, 2013**

Medical conditions treated: **Diabetes, Heart Disease, Asthma**

Treatments Received: **Examinations**

**Doctor or Healthcare Provider 2**

Name: **Dr. Elijah Saunders**

Address: [Redacted]

**Hospital or Clinic 1**

Name of Hospital or Clinic: **Vancouver General Hospital**  
Name of Healthcare Provider who treated Sarah Jones, if known:  
Phone Number: [Redacted]  
Address: [Redacted]  
Patient ID Number, if known:  
Emergency Room Visits: **Yes**  
Emergency Room Visit 1 : **June 2013**  
Inpatient Stays: **No**  
Outpatient Visits: **No**  
Medical conditions treated: **Heart attack**  
Treatment Received:

Tests

**Test 1**

Test Type: **EKG (Heart Test)**  
Date(s) of Test: **June 2013**  
Who ordered this test? **Dr. Samantha Gupta**

**Test 2**

Test Type: **X-ray Chest**  
Date(s) of Test: **June 2013**  
Who ordered this test? **Doctor(s) at Vancouver General Hospital**

**Test 3**

Test Type: **Breathing Test**  
Date(s) of Test: **June 2013**  
Who ordered this test? **Dr. Samantha Gupta**

Medicines

**Medicine 1**

Medicine Name: **Singulair**  
Reason: **Asthma**  
Side Effects:  
Prescribed by: **Dr. Samantha Gupta**

**Medicine 2**

Medicine Name: **Plavix**  
Reason: **Heart Disease**  
Side Effects:  
Prescribed by: **Doctors at Vancouver General Hospital**

**Medicine 3**

Medicine Name: **Cymbalta**

Reason: **Depression and Pain Management**

Side Effects:

Prescribed by: **Dr. Elijah Saunders**

**Medicine 4**

Medicine Name: **Tylenol**

Reason: **Headaches**

Side Effects:

Prescribed by: **No one prescribed this medicine**

**Edit**  **Other Medical Information**

Since Sarah Jones last told us about her other medical information, does anyone else have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else? **Yes**

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address: [Redacted]

Name of Contact Person:

Phone Number: [Redacted]

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reason for Contacts: **Applied for Workers' Comp benefits and was denied**

**Activities/Training**

**Edit**  **Activities**

Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions? **Yes**

Please describe the changes in her daily activities in detail: **She often becomes dizzy and has trouble breathing so she can no longer drive a car or go anywhere alone.**

**Edit**  **Work and Education**

Since Sarah Jones last told us about her work, has she worked or has her work changed? **No**

Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

What type? **Computer training**

Date(s) attended: **March-May 2013**

**Edit**  **Vocational Rehabilitation, Employment, or Other Support**

Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs? **No**

Name of Organization or School: **Online U**

Name of Counselor, Instructor, or Job Coach:

Phone Number: [Redacted]

Address: [REDACTED]

Date when Sarah Jones started participating in the plan or program: **June 21, 2013**


**Review**

 **Remarks**


Remarks: **Sarah cannot work. She has trouble breathing and chest pain every day.**


 **Medical Release Form**

I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)**

 **You will not be able to change this information once you submit the appeal.**  
When you select "Submit Appeal" below, you will be sending this completed information electronically to the Social Security Administration. Please make sure that everything is correct.

### 3.76. Attach File: No Files Added

Text Size  | Accessibility Help



## Social Security

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

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### Disability Appeal

#### Attach Files for Sarah Jones

If you have any additional forms or electronic evidence that will help us obtain your medical records or review your appeal, please attach them here.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

Click "Add File," then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

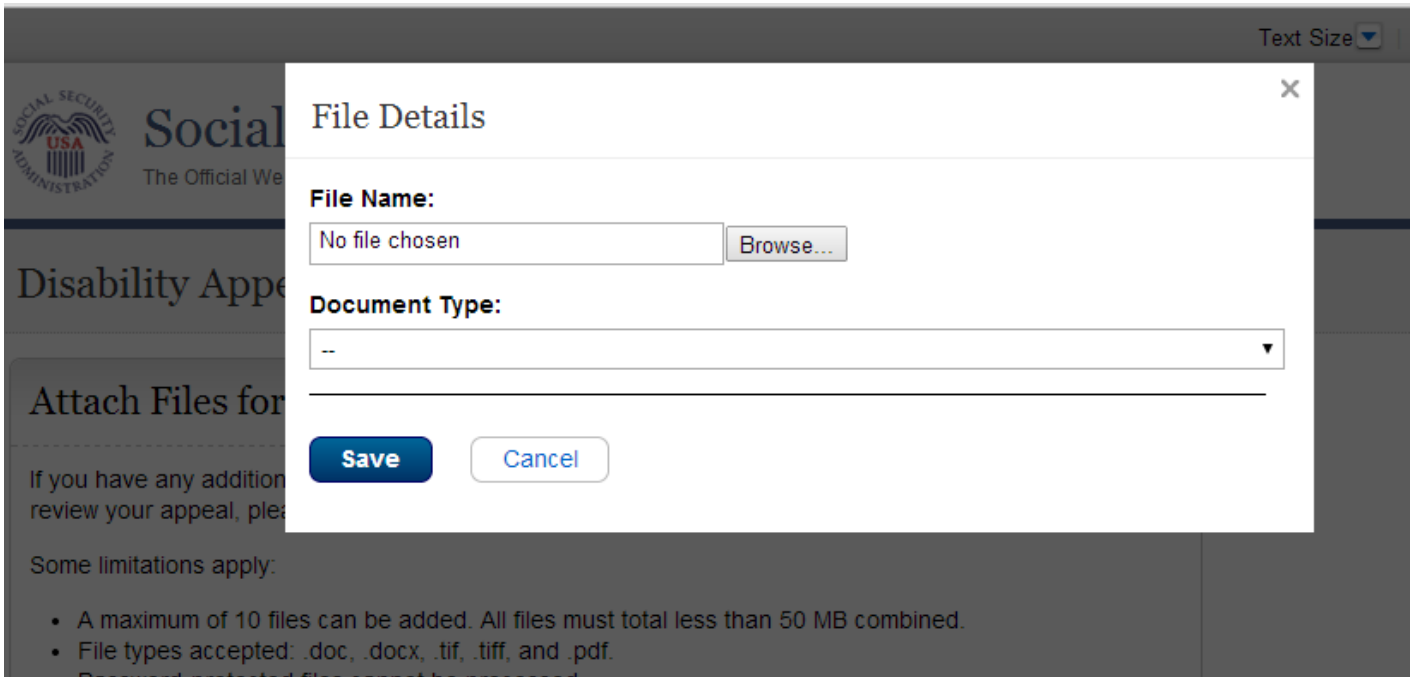
**Your files will not be processed by Social Security until you click "Submit."** If you click "Previous" or "Save & Exit," you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
Click "Add File" to attach a file.			

To add a file, user selects "Add File" button.

