

# Disability Case Selection

SSA Disability Claims System - Microsoft Internet Explorer provided by IE6.0 sP1>Alpha CI

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### Disability Case Selection [Enable JAWS Mode](#)

**Search Criteria**

**Client SSN:**

**Client Name. Last:**  **First:**

**Search Results**

	Client Name	DSI	CEF	DOB	Estab Date	Level	Claim Type	Office Code	Office Type	Claim Status
<input type="radio"/>	<a href="#">Ovard, Joshua</a>	N	Y	06/01/1983	07/31/2005	Reconsideration	DI	<a href="#">X33</a>	FO	Closed
<input type="radio"/>	<a href="#">Ovard, Joshua Q.</a>	N	Y	06/01/1983	01/15/2005	Initial	DI	<a href="#">C65</a>	FO	Closed

# Select Case Level

Select Case Level -- Web Page Dialog

**No EDCS case found. Please select the adjudicative level at which you want the case to be established.**

Initial Classification:

Initial

Reconsideration

Hearing

Appeals Council

Federal Court

MCS Exclusion Claim

CDR Classification:

CDR Initial

CDR Reconsideration

CDR Hearing

OK Cancel


# Confirm Case Creation

**Confirm Case Creation -- Web Page Dialog**

**Client Name:** Joshua Ovard  
**Date of Birth:** 06/01/1983

**The client's information will be collected as:**

An Adult  
 A Child  
 An Age 18

**\*Comparison Point Decision (CPD) Date (mm/dd/yyyy):**  

**\*Have you worked since the CPD date?**  Yes  No  Not Yet Answered

**\*Are you using a Ticket to Work?**  Yes  No  Not Yet Answered

Do you wish to create a case for this person?

# Form Selection

Disability Case Process 999-99-9999 Joshua Ovard - Microsoft Internet Explorer provided by IE6.0 SP1 > AlphaCI

Form(s) Selection - AN: 999-99-9999 CDR CEF: Y CPD CEF: NYA [Open in eView](#) [Hide Instructions](#)

**Form(s) Selection**

\* Form SSA-454-BK Continuing Disability Review Report :  Key  Paper  Not Yet Answered

\* Do you have an appointed representative?  Yes  No  Not Yet Answered

# Link Folder

Disability Case Process 999-99-9999 Joshua Ovard - Microsoft Internet Explorer provided by IE6.0 SP1 > AlphaCI

Link Folder - AN: 999-99-9999 CDR CEF: Y CPD CEF: NYA [Open in eView](#) [Hide Instructions](#)

### Link Folder

Below is the most recent certified electronic folder (CEF) with a favorable disability decision recorded in the electronic folder.

**Name:** Joshua Ovard  
**Level:** Initial

**Claim:** DI  
**Filing date:** 01/15/2005  
**Decision type:** Allowance  
**Decision date:** 10/16/2008  
**Claim number:** 999-99-9999

*Note: It is possible that not all filings relevant to CDRs were recorded in the Electronic Folder. Some folders were recorded in the Electronic Folder, but were not certified electronic. Some folders do not have allowances recorded.*

\* Is this the folder that contains the medical evidence for the last favorable disability determination? (If this folder contains an adopted decision, does the folder contain the necessary medical evidence?)

Yes  No  Not Yet Answered

# CDR Information, Part 1 of 2

User has indicated claimant used other names, but has not entered any

Disability Case Process 123-45-6789 Joshua Ovard - Microsoft Internet Explorer provided by IE6.0 SP1...

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**CDR Information**

**Client Identification**

**Name:** Joshua Ovard  
**Date of birth:** 06/01/1983  
**Mailing address:** 608 W. 100 STREET  
PROVO, UT 84601   
**Residence address:** 608 W. 100 STREET  
PROVO, UT 84601   
**Daytime telephone number:** 801-377-1373

Please enter an alternate phone number or a phone number where a message can be left, if available.

**Alternate Telephone Number is:**  U.S.  Foreign  None  
**Alternate telephone number:**

**Other Names Used**

**Have you used any other names on your medical or educational records in the last 12 months?**  
Examples are maiden name, other married name, or nickname.

