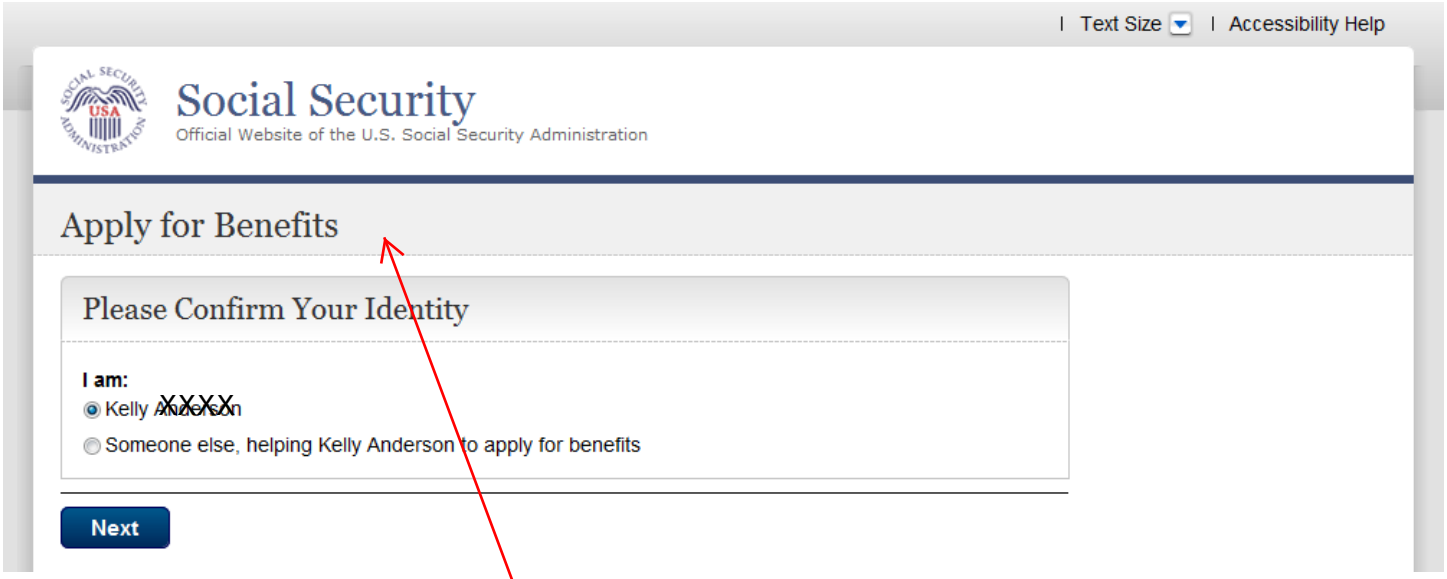
iClaim-i3368 Marriage (1st Party): Screen Package 0.5

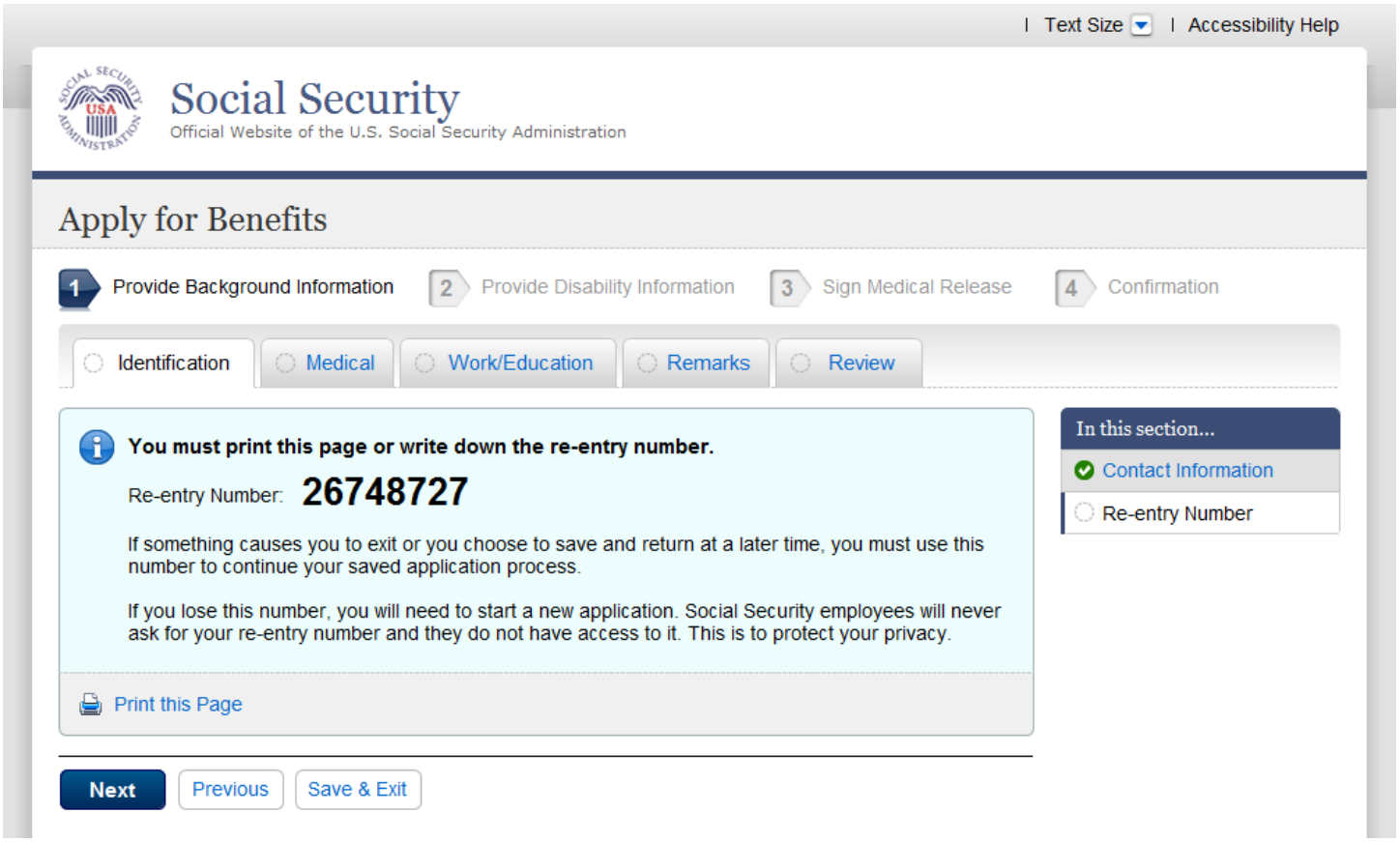
Table of Contents

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

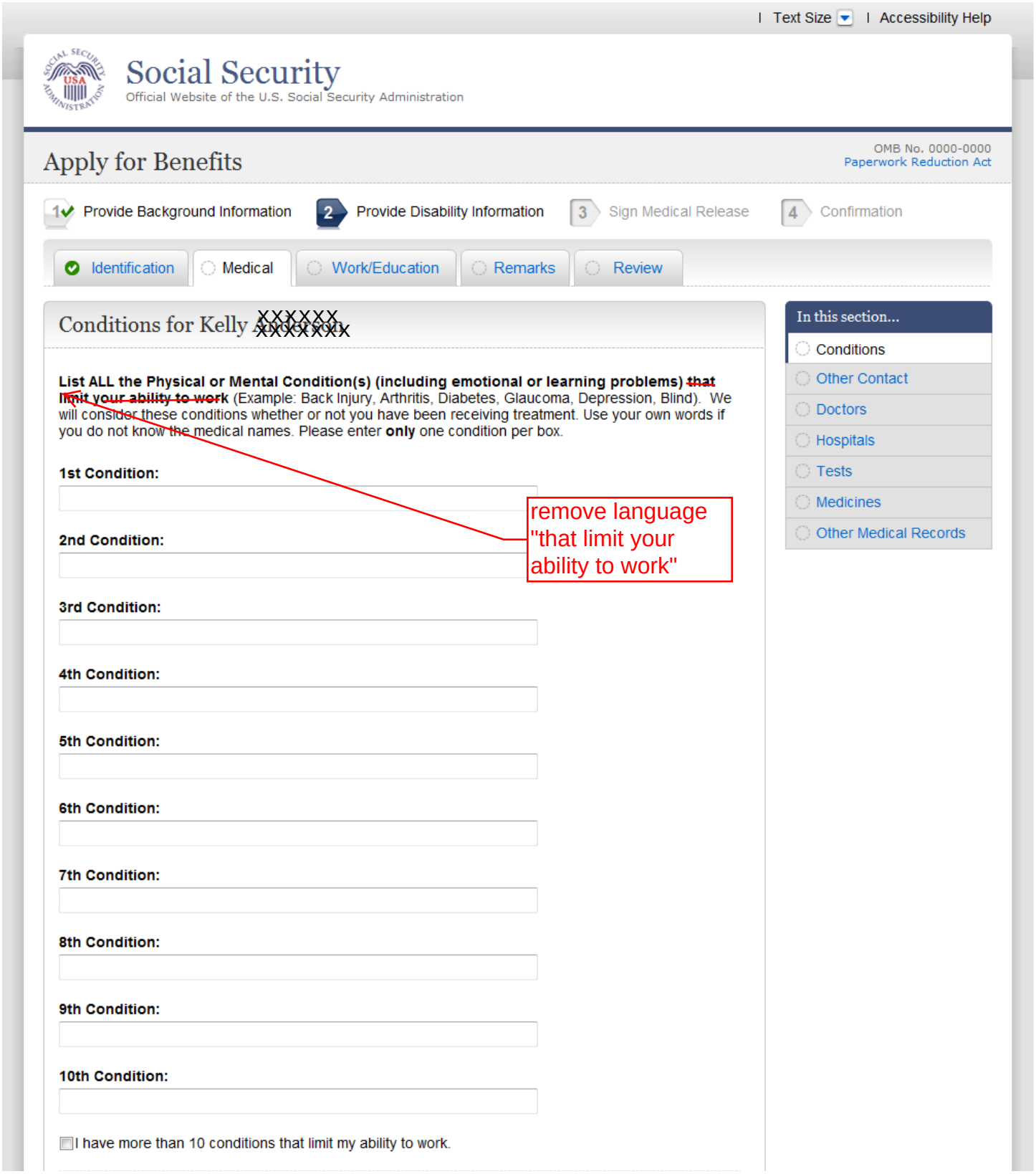


Insert Penalty Warning: Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

2. Re-entry Number (i3368 only)



3. Alg001-1_Conditions



What is your height without shoes?

-- --

Feet Inches

What is your weight without shoes?

lbs

Does your condition cause you pain or other symptoms?

Yes No

Treatment

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

For any physical condition(s):

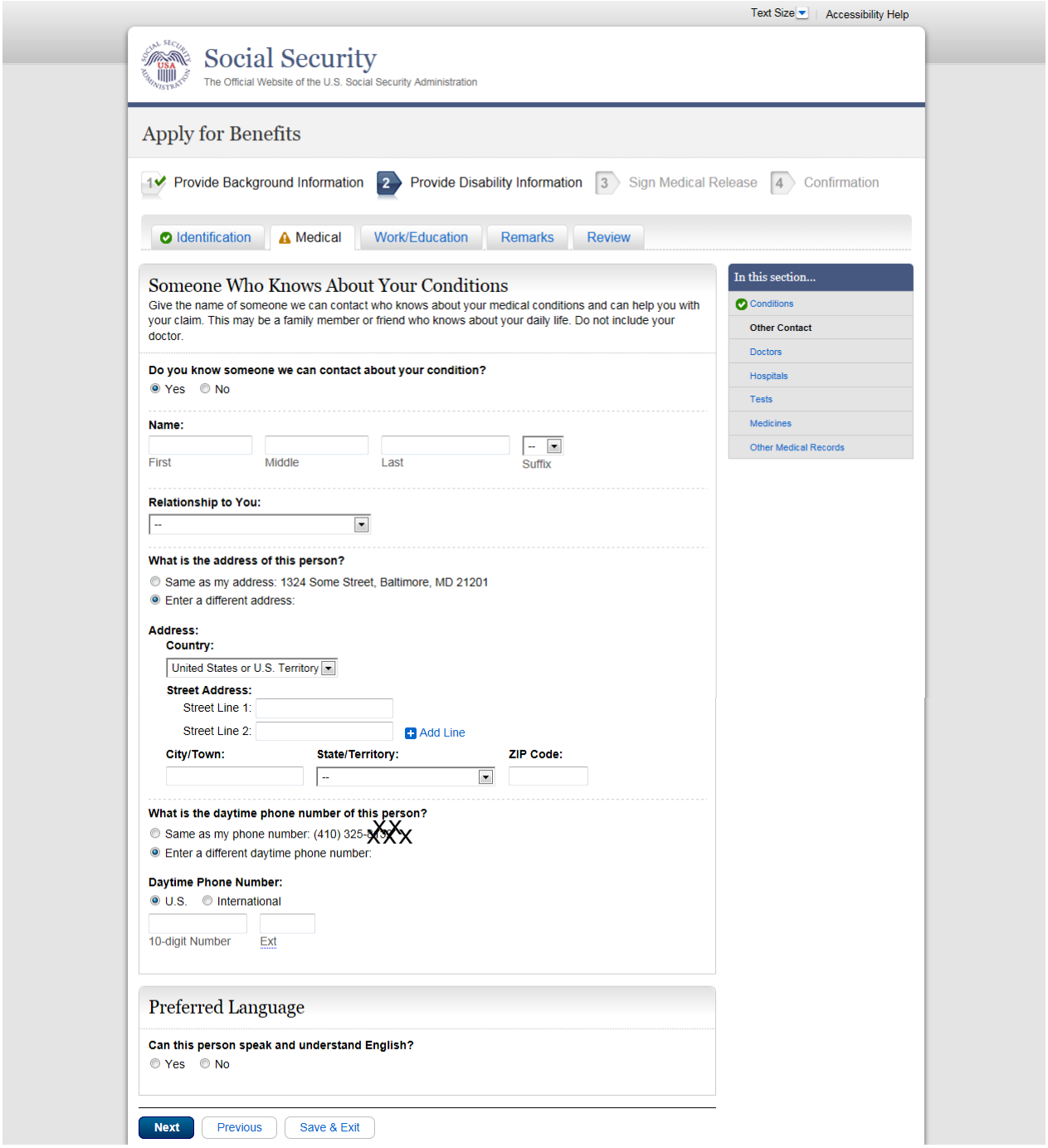
Yes No

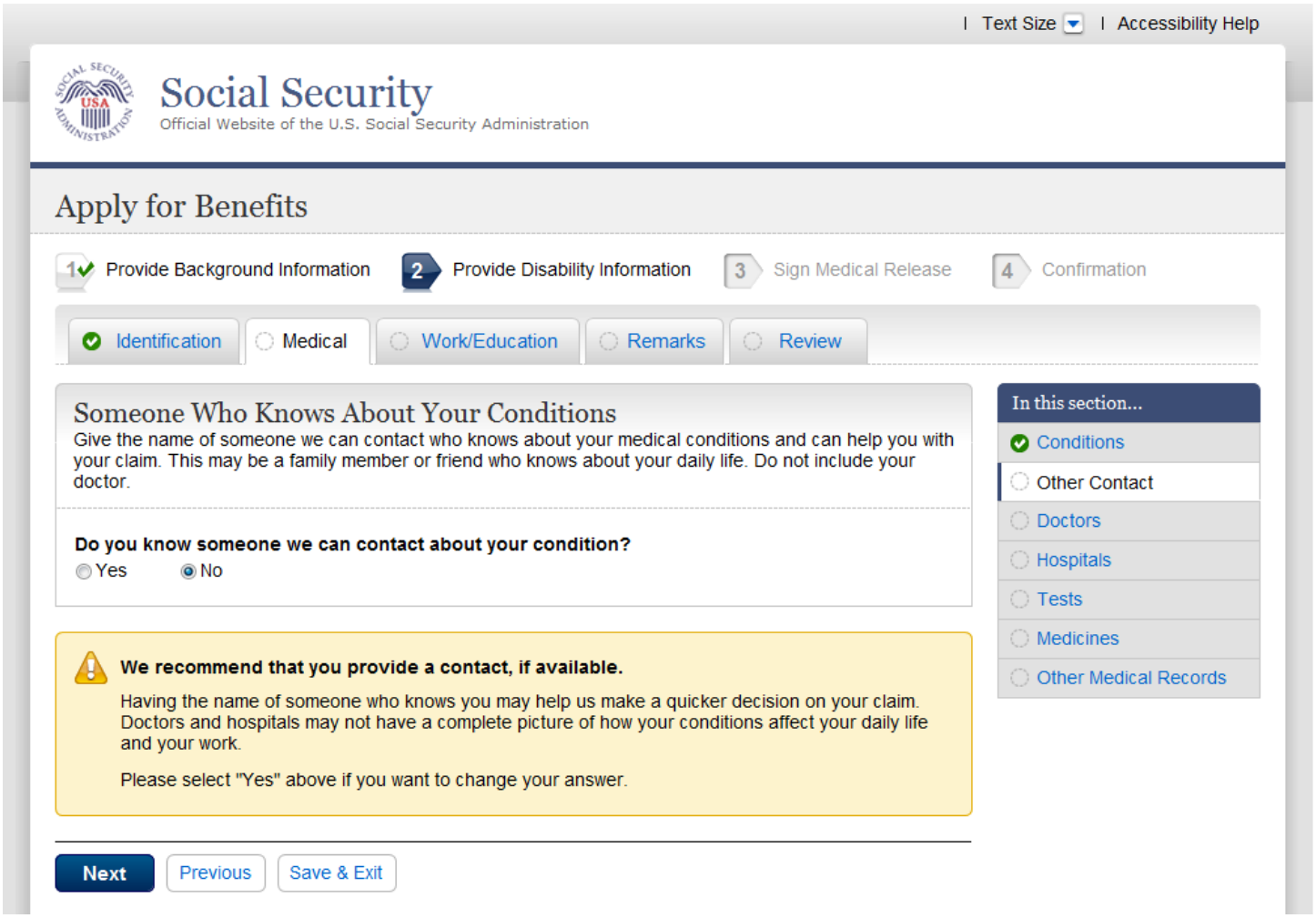
For any mental condition(s):

