

# iClaim-i3368 Marriage (1<sup>st</sup> Party): Screen Package 0.5

## Table of Contents

1.	Confirm Your Identity On Re-entry (1 <sup>st</sup> party to 1 <sup>st</sup> party)	2
2.	Re-entry Number (i3368 only)	3
3.	Alg001-1_Conditions	4
4.	Con001-1_Someone Who Knows About Your Condition	6
5.	Doc001-1_Doctors and healthcare professionals	8
6.	Doc002-1_Doctors and healthcare professionals details	9
7.	Hos001-1_Hospitals and Clinics	12
8.	Hos002-1_Hospital and Clinic Details	13
9.	Tst001-1_Medical tests	17
10.	Tst002-1_Medical Test Details	18
11.	Med001-1_Medicines	20
12.	Med002-1_Medicine Details	21
13.	Msc001-1_Other medical records	23
14.	Msc002-1_Other Medical Record Details	24
16.	Win001-1_Work Status	26
17.	Wac001-1-sw_Work Activity	27
18.	Wac001-1-cw_Work Activity	28
19.	Wac001-1-nw_Work Activity	29
20.	Job001-1-sw_Job History	30
21.	Job001-1-cw_Job History	32
22.	Job001-1-nw_Job History	35
23.	Edu001-1_Education and Training	36
24.	Rmk001-1_Remarks	37
25.	Rvw001-1_Review (i3368)	38
26.	Mrf003-1_Medical Release Form	41
27.	Wtn001-d1_Confirmation (With electronic Signature)	42
<b>Note: Electronically signed medical release form will be displayed in html format similar to the current system.</b>		42
28.	Wtn001-d1_Confirmation (Without electronic Signature)	43
29.	Cov001-1_Cover Sheet Pop-up	44
30.	Rec001-1_Receipt Pop-up	45

## 1. Confirm Your Identity On Re-entry (1<sup>st</sup> party to 1<sup>st</sup> party)

Text Size Accessibility Help

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### Apply for Benefits

#### Please Confirm Your Identity

**I am:**


- Kelly Anderson ~~Anderson~~ XXXX
- Someone else, helping Kelly Anderson to apply for benefits

Next

*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)

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### Apply for Benefits

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


Identification  Medical  Work/Education  Remarks  Review

**i You must print this page or write down the re-entry number.**

Re-entry Number: **26748727**

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 application process.

If you lose this number, you will need to start a new application. Social Security employees will never ask for your re-entry number and they do not have access to it. This is to protect your privacy.


 [Print this Page](#)


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

**In this section...**

- [Contact Information](#)
- [Re-entry Number](#)

### 3. Alg001-1\_Conditions

| Text Size  | Accessibility Help







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## Apply for Benefits

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

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification

Medical

Work/Education

Remarks

Review

### Conditions for Kelly ~~XXXXXXXXXX~~

**List ALL the Physical or Mental Condition(s) (including emotional or learning problems) that limit your ability to work** (Example: Back Injury, Arthritis, Diabetes, Glaucoma, Depression, Blind). We will consider these conditions whether or not you have been receiving treatment. Use your own words if you do not know the medical names. Please enter **only** one condition per box.

**1st Condition:**

**2nd Condition:**

**3rd Condition:**

**4th Condition:**

**5th Condition:**

**6th Condition:**

**7th Condition:**

**8th Condition:**

**9th Condition:**

**10th Condition:**

I have more than 10 conditions that limit my ability to work.

**In this section...**

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

remove language  
"that limit your  
ability to work"

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

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### 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

**Name:**  
First:  Middle:  Last:  Suffix:

**Relationship to You:**

**What is the address of this person?**  
 Same as my address: 1324 Some Street, Baltimore, MD 21201  
 Enter a different address:

**Address:**  
**Country:**

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

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

**What is the daytime phone number of this person?**  
 Same as my phone number: (410) 325-XXXX  
 Enter a different daytime phone number.

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

#### Preferred Language

Can this person speak and understand English?  
 Yes    No

**In this section...**

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



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## 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.


#### In this section...

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

- Next
- Previous
- Save & Exit

## 5. Doc001-1\_Doctors and healthcare professionals

| Text Size  | Accessibility Help





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### Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification Medical Work/Education Remarks Review

#### Doctors and Other Healthcare Professionals for Kelly ~~Anderson~~

If you do not have any more **doctors/healthcare professionals** to enter, click the Next button.