Yes  No  Not Yet Answered

# CDR Information, Part 2 of 2

Other Names = Yes, but no other names entered

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Yes  No  Not Yet Answered

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

**Other Names**

Add

**Your Language Information**

Can you speak and understand English?  Yes  No  Not Yet Answered

**Case Information**

\* CDR type: [ ]

\* Comparison Point Decision (CPD) date (MM/DD/YYYY): 10/16/2008

Is DDS capability development needed?  Yes  No  Not Yet Answered

**Contact Information**


\* CR unit code: 123

\* First name: Claims \* Last name: Representative

\* Telephone number: 801-377-1234 Ext. 5678

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# Other Names Used

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**Other Names Used** [Open in eView](#) [Hide Instructions](#)

Add each name that might appear on your medical or educational records.

\* **First name:**

**Middle name:**

\* **Last name:**

**Suffix**



# CDR Information, Part 2 of 2

Other Names = Yes, with another name entered

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**Other Names Used**

Have you used any other names on your medical or educational records in the last 12 months?  
Examples are maiden name, other married name, or nickname.

Yes  No  Not Yet Answered

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

**Other Names**

- [Ovard, Josh](#)

**Your Language Information**

Can you speak and understand English?  Yes  No  Not Yet Answered

**Case Information**

\* CDR type:

\* Comparison Point Decision (CPD) date (MM/DD/YYYY):

Is DDS capability development needed?  Yes  No  Not Yet Answered

|  |

# CDR Representatives

Appointed Representative = No

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**Flags/Messages**

### CDR Representatives

#### Representative Payee Information

This following table displays all representative payee information found on the MBR/SSR. If more than one is listed, delete all except the correct payee prior to transfer.

To add a representative payee, choose Add Rep Payee. To edit or delete, select the representative payee's name below.

Name	Address	Claim Type

#### Appointed Representative Information

Does this person have an appointed representative?

Yes  No  Not Yet Answered

|  |  |

# CDR Representatives, Part 1 of 2

## Appointed Representative = Yes

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### CDR Representatives

#### Representative Payee Information

This following table displays all representative payee information found on the MBR/SSR. If more than one is listed, delete all except the correct payee prior to transfer.

To add a representative payee, choose Add Rep Payee. To edit or delete, select the representative payee's name below.

Name	Address	Claim Type

#### Appointed Representative Information

Does this person have an appointed representative?

Yes  No  Not Yet Answered

\*First name:  Middle name:  \*Last name:  Suffix:

#### Appointed Representative Address Information

|  |  |

# CDR Representatives, Part 2 of 2

Appointed Representative = Yes

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### Appointed Representative Information

Does this person have an appointed representative?  
 Yes  No  Not Yet Answered

\*First name:  Middle name:  \*Last name:  Suffix:

### Appointed Representative Address Information

Address is:  U.S.  Foreign

Street address line 1:   
Street address line 2:   
Street address line 3:   
Street address line 4:   
City:  State:  Zip Code:

### Appointed Representative Telephone Information

Telephone Number is:  U.S.  Foreign  None  
Type:  Voice  Fax  TTY  
Daytime telephone number: (999-999-9999)  Ext:

|  |  |

# CDR Claims

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Flags/Messages

**CDR Claims**

Select a claim type to view CDR claim information:

Claim Type	Claim Number	BIC
<a href="#">CDBR</a>	999-99-9991	C1
<a href="#">DI</a>	999-99-9992	

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# Contacts, Part 1 of 3

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**454 Contacts**

**Alternate Contact Information**

Is there someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your case?

Yes  No  Not Yet Answered

**Name of Alternate Contact**

First name:  Middle Name:  Last name:  Suffix:

Relationship to Disabled Person:

**Address for Alternate Contact**

Mailing address is:  U.S.  Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

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# Contacts, Part 2 of 3

## Person Completing Report = Claimant

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**Flags/Messages**

Street address line 4:

City:  State: --  Zip Code:

**Telephone for Alternate Contact**

Please enter an alternate phone number or a phone number where a message can be left, if available.

Telephone Number is:  U.S.  Foreign  None

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

**Preferred Language of Alternate Contact**

Can this person speak and understand English?  Yes  No  Not Yet Answered

**Person Completing the Report**

Who is providing information?