Yes No

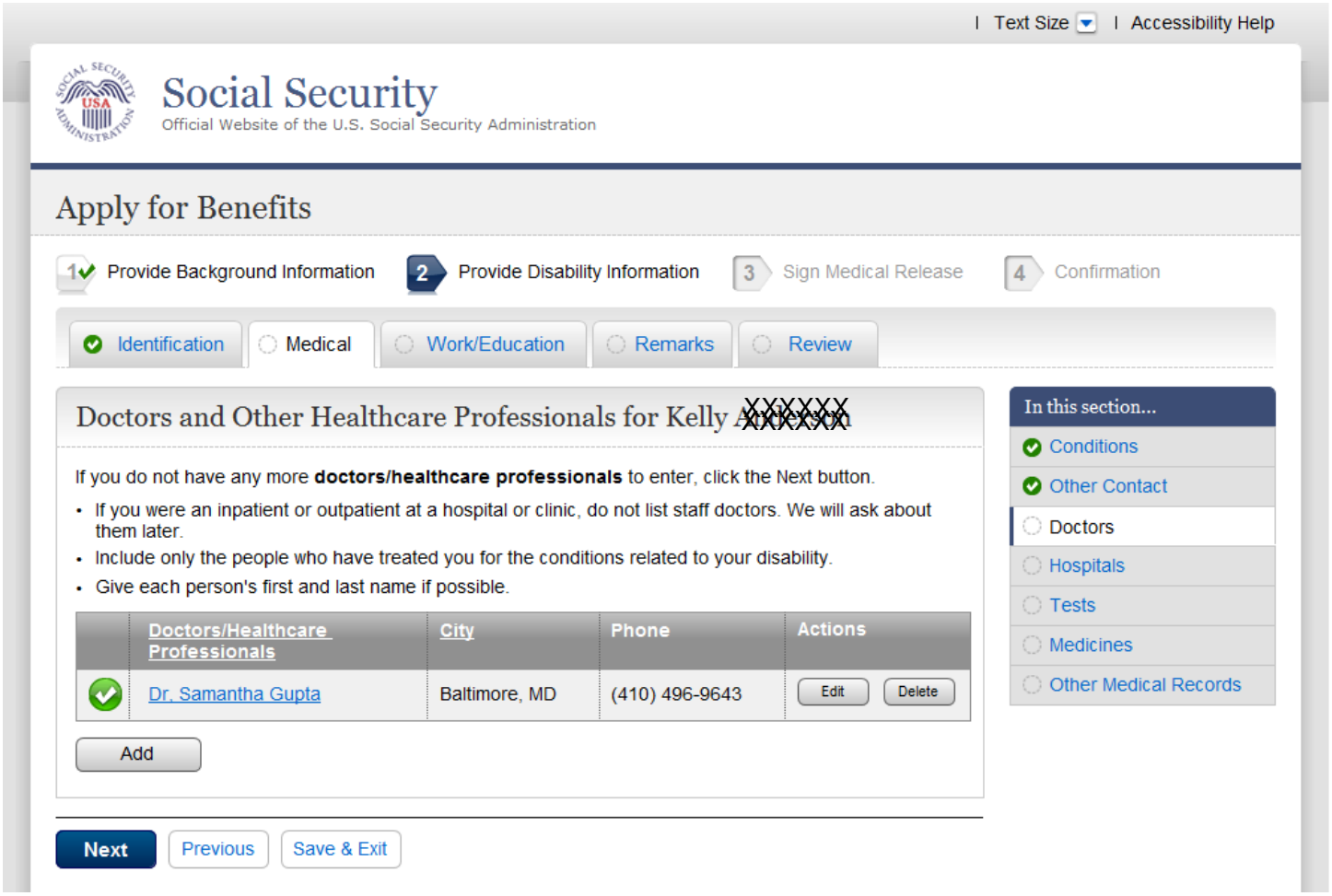
Next Save & Exit

4. Con001-1_Someone Who Knows About Your Condition

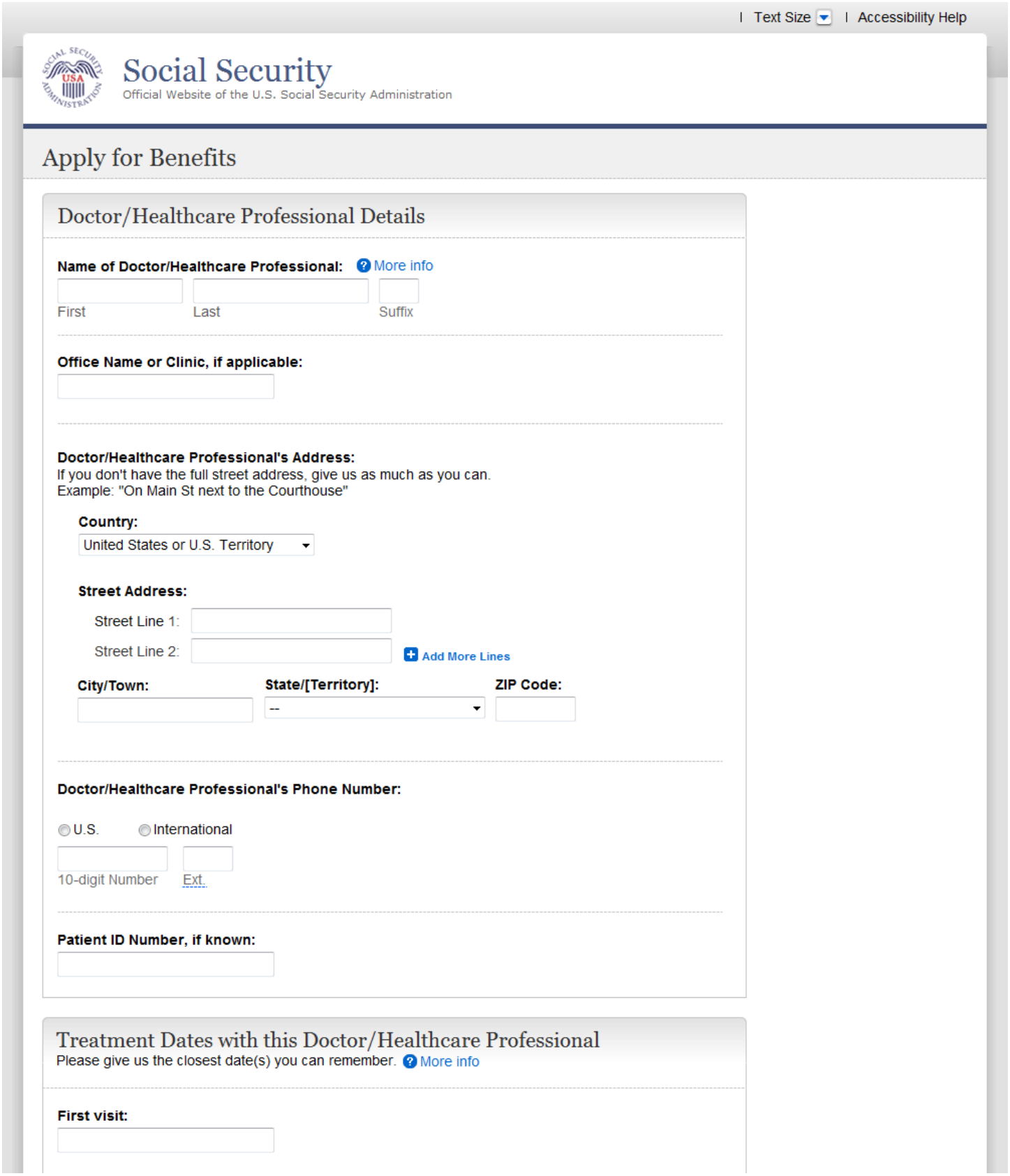



Text Size
Accessibility Help
Social Security
Official Website of the U.S. Social Security Administration
Apply for Benefits
1 Provide Background Information
2 Provide Disability Information
3 Sign Medical Release
4 Confirmation
Identification
Medical
Work/Education
Remarks
Review
Someone Who Knows About Your Conditions
Give the name of someone we can contact who knows about your medical conditions and can help you with your claim. This may be a family member or friend who knows about your daily life. Do not include your doctor.
Do you know someone we can contact about your condition?
Yes
No
We recommend that you provide a contact, if available.
Having the name of someone who knows you may help us make a quicker decision on your claim. Doctors and hospitals may not have a complete picture of how your conditions affect your daily life and your work.
Please select "Yes" above if you want to change your answer.
Next
Previous
Save & Exit
In this section...
Conditions
Other Contact
Doctors
Hospitals
Tests
Medicines
Other Medical Records

5. Doc001-1_Doctors and healthcare professionals



6. Doc002-1_Doctors and healthcare professionals details



Last visit:

Next visit:
Leave blank if no appointment scheduled.

Tests Ordered by this Doctor/Healthcare Professional

More info

Has this doctor/healthcare professional ordered any tests for you?
This includes any medical tests you have had or will have.

Yes No

Details about Test 1:

Kind of Test:

--

Date of Test: More info

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

Details about Test 2:

Kind of Test:

--

Date of Test: More info

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

If you have more tests, we will ask for them later in the process.

Medicines Recommended or Prescribed by this Doctor/Healthcare Professional

Has this doctor/healthcare professional recommended or prescribed any medicines for you?

Yes No

List any medicines you are taking and the reasons you are taking them.
List only one medicine at a time. Look at the medicine container if necessary.

Medicine 1:

Reason 1:

Medicine 2:

Reason 2:

Medicine 3:

Reason 3:

If you have more medicines, we will ask for them later in the process.

Medical Conditions Treated by this Doctor/Healthcare Professional

What medical conditions were treated or evaluated by this doctor/healthcare professional?
Examples: back injury, arthritis, diabetes, depression, blind. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

Treatment from this Doctor/Healthcare Professional

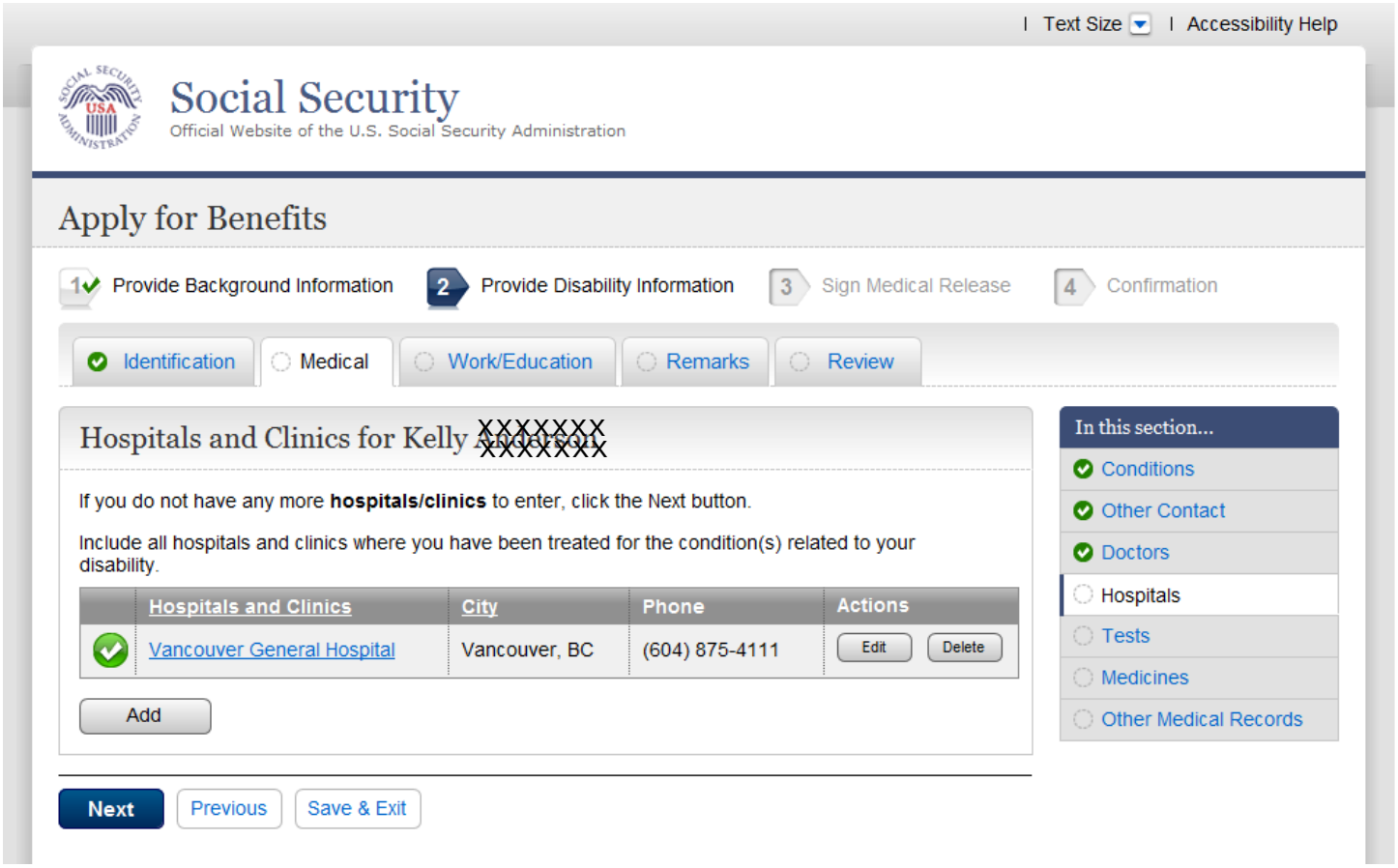
What treatment did you receive from this doctor/healthcare professional?
You DO NOT need to repeat any information that you have already told us about medicines and tests. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters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