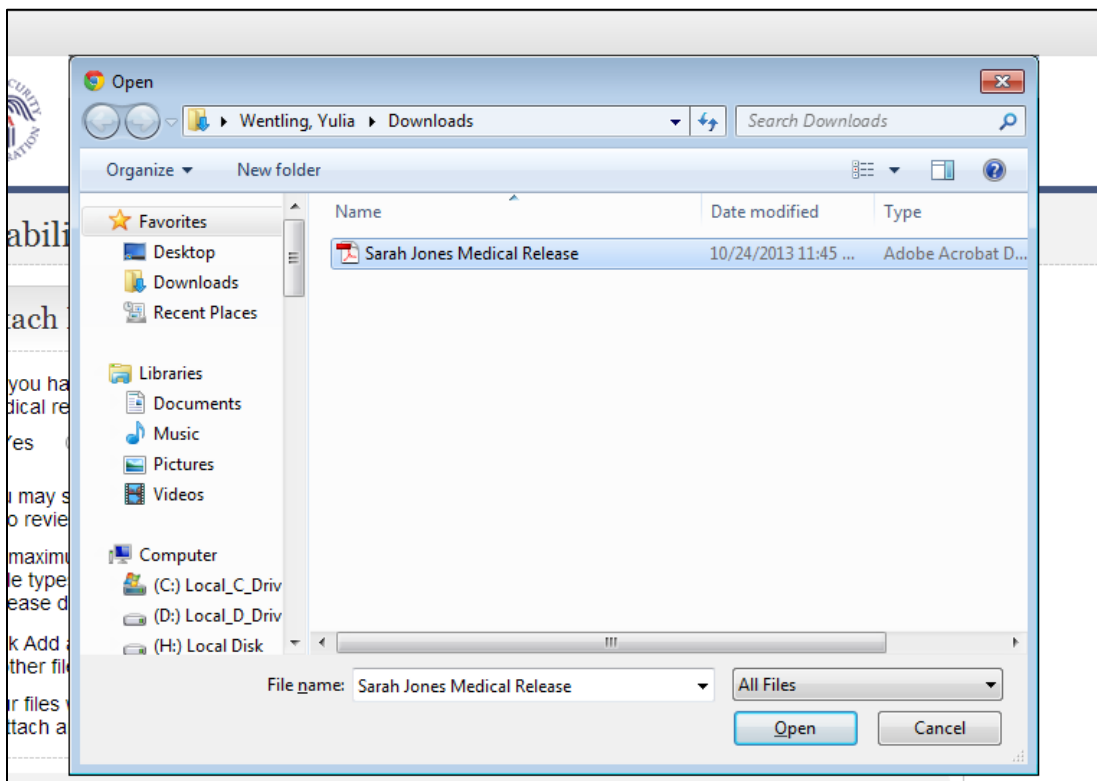


### 3.77. Attach Files: File Details dialog box



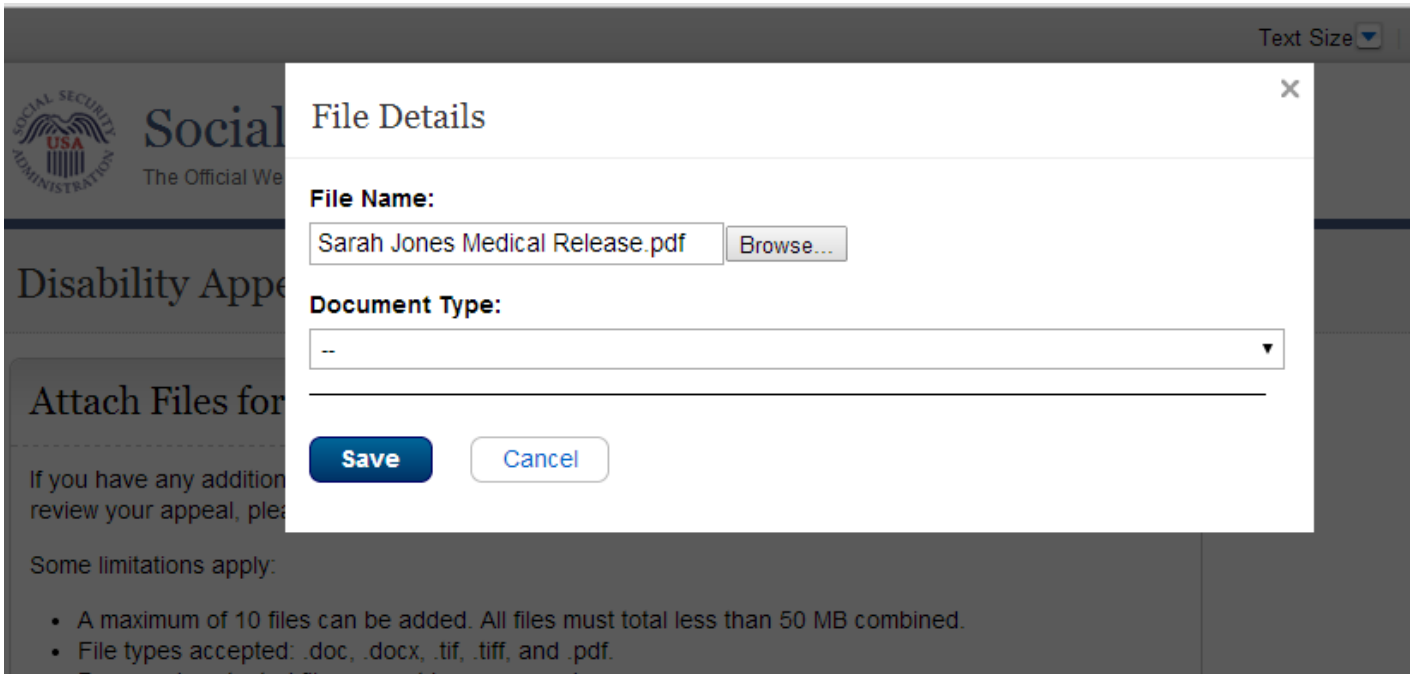
User selects “Browse” button to locate file to attach.

### 3.78. Attach Files: Browse for file to attach



User locates file, selects file, selects “Open”.

### 3.79. Attach Files: Select Document Type



User would select the type of document being attached.


#### List of options for Attorney Representatives & Staff and Non-Attorney Representatives & Staff:


- Appointment of Representative (SSA-1696)
- Identifying Information for Possible Direct Payment of Authorized Fees (SSA-1695)
- Fee Agreement
- Authorization to Disclose Information to the Social Security Administration (SSA-827)
- Questionnaire for Children Claiming SSI Benefits (SSA-3881)
- Good Cause for Late Filing Statement
- Representative Brief
- Waiver of Your Right to Personal Appearance Before an Administrative Law Judge (HA-4608)
- Consent for Release of Information (SSA-3288)
- Medical Evidence
- Other Evidence or Form

#### Note that the following options are not displayed for others:

- Identifying Information for Possible Direct Payment of Authorized Fees (SSA-1695)
- Fee Agreement
- Representative Brief

### 3.80. Attach Files: One file attached

Text Size  | Accessibility Help



## Social Security

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

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### Disability Appeal

#### Attach Files for Sarah Jones

If you have any additional forms or electronic evidence that will help us obtain your medical records or review your appeal, please attach them here.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

Click "Add File", then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

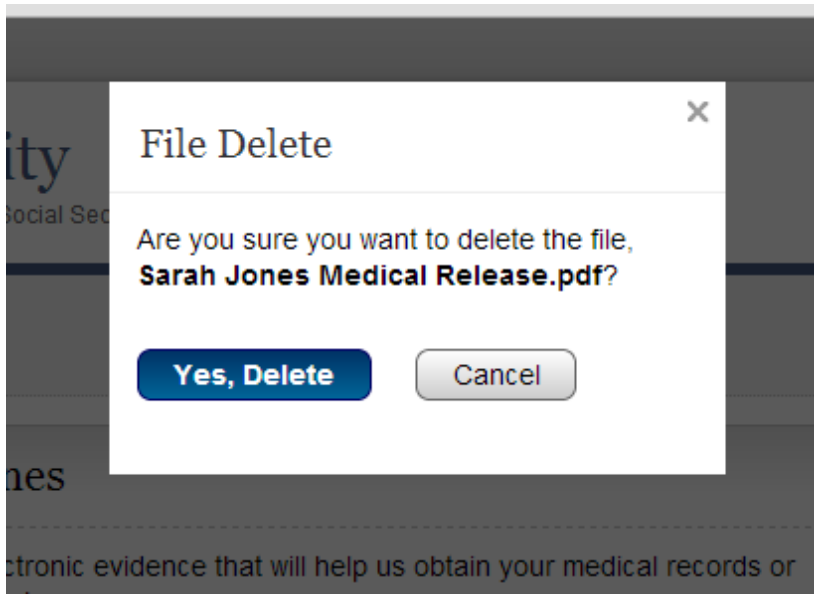
**Your files will not be processed by Social Security until you click "Submit."** If you click "Previous" or "Save & Exit", you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
Sarah Jones Medical Release.pdf	Medical Release (SSA-827)	186.4 KB	<input type="button" value="Delete"/>

**Number of Files Attached:** 1                      **Total Size of Attached File(s):** 186.4 KB

### 3.81. Attach Files: Delete Confirmation


If user selects “Delete” button for any file, dialog box is shown to confirm.



### 3.82. Attach Files: Maximum (10) number of files attached

Since the user has added the maximum number of files allowed, the Add File button is no longer shown.

[Text Size](#) | [Accessibility Help](#)



## Social Security

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

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### Disability Appeal

#### Attach Files for Sarah Jones

If you have any additional forms or electronic evidence that will help us obtain your medical records or review your appeal, please attach them here.

Some limitations apply:


- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

Click "Add File", then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

**Your files will not be processed by Social Security until you click "Submit."** If you click "Previous" or "Save & Exit", you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
Sarah Jones Medical Release.pdf	Medical Release (SSA-827)	186.4 KB	<input type="button" value="Delete"/>
Sarah Jones Bloodwork Results.tiff	Medical Evidence	32.2 KB	<input type="button" value="Delete"/>
Sarah Jones Fee Agreement.pdf	Fee Agreement	186.4 KB	<input type="button" value="Delete"/>
Sarah Jones Good Cause.doc	Good Cause for Late Filing	4.5 MB	<input type="button" value="Delete"/>
Sarah Jones Head MRI.pdf	Medical Evidence	186.4 KB	<input type="button" value="Delete"/>
Sarah Jones Representative Brief.tiff	Representative Brief	32.2 KB	<input type="button" value="Delete"/>
Sarah Jones SSA 1696.pdf	Appointment of Representative (SSA-1696)	186.4 KB	<input type="button" value="Delete"/>
Sarah Jones SSA 3288.pdf	Consent for Release of Information (SSA-3288)	186.4 KB	<input type="button" value="Delete"/>
Sarah Jones SSA 4608.pdf	Waiver Of Your Right To Personal Appearance Before an Administrative Law Judge (HA-4608)	186.4 KB	<input type="button" value="Delete"/>
Sarah Jones Vocational Training Record.tiff	Other Evidence or Forms	32.2 KB	<input type="button" value="Delete"/>
<b>Number of Files Attached: 10</b>		<b>Total Size of Attached File(s): 5.7 MB</b>	


### 3.83. Confirmation with Attachments – 3<sup>rd</sup> Party Public



**Social Security**  
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## Disability Appeal

 **You have successfully submitted Sarah Jones's Disability Appeal on August 23, 2013 at 2:30:18 PM Eastern time.**


We highly recommend that you print or save a copy of the appeal for her records.


### Attachments

File Name	Document Type	Size
Sarah Jones Medical Release.pdf	Medical Release (SSA-827)	186.4 Kb
Sarah Jones Medical Evidence.pdf	Medical Evidence	201.7 Kb
<b>Total File Size</b>		<b>388.1 Kb</b>

### Additional Information

You can use this [personalized cover sheet](#) if you have additional information to submit.

 [If you are unable to print](#)

 **Do you want to begin a new appeal?**

We can copy your contact information into the appeal. You will have the opportunity to edit it later.

This sample shows an appeal with 2 files attached and uploaded.

### 3.84. Confirmation without Attachments – 3<sup>rd</sup> Party Public: With Bullets



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

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## Disability Appeal

 **You successfully submitted Sarah Jones's Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**

We highly recommend that you print or save a copy of the appeal for her records.

### Additional Information

Although you have submitted Sarah Jones's disability appeal online, we still need a few items from her. Please print and have her complete the following: [? If you are unable to print](#)

- [Personalized cover sheet](#)
- [Medical Release Form \(Authorization to Disclose Information to the Social Security Administration\)](#)
- [? Instructions for completing the Medical Release Form](#)
- [Form SSA-1696 \(Appointment of Representative\)](#)




### 3.85. Receipt Pop up without Attachments – 3<sup>rd</sup> Party Public

Paragraph beginning "We may review..." is only displayed for a request for hearing, not a reconsideration.

**Print Now** **Save a Copy** [Can't print or save this document?](#)

---

 **You have successfully submitted Sarah Jones's Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**

We may review Sarah Jones's case to determine if we can make a decision without a hearing. If we determine she needs a hearing, we will appoint an Administrative Law Judge to conduct the hearing. We will provide advance notice of the time and place of the hearing. The hearing office assigned to Sarah Jones's case will also send her more information regarding her appeal.

---

#### Information You Submitted for Sarah Jones

---

##### Identification

---

#### Information about Terry Halpern

---

Home Address: [REDACTED]  
Phone Number: [REDACTED]

---

#### Information about Sarah Jones

---

Name: **Sarah Ann Jones**  
Home Address: [REDACTED]  
Does Sarah Jones receive mail at her home address? **Yes**  
Phone Number: [REDACTED]  
Email Address: [REDACTED]

---

#### Representative

---

Does Sarah Jones currently have an appointed representative? **No**

---

#### Request for Hearing by Administrative Law Judge

---

What is the date on the "Notice of Decision" Sarah Jones received: **June 30, 2013**  
Claim Number:  
Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the

determination made on her claim because. **Her condition has become worse and she can't sit upright or stand for long periods of time.**

Does Sarah Jones have additional evidence to submit? **Yes**

Does Sarah Jones wish to appear at a hearing? **Yes**

### Medical Information

#### Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to Sarah Jones: **Family Member**

Address: [Redacted]

Daytime Phone Number: [Redacted]

Can this person speak and understand English? **Yes**

#### Medical Conditions

Since Sarah Jones last told us about her medical conditions, has there been any change (for better or worse) in her physical or mental conditions? **Yes**

Approximate date change occurred: **January**

Please describe in detail: **Her condition is worse and she can't or stand for long periods of time. She gets dizzy. When she has difficulty breathing, she has to use her nebulizer.**

Since Sarah Jones last told us about her medical conditions, does she have any NEW physical or mental conditions? **No**

#### Medical Treatment

Has Sarah Jones used any other names on her medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled? **Yes**

What type(s) of condition(s) was Sarah Jones treated for, or will Sarah Jones be seen for? **Physical, Mental (including emotional or learning problems)**

#### Doctors and Hospitals

Doctors/Hospitals Visited

**Doctor or Healthcare Provider 1**

Name: **Dr. Samantha Gupta**

Address: [REDACTED]

Phone Number: [REDACTED]