- Joshua Ovard
- Alternate Contact listed above
- Someone else

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# Contacts, Part 3 of 3

## Person Completing Report = Someone Else

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**Flags/Messages**

Someone else

\*First name:  Middle Name:  \*Last name:  Suffix:

Relationship to Disabled Person:

**Address for Person Completing This Report**

Mailing address is:  U.S.  Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City:  State:  Zip Code:

**Telephone for Person Completing This Report**

Telephone Number is:  U.S.  Foreign  None

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



# Medical Conditions, Part 1 of 2

Medical Conditions Propagated from mainframe, no new conditions entered

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**454 Medical Conditions**

**Physical and Mental Conditions**

\* List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

Enter one condition on each line. You will be given additional lines as needed.

1.

2.

**Height and Weight**

What is your height without shoes? feet:  inches:

What is your weight without shoes? pounds:

**Assistive Devices**

Do you use an assistive device?

[Examples](#)

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# Medical Conditions, Part 2 of 2

Medical Conditions Propagated from mainframe, no new conditions entered

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**Flags/Messages**

**\* List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.**  
Enter one condition **on each line**. You will be given additional lines as needed.

1.

2.

**Height and Weight**

What is your height without shoes? feet:  inches:

What is your weight without shoes? pounds:

**Assistive Devices**

Do you use an assistive device?  
[Examples](#)

Always  Sometimes  Never  Not Yet Answered

|  |  |

# Medical Conditions, Part 1 of 2

Medical Conditions Propagated from mainframe, plus one new conditions entered  
User has indicated claimant uses an assistive device

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**454 Medical Conditions**

**Physical and Mental Conditions**

\* List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

Enter one condition on each line. You will be given additional lines as needed.

1.

2.

3.

**Height and Weight**

What is your height without shoes? feet:  inches:

What is your weight without shoes? pounds:

**Assistive Devices**

Do you use an assistive device?

|  |  |

# Medical Conditions, Part 2 of 2

Medical Conditions Propagated from mainframe, plus one new conditions entered  
User has indicated claimant uses an assistive device

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**Flags/Messages**

**Height and Weight**

What is your height without shoes? feet:  inches:

What is your weight without shoes? pounds:

**Assistive Devices**

Do you use an assistive device?

[Examples](#)

Always  Sometimes  Never  Not Yet Answered

Please describe what kind, when, and how you use it.

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# Medical Sources

Initial view

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**Flags/Messages**

**454 Medical Sources**

**Doctors, Therapists, Hospital, Clinics**

**Within the last 12 months, have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:**

\* For any **physical** condition(s)

Yes  No  Not Yet Answered

\* For any **mental** condition(s) (including emotional or learning problems)

Yes  No  Not Yet Answered

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# Medical Sources

User has indicated claimant has medical sources, but has not entered any

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### 454 Medical Sources

**Doctors, Therapists, Hospital, Clinics**

**Within the last 12 months, have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:**

\* For any **physical** condition(s)  
 Yes    No    Not Yet Answered

\* For any **mental** condition(s) (including emotional or learning problems)  
 Yes    No    Not Yet Answered

Tell us who may have medical records covering **the last 12 months** about any of your **physical or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities.




Tell us about your **next appointment**, if you have one scheduled.

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

Name	Address

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# Doctor/Therapist Information, Part 1 of 2

Disability Case Process 123-45-6789 Joshua Ovard - Microsoft Internet Explorer provided by IE6.0 SP1...   

**Doctor/Therapist Information** Source to Merge

**Name:** [John McKell](#)

**Attention:**

**Address:** 147 West 400 North

**Patient ID# (if known):**

**Dates**

**First visit:**

**Last visit:**

**Next appointment:**

**Conditions and Treatments**

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

**What treatment did you receive for the above conditions?**

## Doctor/Therapist Information, Part 2 of 2

### Tests

List any tests **this provider** performed or sent you to **within the last 12 months**, or scheduled you to take in the future.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By

Add Test

### Medicines

List all medicines you are now taking, or have you taken **in the last 12 months**, prescribed or suggested **by this provider**.

To add a medicine, choose Add Medicine. To edit, select the name of the medicine below.

Medicine	Prescribed By	Reason

Add Medicine

### Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add a condition, choose Add Condition. To edit, select the name of the condition below.