Characters remaining: XXXX

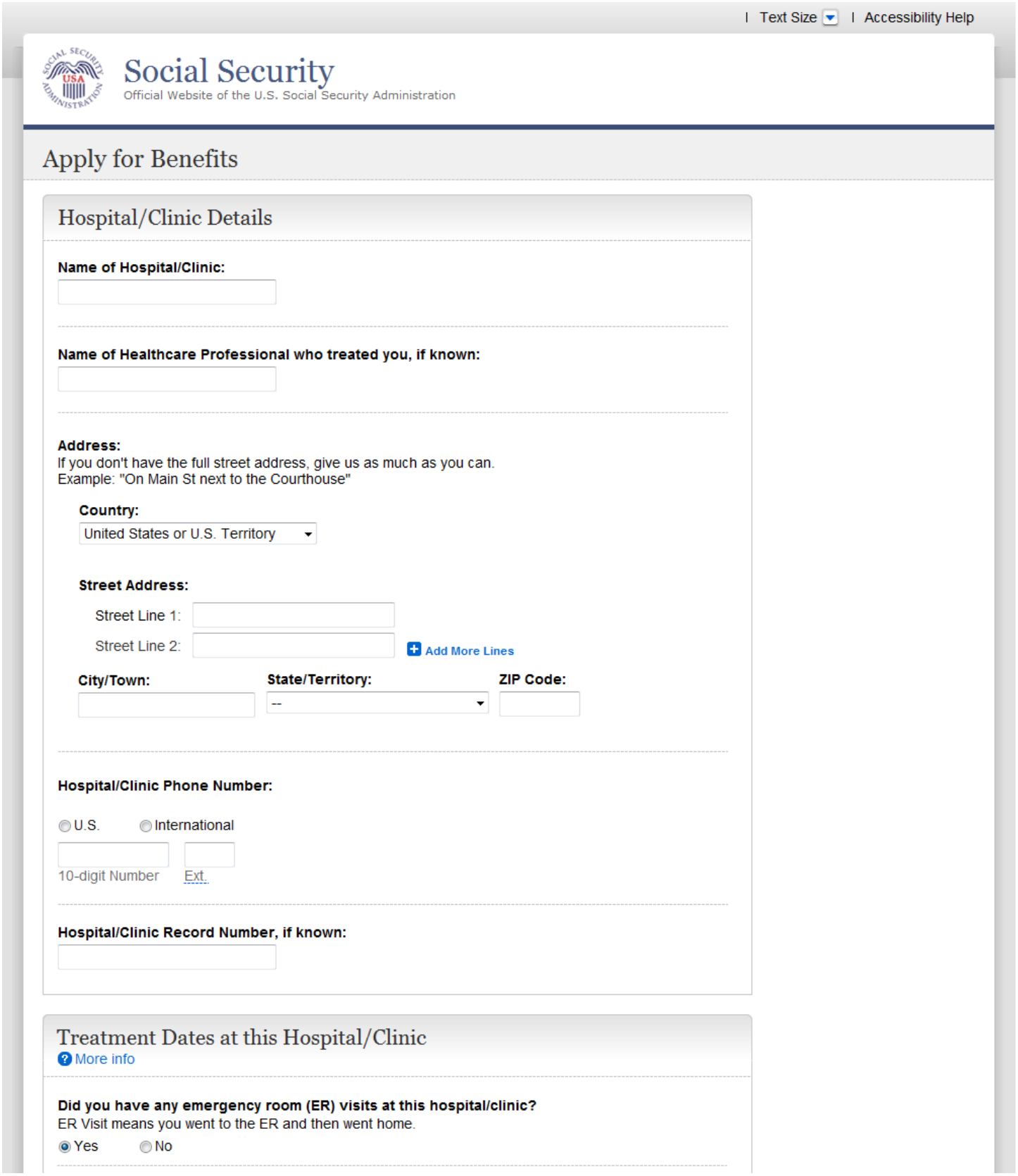
Check Spelling

Save Cancel

7. Hos001-1_Hospitals and Clinics



8. Hos002-1_Hospital and Clinic Details



Dates of Emergency Room visits to this hospital/clinic.
Please give the dates of your most recent Emergency Room visits.

Emergency Room Visit 1:

Emergency Room Visit 2:

Emergency Room Visit 2:

Did you have an inpatient stay at this hospital/clinic?
Inpatient stay means you have stayed at least one night.
(•) Yes ( ) No

Give us the dates of your three most recent stays.

Admission Date 1: **Discharge Date 1:**

Admission Date 2: **Discharge Date 2:**

Admission Date 3: **Discharge Date 3:**

Did you have an outpatient visit at this hospital/clinic, or do you have one scheduled?
Outpatient visit means you went home the same day.
(•) Yes ( ) No

Dates of outpatient visits to this hospital/clinic. More info
Please give us the closest dates you can remember.

First Outpatient Visit:

Last Outpatient Visit:

Next Scheduled Outpatient Visit:
Leave blank if no appointment scheduled.

Tests Ordered by this Hospital/Clinic

More info

Have any of the doctors at this hospital/clinic ordered any tests for you?
This includes any medical tests you have had or will have.
(•) Yes ( ) No

Details about Test 1:

Kind of Test:
--

Date of Test: More info

☐ The doctor(s) at this hospital ordered this test for me more than once.

Details about Test 2:

Kind of Test:

--

Date of Test: More info

☐ The doctor(s) at this hospital ordered this test for me more than once.

If you have more tests, we will ask for them later in the process.

Medicines Recommended or Prescribed by this Hospital/Clinic

Have any of the doctors at this hospital/clinic recommended or prescribed any medicines for you?

◉ Yes ○ No

List any medicines you are taking and the reasons you are taking them.
List only one medicine at a time. Look at the medicine container if necessary.

Medicine 1:

Reason 1:

Medicine 2:

Reason 2:

Medicine 3:

Reason 3:

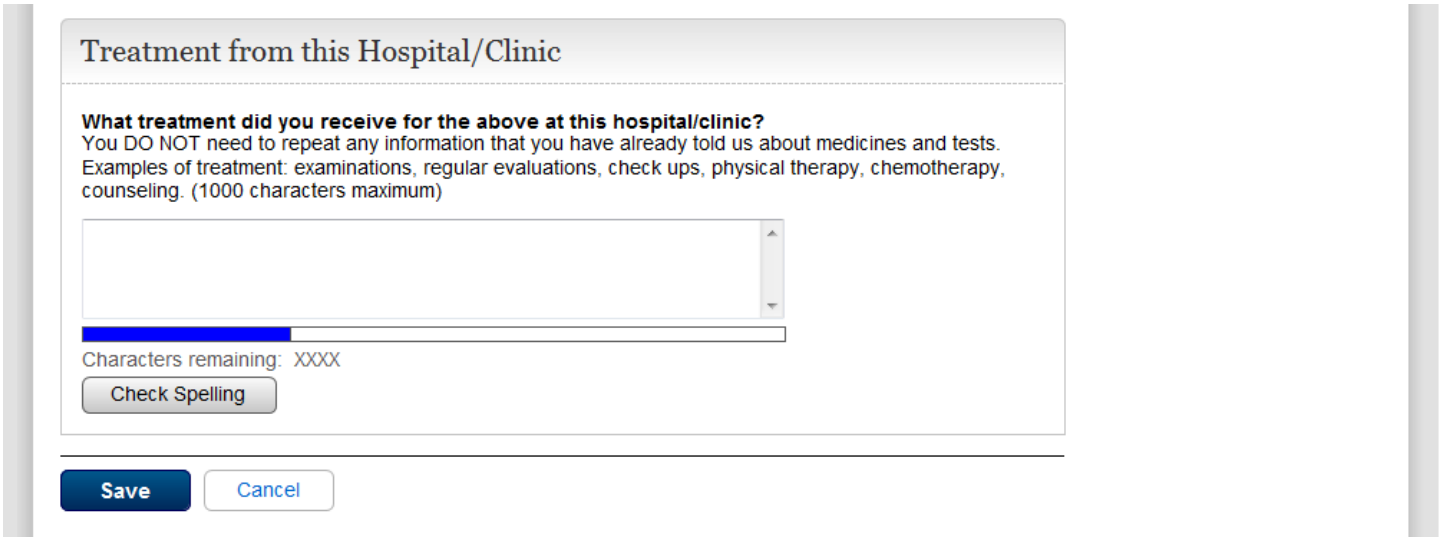
If you have more medicines, we will ask for them later in the process.

Medical Conditions Treated by this Hospital/Clinic

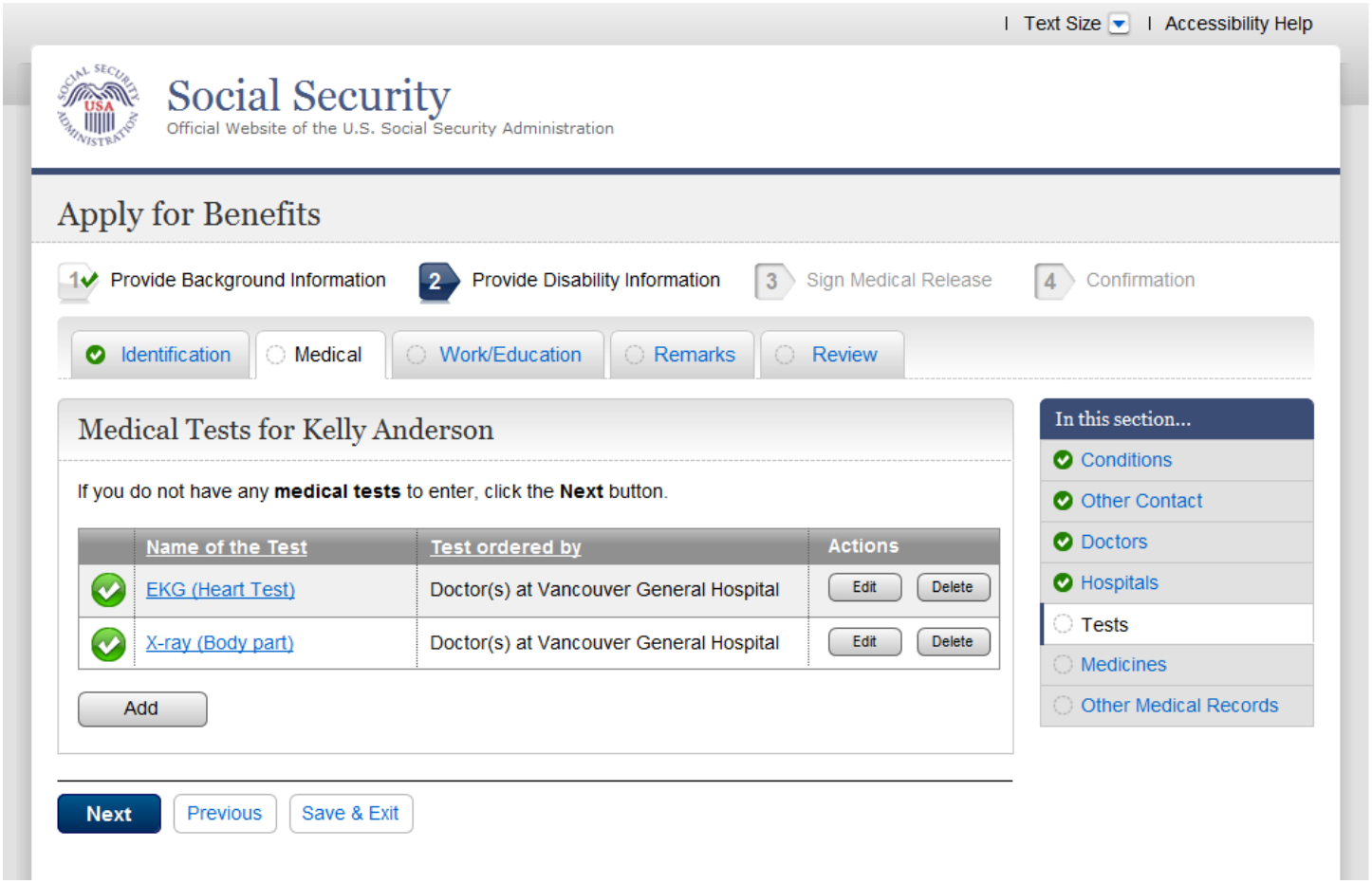
What medical conditions were treated or evaluated by this hospital/clinic?
Examples: back injury, arthritis, diabetes, depression, blind. (1000 characters maximum)

Characters remaining: XXXX

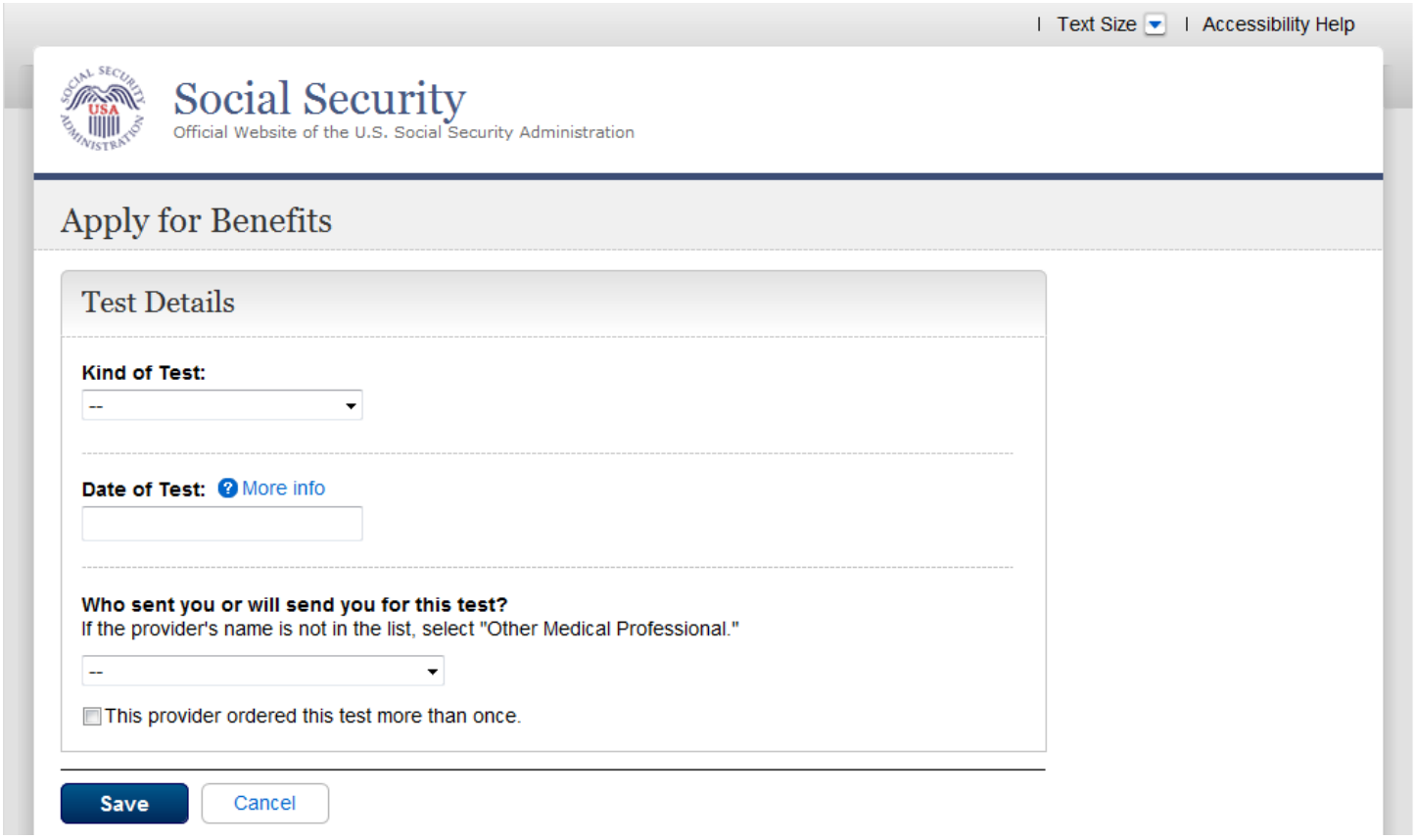
Check Spelling

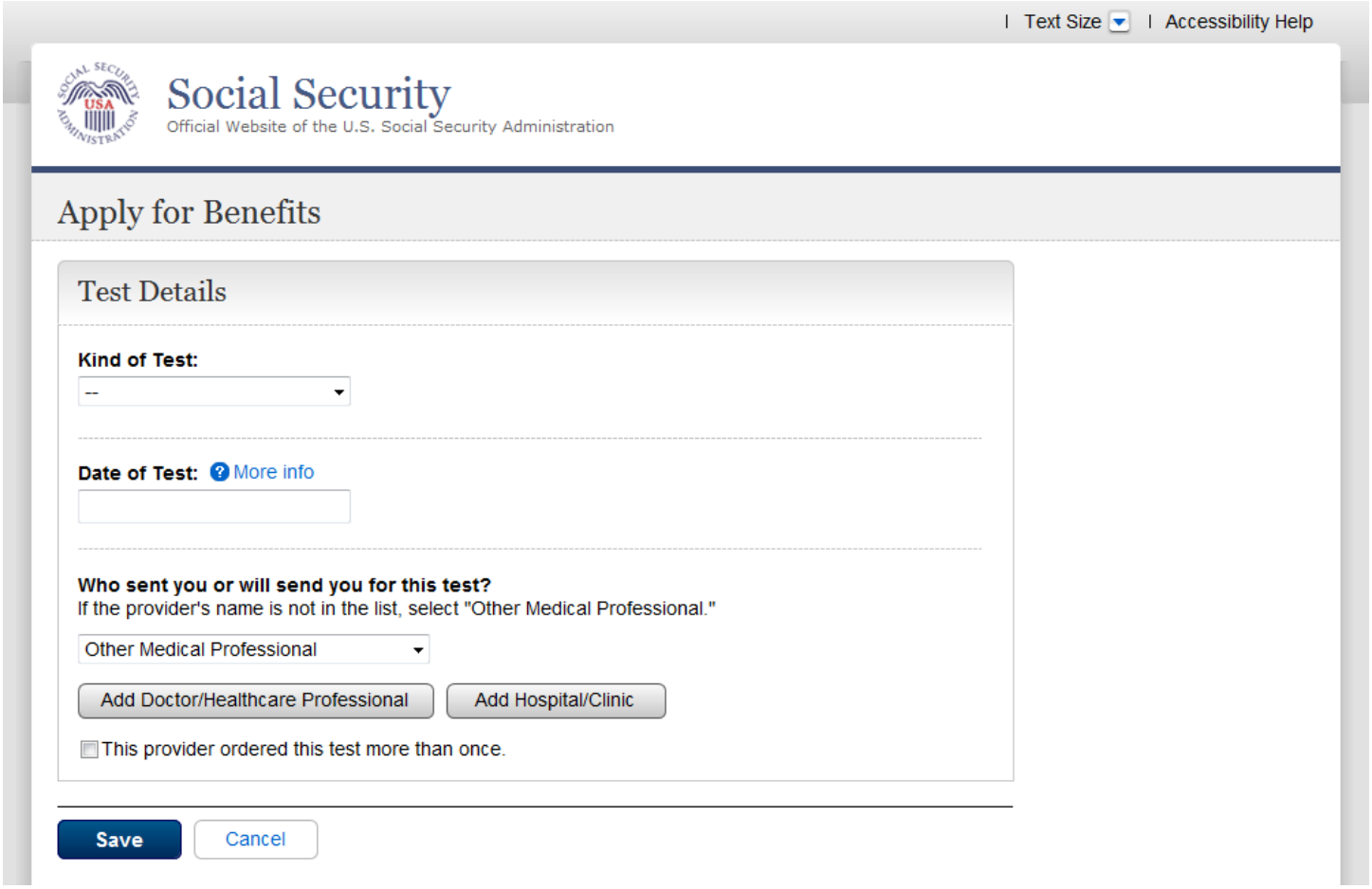

Treatment from this Hospital/Clinic
What treatment did you receive for the above at this hospital/clinic?
You DO NOT need to repeat any information that you have already told us about medicines and tests.
Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy,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

