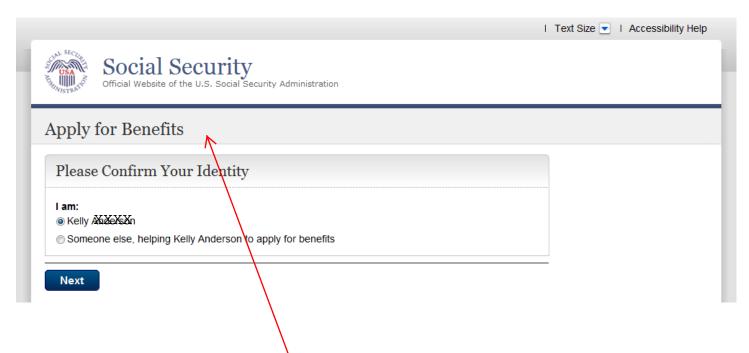
iClaim-i3368 Marriage (1st Party): Screen Package 0.5

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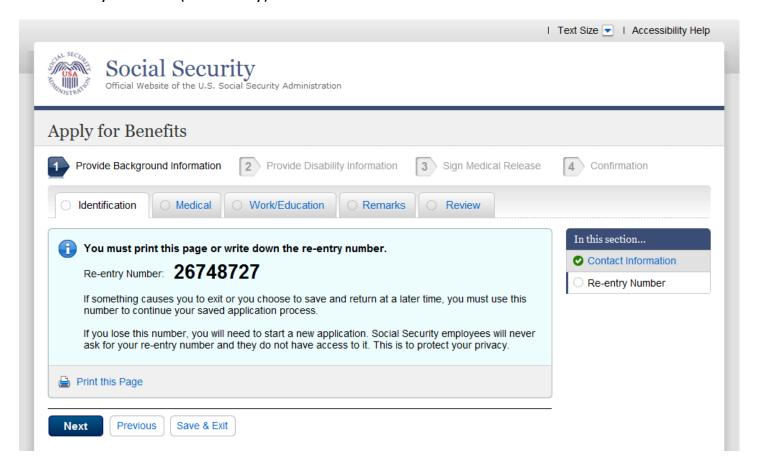


1. Confirm Your Identity On Re-entry (1st party to 1st party)

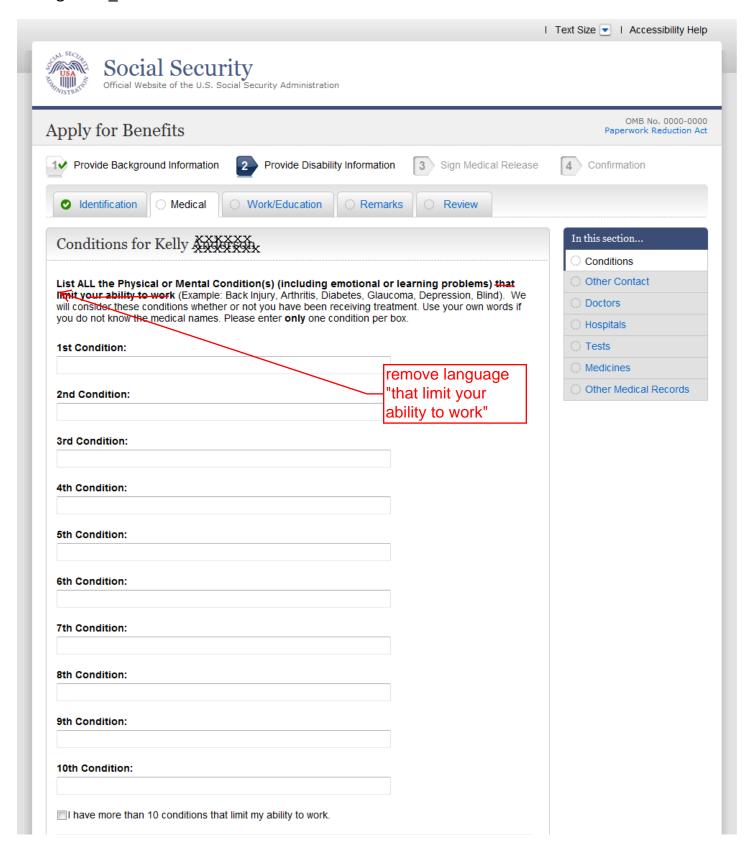


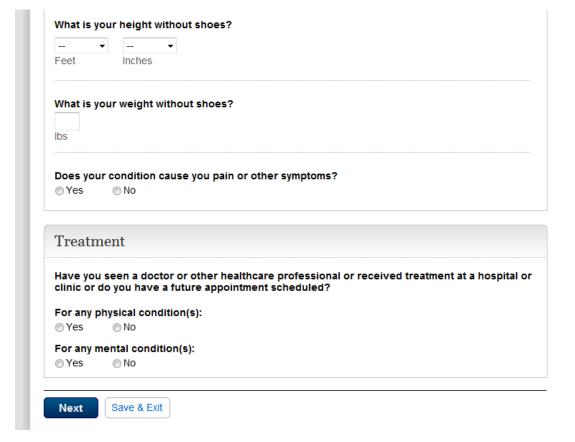
Insert Penalty Warning: Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits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