- If you were an inpatient or outpatient at a hospital or clinic, do not list staff doctors. We will ask about them later.
- Include only the people who have treated you for the conditions related to your disability.
- Give each person's first and last name if possible.


	Doctors/Healthcare Professionals	City	Phone	Actions
<input checked="" type="checkbox"/>	<a href="#">Dr. Samantha Gupta</a>	Baltimore, MD	(410) 496-9643	<input type="button" value="Edit"/> <input type="button" value="Delete"/>


#### In this section...

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



## 6. Doc002-1\_Doctors and healthcare professionals details

| Text Size  | Accessibility Help



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### Apply for Benefits

#### Doctor/Healthcare Professional Details

**Name of Doctor/Healthcare Professional:** [? More info](#)

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

**Office Name or Clinic, if applicable:**

---

**Doctor/Healthcare Professional's Address:**  
If you don't have the full street address, give us as much as you can.  
Example: "On Main St next to the Courthouse"

**Country:**

**Street Address:**

Street Line 1:

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

<b>City/Town:</b> <input type="text"/>	<b>State/[Territory]:</b> <input type="text" value="--"/>	<b>ZIP Code:</b> <input type="text"/>
---	--	--

---

**Doctor/Healthcare Professional's Phone Number:**

U.S.     International

<input type="text"/>	<input type="text"/>
10-digit Number	Ext.

---

**Patient ID Number, if known:**

#### Treatment Dates with this Doctor/Healthcare Professional

Please give us the closest date(s) you can remember. [? More info](#)

**First visit:**

Last visit:

Next visit:

Leave blank if no appointment scheduled.

## Tests Ordered by this Doctor/Healthcare Professional

[? More info](#)

**Has this doctor/healthcare professional ordered any tests for you?**

This includes any medical tests you have had or will have.

Yes  No

**Details about Test 1:**

Kind of Test:

Date of Test: [? More info](#)

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

**Details about Test 2:**

Kind of Test:

Date of Test: [? More info](#)

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

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

## Medicines Recommended or Prescribed by this Doctor/Healthcare Professional

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

Yes  No

**List any medicines you are taking and the reasons you are taking them.**

List only one medicine at a time. Look at the medicine container if necessary.

**Medicine 1:**

**Reason 1:**

**Medicine 2:**

**Reason 2:**

**Medicine 3:**

**Reason 3:**

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

### Medical Conditions Treated by this Doctor/Healthcare Professional

**What medical conditions were treated or evaluated by this doctor/healthcare professional?**

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

Characters remaining: XXXX

Check Spelling

### Treatment from this Doctor/Healthcare Professional

**What treatment did you receive from this doctor/healthcare professional?**

You DO NOT need to repeat any information that you have already told us about medicines and tests.  
Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)


Characters remaining: XXXX


Check Spelling

Save

Cancel

## 7. Hos001-1\_Hospitals and Clinics

| Text Size  | Accessibility Help







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### Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification Medical Work/Education Remarks Review

#### Hospitals and Clinics for Kelly ~~Anderson~~

If you do not have any more **hospitals/clinics** to enter, click the Next button.


Include all hospitals and clinics where you have been treated for the condition(s) related to your disability.

	Hospitals and Clinics	City	Phone	Actions
<input checked="" type="checkbox"/>	<a href="#">Vancouver General Hospital</a>	Vancouver, BC	(604) 875-4111	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

**In this section...**

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

## 8. Hos002-1\_Hospital and Clinic Details

| Text Size  | Accessibility Help



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## Apply for Benefits

### Hospital/Clinic Details


**Name of Hospital/Clinic:**

**Name of Healthcare Professional who treated you, if known:**

**Address:**

If you don't have the full street address, give us as much as you can.  
Example: "On Main St next to the Courthouse"

**Country:**

United States or U.S. Territory 

**Street Address:**

Street Line 1:

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

**City/Town:**

**State/Territory:**

-- 

**ZIP Code:**

**Hospital/Clinic Phone Number:**

U.S.     International

10-digit Number

[Ext.](#)

**Hospital/Clinic Record Number, if known:**

### Treatment Dates at this Hospital/Clinic

[? More info](#)

**Did you have any emergency room (ER) visits at this hospital/clinic?**

ER Visit means you went to the ER and then went home.