9. Tst001-1_Medical tests



10.Tst002-1_Medical Test Details



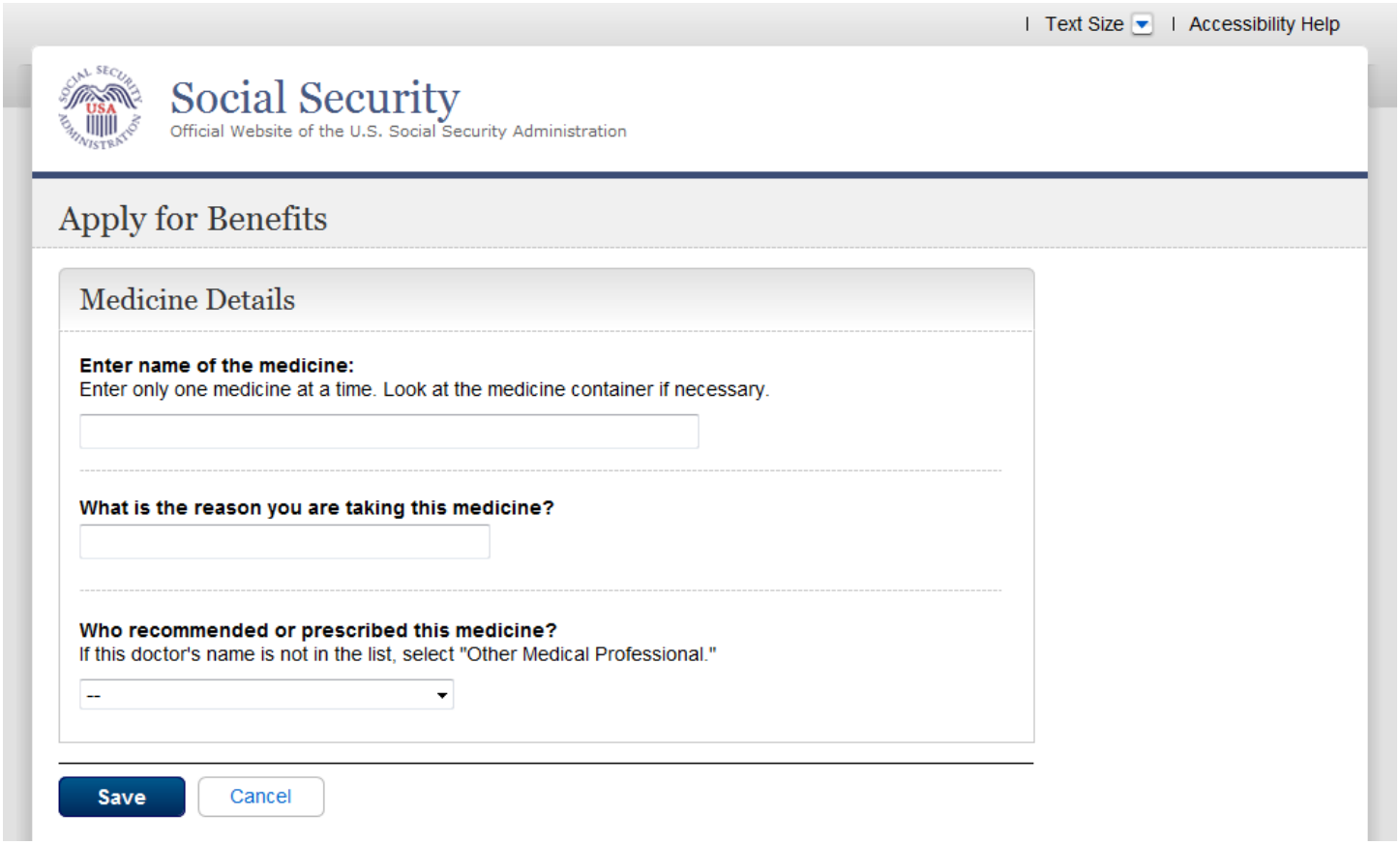


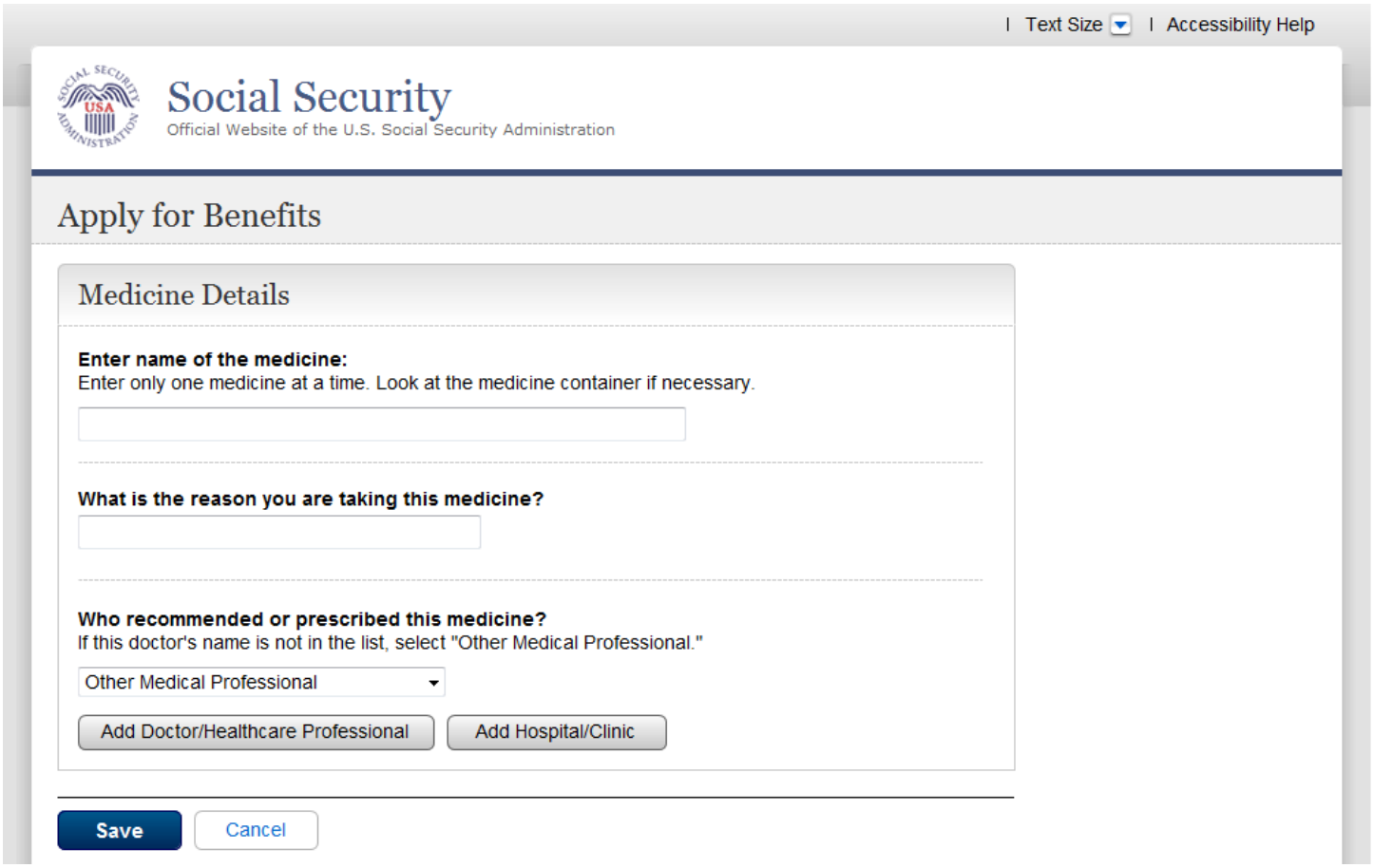
Note: When user selects “Other Medical Professional” in the dropdown for “Who sent you…”, the buttons “Add Doctor/Healthcare Professional” and “Add Hospital/Clinic” are displayed on the screen. It is mandatory for the user to select either of the buttons in order to continue.

When user selects either of the buttons, he is taken to Doctor or Hospital details page. Any action on the Doctor or Hospital details page should navigate them to the Tests page (Tst001-1_Medical tests)

11.Med001-1_Medicines

12.Med002-1_Medicine Details

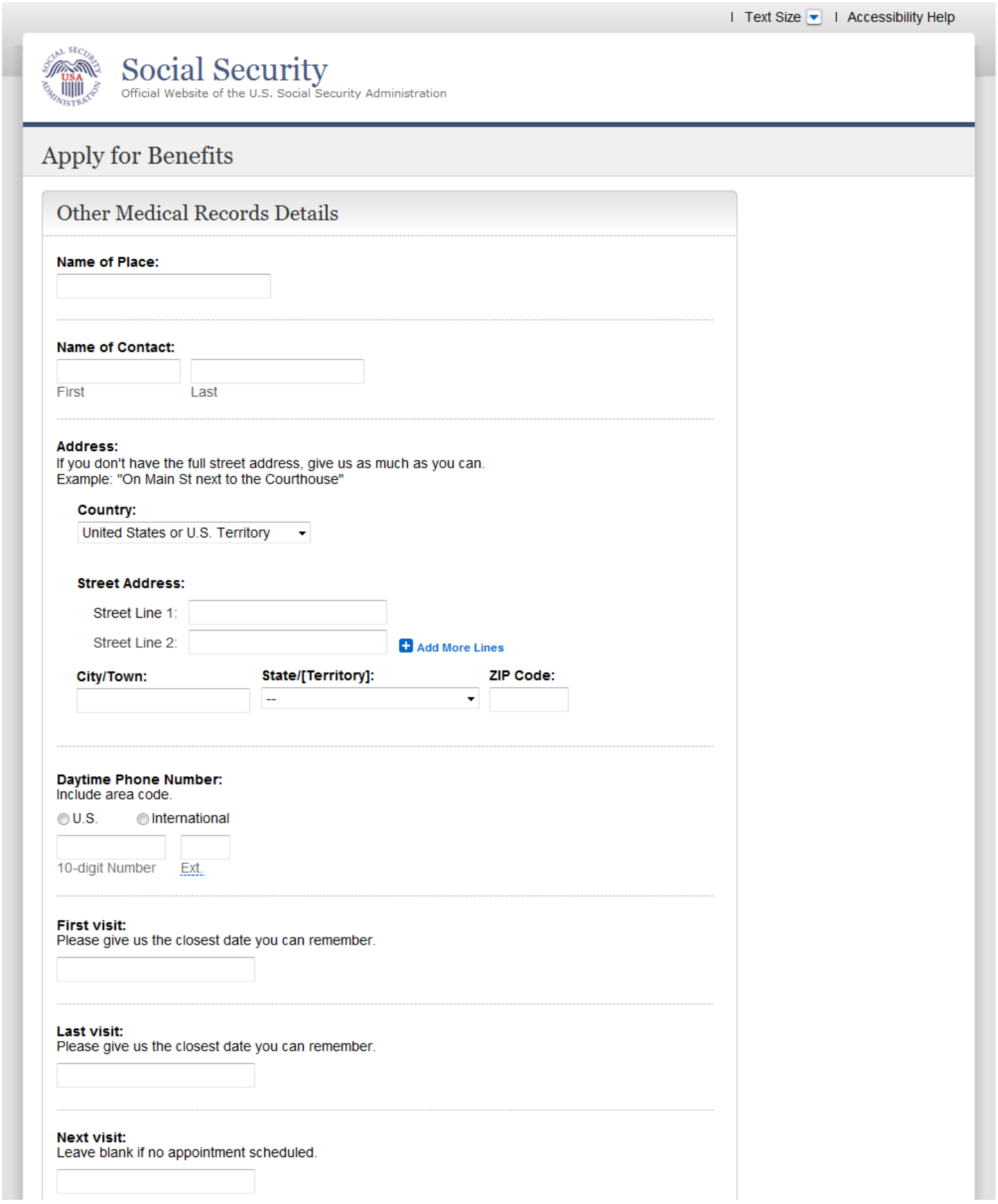


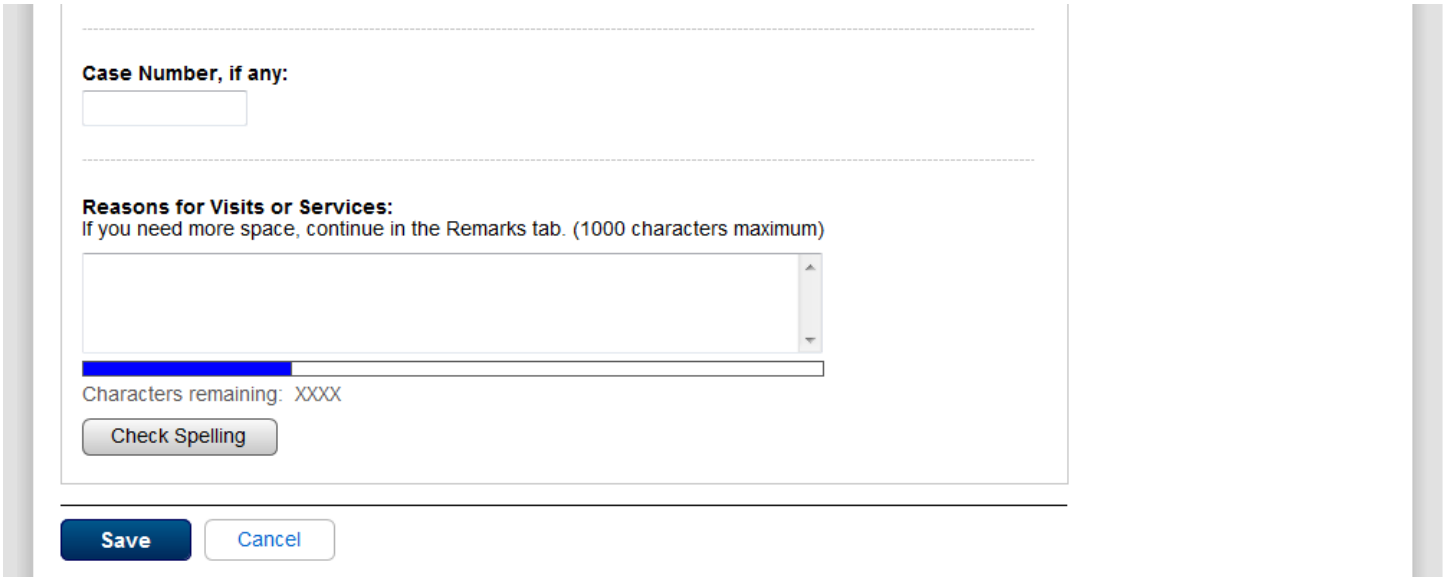


Note: When user selects “Other Medical Professional” in the dropdown for “Who recommended…”, the buttons “Add Doctor/Healthcare Professional” and “Add Hospital/Clinic” are displayed on the screen. It is mandatory for the user to select either of the buttons in order to continue.