Name
Fatigue, Fibromyalgia
Migraines

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

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# Medical Sources

User has indicated claimant has medical sources and entered a doctor

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**454 Medical Sources**

**Doctors, Therapists, Hospital, Clinics**

**Within the last 12 months, have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:**

\* For any **physical** condition(s)

Yes  No  Not Yet Answered

\* For any **mental** condition(s) (including emotional or learning problems)

Yes  No  Not Yet Answered

Tell us who may have medical records covering **the last 12 months** about any of your **physical or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities.

Tell us about your **next appointment**, if you have one scheduled.

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

Name	Address
<a href="#">Dr. John McKell</a>	147 West 400 North

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# Hospital/Clinic Information, Part 1 of 3

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## Hospital/Clinic Information

Name of facility or office: [Utah General Hospital](#)

Attention:

Address: 6701 Main Street

Health care professional who treated you at Utah General Hospital:

Patient ID# (if known):

### Dates at this Facility

Did you have any inpatient stays?  Yes  No  Not Yet Answered

Date In:	<input type="text"/>	Date Out:	<input type="text"/>
Date In:	<input type="text"/>	Date Out:	<input type="text"/>
Date In:	<input type="text"/>	Date Out:	<input type="text"/>

Did you have any outpatient visits?  Yes  No  Not Yet Answered

First visit:

Last visit:

Next appointment:

## Add Hospital/Clinic, Part 2 of 3

Did you have any emergency room visits?

Yes

No

Not Yet Answered

Date of visit:

Date of visit:

Date of visit:

### Conditions and Treatments

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions?

### Tests

List any tests **this provider** performed or sent you to **within the last 12 months**, or scheduled you to take in the future.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By

Add Test

## Add Hospital/Clinic, Part 3 of 3

### Medicines

List any prescription or non-prescription medicines you are now taking, or have you taken **in the last 12 months**, prescribed or suggested by **this provider**.

To add a medicine, choose Add Medicine. To edit, select the name of the medicine below.

Medicine	Prescribed By	Reason

Add Medicine

### Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add a condition, choose Add Condition. To edit, select the name of the condition below.

Name
Fatigue, Fibromyalgia
Migraines

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

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# Tests Summary

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**Flags/Messages**

### 454 Tests Summary

Have you had any medical tests in the last 12 months, or do you have any tests scheduled for your condition?

Yes  No  Not Yet Answered

List all tests that you had or will have for your condition.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By
<a href="#">X-Ray</a>	12/16/2008	Dr. John McKell

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# Test Information

No body part involved or other explanation needed

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**Test Information** [Open in eView](#) [Hide Instructions](#)

**\*Name of Test:**

**Date of Test:**

**Provider who performed, sent you to, or scheduled you to take this test.**  
If you need to add a medical source, you must return to MED SOURCES.

**Physical and Mental Conditions**

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines

# Test Information

## Body part involved

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**Test Information** [Open in eView](#) [Hide Instructions](#)

\*Name of Test:

What part of your body was covered or will be covered by this test?

Date of Test:

Provider who performed, sent you to, or scheduled you to take this test.  
If you need to add a medical source, you must return to MED SOURCES.

**Physical and Mental Conditions**

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines

# Physical and Mental Condition Information – Plan A

Claimant adds physical or mental condition while adding test

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## Physical and Mental Condition Information

[Open in eView](#) [Hide Instructions](#)

Enter one condition on each line. You will be given additional lines as needed.

1.
2.
3.



# Physical and Mental Condition Information – Plan B

Claimant adds physical or mental condition while adding test

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**Physical and Mental Condition Information** [Open in eView](#) [Hide Instructions](#)

**\*Enter a physical and/or mental condition (including emotional or learning problems) that limits your ability to work.**

Check Spelling

# Medicines Summary

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**Flags/Messages**

### 454 Medicines Summary

Are you now taking, or have you taken in the last 12 months, any prescription or non-prescription medicines?

Yes  No  Not Yet Answered

**List all prescription and non-prescription medicines that you take for your condition.**

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

Medicine	Prescribed By	Reason
<a href="#">Ambien</a>	Dr. John McKell	Insomnia

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# Medicine Information

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**Medicine Information** [Open in eView](#) [Hide Instructions](#)

**\*Name of Medicine:**

**Who prescribed this medicine (if prescription):**  
If you need to add a medical source, you must return to MED SOURCES.

