
# iAPPEALS REVITALIZATION 2013

## SCREEN PACKAGE
## VERSION 2.2

# Contents

# 1. Screen Package Version Information

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

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

# 2. About this Screen Package

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

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

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

   will be changed in production to:
   "If the exact date is unknown, enter an approximate date. Examples: 6/2/2013; June 2013; Summer 2013."

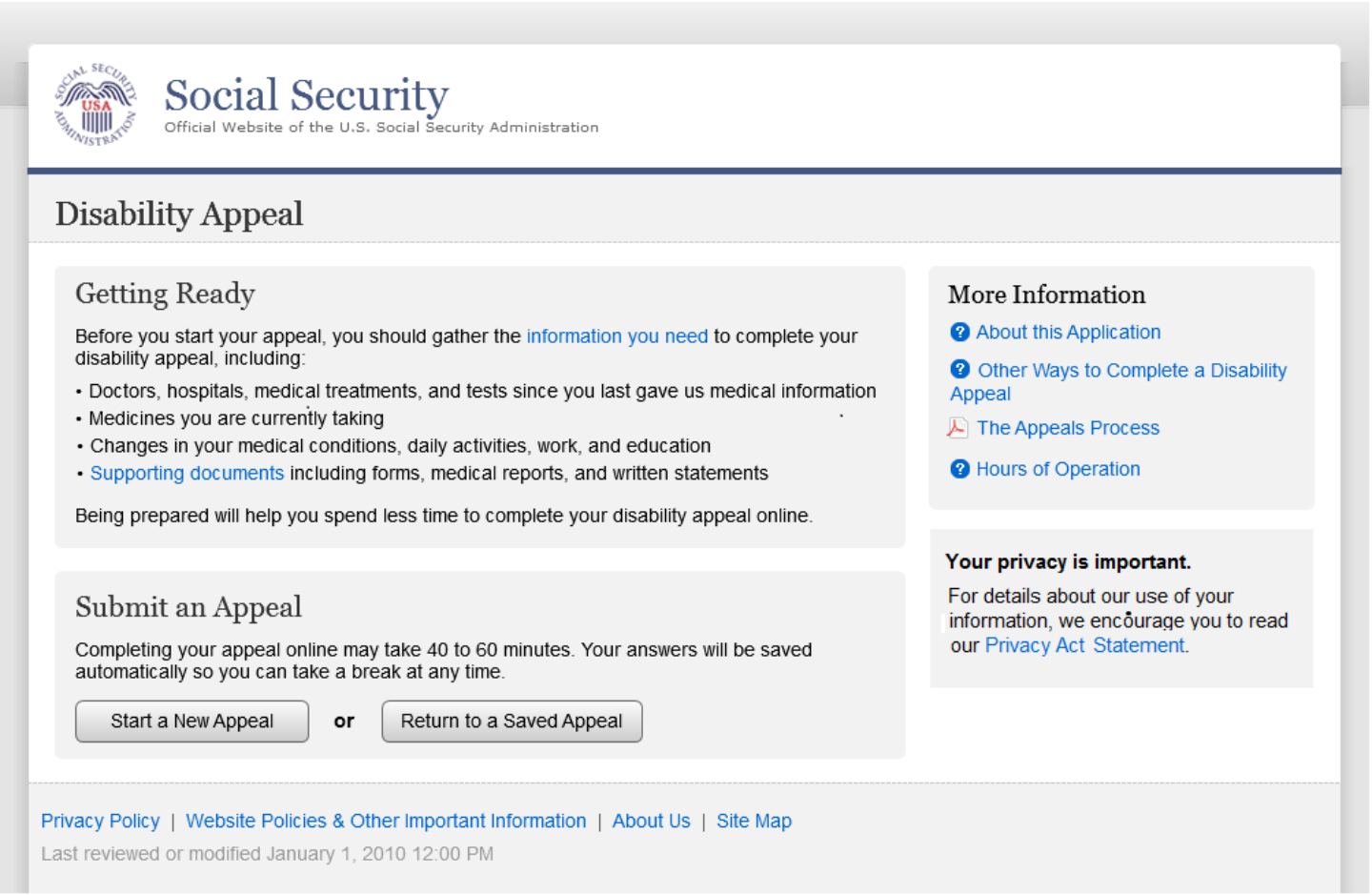
2. There has been a change to the field label and instructional text for side effects (for medicines). The UXG recommendation:
   **Describe any side effects Sarah Jones experienced while taking this medicine:**

   will be changed in production to:
   **Describe any side effects Sarah Jones has while taking this medicine:**
   If none, enter "None"

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

# 3. Third Party Screen Designs

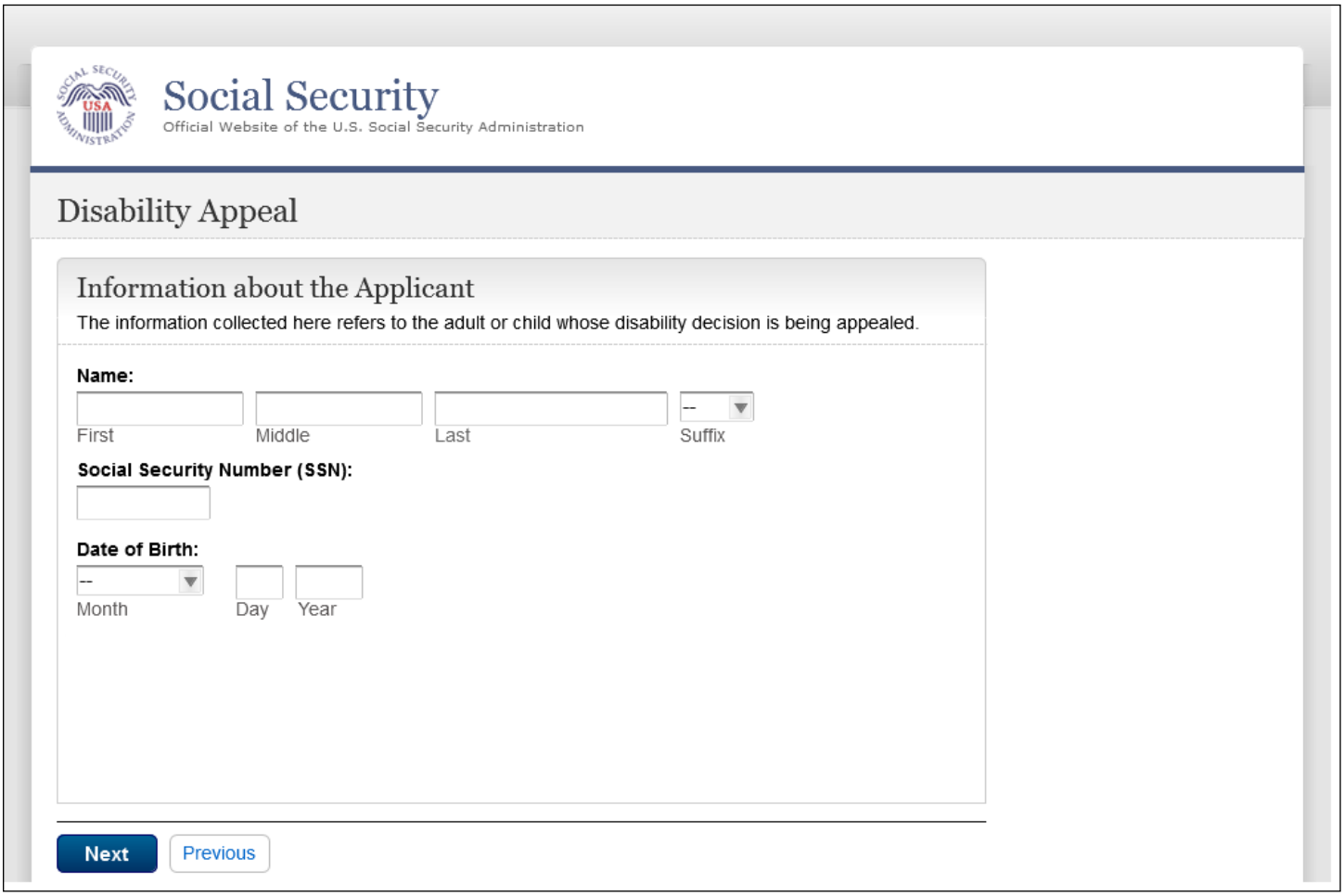
## 3.1. Welcome Page



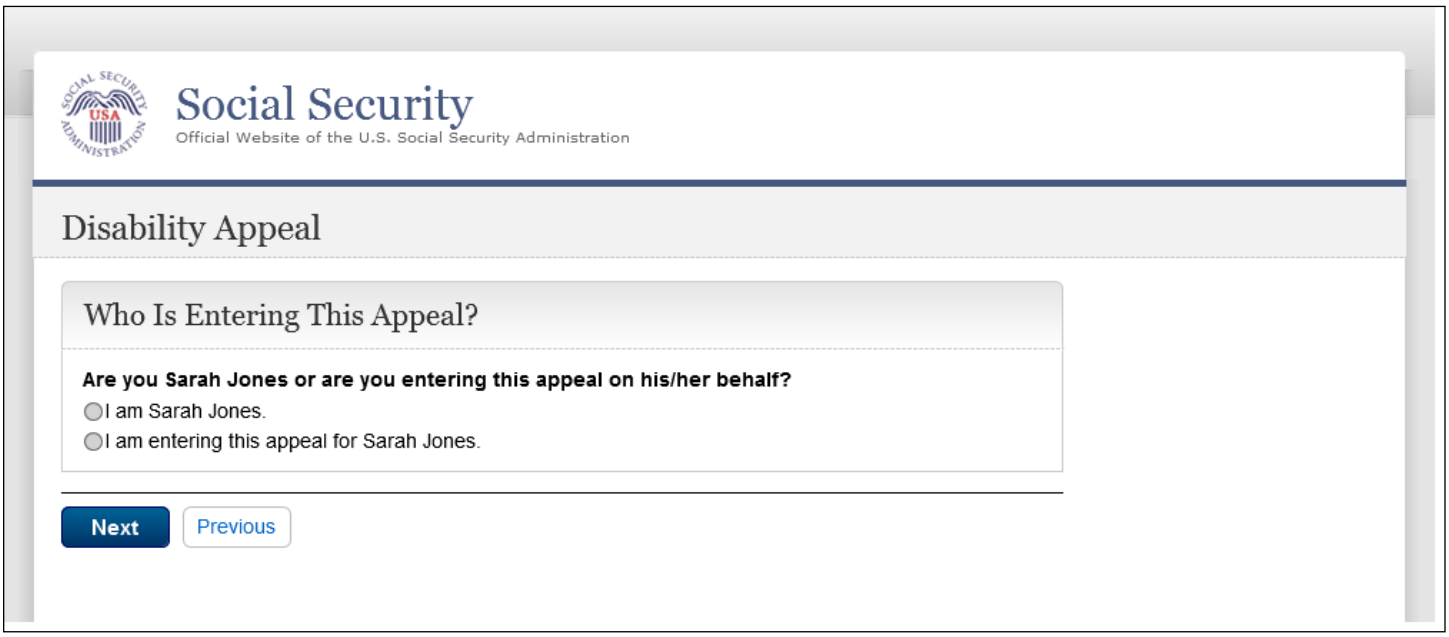
## 3.2. Screening

### 3.3. Screening: Lives in US

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



## 3.4. Who is Entering Appeal



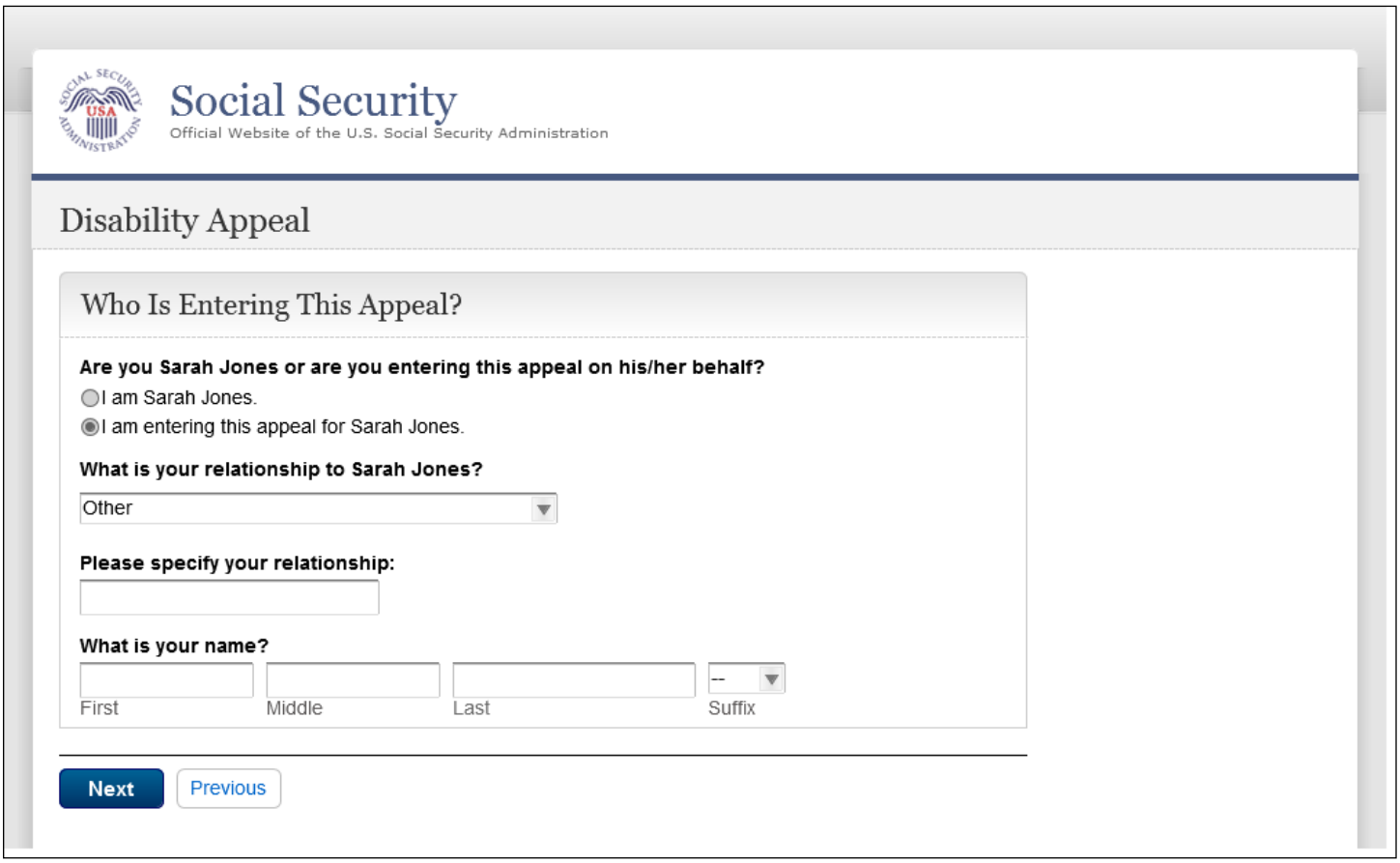
## 3.5. Who is Entering Appeal: Entering for Sarah Jones


Contents of relationship drop list:

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

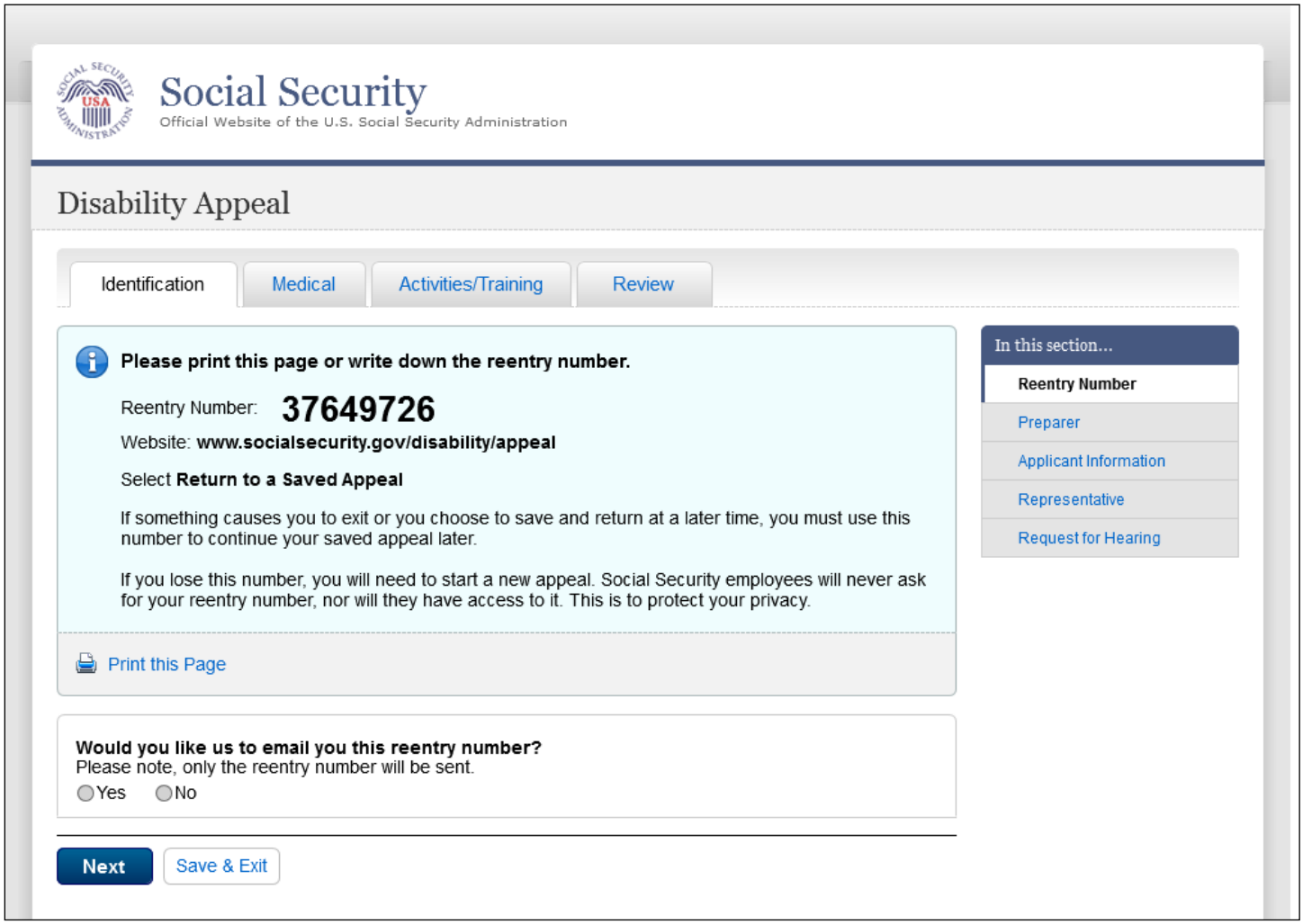
## 3.6. Who is Entering Appeal: Representative Selected

## 3.7. Who is Entering Appeal: Other Selected



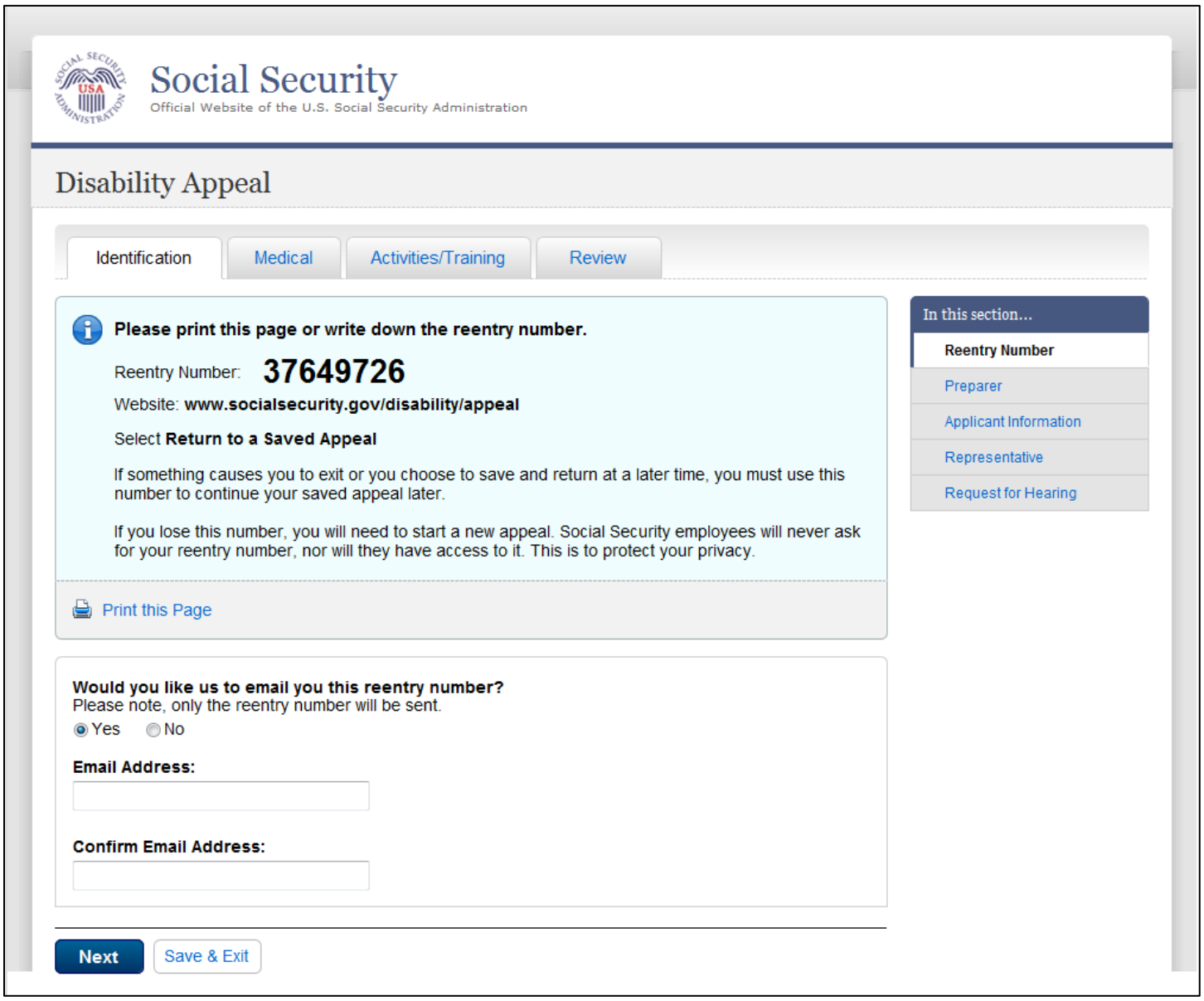
## 3.8. Reentry Number – 3rd Party

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

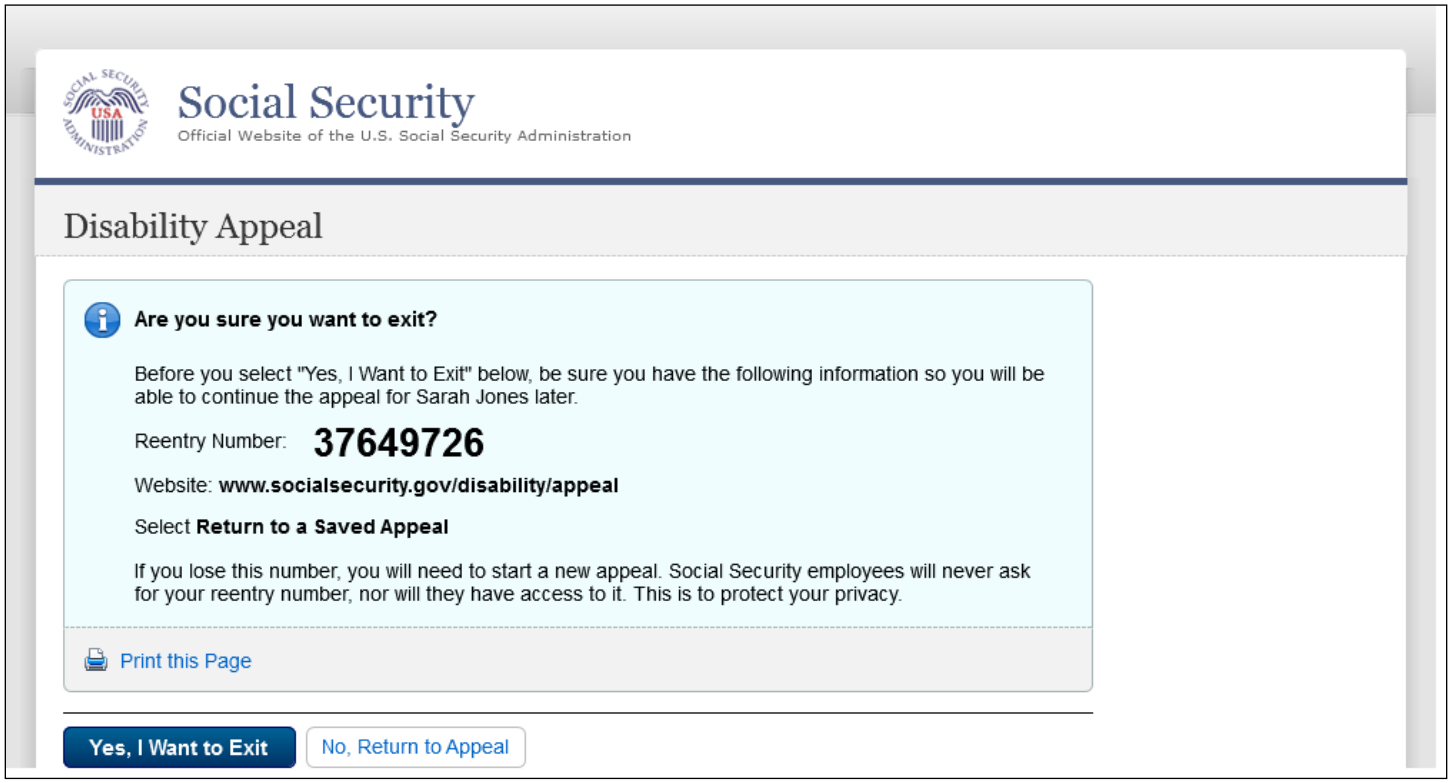


## 3.9. Reentry Number – 3rd Party: Email Selected

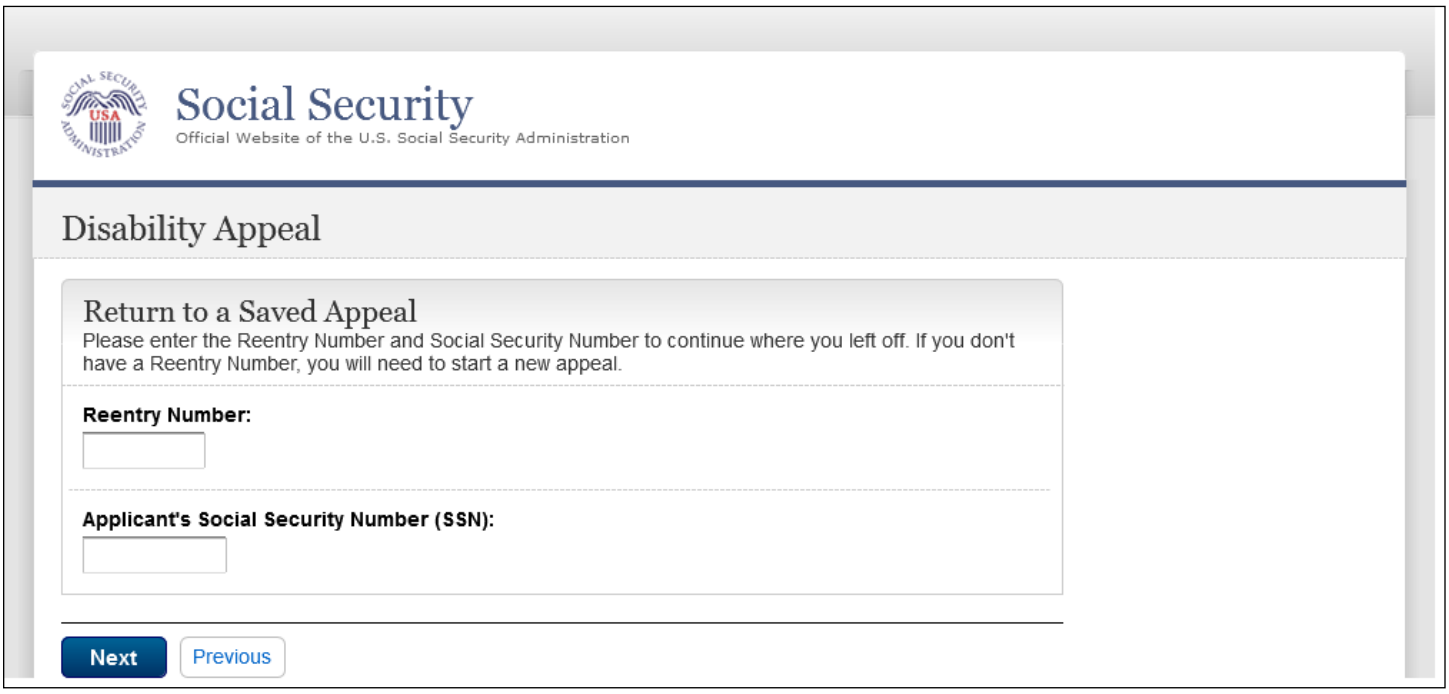
Option to enter email address is not provided if the user navigates back to this page and already provided an email address.



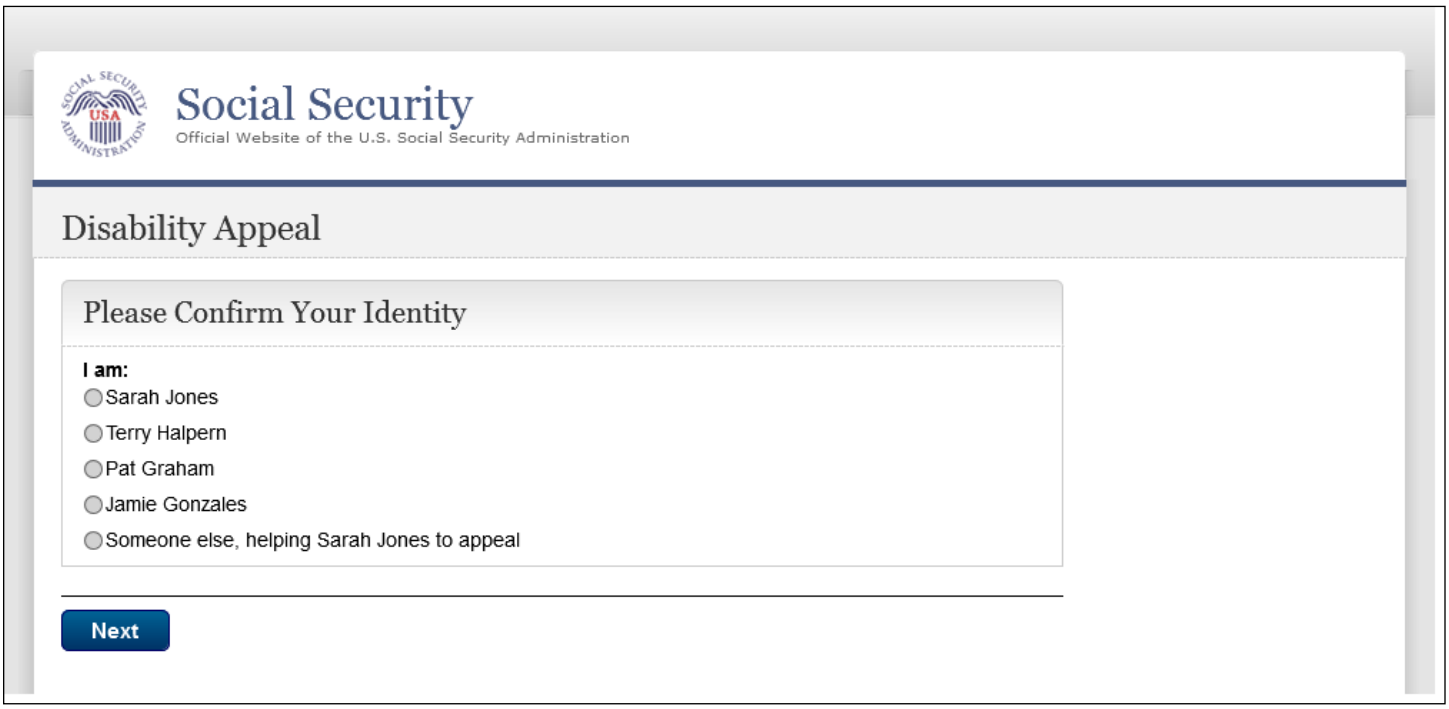
## 3.10. Are You Sure You Want to Exit – 3rd Party



## 3.11. Return to a Saved Appeal – 3rd Party



## 3.12. Who are You – 3rd Party

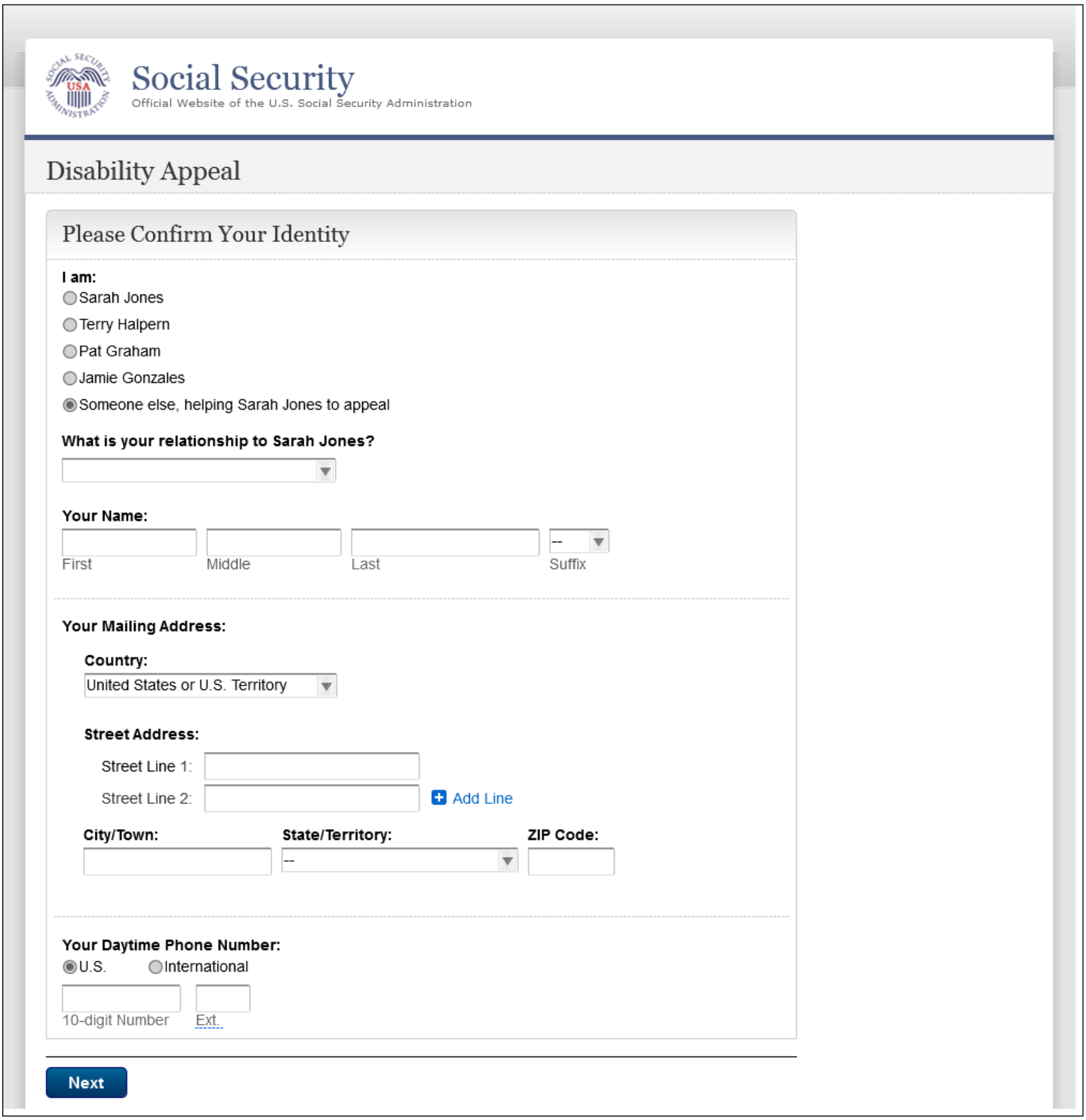



The possibilities for the radio list are determined based on data already provided in the claim. The names shown would correspond to the roles, which should be shown in the following order:

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

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

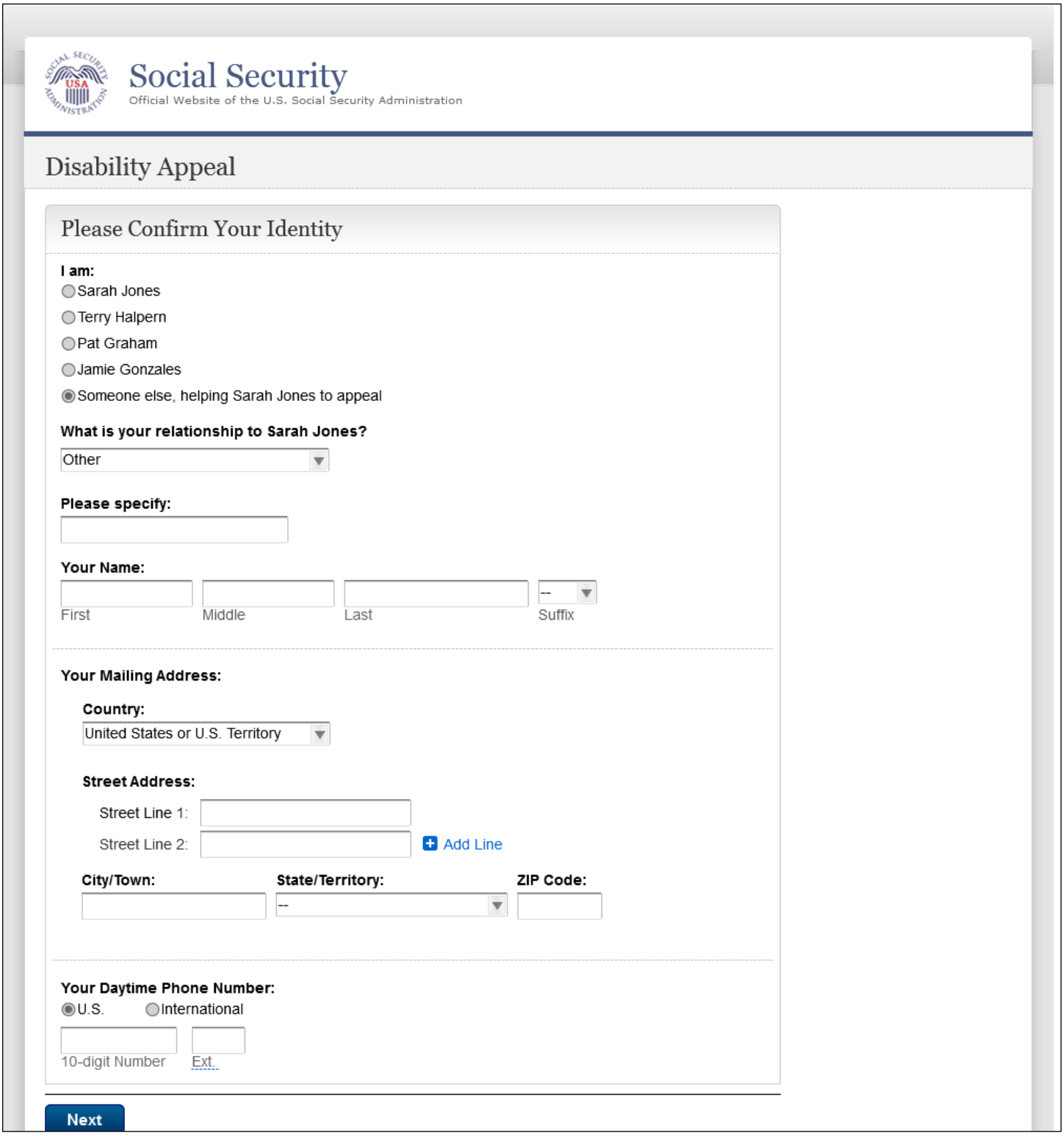
## 3.13. Who are You – 3rd Party: Someone Else



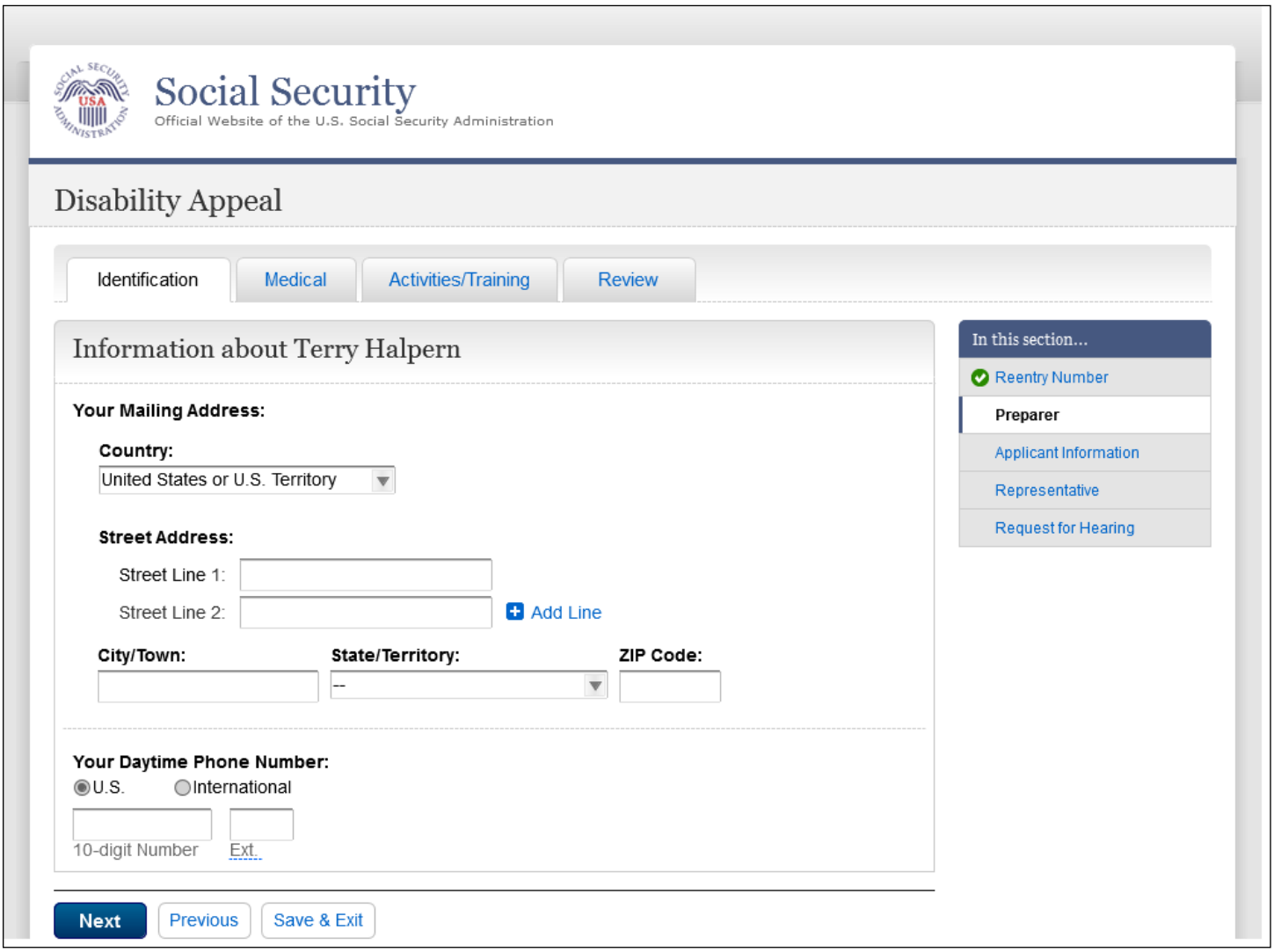
Contents of relationship drop list:

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

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

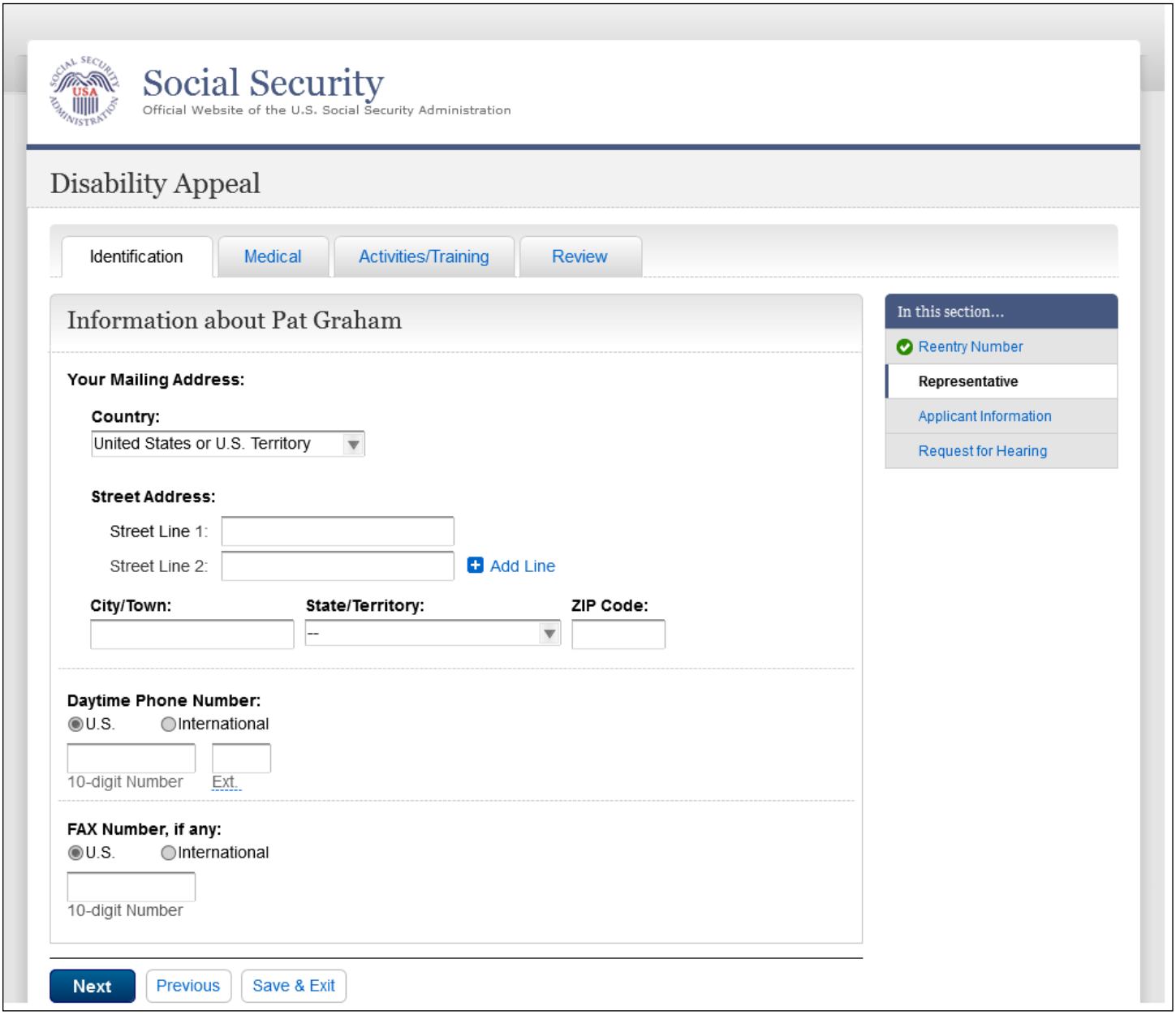


## 3.15. Preparer – 3rd Party



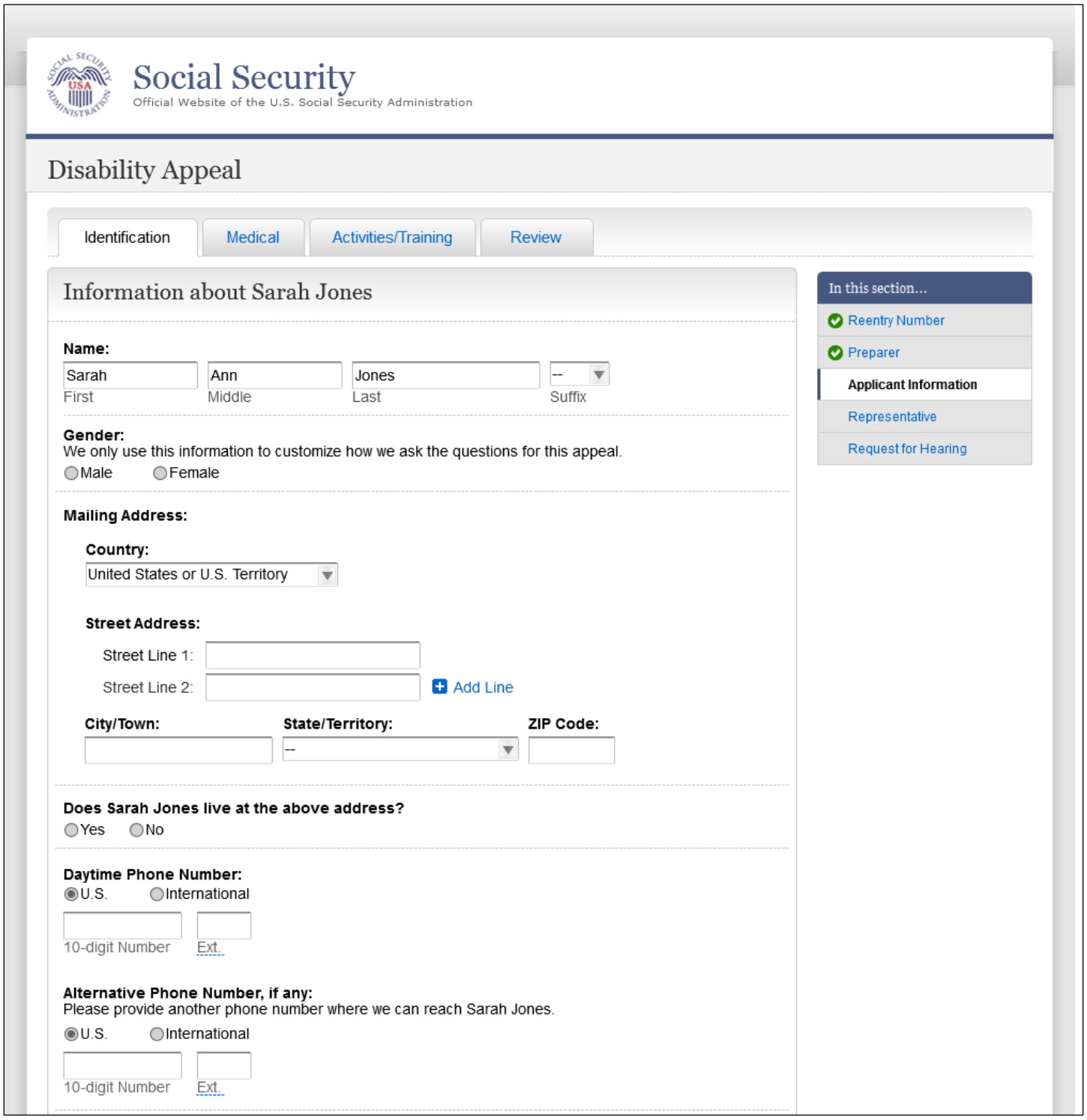
## 3.16. Rep Information – 3rd Party Professional Rep

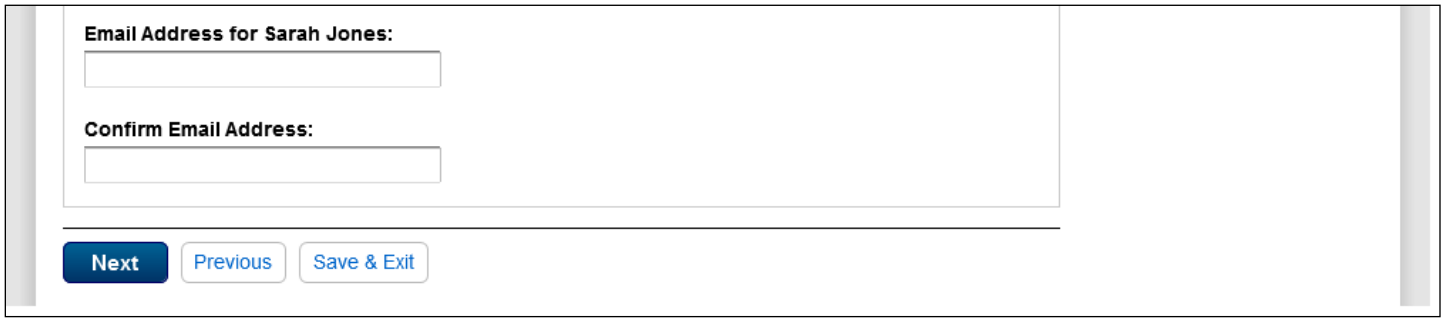
Note: the right-hand secondary navigation adjusts based on selections made in the screening stages. In this example, the representative is completing the appeal.