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Next Scheduled Appointment: **August 1, 2013**

Medical conditions treated: **Diabetes, Heart Disease, Asthma**

Treatments Received:

**Doctor or Healthcare Provider 2**

Name: **Dr. Elijah Saunders**

Address: [REDACTED]

**Hospital or Clinic 1**

Name: **Vancouver General Hospital**

Address: [REDACTED]

Phone Number: [REDACTED]

Emergency Room Visits: **Yes**

Emergency Room Visit 1 : **June 2013**

Inpatient Stays: **No**

Outpatient Visits: **No**

Medical conditions treated: **Heart attack**

Treatment Received:

**Tests**

**Test 1**

Kind of test: **EKG (Heart Test)**

Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

**Test 2**

Kind of test: **X-ray Chest**

Date of Test: **June 2013**

Sent for test by: **Doctor(s) at Vancouver General Hospital**

**Test 3**

Kind of test: **Breathing Test**

Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

**Medicines**

**Medicine 1**

Medicine: **Singulair**

Reason: **Asthma**

Side Effects:

Prescribed by: **Dr. Samantha Gupta**

**Medicine 2**

Medicine: **Plavix**

Reason: **Heart Disease**

Side Effects:

Prescribed by: **Doctors at Vancouver General Hospital**

**Medicine 3**

Medicine: **Cymbalta**

Reason: **Depression and Pain Management**

Side Effects:

Prescribed by: **Dr. Elijah Saunders**

**Medicine 4**

Medicine: **Tylenol**

Reason: **Headache**

Side Effects:

Prescribed by: **No one prescribed this medicine**

**Other Medical Information**

Since Sarah Jones last told us about her other medical information, does anyone else have medical information about any of her physical or mental conditions (including emotional and learning

information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else? **Yes**

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address: [Redacted]

Name of Contact Person:

Phone Number: [Redacted]

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reason for Contacts: **Applied for Workers' Comp benefits and was denied.**

### Activities/Training

#### Activities

Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions? **Yes**

Please describe in detail the changes in her daily activities. **She often becomes dizzy and has trouble breathing so she can no longer drive a car or go anywhere alone.**

#### Work and Education

Since Sarah Jones last told us about her work, has she worked or has her work changed? **No**

Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

#### Vocational Rehabilitation, Employment, or Other Support

Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs? **No**

### Review

#### Remarks

Remarks: **She will be starting to take computer training this fall.**


### Medical Release Form

I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Signed Electronically**

### 3.86. Cover Sheet Popup – 3<sup>rd</sup> Party Public

**Print Now**   [Save a Copy](#)   [Can't print or save this document?](#)

---



## Cover Sheet for Sarah Jones

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on Sarah Jones's claim for benefits.

**Sarah Jones's Address:**  
[REDACTED]

**Sarah Jones's Phone number:**  
[REDACTED]

**Name and address of someone else Social Security can contact who knows about Sarah Jones's condition:**  
Jamie Gonzales  
[REDACTED]

I have attached the following items (check all that apply):

- Medical Release (Authorization to Disclose information to the Social Security Administration)
- Copies of medical records you already have

### 3.87. Cover Sheet Content – 3<sup>rd</sup> Party Public



## Cover Sheet for Sarah Jones

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on Sarah Jones's claim for benefits.

**Sarah Jones's Address:**

[Redacted]

**Sarah Jones's Phone number:**

[Redacted]

**Name and address of someone else Social Security can contact who knows about Sarah Jones's condition:**

Jamie Gonzales

[Redacted]

I have attached the following items (check all that apply):

- Medical Release (Authorization to Disclose information to the Social Security Administration)
- Copies of medical records you already have
- Other (Please list below)

\_\_\_\_\_

**Name of the person completing this application:**


Terry Halpern

**Mail or bring to:**

Social Security Administration

[Redacted]

### 3.88. Overall Summary – Showing section for 3<sup>rd</sup> Party Professional Rep



# Social Security

Official Website of the U.S. Social Security Administration

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## Disability Appeal

✔ Identification ✔ Medical ✔ Activities/Training Review

### Overall Summary for Sarah Jones

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

#### Identification

Edit ✔ Information about Pat Graham

Home Address: [Redacted]  
Phone Number: [Redacted]

Edit ✔ Information about Sarah Jones

Name: **Sarah Ann Jones**  
Home Address: [Redacted]  
Does Sarah Jones receive mail at her home address? **Yes**  
Phone Number: [Redacted]  
Email Address: [Redacted]

Edit ✔ Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" Sarah Jones received: **June 30, 2013**  
Claim Number:  
Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the determination made on her claim because: **Her condition has become worse and she can't sit upright or stand for long periods of time.**  
Does Sarah Jones have additional evidence to submit? **Yes**  
Does Sarah Jones wish to appear at a hearing? **Yes**

#### Medical Information

Edit ✔ Someone We Can Contact


Name: **Jamie Gonzales**  
Relationship to Sarah Jones: **Family Member**  
Address: [Redacted]  
Daytime Phone Number: [Redacted]  
Can this person speak and understand English? **Yes**

#### In this section...

- ✔ Remarks
- ✔ Medical Release
- Summary**




### 3.89. Confirmation – 3<sup>rd</sup> Party Professional Rep



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

---


## Disability Appeal


 **You successfully submitted Sarah Jones's Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**

We highly recommend that you print or save a copy of the appeal for her records.

### Additional Information

You can use this [personalized cover sheet](#) if you have additional information to submit.


 [If you are unable to print](#)

 **Do you want to begin a new appeal?**

We can copy your contact information into the appeal. You will have the opportunity to edit it later.

---


### 3.90. Confirmation – 3<sup>rd</sup> Party Professional Rep: With Bullets



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

---


## Disability Appeal


 **You successfully submitted Sarah Jones's Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**


We highly recommend that you print or save a copy of the appeal for her records.

[Print or Save](#)

### Additional Information

Although you have submitted Sarah Jones's disability appeal online, we still need a few items from her. Please print and have her complete the following:  [If you are unable to print](#)

- [Personalized cover sheet](#)
- [Medical Release Form \(Authorization to Disclose Information to the Social Security Administration\)](#)  
 [Instructions for completing the Medical Release Form](#)
- [Form SSA-1696 \(Appointment of Representative\)](#)

 **Do you want to begin a new appeal?**

We can copy your contact information into the appeal. You will have the opportunity to edit it later.

[Start Another Appeal](#)


[Done](#)

### 3.91. Receipt Pop up – 3<sup>rd</sup> Party Professional Rep

Paragraph beginning "an Administrative Law Judge" is only displayed for a request for hearing, not a reconsideration.

**Print Now**  [Can't print or save this document?](#)

---

 **You have successfully submitted Sarah Jones's Disability Appeal on August 13, 2013 at 10:53:24 AM Eastern time.**

We may review Sarah Jones's case to determine if we can make a decision without a hearing. If we determine she needs a hearing, we will appoint an Administrative Law Judge to conduct the hearing. We will provide advance notice of the time and place of the hearing. The hearing office assigned to this case will also send Sarah Jones more information regarding her appeal.

---

#### Information for Sarah Jones

---

##### Identification

---

#### Information about Pat Graham

---

Home Address:

Phone Number:

---

#### Information about Sarah Jones

---

Name: **Sarah Ann Jones**

Home Address:

Does Sarah Jones receive mail at her home address? **Yes**

Phone Number:

Email Address:

---

#### Request for Hearing by Administrative Law Judge

---

What is the date on the "Notice of Decision" Sarah Jones received: **June 30, 2013**

Claim Number:

Sarah Jones requests a hearing before an Administrative Law Judge. She disagrees with the determination made on her claim because: **Her condition has become worse and she can't sit upright or stand for long periods of time.**

Does Sarah Jones have additional evidence to submit? **Yes**

Does Sarah Jones wish to appear at a hearing? **Yes**

---

#### Medical Information

---

#### Someone We Can Contact

---

Name: **Jamie Gonzales**

Relationship to Sarah Jones: **Family Member**

Address: [Redacted]

Daytime Phone Number: [Redacted]

Can this person speak and understand English? **Yes**

### Medical Conditions

Since Sarah Jones last told us about her medical conditions, has there been any change (for better or worse) in her physical or mental conditions? **Yes**

Approximate date change occurred: **January**

Please describe in detail: **Her condition is worse and she can't or stand for long periods of time. She gets dizzy. When she has difficulty breathing, she has to use her nebulizer.**

Since Sarah Jones last told us about her medical conditions, does she have any NEW physical or mental conditions? **No**

### Medical Treatment

Has Sarah Jones used any other names on your medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled? **Yes**

What type(s) of condition(s) was Sarah Jones treated for, or will Sarah Jones be seen for? **Physical, Mental (including emotional or learning problems)**

### Doctors and Hospitals

#### Doctor or Healthcare Provider 1

Name: **Dr. Samantha Gupta**

Other Name 1: **Sarah Smith**

Since Sarah Jones last told us about her medical treatment, has she seen a doctor or other health care provider, received treatment at a hospital or clinic, or does she have a future appointment scheduled? **Yes**

What type(s) of condition(s) was Sarah Jones treated for, or will Sarah Jones be seen for? **Physical, Mental (including emotional or learning problems)**

### Doctors and Hospitals

#### Doctor or Healthcare Provider 1

Name: **Dr. Samantha Gupta**

Address: [Redacted]

Phone Number: [Redacted]

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Next Scheduled Appointment: **August 1, 2013**

Medical conditions treated: **Diabetes, Heart Disease, Asthma**

Treatments Received: **Examinations**

**Doctor or Healthcare Provider 2**

Name: **Dr. Elijah Saunders**

Address: [Redacted]

**Hospital or Clinic 1**

Name: **Vancouver General Hospital**

Address: [Redacted]

Phone Number: [Redacted]

Emergency Room Visits: **Yes**

Emergency Room Visit 1 : **June 2013**

Inpatient Stays: **No**

Outpatient Visits: **No**

Medical conditions treated: **Heart attack**

Treatment Received:

**Tests**

**Test 1**

Kind of test: **EKG (Heart Test)**

Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

**Test 2**

Kind of test: **X-ray Chest**

Date of Test: **June 2013**

Sent for test by: **Doctor(s) at Vancouver General Hospital**

**Test 3**

Kind of test: **Breathing Test**

Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

**Medicines**

**Medicine 1**

Medicine: **Singularair**

Reason: **Asthma**

Side Effects:

Prescribed by: **Dr. Samantha Gupta**

## Medicines

### Medicine 1

Medicine: **Singulair**

Reason: **Asthma**

Side Effects:

Prescribed by: **Dr. Samantha Gupta**

### Medicine 2

Medicine: **Plavix**

Reason: **Heart Disease**

Side Effects:

Prescribed by: **Doctors at Vancouver General Hospital**

### Medicine 3

Medicine: **Cymbalta**

Reason: **Depression and Pain Management**

Side Effects:

Prescribed by: **Dr. Elijah Saunders**

### Medicine 4

Medicine: **Tylenol**

Reason: **Headache**

Side Effects:

Prescribed by: **No one prescribed this medicine**

## Other Medical Information

Since Sarah Jones last told us about her other medical information, does anyone else have medical information about any of her physical or mental conditions (including emotional and learning problems) or is she scheduled to see anyone else? **Yes**

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address:

Name of Contact Person:

Phone Number:

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reason for Contacts: **Applied for Workers' Comp benefits and was denied.**

### Activities/Training

#### Activities

Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions? **Yes**

Please describe in detail the changes in her daily activities. **She often becomes dizzy and has trouble breathing so she can no longer drive a car or go anywhere alone.**

#### Work and Education

Since Sarah Jones last told us about her work, has she worked or has her work changed? **No**

Since Sarah Jones last told us about her education, has she completed or is she enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

#### Vocational Rehabilitation, Employment, or Other Support

Since Sarah Jones last told us about her vocational rehabilitation, has she participated, or is she participating, in one of these programs? **No**

#### Review

#### Remarks

Remarks:

#### Medical Release Form

Have you submitted Sarah Jones's medical release form to Social Security? **Yes**

## 4. First Party Screen Designs

### 4.1. Reentry Number – 1<sup>st</sup> Party


Option to enter email address is not provided if the user navigates back to this page and already provided an email address.