2. Re-entry Number (i3368 only)

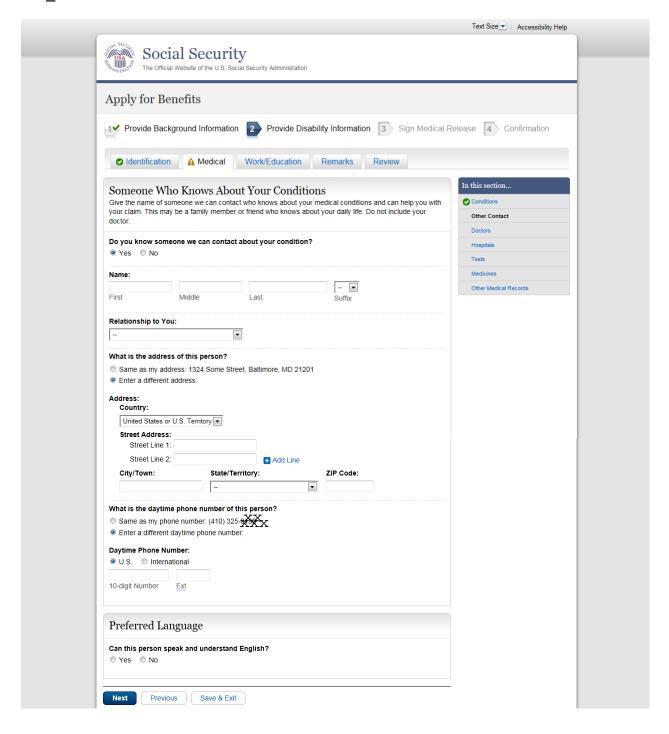


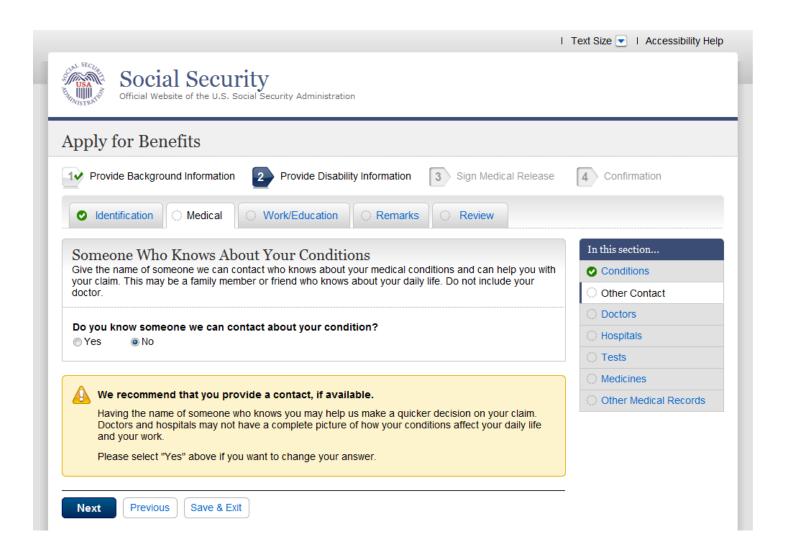
3. Alg001-1_Conditions



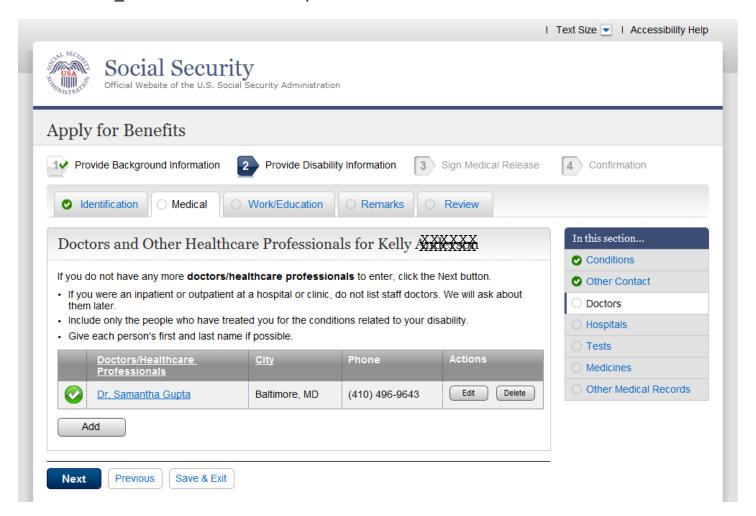


4. Con001-1_Someone Who Knows About Your Condition

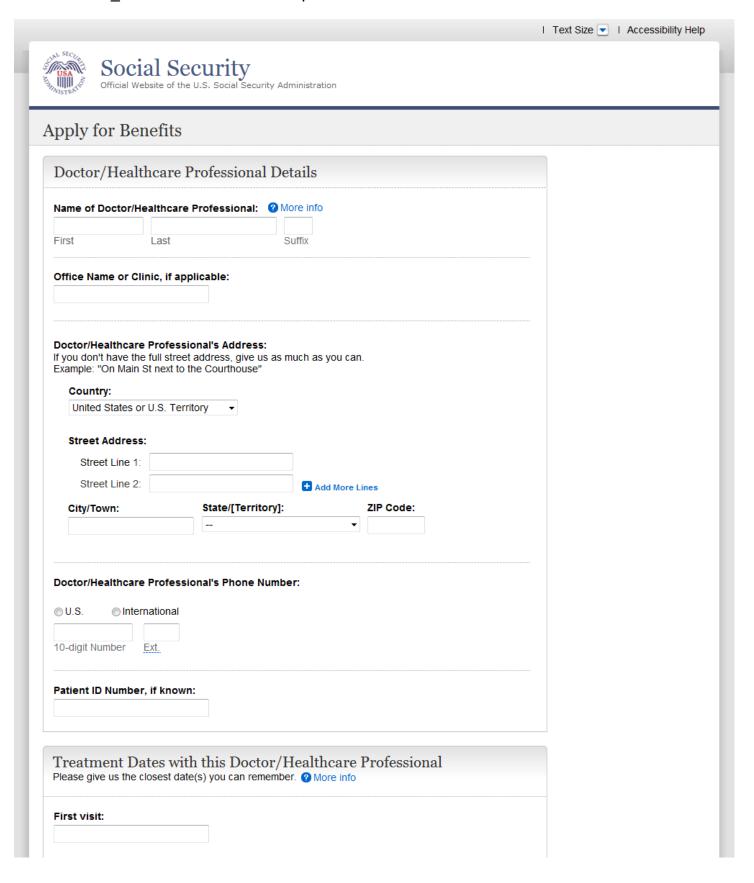


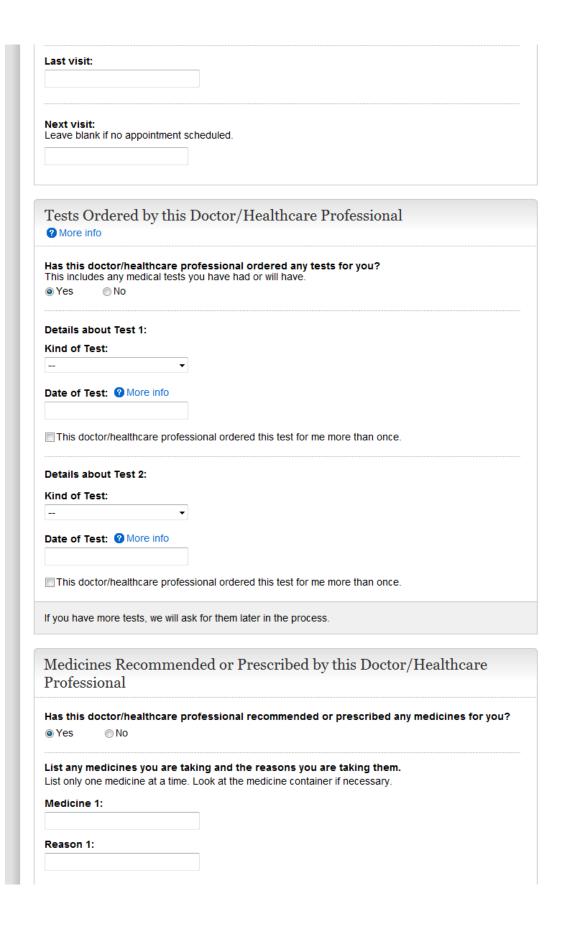


5. Doc001-1_Doctors and healthcare professionals



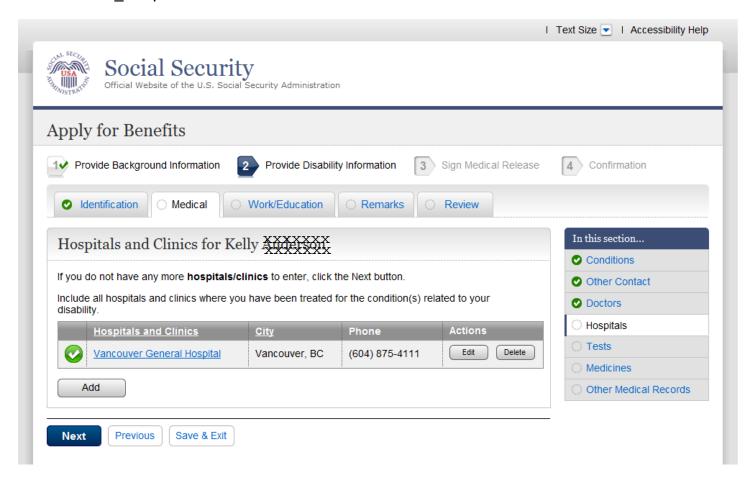
6. Doc002-1 Doctors and healthcare professionals details