## 3.17. Applicant Info – 3rd Party

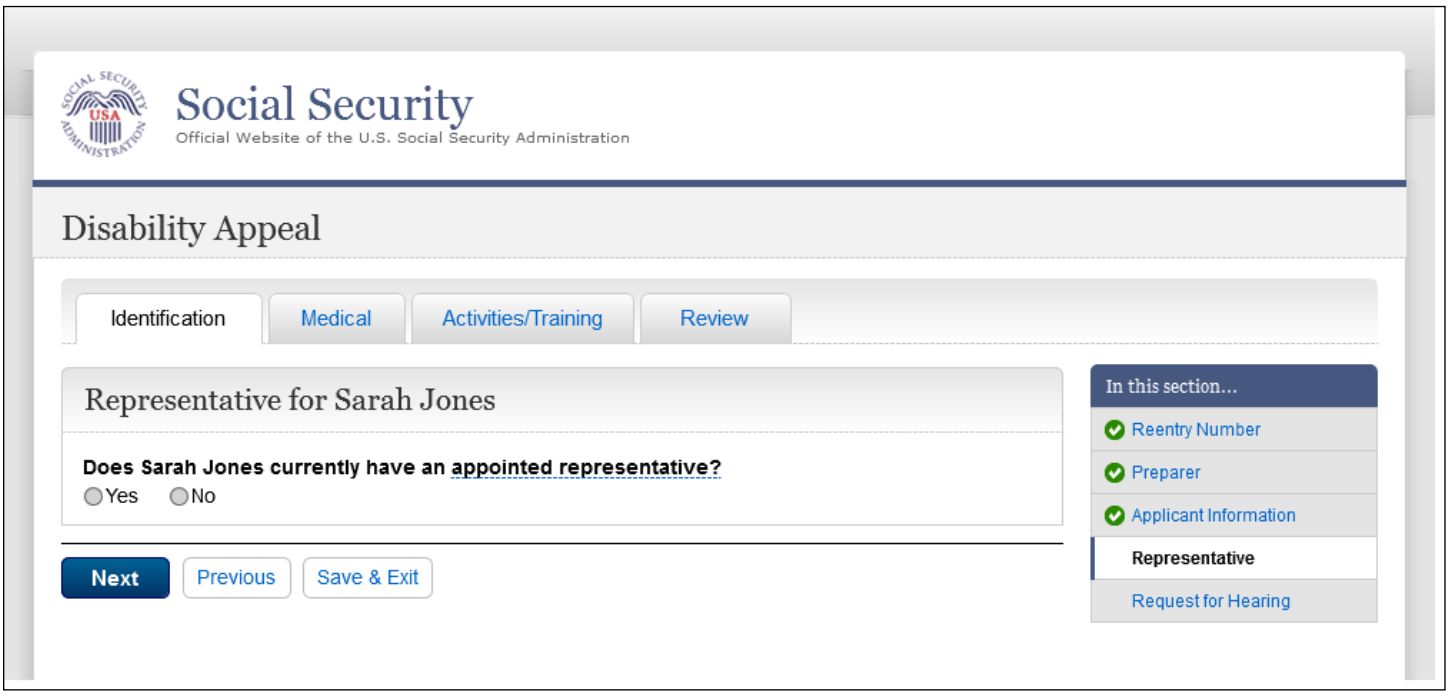
State is prefilled based on selection on screening page, if applicable. Gender is only asked of third parties.



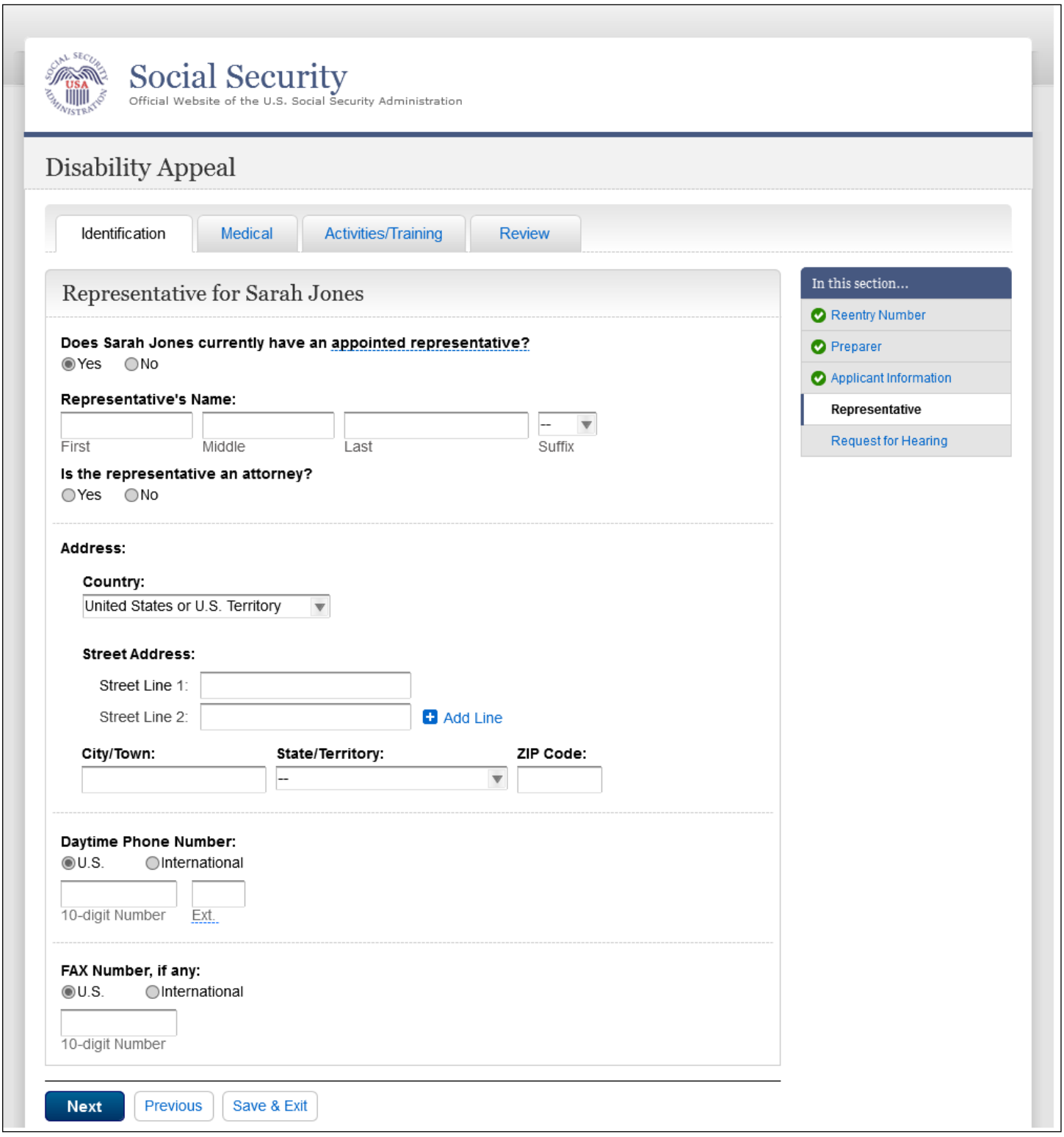

Email Address for Sarah Jones:
Confirm Email Address:
Next
Previous
Save & Exit

## 3.18. Rep – 3rd Party

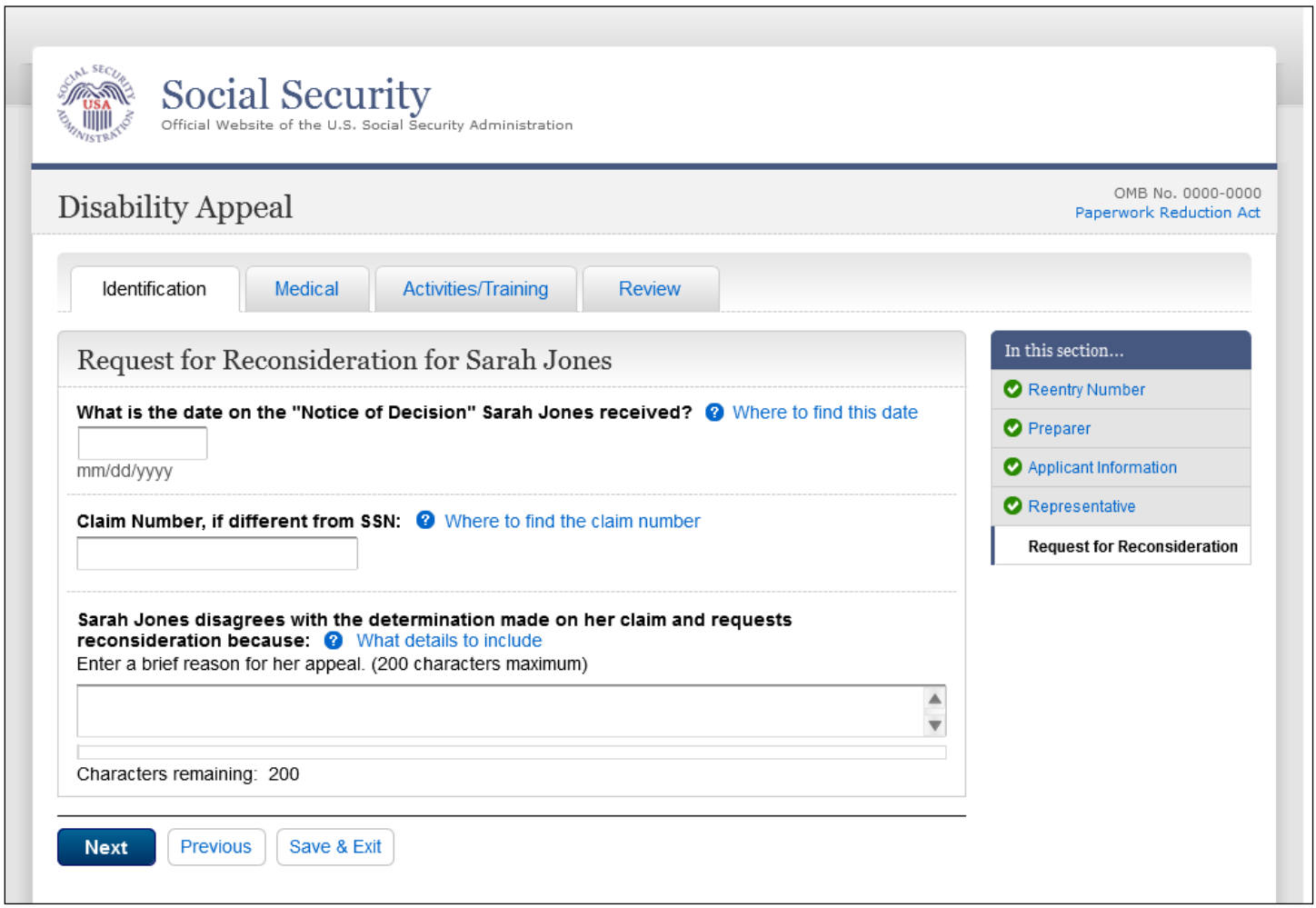
This version of the Representative page would be shown only if a representative has not already been identified.



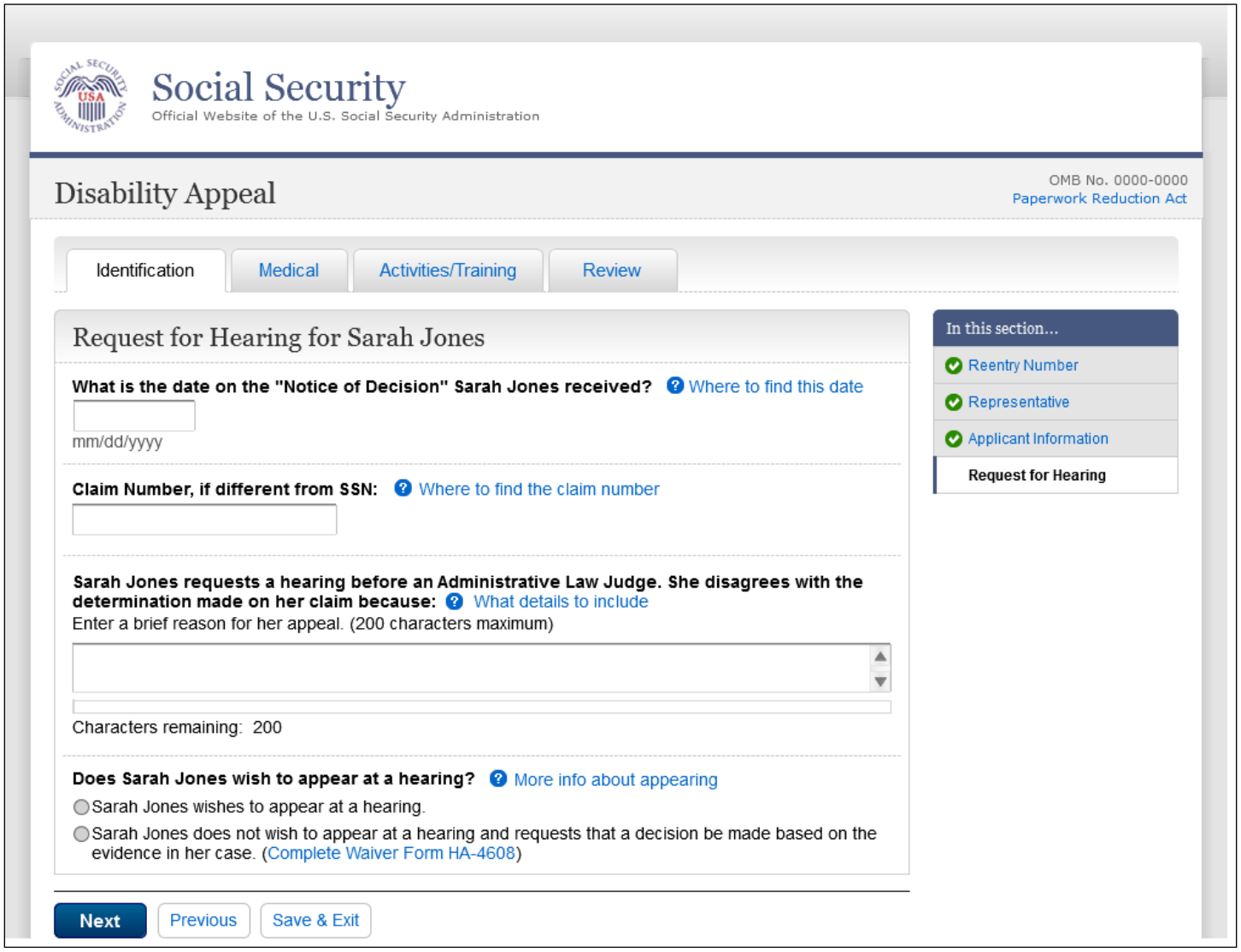
## 3.19. Rep – 3rd Party: Yes Selected



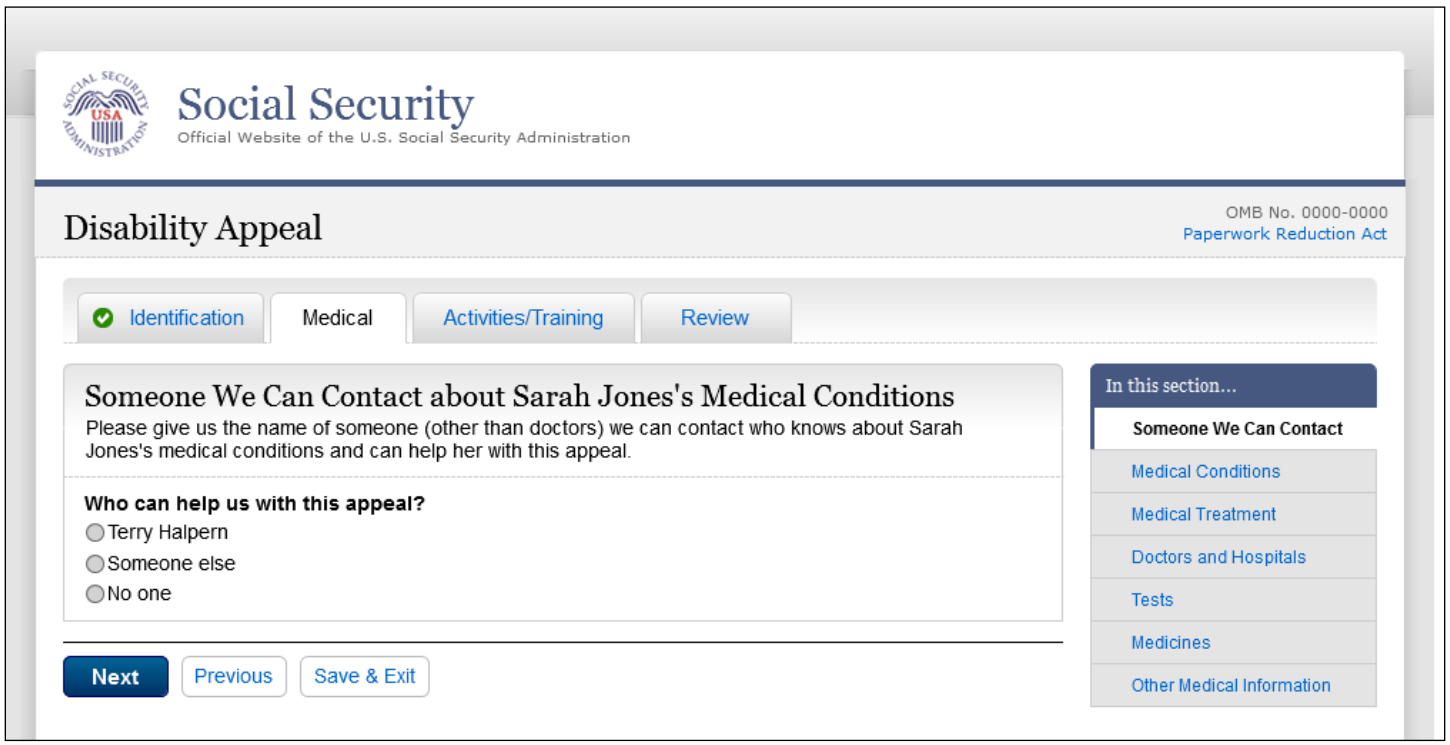
## 3.20. Request for Reconsideration – 3rd Party



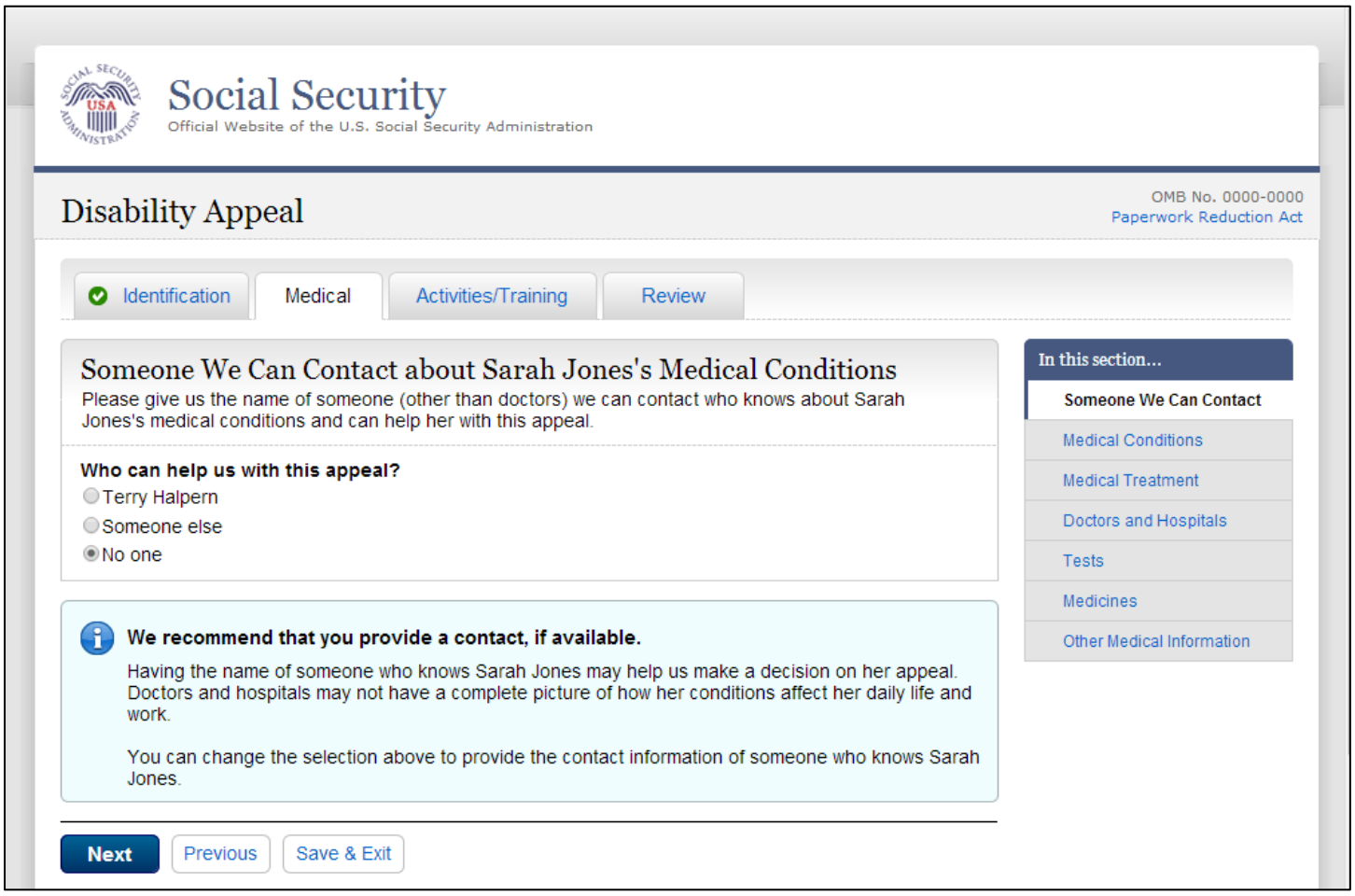
## 3.21. Request for Hearing – 3rd Party



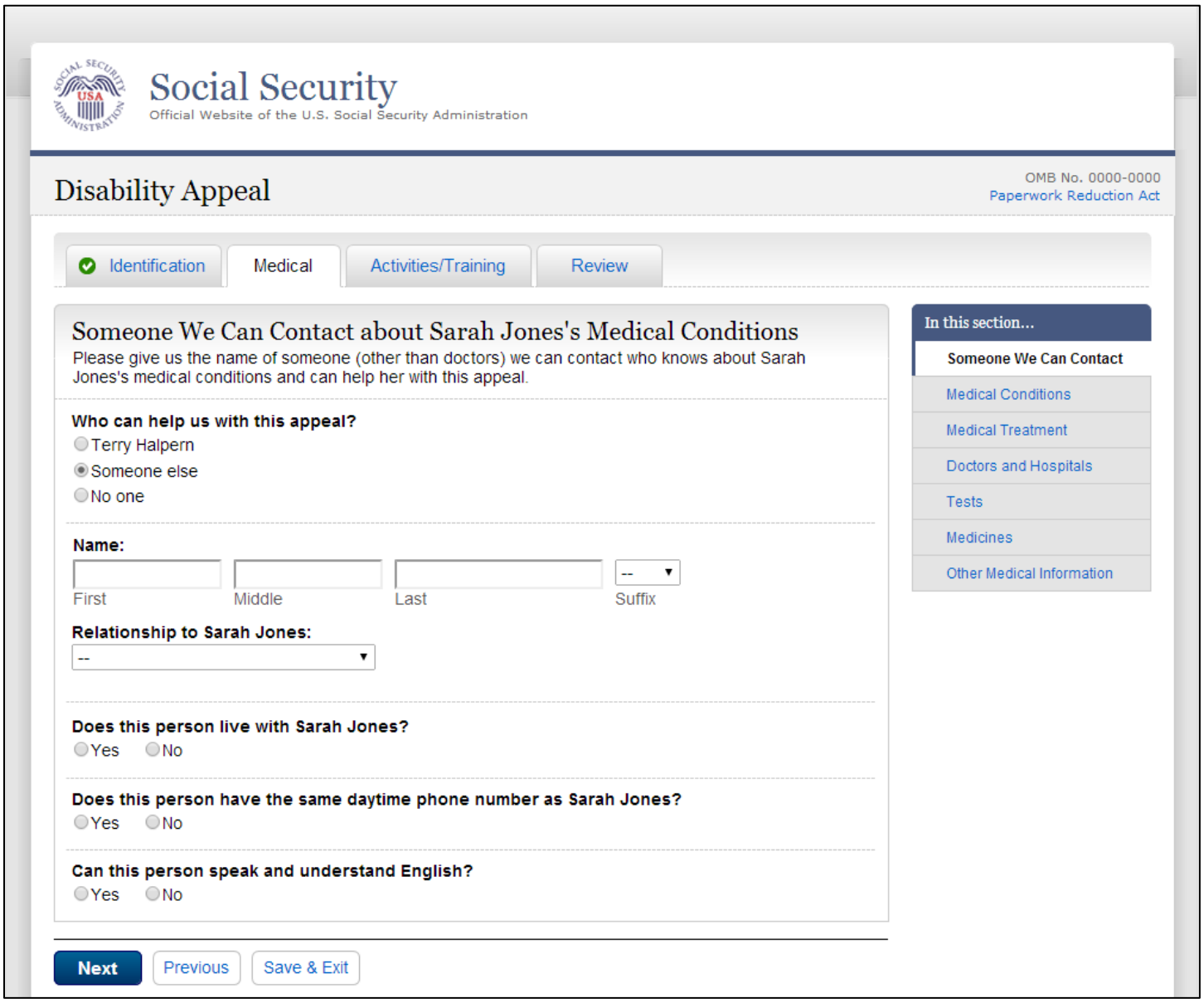
## 3.22. Someone We Can Contact – 3rd Party



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



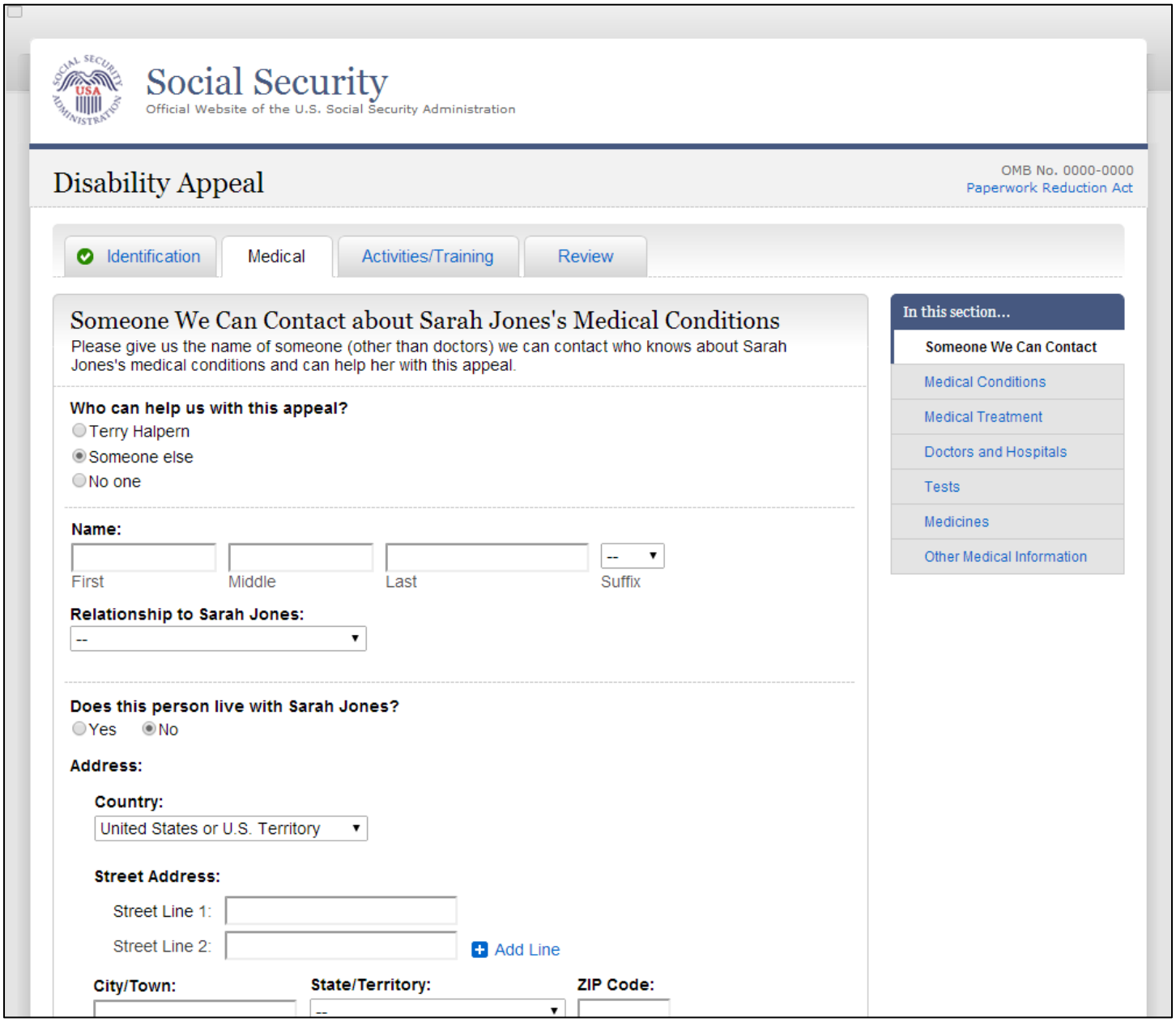
## 3.24. Someone We Can Contact – 3rd Party: Someone else selected

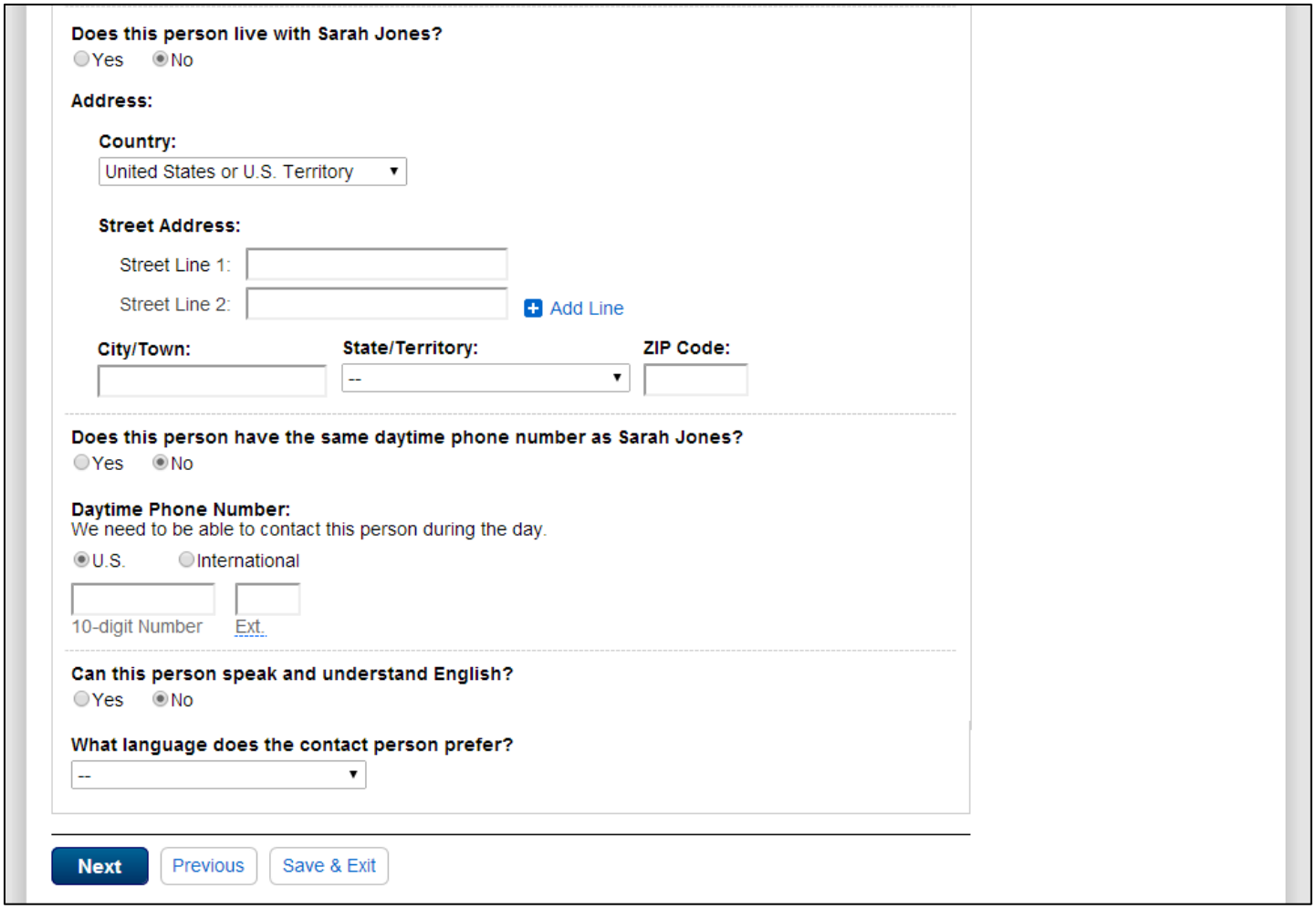



Contents of relationship drop list:

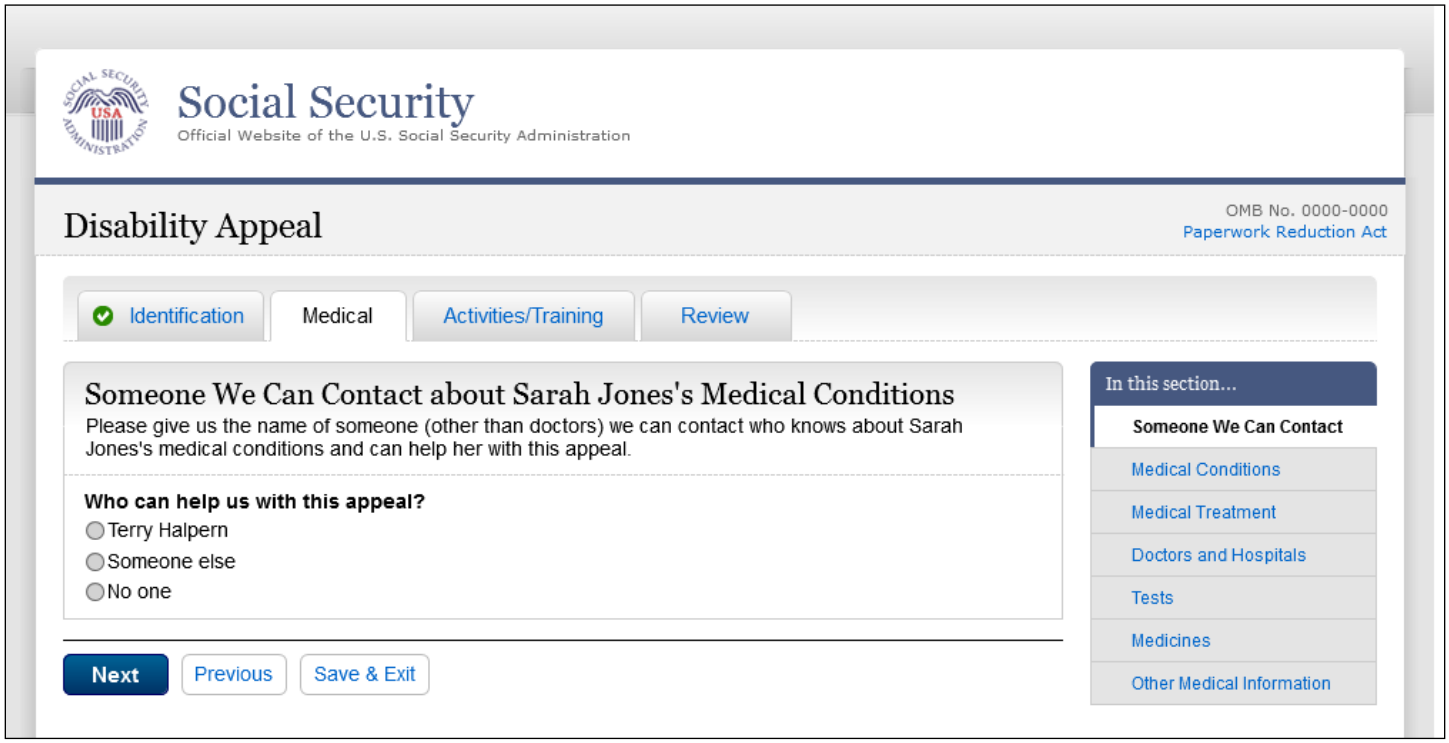
--
Family Member
Friend/Neighbor
Government Agency
Health Service Agency/Hospital
Non-Profit Organization/Legal Aid Group
Nursing Care Facility
Social Worker
Other

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

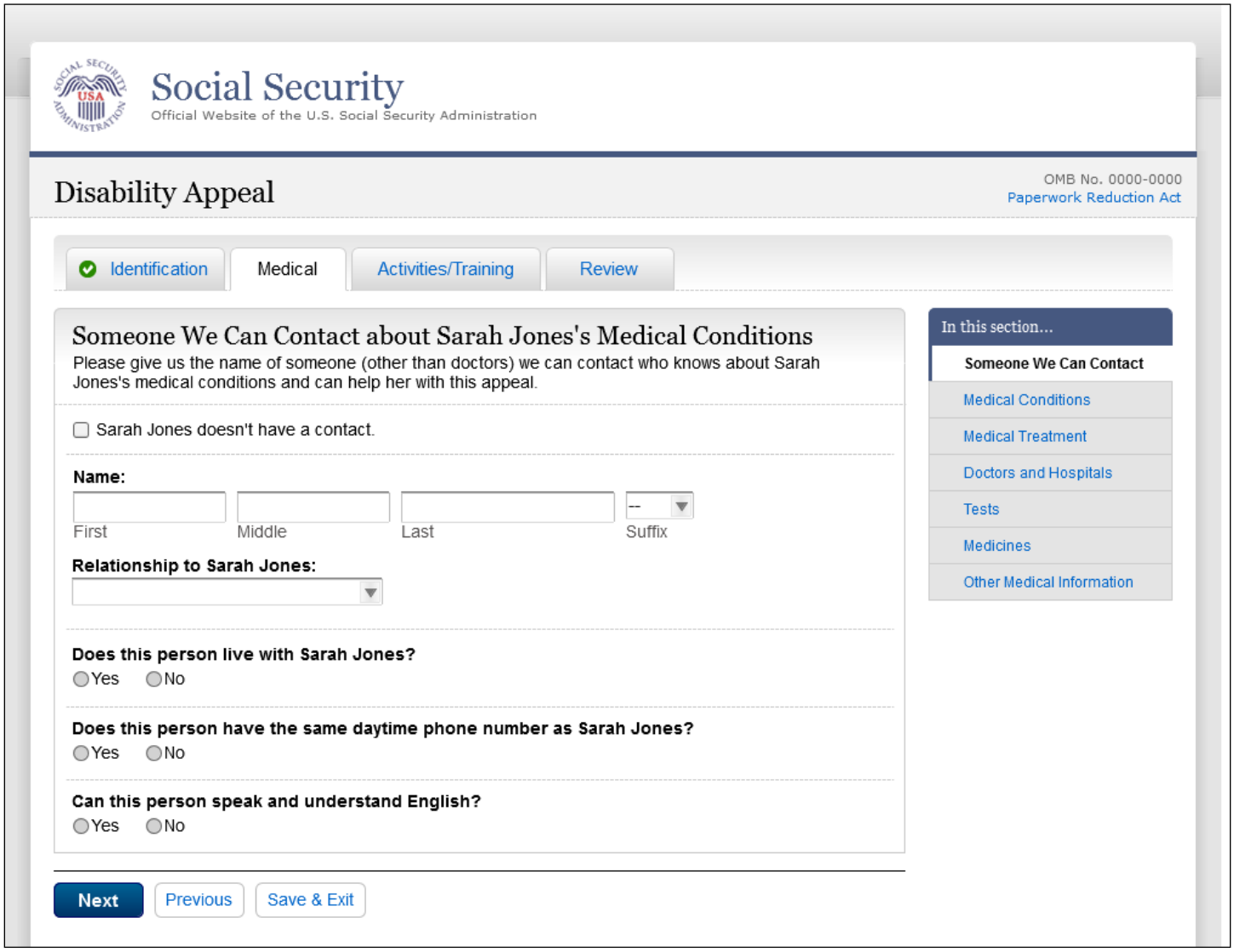



Does this person live with Sarah Jones?
Yes
No
Address:
Country:
United States or U.S. Territory
Street Address:
Street Line 1:
Street Line 2:
Add Line
City/Town:
State/Territory:
--
ZIP Code:
Does this person have the same daytime phone number as Sarah Jones?
Yes
No
Daytime Phone Number:
We need to be able to contact this person during the day.
U.S.
International
10-digit Number
Ext.
Can this person speak and understand English?
Yes
No
What language does the contact person prefer?
--
Next
Previous
Save & Exit

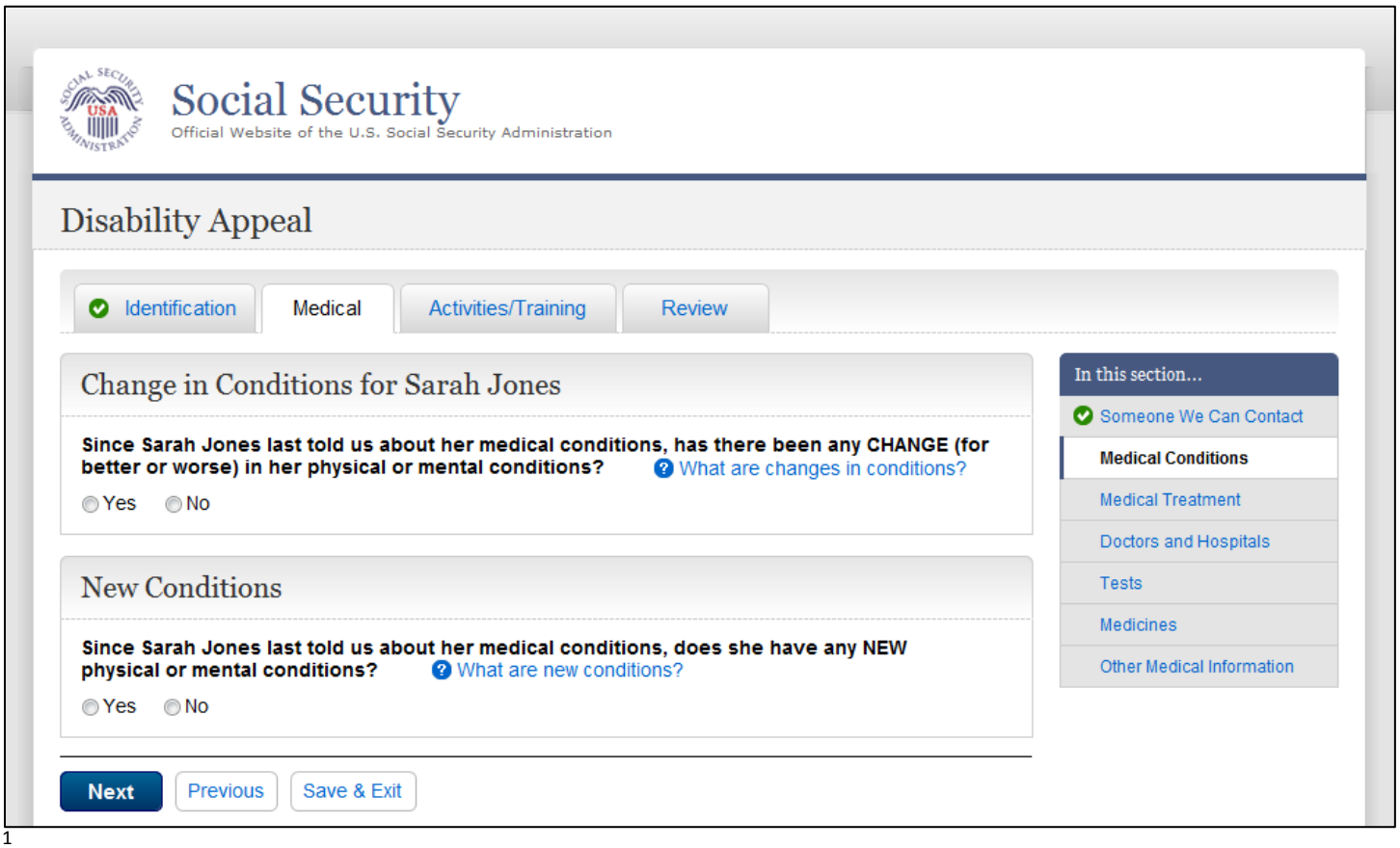
## 3.26. Someone We Can Contact – 3rd Party: Terry Halpern selected



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



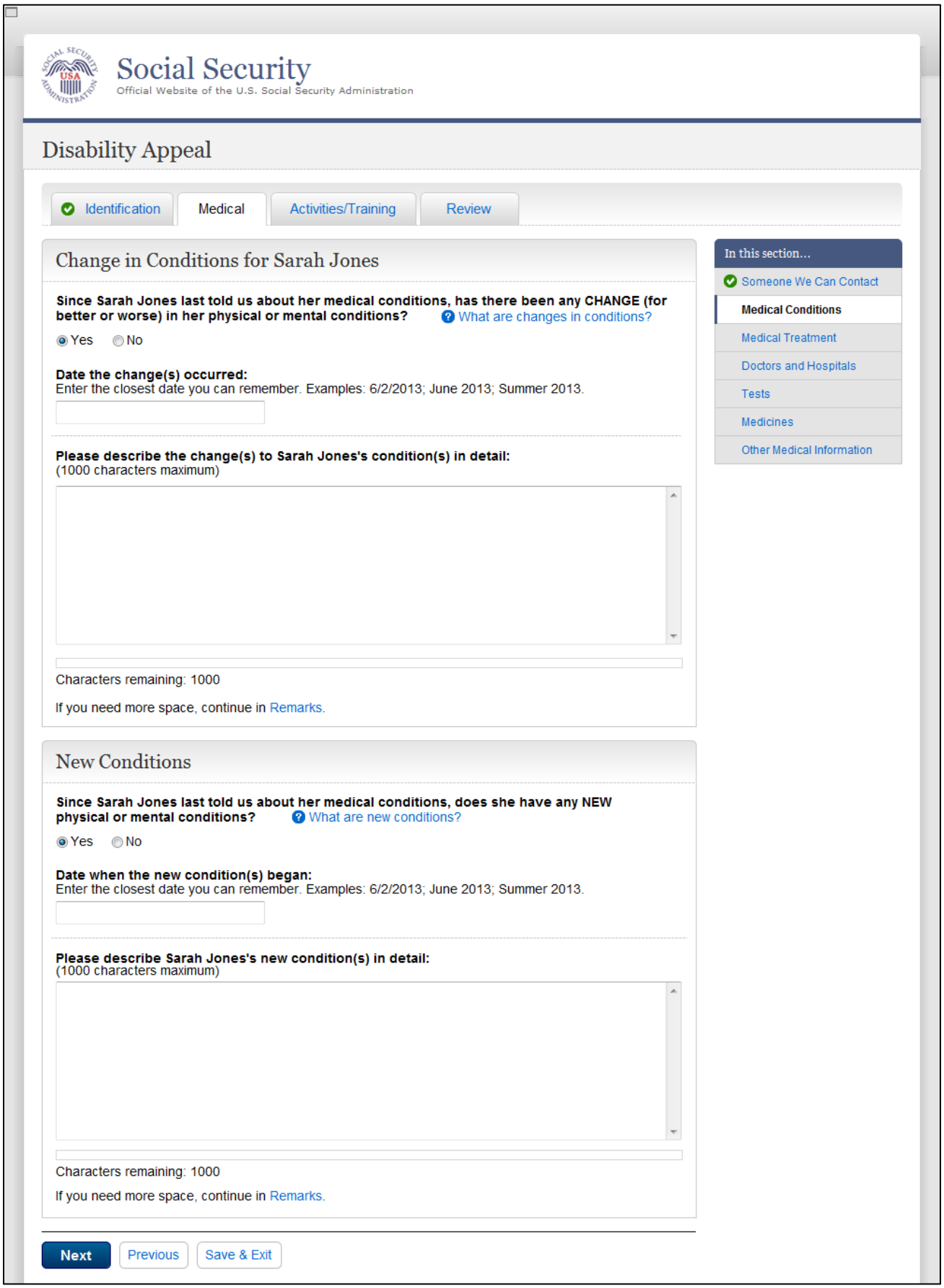
## 3.28. Section3: Medical Conditions – 3rd Party



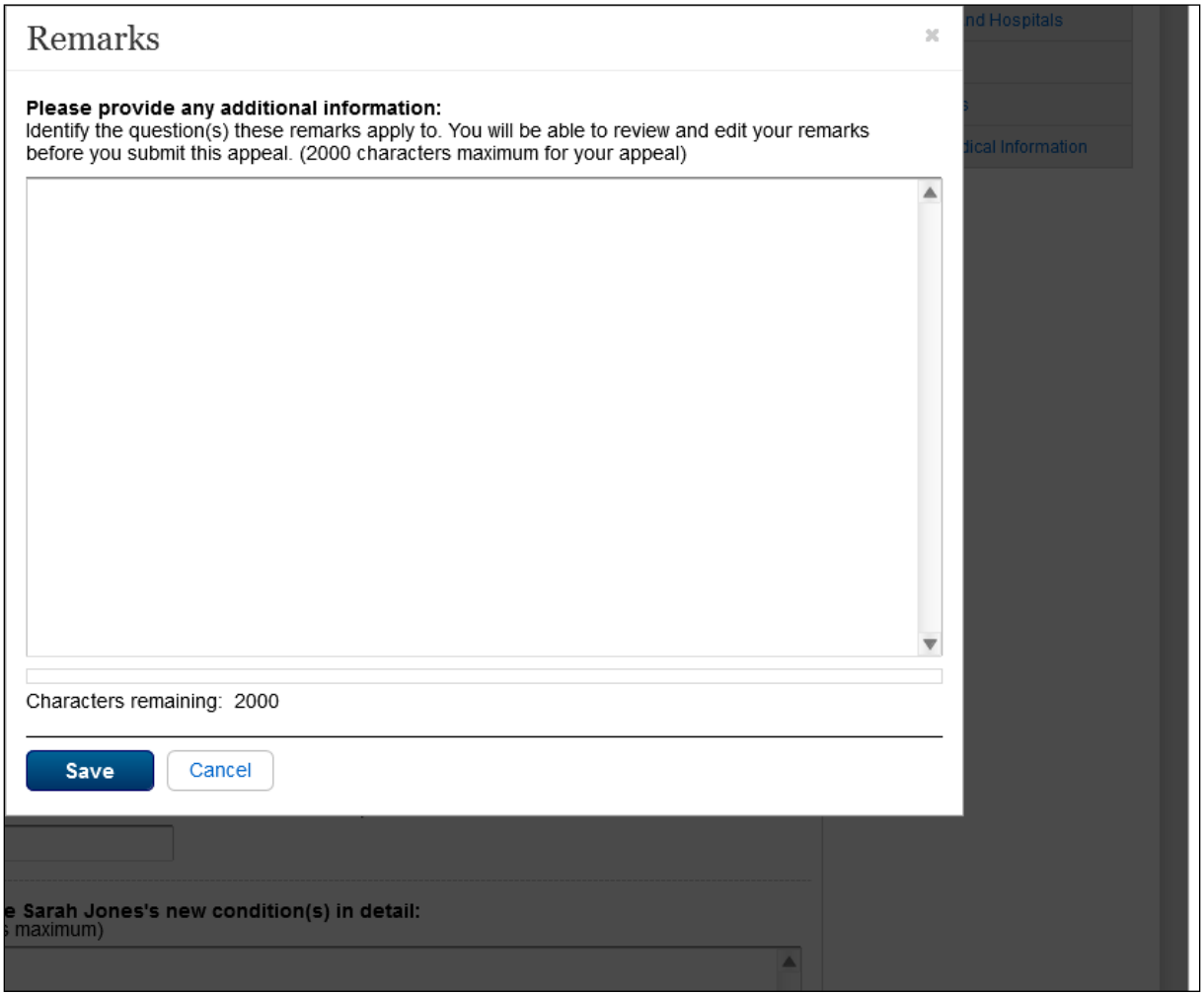
1

[1] Note: the language for these questions has been changed per stakeholders. It does not reflect the recommendation of the User Experience Group.