The screenshot shows the Social Security Administration's website for a Disability Appeal. At the top left is the Social Security Administration logo and the text "Social Security Official Website of the U.S. Social Security Administration". Below this is a header for "Disability Appeal" with four tabs: "Identification", "Medical", "Activities/Training", and "Review". The "Medical" tab is selected. A light blue information box contains the following text: "Please print this page or write down the reentry number." followed by "Reentry Number: 37649726", "Website: www.socialsecurity.gov/disability/appeal", and "Select Return to a Saved Appeal". Below this, there are two paragraphs of explanatory text. A "Print this Page" button is located below the text. A form asks "Would you like us to email you this reentry number?" with "Yes" and "No" radio buttons. At the bottom are "Next" and "Save & Exit" buttons. On the right side, a vertical menu titled "In this section..." lists "Reentry Number", "Your Information", "Representative", and "Request for Hearing".



## 4.2. Reentry Number – 1<sup>st</sup> Party: Email Selected

Option to enter email address is not provided if the user navigates back to this page and already provided an email address.



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

---

### Disability Appeal

Identification   Medical   Activities/Training   Review

**i** Please print this page or write down the reentry number.


Reentry Number: **37649726**

Website: [www.socialsecurity.gov/disability/appeal](http://www.socialsecurity.gov/disability/appeal)

Select **Return to a Saved Appeal**

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue your saved appeal later.

If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy.

 [Print this Page](#)

**Would you like us to email you this reentry number?**  
Please note, only the reentry number will be sent.

Yes    No

**Email Address:**

  
**Confirm Email Address:**

**Next**   Save & Exit

**In this section...**


- Reentry Number**
- [Your Information](#)
- [Representative](#)
- [Request for Hearing](#)

### 4.3. Are You Sure You Want to Exit

If the user did not choose to email the reentry number from the Reentry Number page, the container with the question "**Would you like us to email you this reentry number?**" - as shown on the Reentry Number page - will be displayed here above the navigation bar. If the user emailed the number previously, the page will display as shown here.

The screenshot shows the Social Security Administration's official website. At the top left is the Social Security Administration logo. To its right, the text reads "Social Security" in a large blue font, with "Official Website of the U.S. Social Security Administration" in a smaller font below it. A horizontal line separates the header from the main content area. Below this line, the page title "Disability Appeal" is displayed in a large, dark font. The main content area features a light blue information box with a white border. Inside this box, at the top left, is an information icon (a lowercase 'i' in a blue circle) followed by the question "Are you sure you want to exit?". Below the question, there is a paragraph of text: "Before you select 'Yes, I Want to Exit' below, be sure you have the following information so you will be able to continue your appeal later." This is followed by three lines of text: "Reentry Number: **37649726**", "Website: [www.socialsecurity.gov/disability/appeal](http://www.socialsecurity.gov/disability/appeal)", and "Select **Return to a Saved Appeal**". Below this text is another paragraph: "If you lose this number, you will need to start a new appeal. Social Security employees will never ask for your reentry number, nor will they have access to it. This is to protect your privacy." At the bottom left of the information box is a "Print this Page" link with a printer icon. Below the information box, there are two buttons: a dark blue button with white text that says "Yes, I Want to Exit" and a light blue button with dark blue text that says "No, Return to Appeal".

## 4.4. Return to a Saved Appeal



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

---

### Disability Appeal

#### Return to a Saved Appeal

Please enter the Reentry Number and Social Security Number to continue where you left off. If you don't have a Reentry Number, you will need to start a new appeal.

---

**Reentry Number:**

---

**Applicant's Social Security Number (SSN):**

---

[Next](#) [Previous](#)

## 4.5. Who are You – 1<sup>st</sup> Party

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

### Disability Appeal

Please Confirm Your Identity

**I am:**

- Sarah Jones
- Jamie Gonzales
- Someone else, helping Sarah Jones to appeal

**Next**


The possibilities for the radio list are determined based on data already provided in the claim. The names shown would correspond to the roles, which should be shown in the following order:

1. claimant (always appears)
2. person listed on "Someone we can contact" page, if any
3. representative, if any
4. someone else, helping <claimant name> to appeal (always appears)

If option 4 is selected and completed, the data entered replaces the preparer information previously provided.

Further, if any option other than claimant is selected, user will be placed into third party path (see screen 3.13. Who are You – 3rd Party: Someone Else).

## 4.6. Applicant Detail – 1<sup>st</sup> Party



# Social Security

Official Website of the U.S. Social Security Administration

## Disability Appeal

Identification   **Medical**   Activities/Training   Review

### Information about You

**Name:**  
Sarah   Ann   Jones   --  
First   Middle   Last   Suffix

**Mailing Address:**  
**Country:**  
United States or U.S. Territory

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add Line](#)

**City/Town:**   **State/Territory:** Maryland   **ZIP Code:**

**Do you live at the above address?**  
 Yes    No

**Daytime Phone Number:**  
 U.S.    International  
     
10-digit Number   Ext.

**Alternative Phone Number, if any:**  
Please provide another phone number where we can reach you.  
 U.S.    International  
     
10-digit Number   Ext.

**Email Address:**


**Confirm Email Address:**

**Next**   Previous   Save & Exit

In this section...

- Reentry Number
- Your Information**
- Representative
- Request for Hearing

### 4.7. Rep – 1<sup>st</sup> Party



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

---

## Disability Appeal

Identification   **Medical**   Activities/Training   Review

---

### Representative

**Do you currently have an appointed representative?**


Yes    No

**Next**   Previous   Save & Exit

In this section...

- ✓ Reentry Number
- ✓ Your Information
- Representative**
- Request for Hearing

## 4.8. Rep – 1<sup>st</sup> Party: Yes Selected



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

---

### Disability Appeal

Identification   **Medical**   Activities/Training   Review

#### Representative

**Do you currently have an appointed representative?**  
 Yes    No

**Representative's Name:**

First:  Middle:  Last:  Suffix:

**Is the representative an attorney?**  
 Yes    No

---

**Address:**

**Country:**

**Street Address:**

Street Line 1:

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

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

---

**Daytime Phone Number:**  
 U.S.    International

10-digit Number   Ext.

---


**FAX Number, if any:**  
  
10-digit Number

**In this section...**

- Reentry Number
- Your Information
- Representative**
- Request for Hearing

**Next**   Previous   Save & Exit

## 4.9. Request for Reconsideration – 1<sup>st</sup> Party



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

Disability Appeal OMB No. 0000-0000  
Paperwork Reduction Act

Identification | **Medical** | Activities/Training | Review

### Request for Reconsideration

**What is the date on the "Notice of Decision" you received?** [? Where to find this date](#)

mm/dd/yyyy

**Claim Number, if different from SSN:** [? Where to find the claim number](#)

**I do not agree with the determination made on the above claim and request reconsideration.**  
**My reasons are:** [? What details to include](#)  
Enter a brief reason for your appeal. (200 characters maximum)

Characters remaining: 200


**In this section...**

- ✓ Reentry Number
- ✓ Representative
- ✓ Your Information
- Request for Reconsideration**

**Next** | Previous | Save & Exit



## 4.10. Request for Hearing – 1<sup>st</sup> Party



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

Disability Appeal OMB No. 0000-0000  
Paperwork Reduction Act

Identification | **Medical** | Activities/Training | Review

### Request for Hearing

**What is the date on the "Notice of Decision" you received?** [? Where to find this date](#)

mm/dd/yyyy

**Claim Number, if different from SSN:** [? Where to find the claim number](#)

**I request a hearing before an Administrative Law Judge. I disagree with the determination made on my claim because:** [? What details to include](#)  
Enter a brief reason for your appeal. (200 characters maximum)

Characters remaining: 200

**Do you wish to appear at a hearing?** [? More info about appearing](#)

I wish to appear at a hearing.

I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. ([Complete Waiver Form HA-4608](#))

**In this section...**

- Reentry Number
- Your Information
- Representative
- Request for Hearing**

**Next** | Previous | Save & Exit

### 4.11. Someone We Can Contact – 1<sup>st</sup> Party

The screenshot shows the Social Security Administration's website for a Disability Appeal. The page title is "Disability Appeal" and it includes the OMB No. 0000-0000 Paperwork Reduction Act. The navigation tabs are "Identification" (selected), "Medical", "Activities/Training", and "Review".

The main section is titled "Someone We Can Contact about Your Medical Conditions" and asks for the name of someone (other than doctors) who can help with the appeal. It includes a checkbox for "I don't have a contact." and a form for entering the name (First, Middle, Last, Suffix) and relationship to the appellant. There are also three questions with radio button options: "Does this person live with you?", "Does this person have the same daytime phone number as you?", and "Can this person speak and understand English?".


At the bottom of the form are buttons for "Next", "Previous", and "Save & Exit".

On the right side, there is a sidebar titled "In this section..." with a list of links: "Someone We Can Contact" (selected), "Medical Conditions", "Medical Treatment", "Doctors and Hospitals", "Tests", "Medicines", and "Other Medical Information".

Contents of relationship drop list:

- 
- Family Member
- Friend/Neighbor
- Government Agency
- Health Service Agency/Hospital
- Non-Profit Organization/Legal Aid Group
- Nursing Care Facility
- Social Worker
- Other

## 4.12. Someone We Can Contact – 1<sup>st</sup> Party: Follow up questions



# Social Security

Official Website of the U.S. Social Security Administration

---

## Disability Appeal

OMB No. 0000-0000  
Paperwork Reduction Act

Identification     Medical     Activities/Training     Review

### Someone We Can Contact about Your Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about your medical conditions and can help you with this appeal.

I don't have a contact.

**Name:**

First:  Middle:  Last:  Suffix:

**Relationship to You:**

**Does this person live with you?**

Yes     No

**Address:**

**Country:**

**Street Address:**

Street Line 1:

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

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

**Does this person have the same daytime phone number as you?**

Yes     No

**Daytime Phone Number:**  
We need to be able to contact this person during the day.

U.S.     International

10-digit Number:     Ext.:

**Can this person speak and understand English?**


Yes     No

**What language does the contact person prefer?**

In this section...