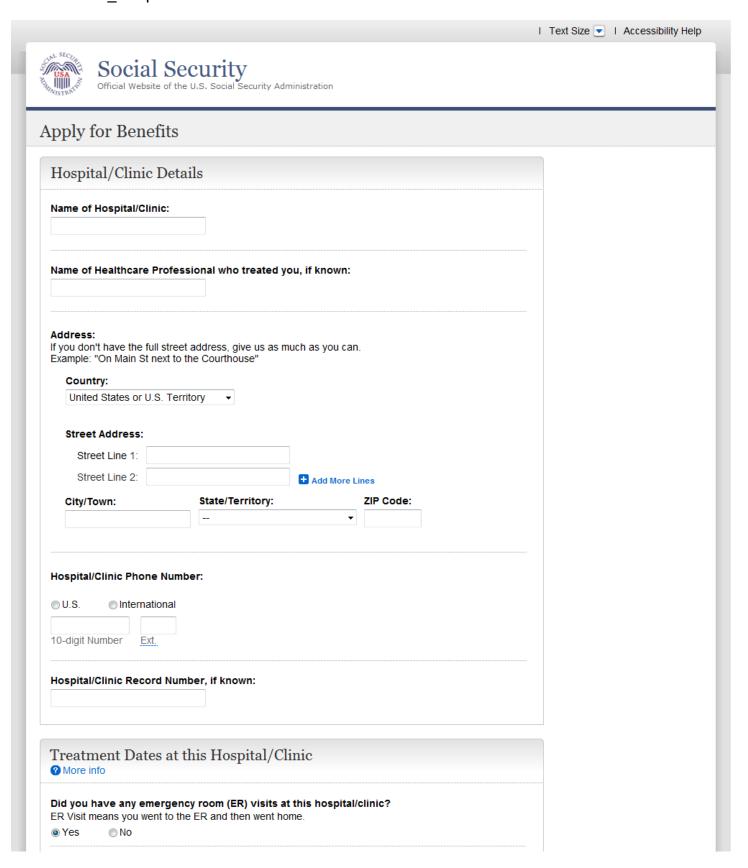


Reason 2:	
Medicine 3:	
Reason 3:	
If you have more medicines, we	will ask for them later in the process.
Medical Conditions Tr	reated by this Doctor/Healthcare Professional
	e treated or evaluated by this doctor/healthcare professional? diabetes, depression, blind. (1000 characters maximum)
	_
	-
Characters remaining: XXXX	
Characters remaining: XXXX Check Spelling	
Check Spelling	Ooctor/Healthcare Professional
Check Spelling Treatment from this D What treatment did you recei You DO NOT need to repeat any	ve from this doctor/healthcare professional? y information that you have already told us about medicines and tests.
Check Spelling Treatment from this D What treatment did you recei You DO NOT need to repeat any Examples of treatment: examinat	ve from this doctor/healthcare professional? y information that you have already told us about medicines and tests. tions, regular evaluations, check ups, physical therapy, chemotherapy,
Check Spelling Treatment from this D What treatment did you recei You DO NOT need to repeat any	ve from this doctor/healthcare professional? y information that you have already told us about medicines and tests. tions, regular evaluations, check ups, physical therapy, chemotherapy,
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7. Hos001-1_Hospitals and Clinics



8. Hos002-1_Hospital and Clinic Details

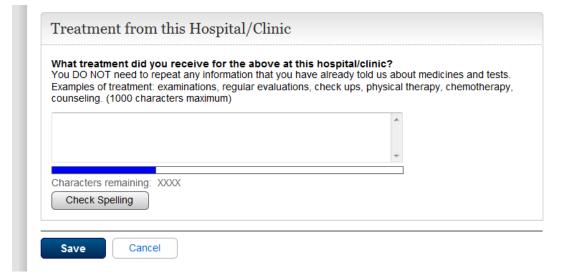


Emergency Room Visit 1:	
Emergency Room Visit 2:	
Emergency Room Visit 2:	
Did you have an inpatient sta Inpatient stay means you have s Yes No	
Give us the dates of your thro	ee most recent stays. Discharge Date 1:
Admission Date 2:	Discharge Date 2:
Admission Date 3:	Discharge Date 3:
	sit at this hospital/clinic, or do you have one scheduled?
Did you have an outpatient vi Outpatient visit means you went	sit at this hospital/clinic, or do you have one scheduled?
Outpatient visit means you went Yes No	isit at this hospital/clinic, or do you have one scheduled? home the same day. his hospital/clinic. More info you can remember.
Outpatient visit means you went Yes No No Dates of outpatient visits to t Please give us the closest dates First Outpatient Visit: Last Outpatient Visit: Next Scheduled Outpatient Vi	sit at this hospital/clinic, or do you have one scheduled? home the same day. his hospital/clinic. ② More info you can remember.
Outpatient visit means you went Yes No Dates of outpatient visits to telease give us the closest dates First Outpatient Visit: Last Outpatient Visit: Next Scheduled Outpatient Viceave blank if no appointment so More info Have any of the doctors at the This includes any medical tests y	sit at this hospital/clinic, or do you have one scheduled? home the same day. his hospital/clinic. More info you can remember. his hospital/Clinic his hospital/Clinic
Outpatient visit means you went Yes No Dates of outpatient visits to telease give us the closest dates First Outpatient Visit: Last Outpatient Visit: Next Scheduled Outpatient Visit and provintment so Please Dank if no appointment so More info Have any of the doctors at the This includes any medical tests yo Yes No	sit at this hospital/clinic, or do you have one scheduled? home the same day. his hospital/clinic. More info you can remember. his hospital/Clinic his hospital/Clinic
Outpatient visit means you went Yes No Dates of outpatient visits to telease give us the closest dates First Outpatient Visit: Last Outpatient Visit: Next Scheduled Outpatient Visit: Leave blank if no appointment so More info Have any of the doctors at the This includes any medical tests you yes No Details about Test 1:	sit at this hospital/clinic, or do you have one scheduled? home the same day. his hospital/clinic. More info you can remember. his hospital/Clinic his hospital/Clinic
Outpatient visit means you went Yes No Dates of outpatient visits to telease give us the closest dates First Outpatient Visit: Last Outpatient Visit: Next Scheduled Outpatient Visit and provintment so Please Dank if no appointment so More info Have any of the doctors at the This includes any medical tests yo Yes No	sit at this hospital/clinic, or do you have one scheduled? home the same day. his hospital/clinic. More info you can remember. his hospital/Clinic his hospital/Clinic

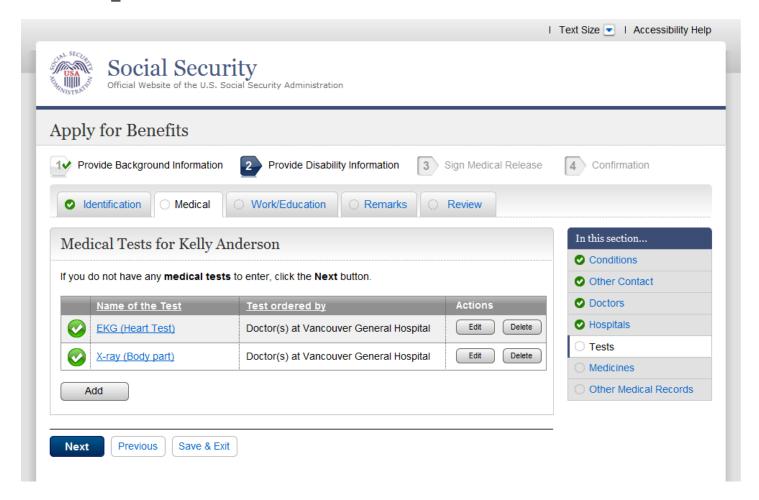


Details about Test 2:	
Kind of Test:	
v	
Date of Test: More info	
The doctor(s) at this hospital	I ordered this test for me more than once.
f you have more tests, we will a	ask for them later in the process.
Medicines Recomme	nded or Prescribed by this Hospital/Clinic
Have any of the doctors at the for you? Yes No	his hospital/clinic recommended or prescribed any medicines
List only one medicine at a time	aking and the reasons you are taking them. e. 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	e will ask for them later in the process.
Medical Conditions T	reated by this Hospital/Clinic
What medical conditions we	re treated or evaluated by this hospital/clinic? diabetes, depression, blind. (1000 characters maximum)
Characters remaining: XXXX	T
Check Spelling	