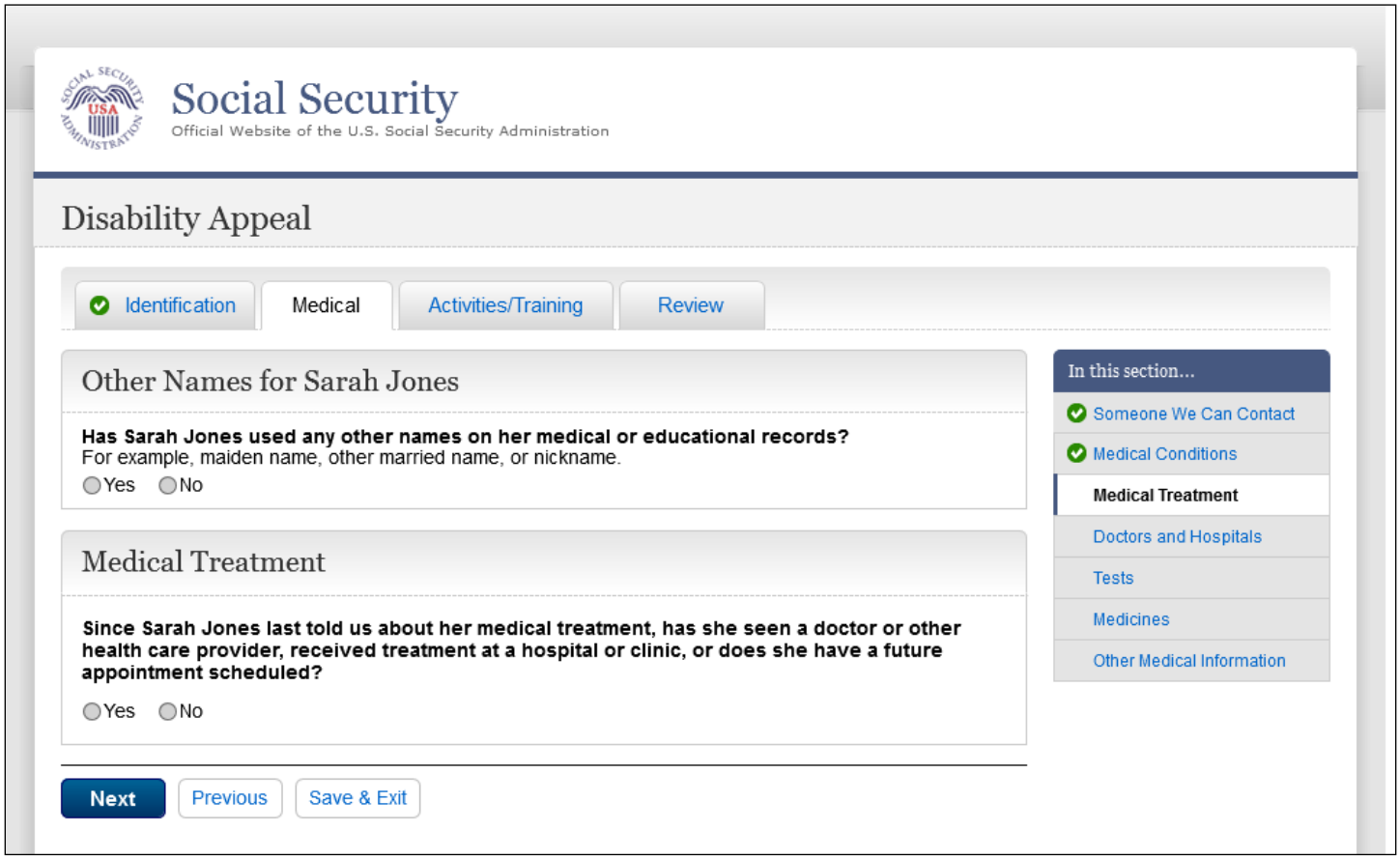
## 3.29. Section3: Medical Conditions – 3rd Party: Follow up questions



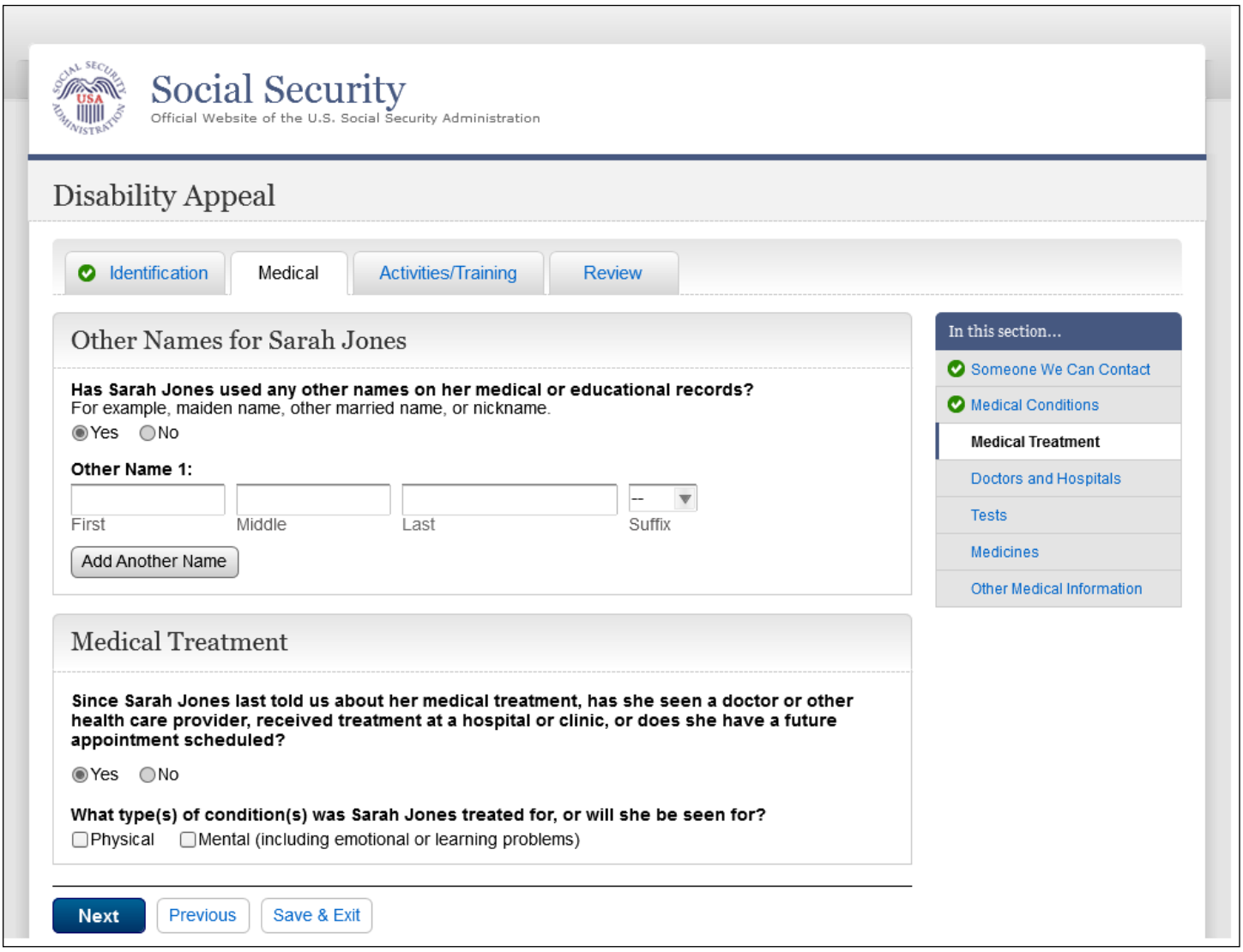
## 3.30. Section3: Medical Conditions – 3rd Party: Remarks Pop Up



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

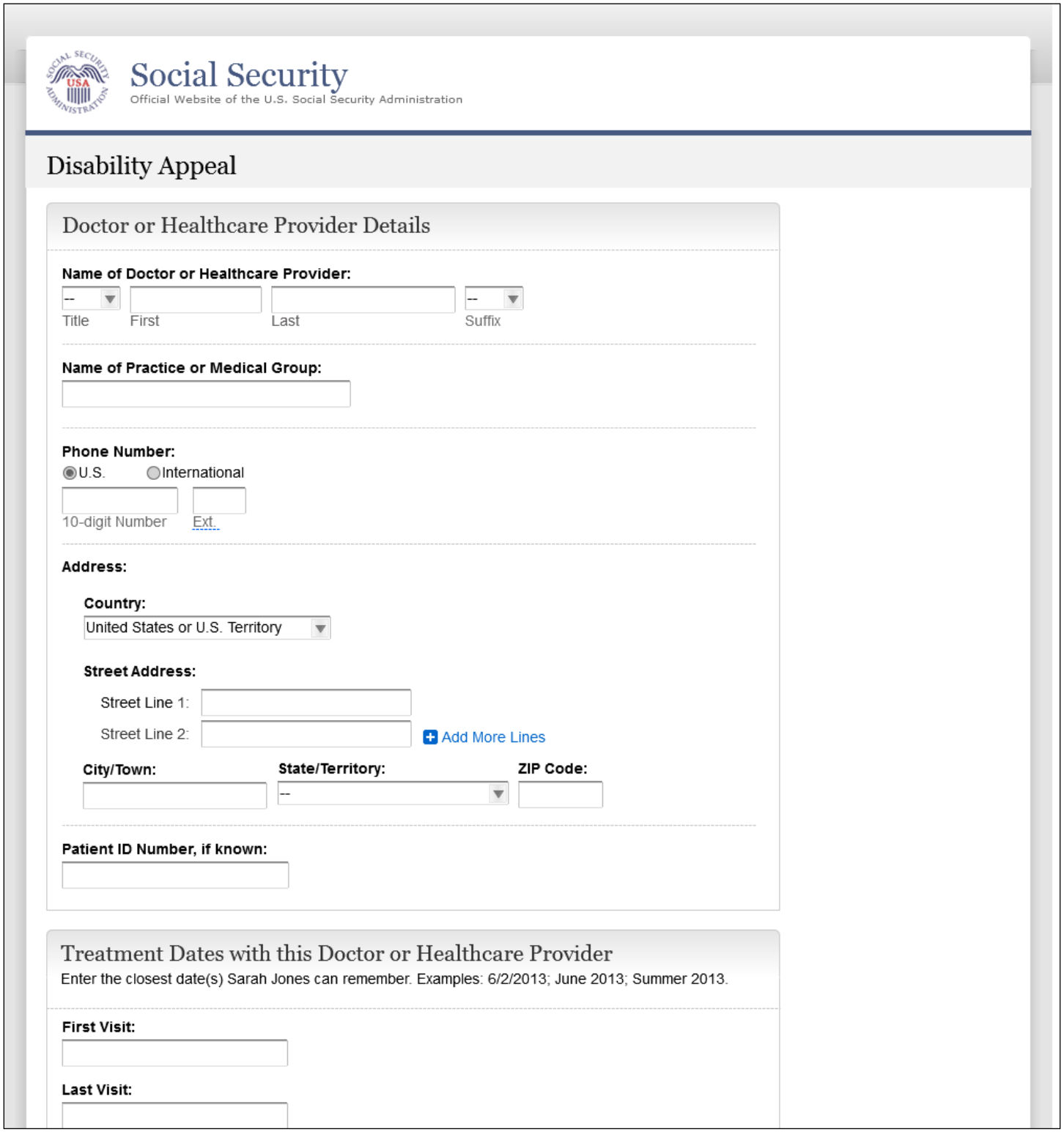


## 3.32. Section4: Medical Treatment – 3rd Party: Follow up questions



## 3.33. Doctors & Hospitals – 3rd Party

## 3.34. Add New Doctors – 3rd Party



**Next Scheduled Appointment, if any:**

## Medical Conditions Treated by this Doctor or Healthcare Provider

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

Characters remaining: 1000

## Treatment from this Doctor or Healthcare Provider

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

Characters remaining: 1000

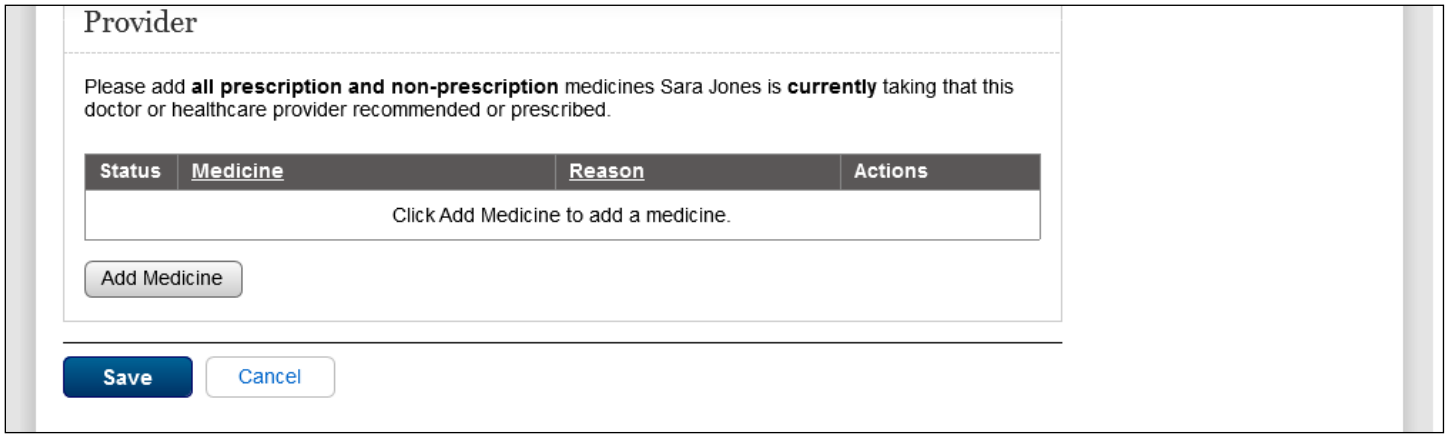
## Tests Ordered by this Doctor or Healthcare Provider

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

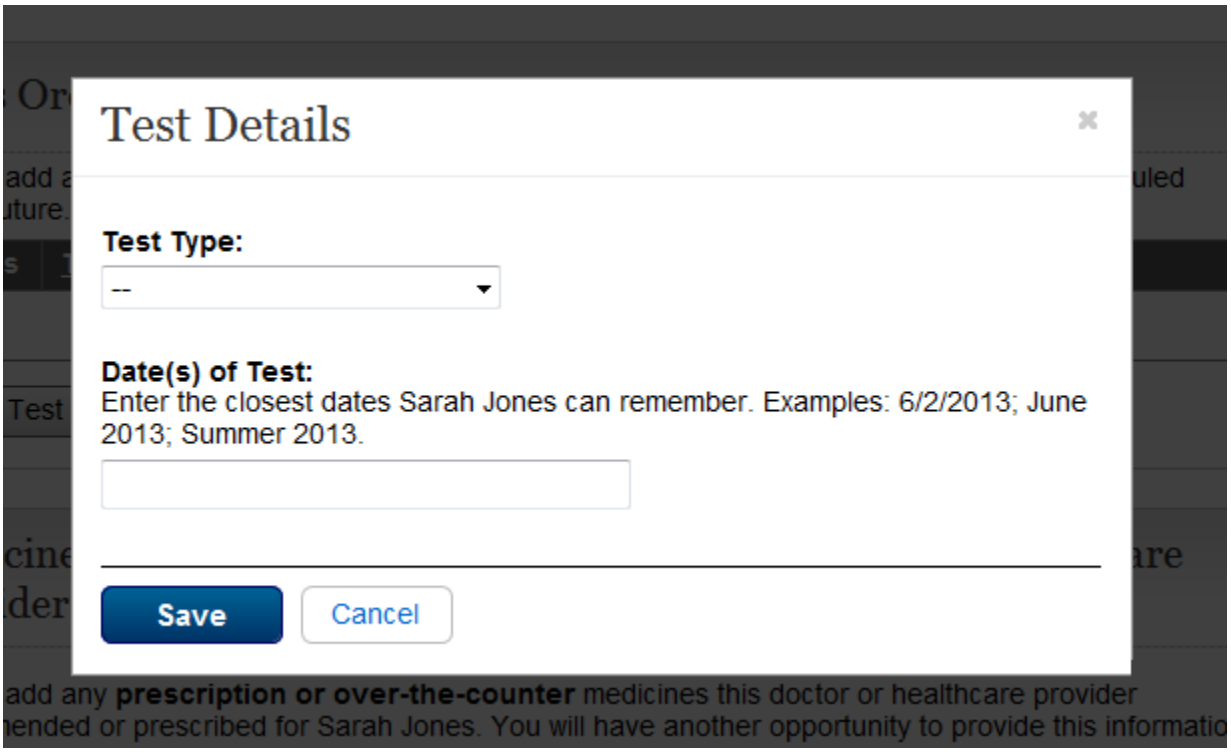
| Status | Test Type | Actions |
|---|---|---|
| Click Add Test to add a test. | | |

Add Test

## Medicines Recommended or Prescribed by this Doctor or Healthcare


Provider
Please add all prescription and non-prescription medicines Sara Jones is currently taking that this doctor or healthcare provider recommended or prescribed.
Status
Medicine
Reason
Actions
Click Add Medicine to add a medicine.
Add Medicine
Save
Cancel

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




Contents of "Test Type" drop list:

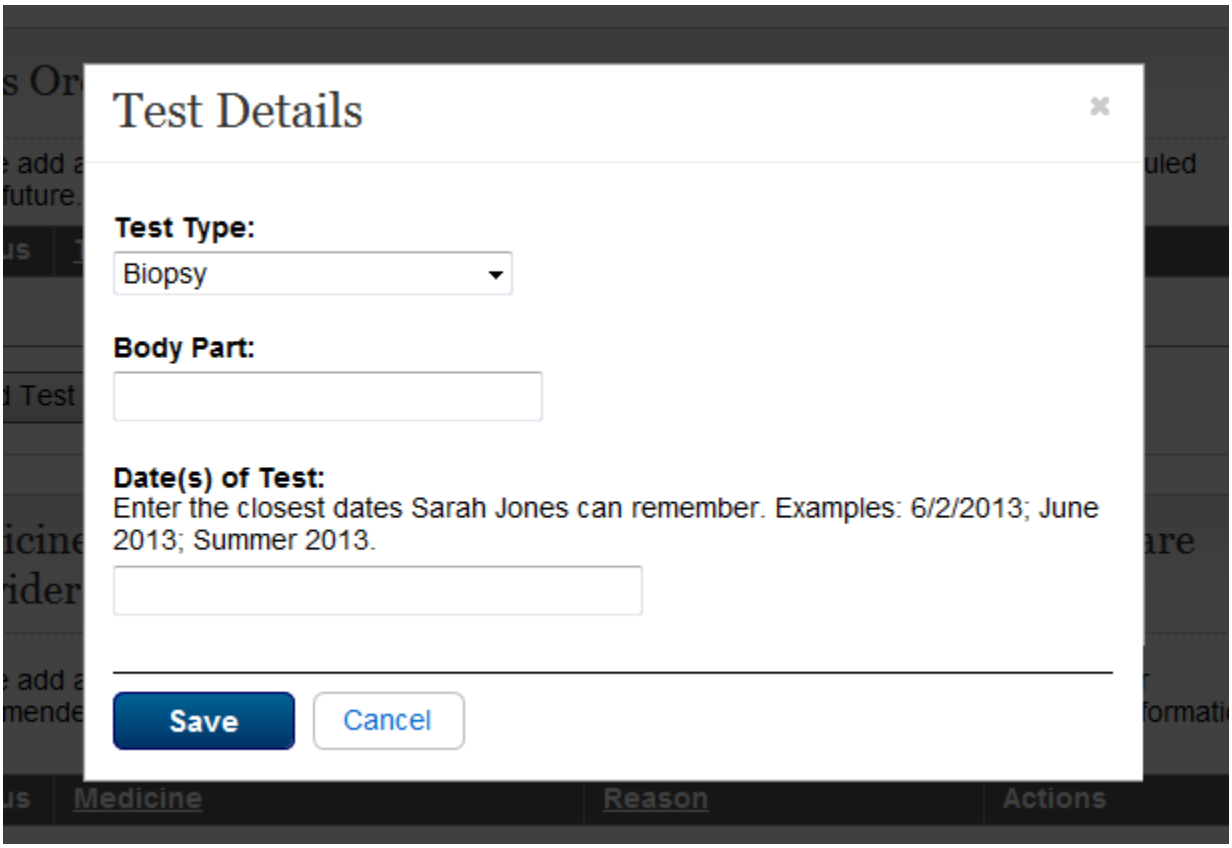
- --
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

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

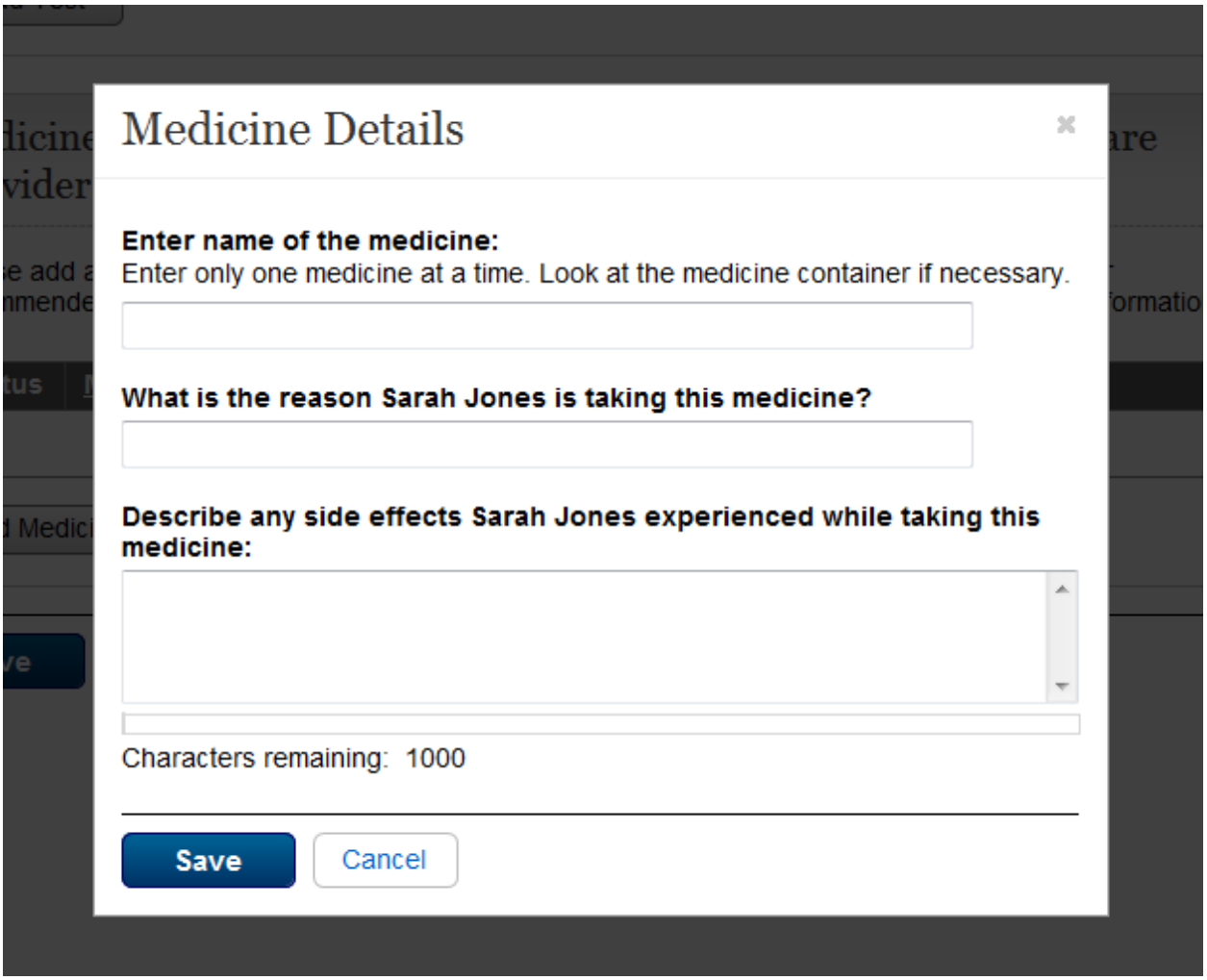
- Biopsy
- X-Ray
- Other

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

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

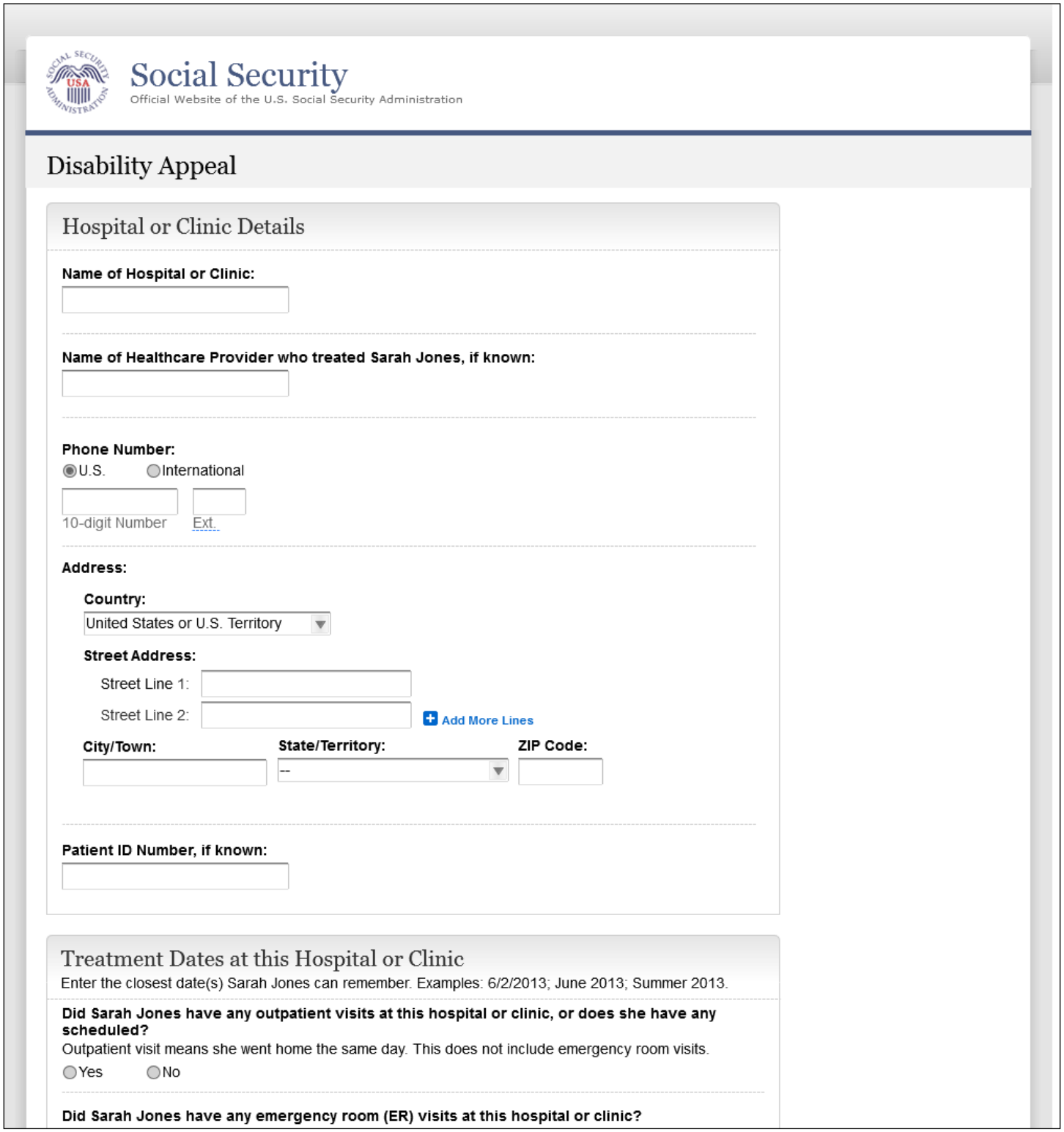


### 3.37. Add New Doctors – 3rd Party: Medicine Popup



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

## 3.39. Add New Hospitals – 3rd Party



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

◯ Yes ◯ No

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

◯ Yes ◯ No

## Medical Conditions Treated by this Hospital or Clinic

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

Characters remaining: 1000

## Treatment from this Hospital or Clinic

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

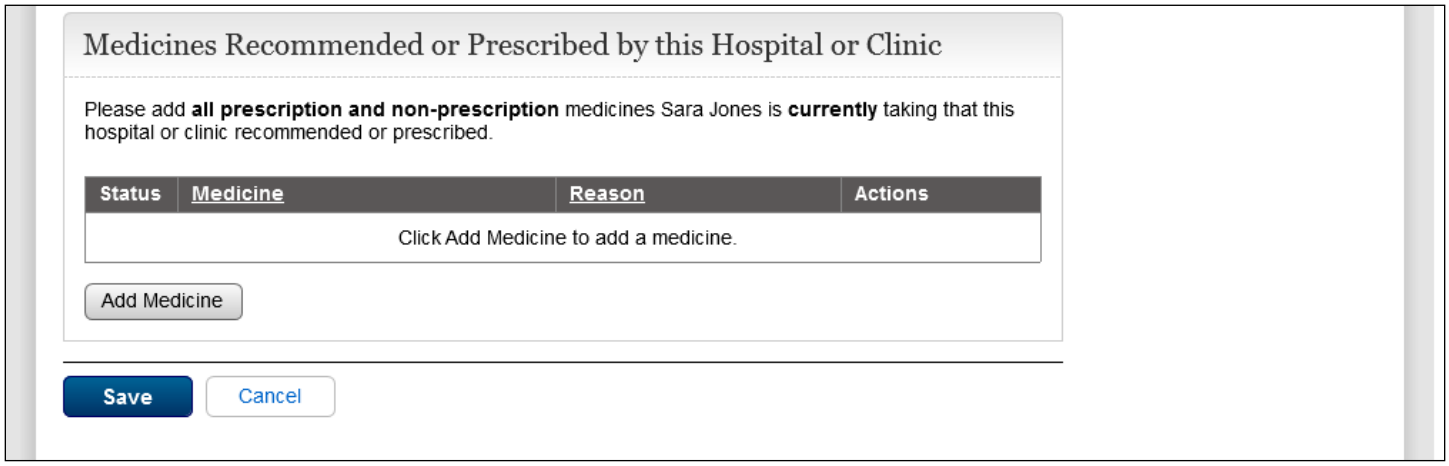
Characters remaining: 1000

## Tests Ordered at this Hospital or Clinic

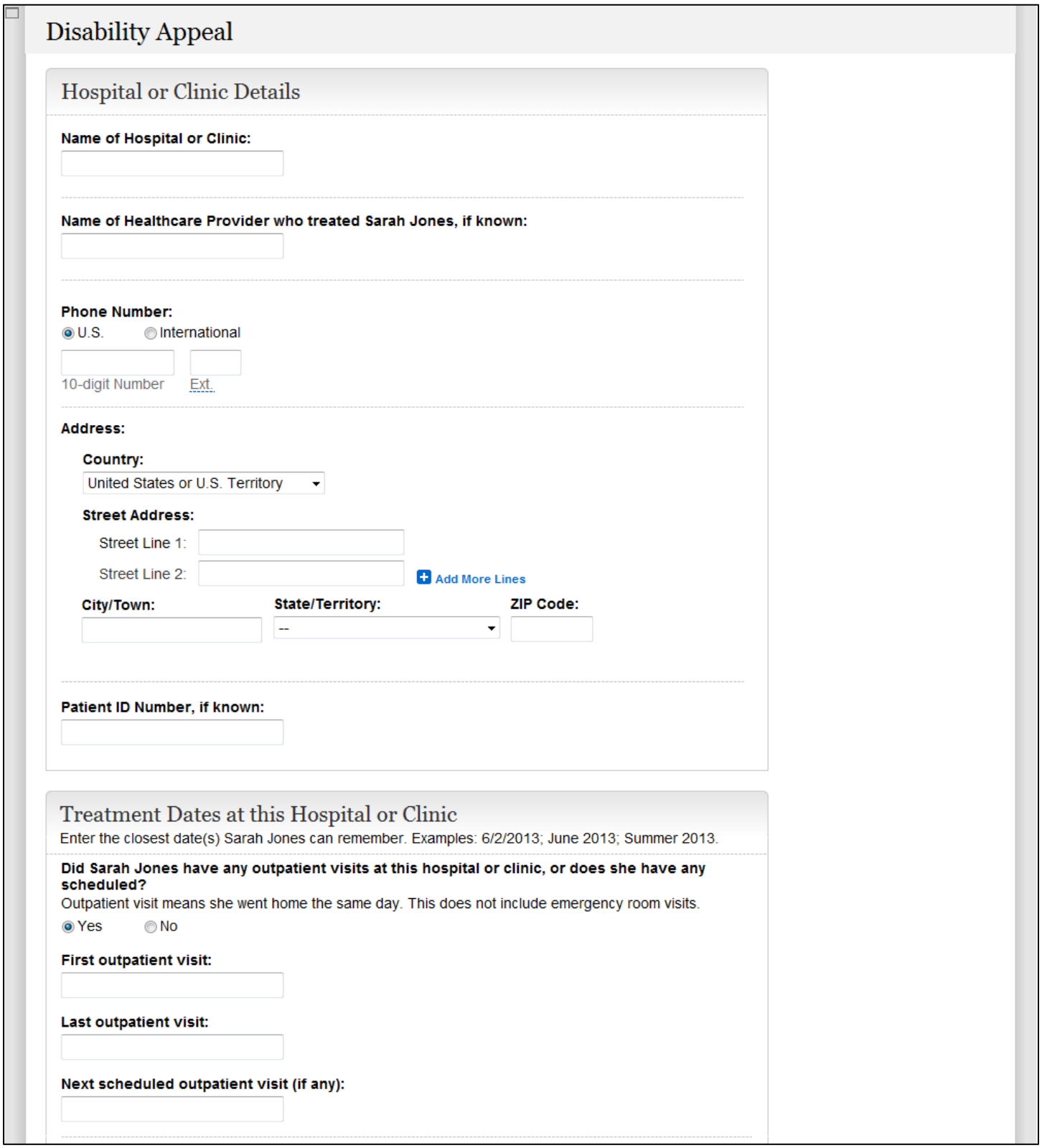
Please add any tests this hospital or clinic ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.

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

Add Test


Medicines Recommended or Prescribed by this Hospital or Clinic
Please add all prescription and non-prescription medicines Sara Jones is currently taking that this hospital or clinic recommended or prescribed.
Status
Medicine
Reason
Actions
Click Add Medicine to add a medicine.
Add Medicine
Save
Cancel

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



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

◉ Yes ○ No

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

**Emergency Room Visit 1:**

**Emergency Room Visit 2:**

**Emergency Room Visit 3:**

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

◉ Yes ○ No

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

**Visit 1:**

Date In Date Out

**Visit 2:**

Date In Date Out

**Visit 3:**

Date In Date Out

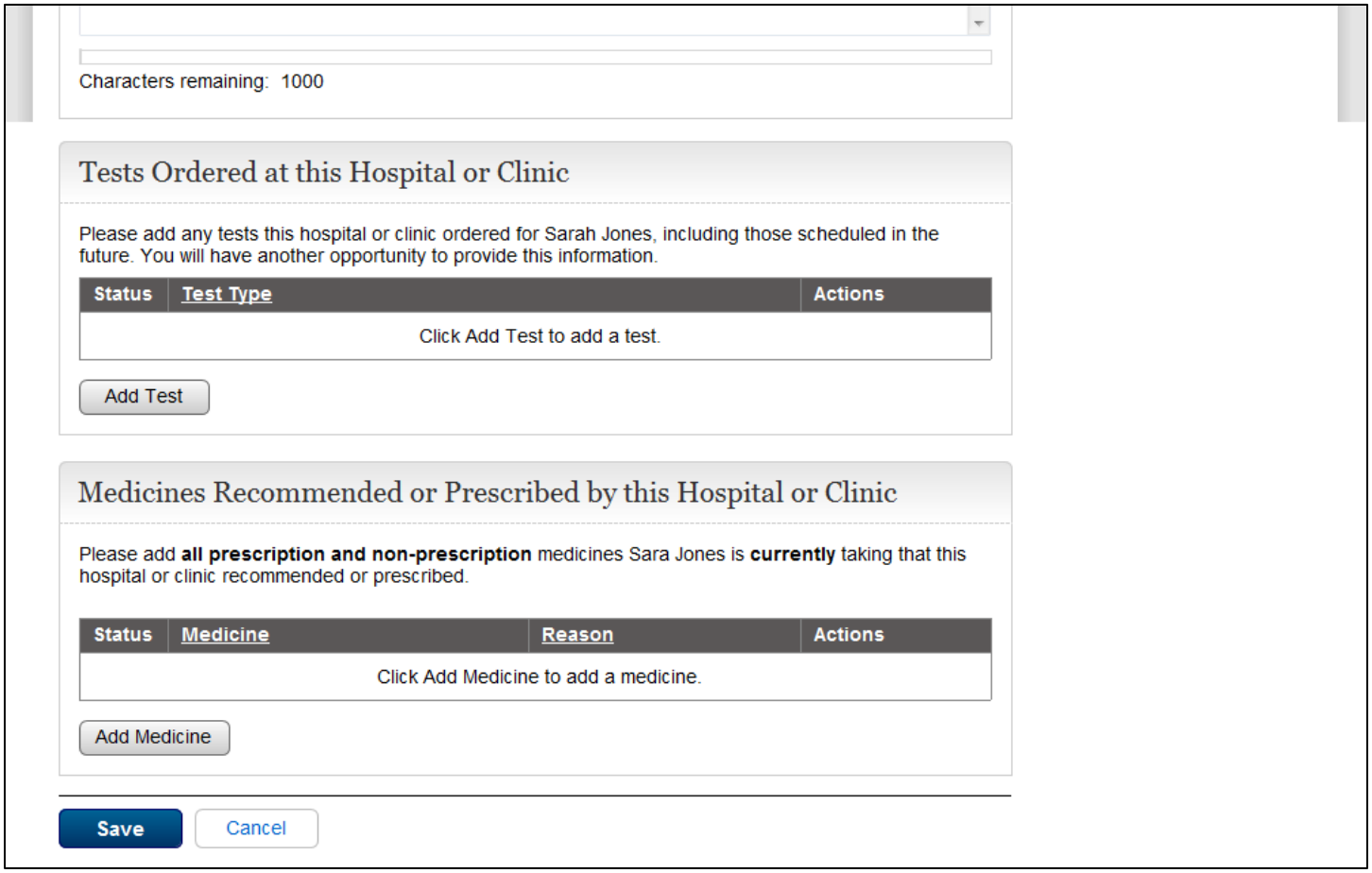
## Medical Conditions Treated by this Hospital or Clinic

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

Characters remaining: 1000

## Treatment from this Hospital or Clinic

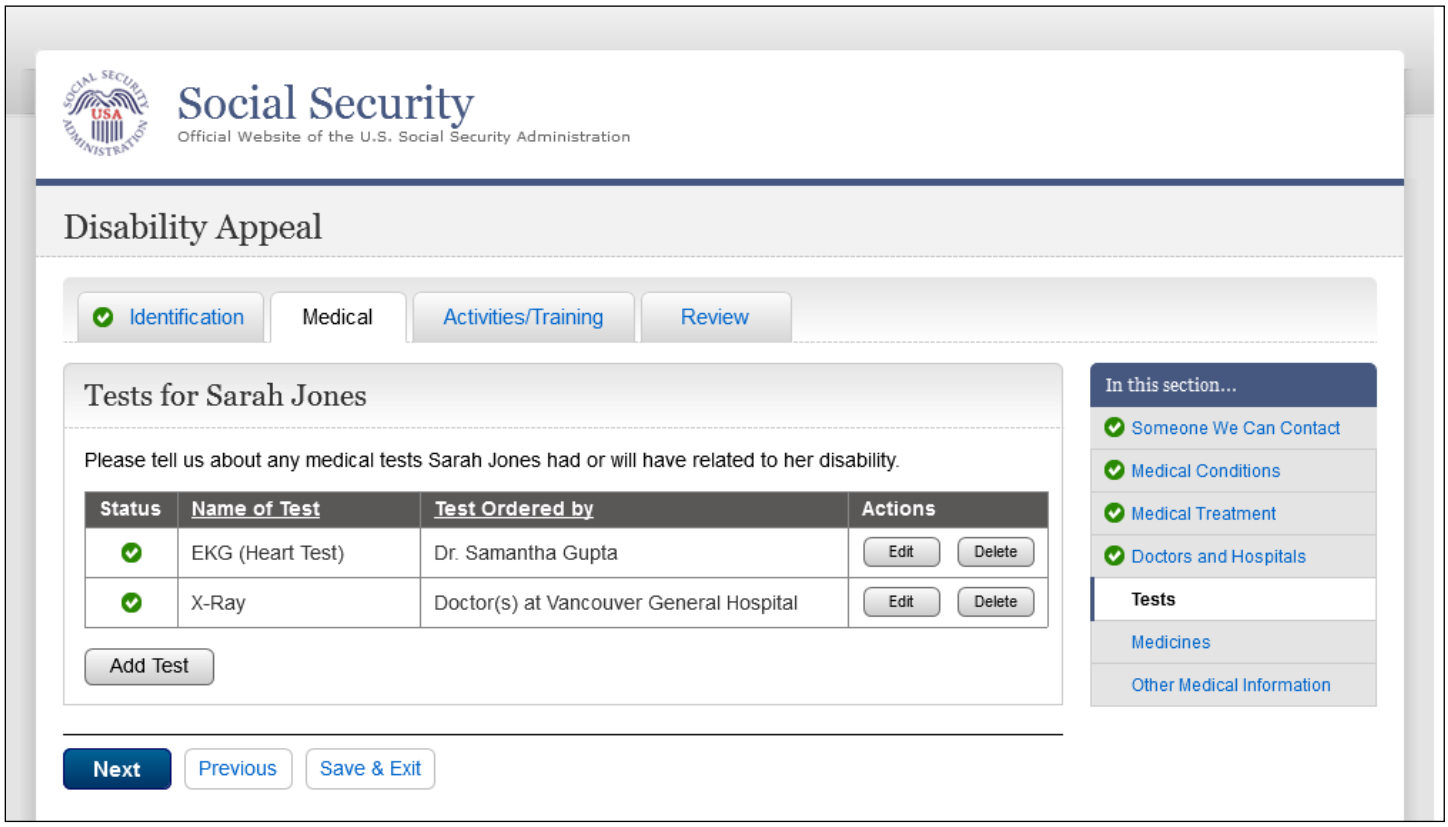
**What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?**
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)


Characters remaining: 1000
Tests Ordered at this Hospital or Clinic
Please add any tests this hospital or clinic ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.
Status
Test Type
Actions
Click Add Test to add a test.
Add Test
Medicines Recommended or Prescribed by this Hospital or Clinic
Please add all prescription and non-prescription medicines Sara Jones is currently taking that this hospital or clinic recommended or prescribed.
Status
Medicine
Reason
Actions
Click Add Medicine to add a medicine.
Add Medicine
Save
Cancel

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

## 3.42. Tests – 3rd Party

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



## 3.43. Add New Test – 3rd Party


Contents of Test Type drop list:

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

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

- Biopsy
- X-Ray
- Other

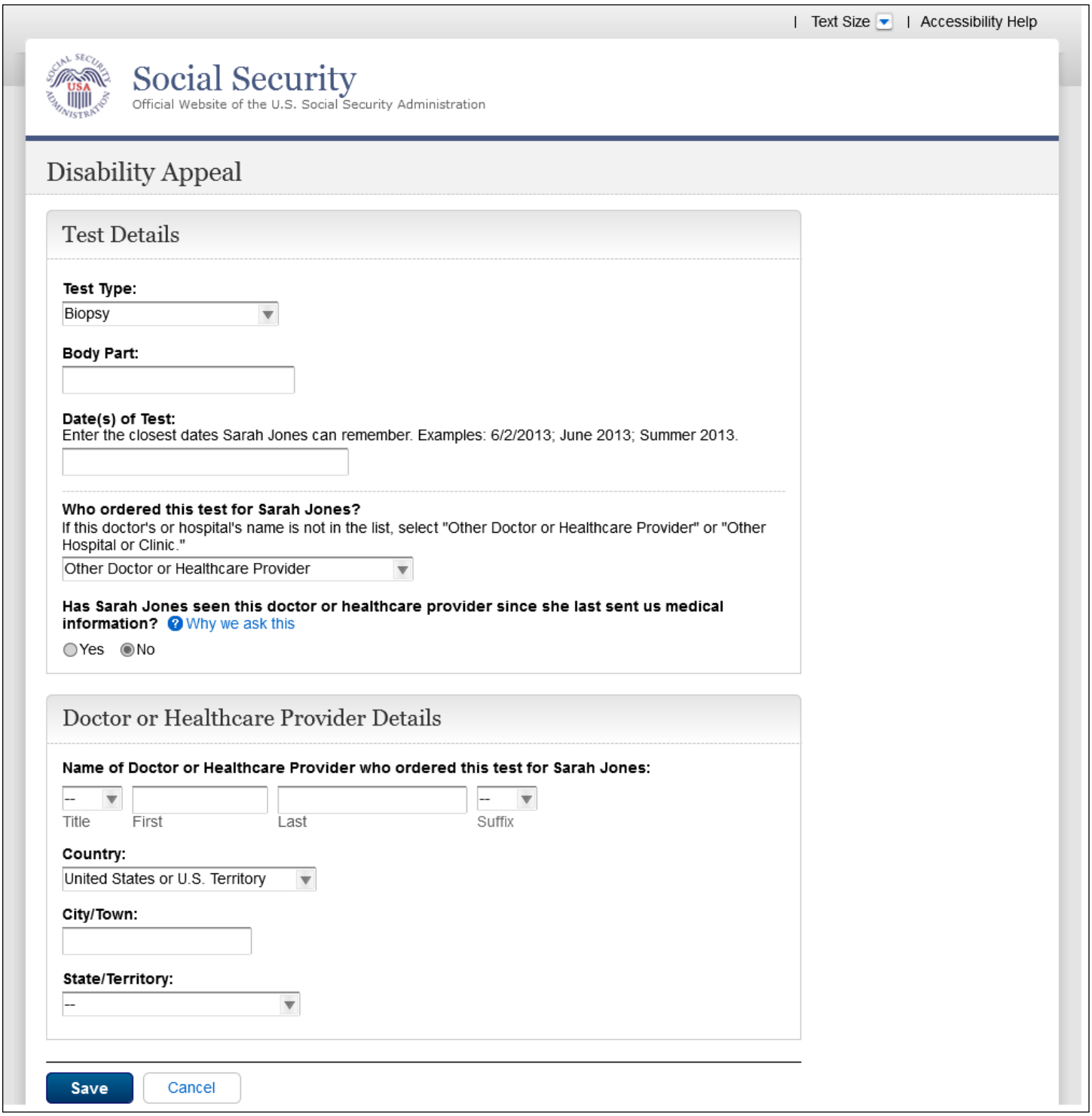
Selecting “Other” will also dynamically display the “Please specify test type” question.