Yes     No

**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

| Text Size  | Accessibility Help







# Social Security

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### Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification Medical Work/Education Remarks Review

#### Medical Tests for Kelly Anderson


If you do not have any **medical tests** to enter, click the **Next** button.


	Name of the Test	Test ordered by	Actions
<input checked="" type="checkbox"/>	<a href="#">EKG (Heart Test)</a>	Doctor(s) at Vancouver General Hospital	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	<a href="#">X-ray (Body part)</a>	Doctor(s) at Vancouver General Hospital	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

#### In this section...

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

# 10.Tst002-1\_Medical Test Details

| Text Size  | Accessibility Help



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## Apply for Benefits

### Test Details

**Kind of Test:**

---

**Date of Test:** [? More info](#)

---

**Who sent you or will send you for this test?**  
If the provider's name is not in the list, select "Other Medical Professional."

This provider ordered this test more than once.



## Apply for Benefits


### Test Details

Kind of Test:

Date of Test: [? More info](#)

Who sent you or will send you for this test?

If the provider's name is not in the list, select "Other Medical Professional."

Other Medical Professional 

Add Doctor/Healthcare Professional

Add Hospital/Clinic

This provider ordered this test more than once.

Save

Cancel

**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)



## Apply for Benefits

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

- Identification
- Medical
- Work/Education
- Remarks
- Review

### Medicines for Kelly Anderson

If you do not have any **medicines** to enter, click **Next** button. Please make sure to include all the prescription and over the counter medicines that you are taking.

	Name of Medicine	Reason	Prescribed/ Recommended by	Actions
<input checked="" type="checkbox"/>	Singularair	COPD	Dr. Samantha <del>XXXX</del>	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	Plavix	Heart Disease	Dr. Samantha <del>XXXX</del>	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	Cymbalta	Depression	Dr. Elijah <del>XXXX</del>	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	Tylenol	Pain	No one prescribed this medicine	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

- In this section...
- Conditions
  - Contact
  - Doctors
  - Hospitals
  - Tests
  - Medicines
  - Other Medical Records

- 
- 
-



## Apply for Benefits

### Medicine Details

**Enter name of the medicine:**

Enter only one medicine at a time. Look at the medicine container if necessary.

**What is the reason you are taking this medicine?**

**Who recommended or prescribed this medicine?**

If this doctor's name is not in the list, select "Other Medical Professional."

Save

Cancel



## Apply for Benefits

### Medicine Details

**Enter name of the medicine:**

Enter only one medicine at a time. Look at the medicine container if necessary.

**What is the reason you are taking this medicine?**

**Who recommended or prescribed this medicine?**

If this doctor's name is not in the list, select "Other Medical Professional."

Add Doctor/Healthcare Professional

Add Hospital/Clinic

Save

Cancel

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

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

# 13.Msc001-1\_Other medical records

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



## Social Security

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### Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification Medical Work/Education Remarks Review

#### Other Medical Records for Kelly XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX

Although this does not apply to everyone, some people may have relevant Medical records in other places. These other medical records may be available from:

- vocational rehabilitation services
- worker's compensation
- public welfare
- doctors in a prison or jail
- records held by an attorney or lawyer or
- medical records at another place

These other records may contain important information that we need to consider in evaluating the disability application.

Note: You do not need to list any organization that you have already mentioned.

If you do not have any more sources of **other medical records**, please click the **Next** button.

Name of Organization/Office	City	Phone	Actions
No Organization/Office information has been added.			

- In this section...
- [Conditions](#)
  - [Other Contact](#)
  - [Doctors](#)
  - [Hospitals](#)
  - [Tests](#)
  - [Medicines](#)
  - [Other Medical Records](#)



## 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:**

**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

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### Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification Medical Work/Education Remarks Review

#### Work Status for Kelly ~~XXXXXXXXXX~~

In determining whether you meet the requirements for receiving disability benefits, we must consider your work experience and job skills. [More info](#)

---

This section of the report asks for information about:

- when your condition(s) began to affect your ability to work;
- your 5 most recent jobs; and
- your education and training.

Please give as much information as you can. We will contact you later if we need more information.