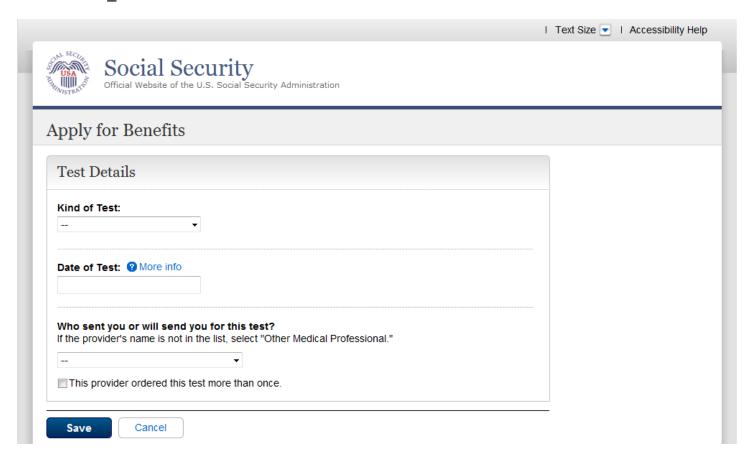


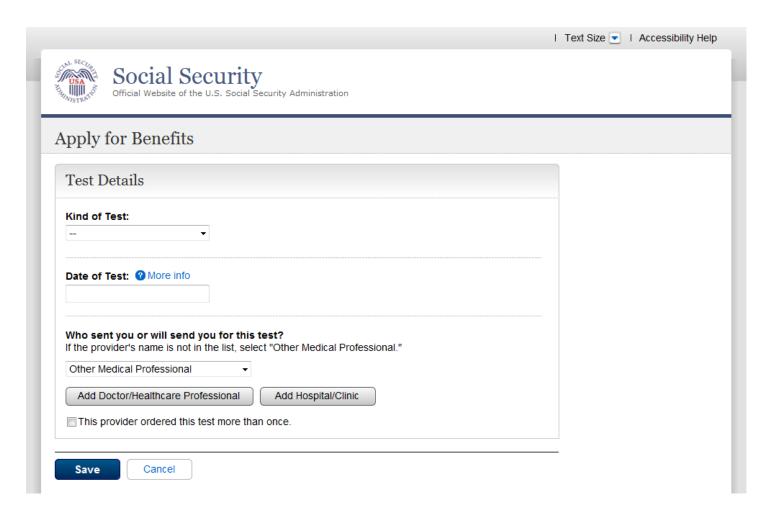


9. Tst001-1_Medical tests



10.Tst002-1_Medical Test Details



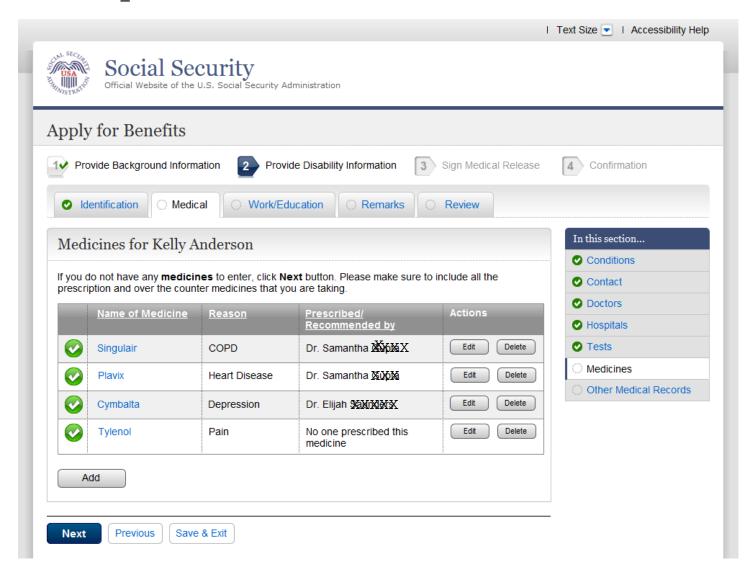


Note: When user selects "Other Medical Professional" in the dropdown for "Who sent you...", the buttons "Add Doctor/Healthcare Professional" and "Add Hospital/Clinic" are displayed on the screen. It is mandatory for the user to select either of the buttons in order to continue.

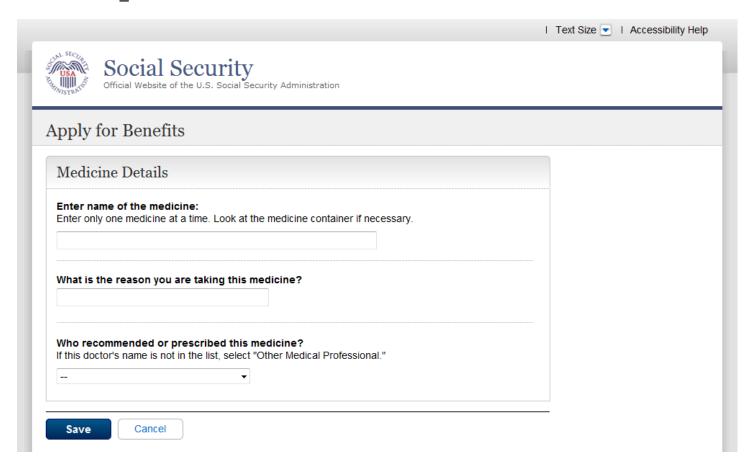
When user selects either of the buttons, he is taken to Doctor or Hospital details page. Any action on the Doctor or Hospital details page should navigate them to the Tests page (Tst001-1_Medical tests)