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

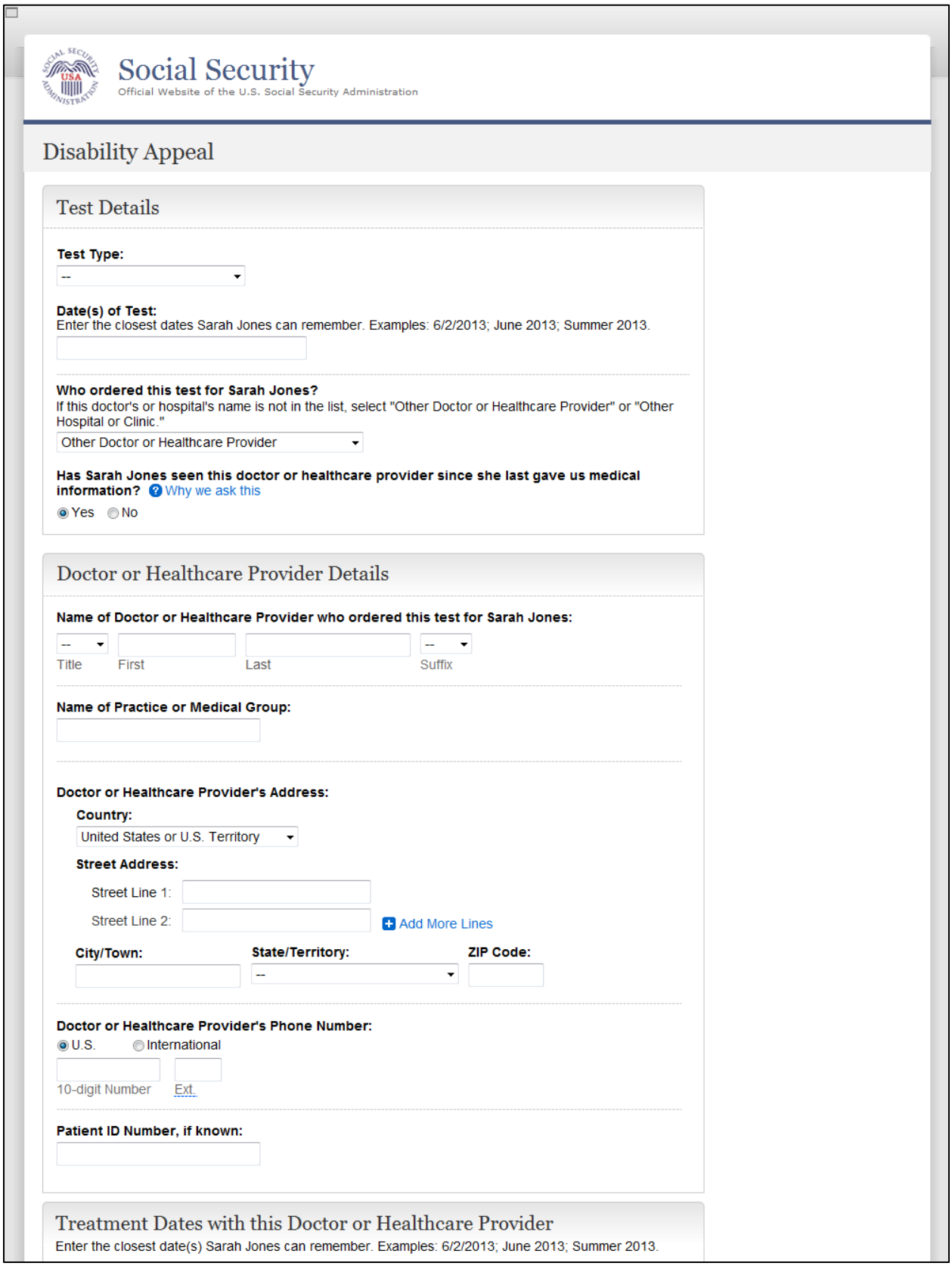
--
*(All doctors previously entered)*
*(All hospitals previously entered)*
Other Doctor or Healthcare Provider
Other Hospital or Clinic
No one recommended or prescribed this medicine
I don’t know

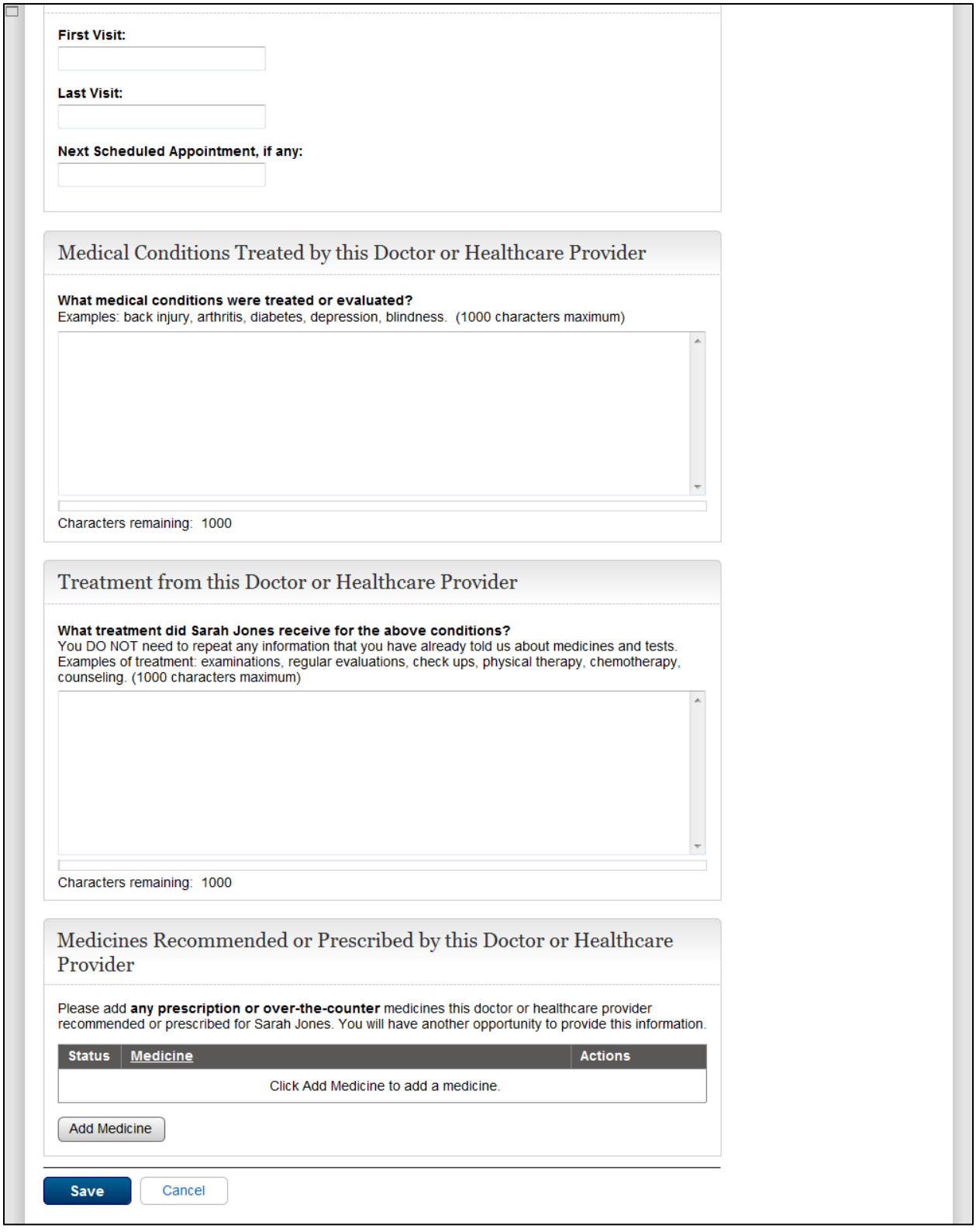
## 3.44. Add New Test – 3rd Party: Follow up question and Other Doctor

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



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





**First Visit:**

**Last Visit:**

**Next Scheduled Appointment, if any:**

## Medical Conditions Treated by this Doctor or Healthcare Provider

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

Characters remaining: 1000

## Treatment from this Doctor or Healthcare Provider

**What treatment did Sarah Jones receive for the above conditions?**
You DO NOT need to repeat any information that you have already told us about medicines and tests. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

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

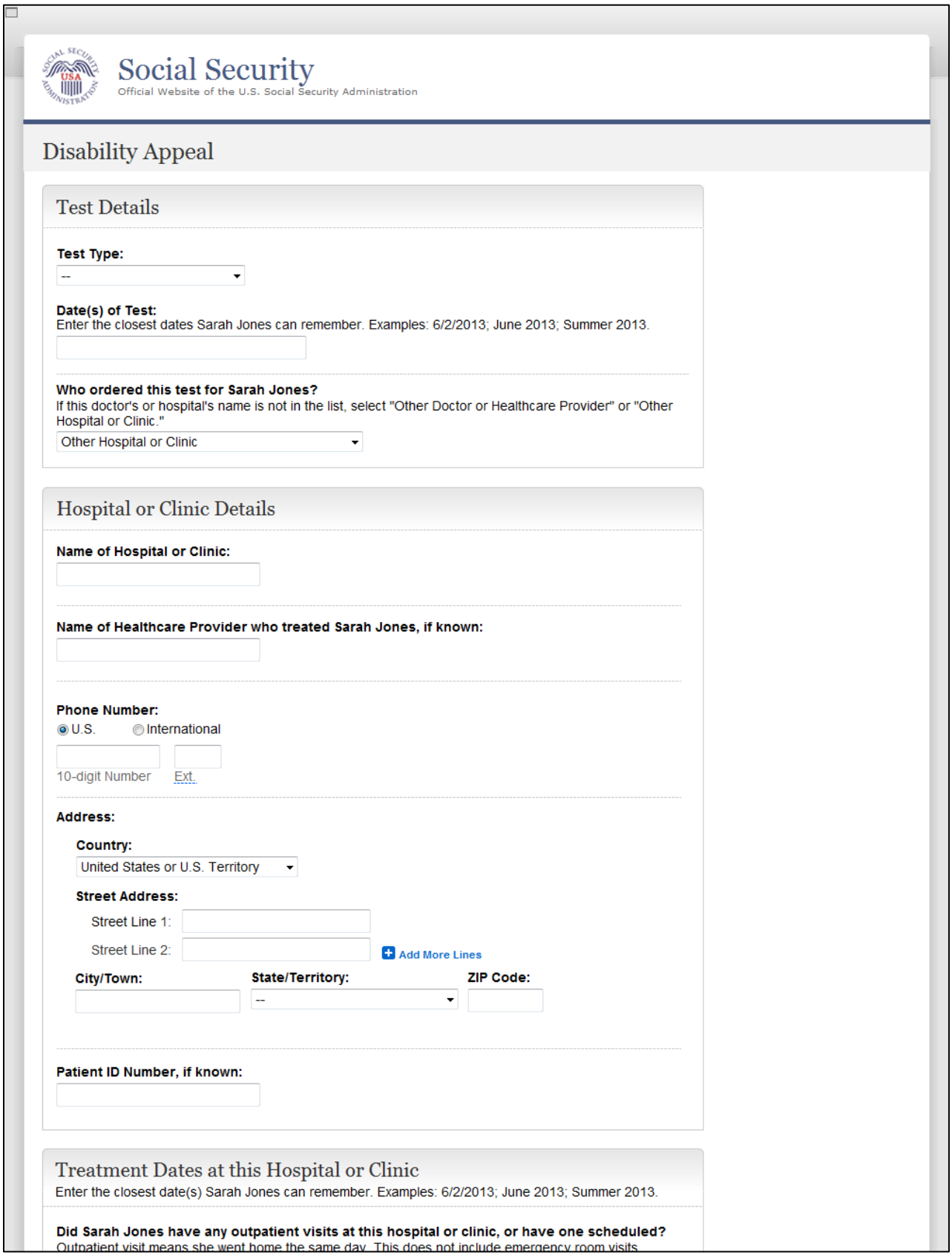
Please add **any prescription or over-the-counter** medicines this doctor or healthcare provider recommended or prescribed for Sarah Jones. You will have another opportunity to provide this information.

| Status | Medicine | Actions |
|---|---|---|
| Click Add Medicine to add a medicine. | | |

Add Medicine

Save Cancel

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



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

○ Yes ◉ No

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

○ Yes ◉ No

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

○ Yes ○ No

## Medical Conditions Treated by this Hospital or Clinic

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

Characters remaining: 1000

## Treatment from this Hospital or Clinic

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

Characters remaining: 1000

## Medicines Recommended or Prescribed by this Hospital or Clinic

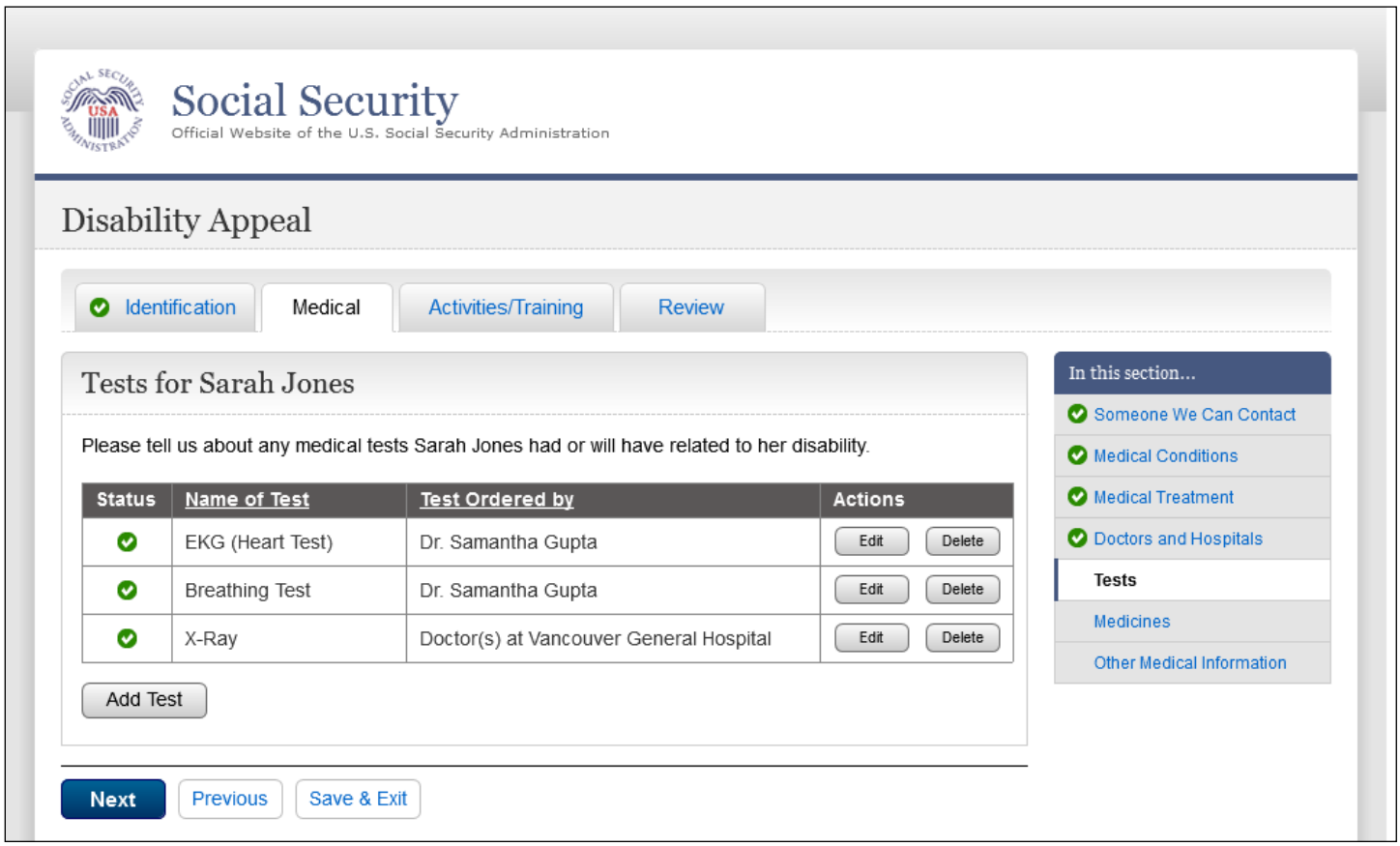
Please add **all prescription and non-prescription** medicines Sara Jones is **currently** taking that this hospital or clinic recommended or prescribed.

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

Add Medicine

Save Cancel

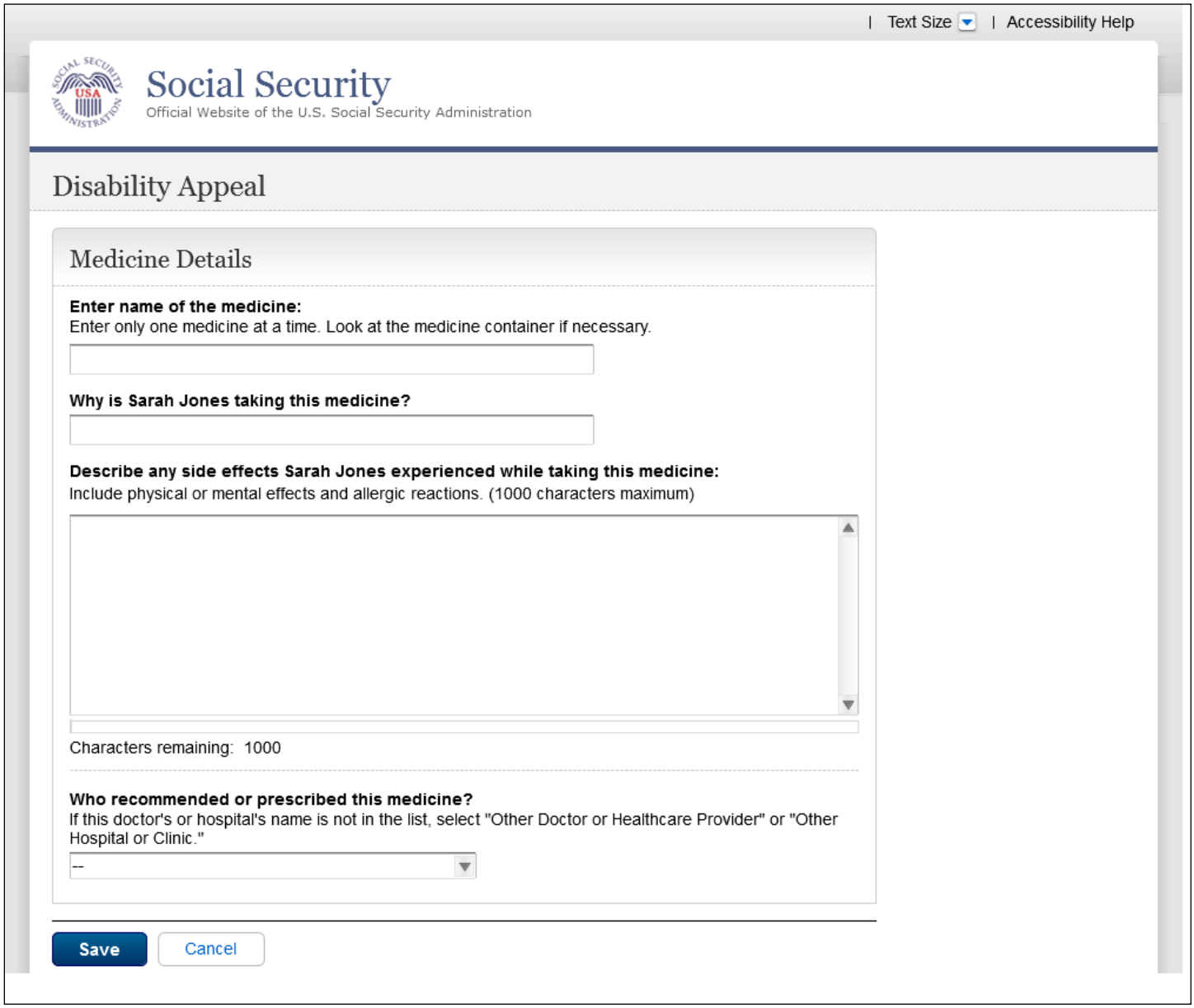
## 3.48. Tests 3 Rows Filled – 3rd Party



### 3.49. Medicines – 3rd Party

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

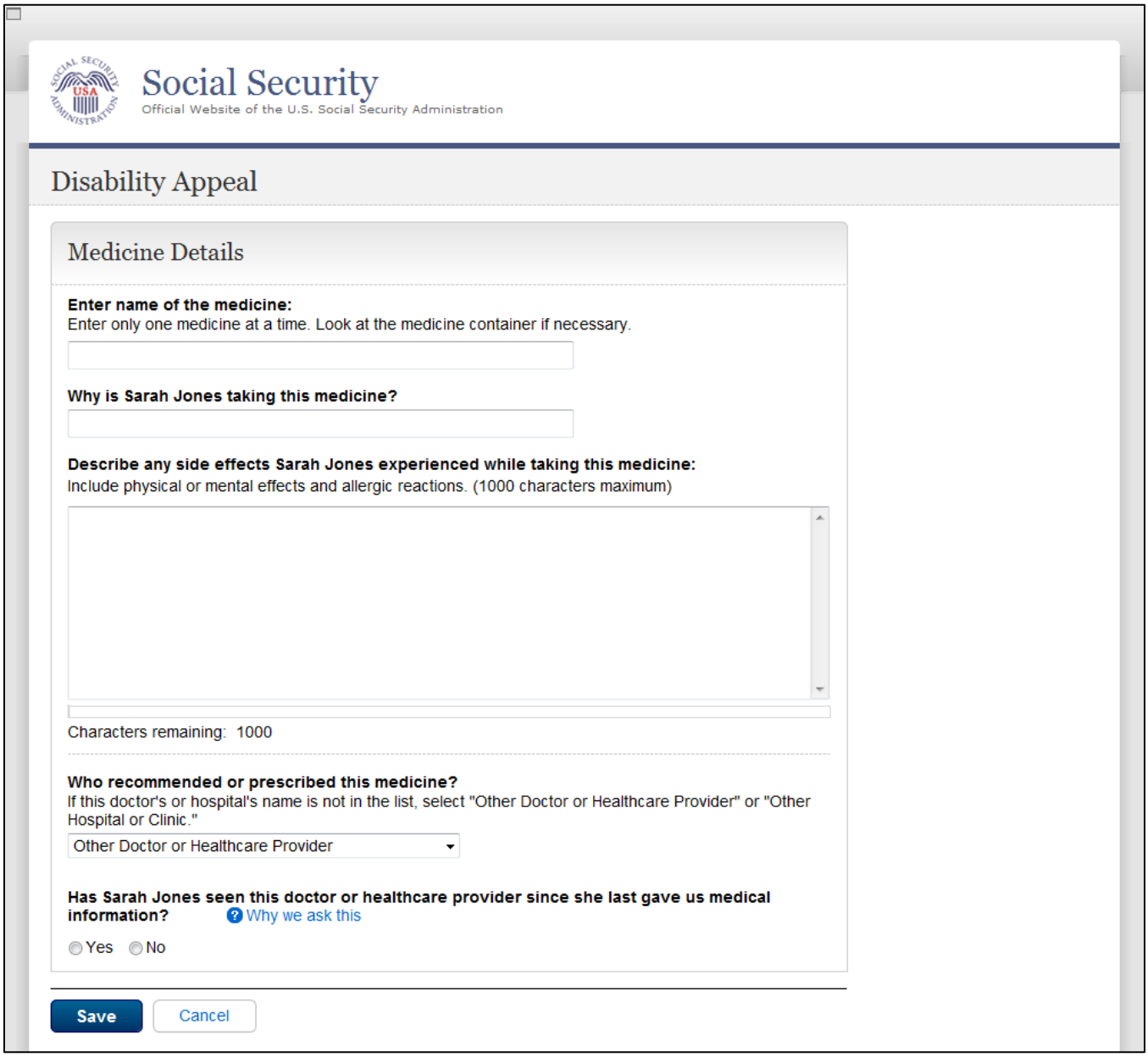
## 3.50. Add New Medicine – 3rd Party



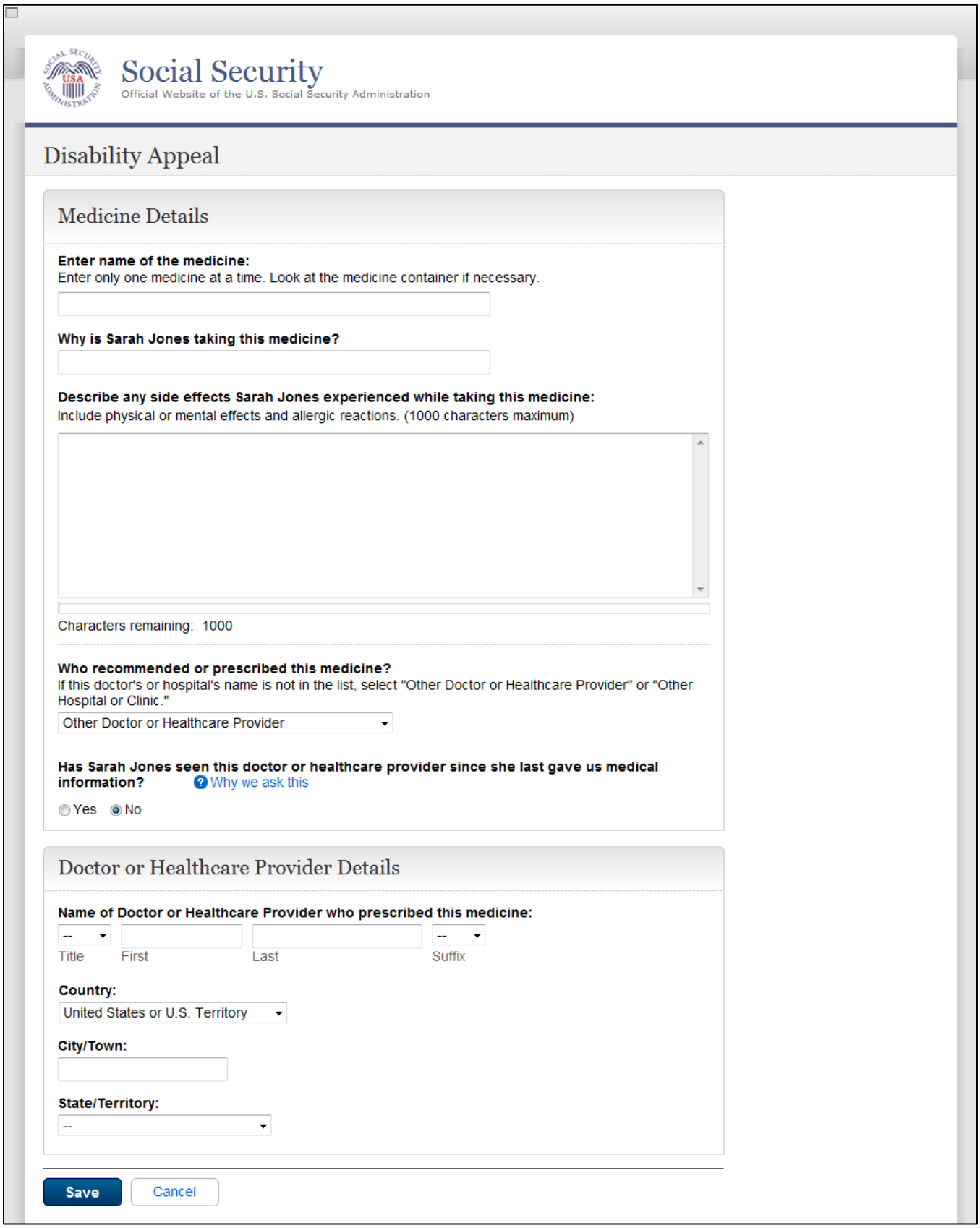

Contents of "Who recommended..." drop list:

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

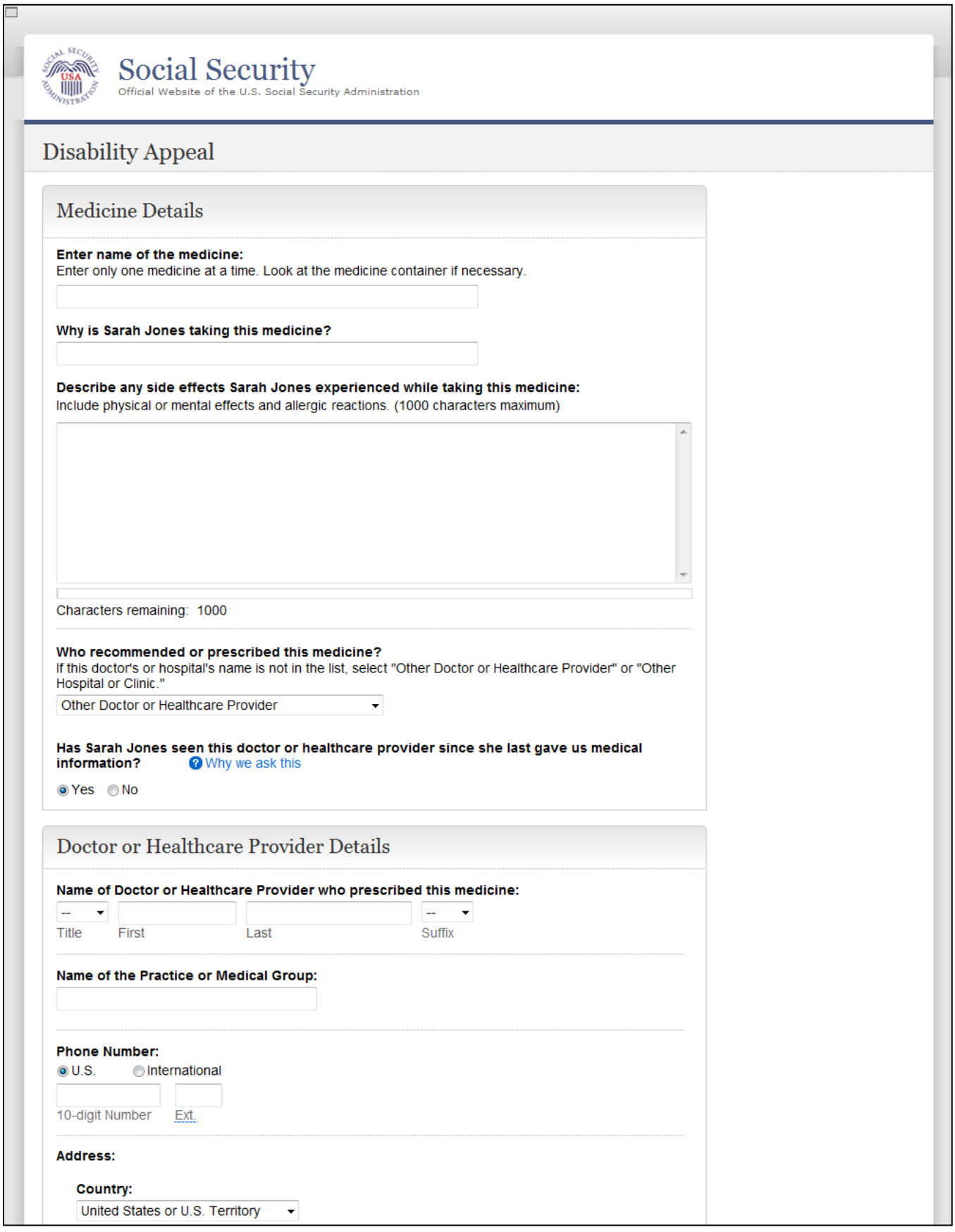
## 3.51. Add New Medicine – 3rd Party: Other doctor



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



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



**Street Address:**

Street Line 1:

Street Line 2: Add More Lines

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

**Patient ID Number, if known:**

## Treatment Dates with this Doctor or Healthcare Provider

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

**First Visit:**

**Last Visit:**

**Next Scheduled Appointment, if any:**

## Medical Conditions Treated by this Doctor or Healthcare Provider

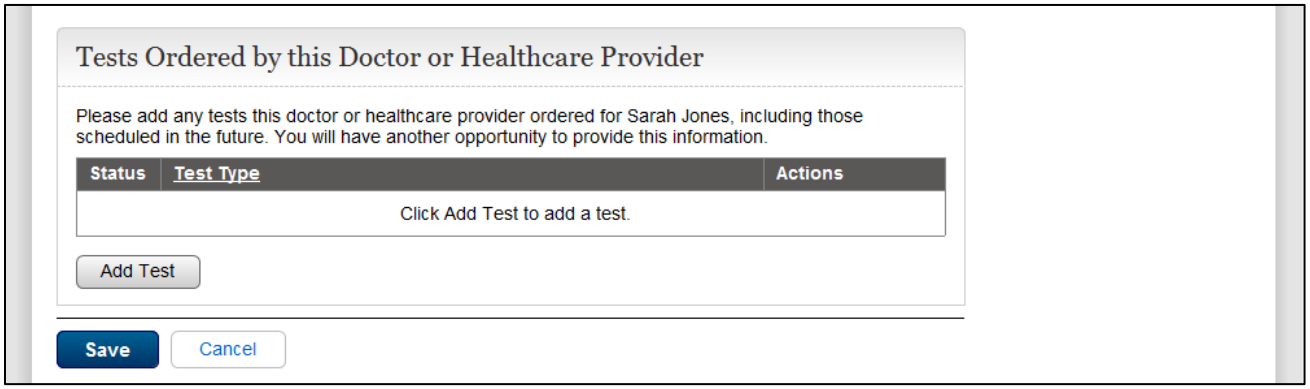
**What medical conditions were treated or evaluated?**
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

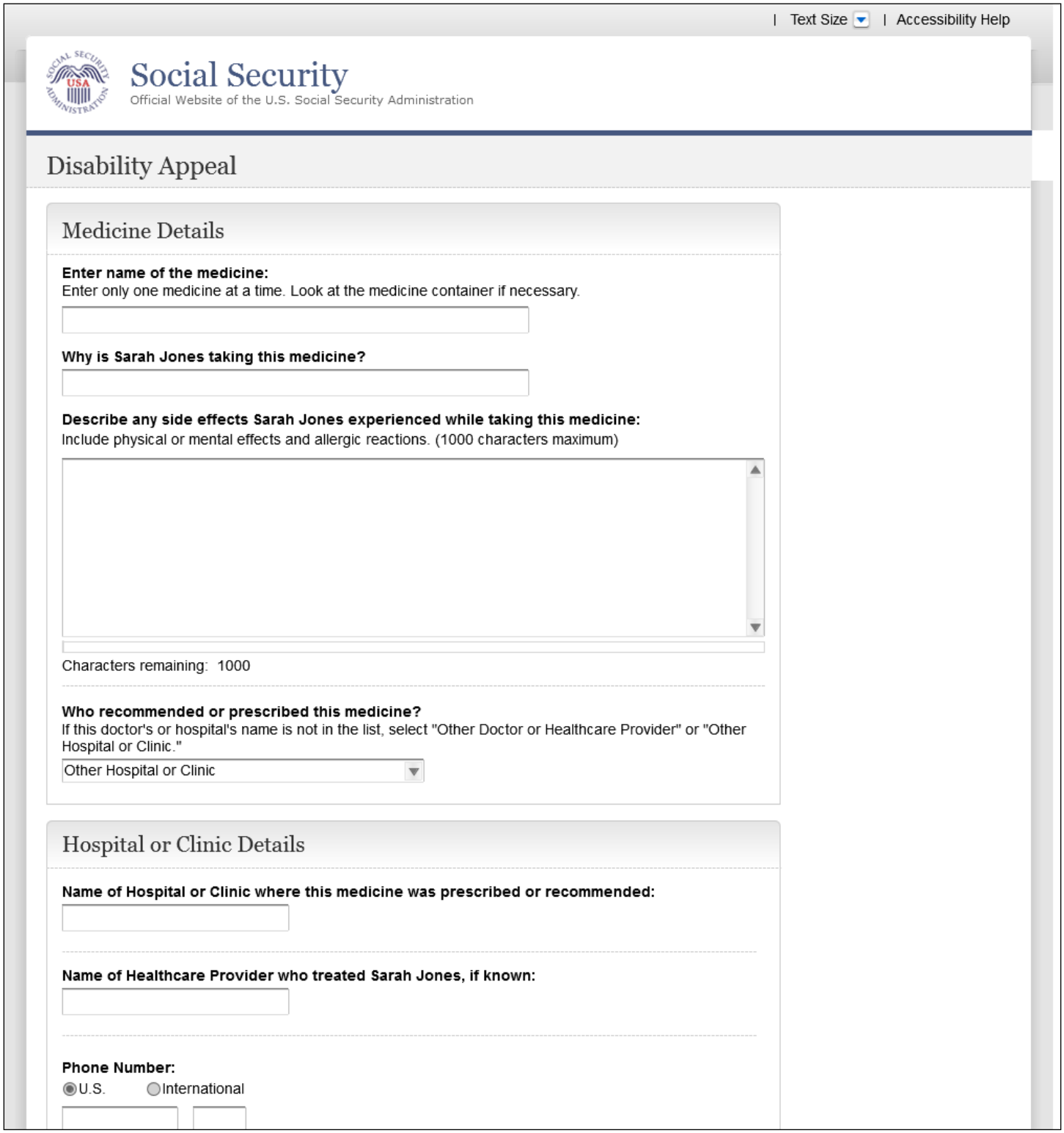
## Treatment from this Doctor or Healthcare Provider

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

Characters remaining: 1000


Tests Ordered by this Doctor or Healthcare Provider
Please add any tests this doctor or healthcare provider ordered for Sarah Jones, including those scheduled in the future. You will have another opportunity to provide this information.
Status
Test Type
Actions
Click Add Test to add a test.
Add Test
Save
Cancel

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



U.S. International

10-digit Number Ext.

**Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

Street Line 2: Add More Lines

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

--

**Patient ID Number, if known:**

## Treatment Dates at this Hospital or Clinic

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

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

Yes No

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

Yes No

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

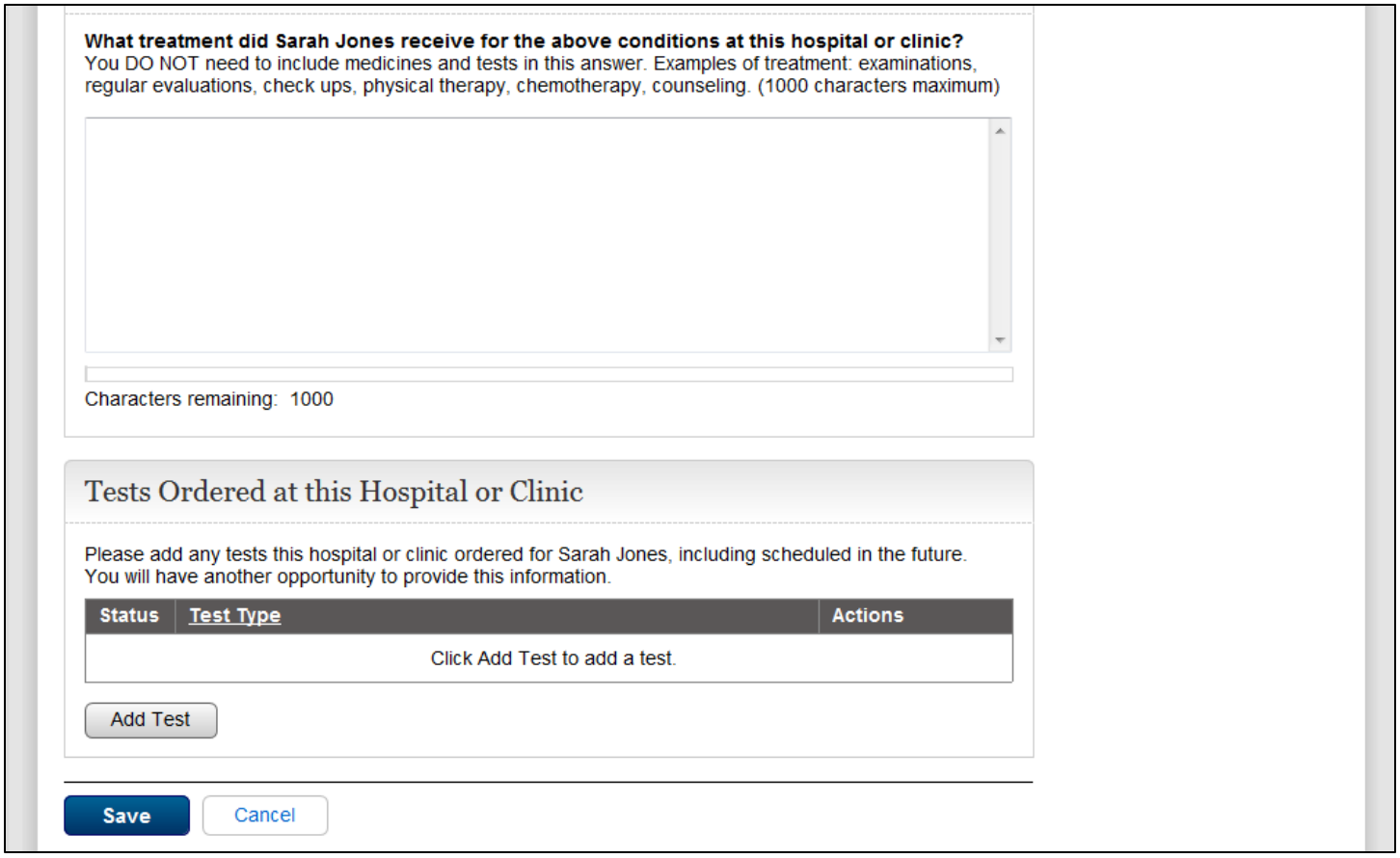
Yes No

## Medical Conditions Treated by this Hospital or Clinic

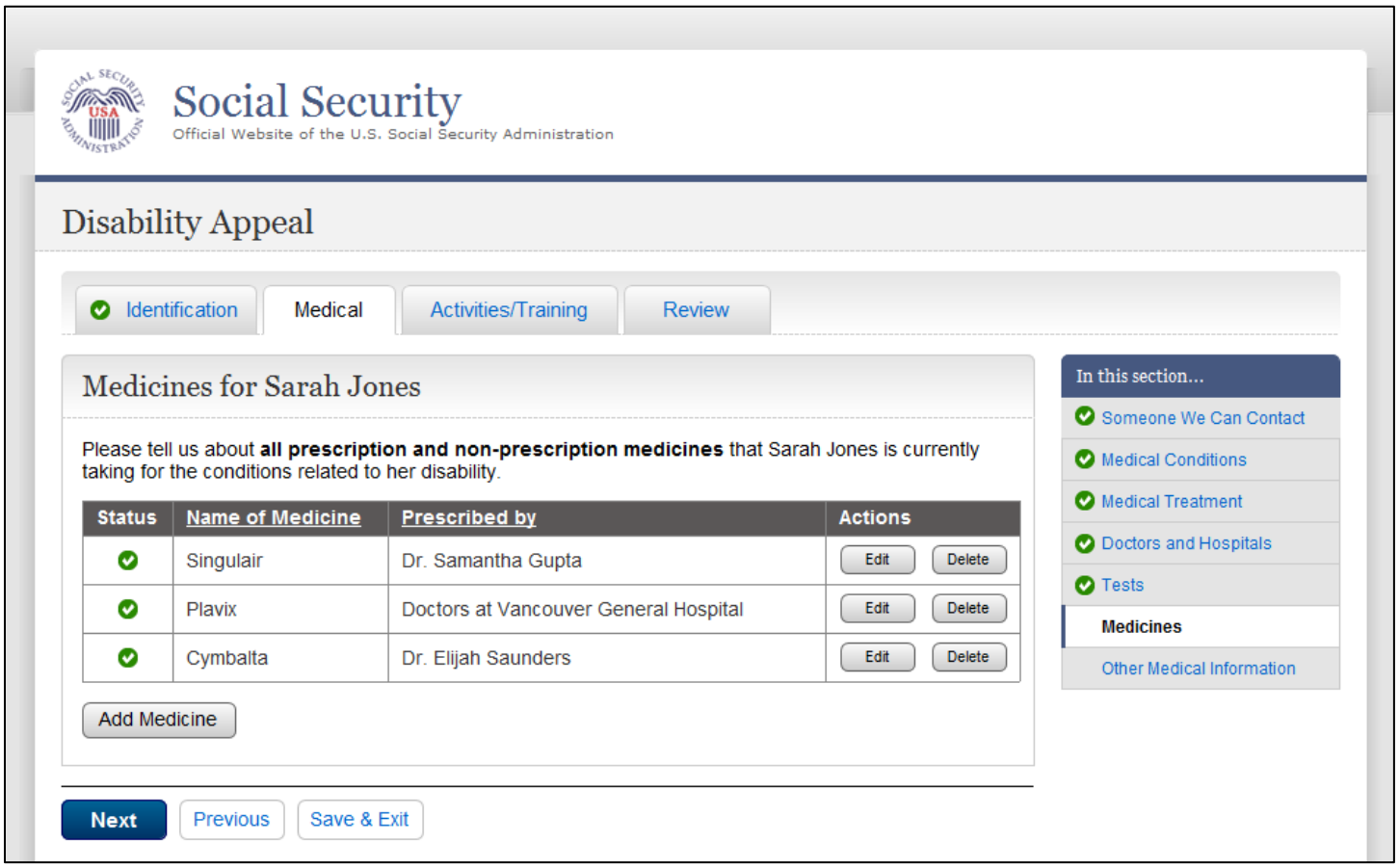
**What medical conditions were treated or evaluated by this hospital or clinic?**
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

## Treatment from this Hospital or Clinic


What treatment did Sarah Jones receive for the above conditions at this hospital or clinic?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)
Characters remaining: 1000
Tests Ordered at this Hospital or Clinic
Please add any tests this hospital or clinic ordered for Sarah Jones, including scheduled in the future. You will have another opportunity to provide this information.
Status
Test Type
Actions
Click Add Test to add a test.
Add Test
Save
Cancel

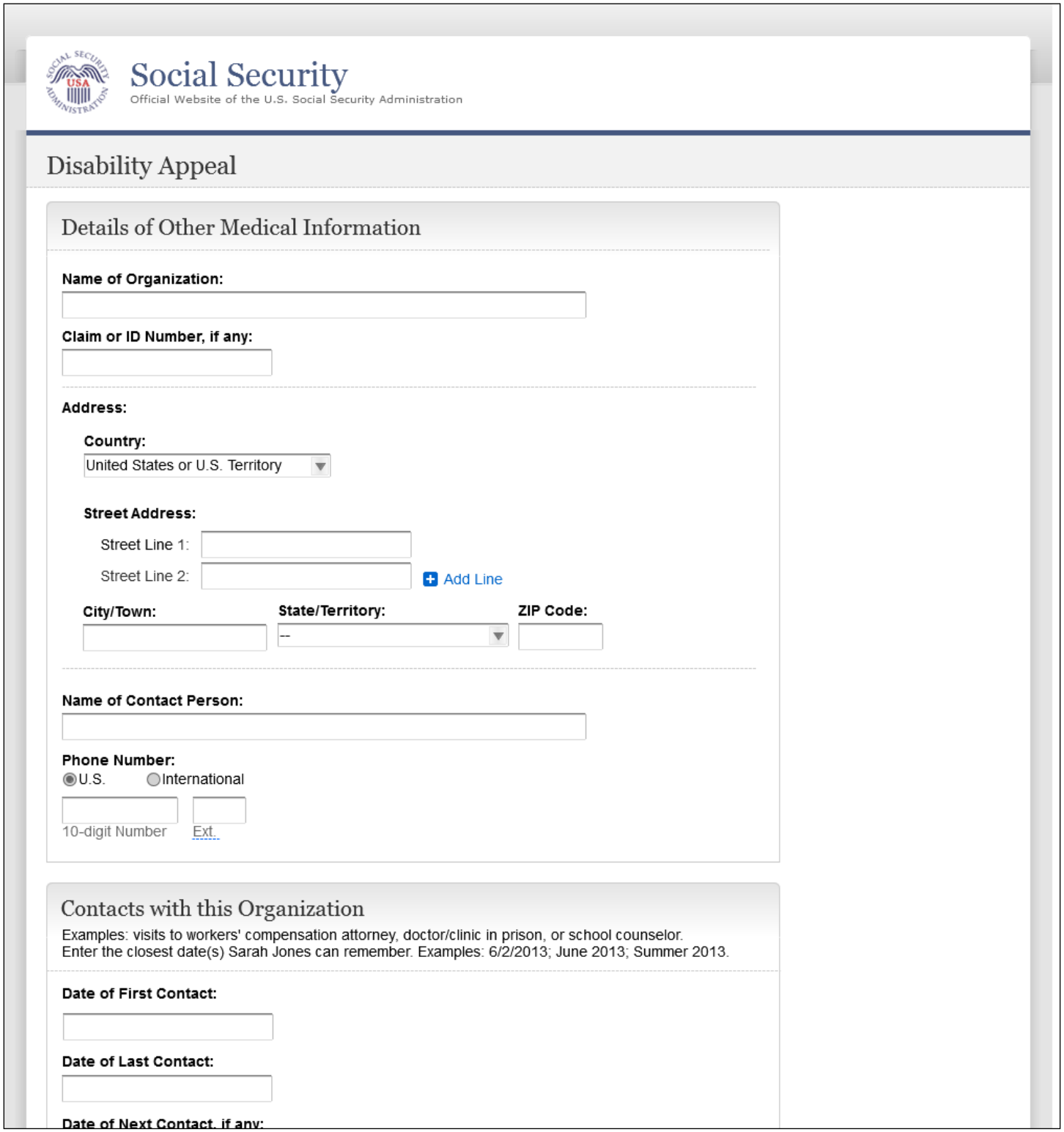
## 3.55. Medicines 3 Rows Filled – 3rd Party



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

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

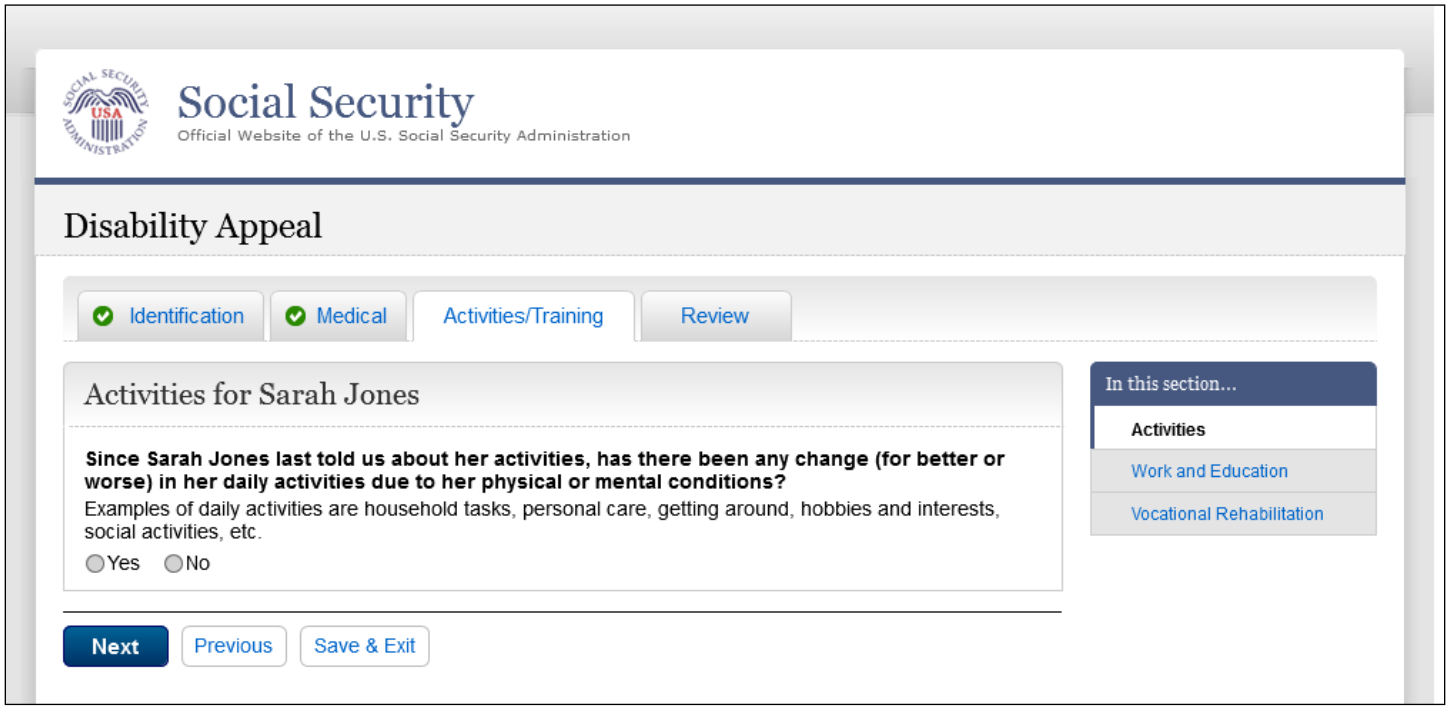
## 3.58. Add Other Medical Info – 3rd Party




Reasons for Contacts:
(1000 characters maximum) If you need more space, please continue in Remarks.
Characters remaining: 1000
Save
Cancel

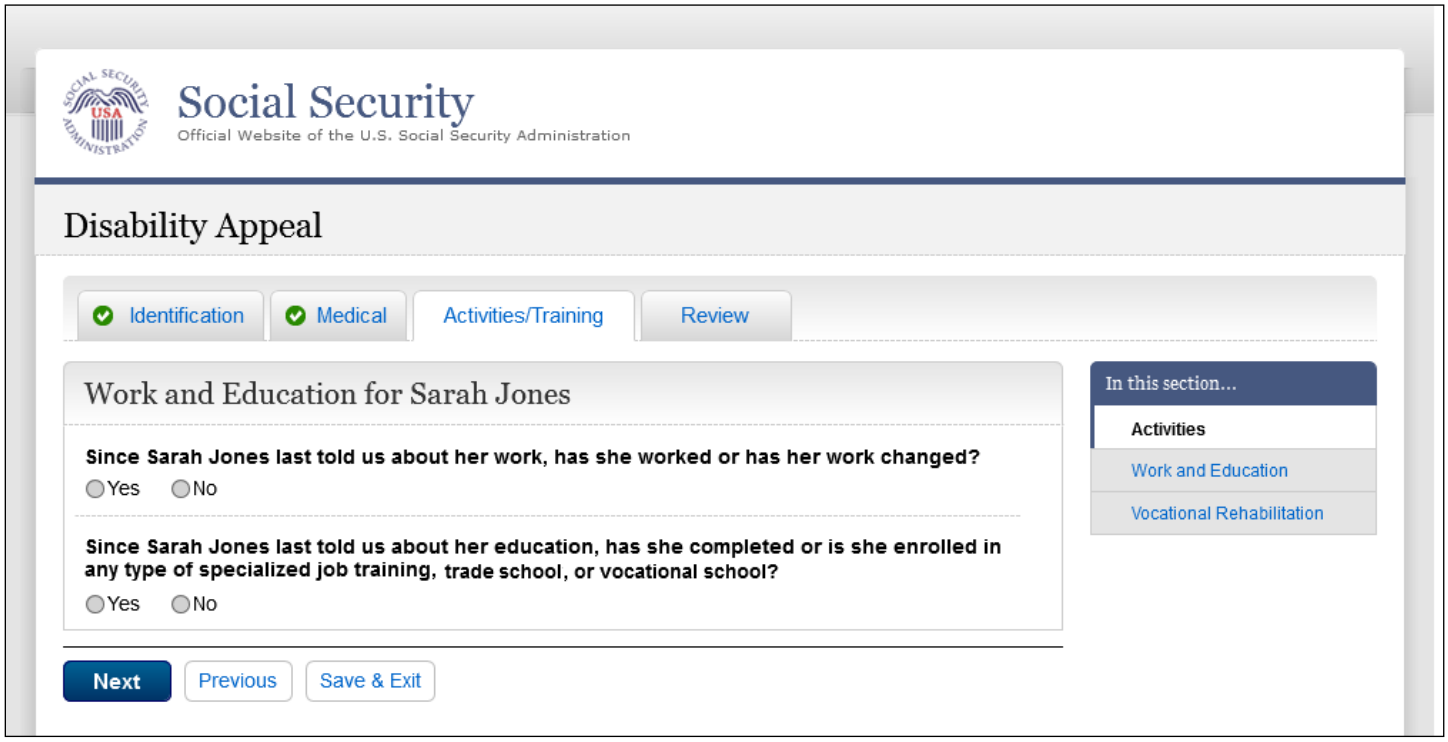
## 3.59. Added Other Medical Info – 3rd Party

## 3.60. Section7: Activities – 3rd Party

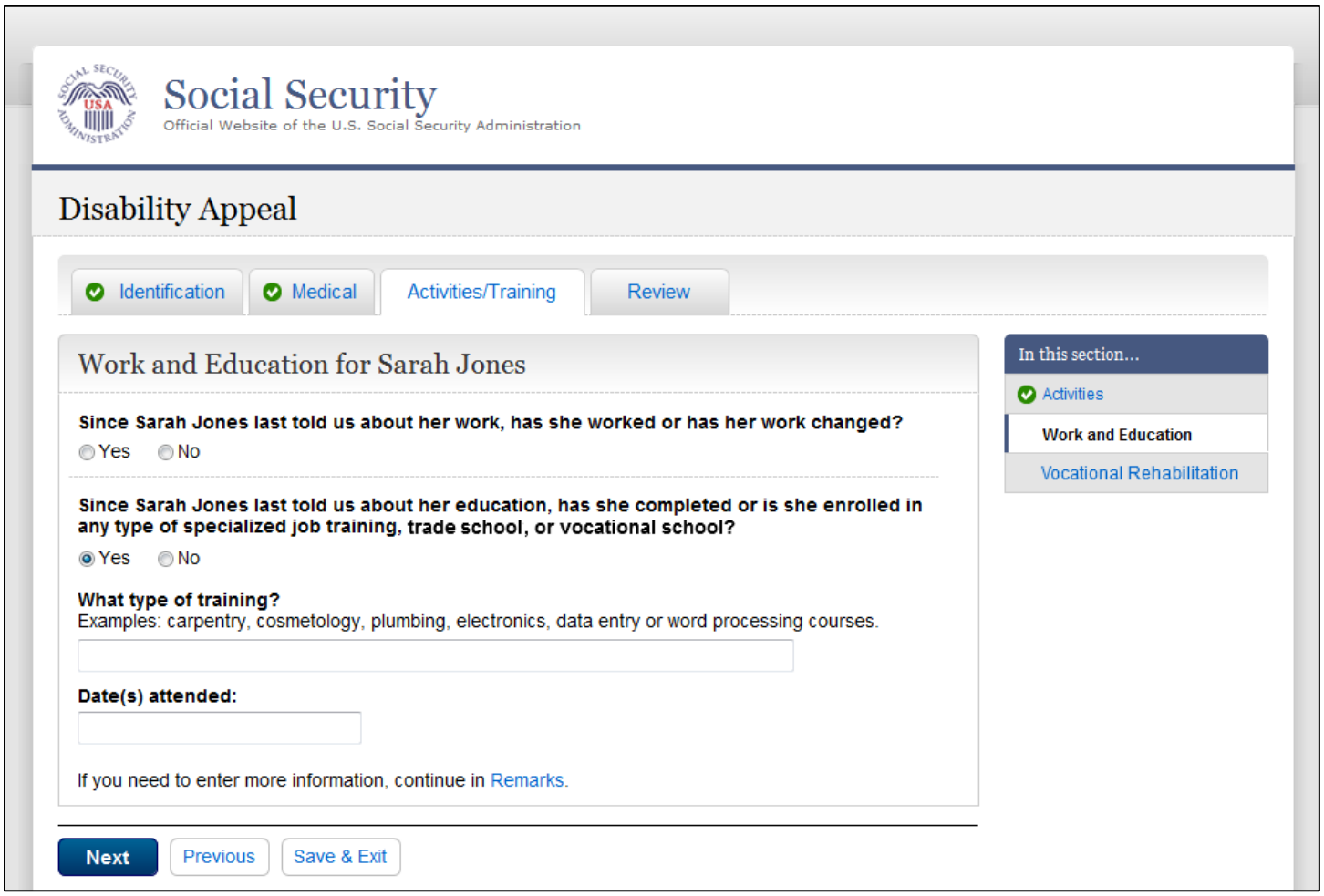


## 3.61. Section7: Activities – 3rd Party: Follow up question

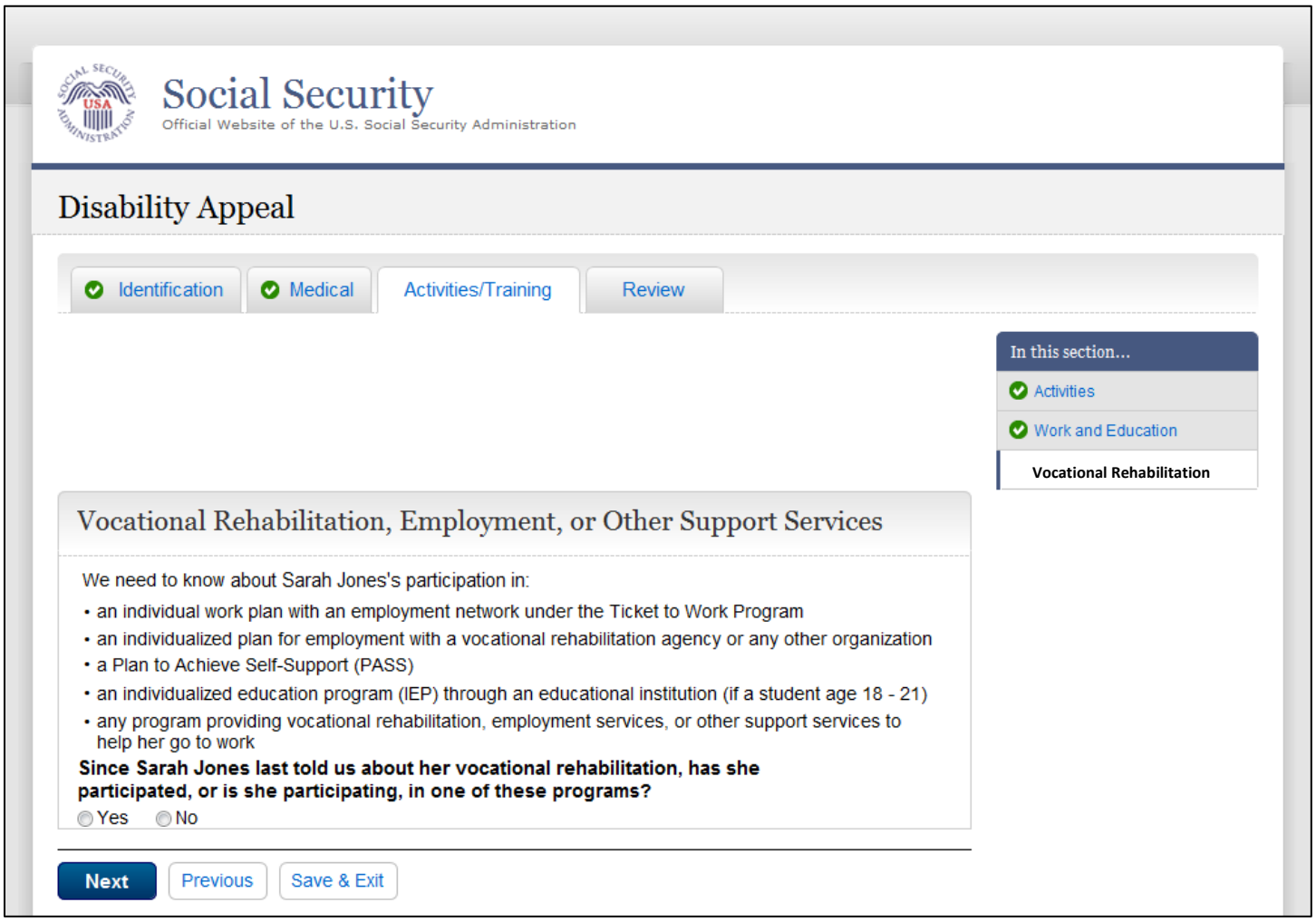
## 3.62. Section8: Work & Education – 3rd Party