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

### 4.13. Someone We Can Contact – 1<sup>st</sup> Party: No Contact



# Social Security

Official Website of the U.S. Social Security Administration

---

## Disability Appeal

OMB No. 0000-0000  
Paperwork Reduction Act

Identification    Medical    Activities/Training    Review

### Someone We Can Contact about Your Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about your medical conditions and can help you with this appeal.

I don't have a contact.

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

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


You can change the selection above to provide the contact information of someone who knows you.

**In this section...**

- Someone We Can Contact**
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

**Next**    Previous    Save & Exit

### 4.14. Section3: Medical Conditions – 1<sup>st</sup> Party



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

---

## Disability Appeal

Identification    Medical    **Activities/Training**    Review

### Change in Conditions

Since you last told us about your medical conditions, has there been any **CHANGE** (for better or worse) in your physical or mental conditions? [? What are changes in conditions?](#)

Yes     No

### New Conditions

Since you last told us about your medical conditions, do you have any **NEW** physical or mental conditions? [? What are new conditions?](#)


Yes     No

**Next**    Previous    Save & Exit

**In this section...**

- Someone We Can Contact
- Medical Conditions**
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

### 4.15. Section3: Medical Conditions – 1<sup>st</sup> Party: Follow Up questions



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

---

## Disability Appeal

Identification    Medical    **Activities/Training**    Review

### Change in Conditions

Since you last told us about your medical conditions, has there been any **CHANGE (for better or worse) in your physical or mental conditions?** [? What are changes in conditions?](#)

Yes     No

**Date the change(s) occurred:**  
Enter the closest date you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Please describe the change(s) to your condition(s) in detail:**  
(1000 characters maximum)

Characters remaining: 1000

If you need more space, continue in [Remarks](#).

### New Conditions

Since you last told us about your medical conditions, do you have any **NEW physical or mental conditions?** [? What are new conditions?](#)

Yes     No

**Date when the new condition(s) began:**  
Enter the closest date you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Please describe your new condition(s) in detail:**  
(1000 characters maximum)


Characters remaining: 1000

If you need more space, continue in [Remarks](#).

**In this section...**

- Someone We Can Contact
- Medical Conditions**
  - Medical Treatment
  - Doctors and Hospitals
  - Tests
  - Medicines
  - Other Medical Information

## 4.16. Section4: Medical Treatment – 1<sup>st</sup> Party



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

---

### Disability Appeal

Identification    Medical    **Activities/Training**    Review

#### Other Names

**Have you used any other names on your medical or educational records?**  
For example, maiden name, other married name, or nickname.

Yes     No

#### Medical Treatment

**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

**Next**    Previous    Save & Exit

**In this section...**

- Someone We Can Contact
- Medical Conditions
- Medical Treatment**
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

### 4.17. Section4: Medical Treatment – 1<sup>st</sup> Party: Follow Up Questions



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

---

## Disability Appeal

Identification    Medical    **Activities/Training**    Review

### Other Names

**Have you used any other names on your medical or educational records?**  
For example, maiden name, other married name, or nickname.

Yes     No

**Other Name 1:**

           --   

First                      Middle                      Last                      Suffix

### Medical Treatment

**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

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

Physical     Mental (including emotional or learning problems)

**In this section...**

- Someone We Can Contact
- Medical Conditions
- Medical Treatment**
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information



## 4.18. Doctors & Hospitals – 1<sup>st</sup> Party



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

---

### Disability Appeal

Identification    Medical    **Activities/Training**    Review

#### Doctors and Hospitals

Please tell us about anyone who has **new** medical records about any of your physical or mental conditions (including emotional or learning problems).

##### Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
Click Add Doctor to add a doctor or healthcare provider.			

---


##### Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
Click Add Hospital or Clinic to add a hospital or clinic.			

**In this section...**

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals**
- Tests
- Medicines
- Other Medical Information

### 4.19. Add New Doctors – 1<sup>st</sup> Party



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

---

#### Disability Appeal

---

#### Doctor or Healthcare Provider Details

---

**Name of Doctor or Healthcare Provider:**

--			--
Title	First	Last	Suffix

---

**Name of Practice or Medical Group:**

---

**Phone Number:**

U.S.     International

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

---

**Address:**

**Country:**

**Street Address:**

Street Line 1:

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

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

---

**Patient ID Number, if known:**

---

#### Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**First Visit:**

**Last Visit:**

**Next Scheduled Appointment, if any:**

**Medical Conditions Treated by this Doctor or Healthcare Provider**

**What medical conditions were treated or evaluated?**

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

Characters remaining: 1000

**Treatment from this Doctor or Healthcare Provider**

**What treatment did you receive for the above conditions?**

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

**Tests Ordered by this Doctor or Healthcare Provider**

Please add any tests this doctor or healthcare provider ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

**Medicines Recommended or Prescribed by this Doctor or Healthcare**

### Provider

Please add **all prescription and non-prescription** medicines you are **currently** taking that this doctor or healthcare provider recommended or prescribed.

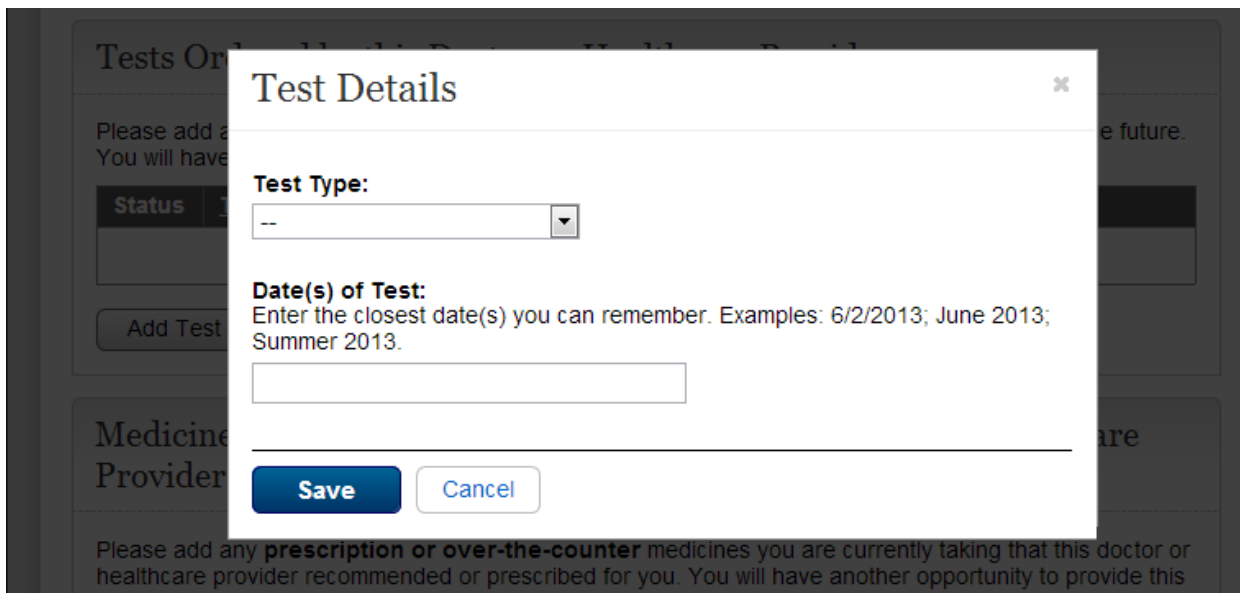
Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

## 4.20. Add New Doctors – 1<sup>st</sup> Party: Test Popup



Contents of "Test Type" drop list:

- 
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

Of these Test Types, selection of the following items will dynamically display a Body Part field:

- Biopsy
- X-Ray
- Other

Selecting "Other" will also dynamically display the "Please specify type" question.

### 4.21. Add New Doctors – 1<sup>st</sup> Party: Test Popup with follow up question

**Test Details** [Close]

**Test Type:**  
Biopsy

**Body Part:**

**Date(s) of Test:**  
Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**Save** **Cancel**

## 4.22. Add New Doctors – 1<sup>st</sup> Party: Medicine Popup

**Medicine Details** ✕

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

**Why are you taking this medicine?**

**Describe any side effects you experienced while taking this medicine:**  
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

**Save** Cancel

### 4.23. Doctors & Hospitals – 1<sup>st</sup> Party: 1 Row Filled



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---

## Disability Appeal

✔ Identification | Medical | Activities/Training | Review

### Doctors and Hospitals

Please tell us about anyone who has **new** medical records about any of your physical or mental conditions (including emotional or learning problems).

#### Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
✔	Dr. Samantha Gupta	Baltimore	<span>Edit</span> <span>Delete</span>

Add Doctor

---

#### Hospitals and Clinics

Status	Hospital or Clinic	City	Actions
Click Add Hospital or Clinic to add a hospital or clinic.			

Add Hospital or Clinic


**In this section...**

- ✔ [Someone We Can Contact](#)
- ✔ [Medical Conditions](#)
- ✔ [Medical Treatment](#)
- Doctors and Hospitals**
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

Next | Previous | Save & Exit



## 4.24. Add New Hospitals – 1<sup>st</sup> Party



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---

### Disability Appeal

#### Hospital or Clinic Details

**Name of Hospital or Clinic:**

---

**Name of Healthcare Provider who treated you, if known:**

---

**Phone Number:**  
 U.S.     International

     
10-digit Number    Ext.

---

**Address:**

**Country:**

**Street Address:**

Street Line 1:

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

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

---

**Patient ID Number, if known:**

#### Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?**  
Outpatient visit means you went home the same day. This does not include emergency room visits.

Yes     No

---

**Did you have any emergency room (ER) visits at this hospital or clinic?**

ER visit means you went to the ER and then went home.

Yes  No

**Did you have any overnight stays at this hospital or clinic?**

Yes  No

### Medical Conditions Treated by this Hospital or Clinic

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

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

Characters remaining: 1000

### Treatment from this Hospital or Clinic

**What treatment did you receive for the above conditions at this hospital or clinic?**

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

### Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

### Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines you are **currently** taking that this hospital or clinic recommended or prescribed.


Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

### 4.25. Add New Hospitals – 1<sup>st</sup> Party: Yes to Treatment Dates



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---

#### Disability Appeal

---

#### Hospital or Clinic Details

**Name of Hospital or Clinic:**

---

**Name of Healthcare Provider who treated you, if known:**

---

**Phone Number:**  
 U.S.     International

     
10-digit Number    [Ext.](#)

---

**Address:**

**Country:**

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add More Lines](#)

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

---

**Patient ID Number, if known:**

#### Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?**  
Outpatient visit means you went home the same day. This does not include emergency room visits.  
 Yes     No

**First outpatient visit:**

#### Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?**  
Outpatient visit means you went home the same day. This does not include emergency room visits.  
 Yes     No

**First outpatient visit:**

**Last outpatient visit:**

**Next scheduled outpatient visit (if any):**

**Did you have any emergency room (ER) visits at this hospital or clinic?**

ER visit means you went to the ER and then went home.

Yes     No

Please give the dates of your most recent emergency room visits.