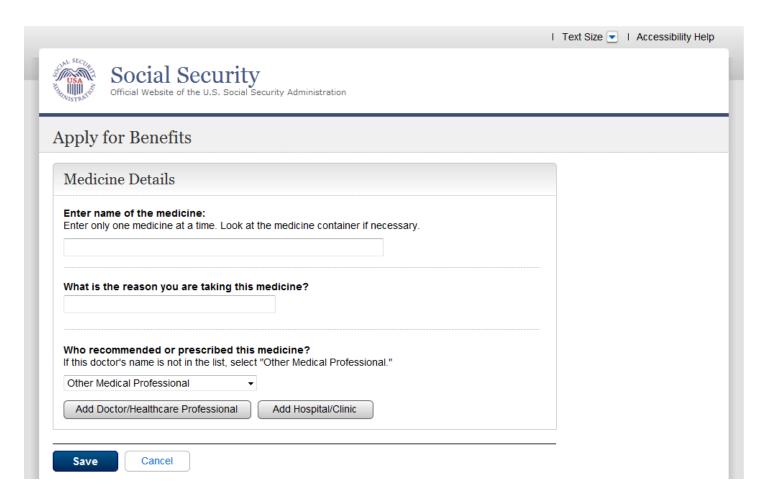


11.Med001-1_Medicines



12.Med002-1_Medicine Details



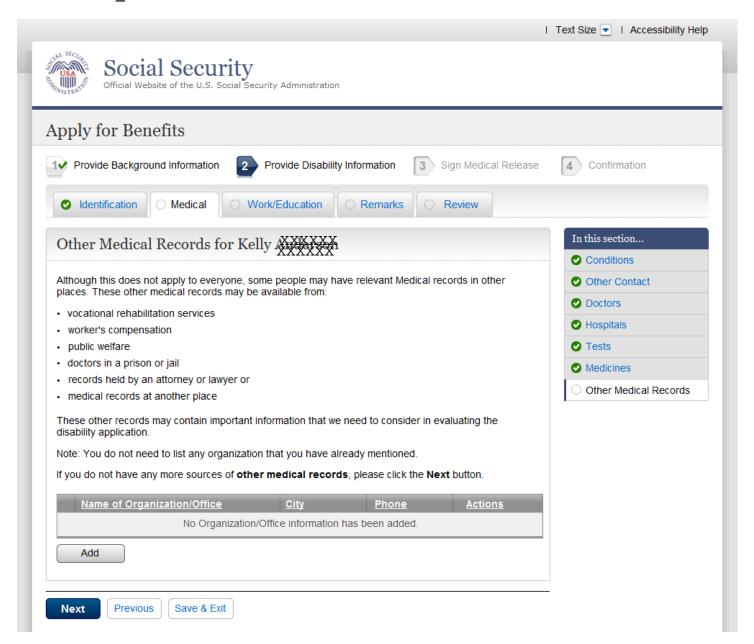


Note: When user selects "Other Medical Professional" in the dropdown for "Who recommended...", the buttons "Add Doctor/Healthcare Professional" and "Add Hospital/Clinic" are displayed on the screen. It is mandatory for the user to select either of the buttons in order to continue.

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)

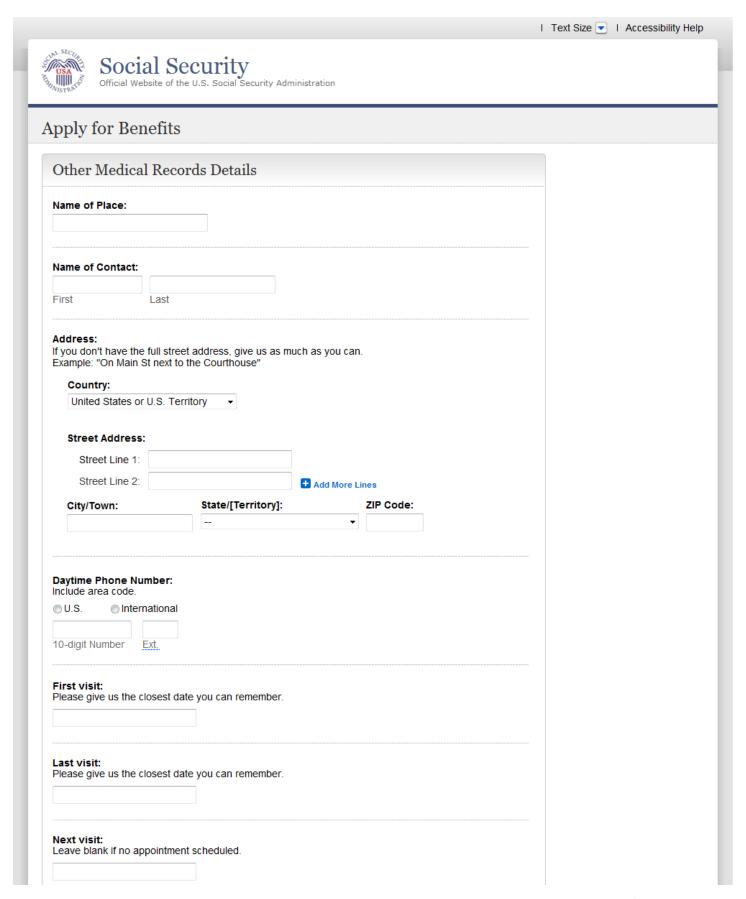


13.Msc001-1_Other medical records

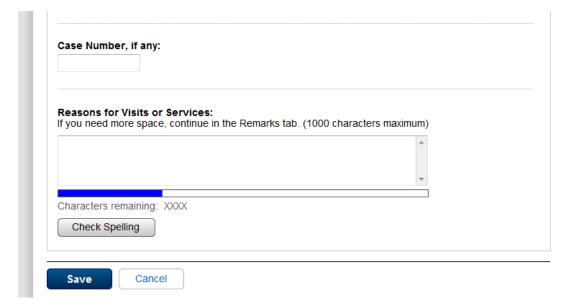




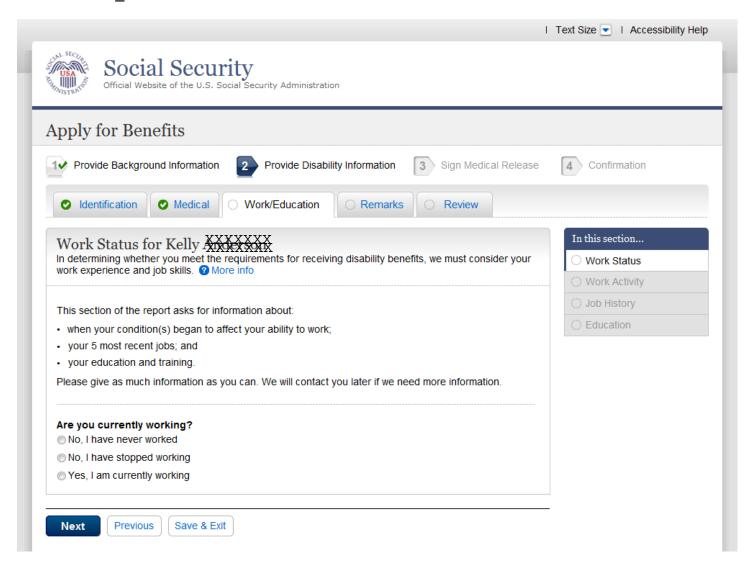
14.Msc002-1_Other Medical Record Details