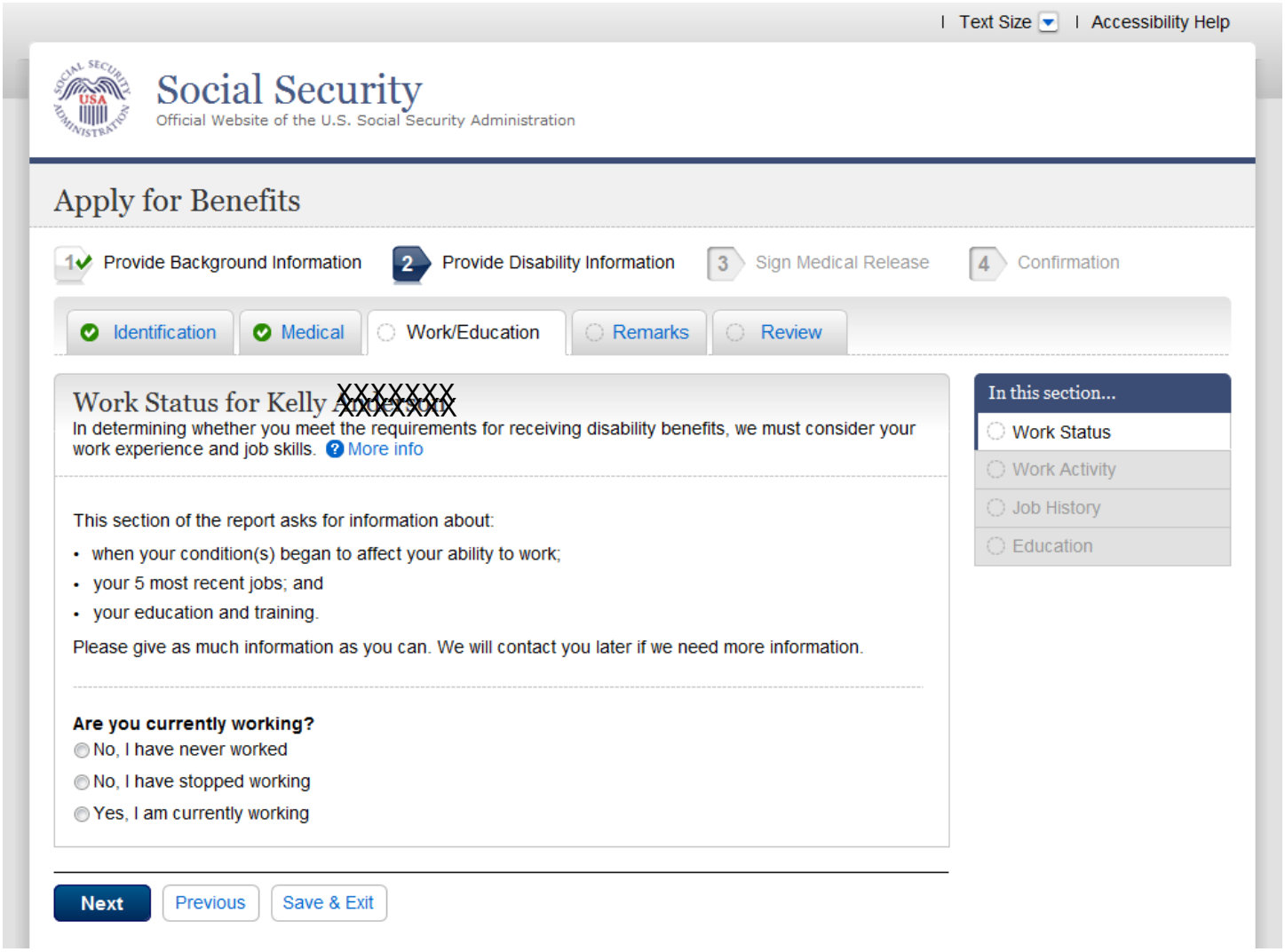
When user selects either of the buttons, he is taken to Doctor or Hospital details page. Any action on the Doctor or Hospital details page should navigate them to the Medicines page (Med001-1_Medicines)

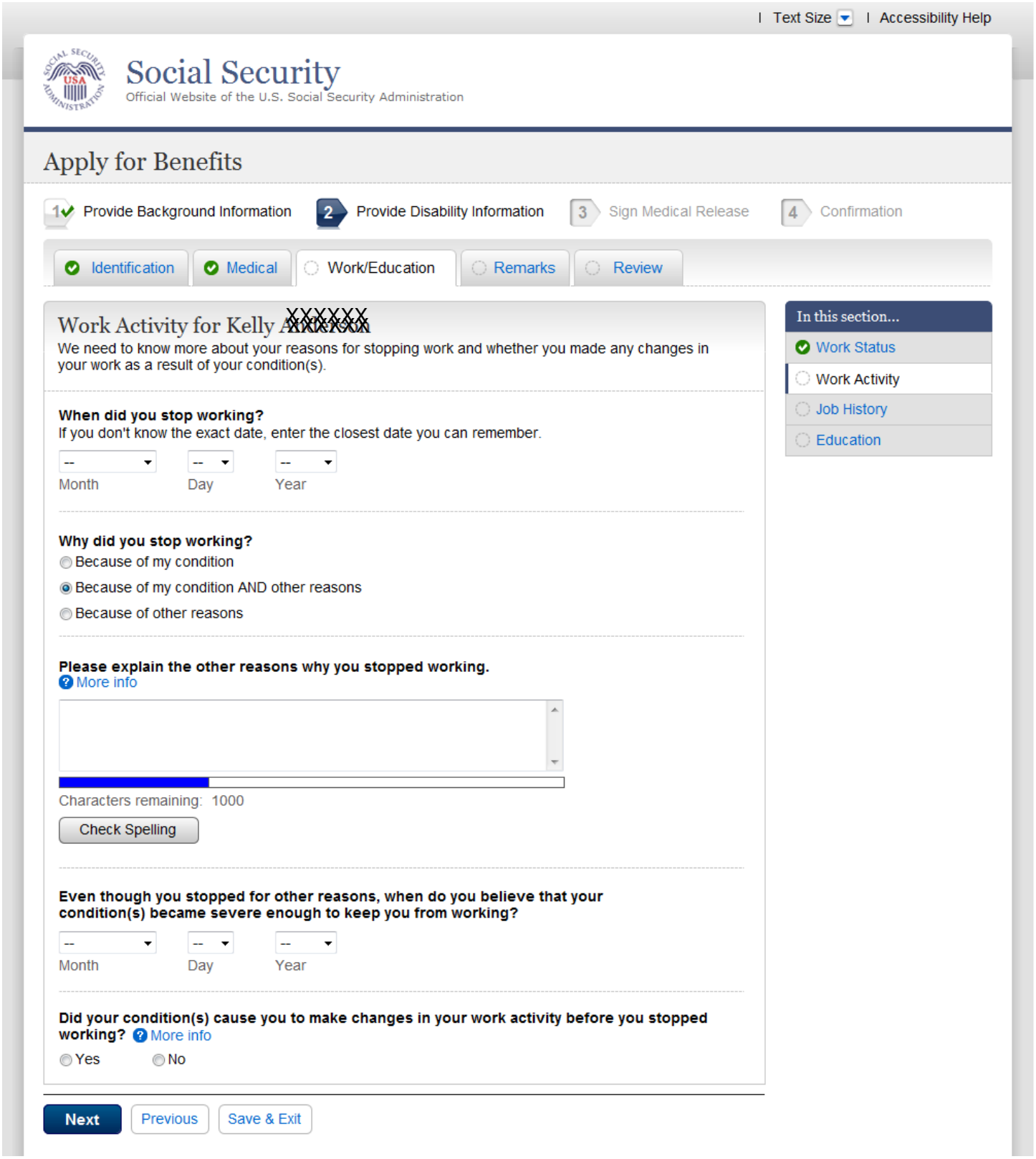
13.Msc001-1_Other medical records


| Text Size | Accessibility Help
Social Security
Official Website of the U.S. Social Security Administration
Apply for Benefits
Other Medical Records Details
Name of Place:
Name of Contact:
First
Last
Address:
If you don't have the full street address, give us as much as you can.
Example: "On Main St next to the Courthouse"
Country:
United States or U.S. Territory
Street Address:
Street Line 1:
Street Line 2:
Add More Lines
City/Town:
State/[Territory]:
--
ZIP Code:
Daytime Phone Number:
Include area code.
U.S.
International
10-digit Number
Ext.
First visit:
Please give us the closest date you can remember.
Last visit:
Please give us the closest date you can remember.
Next visit:
Leave blank if no appointment scheduled.

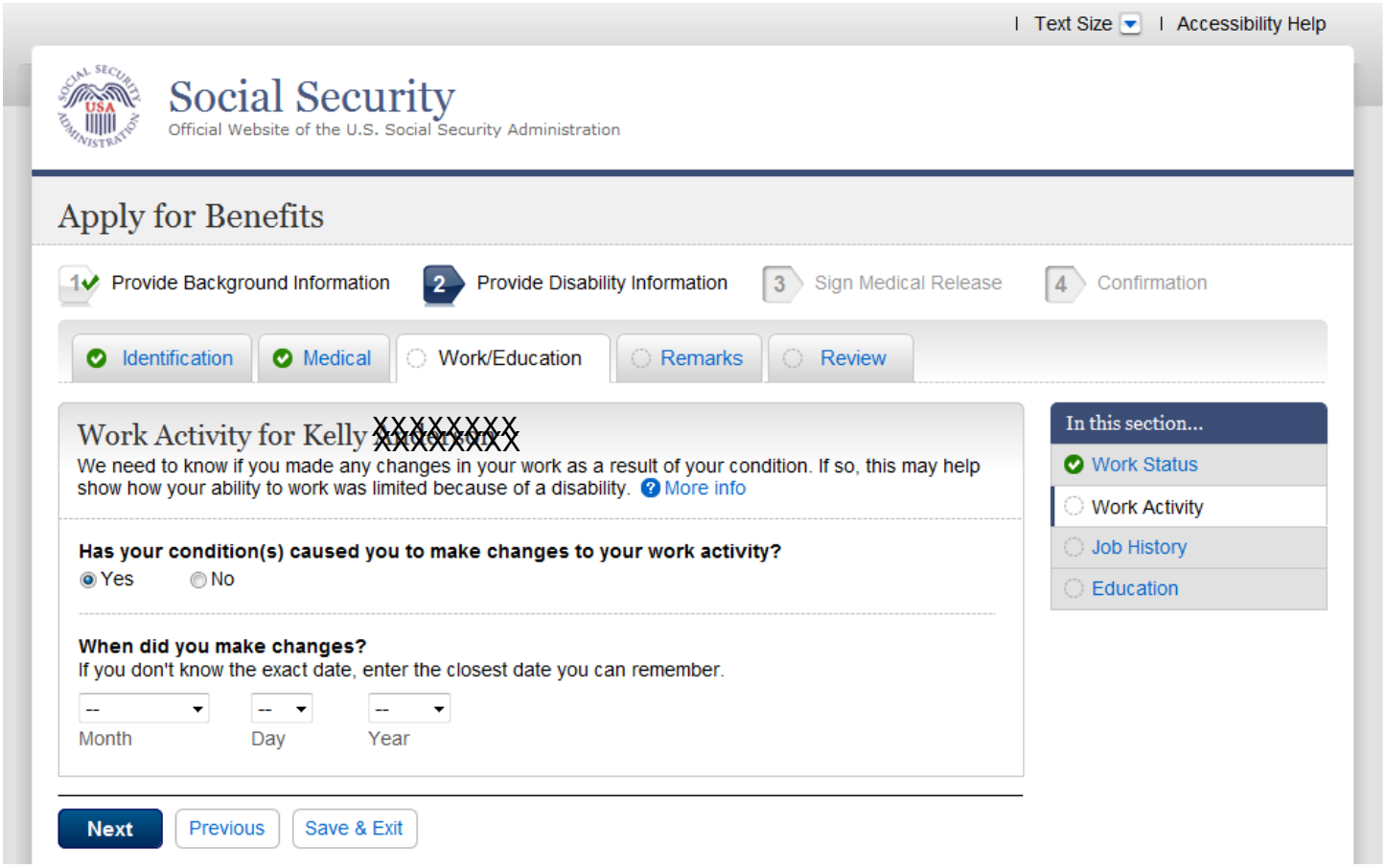

Case Number, if any:
Reasons for Visits or Services:
If you need more space, continue in the Remarks tab. (1000 characters maximum)
Characters remaining: XXXX
Check Spelling
Save
Cancel

16.Win001-1_Work Status

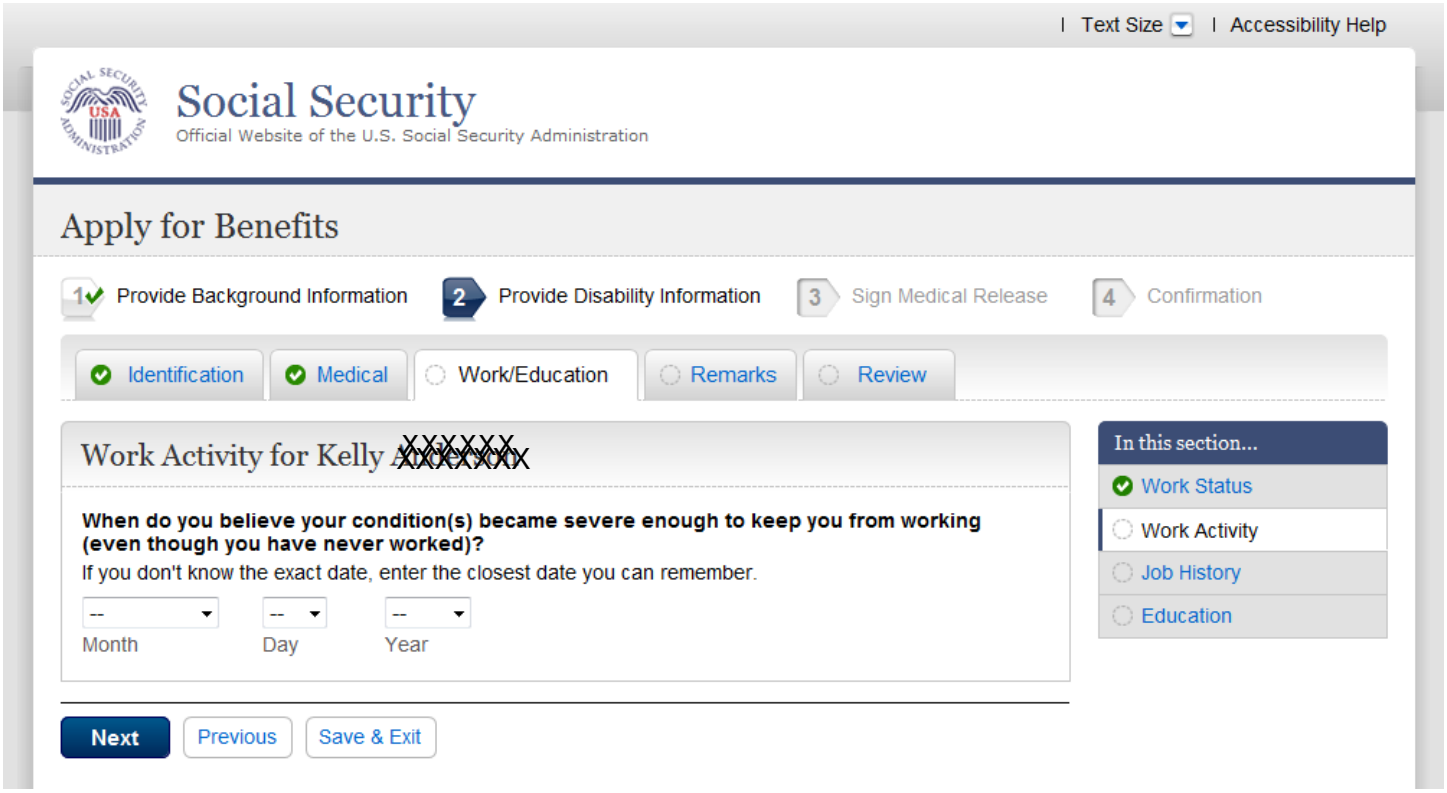



Text Size
Accessibility Help
Social Security
Official Website of the U.S. Social Security Administration
Apply for Benefits
1 Provide Background Information
2 Provide Disability Information
3 Sign Medical Release
4 Confirmation
Identification
Medical
Work/Education
Remarks
Review
Work Activity for Kelly XXXXXX
We need to know more about your reasons for stopping work and whether you made any changes in your work as a result of your condition(s).
When did you stop working?
If you don't know the exact date, enter the closest date you can remember.
Month
Day
Year
Why did you stop working?
Because of my condition
Because of my condition AND other reasons
Because of other reasons
Please explain the other reasons why you stopped working.
More info
Characters remaining: 1000
Check Spelling
Even though you stopped for other reasons, when do you believe that your condition(s) became severe enough to keep you from working?
Month
Day
Year
Did your condition(s) cause you to make changes in your work activity before you stopped working?
More info
Yes
No
Next
Previous
Save & Exit
In this section...
Work Status
Work Activity
Job History
Education