**Reason for medicine:**  
Examples:  
• Slows down my heart rate  
• Regulates my blood sugar  
• Stops the pain

**Physical and Mental Conditions**  
List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.  
To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

# Other Medical Information

## Initial View

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**Flags/Messages**

**454 Other Medical Information**

**Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems) covering the last 12 months, or are you scheduled to see anyone else?**

Examples:

- Workers' Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency

Yes    No    Not Yet Answered

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# Other Medical Information

User has indicated claimant has other medical source, but has not entered any

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**Flags/Messages**

**454 Other Medical Information**

**Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems) covering the last 12 months, or are you scheduled to see anyone else?**

Examples:

- Workers' Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency

Yes  No  Not Yet Answered

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

Name	Address

Add Source

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# Other Medical Information

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**Other Medical Information** [Open in eView](#) [Hide Instructions](#)

**Name:**  
**Attn:**  
**Address:**

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

**Dates**

**Date of first contact, in last 12 months:**

**Date of last contact:**

**Date of next contact, if any:**

**Reasons for Contacts**

**Reasons for contacts:**

**Physical and Mental Conditions**

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

# Other Medical Information

User has entered an other medical source

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**454 Other Medical Information**

**Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems) covering the last 12 months, or are you scheduled to see anyone else?**

Examples:

- Workers' Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency

Yes    No    Not Yet Answered

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

Name	Address
<a href="#">CoreSource</a>	PO Box 2920, Clinton, IA

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# Education and Training

## Initial View

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**454 Education and Training**

**Education**

Have you received any education since 10/16/2008?

Yes  No  Not Yet Answered

**Training**

Have you received any type of specialized job, trade, or vocational training since 10/16/2008?

Yes  No  Not Yet Answered

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# Education and Training, Part 1 of 2

User has indicated claimant received education and training

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**Flags/Messages**

### 454 Education and Training

#### Education

Have you received any education since 10/16/2008?

Yes  No  Not Yet Answered

Please describe the education received.

What year did you last attend any school?

#### Training

Have you received any type of specialized job, trade, or vocational training since 10/16/2008?

Yes  No  Not Yet Answered

Name of Training Facility:

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# Education and Training, Part 2 of 2

User has indicated claimant received training

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**Flags/Messages**

**Have you received any type of specialized job, trade, or vocational training since 10/16/2008?**

Yes    No    Not Yet Answered

**Name of Training Facility:**

**Telephone Number is:**  U.S.    Foreign    None

**Telephone number: (999-999-9999)**  Ext:

**Mailing address is:**  U.S.    Foreign

**Street address line 1:**

**Street address line 2:**

**Street address line 3:**

**Street address line 4:**

**City:**    **State:** --  **Zip Code:**

**Type of Program:**

**Approximate Date Completed (or scheduled to be completed):**

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

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**Flags/Messages**

**454 Vocational Rehabilitation, Employment, or Other Support Services**

Since the date of your last medical disability decision, have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self Support (PASS);
- An individualized education program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

Yes    No    Not Yet Answered

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# Vocational Rehabilitation

User has indicated claimant received vocational rehabilitation, but has not entered any

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**Flags/Messages**

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

**Since the date of your last medical disability decision**, have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self Support (PASS);
- An individualized education program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

Yes    No    Not Yet Answered

**List all plans or programs attended.**

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

Organization/School	Name of Counselor/Instructor

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# Vocational Rehabilitation, Employment, or Other Support Services Information, Part 1 of 2

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**Vocational Rehabilitation, Employment, or Other Support Services Information** [Open in eView](#) [Hide Instructions](#)

**Name:** Utah Vocational Rehabilitation  
**Attention:**  
**Address:** 125 N. Temple Street W.

**Dates Seen**

**When did you start participating in the plan or program?**

**Are you still participating in the plan or program?**

Yes. Scheduled to be completed on:

No. I completed the plan or program on:

No. I stopped participating in the plan or program before completing it because:

Not Yet Answered

**Types of Services**

**What types of services, tests, or evaluations were provided?**

[Examples](#)

# Vocational Rehabilitation, Employment, or Other Support Services Information, Part 2 of 2

**Physical and Mental Conditions**

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

# Daily Activities

## Initial View

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**454 Daily Activities**

**Typical Day**

**Describe what you do in a typical day:**  
For example: I get up around 7 A.M., take a shower, eat breakfast, etc.

**Hobbies or Interests**

**Do you have hobbies or interests?**

Yes    No    Not Yet Answered

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# Daily Activities

User has indicated claimant has hobbies or interests

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**454 Daily Activities**

**Typical Day**

**Describe what you do in a typical day:**

For example: I get up around 7 A.M. , take a shower, eat breakfast, etc.