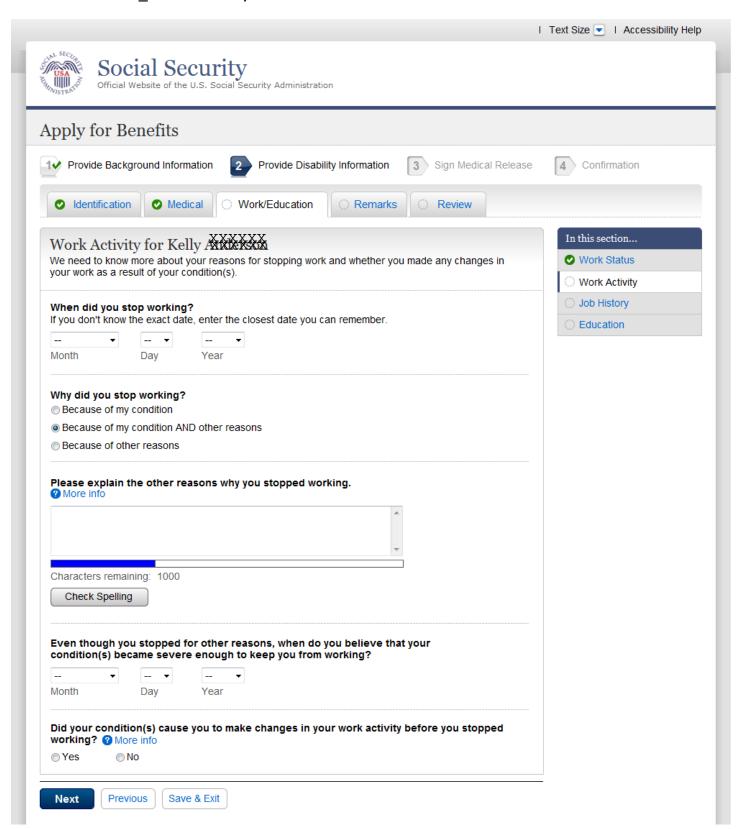




16.Win001-1_Work Status

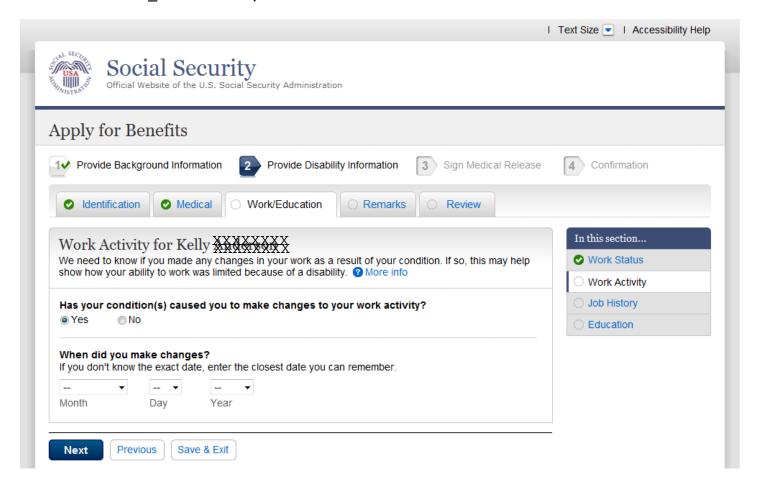


17.Wac001-1-sw_Work Activity

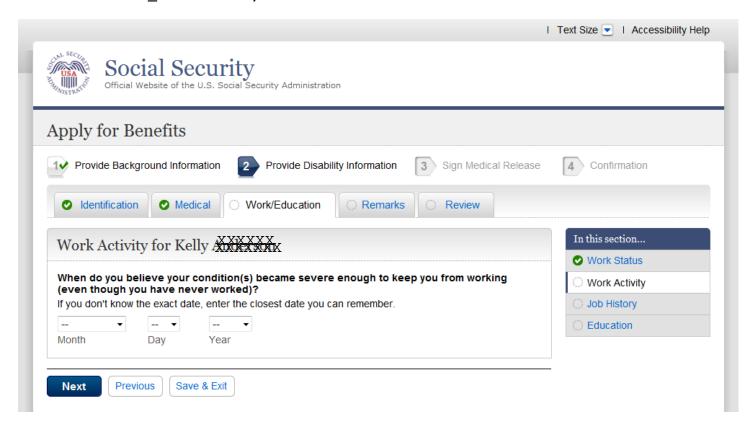




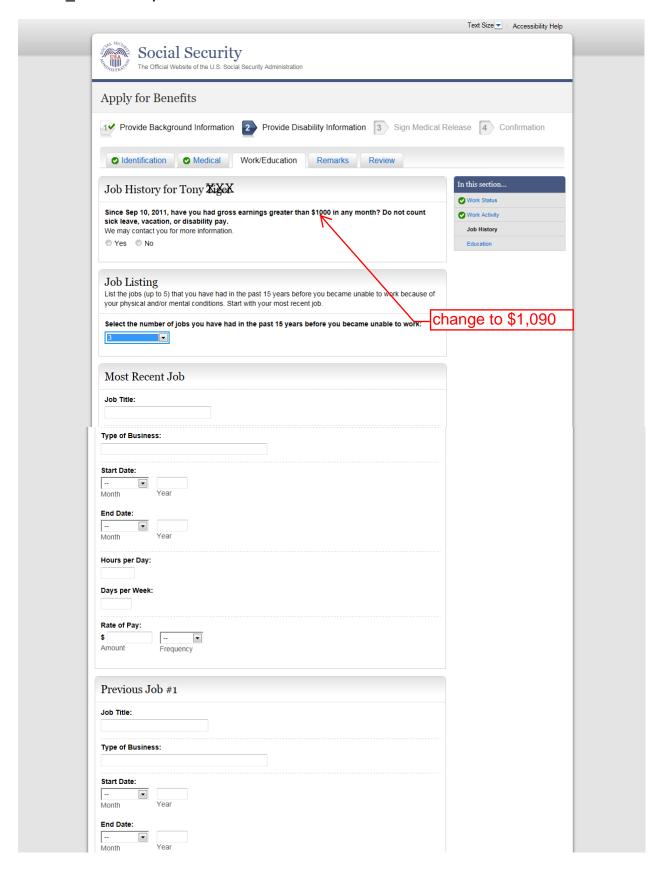
18.Wac001-1-cw_Work Activity



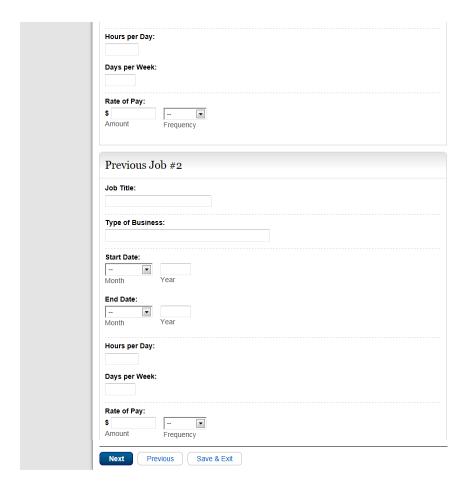
19.Wac001-1-nw_Work Activity



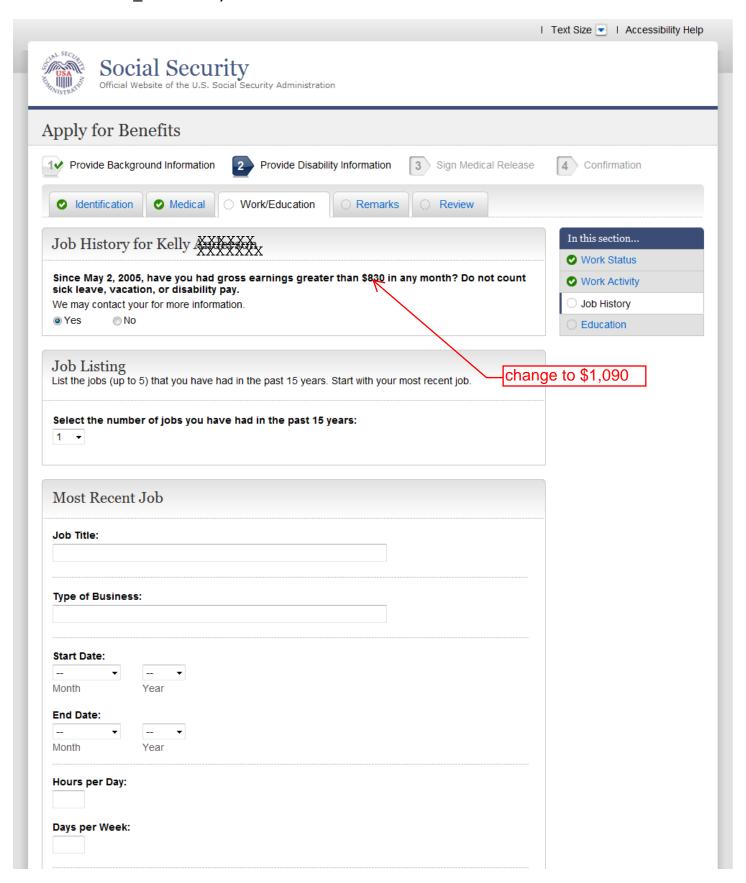
20.Job001-1-sw_Job History







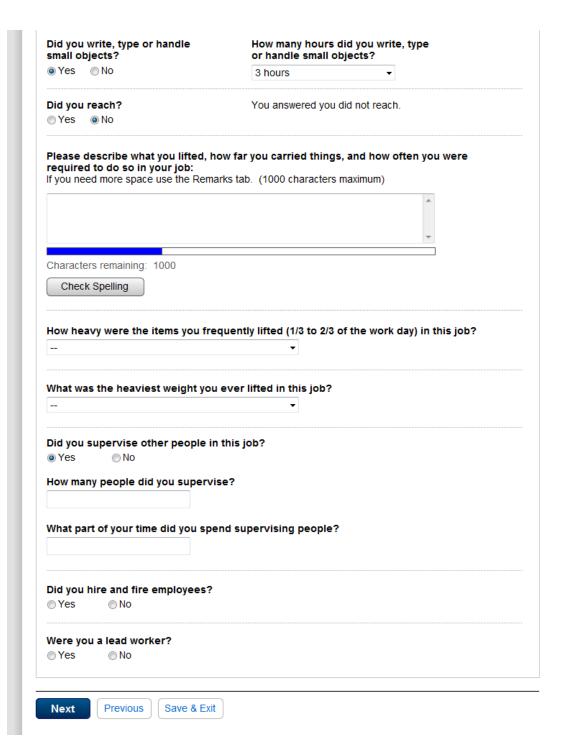
21.Job001-1-cw_Job History



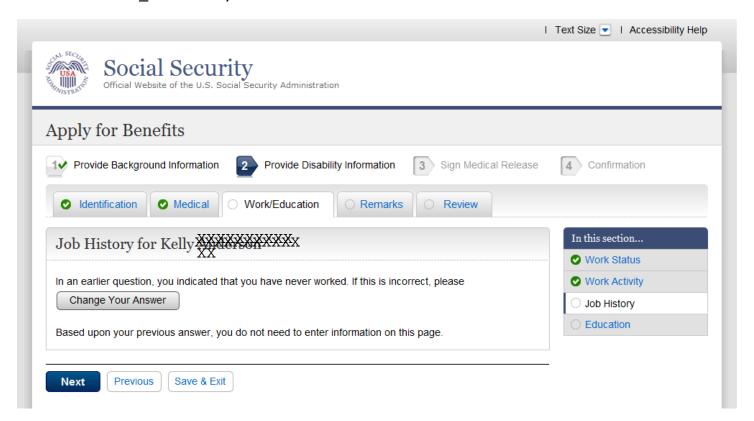




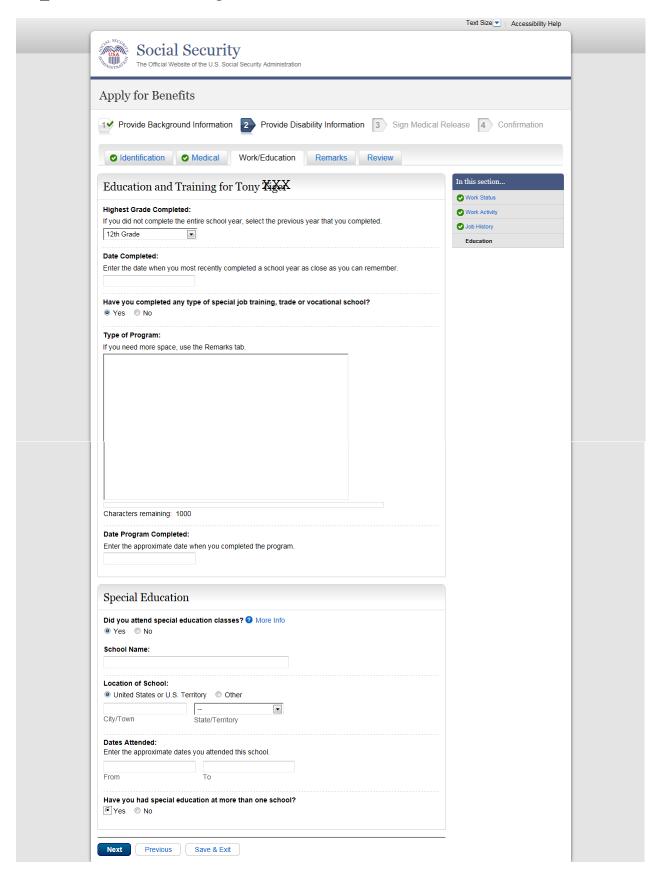




22.Job001-1-nw_Job History

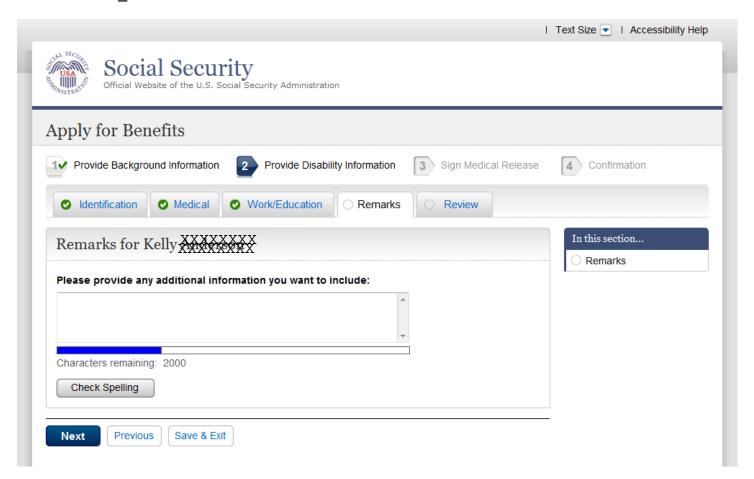


23.Edu001-1_Education and Training

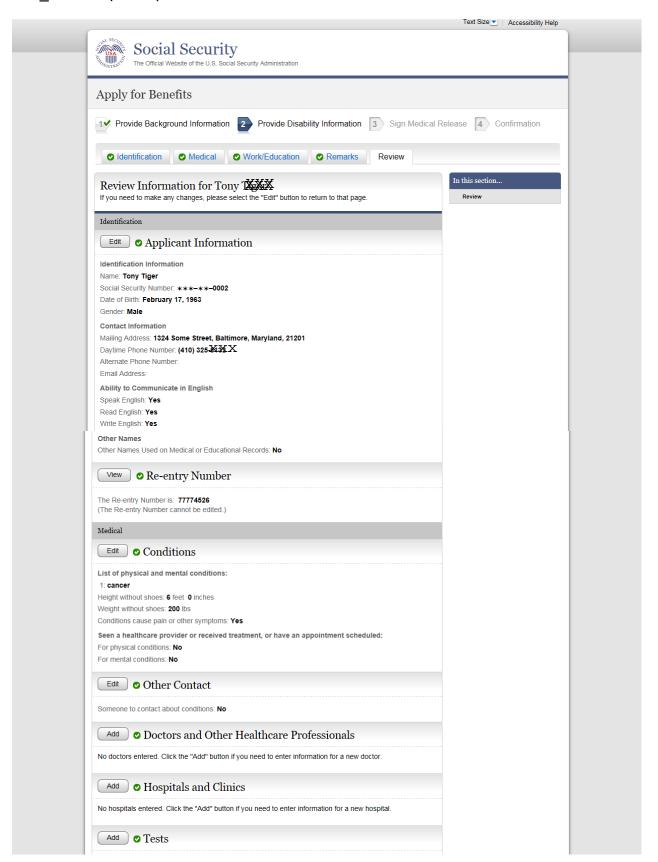




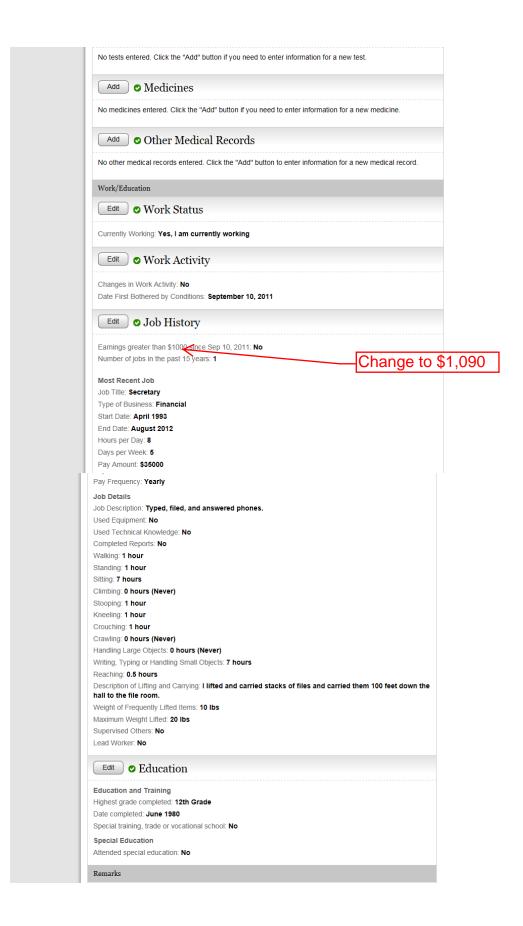
24.Rmk001-1_Remarks

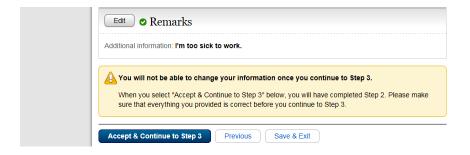


25.Rvw001-1 Review (i3368)

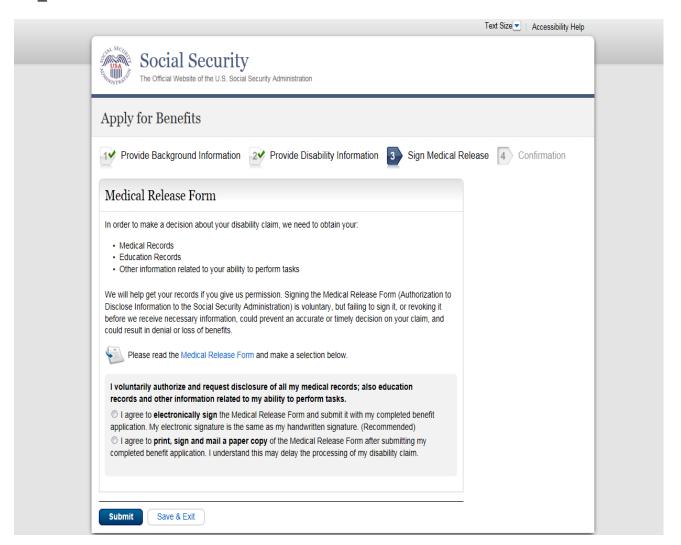