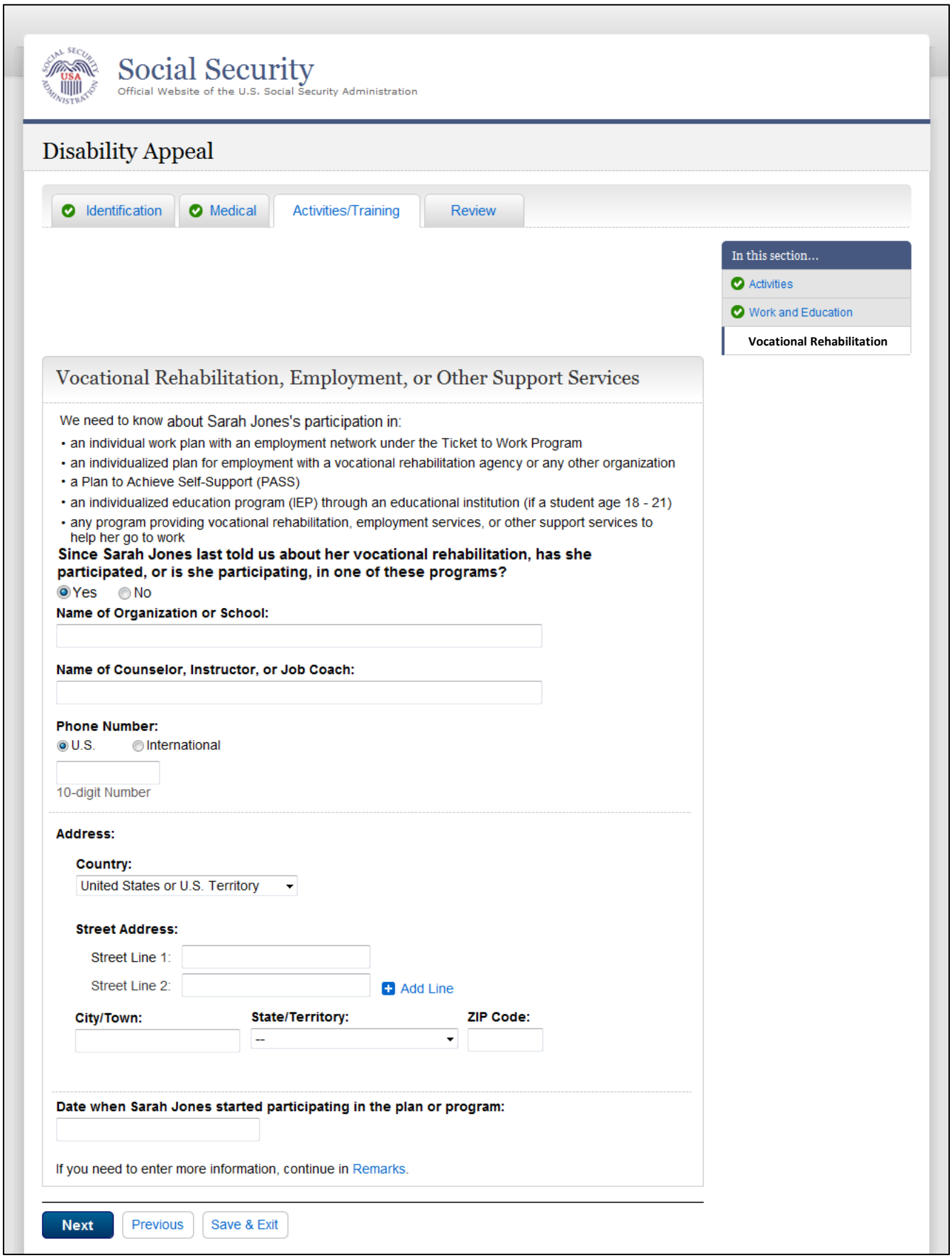
## 3.63. Section8: Work Education – 3rd Party: Follow up question



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

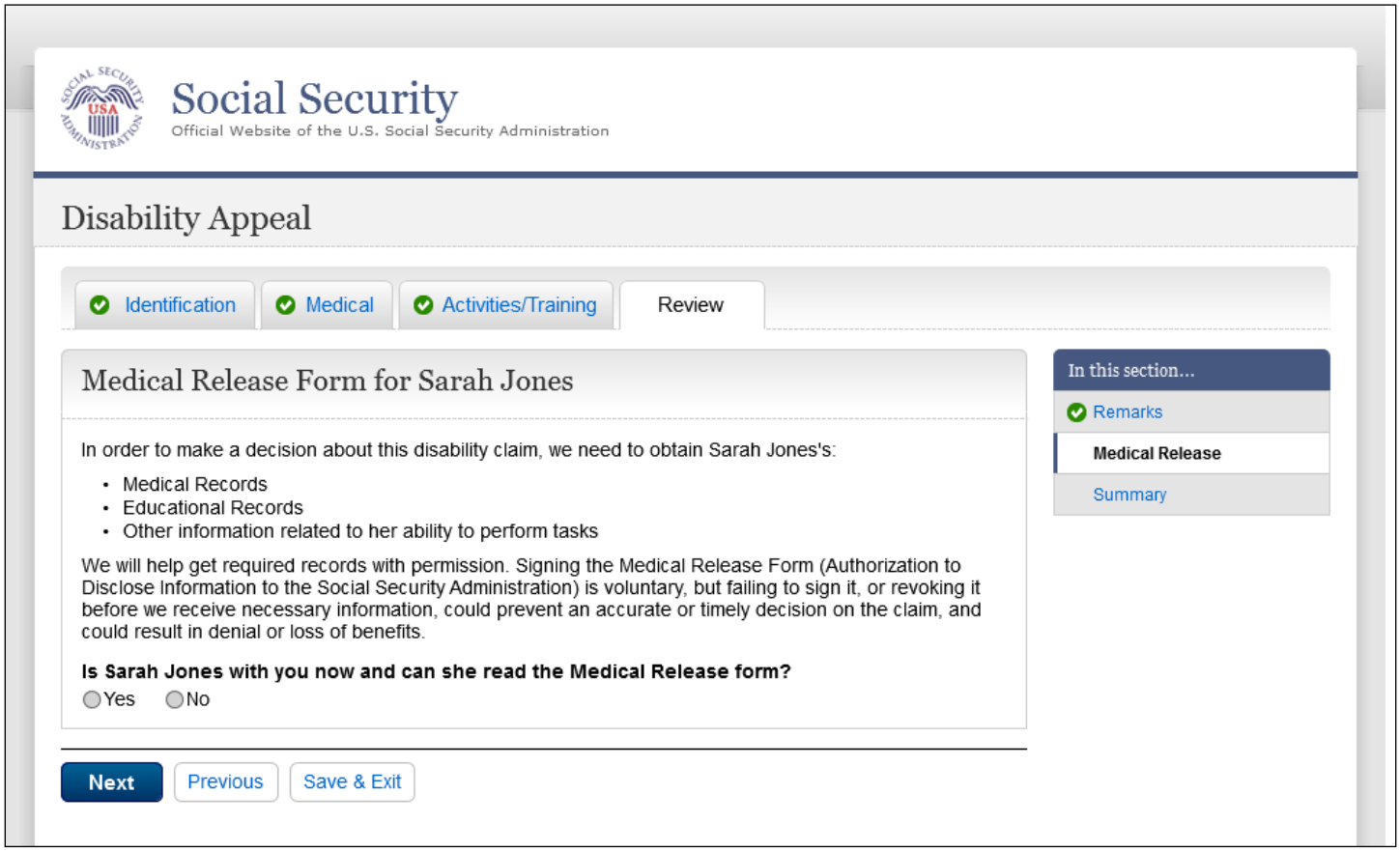


## 3.65. Section9: Voc Rehab – 3rd Party: Second follow up questions

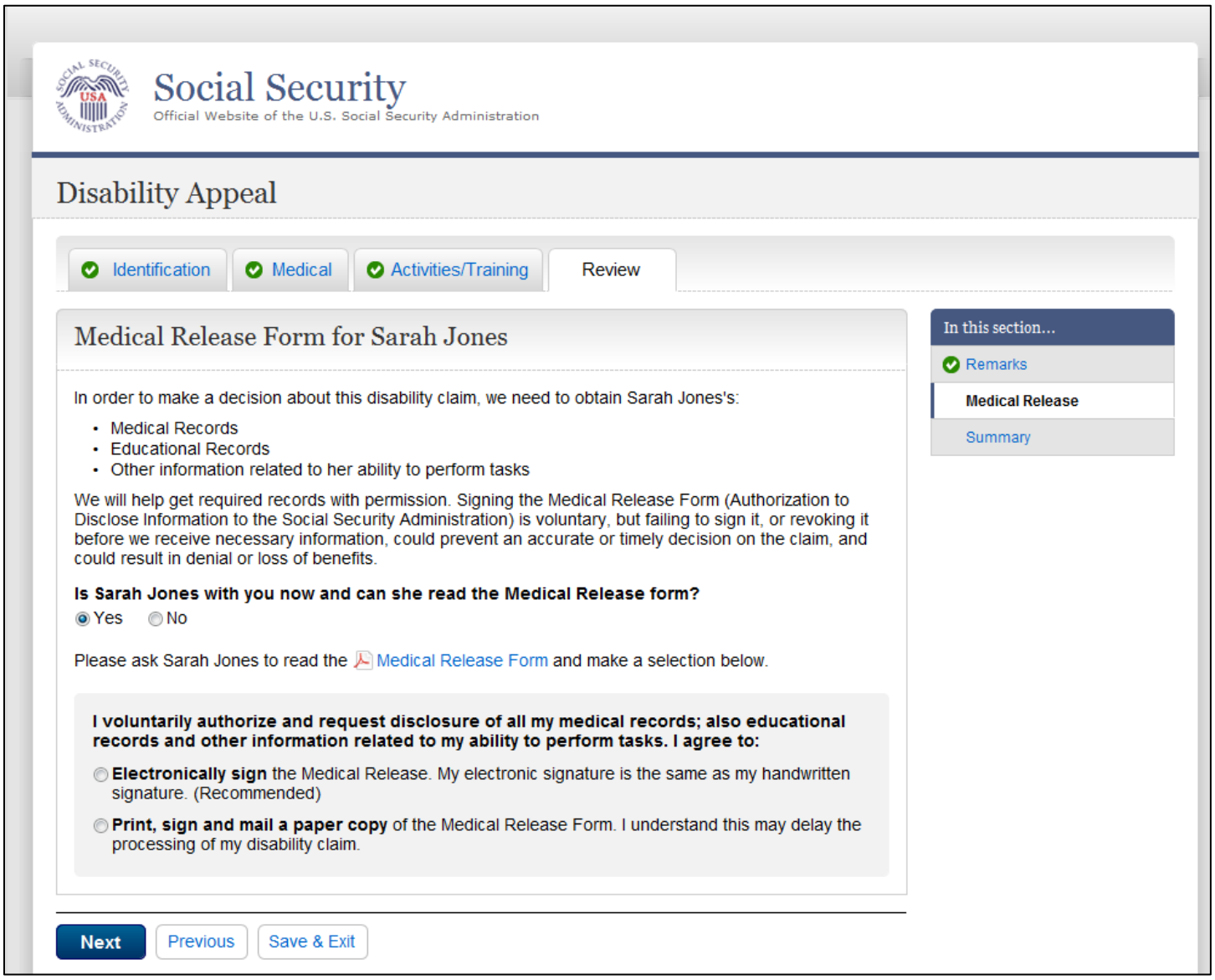


## 3.66. Remarks – 3rd Party

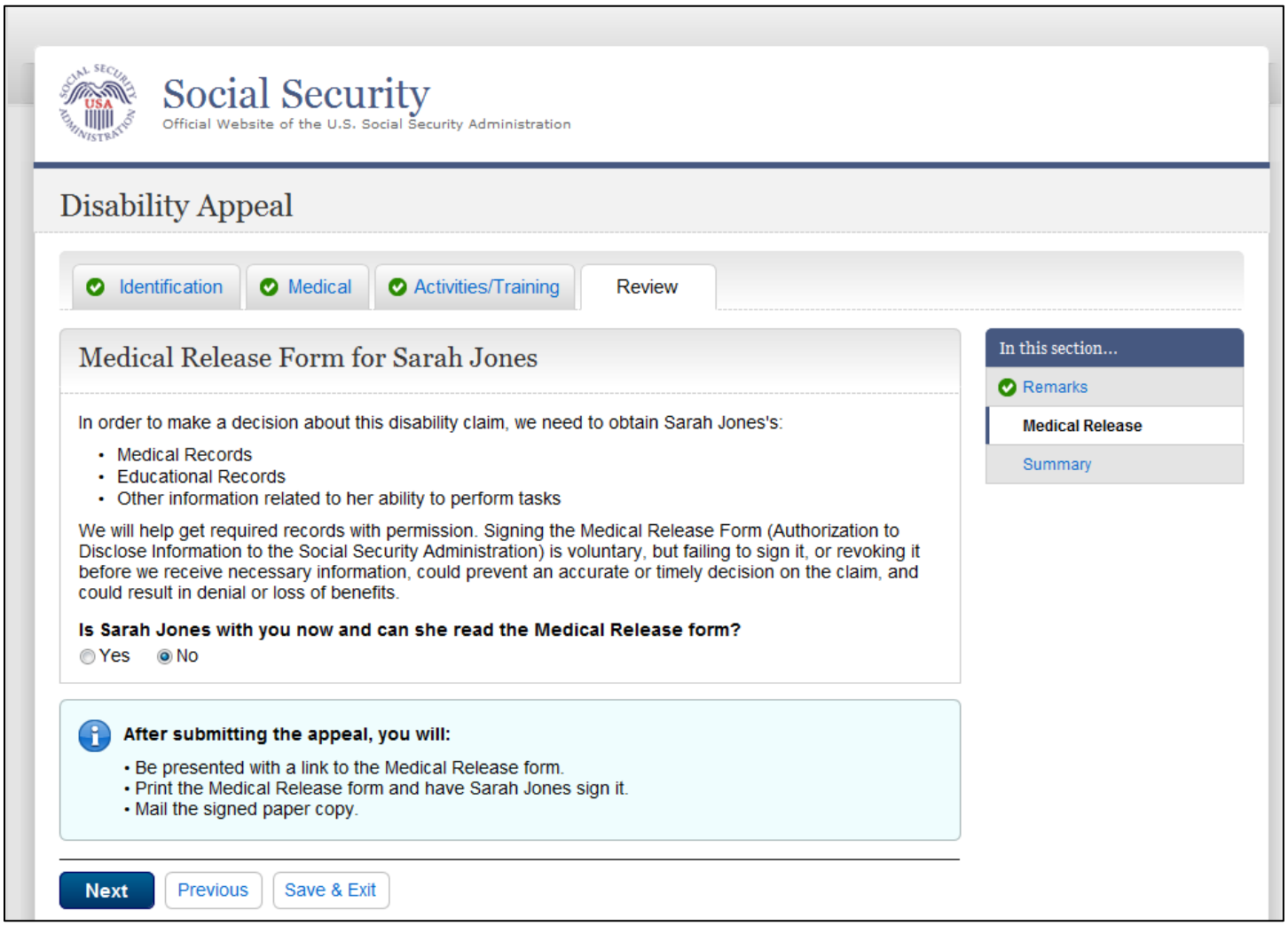
## 3.67. Medical Release – 3rd Party



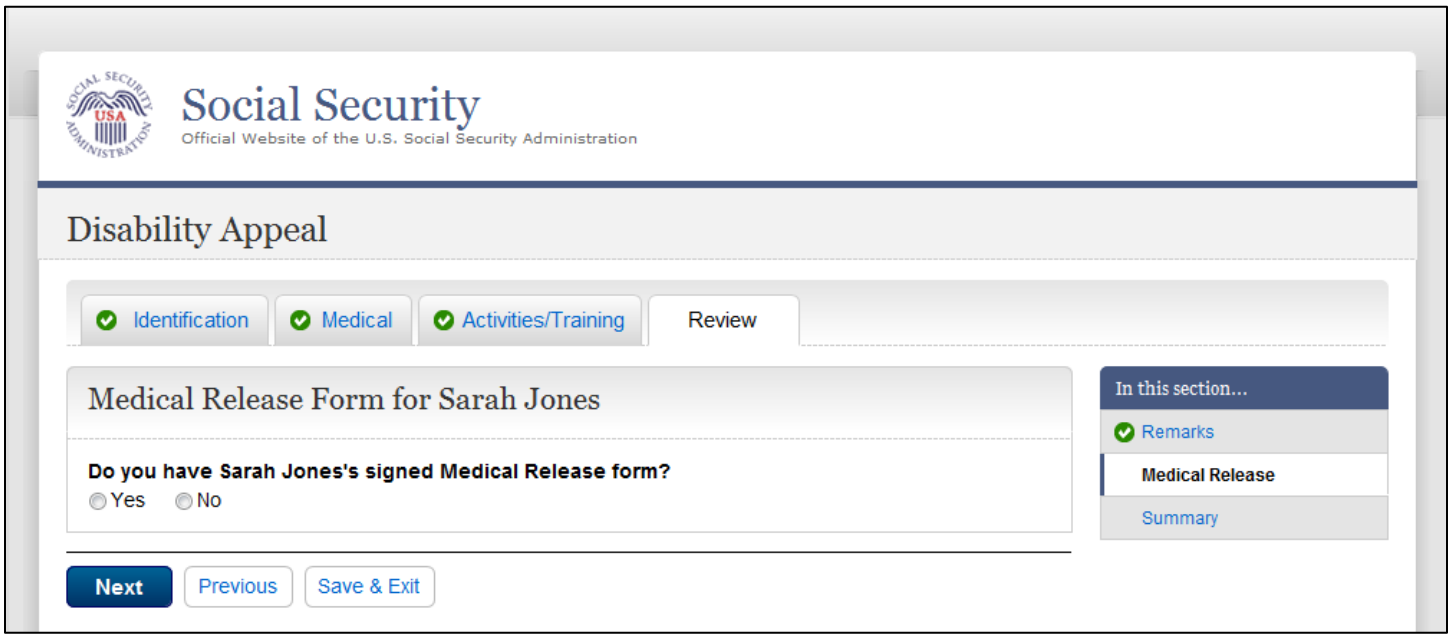
## 3.68. Medical Release – 3rd Party: Applicant is Present



## 3.69. Medical Release – 3rd Party: Applicant is Not Present

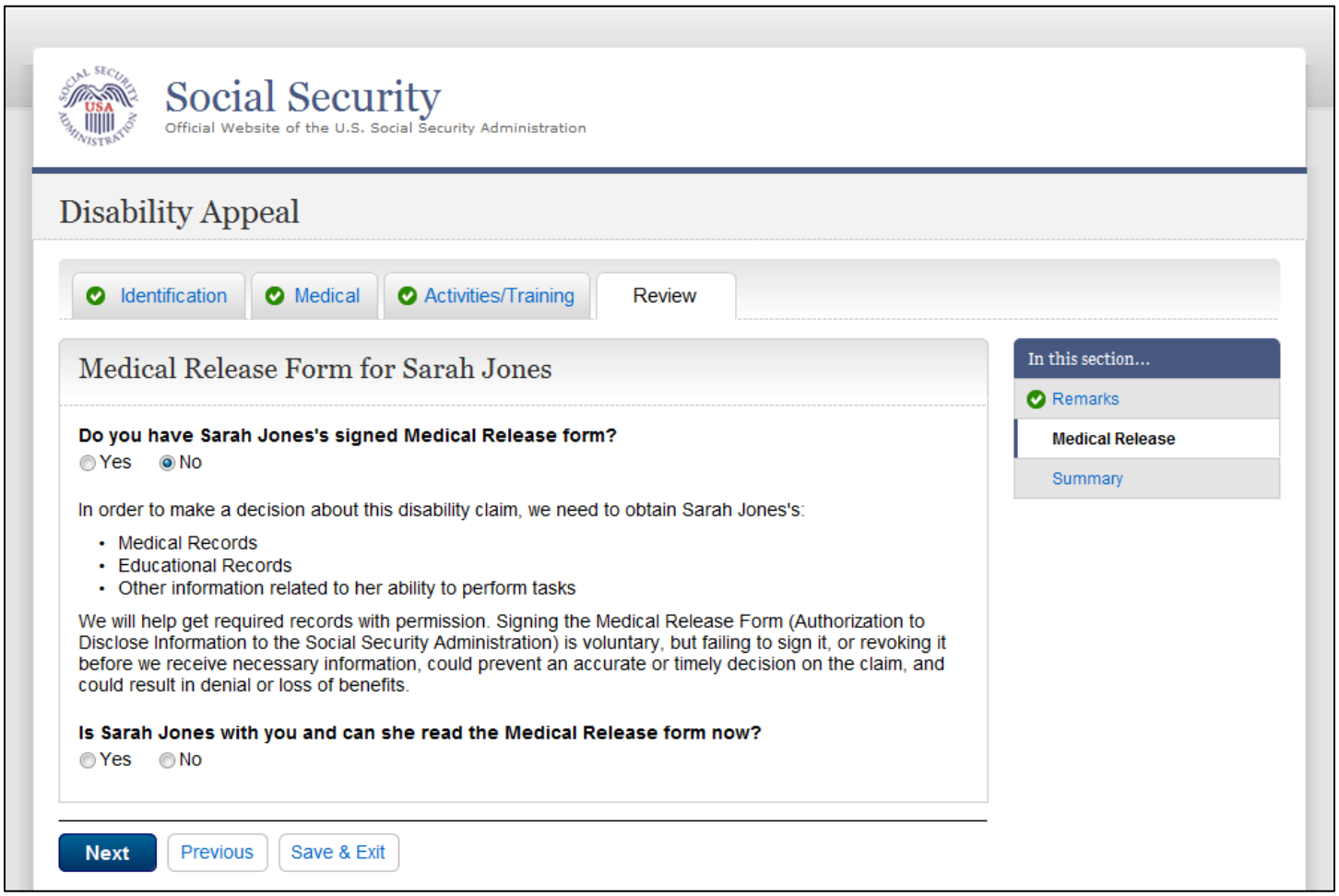


## 3.70. Medical Release – 3rd Party Professional Rep



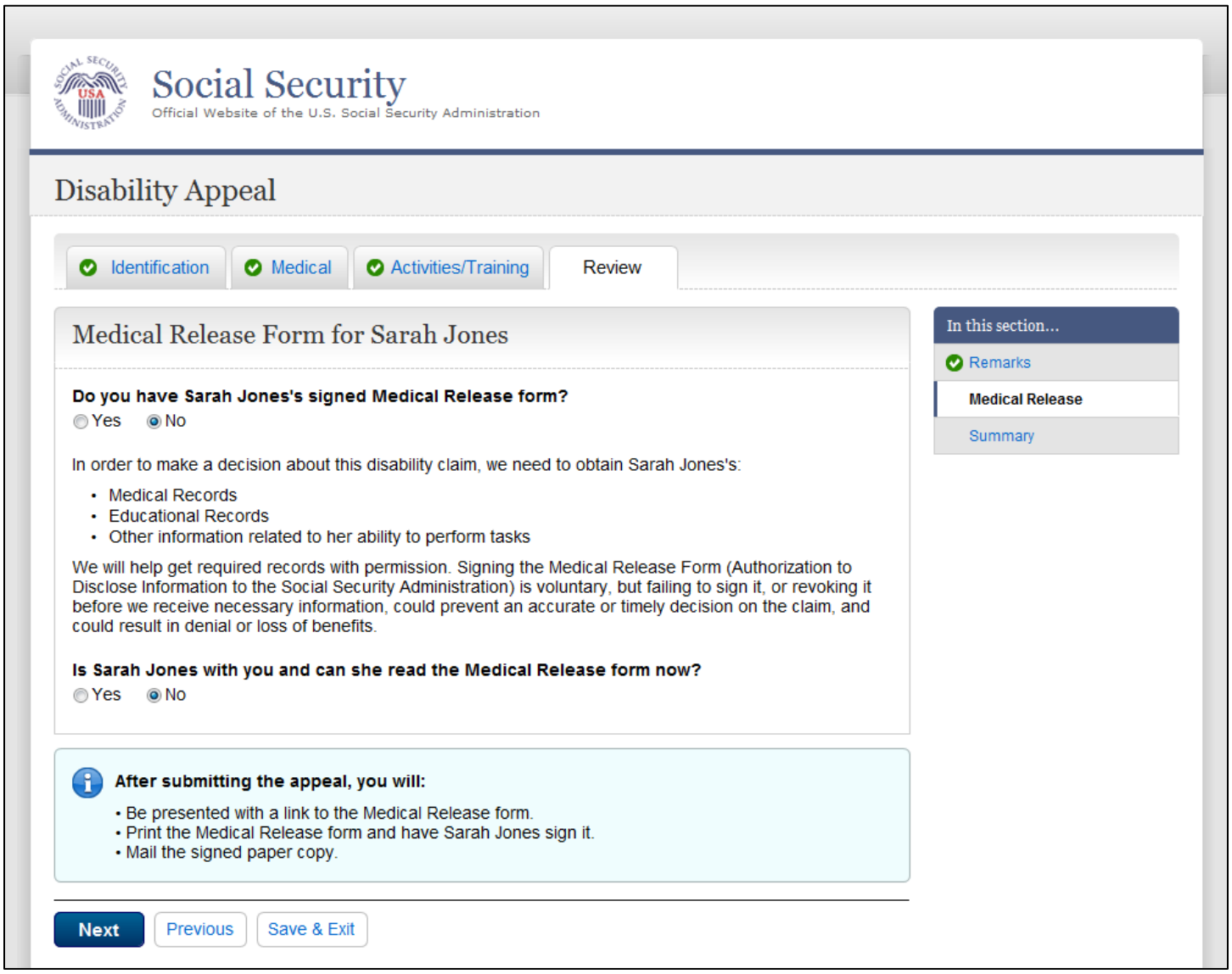
## 3.71. Medical Release – 3rd Party Professional Rep: Has signed form

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



## 3.73. Medical Release – 3rd Party Professional Rep: Applicant is Present

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



## 3.75. Overall Summary – 3rd Party Public

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

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

## Medical

### Someone We Can Contact

Edit

Name: **Jamie Gonzales**

Relationship to Sarah Jones: **Family Member**

Address:

Daytime Phone Number:

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

### Medical Conditions

Edit

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

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

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

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

Date the change occurred: **June**

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

### Medical Treatment

Edit

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

Other Name 1: **Sarah Smith**

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

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

### Doctors and Hospitals

Edit

**Doctor or Healthcare Provider 1**

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

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

Phone Number:

Address:

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Patient ID Number, if known:

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

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

Treatments Received: **Examinations**

**Doctor or Healthcare Provider 2**

Name: **Dr. Elijah Saunders**

Address:

**Hospital or Clinic 1**

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

Edit Tests

**Test 1**

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

**Test 2**

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

**Test 3**

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

Edit Medicines

**Medicine 1**

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

**Medicine 2**

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

**Medicine 3**

Medicine Name: **Cymbalta**

Reason: **Depression and Pain Management**
Side Effects:
Prescribed by: **Dr. Elijah Saunders**

**Medicine 4**
Medicine Name: **Tylenol**
Reason: **Headaches**
Side Effects:
Prescribed by: **No one prescribed this medicine**

Edit ✔ Other Medical Information

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

Name of Organization: **Workers' Insurance, Inc.**
Claim or ID Number, if any:
Address: [redacted]
Name of Contact Person:
Phone Number: [redacted]
Date of First Contact: **10/2012**
Date of Last Contact: **12/2012**
Date of Next Contact, if any:
Reason for Contacts: **Applied for Workers' Comp benefits and was denied**

## Activities/Training

Edit ✔ Activities

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

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

Edit ✔ Work and Education

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

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

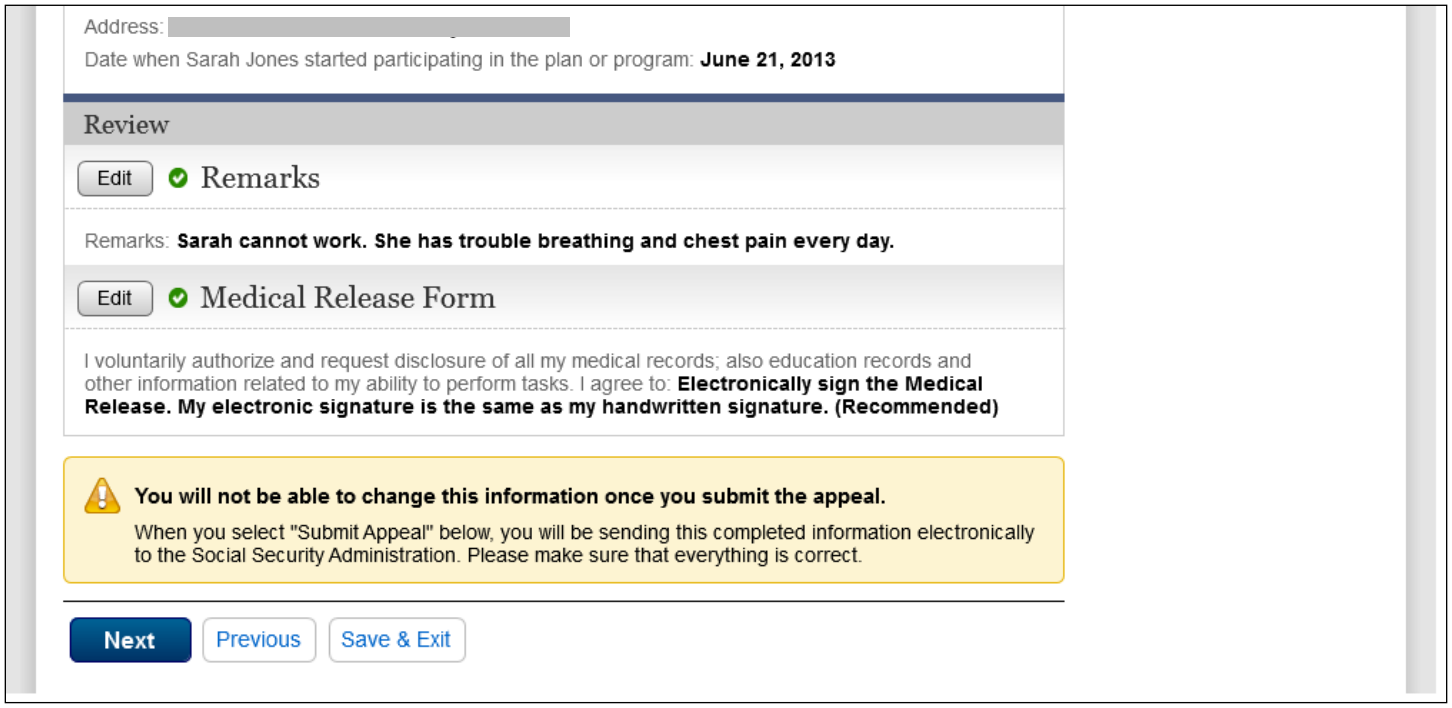
What type? **Computer training**

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

Edit ✔ Vocational Rehabilitation, Employment, or Other Support

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

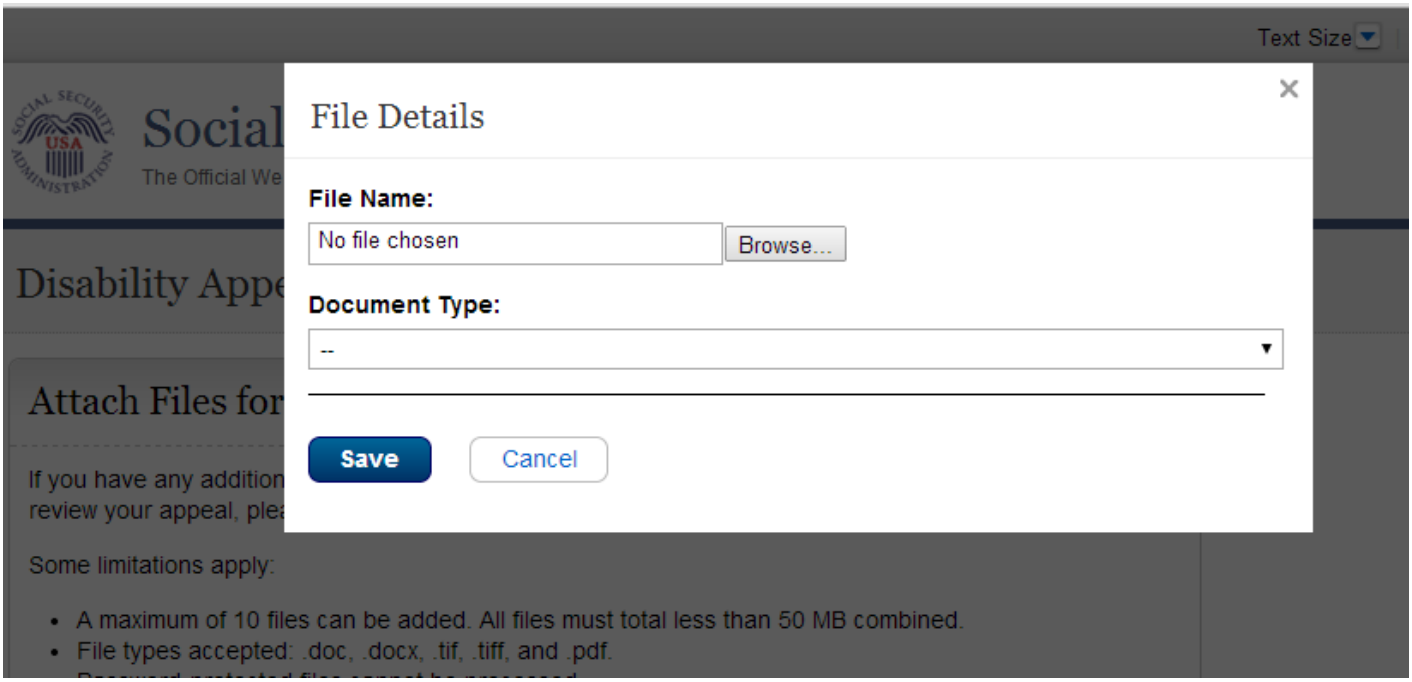
Name of Organization or School: **Online U**
Name of Counselor, Instructor, or Job Coach:
Phone Number: [redacted]


Address:
Date when Sarah Jones started participating in the plan or program: June 21, 2013
Review
Edit
Remarks
Remarks: Sarah cannot work. She has trouble breathing and chest pain every day.
Edit
Medical Release Form
I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)
You will not be able to change this information once you submit the appeal.
When you select "Submit Appeal" below, you will be sending this completed information electronically to the Social Security Administration. Please make sure that everything is correct.
Next
Previous
Save & Exit

## 3.76. Attach File: No Files Added

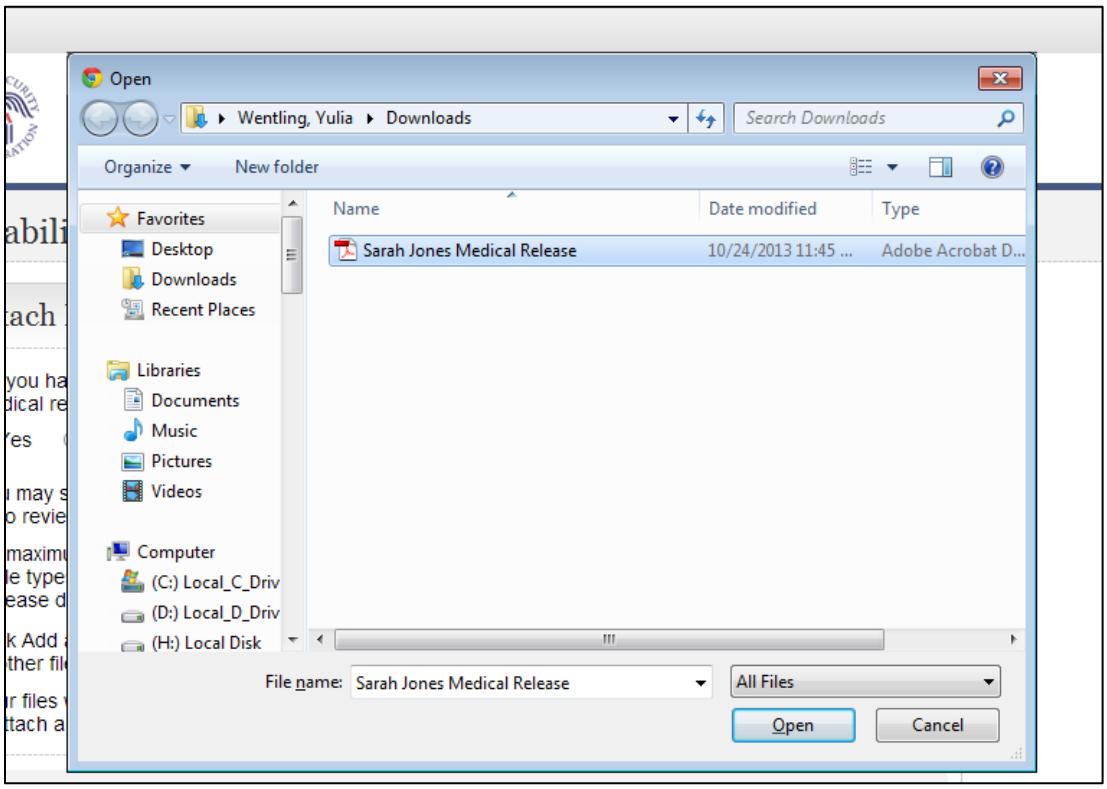

To add a file, user selects “Add File” button.

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



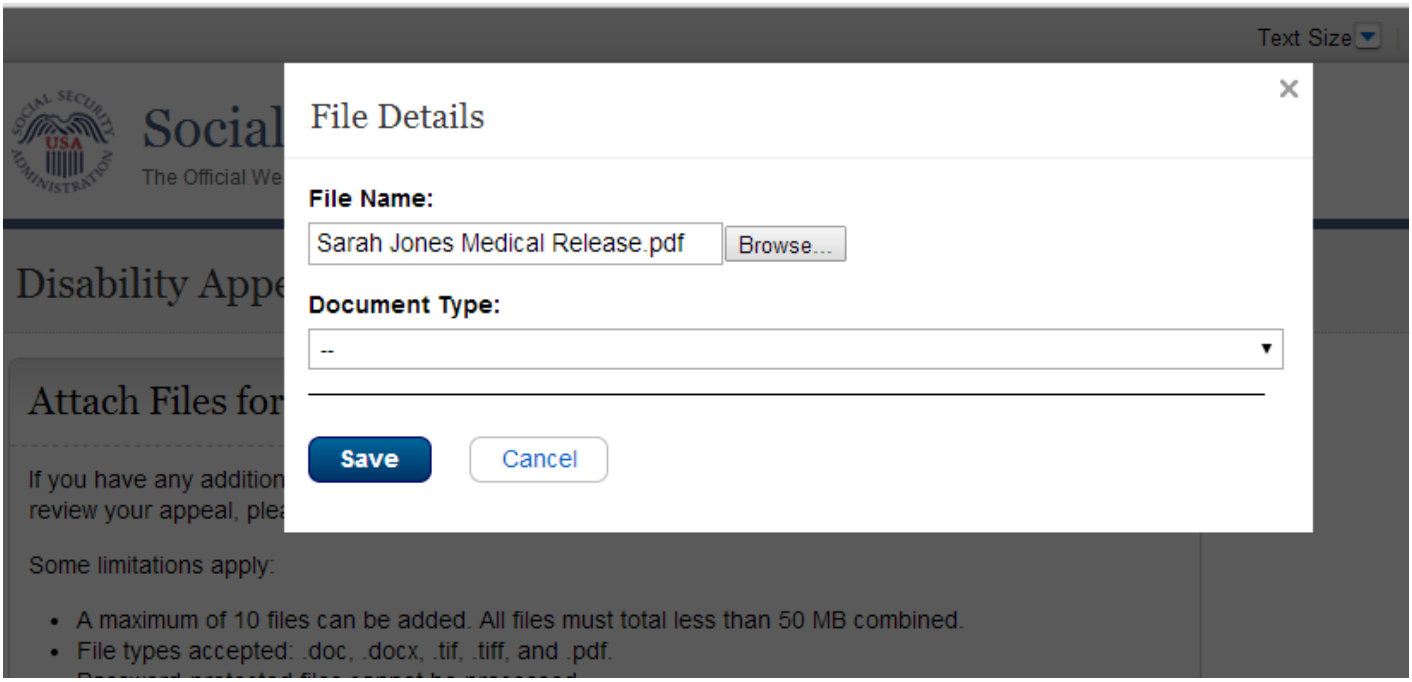

User selects “Browse” button to locate file to attach.

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




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

## 3.79. Attach Files: Select Document Type




User would select the type of document being attached.

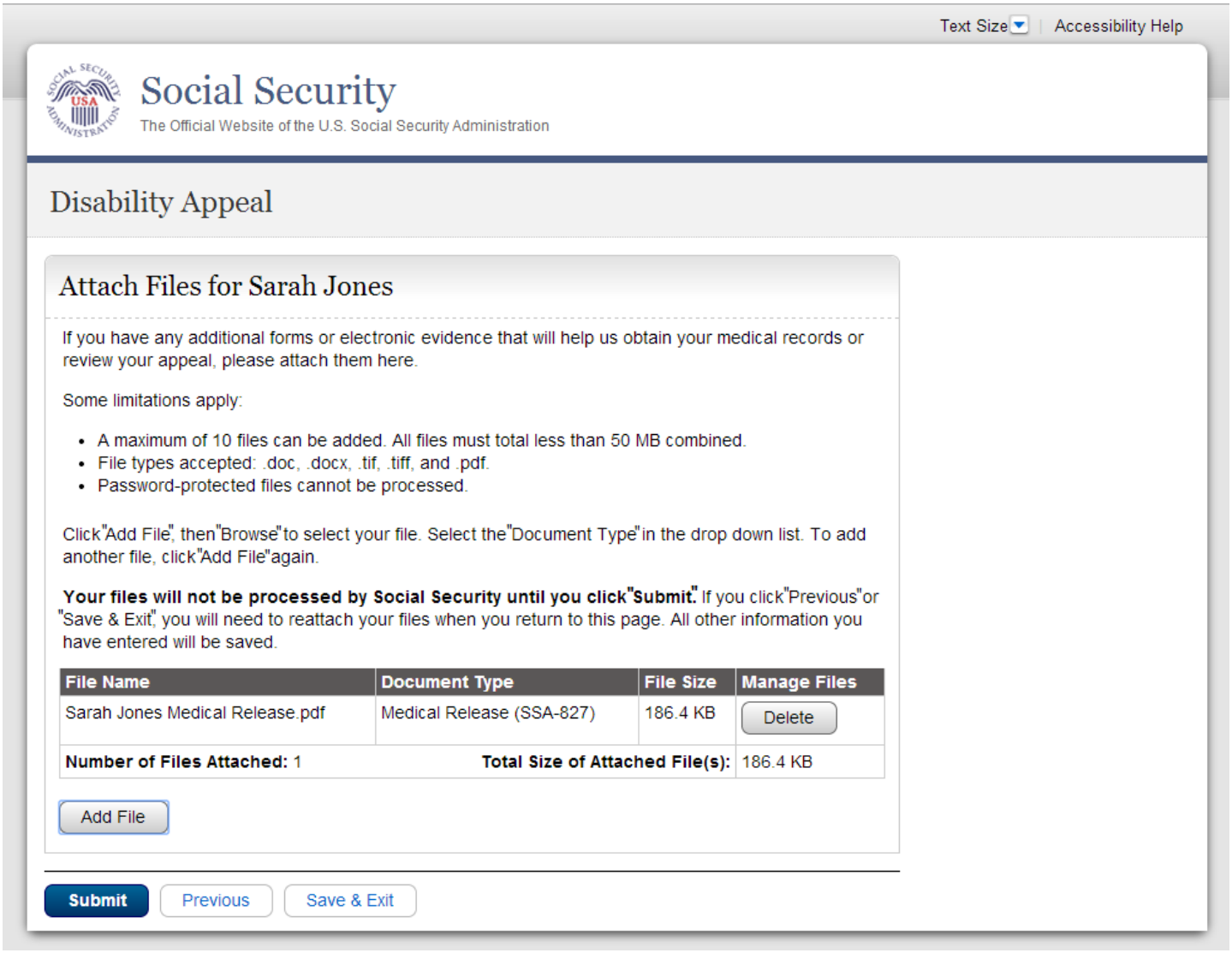
### List of options for Attorney Representatives & Staff and Non-Attorney Representatives & Staff:

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

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

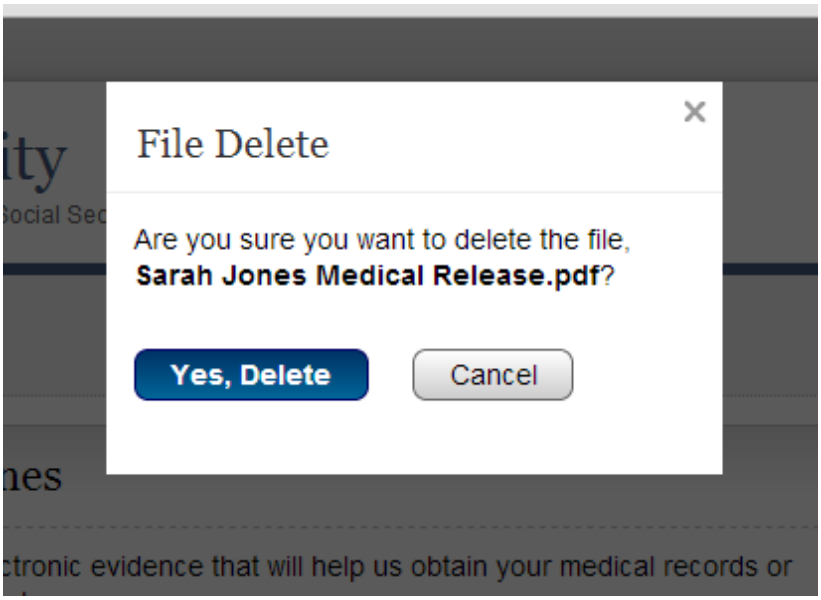
- Identifying Information for Possible Direct Payment of Authorized Fees (SSA-1695)
- Fee Agreement
- Representative Brief

## 3.80. Attach Files: One file attached



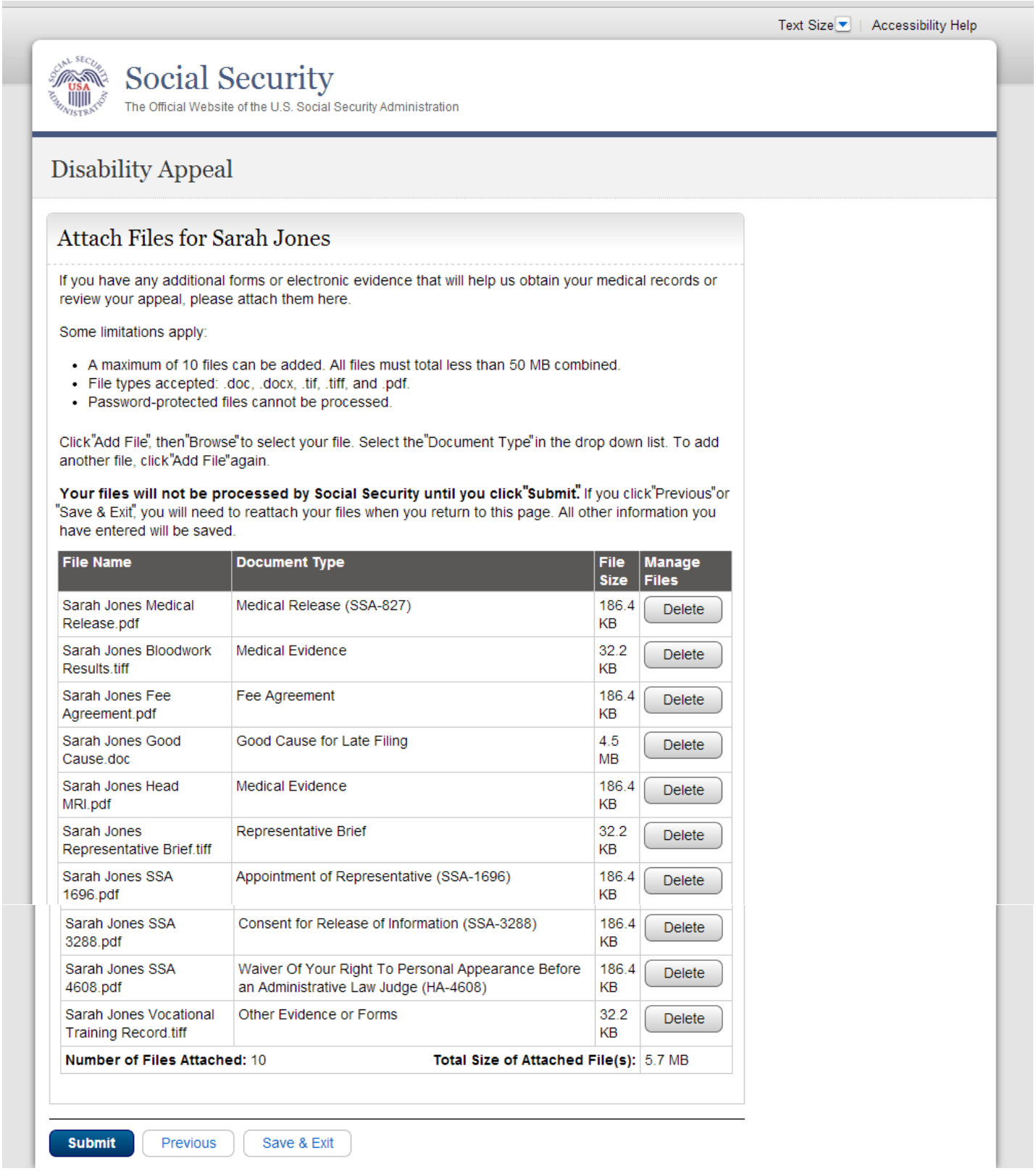
### 3.81. Attach Files: Delete Confirmation