---

**Are you currently working?**

No, I have never worked

No, I have stopped working

Yes, I am currently working

**Next**PreviousSave & Exit

In this section...	
<input type="radio"/>	Work Status
<input type="radio"/>	Work Activity
<input type="radio"/>	Job History
<input type="radio"/>	Education



## 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 ~~XXXXXXXXXXXXXXXXXX~~

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

#### 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





- 
- 
- 

#### In this section...

- Work Status
- Work Activity
- Job History
- Education



## 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 ~~XXXXXXXXXX~~ ~~XXXXXXXXXX~~


We need to know if you made any changes in your work as a result of your condition. If so, this may help show how your ability to work was limited because of a disability. [? More info](#)

**Has your condition(s) caused you to make changes to your work activity?**

- Yes     No

**When did you make changes?**

If you don't know the exact date, enter the closest date you can remember.

--     --     --   
Month                      Day                      Year

**In this section...**

- Work Status
- Work Activity
- Job History
- Education

- Next**
- Previous
- Save & Exit



## 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 ~~XXXXXXXXXX~~

**When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)?**

If you don't know the exact date, enter the closest date you can remember.


-- -- --  
Month Day Year

#### In this section...

- Work Status
- Work Activity
- Job History
- Education

- Next**
- Previous
- Save & Exit

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

### Job History for Tony ~~XXX~~

Since **Sep 10, 2011**, have you had gross earnings greater than **\$1000** in any month? Do not count sick leave, vacation, or disability pay.  
We may contact you for more information.

Yes    No

### Job Listing

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

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

### 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

### Previous Job #1

Job Title:

Type of Business:

Start Date:   /

Month   Year

End Date:   /

Month   Year

### In this section...

- Work Status
- Work Activity
- Job History**
- Education

change to \$1,090

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](#)



## 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 ~~XXXXXXXXXX~~ ~~XXXXXXXXXX~~

Since May 2, 2005, have you had gross earnings greater than \$830 in any month? Do not count sick leave, vacation, or disability pay.

We may contact your for more information.

- Yes     No

#### In this section...

- Work Status
- Work Activity
- Job History
- Education

### Job Listing

List the jobs (up to 5) that you have had in the past 15 years. Start with your most recent job.

change to \$1,090

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

**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?**

**Did you stand?**

Yes  No

You answered you did not stand.

**Did you sit?**

Yes  No

**How many hours did you sit?**

**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?**

**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



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- 2  Provide Disability Information
- 3  Sign Medical Release
- 4  Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

### Job History for Kelly ~~XXXXXXXXXXXX~~ ~~Anderson~~ ~~XX~~

In an earlier question, you indicated that you have never worked. If this is incorrect, please

Based upon your previous answer, you do not need to enter information on this page.

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

- 
- 
-



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- Medical
- Work/Education
- Remarks
- Review

### Education and Training for Tony Tiger

**Highest Grade Completed:**

If you did not complete the entire school year, select the previous year that you completed.

12th Grade

**Date Completed:**

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

**Have you completed any type of special job training, trade or vocational school?**

- Yes
- No

**Type of Program:**

If you need more space, use the Remarks tab.

Characters remaining: 1000

**Date Program Completed:**

Enter the approximate date when you completed the program.

In this section...

Work Status

Work Activity

Job History

Education

### Special Education

**Did you attend special education classes?** More Info

- Yes
- No

**School Name:**

**Location of School:**

- United States or U.S. Territory
- Other

City/Town State/Territory

**Dates Attended:**

Enter the approximate dates you attended this school.

From To

**Have you had special education at more than one school?**

- Yes
- No

- Next
- Previous
- Save & Exit



## Apply for Benefits

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

- Identification
- Medical
- Work/Education
- Remarks
- Review

Remarks for Kelly XXXXXXXX  
XXXXXXXXXX

Please provide any additional information you want to include:

Characters remaining: 2000

In this section...

- Remarks

- 
- 
-



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## 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 Tiger

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

In this section...

Review

#### Identification

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) 325-3333**  
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**

Re-entry Number

The Re-entry Number is: **77774526**  
(The Re-entry Number cannot be edited.)