**Emergency Room Visit 1:**

**Emergency Room Visit 2:**

**Emergency Room Visit 3:**

**Did you have any overnight stays at this hospital or clinic?**

Yes     No

Give us the dates of your three most recent stays.

**Visit 1:**

Date In

Date Out

**Visit 2:**

Date In

Date Out

**Visit 3:**

Date In

Date Out

### Medical Conditions Treated by this Hospital or Clinic

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

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

Characters remaining: 1000

### Treatment from this Hospital or Clinic

**What treatment did you receive for the above conditions at this hospital or clinic?**  
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

### Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

### Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines you are **currently** taking that this hospital or clinic recommended or prescribed.

Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save Cancel

### 4.27. Doctors & Hospitals – 1<sup>st</sup> Party: 2 Rows Filled

| Text Size ▾ | Accessibility Help



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## Disability Appeal

✔ IdentificationMedicalActivities/TrainingReview

### Doctors and Hospitals

Please tell us about anyone who has **new** medical records about any of your physical or mental conditions (including emotional or learning problems).

#### Doctors and Healthcare Providers

Status	Doctor or Healthcare Provider	City	Actions
✔	Dr. Samantha Gupta	Baltimore	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

---

#### Hospitals and Clinics


Status	Hospital or Clinic	City	Actions
✔	Vancouver General Hospital	Vancouver	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- ✔ [Someone We Can Contact](#)
- ✔ [Medical Conditions](#)
- ✔ [Medical Treatment](#)
- Doctors and Hospitals**
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 4.28. Tests – 1<sup>st</sup> Party

Table will be prefilled with what was entered in doctors/hospitals pages



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---

## Disability Appeal

✔ Identification

Medical

Activities/Training

Review

### Tests

Please tell us about any medical tests you had or will have related to your disability.

Status	Name of Test	Test Ordered by	Actions
✔	EKG (Heart Test)	Dr. Samantha Gupta	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
✔	X-Ray	Doctor(s) at Vancouver General Hospital	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Next

Previous

Save & Exit

In this section...

- ✔ [Someone We Can Contact](#)
- ✔ [Medical Conditions](#)
- ✔ [Medical Treatment](#)
- ✔ [Doctors and Hospitals](#)
- Tests**
- [Medicines](#)
- [Other Medical Information](#)



## 4.29. Add New Test – 1<sup>st</sup> Party

SOCIAL SECURITY ADMINISTRATION USA

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## Disability Appeal

### Test Details

**Test Type:**  
--

**Date(s) of Test:**  
Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**Who ordered this test for you?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Save Cancel

Contents of "Test Type" drop list:

- 
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

Of these Test Types, selection of the following items will dynamically display a Body Part field:

- Biopsy
- X-Ray
- Other

Selecting "Other" will also dynamically display the "Please specify type" question.

Contents of "Who ordered..." drop list:

--

*(All doctors previously entered)*

*(All hospitals previously entered)*


Other Doctor or Healthcare Provider

Other Hospital or Clinic

No one recommended or prescribed this medicine

I don't know

### 4.30. Add New Test – 1<sup>st</sup> Party: Follow up question and Other Doctor



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## Disability Appeal

### Test Details

**Test Type:**

**Body Part:**


**Date(s) of Test:**  
Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Who ordered this test for you?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

**Have you seen this doctor or healthcare provider since you last gave us medical information?**  
[? Why we ask this](#)  
 Yes  No

### 4.31. Add New Test – 1<sup>st</sup> Party: Have not seen the doctor



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---

## Disability Appeal

### Test Details

**Test Type:**

**Body Part:**

**Date(s) of Test:**  
Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**Who ordered this test for you?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

**Have you seen this doctor or healthcare provider since you last gave us medical information?**  
[Why we ask this](#)  
 Yes  No

### Doctor or Healthcare Provider Details

**Name of Doctor or Healthcare Provider who ordered this test for you:**


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

**Country:**

**City/Town:**

**State/Territory:**

### 4.32. Add New Test – 1<sup>st</sup> Party: Have seen the doctor



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---

#### Disability Appeal

#### Test Details

**Test Type:**  
Biopsy

**Body Part:**

**Date(s) of Test:**  
Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**Who ordered this test for you?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."  
Other Doctor or Healthcare Provider

**Have you seen this doctor or healthcare provider since you last gave us medical information?**  
[Why we ask this](#)  
 Yes  No

#### Doctor or Healthcare Provider Details

**Name of Doctor or Healthcare Provider who ordered this test for you:**

--   --  
Title First Last Suffix

**Name of Practice or Medical Group:**

**Address:**  
**Country:**  
United States or U.S. Territory

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add More Lines](#)

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

---

**Phone Number:**  
 U.S.     International  
   
10-digit Number    [Ext.](#)

---

**Patient ID Number, if known:**

---

**Treatment Dates with this Doctor or Healthcare Provider**  
Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**First Visit:**

**Last Visit:**

**Next Scheduled Appointment, if any:**

---

**Medical Conditions Treated by this Doctor or Healthcare Provider**

**What medical conditions were treated or evaluated?**  
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

### Treatment from this Doctor or Healthcare Provider

**What treatment did Sarah Jones receive for the above conditions?**

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

### Medicines Recommended or Prescribed by this Doctor or Healthcare Provider

Please add **all prescription and non-prescription** medicines you are **currently** taking that this doctor or healthcare provider recommended or prescribed.


Status	Medicine	Actions
Click Add Medicine to add a medicine.		

Add Medicine

Save

Cancel

### 4.33. Add New Test – 1<sup>st</sup> Party: Other Hospital



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---

#### Disability Appeal

---

#### Test Details

**Test Type:**

**Body Part:**

**Date(s) of Test:**  
Enter the closest dates you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Who ordered this test for you?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

#### Hospital or Clinic Details



United States or U.S. Territory ▾

**Street Address:**

Street Line 1:

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

**City/Town:**  **State/Territory:**  ▾ **ZIP Code:**

---

**Patient ID Number, if known:**

**Treatment Dates at this Hospital or Clinic**

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

---

**Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?**  
Outpatient visit means you went home the same day. This does not include emergency room visits.

Yes  No

---

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

Yes  No

---

**Did you have any overnight stays at this hospital or clinic?**

Yes  No

**Medical Conditions Treated by this Hospital or Clinic**

---

**What medical conditions were treated or evaluated by this hospital or clinic?**  
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

---

Characters remaining: 1000

### Treatment from this Hospital or Clinic

**What treatment did you receive for the above conditions at this hospital or clinic?**

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

### Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines you are **currently** taking that this hospital or clinic recommended or prescribed.


Status	Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save

Cancel

### 4.34. Tests – 1<sup>st</sup> Party: 3 Rows Filled



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## Disability Appeal

Identification **Medical** Activities/Training Review

### Tests

Please tell us about any medical tests you had or will have related to your disability.

Status	Name of Test	Test Ordered by	Actions
✓	EKG (Heart Test)	Dr. Samantha Gupta	Edit Delete
✓	Breathing Test	Dr. Samantha Gupta	Edit Delete
✓	X-Ray	Doctor(s) at Vancouver General Hospital	Edit Delete

Add Test

In this section...

- ✓ Someone We Can Contact
- ✓ Medical Conditions
- ✓ Medical Treatment
- ✓ Doctors and Hospitals
- Tests**
- Medicines
- Other Medical Information

Next Previous Save & Exit

### 4.35. Medicines – 1<sup>st</sup> Party

Table will be prefilled with medicines previously entered in doctors/hospitals pages. No medicines has been provided yet in this example.

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## Disability Appeal

Identification Medical Activities/Training Review

### Medicines

Please tell us about **all prescription and non-prescription medicines** that you are currently taking for the conditions related to your disability.

Status	Name of Medicine	Prescribed by	Actions
Click Add Medicine to add a medicine.			

Add Medicine

**In this section...**

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines**
- Other Medical Information

Next Previous Save & Exit

### 4.36. Add New Medicine – 1<sup>st</sup> Party

The screenshot shows the 'Disability Appeal' section of the Social Security Administration's website. At the top right, there are links for 'Text Size' and 'Accessibility Help'. The Social Security Administration logo and name are at the top left. The main heading is 'Disability Appeal'. Below this is a form titled 'Medicine Details'. The form contains three main sections: 1) 'Enter name of the medicine:' with a text input field and instructions to enter only one medicine at a time. 2) 'Why are you taking this medicine?' with a text input field. 3) 'Describe any side effects you experienced while taking this medicine:' with a large text area and instructions to include physical or mental effects and allergic reactions, with a 1000-character limit. Below the text area is a 'Characters remaining: 1000' indicator. At the bottom of the form is a dropdown menu labeled 'Who recommended or prescribed this medicine?' with instructions to select 'Other Doctor or Healthcare Provider' or 'Other Hospital or Clinic' if the doctor's or hospital's name is not in the list. At the very bottom of the form are two buttons: 'Save' and 'Cancel'.

Contents of "Who ordered..." drop list:

--

*(All doctors previously entered)*

*(All hospitals previously entered)*


Other Doctor or Healthcare Provider

Other Hospital or Clinic

No one recommended or prescribed this medicine

I don't know

### 4.37. Add New Medicine – 1<sup>st</sup> Party: Other Doctor



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---

## Disability Appeal

### Medicine Details

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

**Why are you taking this medicine?**

**Describe any side effects you experienced while taking this medicine:**  
Include physical or mental effects and allergic reactions. (1000 characters maximum)


Characters remaining: 1000

**Who recommended or prescribed this medicine?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

**Have you seen this doctor or healthcare provider since you last gave us medical information?**  
[? Why we ask this](#)

Yes  No

### 4.38. Add New Medicine – 1<sup>st</sup> Party: Have not seen the doctor



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---

## Disability Appeal

---

### Medicine Details

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

**Why are you taking this medicine?**

**Describe any side effects you experienced while taking this medicine:**  
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

**Who recommended or prescribed this medicine?**  
If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

Other Doctor or Healthcare Provider

**Have you seen this doctor or healthcare provider since you last gave us medical information?**

Why we ask this

Yes  No

---

### Doctor or Healthcare Provider Details

**Name of Doctor or Healthcare Provider who prescribed this medicine:**

--   --  
Title First Last Suffix

**Country:**  
United States or U.S. Territory

**City/Town:**

**State/Territory:**  
--

**Name of Doctor or Healthcare Provider who prescribed this medicine:**

--   --  
Title First Last Suffix

**Country:**  
United States or U.S. Territory

**City/Town:**

**State/Territory:**  
--

### 4.39. Add New Medicine – 1<sup>st</sup> Party: Have seen the doctor

## Social Security

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---

### Disability Appeal

#### Medicine Details

**Enter name of the medicine:**

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

**Why are you taking this medicine?**

**Describe any side effects you experienced while taking this medicine:**

Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

**Who recommended or prescribed this medicine?**

If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

**Have you seen this doctor or healthcare provider since you last gave us medical information?**

[? Why we ask this](#)

Yes  No

---

#### Doctor or Healthcare Provider Details

**Name of Doctor or Healthcare Provider who prescribed this medicine:**

Title First Last Suffix

**Name of the Practice or Medical Group:**



**Phone Number:**

U.S.     International

     
10-digit Number    Ext.

**Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

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

**City/Town:**

**State/Territory:**

--

**ZIP Code:**

**Patient ID Number, if known:**

**Treatment Dates with this Doctor or Healthcare Provider**

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**First Visit:**

**Last Visit:**

**Next Scheduled Appointment, if any:**

**Medical Conditions Treated by this Doctor or Healthcare Provider**

**What medical conditions were treated or evaluated?**

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

Characters remaining: 1000

### Treatment from this Doctor or Healthcare Provider

**What treatment did you receive for the above conditions?**

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

### Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Save Cancel

## 4.40. Add New Medicine – 1<sup>st</sup> Party: Other Hospital

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### Disability Appeal

#### Medicine Details

**Enter name of the medicine:**

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

**Why are you taking this medicine?**

**Describe any side effects you experienced while taking this medicine:**

Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

**Who recommended or prescribed this medicine?**

If this doctor's or hospital's name is not in the list, select "Other Doctor or Healthcare Provider" or "Other Hospital or Clinic."

#### Hospital or Clinic Details

**Name of Hospital or Clinic:**

**Name of Healthcare Provider who treated you, if known:**

**Phone Number:**

U.S.     International

10-digit Number    Ext.

**Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

Street Line 2:

Add More Lines

**City/Town:**

**State/Territory:**

--

**ZIP Code:**

**Patient ID Number, if known:**

**Treatment Dates at this Hospital or Clinic**

Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?**

Outpatient visit means you went home the same day. This does not include emergency room visits.

Yes     No

**Did you have any emergency room (ER) visits at this hospital or clinic?**

ER visit means you went to the ER and then went home.

Yes     No

**Did you have any overnight stays at this hospital or clinic?**

Yes     No

**Medical Conditions Treated by this Hospital or Clinic**

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

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

Characters remaining: 1000

### Treatment from this Hospital or Clinic

**What treatment did you receive for the above conditions at this hospital or clinic?**  
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

### Tests Ordered at this Hospital or Clinic


Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Test Type	Actions
Click Add Test to add a test.		

Add Test

Save Cancel

### 4.41. Medicines – 1<sup>st</sup> Party: 3 Rows Filled



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## Disability Appeal

Identification Medical Activities/Training Review

### Medicines

Please tell us about **all prescription and non-prescription medicines** that you are taking for the conditions related to your disability.

Status	Name of Medicine	Prescribed by	Actions
✓	Singular	Dr. Samantha Gupta	Edit Delete
✓	Plavix	Doctors at Vancouver General Hospital	Edit Delete
✓	Cymbalta	Dr. Elijah Saunders	Edit Delete

Add Medicine

Next Previous Save & Exit

In this section...

- ✓ Someone We Can Contact
- ✓ Medical Conditions
- ✓ Medical Treatment
- ✓ Doctors and Hospitals
- ✓ Tests
- Medicines**
- Other Medical Information

## 4.42. Section5: Other Medical Info – 1<sup>st</sup> Party



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### Disability Appeal

Identification    Medical    **Activities/Training**    Review

#### Other Medical Information

We need to know if anyone else has medical information about any of your conditions or if you are scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

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

Yes     No

**In this section...**

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information**

**Next**    Previous    Save & Exit

### 4.43. Section5: Other Medical Info – 1<sup>st</sup> Party: Yes selected



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## Disability Appeal

✔ Identification

Medical

Activities/Training

Review

### Other Medical Information

We need to know if anyone else has medical information about any of your conditions or if you are scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

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

Yes   
  No

Status	Medical Information Source	City	Phone	Actions
Click Add Source to add a medical information source.				

Next

Previous


Save & Exit

In this section...

- ✔ Someone We Can Contact
- ✔ Medical Conditions
- ✔ Medical Treatment
- ✔ Doctors and Hospitals
- ✔ Tests
- ✔ Medicines
- Other Medical Information**



## 4.44. Add Other Medical Info – 1<sup>st</sup> Party: Details



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---

### Disability Appeal

#### Details of Other Medical Information

**Name of Organization:**

**Claim or ID Number, if any:**

**Address:**

**Country:**

**Street Address:**

Street Line 1:

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

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

**Name of Contact Person:**

**Phone Number:**  
 U.S.     International

10-digit Number    Ext.

#### Contacts with this Organization

Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor.  
Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.

**Date of First Contact:**

**Date of Last Contact:**

**Date of Next Contact, if any:**

---

**Reasons for Contacts:**  
(1000 characters maximum)

Characters remaining: 1000  
If you need more space, please continue in [Remarks](#).

SaveCancel

### 4.45. Added Other Medical Info – 1<sup>st</sup> Party: One Row Filled



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## Disability Appeal

Identification Medical Activities/Training Review

### Other Medical Information

We need to know if anyone else has medical information about any of your conditions or if you are scheduled to see anyone else.

This may include:

- workers' compensation
- vocation rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

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

Yes  No

Status	Medical Information Source	City	Actions
<input checked="" type="checkbox"/>	Workers' Insurance, Inc.	Baltimore	Edit Delete


Add Source

Next Previous Save & Exit

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information**

### 4.46. Section7: Activities – 1<sup>st</sup> Party



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---

## Disability Appeal

Identification    Medical   **Activities/Training**   Review

### Activities

**Since you last told us about your activities, has there been any change (for better or for worse) in your daily activities due to your physical or mental conditions?**  
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

Yes    No

**Next**   Previous   Save & Exit

In this section...

- Activities**
- [Work and Education](#)
- [Vocational Rehabilitation](#)

### 4.47. Section7: Activities – 1<sup>st</sup> Party: Follow up question



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## Disability Appeal

Identification    Medical   **Activities/Training**   Review

### Activities for Sarah Jones

**Since Sarah Jones last told us about her activities, has there been any change (for better or worse) in her daily activities due to her physical or mental conditions?**  
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.

Yes    No

**Please describe the changes in her daily activities in detail:**  
(1000 characters maximum)


Characters remaining: 1000

**Next**   Previous   Save & Exit

**In this section...**

- Activities
- Work and Education
- Vocational Rehabilitation

### 4.48. Section8: Work & Education – 1<sup>st</sup> Party



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---

## Disability Appeal

✔ Identification ✔ Medical Activities/Training Review

### Work and Education

**Since you last told us about your work, have you worked or has your work changed?**  
 Yes  No

---


**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

**Next** Previous Save & Exit

In this section...

- ✔ Activities
- Work and Education**
- Vocational Rehabilitation

### 4.49. Section8: Work & Education – 1<sup>st</sup> Party: Follow up question



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---

## Disability Appeal

Identification    Medical   [Activities/Training](#)   [Review](#)

### Work and Education

**Since you last told us about your work, have you worked or has your work changed?**

Yes    No

**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

**What type of training?**  
Examples: carpentry, cosmetology, plumbing, electronics, data entry or word processing courses.

**Date(s) attended:**


If you need to enter more information, continue in [Remarks](#).

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

**In this section...**

- [Activities](#)
- [Work and Education](#)**
- [Vocational Rehabilitation](#)

### 4.50. Section9: Voc Rehab – 1<sup>st</sup> Party: First follow up question



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---

## Disability Appeal

✔ Identification    ✔ Medical    Activities/Training    Review

In this section...

- ✔ Activities
- ✔ Work and Education
- Vocational Rehabilitation**

### Vocational Rehabilitation, Employment, or Other Support Services

We need to know about your participation 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)
- any program providing vocational rehabilitation, employment services, or other support services to help her go to work


**Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs?**

Yes     No

**Next**    Previous    Save & Exit



### 4.51. Section9: Voc Rehab – 1<sup>st</sup> Party: Second follow up questions



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---

## Disability Appeal

Identification    Medical   **Activities/Training**   Review

**In this section...**

- Activities
- Work and Education
- Vocational Rehabilitation**

### Vocational Rehabilitation, Employment, or Other Support Services

We need to know about your participation 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)
- any program providing vocational rehabilitation, employment services, or other support services to help her go to work

**Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs?**

Yes    No

**Name of Organization or School:**

**Name of Counselor, Instructor, or Job Coach:**

**Phone Number:**

U.S.    International

  
10-digit Number

---

**Address:**

**Country:**

United States or U.S. Territory ▾

**Street Address:**

Street Line 1:

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

**City/Town:**    **State/Territory:**  ▾   **ZIP Code:**

---


**Date when you started participating in the plan or program:**

If you need to enter more information, continue in [Remarks](#).

**Next**   Previous   Save & Exit

### 4.52. Remarks – 1<sup>st</sup> Party



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---

## Disability Appeal

Identification    Medical    Activities/Training    Review

### Remarks


**Please provide any additional information:**  
Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. (2000 characters maximum)

Characters remaining: 2000

In this section...

- Remarks
- Medical Release
- Summary

## 4.54. Medical Release – 1<sup>st</sup> Party



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---

### Disability Appeal

✔ Identification    ✔ Medical    ✔ Activities/Training    Review

#### Medical Release Form

In order to make a decision about this disability claim, we need to obtain your:

- Medical Records
- Educational Records
- Other information related to your ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Please read the [Medical Release Form](#) and make a selection below.

**I voluntarily authorize and request disclosure of all my medical records; also educational records and other information related to my ability to perform tasks. I agree to:**

**Electronically sign** the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)

**Print, sign and mail a paper copy** of the Medical Release Form. I understand this may delay the processing of my disability claim.

**In this section...**

✔ Remarks


**Medical Release**

Summary

**Next**    Previous    Save & Exit

### 4.55. Overall Summary – 1<sup>st</sup> Party

**Please note:** If a Yes/No question is answered No, any conditional fields below are not displayed.



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---

## Disability Appeal

Identification

Medical

Activities/Training

Review

### Overall Summary

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

#### Identification

Information about You

Name: **Sarah Ann Jones**

Mailing Address:

Do you live at the above address? **Yes**

Daytime Phone Number:

Alternative Phone Number, if any:

Email Address:

#### Representative

Representative

Do you currently have an appointed representative? **Yes**

Representative's Name: **Pat Graham**

Is the representative an attorney? **Yes**

Address:

Daytime Phone Number:

FAX Number, if any:

#### Request for Hearing by Administrative Law Judge

Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" you received: **06/30/2013**

Claim Number, if different from SSN:

I request a hearing before an Administrative Law Judge. I disagree with the determination made on my claim because: **My condition has become worse and I can't sit upright or stand for long periods of time.**

Do you wish to appear at a hearing? **Yes**

In this section...