**Hobbies or Interests**

**Do you have hobbies or interests?**

Yes    No    Not Yet Answered

**Please describe what they are and how much time you spend doing them.**

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# Daily Activities, continued, Part 1 of 2

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**454 Daily Activities, continued**

Do you ever have difficulty doing any of the following?

**Dressing:**       Yes    No    Not Yet Answered

**Bathing:**       Yes    No    Not Yet Answered

**Caring for hair:**       Yes    No    Not Yet Answered

**Taking medicines:**       Yes    No    Not Yet Answered

**Preparing meals:**       Yes    No    Not Yet Answered

**Feeding self:**       Yes    No    Not Yet Answered

**Doing chores (inside/outside house):**       Yes    No    Not Yet Answered

**Driving or using public transportation:**       Yes    No    Not Yet Answered

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# Daily Activities, continued, Part 2 of 2

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**Flags/Messages**

**Preparing meals:**  Yes  No  Not Yet Answered

**Feeding self:**  Yes  No  Not Yet Answered

**Doing chores (inside/outside house):**  Yes  No  Not Yet Answered

**Driving or using public transportation:**  Yes  No  Not Yet Answered

**Shopping:**  Yes  No  Not Yet Answered

**Managing money:**  Yes  No  Not Yet Answered

**Walking:**  Yes  No  Not Yet Answered

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# Daily Activities, continued

User has indicated claimant has difficulty bathing

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**Flags/Messages**

**454 Daily Activities, continued**

**Do you ever have difficulty doing any of the following?**

**Dressing:**  Yes  No  Not Yet Answered

**Bathing:**  Yes  No  Not Yet Answered

Please explain:

**Caring for hair:**  Yes  No  Not Yet Answered

**Taking medicines:**  Yes  No  Not Yet Answered

**Preparing meals:**  Yes  No  Not Yet Answered

**Feeding self:**  Yes  No  Not Yet Answered

**Doing chores (inside/outside house):**  Yes  No  Not Yet Answered

**Driving or using**  Yes  No  Not Yet Answered

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# Work

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**454 Work**

Has Joshua Ovard worked since 10/16/2008?

Yes  No

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# Daily Activities, cont 2, Part 1 of 2

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**454 Daily Activities, continued**

Do you ever have difficulty doing any of the following?

**Standing:**  Yes  No  Not Yet Answered

**Lifting objects:**  Yes  No  Not Yet Answered

**Using arms:**  Yes  No  Not Yet Answered

**Using hands or fingers:**  Yes  No  Not Yet Answered

**Sitting:**  Yes  No  Not Yet Answered

**Seeing, hearing, or speaking:**  Yes  No  Not Yet Answered

**Concentrating:**  Yes  No  Not Yet Answered

**Remembering:**  Yes  No  Not Yet Answered

**Understanding or**  Yes  No  Not Yet Answered

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# Daily Activities, cont 2, Part 2 of 2

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**Concentrating:**     Yes     No     Not Yet Answered

**Remembering:**     Yes     No     Not Yet Answered

**Understanding or following directions:**     Yes     No     Not Yet Answered

**Completing tasks:**     Yes     No     Not Yet Answered

**Getting along with people:**     Yes     No     Not Yet Answered

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# Remarks

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**Flags/Messages**

**454 Remarks**

Please provide any additional information you did not give in earlier parts of this report.

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***SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting:***

**Privacy Act Statement  
Collection and Use of Personal Information**

Sections 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a decision on the named claimant's claim. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent an accurate or timely decision on the named claimant's claim.

We rarely use the information you supply for any purpose other than to make a decision on the named claimant's claim. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs);
2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs. (e.g., to the Bureau of Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices entitled, Supplemental Security Income Record and Special Veterans Benefits (60-0103), Claims Folders System (60-0089), Master Beneficiary Record (60-0090), and Electronic Disability Claim File (60-0320). Additional information about this and other system of records notices and our programs are available from our Internet website at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.



***SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:***

**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 60 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 21235-0001.***