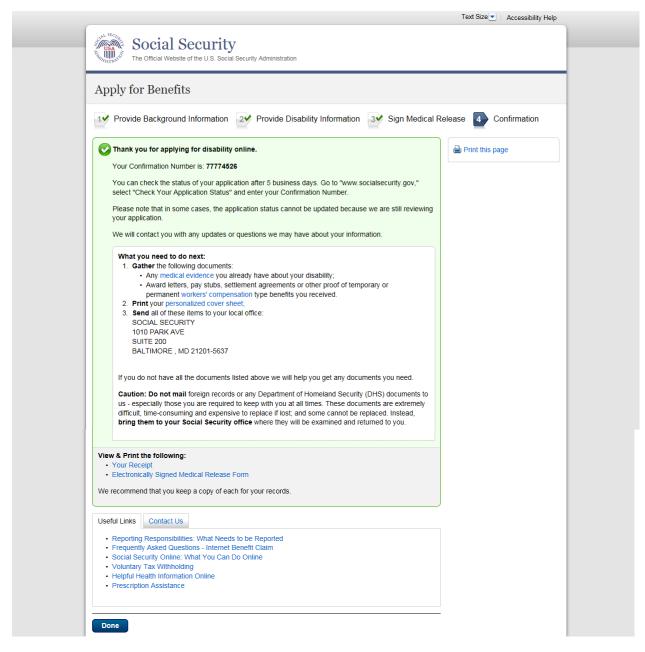




26.Mrf003-1_Medical Release Form

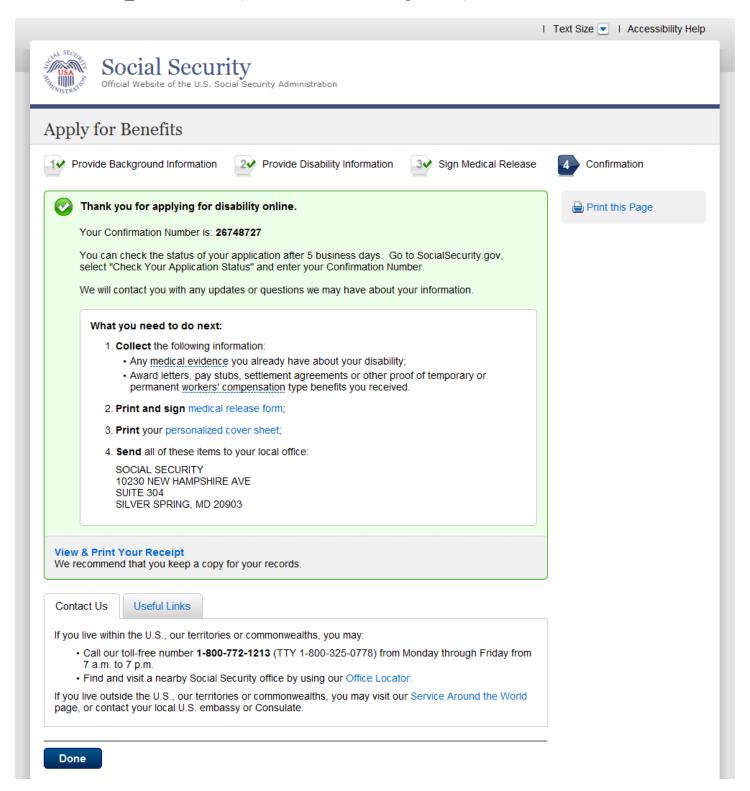


27. Wtn001-d1_Confirmation (With electronic Signature)



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

Print Now

Cover Sheet for Tony TYZEK
I have applied for disability online. I understand that the information I provided and sent to SSA electronically will be used in making a decision on this claim for benefits.
My address:
1324 Some Street Baltimore, MD 21201
My phone number:
(410) 325-8132
When necessary, SSA can contact this person who knows about my condition:
I have attached the following items (check all that apply):
□ Copies of Medical Records I Already Have
□ Other (Please list below)
Name of the person completing this application:
Tony Tiger
Mail or bring to:
SOCIAL SECURITY 1010 PARK AVE SUITE 200 BALTIMORE, MD 21201-5637

30. Rec001-1_Receipt Pop-up

Print Now

Disability Information for Tony ™™X

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) 325-8(3)

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: cance

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

 ${\it Date\ Conditions\ Became\ Severe\ Enough\ to\ Keep\ From\ Working:\ \textbf{September\ 10,\ 2011}}$

Job History

Never worked.

Education

Education and Training

Highest grade completed: 12th Grade

Date completed: June 1980

Special training, trade or vocational school: $\ensuremath{\text{No}}$

Special Education

Attended special education: No

Disability Information: Remarks

Remarks

Additional information: I'm too sick to work.

Medical Release Form for Tony XigeX

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 <u>Paperwork Reduction Act of 1995</u>. 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.