- Remarks
- Medical Release
- Summary**

### Medical

Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to You: **Family Member**

Address:

Daytime Phone Number: [REDACTED]

Can this person speak and understand English? **Yes**

**Edit**  **Medical Conditions**

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

Date the change(s) occurred: **early January 2013**

Please describe in detail: **My condition is worse and I can't or stand for long periods of time. I get dizzy.**

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

Date when the new condition(s) began: **July**

Please describe your new condition(s) in detail: **I am being treated for a heart condition. When I have difficulty breathing, I have to use a nebulizer.**

**Edit**  **Medical Treatment**

Have you used any other names on your medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

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

What type(s) of condition(s) were you treated for, or will you be seen for? **Physical, Mental (including emotional or learning problems)**

**Edit**  **Doctors and Hospitals**

**Doctor or Healthcare Provider 1**

Name of Doctor or Health Care Provider: **Dr. Samantha Gupta**

Name of Practice of Medical Group: **Gupta & Associates**

Phone Number: [REDACTED]

Address: [REDACTED]

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Patient ID Number, if known:

Next Scheduled Appointment: **August 1, 2013**

Medical conditions treated: **Diabetes, Heart Disease, Asthma**

Treatments Received: **Examinations**

**Doctor or Healthcare Provider 2**

Name: **Dr. Elijah Saunders**

Address: **Baltimore, MD**

**Hospital or Clinic 1**

Name of Hospital or Clinic: **Vancouver General Hospital**

Name of Healthcare Provider who treated you, if known:

Phone Number: [REDACTED]

Address: [REDACTED]

Patient ID Number, if known:

Emergency Room Visits: **Yes**  
Emergency Room Visit 1 : **June 2013**  
Overnight Stays: **No**  
Outpatient Visits: **No**  
Medical conditions treated: **Heart attack**  
Treatment Received:

 **Tests**

**Test 1**

Test Type: **EKG (Heart Test)**  
Date(s) of Test: **June 2013**  
Who ordered this test? **Dr. Samantha Gupta**

**Test 2**

Test Type: **X-ray Chest**  
Date(s) of Test: **June 2013**  
Who ordered this test? **Doctor(s) at Vancouver General Hospital**

**Test 3**

Test Type: **Breathing Test**  
Date(s) of Test: **June 2013**  
Who ordered this test? **Dr. Samantha Gupta**

 **Medicines**

**Medicine 1**

Medicine Name: **Singularir**  
Reason: **Asthma**  
Side Effects:  
Prescribed by: **Dr. Samantha Gupta**

**Medicine 2**

Medicine Name: **Plavix**  
Reason: **Heart Disease**  
Side Effects:  
Prescribed by: **Doctors at Vancouver General Hospital**

**Medicine 3**

Medicine Name: **Cymbalta**  
Reason: **Depression and Pain Management**  
Side Effects:  
Prescribed by: **Dr. Elijah Saunders**

**Medicine 4**

Medicine Name: **Tylenol**  
Reason: **Headaches**  
Side Effects:  
Prescribed by: **No one prescribed this medicine**

Prescribed by: ~~No one prescribed this medicine~~

**Other Medical Information**

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

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address: [Redacted]

Name of Contact Person:

Phone Number: [Redacted]

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reasons for Contacts: **Applied for Workers' Comp benefits and was denied**

**Activities/Training**

**Activities**

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

Please describe the changes in your daily activities in detail: **I often become dizzy and have trouble breathing.**

**Work and Education**

Since you last told us about your work, have you worked or has your work changed? **No**

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**

What type of training? **Computer training**

Date(s) attended: **March-May 2013**

**Vocational Rehabilitation, Employment, or Other Support**

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs? **No**

Name of Organization or School: **Online U**

Name of Counselor, Instructor, or Job Coach:

Phone Number: [Redacted]

Address: [Redacted]

Date when you started participating in the plan or program: **June 21, 2013**


**Review**

**Remarks**

Remarks: **I cannot work. I have trouble breathing and chest pain every day.**

[Edit](#)  **Medical Release Form**


I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)**


 **You will not be able to change this information once you submit the appeal.**  
When you select "Submit Appeal" below, you will be sending this completed information electronically to the Social Security Administration. Please make sure that everything is correct.

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



## 4.57. Attach Files: No Files Attached

Text Size  | Accessibility Help



# Social Security

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## Disability Appeal

### Attach Files for Sarah Jones

If you have any additional forms or electronic evidence that will help us obtain your medical records or review your appeal, please attach them here.

Some limitations apply:

- A maximum of 10 files can be added. All files must total less than 50 MB combined.
- File types accepted: .doc, .docx, .tif, .tiff, and .pdf.
- Password-protected files cannot be processed.

Click "Add File," then "Browse" to select your file. Select the "Document Type" in the drop down list. To add another file, click "Add File" again.

**Your files will not be processed by Social Security until you click "Submit."** If you click "Previous" or "Save & Exit," you will need to reattach your files when you return to this page. All other information you have entered will be saved.

File Name	Document Type	File Size	Manage Files
Click "Add File" to attach a file.			

### 4.58. Confirmation – 1<sup>st</sup> Party

This is a sample of a confirmation for a request for Reconsideration.




The screenshot shows the Social Security Administration's website interface. At the top left is the SSA logo, and to its right is the text "Social Security" and "Official Website of the U.S. Social Security Administration". Below this is a header section titled "Disability Appeal". The main content area features a green-bordered box with a checkmark icon and the text: "You successfully submitted your Disability Appeal on August 20, 2013 at 1:41 PM Eastern time." Below this, it says "We highly recommend that you print or save a copy of the appeal for her records." and includes a "Print or Save" button. Underneath is a section titled "Additional Information" which contains the text: "You can use this [personalized cover sheet](#) if you have additional information to submit." and a link: "If you are unable to print". At the bottom left of the page is a blue "Done" button.

### 4.59. Receipt Pop up – 1<sup>st</sup> Party

In the green Confirmation notice, the paragraph beginning "an Administrative Law Judge" is only displayed for a request for hearing, not reconsideration.

**Print Now**   **Save a Copy**   [Can't print or save this document?](#)

---

 **You successfully submitted your Disability Appeal on August 20, 2013 at 1:41 PM Eastern time.**

We may review your case to determine if we can make a decision without a hearing. If we determine you need a hearing, we will appoint an Administrative Law Judge to conduct the hearing. We will provide advance notice of the time and place of the hearing. The hearing office assigned to your case will also send you more information regarding your appeal.

---

#### Information You Submitted

---

##### Identification

---

##### Information about You

Name: **Sarah Ann Jones**  
Mailing Address: [REDACTED]  
Do you live at the above address? **Yes**  
Daytime Phone Number: [REDACTED]  
Alternative Phone Number, if any: [REDACTED]  
Email Address: [REDACTED]

---

##### Representative

Do you currently have an appointed representative? **No**

---

##### Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" you received: **June 30, 2013**  
Claim Number:  
I request a hearing before an Administrative Law Judge. I disagree with the determination made on my claim because: **My condition has become worse and I can't sit upright or stand for long periods of time.**  
Does you have additional evidence to submit? **Yes**  
Does you wish to appear at a hearing? **Yes**

Does you wish to appear at a hearing? **Yes**

### Medical Information

### Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to You: **Family Member**

Address: [Redacted]

Daytime Phone Number: [Redacted]

Can this person speak and understand English? **Yes**

### Medical Conditions

Since you last told us about your medical conditions, has there been any change (for better or for worse) in your physical or mental conditions? **Yes**

Approximate date change occurred: **January**

Please describe in detail: **My condition is worse and I can't or stand for long periods of time. I got dizzy.**

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? **No**

### Medical Treatment

Has you used any other names on your medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since you last told us about her medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled? **Yes**

What type(s) of condition(s) were you treated for, or will you be seen for? **Physical, Mental (including emotional or learning problems)**

### Doctors and Hospitals

#### Doctor or Healthcare Provider 1

Name: **Dr. Samantha Gupta**

Address: [Redacted]

Phone Number: [Redacted]

First Visit: **Sometime in 1999**  
Last Visit: **June 6, 2013**  
Next Scheduled Appointment: **August 1, 2013**  
Medical conditions treated: **Diabetes, Heart Disease, Asthma**  
Treatments Received:

**Doctor or Healthcare Provider 2**

Name: **Dr. Elijah Saunders**  
Address: [REDACTED]

**Hospital or Clinic 1**

Name: **Vancouver General Hospital**  
Address: [REDACTED]  
Phone Number: [REDACTED]  
Emergency Room Visits: **Yes**  
Emergency Room Visit 1 : **June 2013**  
Inpatient Stays: **No**  
Outpatient Visits: **No**  
Medical conditions treated: **Heart attack**  
Treatment Received:

**Tests**

**Test 1**

Kind of test: **EKG (Heart Test)**  
Date of Test: **June 2013**  
Sent for test by: **Dr. Samantha Gupta**

**Test 2**

Kind of test: **X-ray Chest**  
Date of Test: **June 2013**  
Sent for test by: **Doctor(s) at Vancouver General Hospital**

**Test 3**

Kind of test: **Breathing Test**  
Date of Test: **June 2013**

Sent for test by: **Dr. Samantha Gupta**

## Medicines

### Medicine 1

Medicine: **Singulair**

Reason: **Asthma**

Side Effects:

Prescribed by: **Dr. Samantha Gupta**

### Medicine 2

Medicine: **Plavix**

Reason: **Heart Disease**

Side Effects:

Prescribed by: **Doctors at Vancouver General Hospital**

### Medicine 3

Medicine: **Cymbalta**

Reason: **Depression and Pain Management**

Side Effects:

Prescribed by: **Dr. Elijah Saunders**

### Medicine 4

Medicine: **Tylenol**

Reason: **Headache**

Side Effects:

Prescribed by: **No one prescribed this medicine**

## Other Medical Information

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

Name of Organization: **Workers' Insurance, Inc.**

Claim or ID Number, if any:

Address: [REDACTED]

Name of Contact Person:

Phone Number: [REDACTED]

Date of First Contact: **10/2012**

Date of Last Contact: **12/2012**

Date of Next Contact, if any:

Reason for Contacts: **Applied for Workers' Comp benefits and was denied.**

### Activities/Training

#### Activities

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

Please describe in detail the changes in your daily activities. **I often becomes dizzy and have trouble breathing so I can no longer drive a car or go anywhere alone.**

### Work and Education

Since you last told us about your work, have you worked or has your work changed? **No**

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**

### Vocational Rehabilitation, Employment, or Other Support

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs? **No**

### Review

#### Remarks

Remarks: **I cannot work. I have trouble breathing and chest pain every day.**


### Medical Release Form

I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)**

### 4.60. Cover Sheet Popup – 1<sup>st</sup> Party

**Print Now**   [Save a Copy](#)   [Can't print or save this document?](#)

---



## Cover Sheet for Sarah Jones

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on my claim for benefits.

**My Address:**  
[REDACTED]

**My Phone number:**  
[REDACTED]

**Name and address of someone else Social Security can contact who knows about my condition:**  
Jamie Gonzales  
[REDACTED]

I have attached the following items (check all that apply):

- Medical Release (Authorization to Disclose information to the Social Security Administration)
- Copies of medical records you already have



### 4.61. Cover Sheet Content – 1<sup>st</sup> Party



## Cover Sheet for Sarah Jones

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on my claim for benefits.

**My Address:**

[Redacted address]

**My Phone number:**

[Redacted phone number]

**Name and address of someone else Social Security can contact who knows about my condition:**

Jamie Gonzales

[Redacted address]

I have attached the following items (check all that apply):

- Medical Release (Authorization to Disclose information to the Social Security Administration)
- Copies of medical records you already have
- Other (Please list below)

\_\_\_\_\_

**Mail or bring to:**

Social Security Administration

[Redacted address]