#### 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**

Doctors and Other Healthcare Professionals

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

Hospitals and Clinics

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

Tests

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

Medicines

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

Other Medical Records

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

#### Work/Education

Work Status

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

Work Activity

Changes in Work Activity: **No**

Date First Bothered by Conditions: **September 10, 2011**

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: **1 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**

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

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

#### Medical Release Form

In order to make a decision about your disability claim, we need to obtain your:

- Medical Records
- Education Records
- Other information related to your ability to perform tasks

We will help get your records if you give us 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 your 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 education records and other information related to my ability to perform tasks.**


I agree to **electronically sign** the Medical Release Form and submit it with my completed benefit application. My electronic signature is the same as my handwritten signature. (Recommended)

I agree to **print, sign and mail a paper copy** of the Medical Release Form after submitting my completed benefit application. I understand this may delay the processing of my disability claim.

**Submit**   Save & Exit

## 27.Wtn001-d1\_Confirmation (With electronic Signature)

Text Size ▾ | Accessibility Help



### Social Security

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

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## Apply for Benefits

1 ✓ Provide Background Information2 ✓ Provide Disability Information3 ✓ Sign Medical Release4 Confirmation

✓ **Thank you for applying for disability online.**[Print this page](#)

Your Confirmation Number is: **77774526**

You can check the status of your application after 5 business days. Go to "www.socialsecurity.gov," select "Check Your Application Status" and enter your Confirmation Number.

Please note that in some cases, the application status cannot be updated because we are still reviewing your application.

We will contact you with any updates or questions we may have about your information.

**What you need to do next:**

1. **Gather** the following documents:
  - Any [medical evidence](#) you already have about your disability;
  - Award letters, pay stubs, settlement agreements or other proof of temporary or permanent [workers' compensation](#) type benefits you received.
2. **Print** your [personalized cover sheet](#);
3. **Send** all of these items to your local office:  
SOCIAL SECURITY  
1010 PARK AVE  
SUITE 200  
BALTIMORE, MD 21201-5637

If you do not have all the documents listed above we will help you get any documents you need.

**Caution: Do not mail** foreign records or any Department of Homeland Security (DHS) documents to us - especially those you are required to keep with you at all times. These documents are extremely difficult, time-consuming and expensive to replace if lost; and some cannot be replaced. Instead, **bring them to your Social Security office** where they will be examined and returned to you.

**View & Print the following:**

- [Your Receipt](#)
- [Electronically Signed Medical Release Form](#)

We recommend that you keep a copy of each for your records.

Useful Links Contact Us





- [Reporting Responsibilities: What Needs to be Reported](#)
- [Frequently Asked Questions - Internet Benefit Claim](#)
- [Social Security Online: What You Can Do Online](#)
- [Voluntary Tax Withholding](#)
- [Helpful Health Information Online](#)
- [Prescription Assistance](#)

Done

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



## Apply for Benefits


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

### Thank you for applying for disability online.

Your Confirmation Number is: **26748727**

You can check the status of your application after 5 business days. Go to [SocialSecurity.gov](http://SocialSecurity.gov), select "Check Your Application Status" and enter your Confirmation Number.

We will contact you with any updates or questions we may have about your information.

 [Print this Page](#)

#### What you need to do next:

1. **Collect** the following information:
  - Any [medical evidence](#) you already have about your disability;
  - Award letters, pay stubs, settlement agreements or other proof of temporary or permanent [workers' compensation](#) type benefits you received.
2. **Print and sign** [medical release form](#);
3. **Print** your [personalized cover sheet](#);
4. **Send** all of these items to your local office:

SOCIAL SECURITY  
10230 NEW HAMPSHIRE AVE  
SUITE 304  
SILVER SPRING, MD 20903

#### [View & Print Your Receipt](#)

We recommend that you keep a copy for your records.

Contact Us

[Useful Links](#)

If you live within the U.S., our territories or commonwealths, you may:

- Call our toll-free number **1-800-772-1213** (TTY 1-800-325-0778) from Monday through Friday from 7 a.m. to 7 p.m.
- Find and visit a nearby Social Security office by using our [Office Locator](#).

If you live outside the U.S., our territories or commonwealths, you may visit our [Service Around the World](#) page, or contact your local U.S. embassy or Consulate.

**Done**

Print Now

### Cover Sheet for Tony Tiger

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 ~~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-~~503~~**  
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

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](http://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.***