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

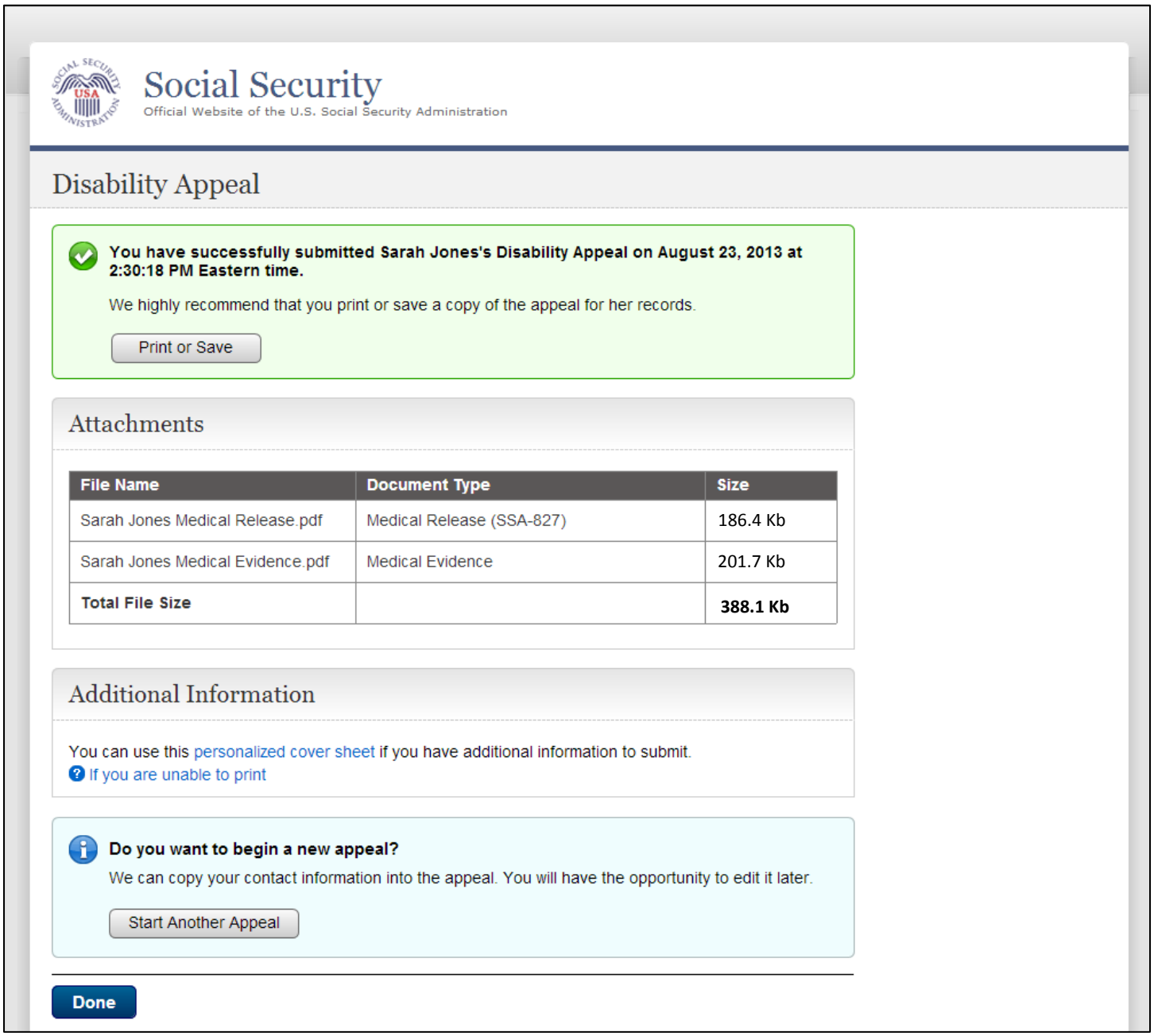


## 3.82. Attach Files: Maximum (10) number of files attached

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

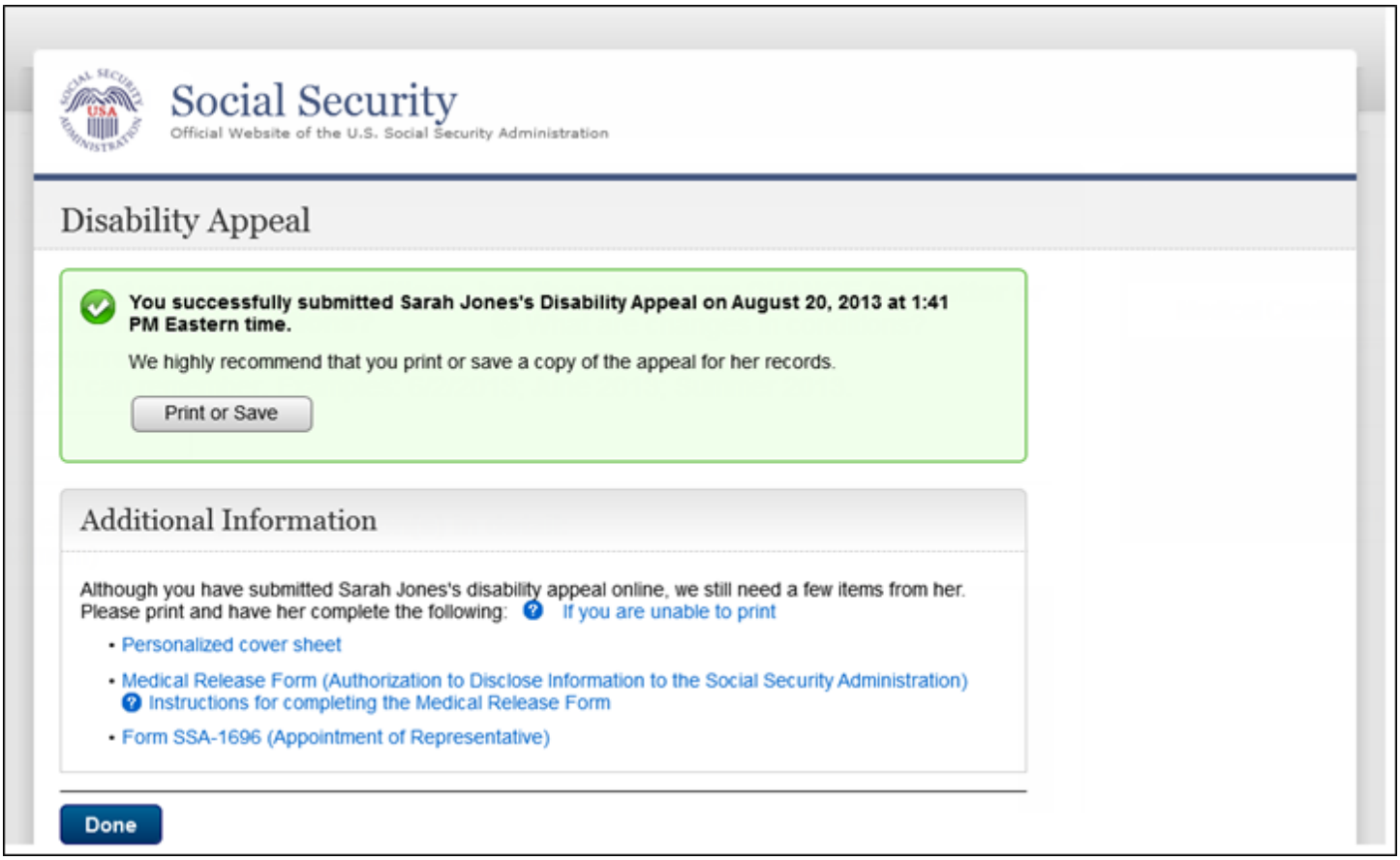


## 3.83. Confirmation with Attachments – 3rd Party Public



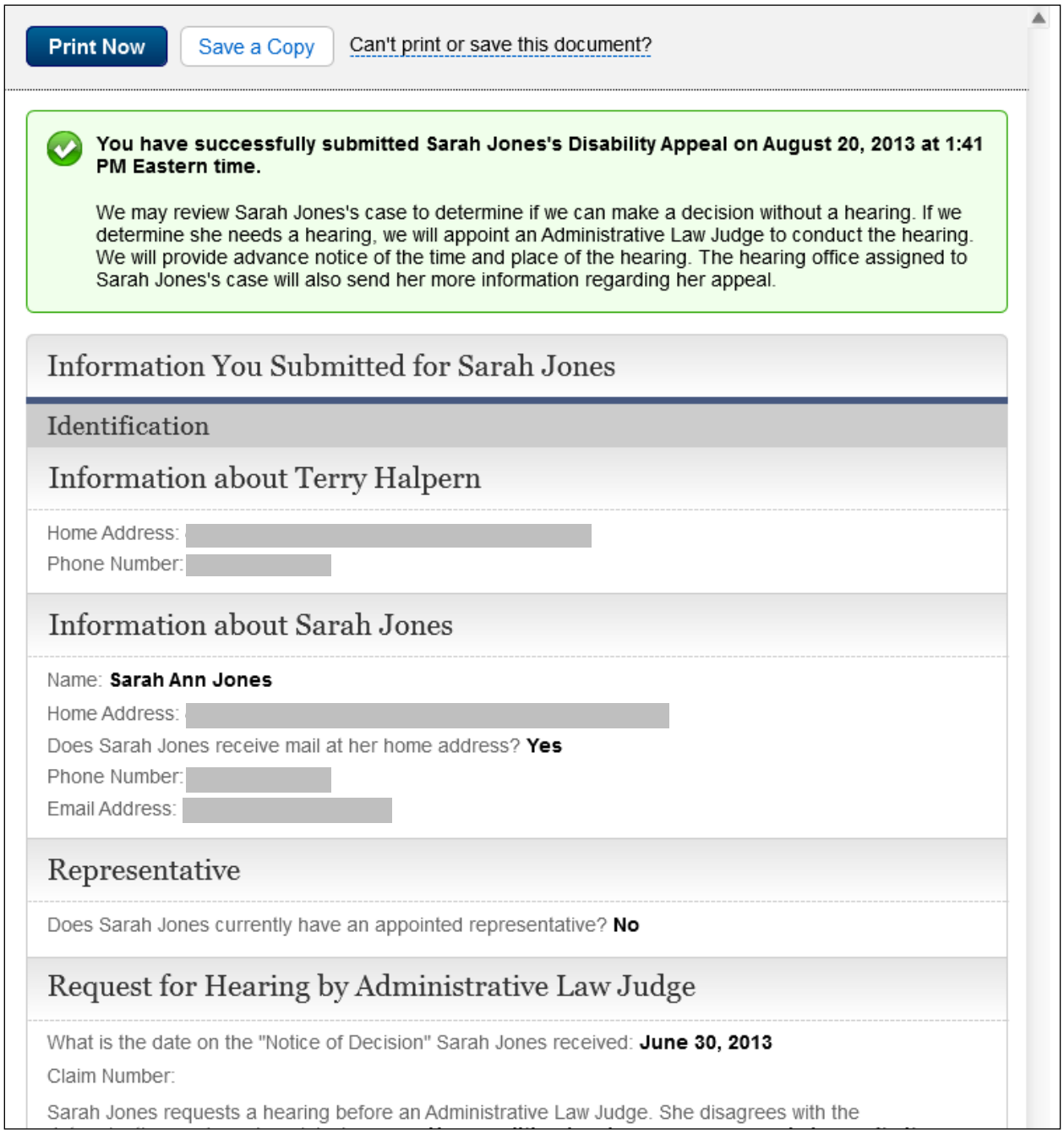

This sample shows an appeal with 2 files attached and uploaded.

## 3.84. Confirmation without Attachments – 3rd Party Public: With Bullets



## 3.85. Receipt Pop up without Attachments – 3rd Party Public

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



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

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

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

## Medical Information

### Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to Sarah Jones: **Family Member**

Address:

Daytime Phone Number:

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

### Medical Conditions

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

Approximate date change occurred: **January**

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

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

### Medical Treatment

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

Other Name 1: **Sarah Smith**

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

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

### Doctors and Hospitals

**Doctor or Healthcare Provider 1**

Name: **Dr. Samantha Gupta**

Address:

Phone Number:

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

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

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

Treatments Received:

**Doctor or Healthcare Provider 2**

Name: **Dr. Elijah Saunders**

Address:

**Hospital or Clinic 1**

Name: **Vancouver General Hospital**

Address:

Phone Number:

Emergency Room Visits: **Yes**

Emergency Room Visit 1 : **June 2013**

Inpatient Stays: **No**

Outpatient Visits: **No**

Medical conditions treated: **Heart attack**

Treatment Received:

## Tests

**Test 1**

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

Date of Test: **June 2013**

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

**Test 2**

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

Date of Test: **June 2013**

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

**Test 3**
Kind of test: **Breathing Test**
Date of Test: **June 2013**
Sent for test by: **Dr. Samantha Gupta**

## Medicines

**Medicine 1**
Medicine: **Singulair**
Reason: **Asthma**
Side Effects:
Prescribed by: **Dr. Samantha Gupta**

**Medicine 2**
Medicine: **Plavix**
Reason: **Heart Disease**
Side Effects:
Prescribed by: **Doctors at Vancouver General Hospital**

**Medicine 3**
Medicine: **Cymbalta**
Reason: **Depression and Pain Management**
Side Effects:
Prescribed by: **Dr. Elijah Saunders**

**Medicine 4**
Medicine: **Tylenol**
Reason: **Headache**
Side Effects:
Prescribed by: **No one prescribed this medicine**

## Other Medical Information

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

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

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

Claim or ID Number, if any:

Address:

Name of Contact Person:

Phone Number:

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

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

Date of Next Contact, if any:

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

## Activities/Training

### Activities

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

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

### Work and Education

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

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

### Vocational Rehabilitation, Employment, or Other Support

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

## Review

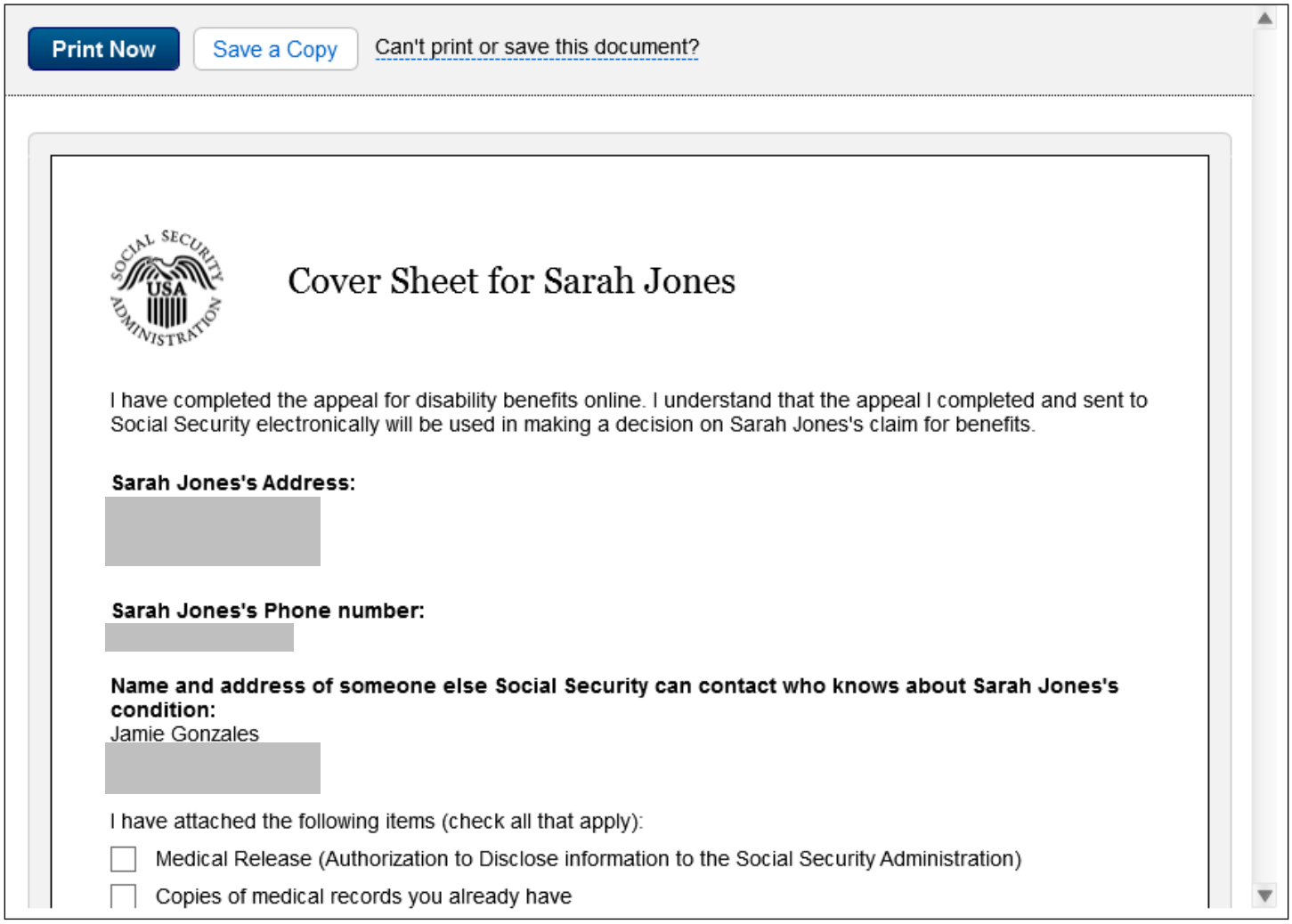
### Remarks

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

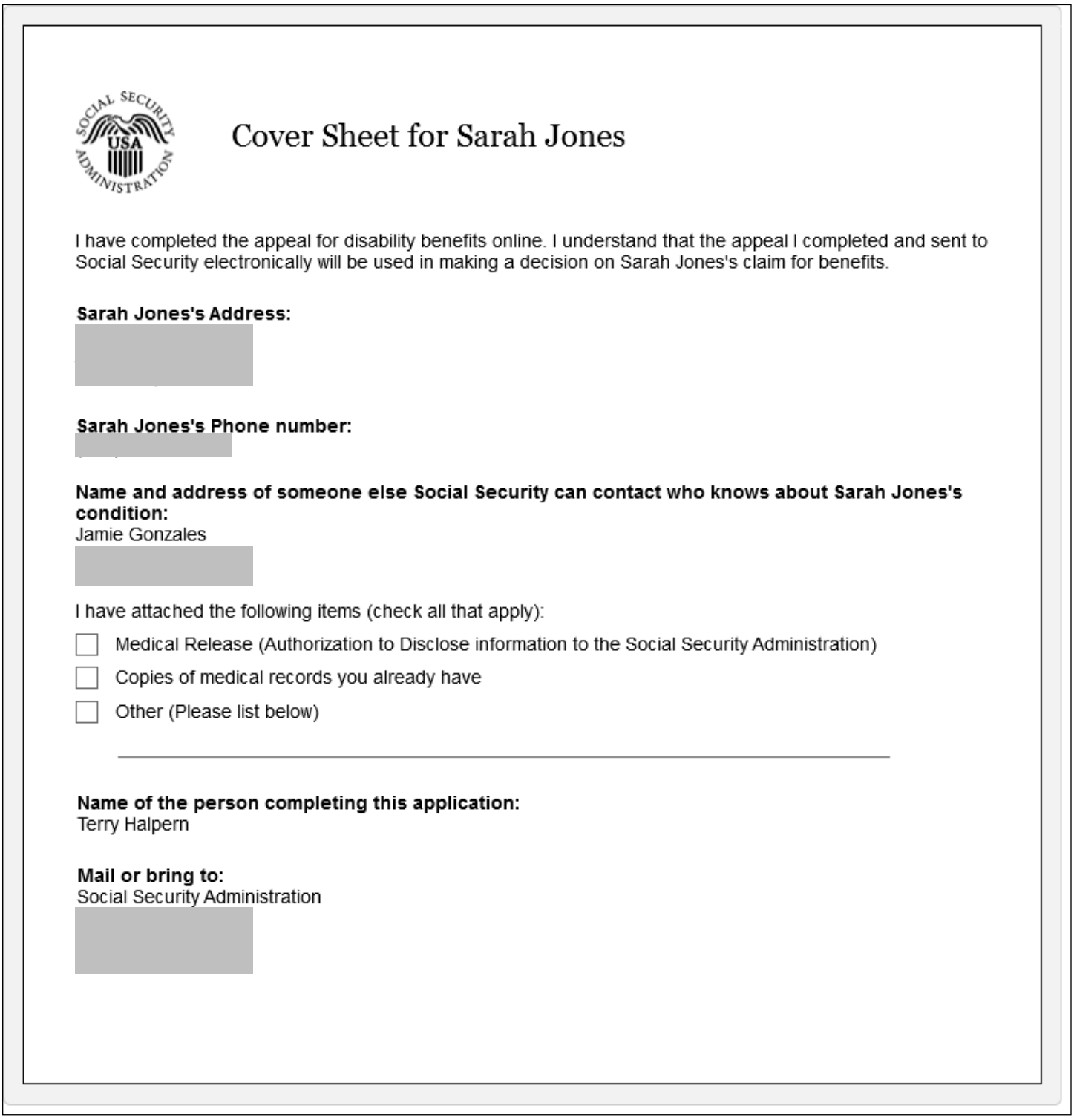
### Medical Release Form

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

## 3.86. Cover Sheet Popup – 3rd Party Public



## 3.87. Cover Sheet Content – 3rd Party Public



Cover Sheet for Sarah Jones

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

**Sarah Jones's Address:**

**Sarah Jones's Phone number:**

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

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

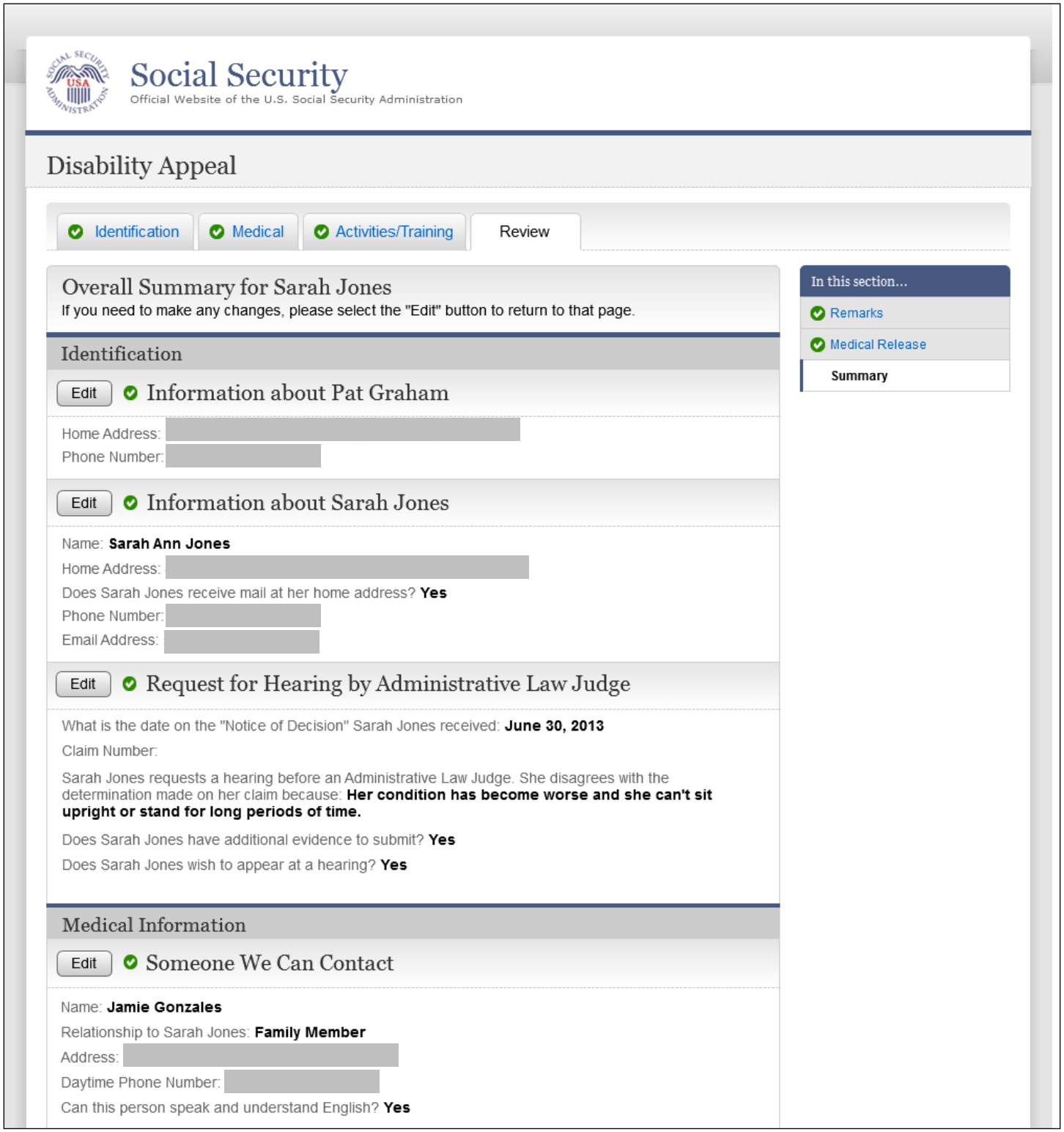
- ☐ Medical Release (Authorization to Disclose information to the Social Security Administration)
- ☐ Copies of medical records you already have
- ☐ Other (Please list below)

_____

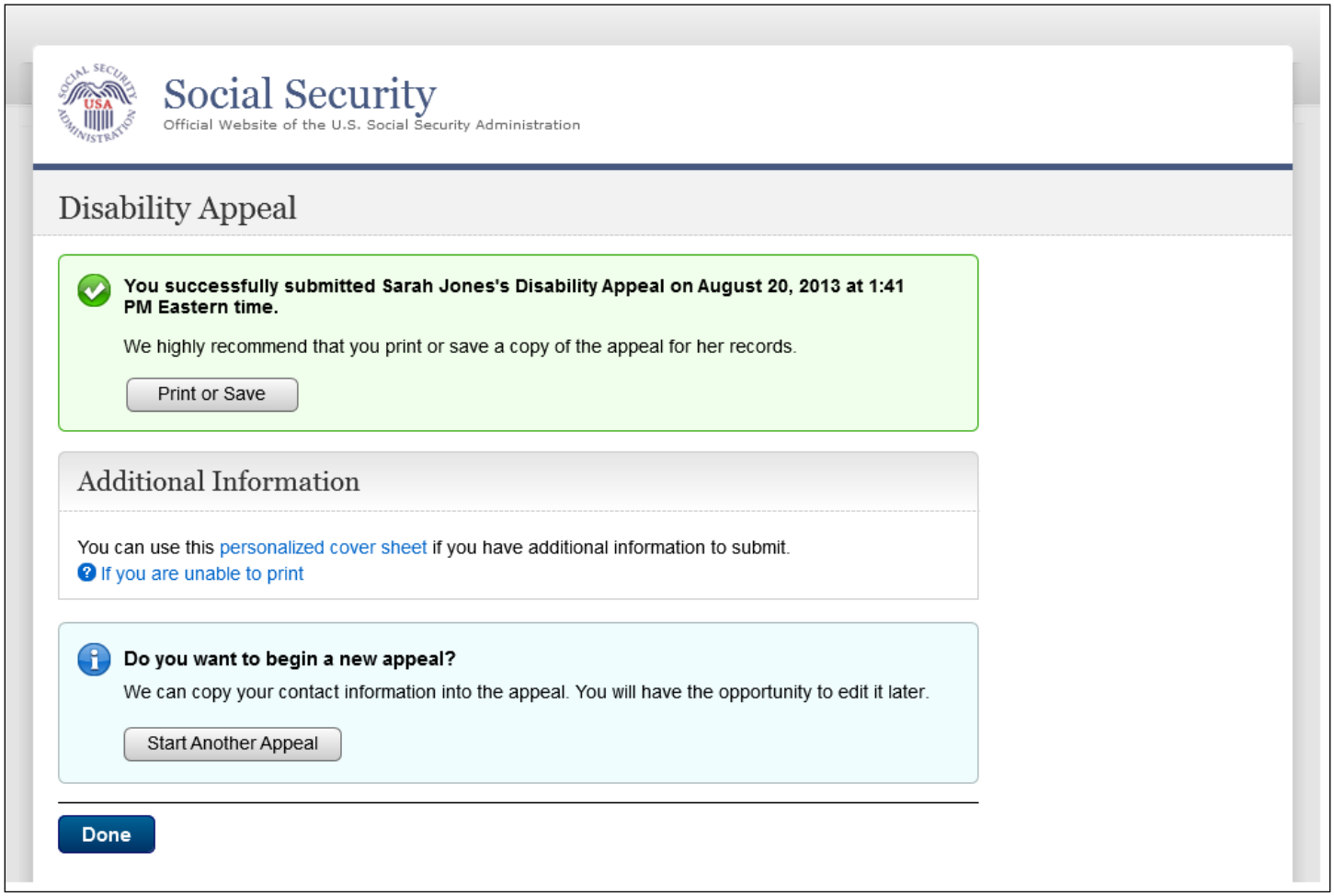
**Name of the person completing this application:**
Terry Halpern

**Mail or bring to:**
Social Security Administration

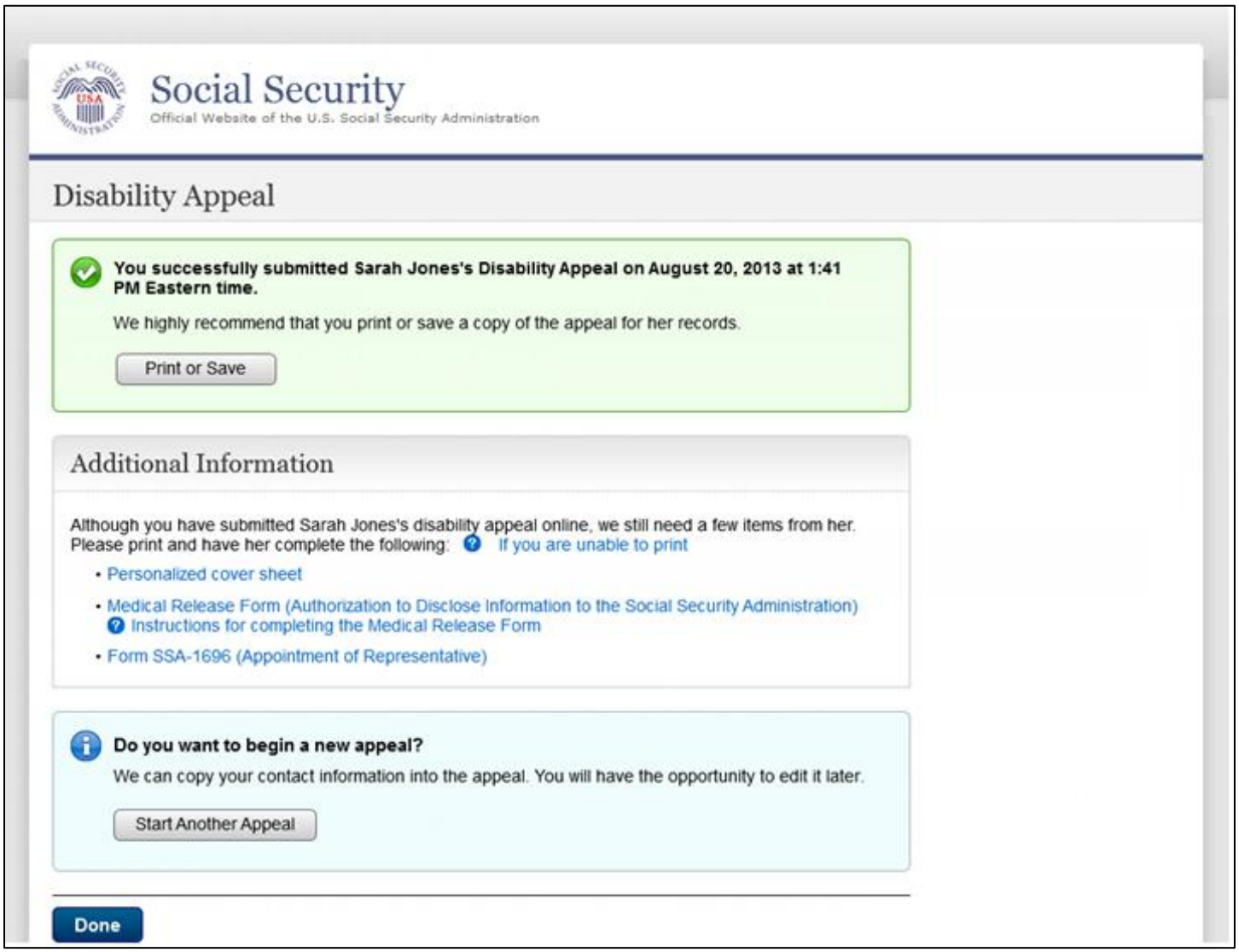
## 3.88. Overall Summary – Showing section for 3rd Party Professional Rep



## 3.89. Confirmation – 3rd Party Professional Rep

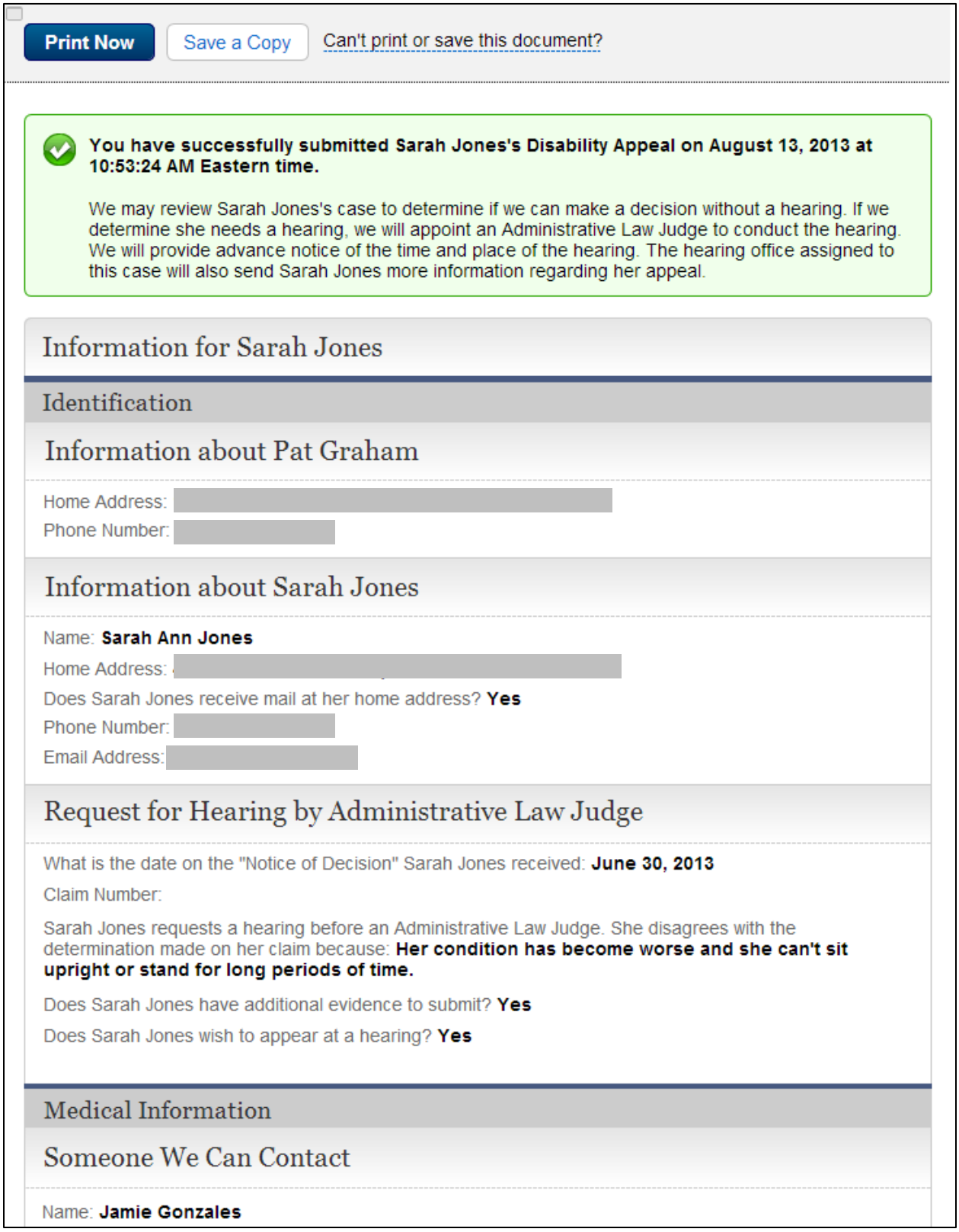


## 3.90. Confirmation – 3rd Party Professional Rep: With Bullets



## 3.91. Receipt Pop up – 3rd Party Professional Rep

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



Relationship to Sarah Jones: **Family Member**

Address:

Daytime Phone Number:

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

## Medical Conditions

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

Approximate date change occurred: **January**

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

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

## Medical Treatment

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

Other Name 1: **Sarah Smith**

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

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

## Doctors and Hospitals

**Doctor or Healthcare Provider 1**

Name: **Dr. Samantha Gupta**

Other Name 1: **Sarah Smith**

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

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

## Doctors and Hospitals

**Doctor or Healthcare Provider 1**

Name: **Dr. Samantha Gupta**

Address:

Phone Number:

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

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

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

Treatments Received: **Examinations**

**Doctor or Healthcare Provider 2**

Name: **Dr. Elijah Saunders**

Address:

**Hospital or Clinic 1**

Name: **Vancouver General Hospital**

Address:

Phone Number:

Emergency Room Visits: **Yes**

Emergency Room Visit 1 : **June 2013**

Inpatient Stays: **No**

Outpatient Visits: **No**

Medical conditions treated: **Heart attack**

Treatment Received:

## Tests

**Test 1**

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

Date of Test: **June 2013**

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

**Test 2**

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

Date of Test: **June 2013**

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

**Test 3**

Kind of test: **Breathing Test**

Date of Test: **June 2013**

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

## Medicines

**Medicine 1**

Medicine: **Singulair**

Reason: **Asthma**

Side Effects:

Prescribed by: **Dr. Samantha Gupta**

## Medicines

**Medicine 1**
Medicine: **Singulair**
Reason: **Asthma**
Side Effects:
Prescribed by: **Dr. Samantha Gupta**

**Medicine 2**
Medicine: **Plavix**
Reason: **Heart Disease**
Side Effects:
Prescribed by: **Doctors at Vancouver General Hospital**

**Medicine 3**
Medicine: **Cymbalta**
Reason: **Depression and Pain Management**
Side Effects:
Prescribed by: **Dr. Elijah Saunders**

**Medicine 4**
Medicine: **Tylenol**
Reason: **Headache**
Side Effects:
Prescribed by: **No one prescribed this medicine**

## Other Medical Information

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

Name of Organization: **Workers' Insurance, Inc.**
Claim or ID Number, if any:
Address:
Name of Contact Person:
Phone Number:
Date of First Contact: **10/2012**
Date of Last Contact: **12/2012**
Date of Next Contact, if any:
Reason for Contacts: **Applied for Workers' Comp benefits and was denied.**

## Activities/Training

### Activities

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

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

### Work and Education

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

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

### Vocational Rehabilitation, Employment, or Other Support

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

## Review

### Remarks

Remarks:

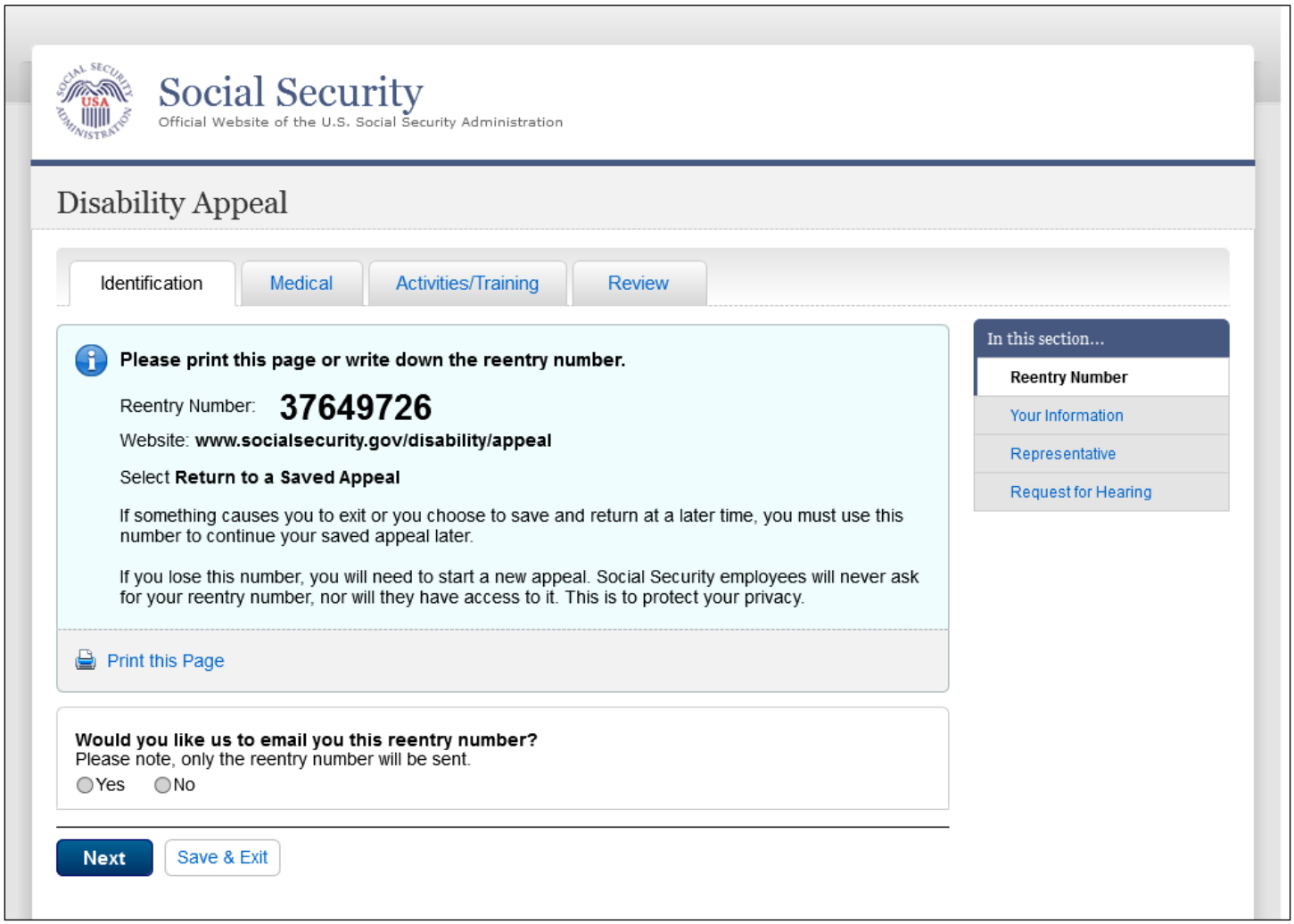
### Medical Release Form

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

# 4. First Party Screen Designs

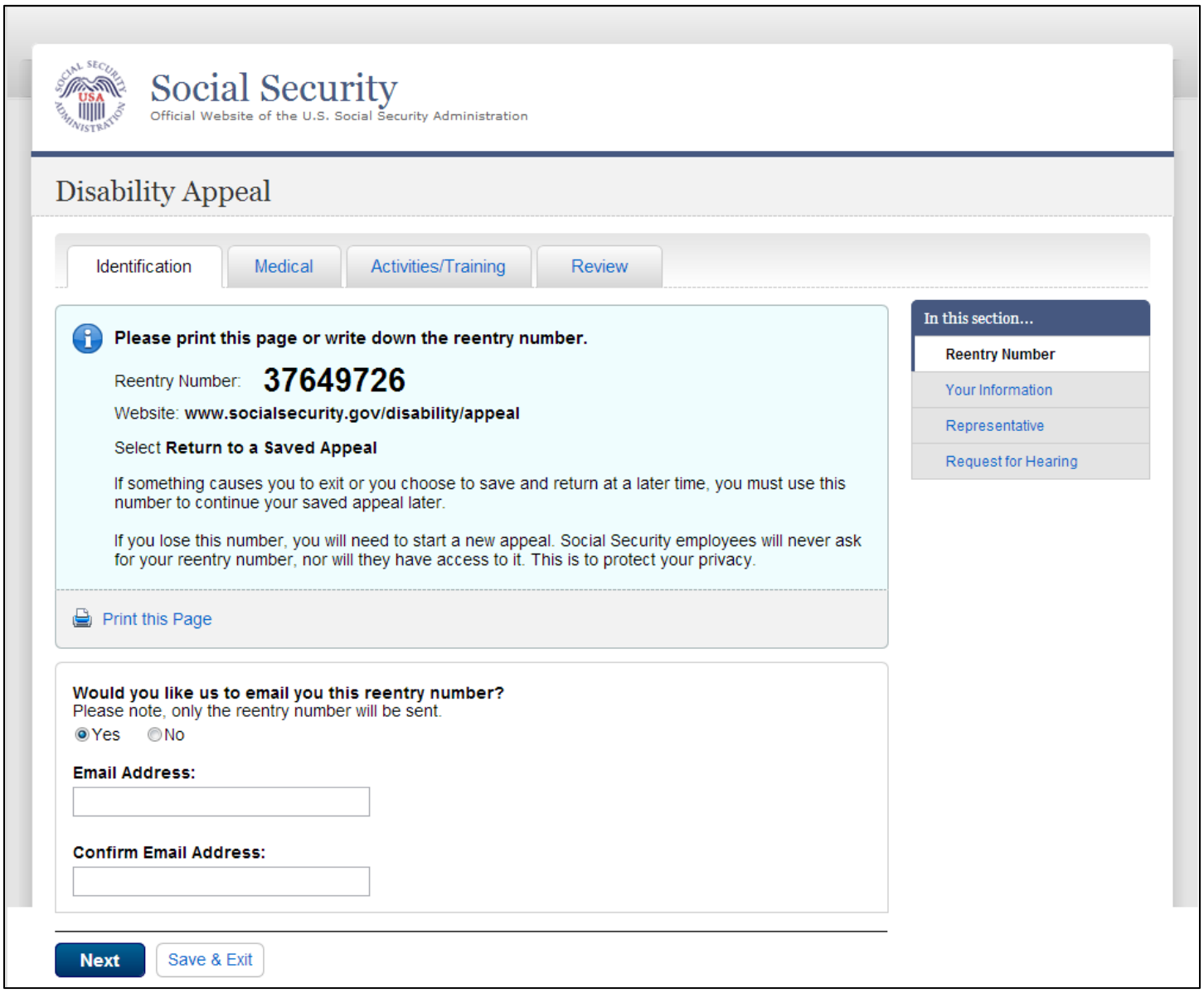
## 4.1. Reentry Number – 1st Party

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



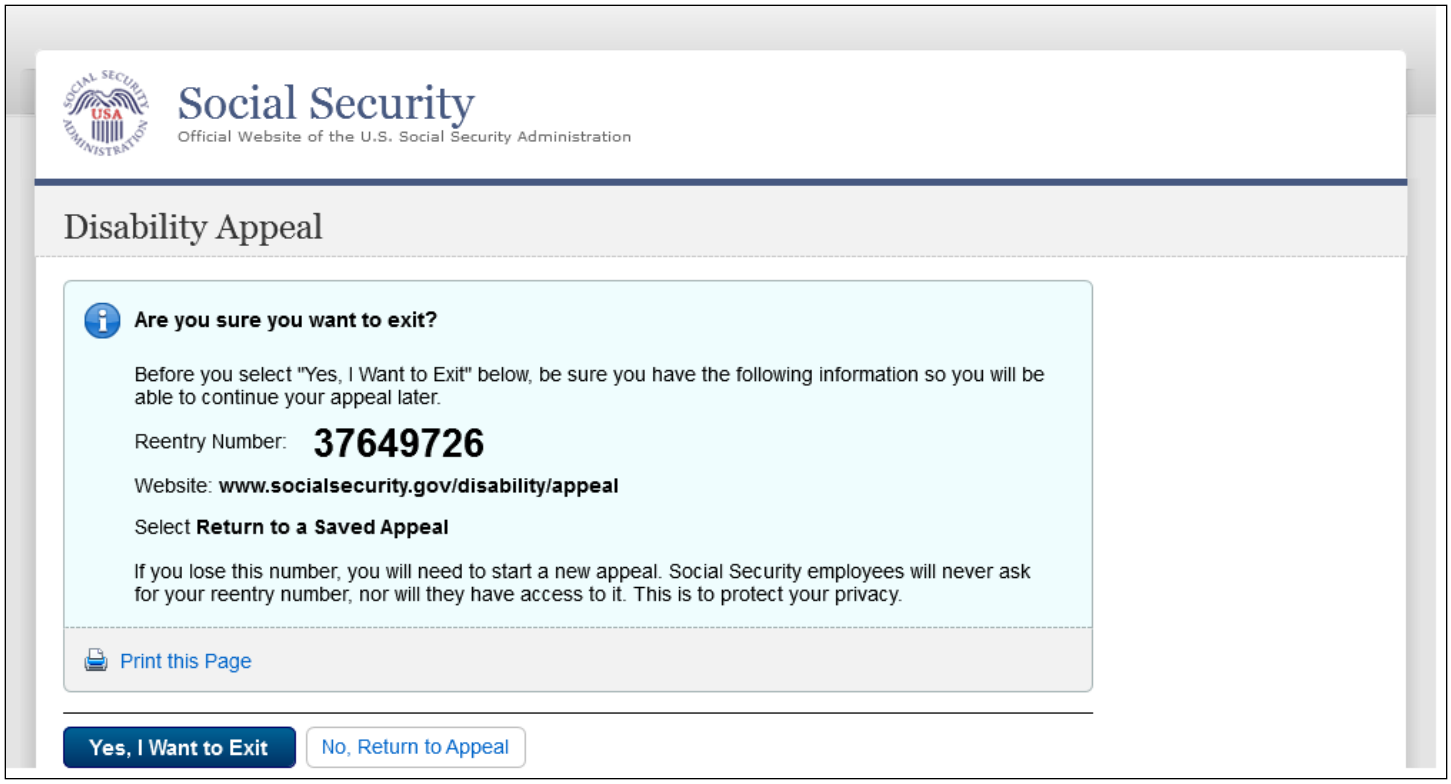
## 4.2. Reentry Number – 1st Party: Email Selected

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

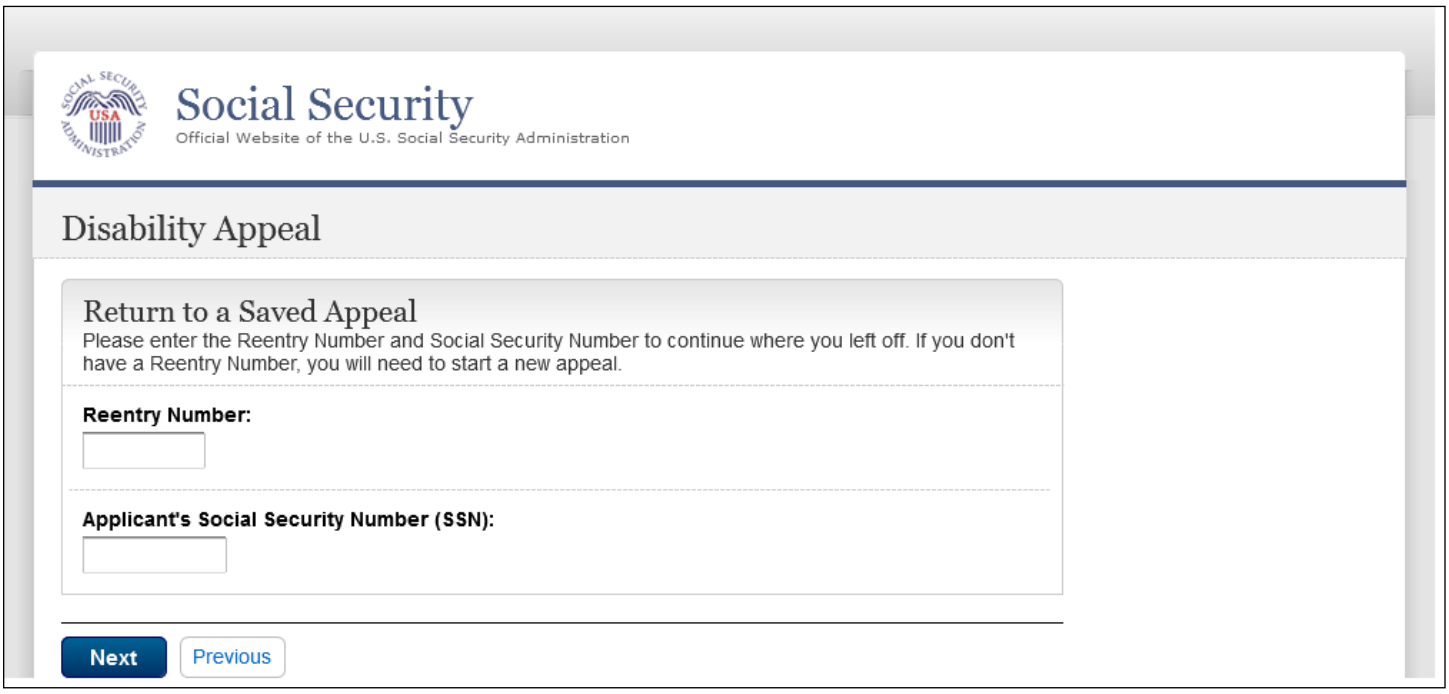


### 4.3. Are You Sure You Want to Exit

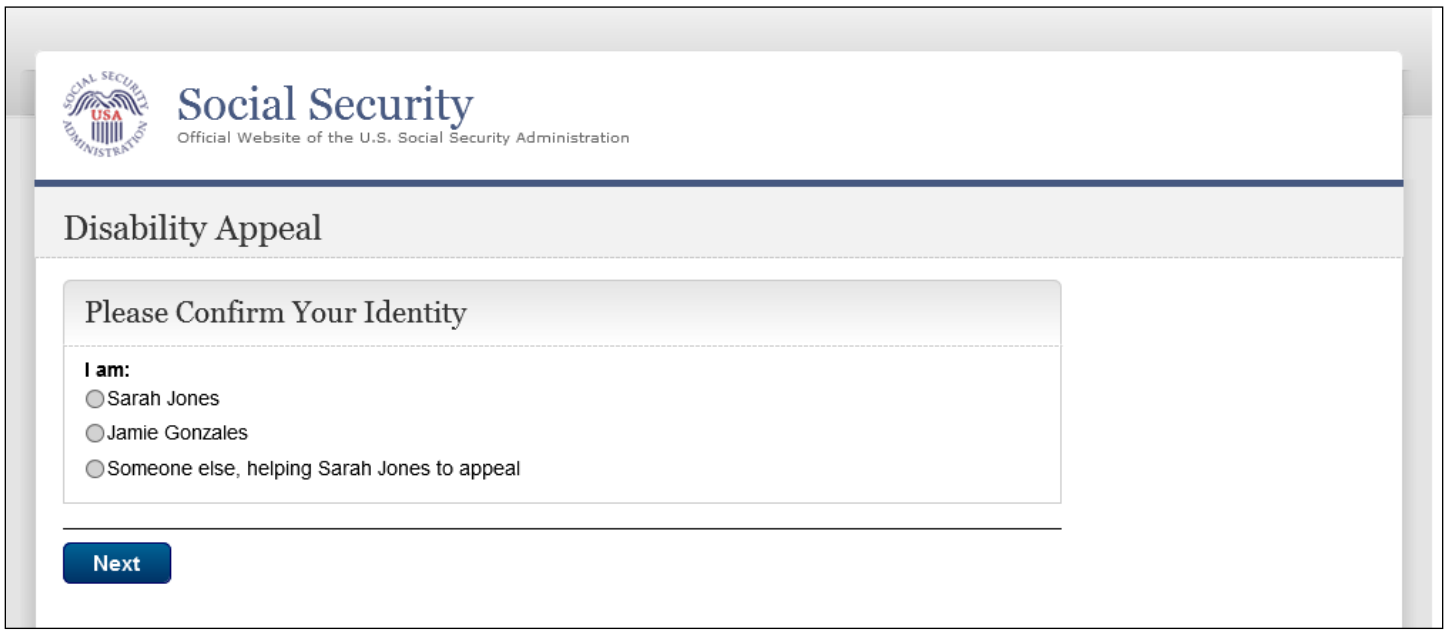
If the user did not choose to email the reentry number from the Reentry Number page, the container with the question "**Would you like us to email you this reentry number?" -** as shown on the Reentry Number page - will be displayed here above the navigation bar. If the user emailed the number previously,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