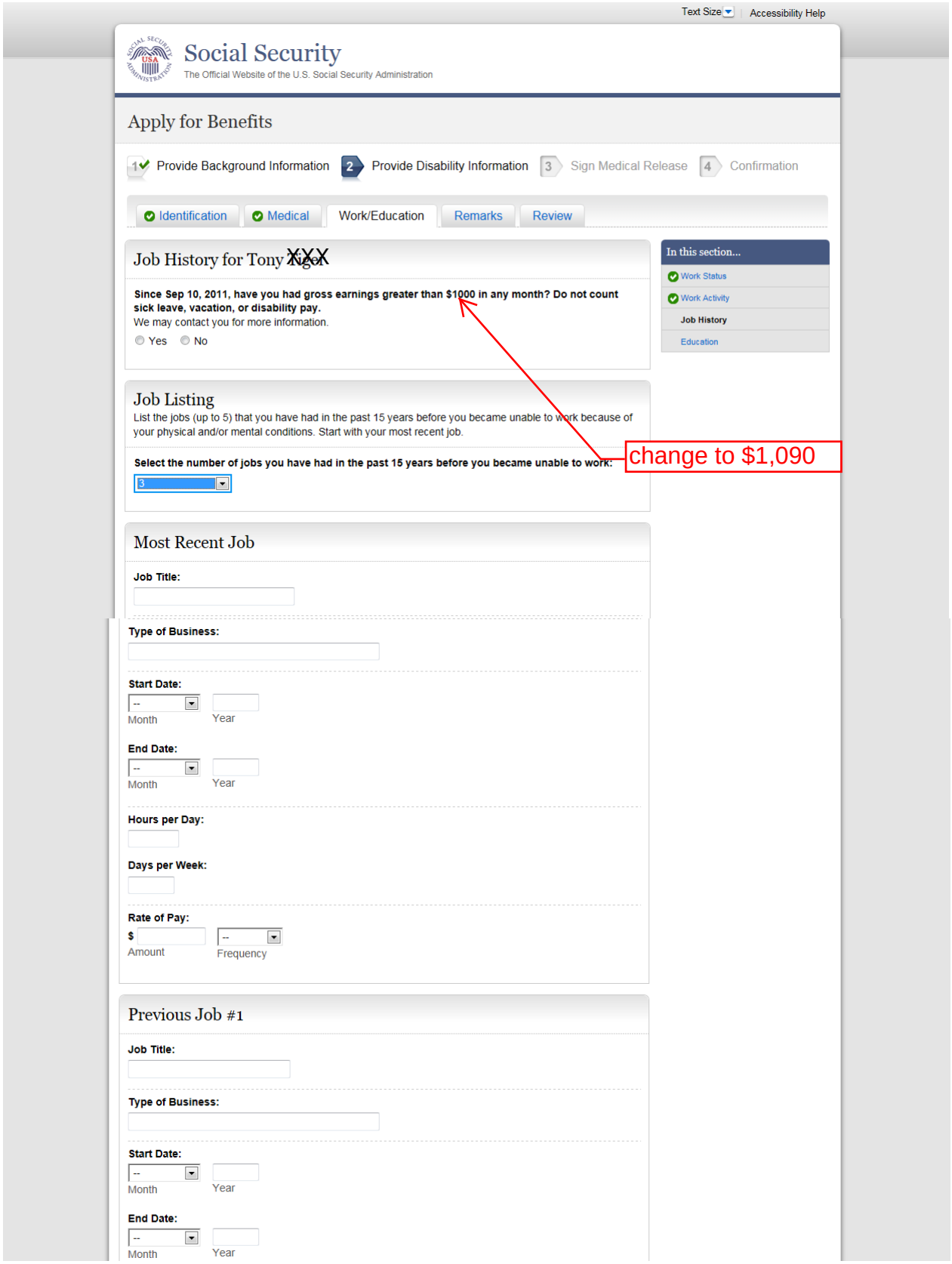
18.Wac001-1-cw_Work Activity

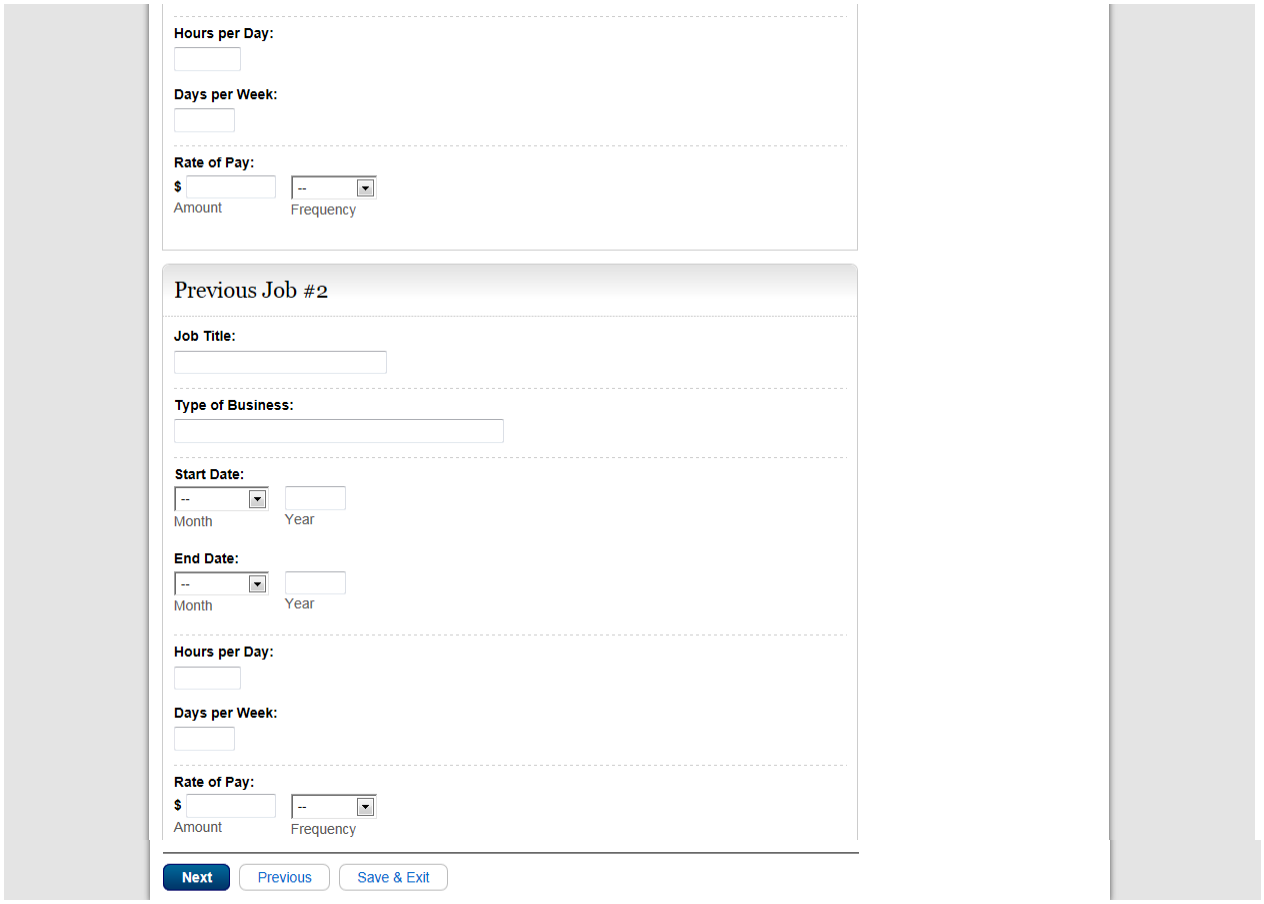


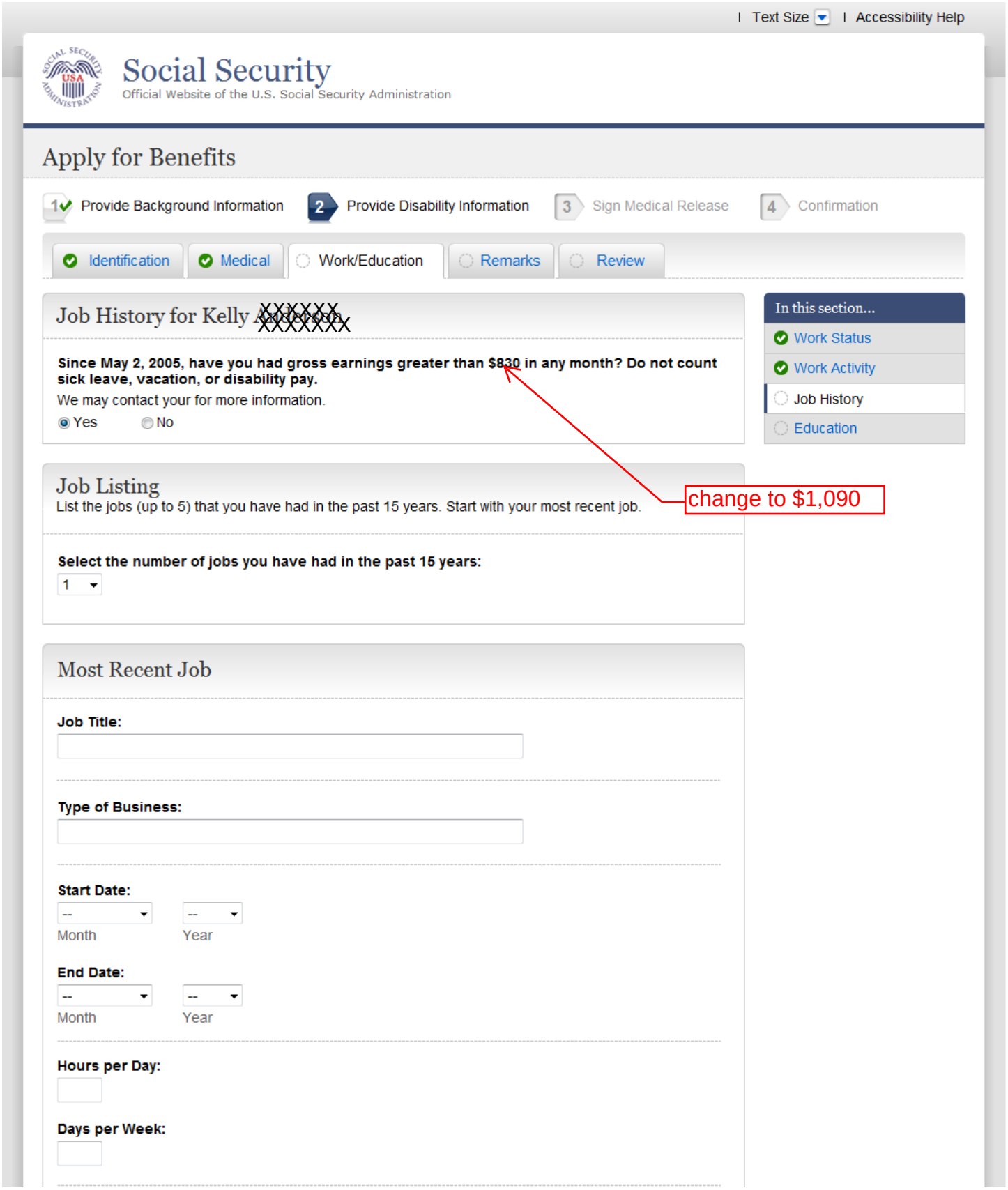
19.Wac001-1-nw_Work Activity



20.Job001-1-sw_Job History




Hours per Day:
Days per Week:
Rate of Pay:
$
Amount
--
Frequency
Previous Job #2
Job Title:
Type of Business:
Start Date:
--
Month
Year
End Date:
--
Month
Year
Hours per Day:
Days per Week:
Rate of Pay:
$
Amount
--
Frequency
Next
Previous
Save & Exit


Text Size
Accessibility Help
Social Security
Official Website of the U.S. Social Security Administration
Apply for Benefits
1 Provide Background Information
2 Provide Disability Information
3 Sign Medical Release
4 Confirmation
Identification
Medical
Work/Education
Remarks
Review
Job History for Kelly XXXXXX
Since May 2, 2005, have you had gross earnings greater than $830 in any month? Do not count sick leave, vacation, or disability pay.
We may contact your for more information.
Yes
No
In this section...
Work Status
Work Activity
Job History
Education
change to $1,090
Job Listing
List the jobs (up to 5) that you have had in the past 15 years. Start with your most recent job.
Select the number of jobs you have had in the past 15 years:
1
Most Recent Job
Job Title:
Type of Business:
Start Date:
Month
Year
End Date:
Month
Year
Hours per Day:
Days per Week:

Rate of Pay:

$ [ ] [--]

Amount Frequency

Job Details

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

Characters remaining: XXXX

Check Spelling

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

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

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

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

Did you walk?
◉ Yes ○ No

How many hours did you walk?
0.5 hours

Did you stand?
○ Yes ◉ No

You answered you did not stand.

Did you sit?
◉ Yes ○ No

How many hours did you sit?
3 hours

Did you climb?
○ Yes ◉ No

You answered you did not climb.

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

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

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

Did you crawl?
○ Yes ○ No

Did you handle large objects?
◉ Yes ○ No

How many hours did you handle large objects?
0.5 hours

Did you write, type or handle small objects?

(•) Yes ( ) No

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

3 hours

Did you reach?

( ) Yes (•) No

You answered you did not reach.

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

Characters remaining: 1000

Check Spelling

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

--

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

--

Did you supervise other people in this job?

(•) Yes ( ) No

How many people did you supervise?

What part of your time did you spend supervising people?

Did you hire and fire employees?

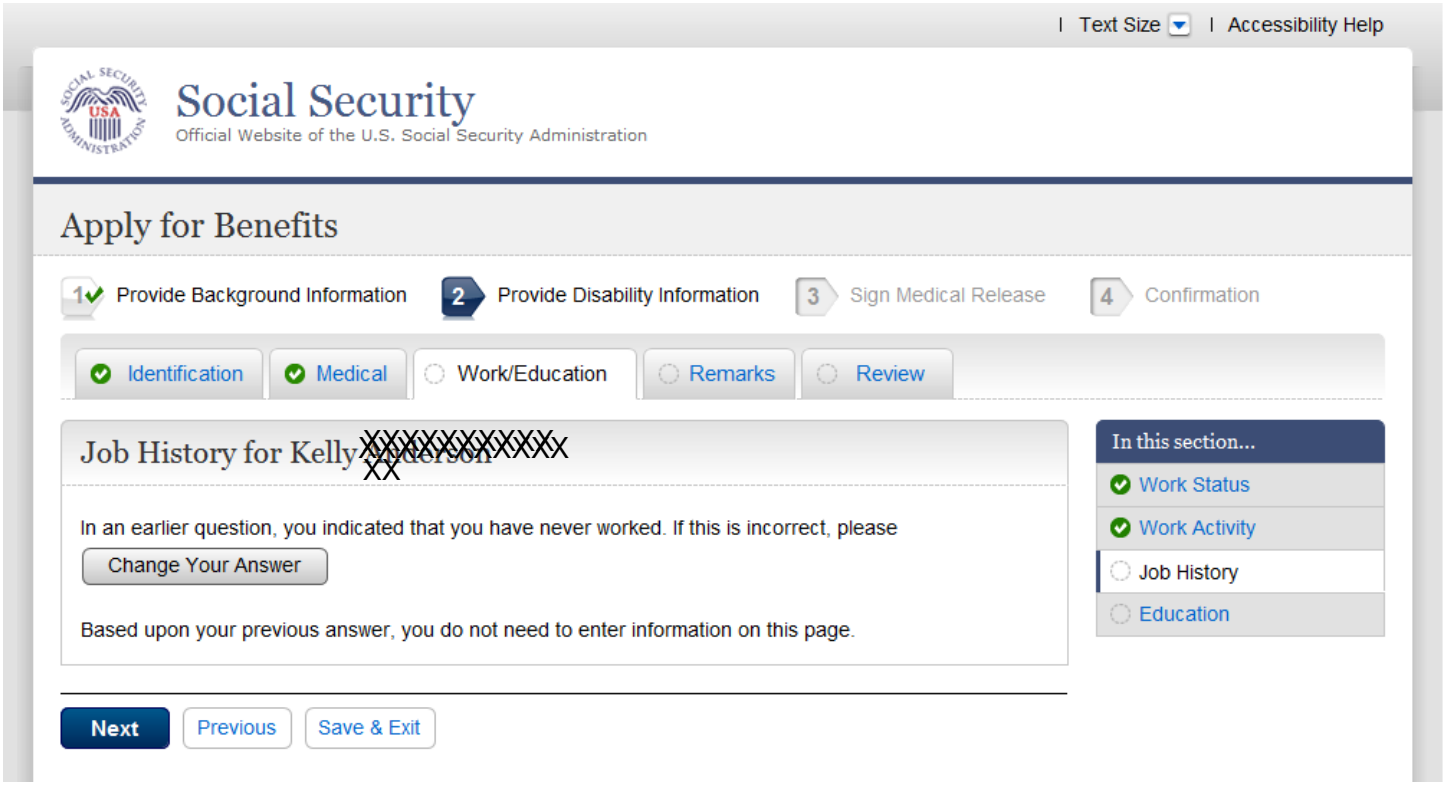
( ) Yes ( ) No

Were you a lead worker?