## 4.4. Return to a Saved Appeal



## 4.5. Who are You – 1st Party



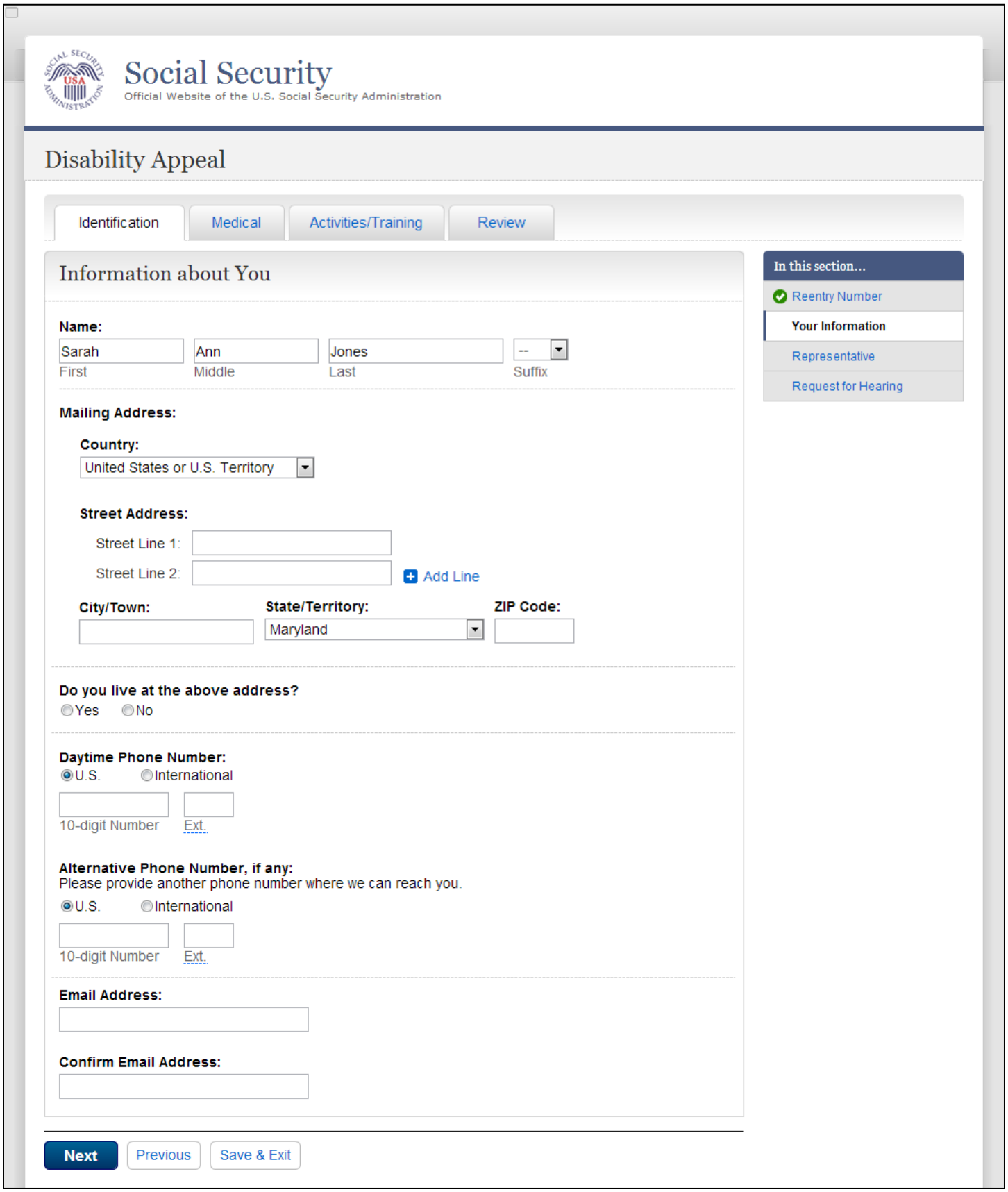

The possibilities for the radio list are determined based on data already provided in the claim. The names shown would correspond to the roles, which should be shown in the following order:

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

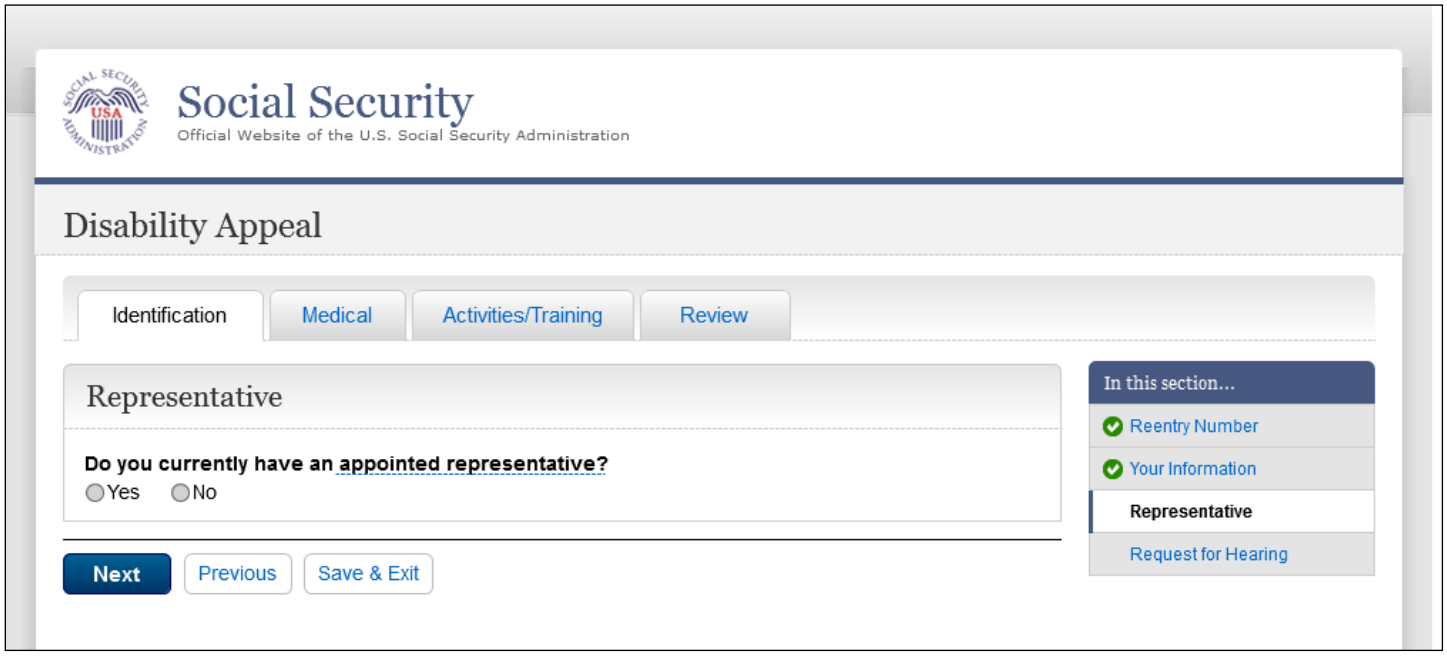
If option 4 is selected and completed, the data entered replaces the preparer information previously provided.

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

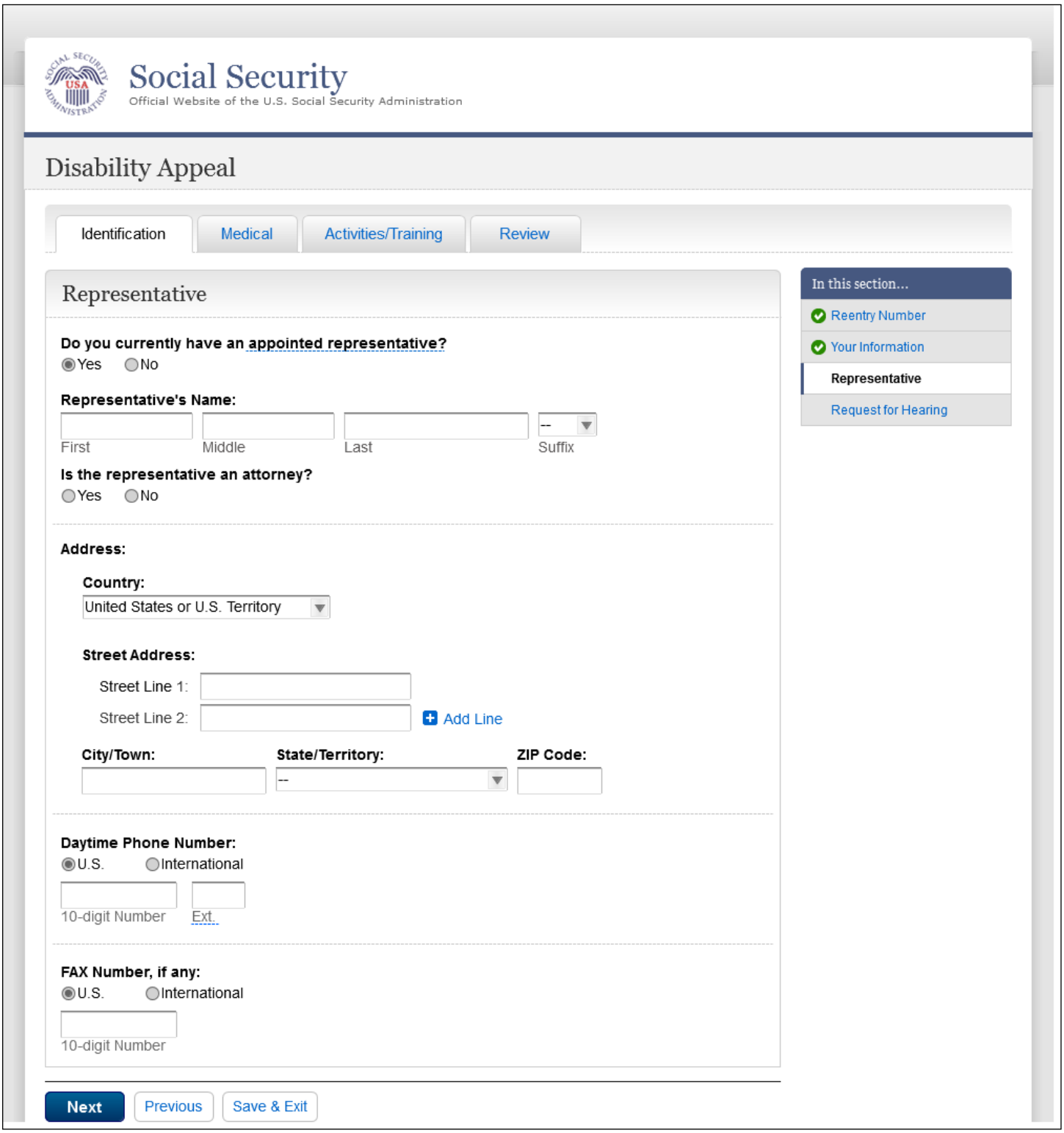
## 4.6. Applicant Detail – 1st Party



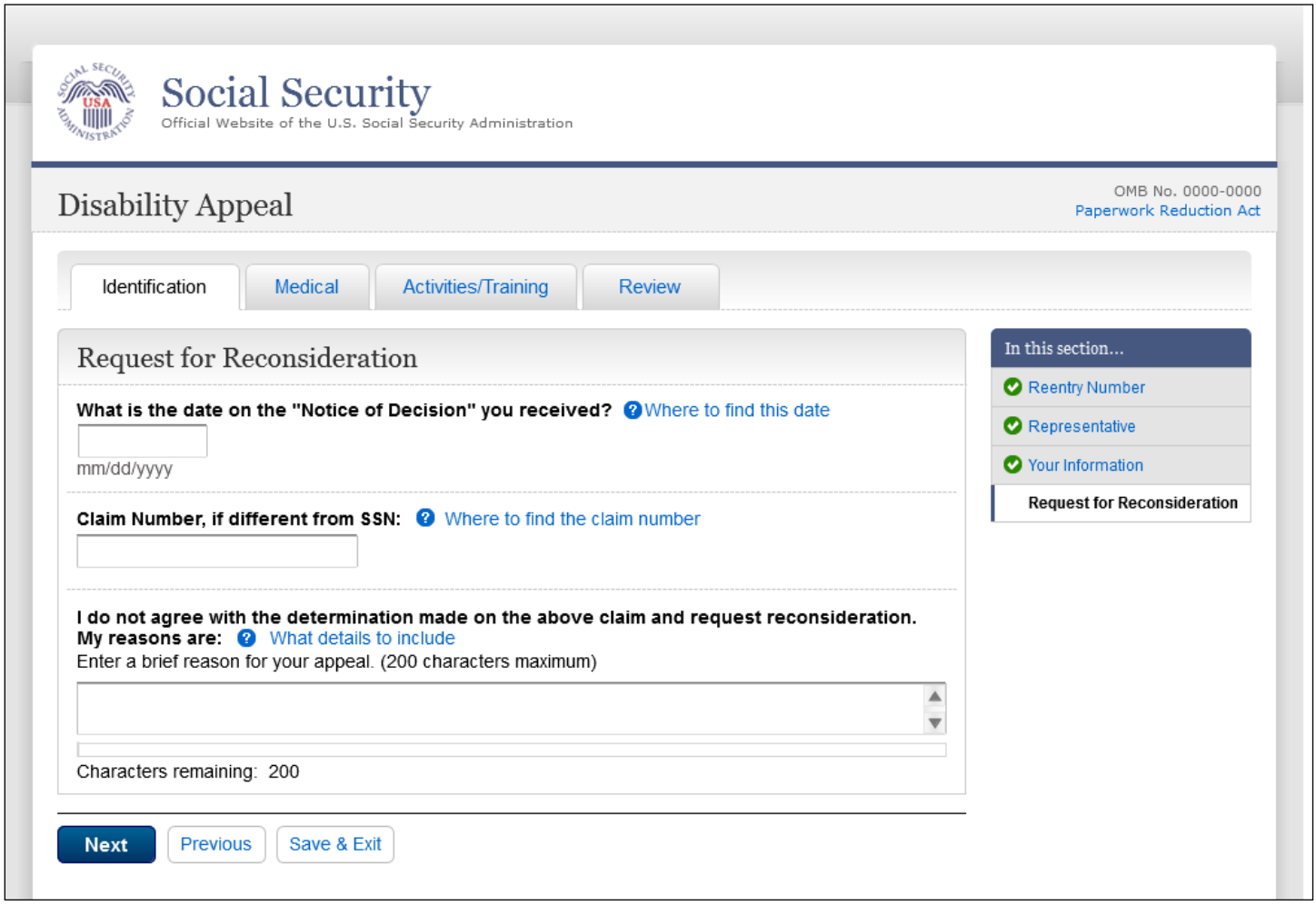
## 4.7. Rep – 1st Party



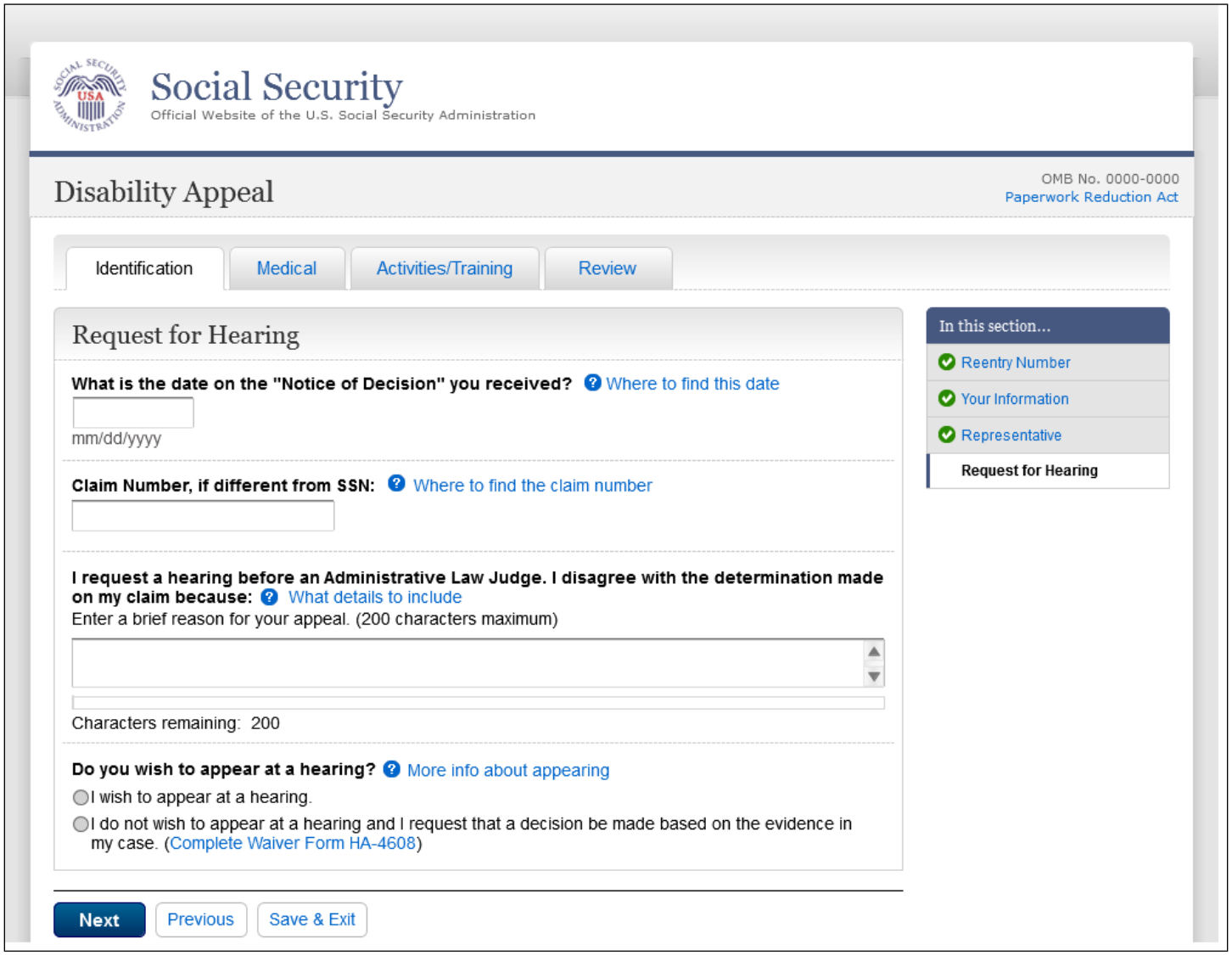
## 4.8. Rep – 1st Party: Yes Selected



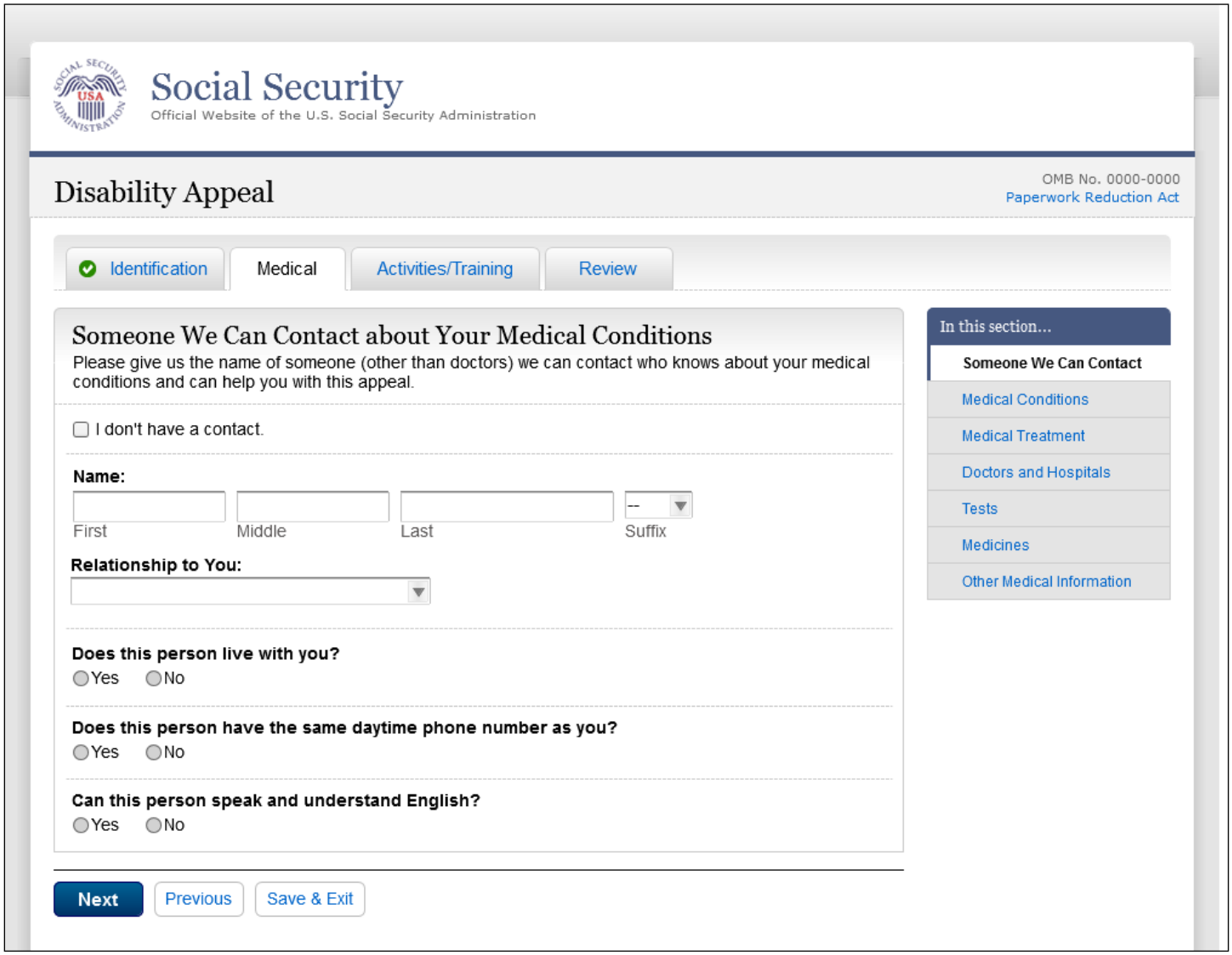
## 4.9. Request for Reconsideration – 1st Party



## 4.10. Request for Hearing – 1st Party



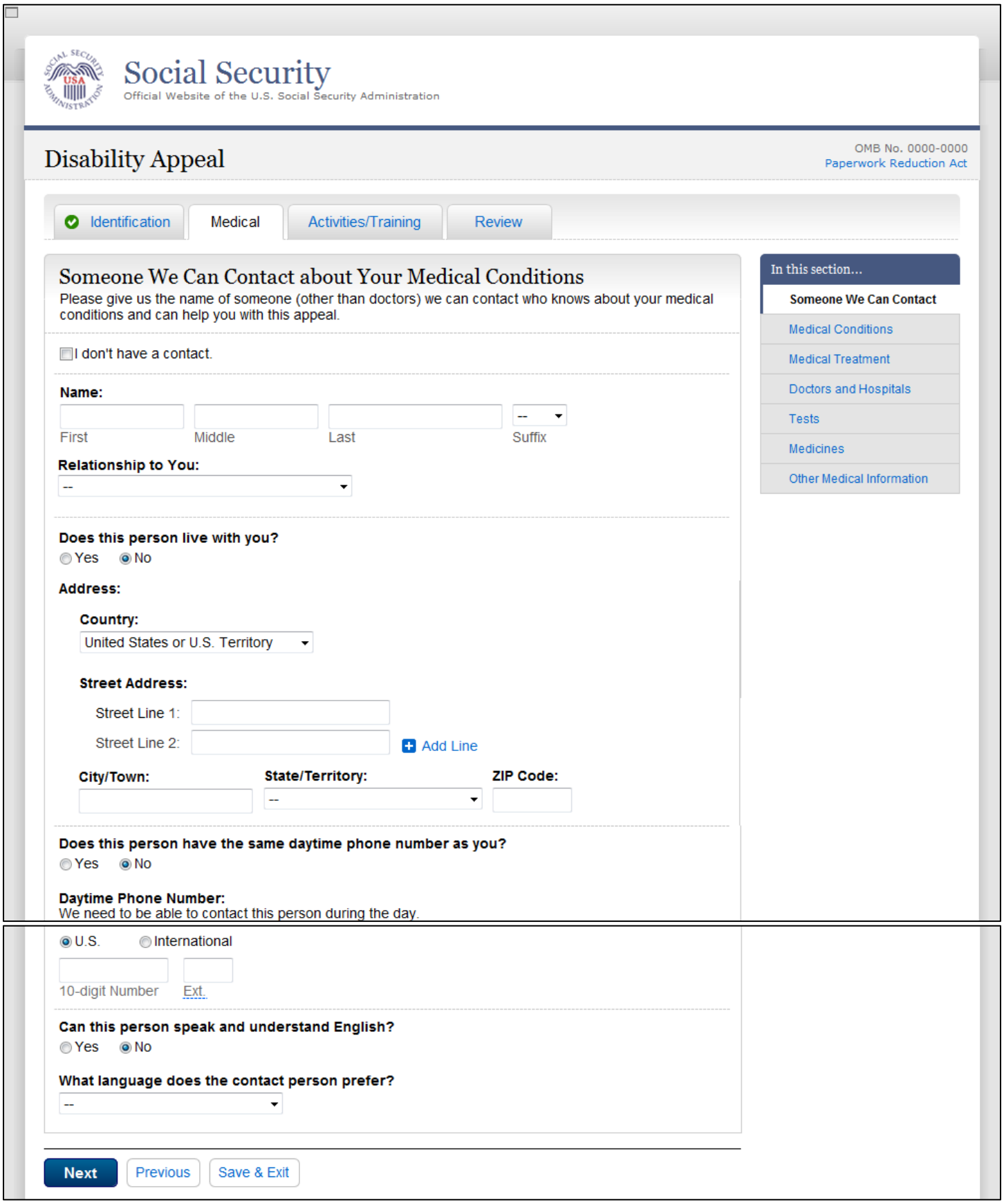
## 4.11. Someone We Can Contact – 1st Party



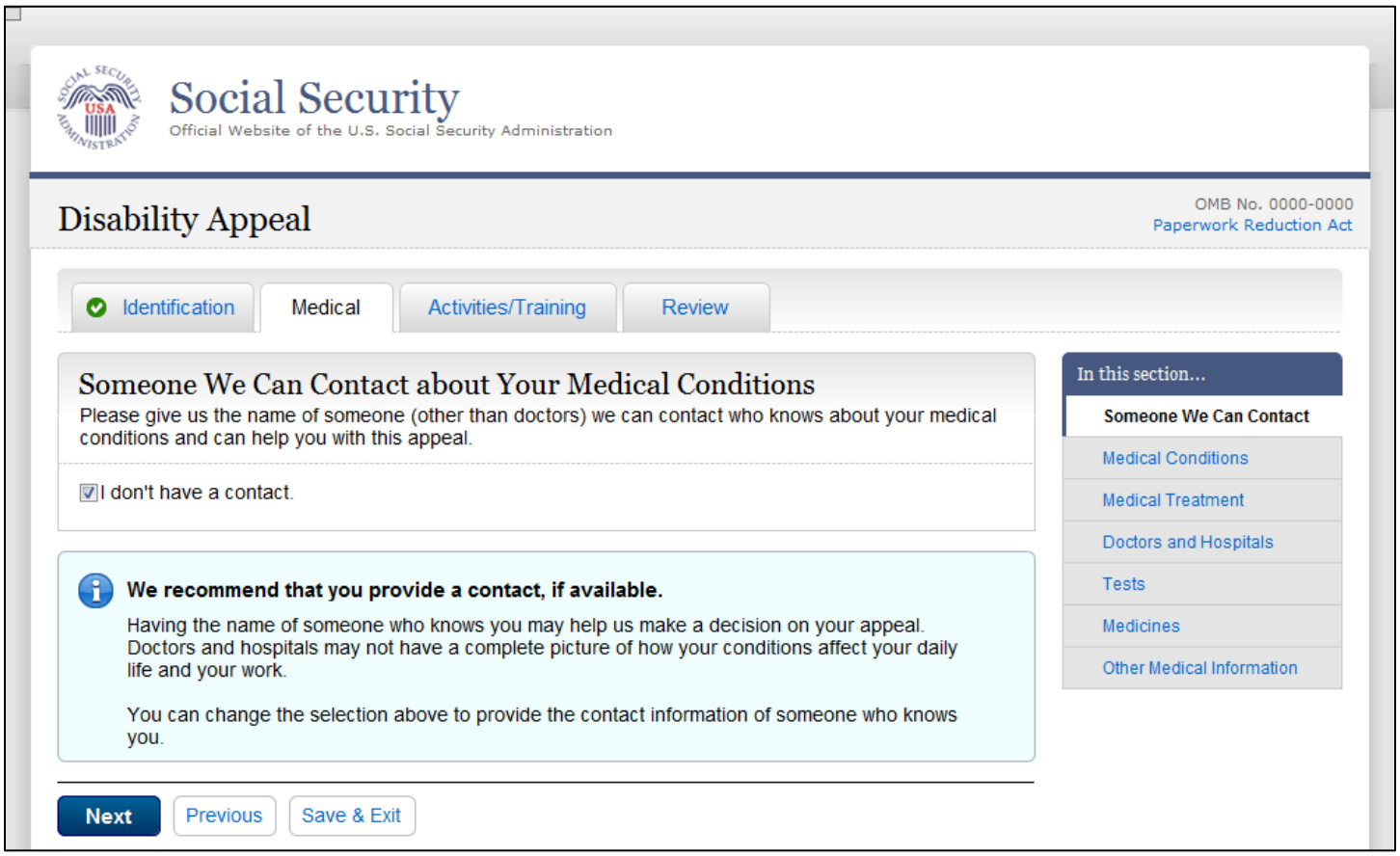

Contents of relationship drop list:

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

## 4.12. Someone We Can Contact – 1st Party: Follow up questions

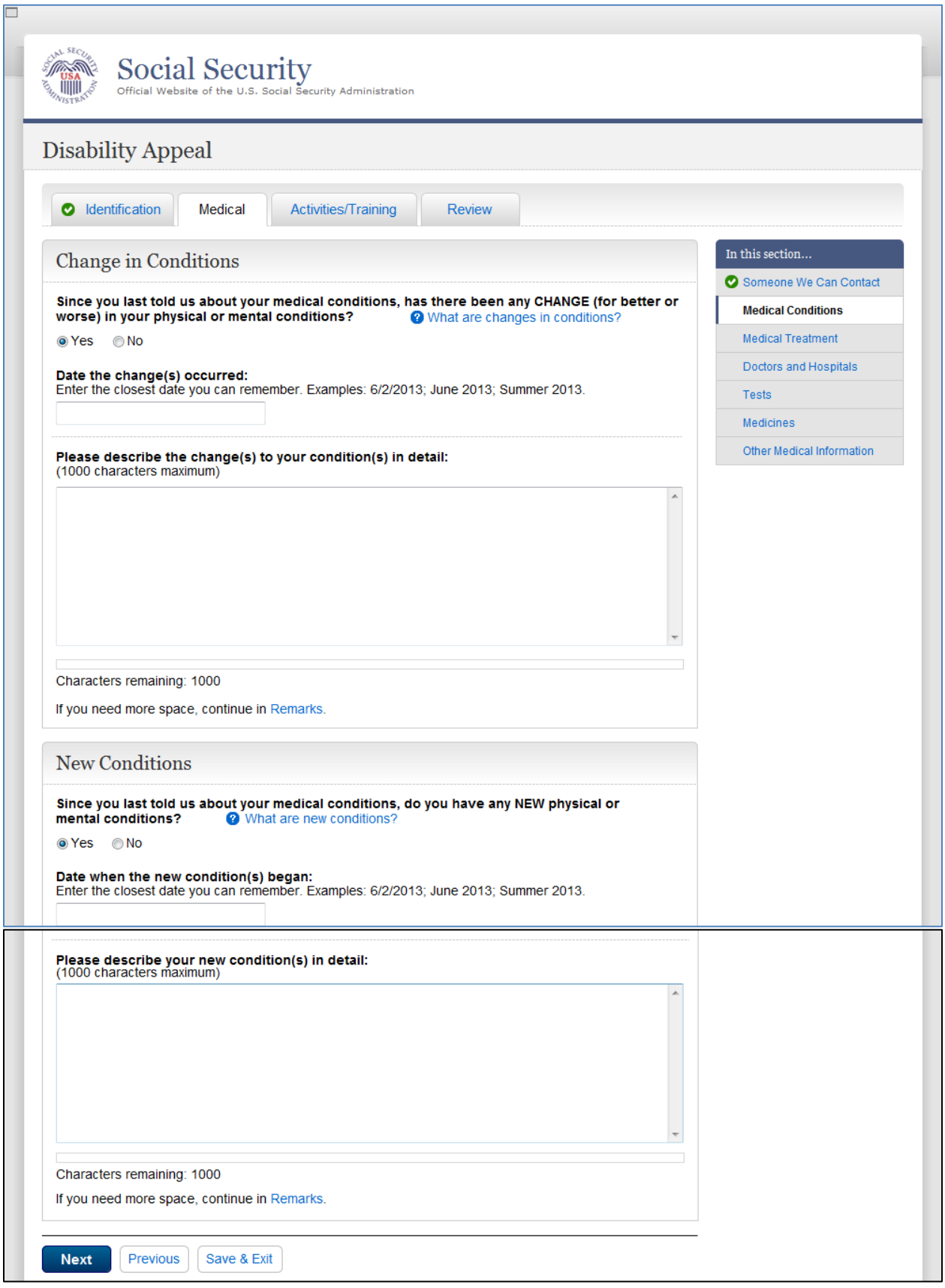


## 4.13. Someone We Can Contact – 1st Party: No Contact

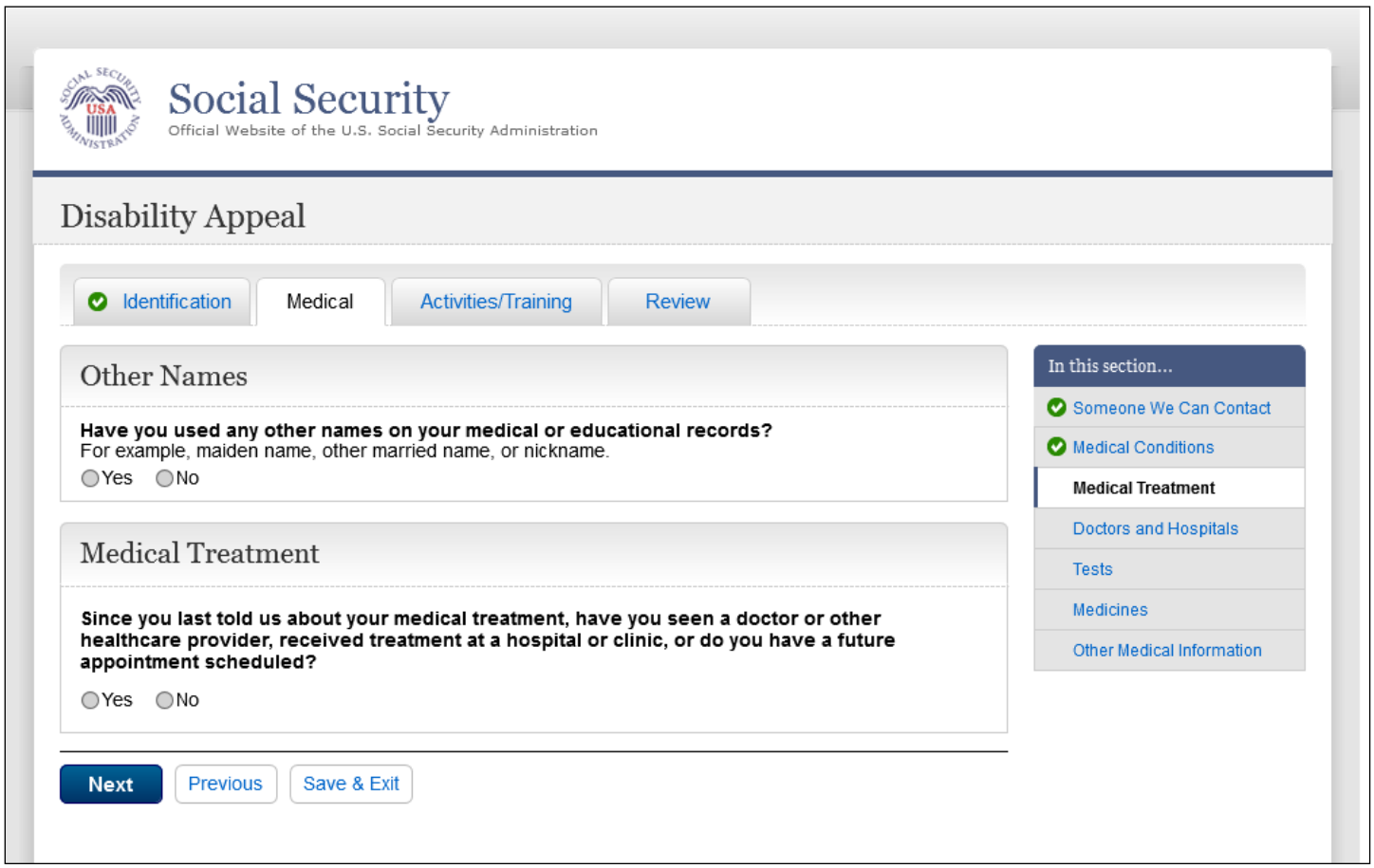


## 4.14. Section3: Medical Conditions – 1st Party

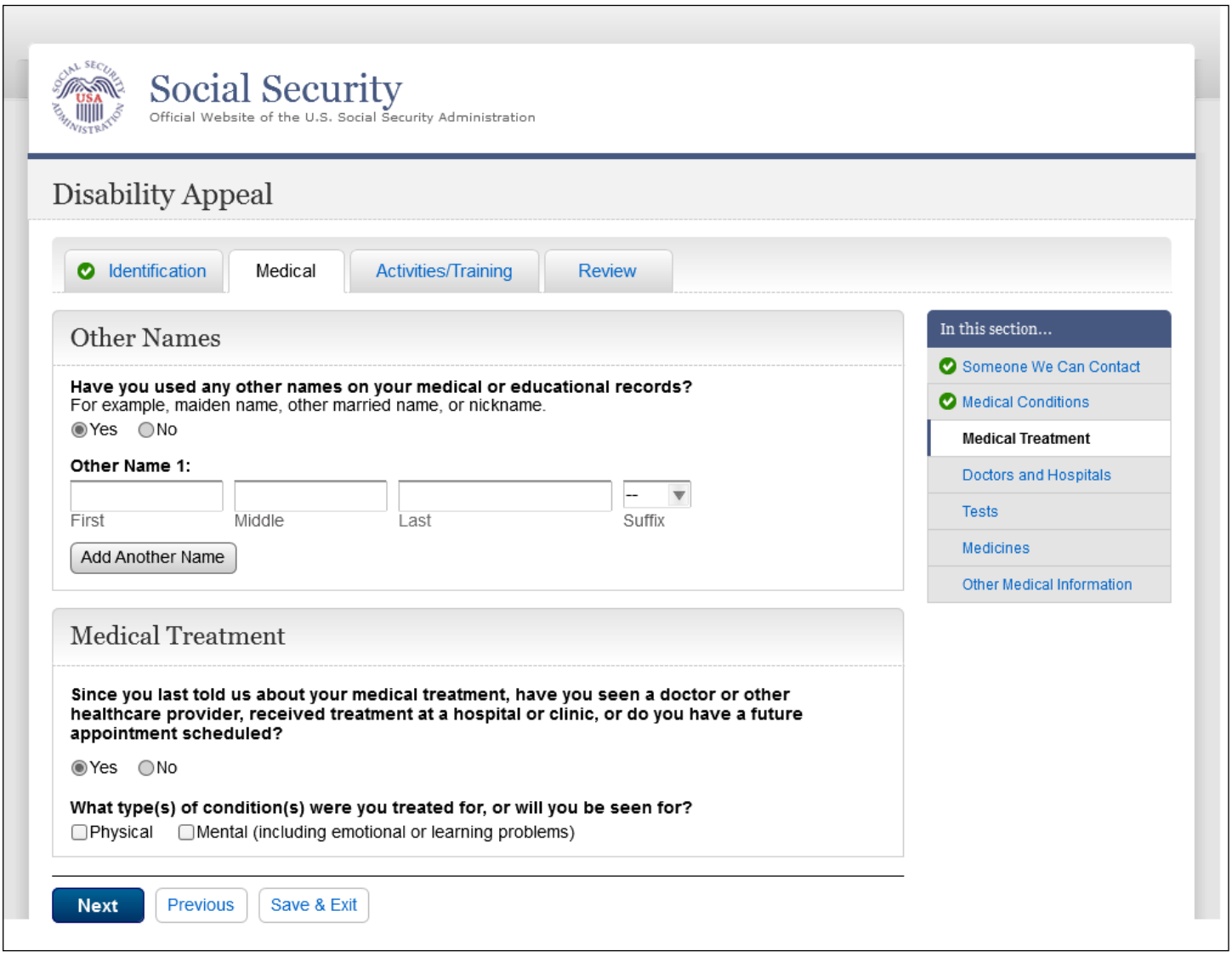
## 4.15. Section3: Medical Conditions – 1st Party: Follow Up questions



## 4.16. Section4: Medical Treatment – 1st Party

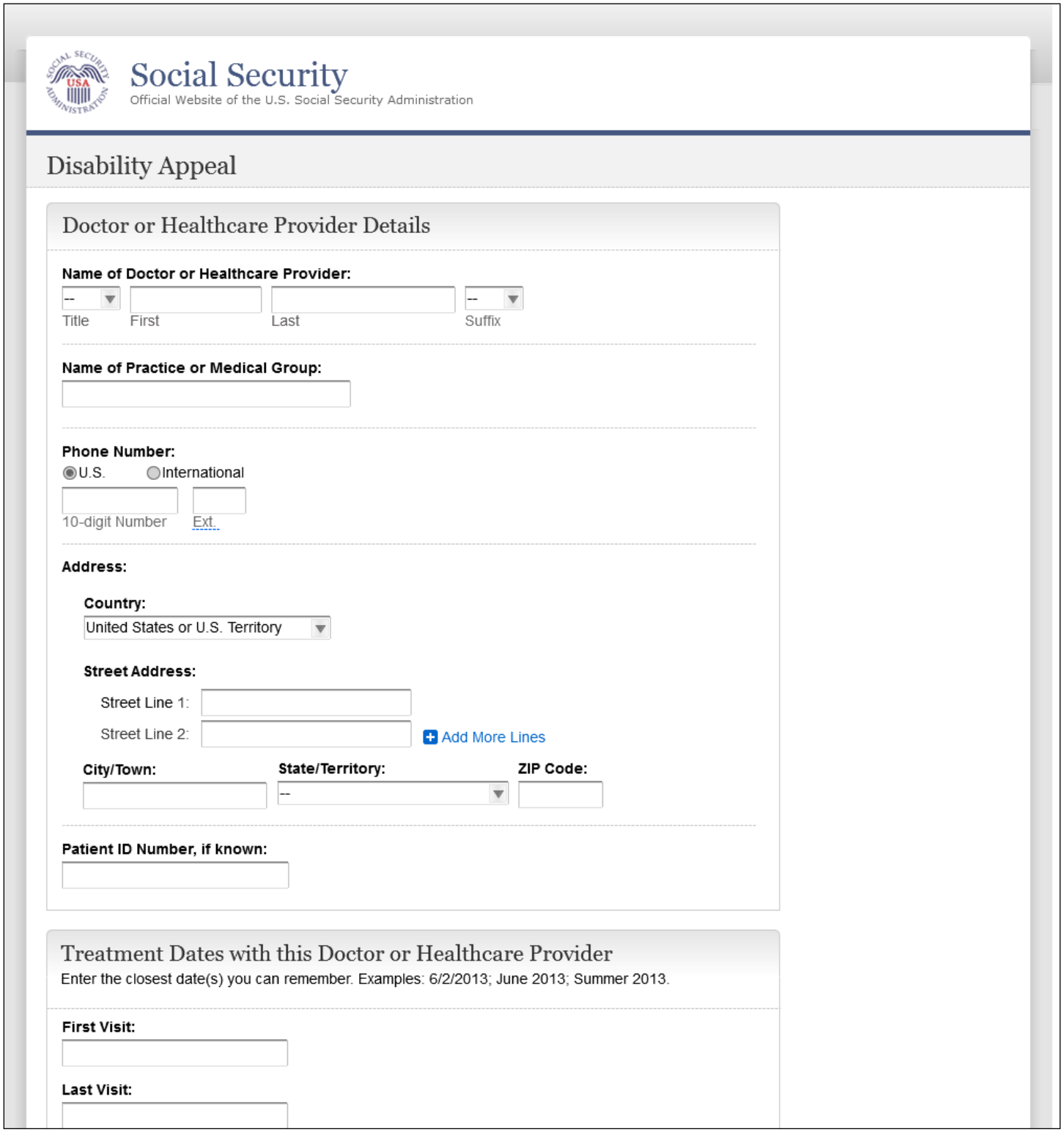


## 4.17. Section4: Medical Treatment – 1st Party: Follow Up Questions



## 4.18. Doctors & Hospitals – 1st Party

## 4.19. Add New Doctors – 1st Party



**Next Scheduled Appointment, if any:**

## Medical Conditions Treated by this Doctor or Healthcare Provider

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

Characters remaining: 1000

## Treatment from this Doctor or Healthcare Provider

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

Characters remaining: 1000

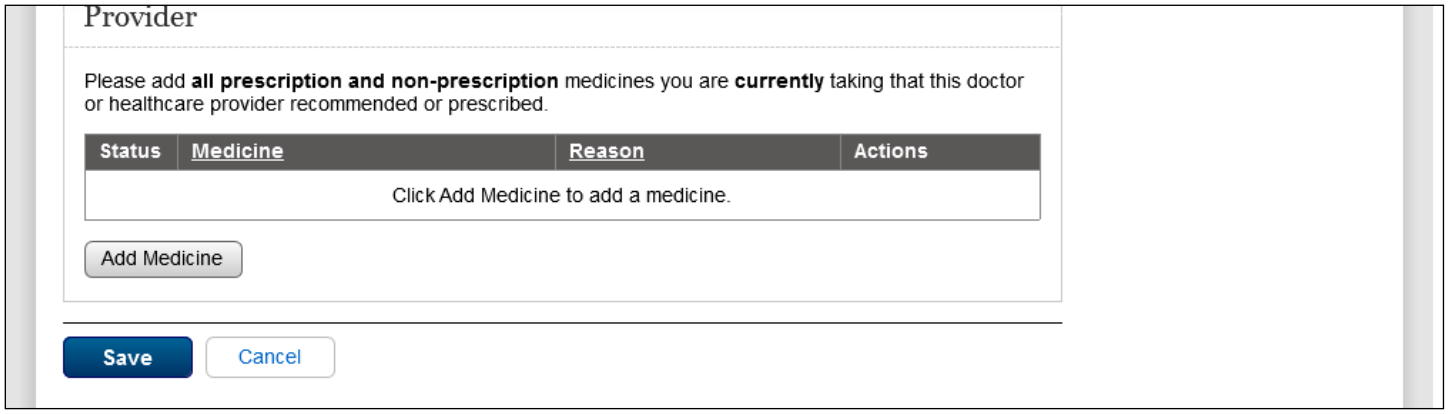
## Tests Ordered by this Doctor or Healthcare Provider

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

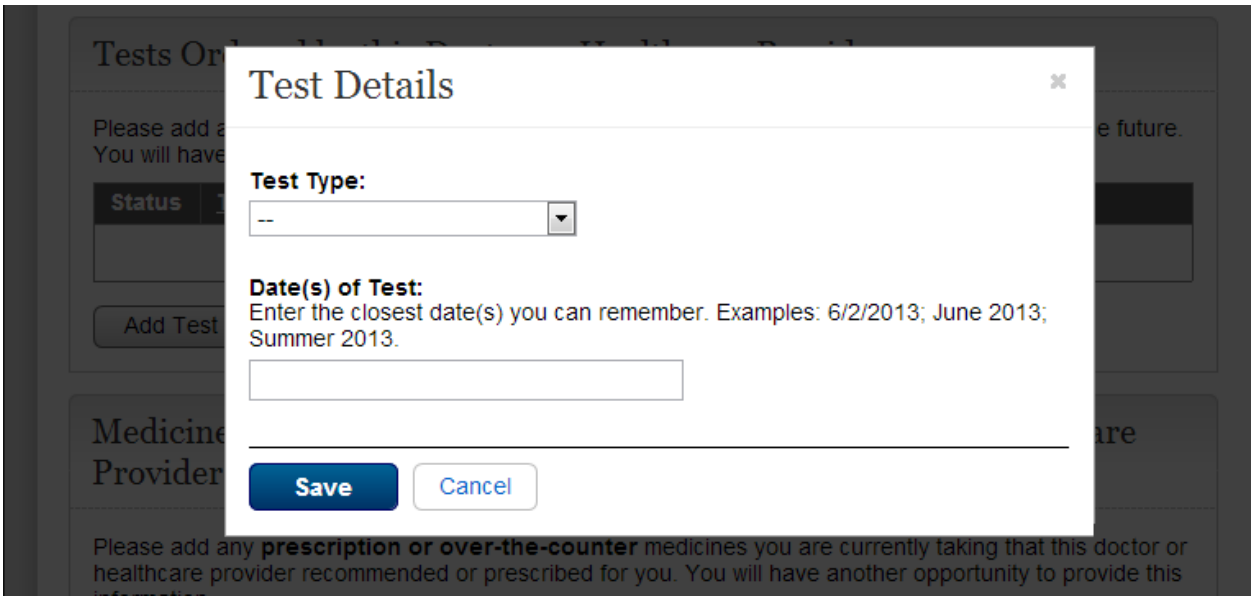
| Status | Test Type | Actions |
|---|---|---|
| Click Add Test to add a test. | | |

Add Test

## Medicines Recommended or Prescribed by this Doctor or Healthcare


Provider
Please add all prescription and non-prescription medicines you are currently taking that this doctor or healthcare provider recommended or prescribed.
Status
Medicine
Reason
Actions
Click Add Medicine to add a medicine.
Add Medicine
Save
Cancel

## 4.20. Add New Doctors – 1st Party: Test Popup




Contents of "Test Type" drop list:

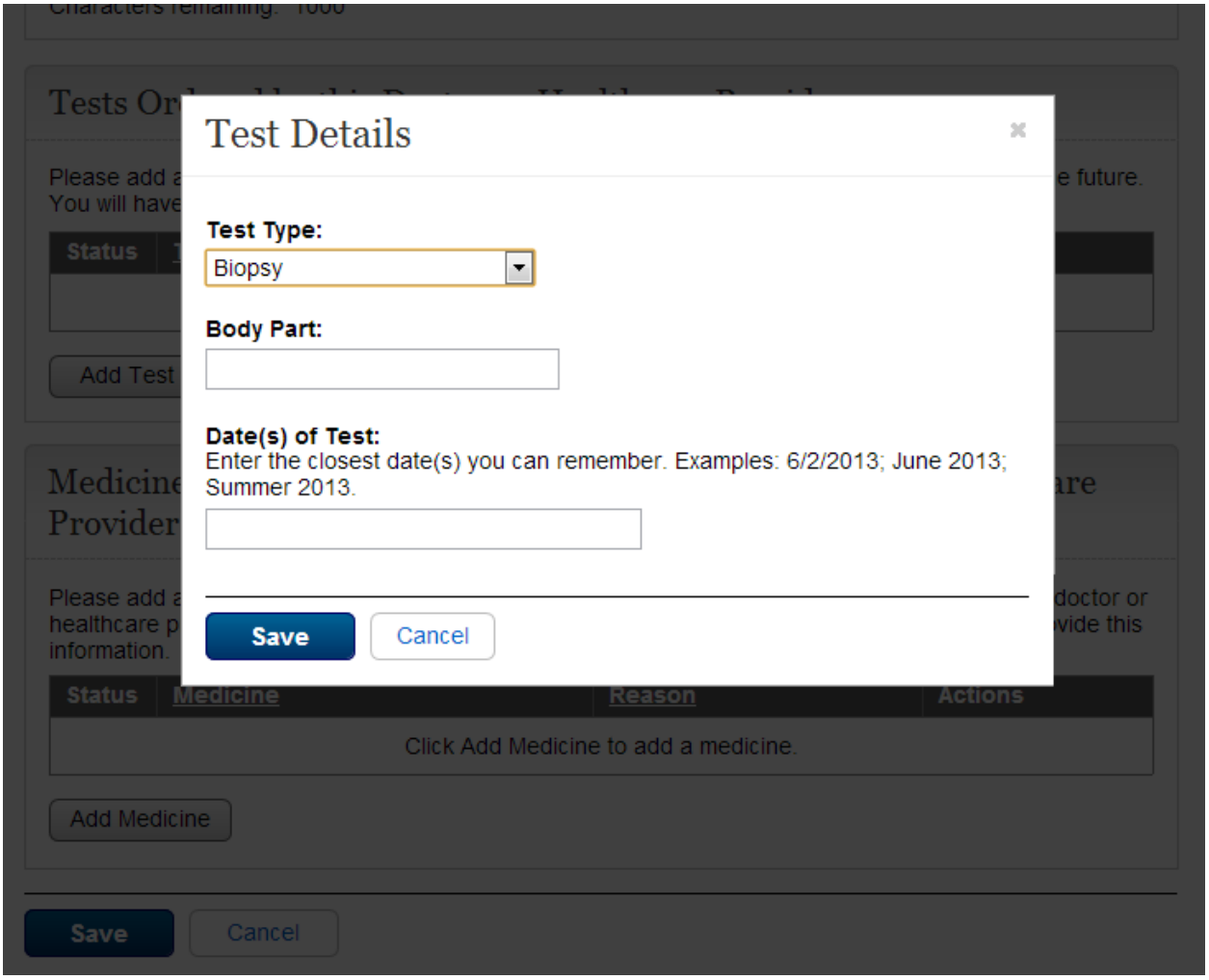
- --
- Biopsy
- Blood Test (not HIV)
- Breathing Test
- Cardiac Catheterization
- EEG (Brain Wave Test)
- EKG (Heart Test)
- Hearing Test
- HIV Test
- IQ Test
- MRI / CT Scan
- Speech / Language Test
- Treadmill (Exercise Test)
- Vision Test
- X-Ray
- Other

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

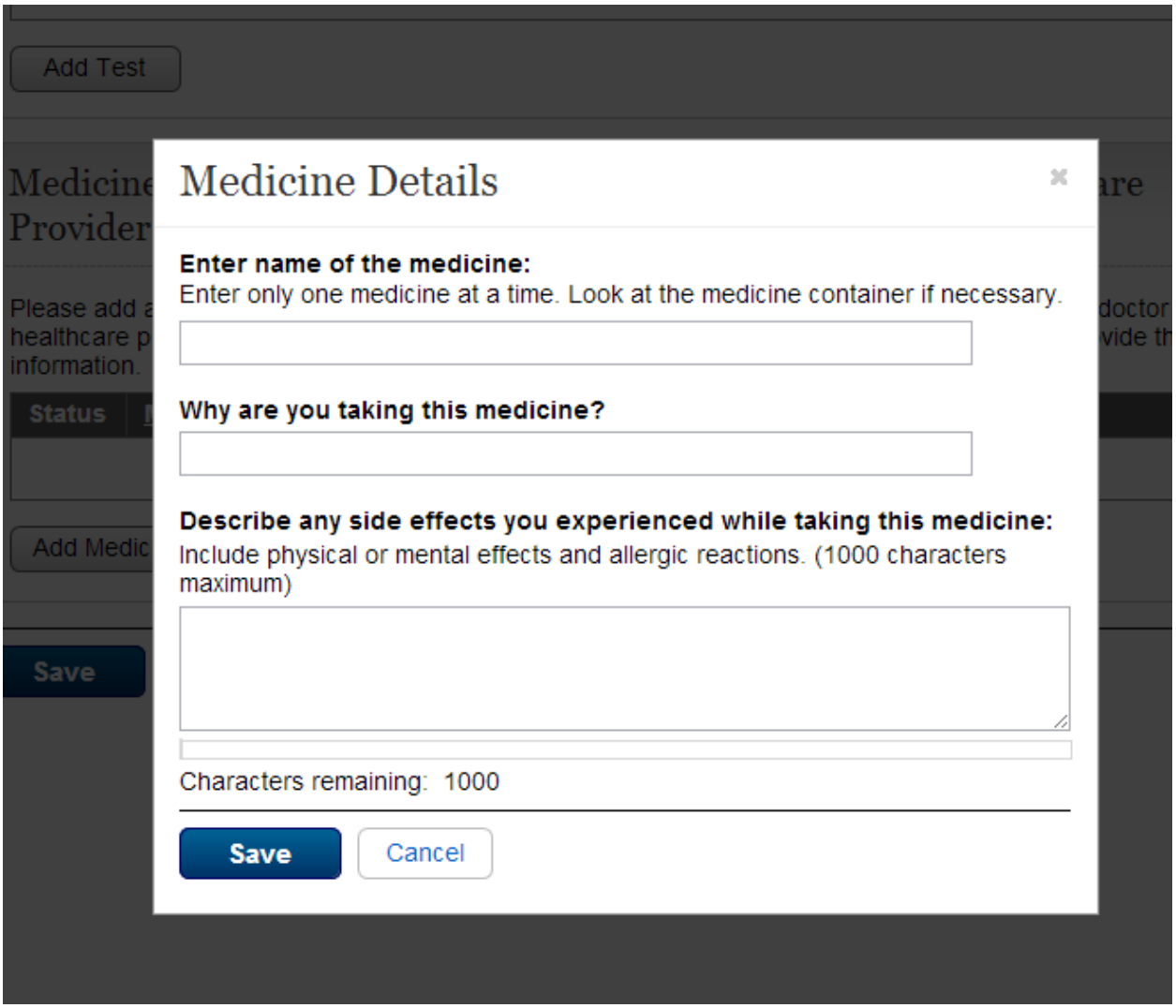
- Biopsy
- X-Ray
- Other

Selecting “Other” will also dynamically display the “Please specify type” question.