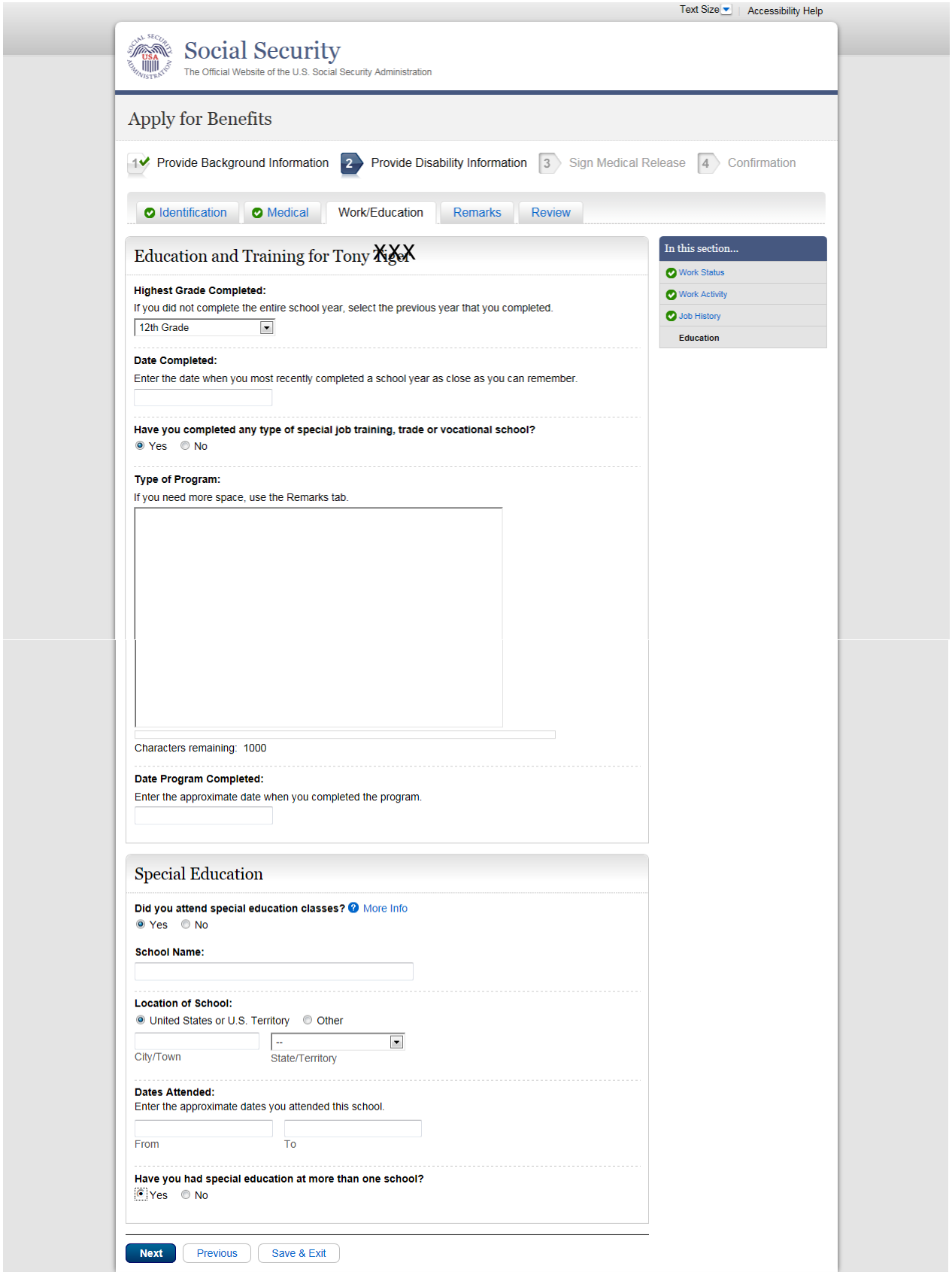
( ) Yes ( ) No

Next Previous Save & Exit

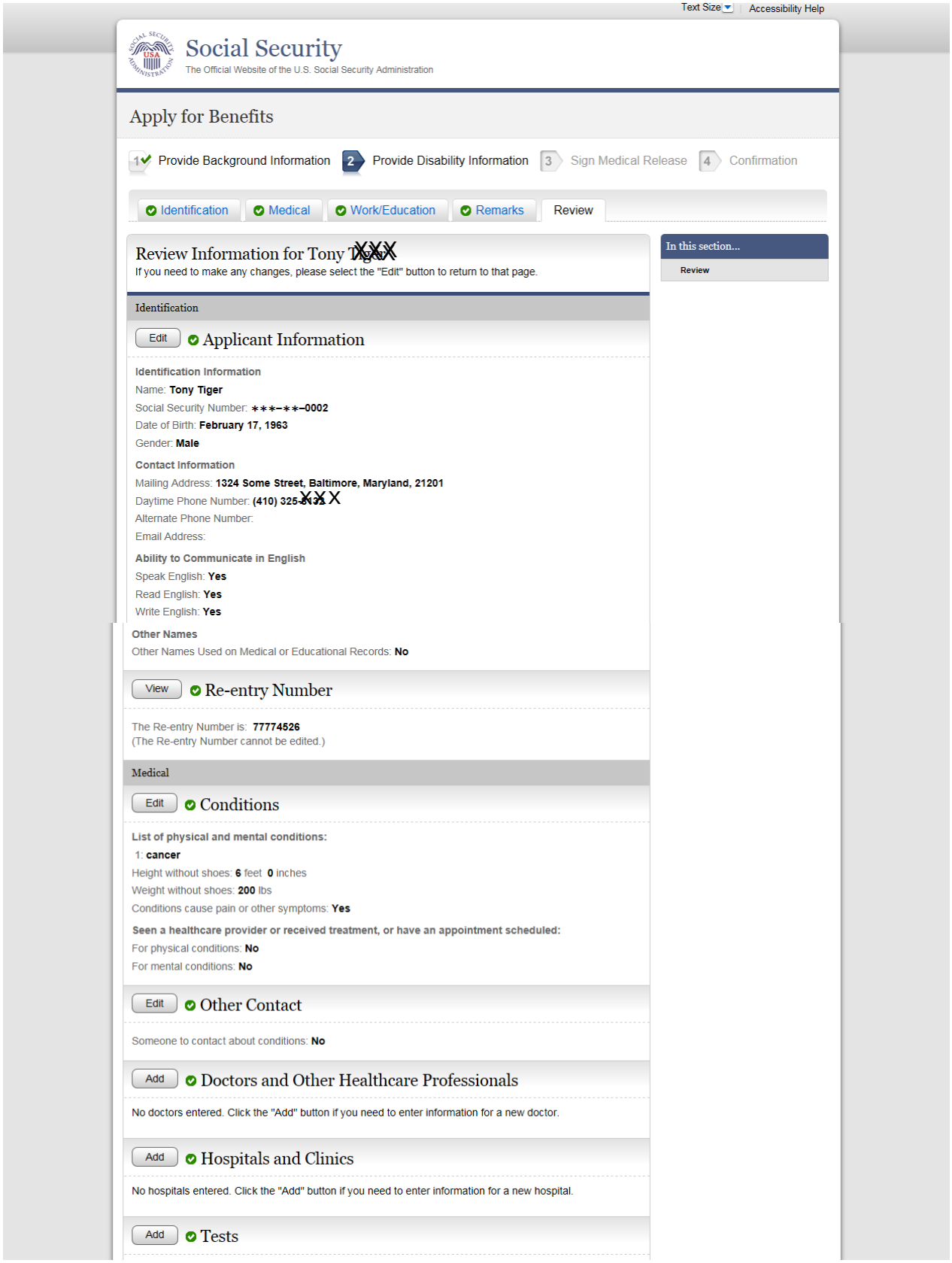
22.Job001-1-nw_Job History



23.Edu001-1_Education and Training



24.Rmk001-1_Remarks


Text Size
Accessibility Help
Social Security
The Official Website of the U.S. Social Security Administration
Apply for Benefits
1 Provide Background Information
2 Provide Disability Information
3 Sign Medical Release
4 Confirmation
Identification
Medical
Work/Education
Remarks
Review
Review Information for Tony XXX
If you need to make any changes, please select the "Edit" button to return to that page.
In this section...
Review
Identification
Edit
Applicant Information
Identification Information
Name: Tony Tiger
Social Security Number: ***-**-0002
Date of Birth: February 17, 1963
Gender: Male
Contact Information
Mailing Address: 1324 Some Street, Baltimore, Maryland, 21201
Daytime Phone Number: (410) 325-XXX
Alternate Phone Number:
Email Address:
Ability to Communicate in English
Speak English: Yes
Read English: Yes
Write English: Yes
Other Names
Other Names Used on Medical or Educational Records: No
View
Re-entry Number
The Re-entry Number is: 77774526
(The Re-entry Number cannot be edited.)
Medical
Edit
Conditions
List of physical and mental conditions:
1: cancer
Height without shoes: 6 feet 0 inches
Weight without shoes: 200 lbs
Conditions cause pain or other symptoms: Yes
Seen a healthcare provider or received treatment, or have an appointment scheduled:
For physical conditions: No
For mental conditions: No
Edit
Other Contact
Someone to contact about conditions: No
Add
Doctors and Other Healthcare Professionals
No doctors entered. Click the "Add" button if you need to enter information for a new doctor.
Add
Hospitals and Clinics
No hospitals entered. Click the "Add" button if you need to enter information for a new hospital.
Add
Tests

No tests entered. Click the "Add" button if you need to enter information for a new test.

Add Medicines

No medicines entered. Click the "Add" button if you need to enter information for a new medicine.

Add Other Medical Records

No other medical records entered. Click the "Add" button to enter information for a new medical record.

Work/Education

Edit Work Status

Currently Working: **Yes, I am currently working**

Edit Work Activity

Changes in Work Activity: **No**
Date First Bothered by Conditions: **September 10, 2011**

Edit Job History

Earnings greater than $1000 since Sep 10, 2011: **No**
Number of jobs in the past 15 years: **1**

Change to $1,090

Most Recent Job
Job Title: **Secretary**
Type of Business: **Financial**
Start Date: **April 1993**
End Date: **August 2012**
Hours per Day: **8**
Days per Week: **5**
Pay Amount: **$35000**
Pay Frequency: **Yearly**

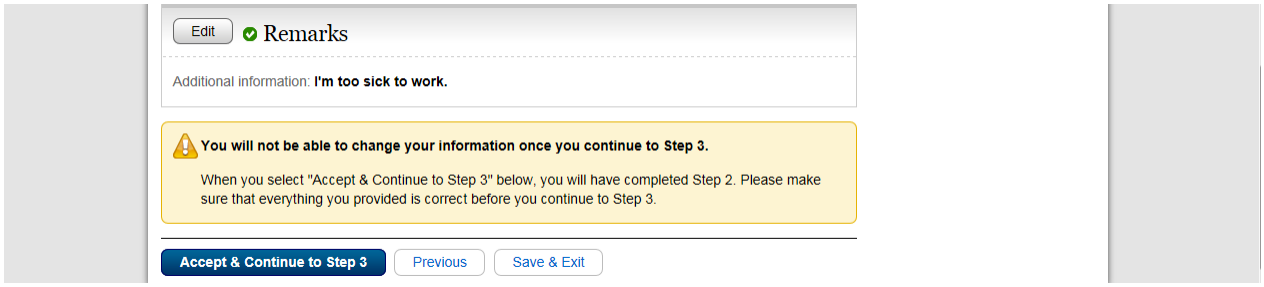
Job Details
Job Description: **Typed, filed, and answered phones.**
Used Equipment: **No**
Used Technical Knowledge: **No**
Completed Reports: **No**
Walking: **1 hour**
Standing: **1 hour**
Sitting: **7 hours**
Climbing: **0 hours (Never)**
Stooping: **1 hour**
Kneeling: **1 hour**
Crouching: **1 hour**
Crawling: **0 hours (Never)**
Handling Large Objects: **0 hours (Never)**
Writing, Typing or Handling Small Objects: **7 hours**
Reaching: **0.5 hours**
Description of Lifting and Carrying: **I lifted and carried stacks of files and carried them 100 feet down the hall to the file room.**
Weight of Frequently Lifted Items: **10 lbs**
Maximum Weight Lifted: **20 lbs**
Supervised Others: **No**
Lead Worker: **No**

Edit Education

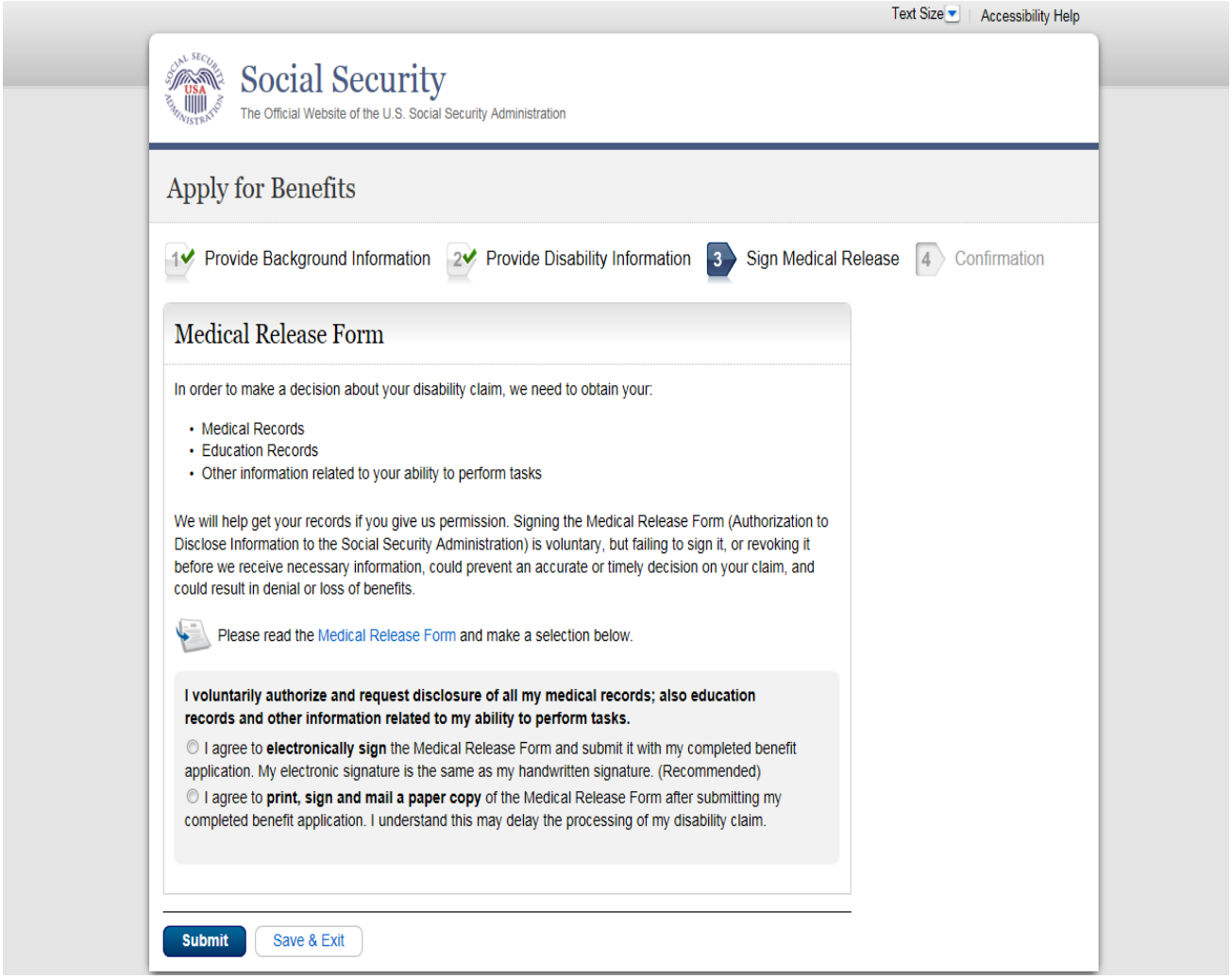
Education and Training
Highest grade completed: **12th Grade**
Date completed: **June 1980**
Special training, trade or vocational school: **No**

Special Education
Attended special education: **No**

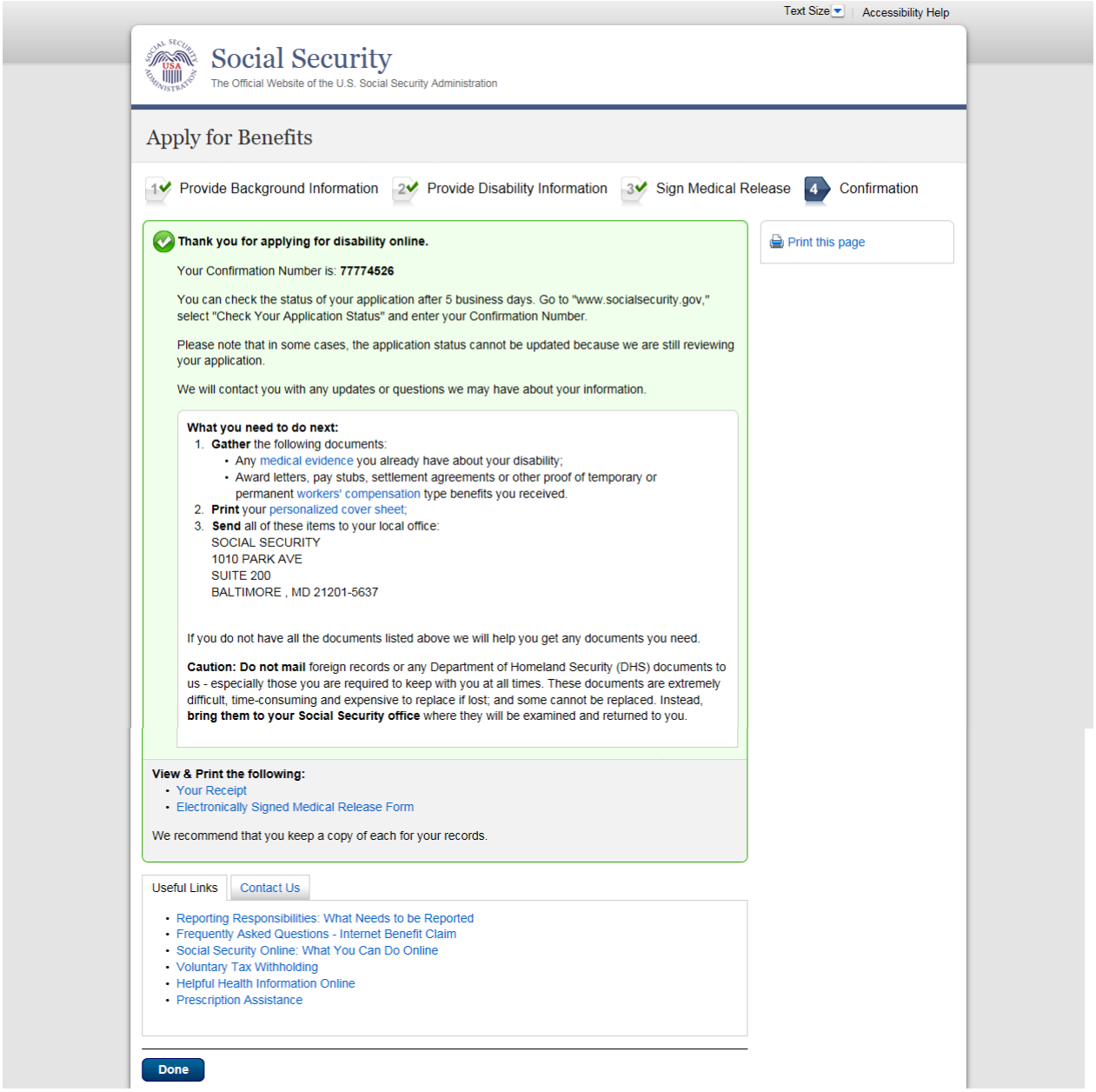
Remarks


Edit
Remarks
Additional information: I'm too sick to work.
You will not be able to change your information once you continue to Step 3.
When you select "Accept & Continue to Step 3" below, you will have completed Step 2. Please make sure that everything you provided is correct before you continue to Step 3.
Accept & Continue to Step 3
Previous
Save & Exit

26.Mrf003-1_Medical Release Form

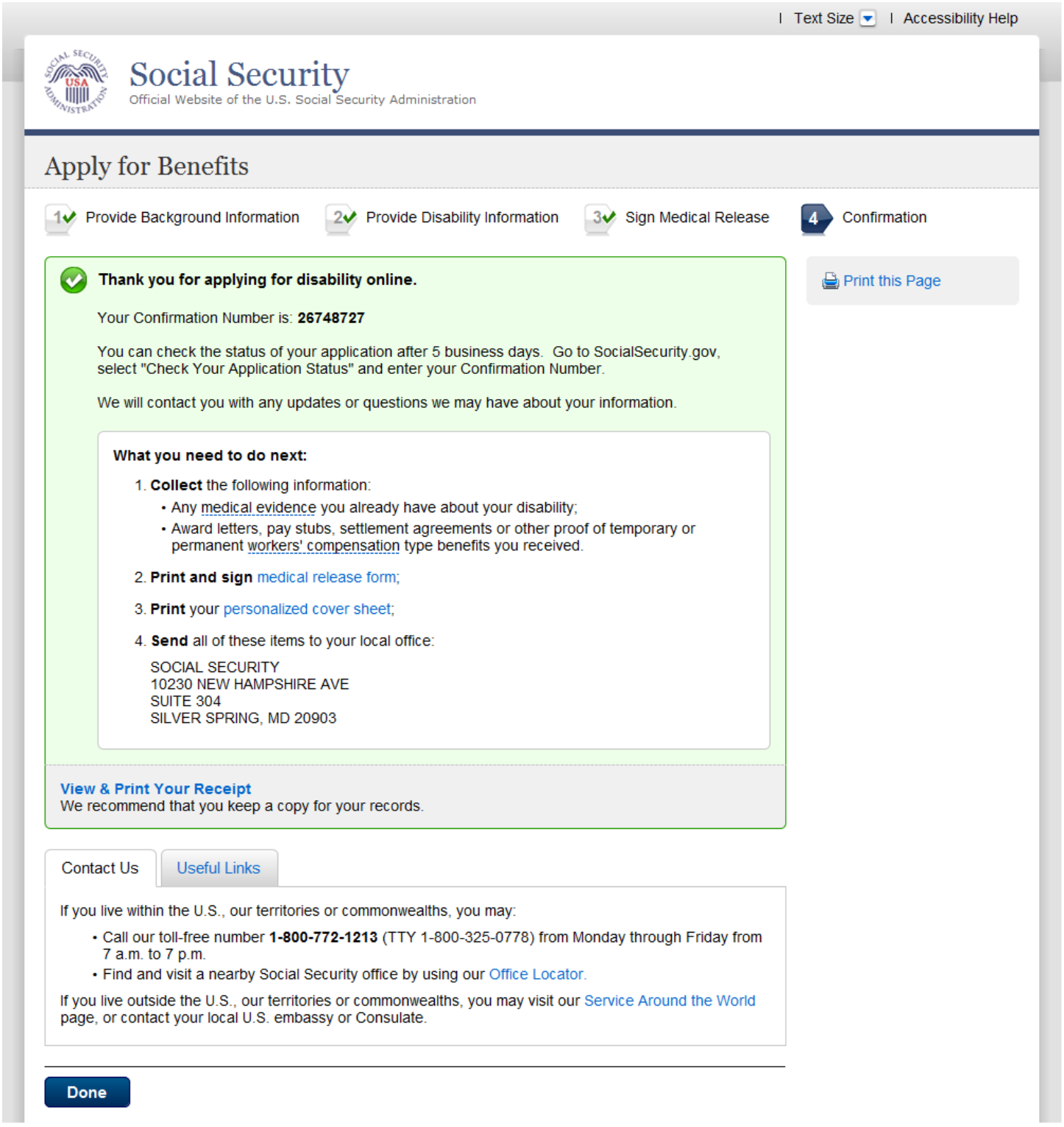


27.Wtn001-d1_Confirmation (With electronic Signature)

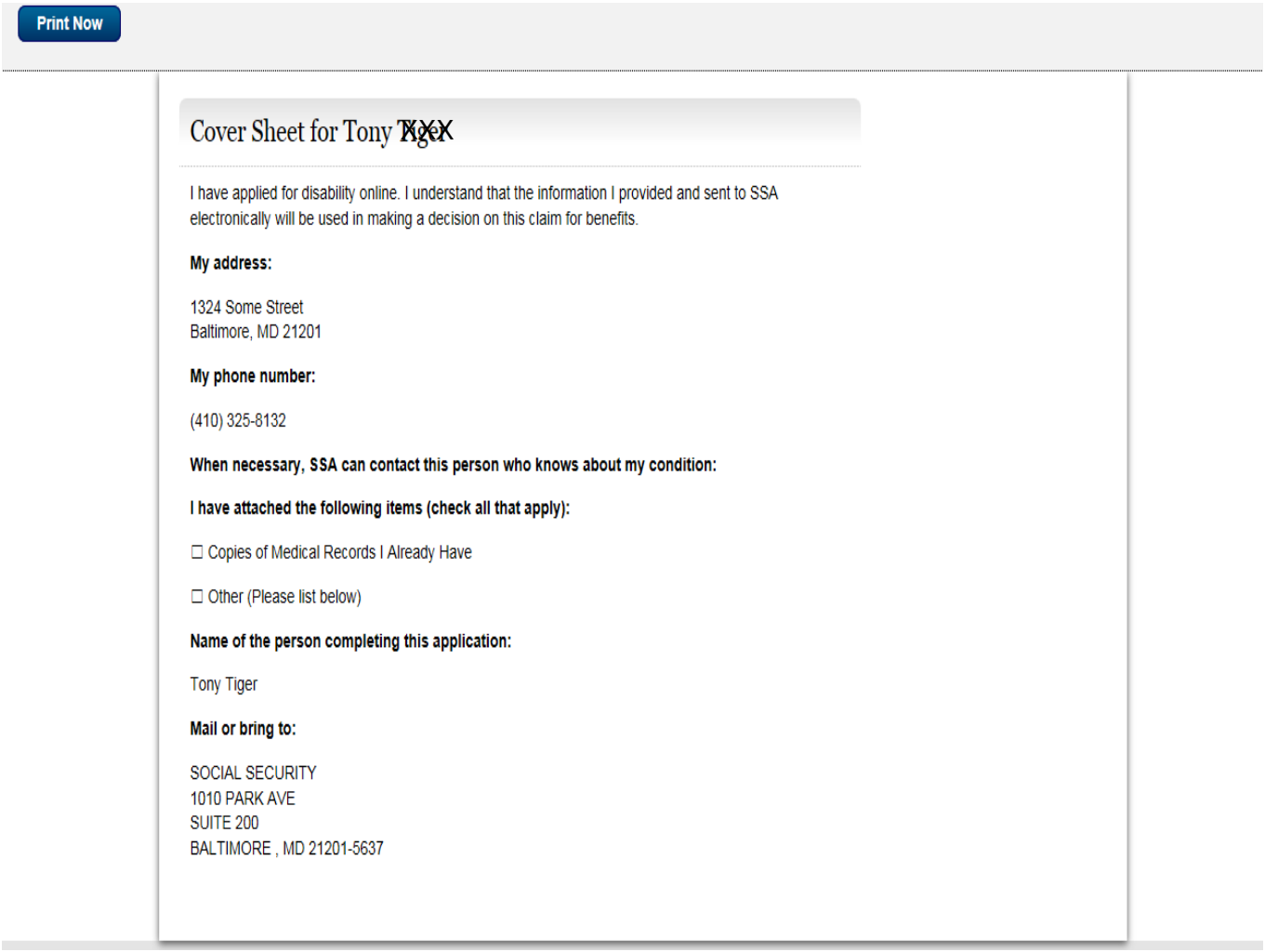


Note: Electronically signed medical release form will be displayed in html format similar to the current system.

28.Wtn001-d1_Confirmation (Without electronic Signature)



29.Cov001-1_Cover Sheet Pop-up



30. Rec001-1_Receipt Pop-up

Print Now

Disability Information for Tony Tiger

Your information was received on February 24, 2015 at 4:16:40 PM.

Disability Information: Identification

Applicant Information

Identification Information

Name: **Tony Tiger**
Social Security Number: ***-**-0000
Date of Birth: **February 17, 1963**
Gender: **Male**

Contact Information

Mailing Address: **1324 Some Street, Baltimore, Maryland, 21201**
Daytime Phone Number: **(410) 325-8XXX**
Alternate Phone Number:
Email Address:

Ability to Communicate in English

Speak English: **Yes**
Read English: **Yes**
Write English: **Yes**

Other Names

Other Names Used on Medical or Educational Records: **No**

Disability Information: Medical

Conditions

List of physical and mental conditions:

1: **cancer**
Height without shoes: **6** feet **0** inches
Weight without shoes: **200** lbs
Conditions cause pain or other symptoms: **Yes**

Seen a healthcare provider or received treatment, or have an appointment scheduled:

For physical conditions: **No**
For mental conditions: **No**

Other Contact

Someone to contact about conditions: **No**

Doctor/Healthcare Professional 1

Doctor/Healthcare Professional Details

Name: **Dr. Isee Clearly**
Office Name:
Address: **3800 Hooper Avenue, Baltimore, Maryland, 21211**
Phone Number: **(443) 436-7931**
Patient ID Number:

Treatment

First Visit: **March 2013**
Last Visit:
Next Scheduled Appointment:
Medical Conditions Treated: **headache**
Treatment Received: **Bandaid**

Hospital/Clinic 1

Hospital/Clinic Details

Name: **Johns Hopkins**
Name of Healthcare Professional Treated By:
Address: **1800 Orleans Street, Baltimore, Maryland, 21205**
Phone Number: **(443) 436-7507**
Record Number:
Emergency Room Visits: **No**

Inpatient Stays: **Yes**
Admission Date 1: **March 10 2013**
Discharge Date 1: **March 15 2013**
Admission Date 2:
Discharge Date 2:
Admission Date 3:
Discharge Date 3:
Outpatient Visits: **No**
Medical Conditions Treated: **headache**
Treatment Received: **head examination**

Test 1

Kind of Test: **EEG (Brain Wave Test)**
Date of Test: **12/29/2012**
Sent for Test by: **No one ordered this test**

Medicine 1

Medicine: **Triopenin**
Reason: **Headache**
Prescribed by: **No one prescribed this medicine**

Other Medical Record 1

Name of Place: **Hanover Eye Associates**
Name of Contact: **Sarah Smyle**
Address: **1224 Baltimore Street, Hanover, Pennsylvania, 17331**
Phone Number: **(717) 633-5407**
First Visit: **10/27/2012**
Last Visit: **10/27/2012**
Next Visit:
Case Number:
Reasons for Visits: **Headache**

Disability Information: Work/Education

Work Status

Currently Working: **No, I have never worked**

Work Activity

Date Conditions Became Severe Enough to Keep From Working: **September 10, 2011**

Job History

Never worked.

Education

Education and Training
Highest grade completed: **12th Grade**
Date completed: **June 1980**
Special training, trade or vocational school: **No**

Special Education
Attended special education: **No**

Disability Information: Remarks

Remarks

Additional information: **I'm too sick to work.**

Medical Release Form for Tony Tiger

~~XXX~~

Your information was received on February 24, 2015 at 4:16:40 PM.

Medical Release Form

Agreed to electronically sign the medical release form.

Privacy Act Statement
Collection and Use of Personal Information

Section 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, allow us to collect this information. We will use the information you provide to make a decision on the named claimant's claim. The Privacy Act (5 U.S.C. & 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses. Giving us this information is voluntary; however, failing to complete the required fields could prevent us from processing your request. Additional information regarding this form, routine uses of information, and other Social Security programs, is available on our internet website, www.socialsecurity.gov, or at your local Social Security office.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 90 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*