## 4.21. Add New Doctors – 1st Party: Test Popup with follow up question

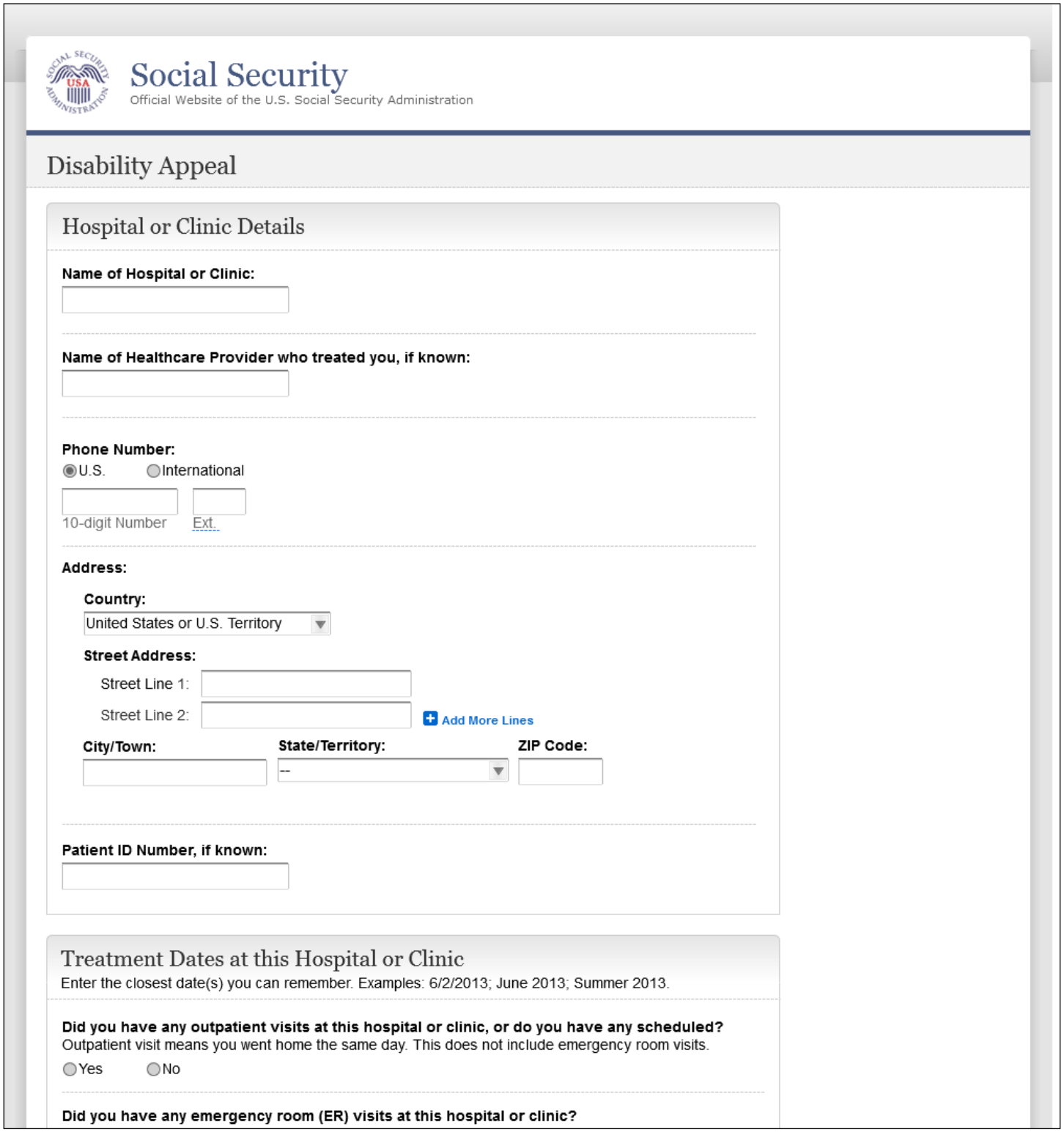


## 4.22. Add New Doctors – 1st Party: Medicine Popup



## 4.23. Doctors & Hospitals – 1st Party: 1 Row Filled

## 4.24. Add New Hospitals – 1st Party



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

◯ Yes ◯ No

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

◯ Yes ◯ No

## Medical Conditions Treated by this Hospital or Clinic

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

Characters remaining: 1000

## Treatment from this Hospital or Clinic

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

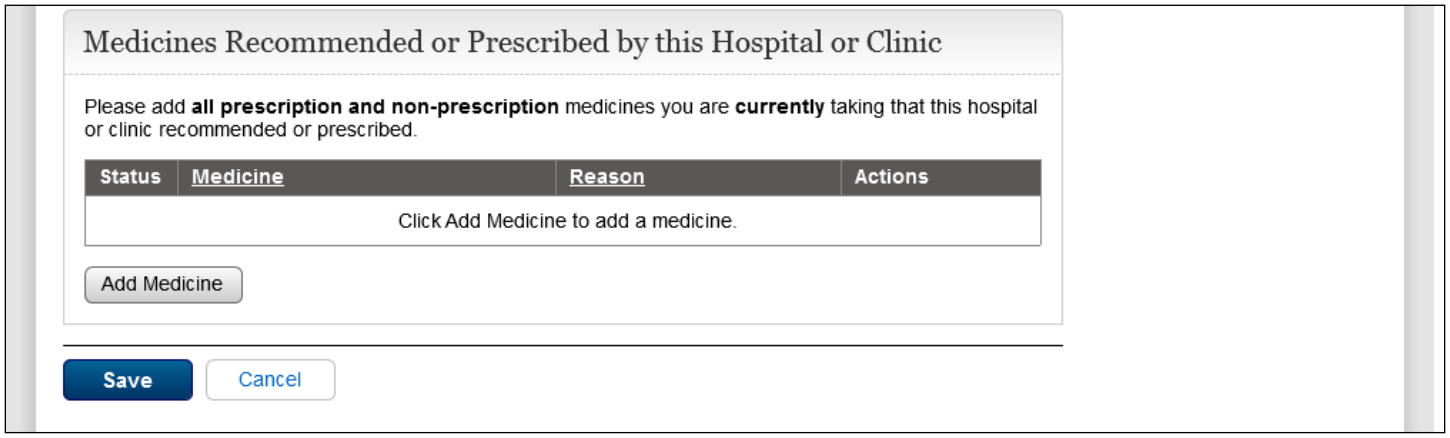
Characters remaining: 1000

## Tests Ordered at this Hospital or Clinic

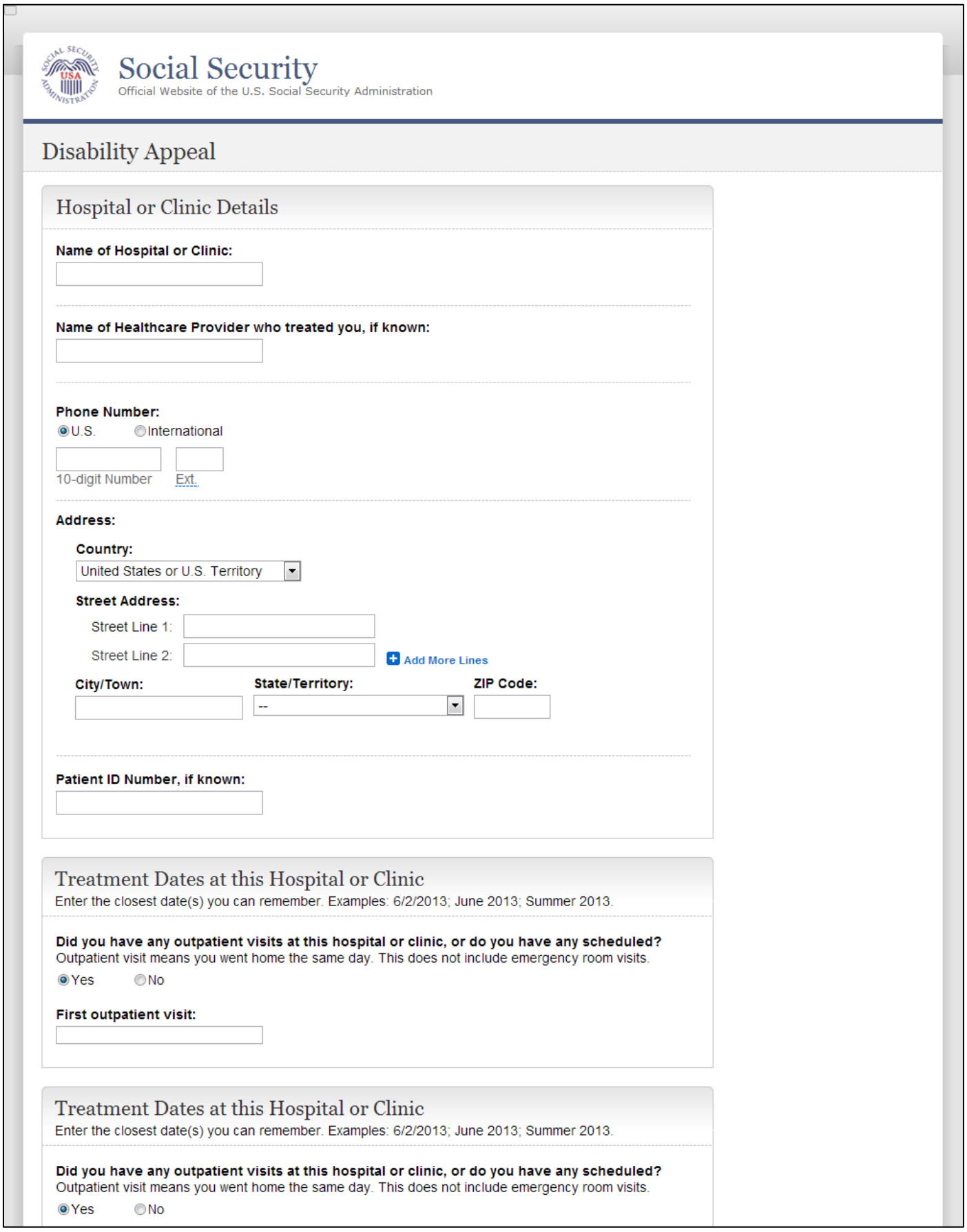
Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

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

Add Test


Medicines Recommended or Prescribed by this Hospital or Clinic
Please add all prescription and non-prescription medicines you are currently taking that this hospital or clinic recommended or prescribed.
Status
Medicine
Reason
Actions
Click Add Medicine to add a medicine.
Add Medicine
Save
Cancel

## 4.25. Add New Hospitals – 1st Party: Yes to Treatment Dates



**First outpatient visit:**

**Last outpatient visit:**

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

**Did you have any emergency room (ER) visits at this hospital or clinic?**
ER visit means you went to the ER and then went home.
(•) Yes ( ) No

Please give the dates of your most recent emergency room visits.

**Emergency Room Visit 1:**

**Emergency Room Visit 2:**

**Emergency Room Visit 3:**

**Did you have any overnight stays at this hospital or clinic?**
(•) Yes ( ) No

Give us the dates of your three most recent stays.

**Visit 1:**
Date In Date Out

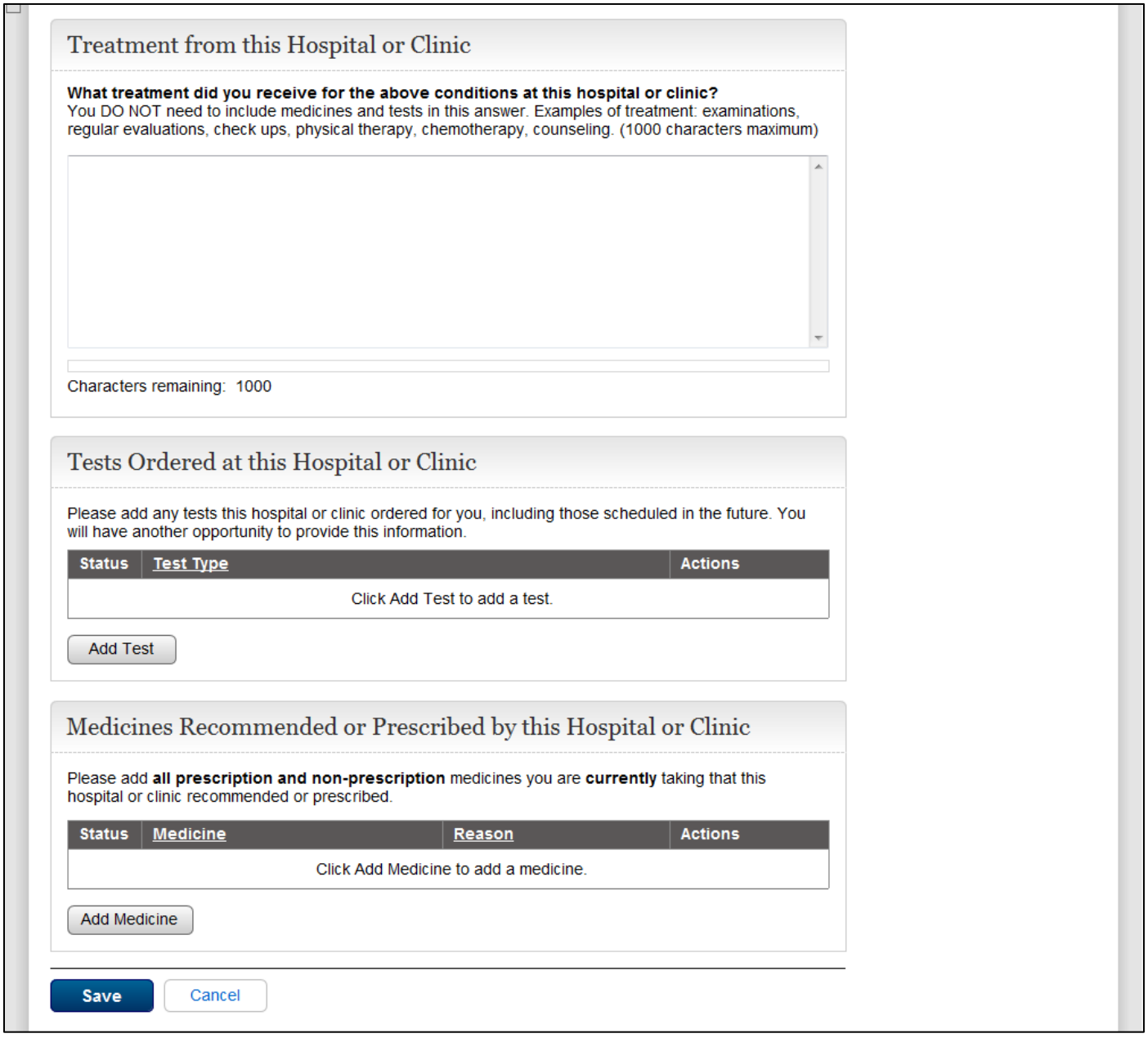
**Visit 2:**
Date In Date Out

**Visit 3:**
Date In Date Out

## Medical Conditions Treated by this Hospital or Clinic

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

Characters remaining: 1000



## Treatment from this Hospital or Clinic

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

Characters remaining: 1000

## Tests Ordered at this Hospital or Clinic

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

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

Add Test

## Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **all prescription and non-prescription** medicines you are **currently** taking that this hospital or clinic recommended or prescribed.

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

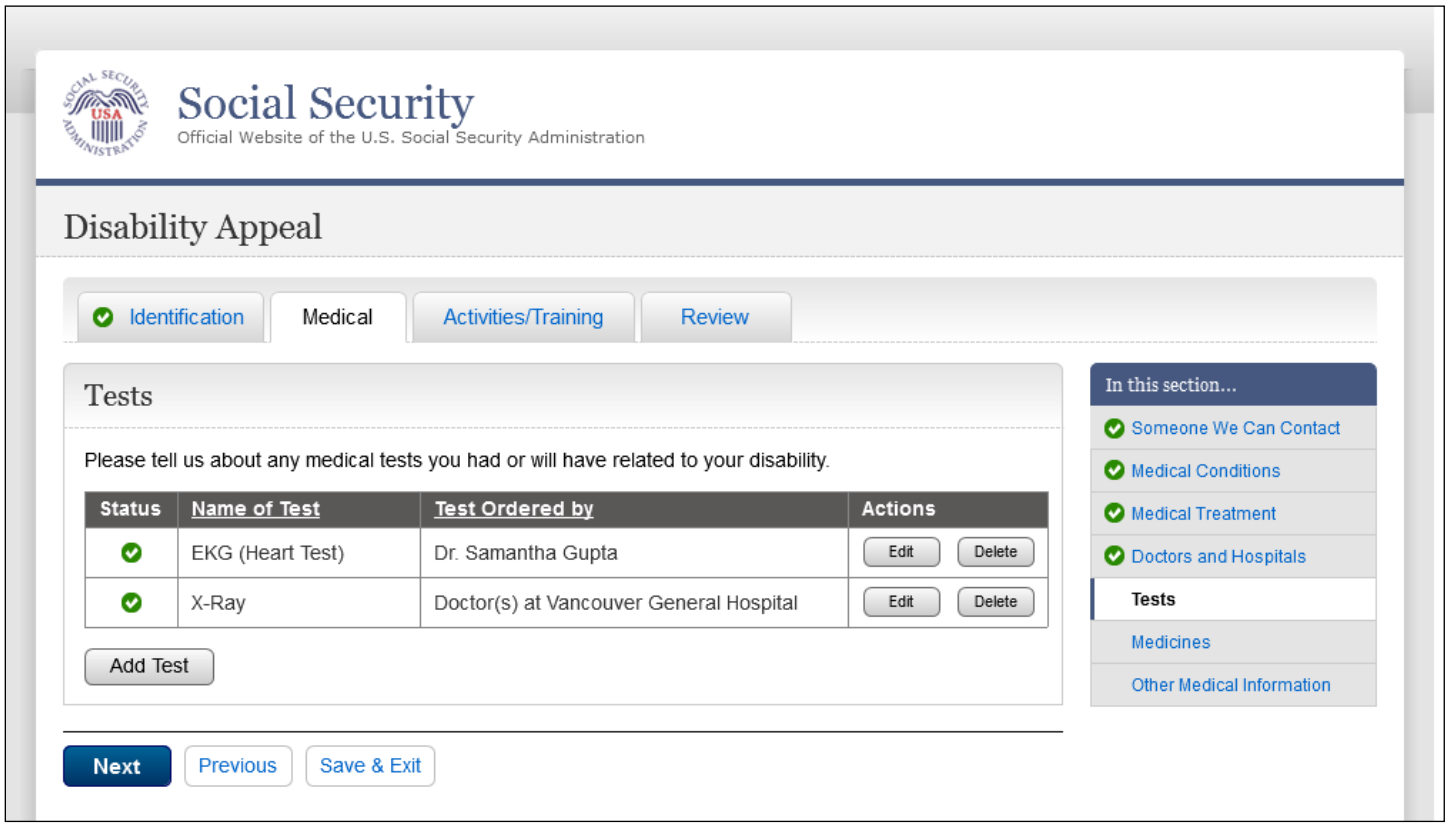
Add Medicine

Save Cancel

## 4.27. Doctors & Hospitals – 1st Party: 2 Rows Filled

## 4.28. Tests – 1st Party

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



## 4.29. Add New Test – 1st Party


Contents of "Test Type" drop list:

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

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

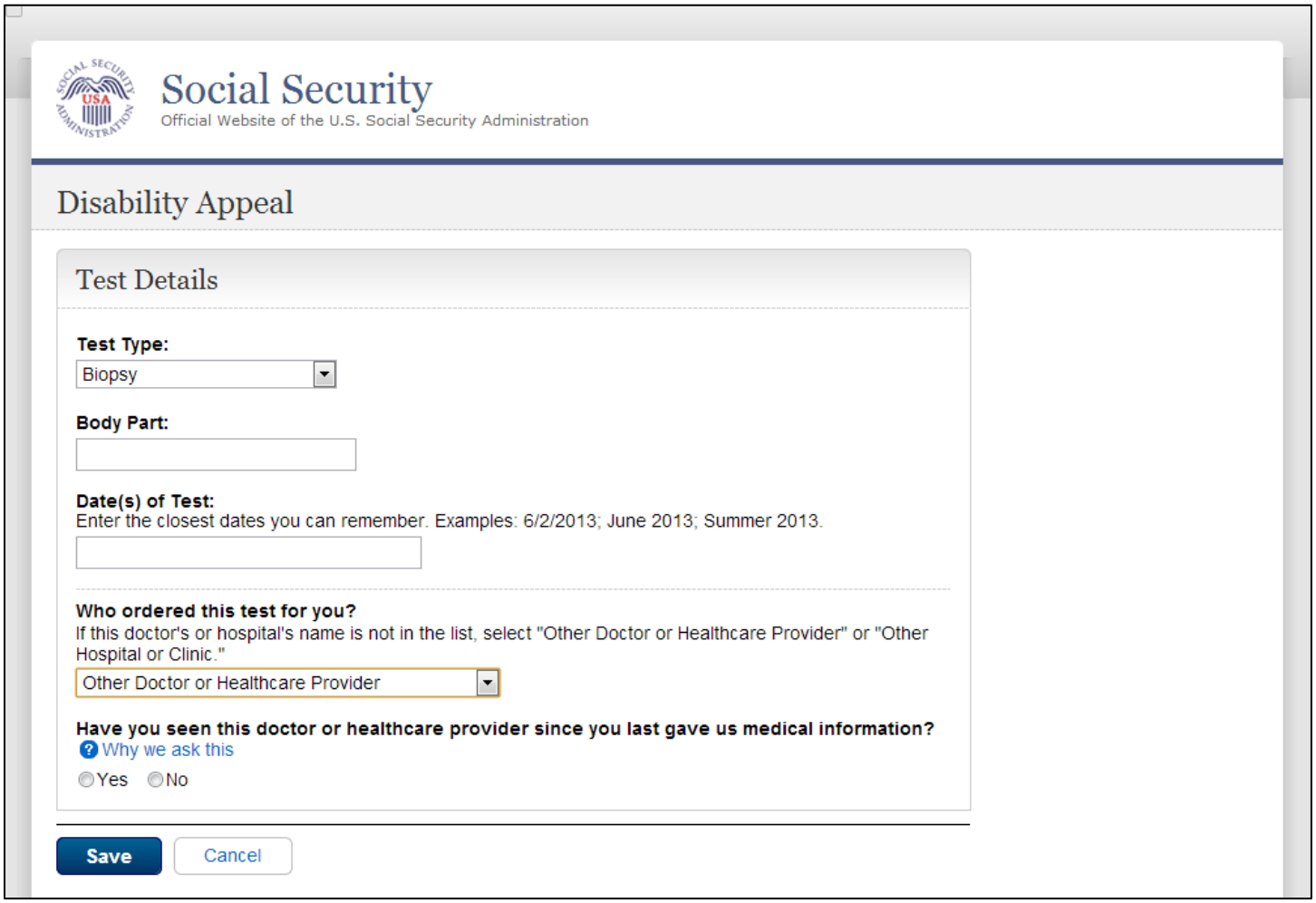
- Biopsy
- X-Ray
- Other

Selecting “Other” will also dynamically display the “Please specify type” question.

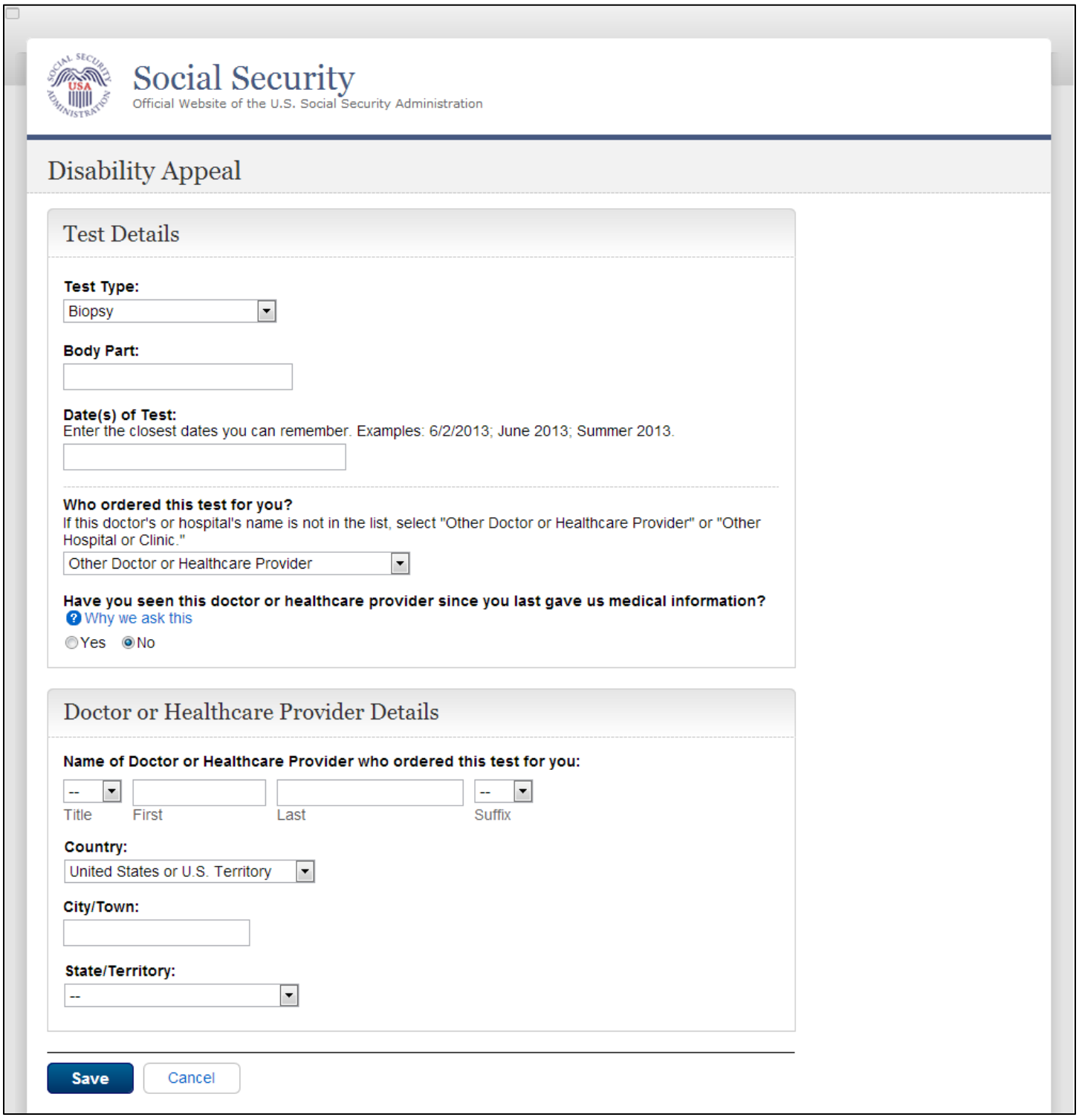
Contents of "Who ordered..." drop list:

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

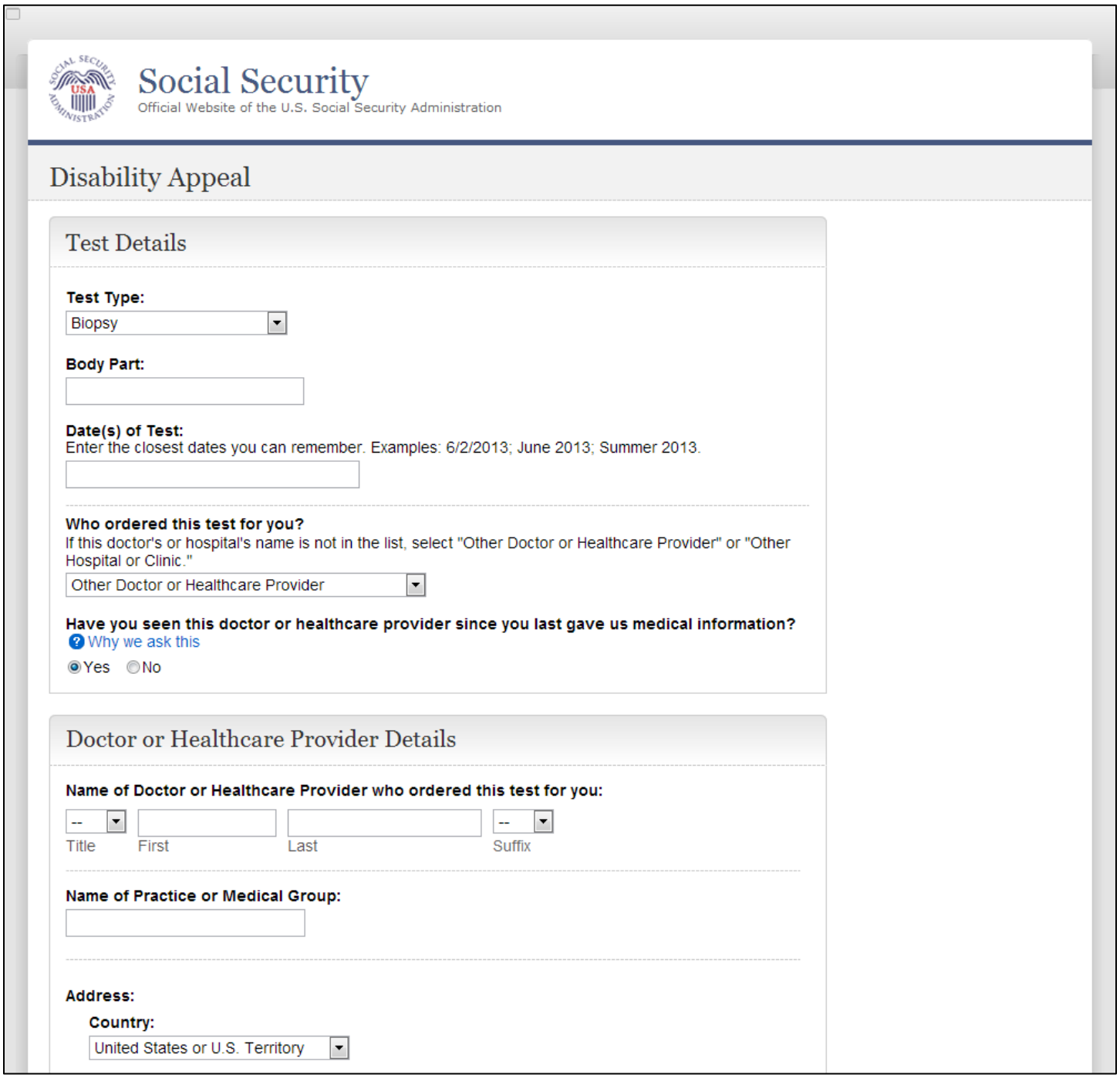
## 4.30. Add New Test – 1st Party: Follow up question and Other Doctor

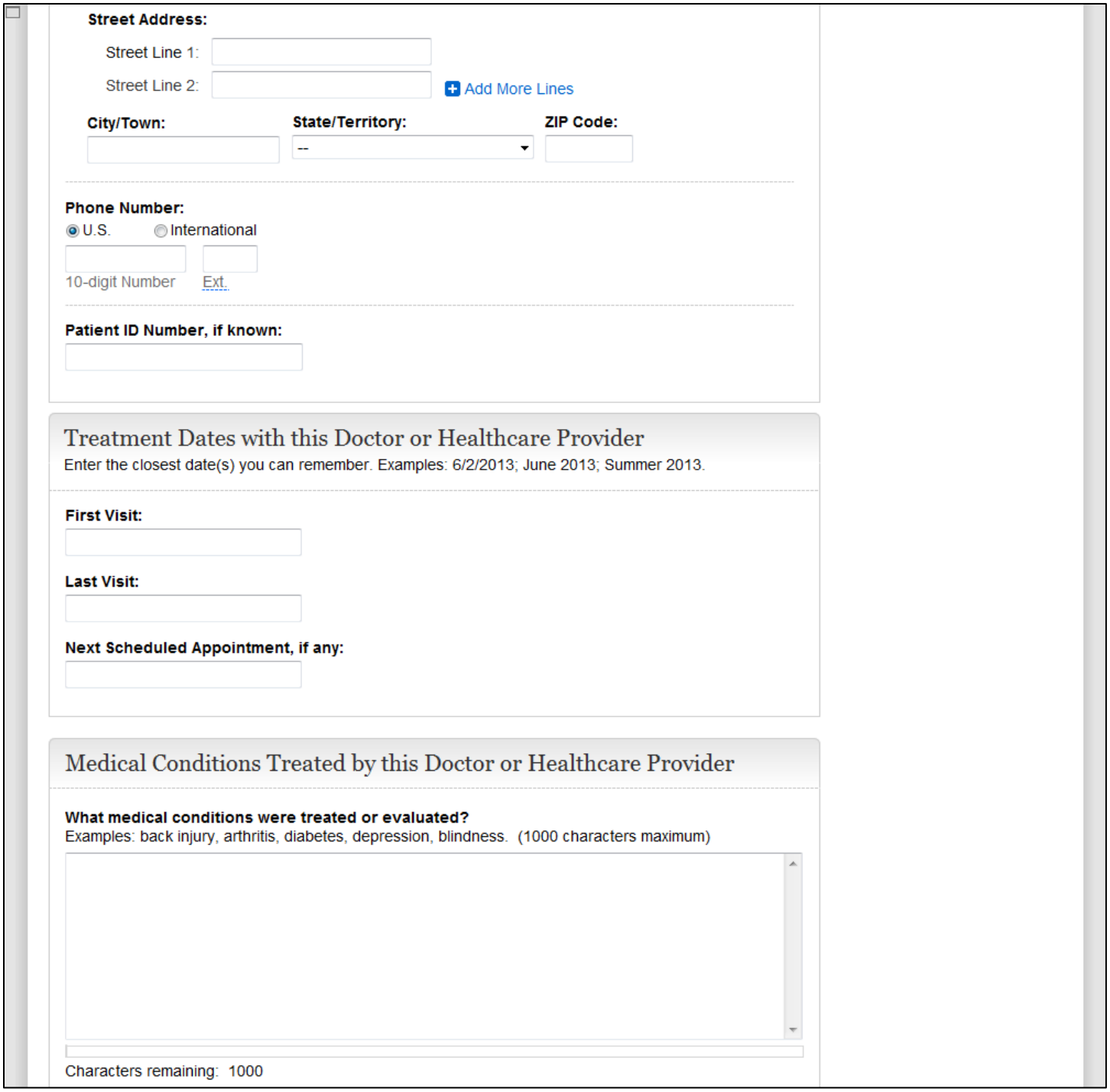


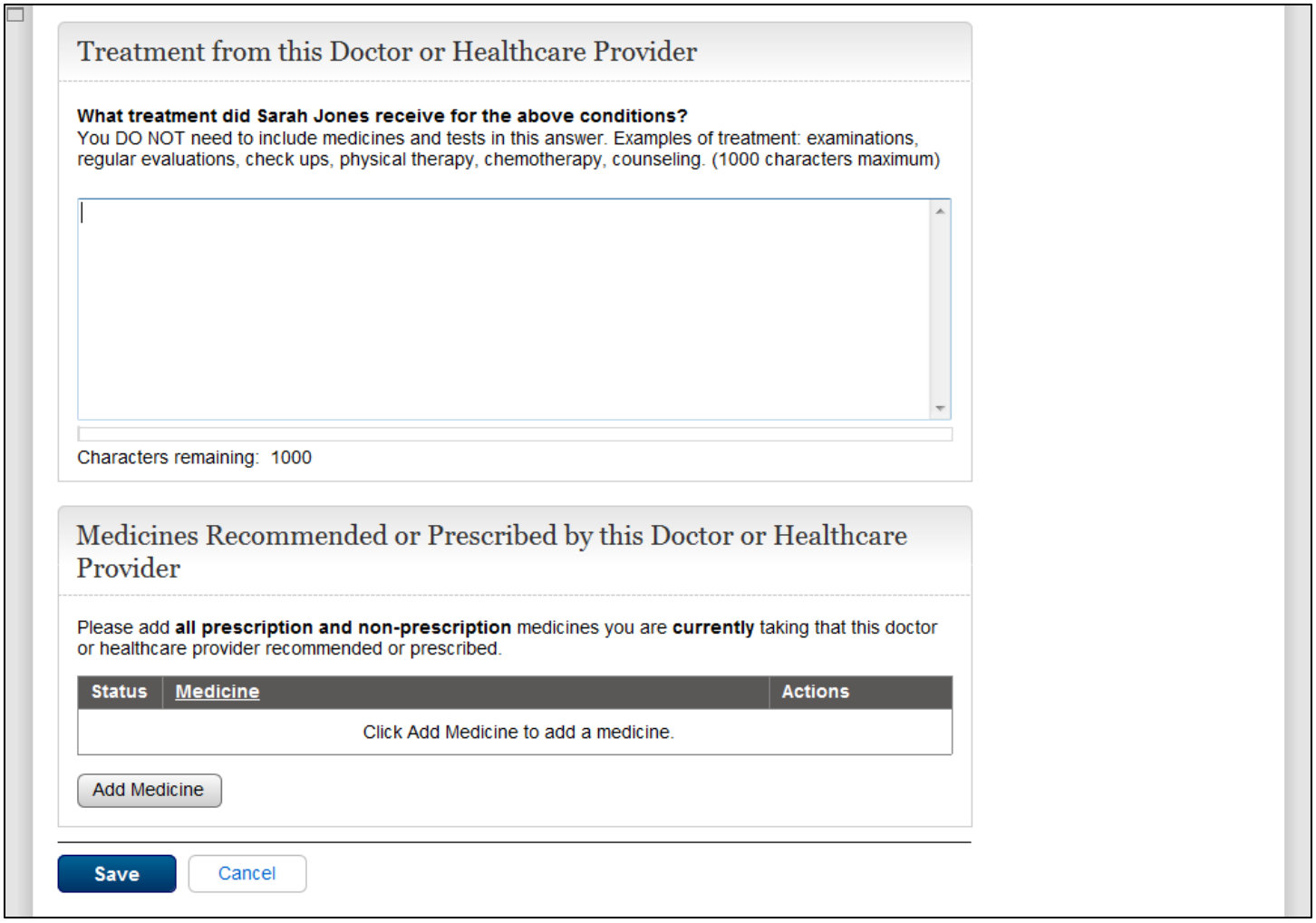
## 4.31. Add New Test – 1st Party: Have not seen the doctor



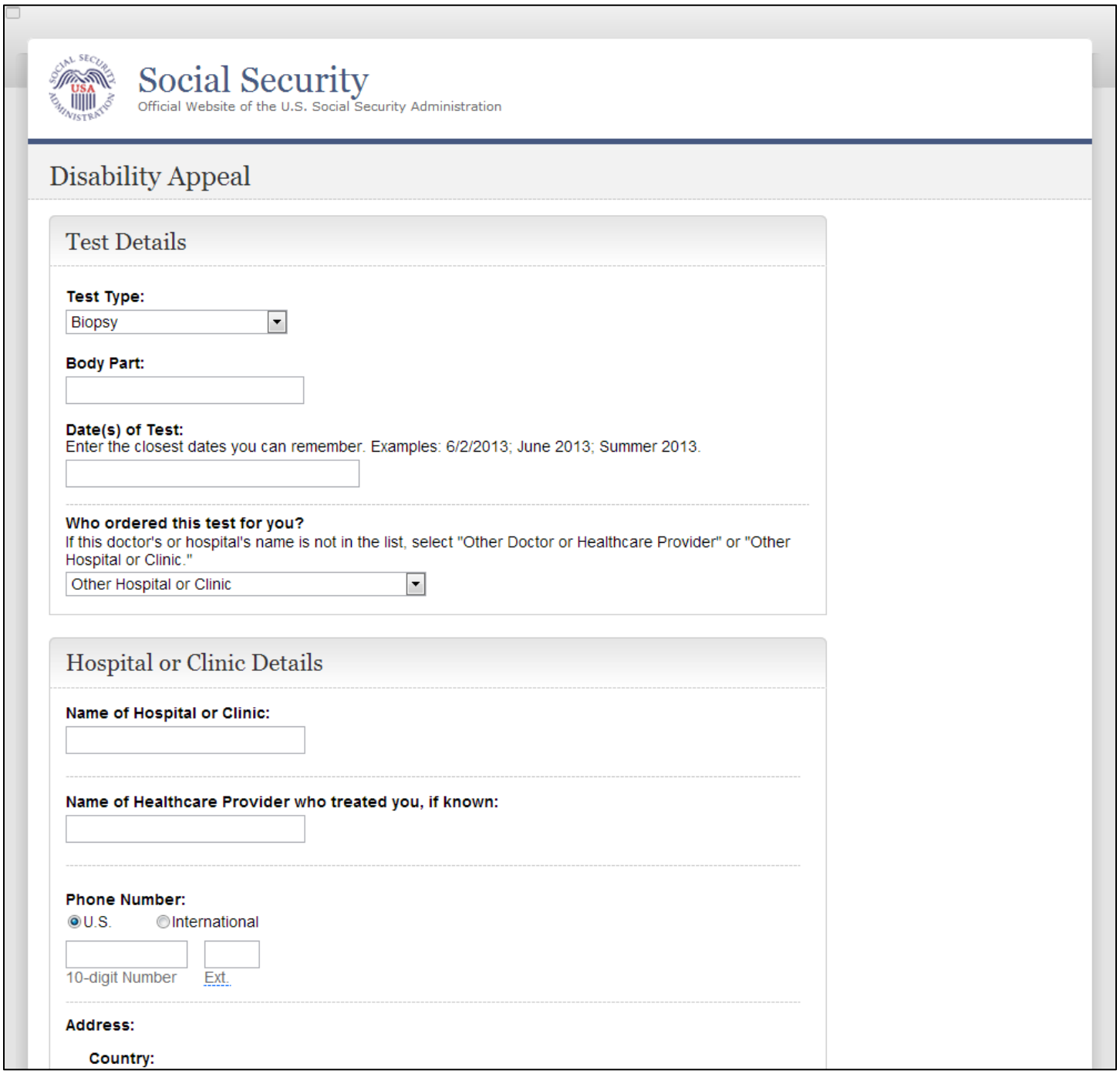
## 4.32. Add New Test – 1st Party: Have seen the doctor

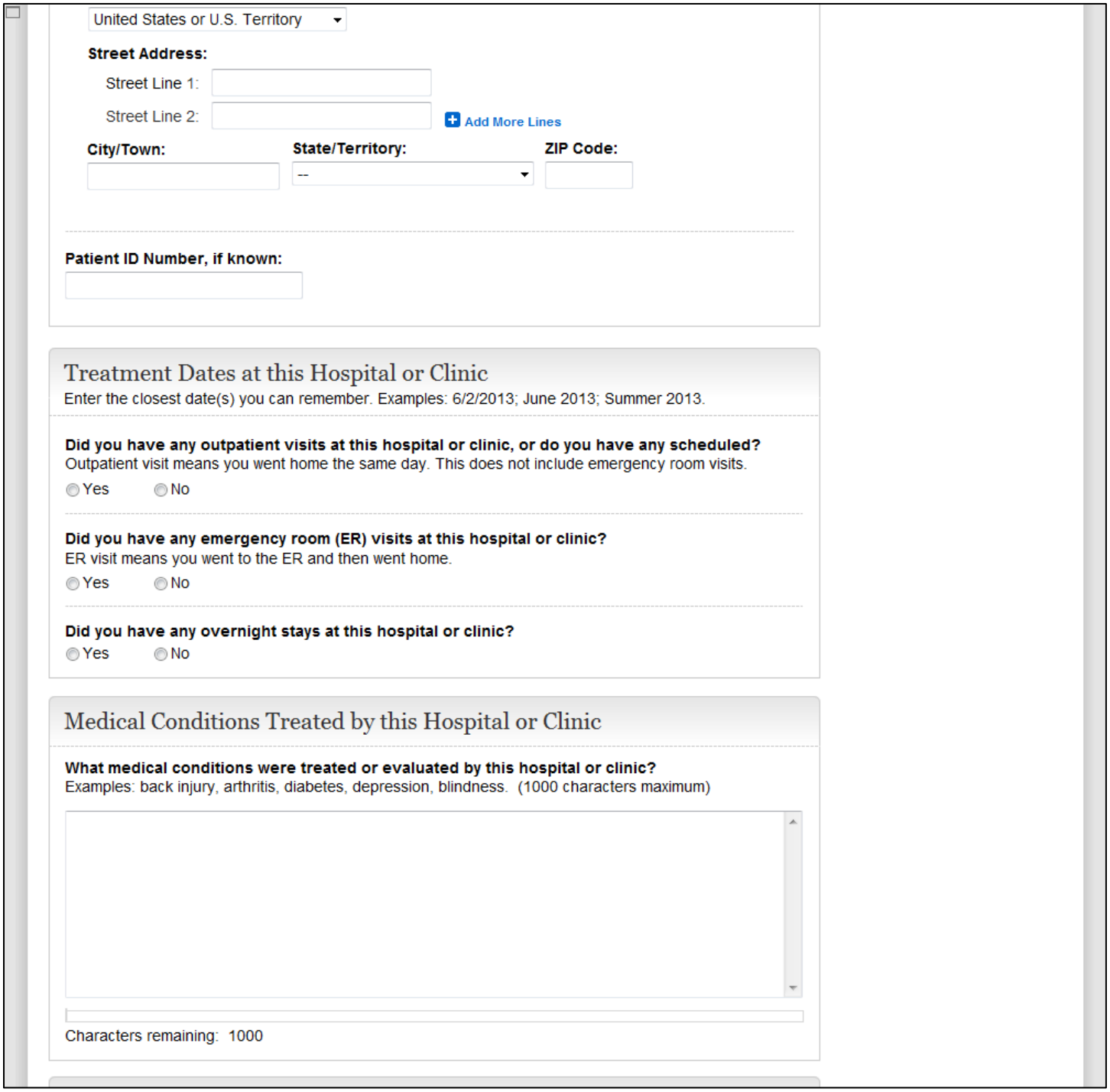



Street Address:
Street Line 1:
Street Line 2:
Add More Lines
City/Town:
State/Territory:
--
ZIP Code:
Phone Number:
U.S.
International
10-digit Number
Ext.
Patient ID Number, if known:
Treatment Dates with this Doctor or Healthcare Provider
Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.
First Visit:
Last Visit:
Next Scheduled Appointment, if any:
Medical Conditions Treated by this Doctor or Healthcare Provider
What medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)
Characters remaining: 1000


Treatment from this Doctor or Healthcare Provider
What treatment did Sarah Jones receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)
Characters remaining: 1000
Medicines Recommended or Prescribed by this Doctor or Healthcare Provider
Please add all prescription and non-prescription medicines you are currently taking that this doctor or healthcare provider recommended or prescribed.
Status
Medicine
Actions
Click Add Medicine to add a medicine.
Add Medicine
Save
Cancel

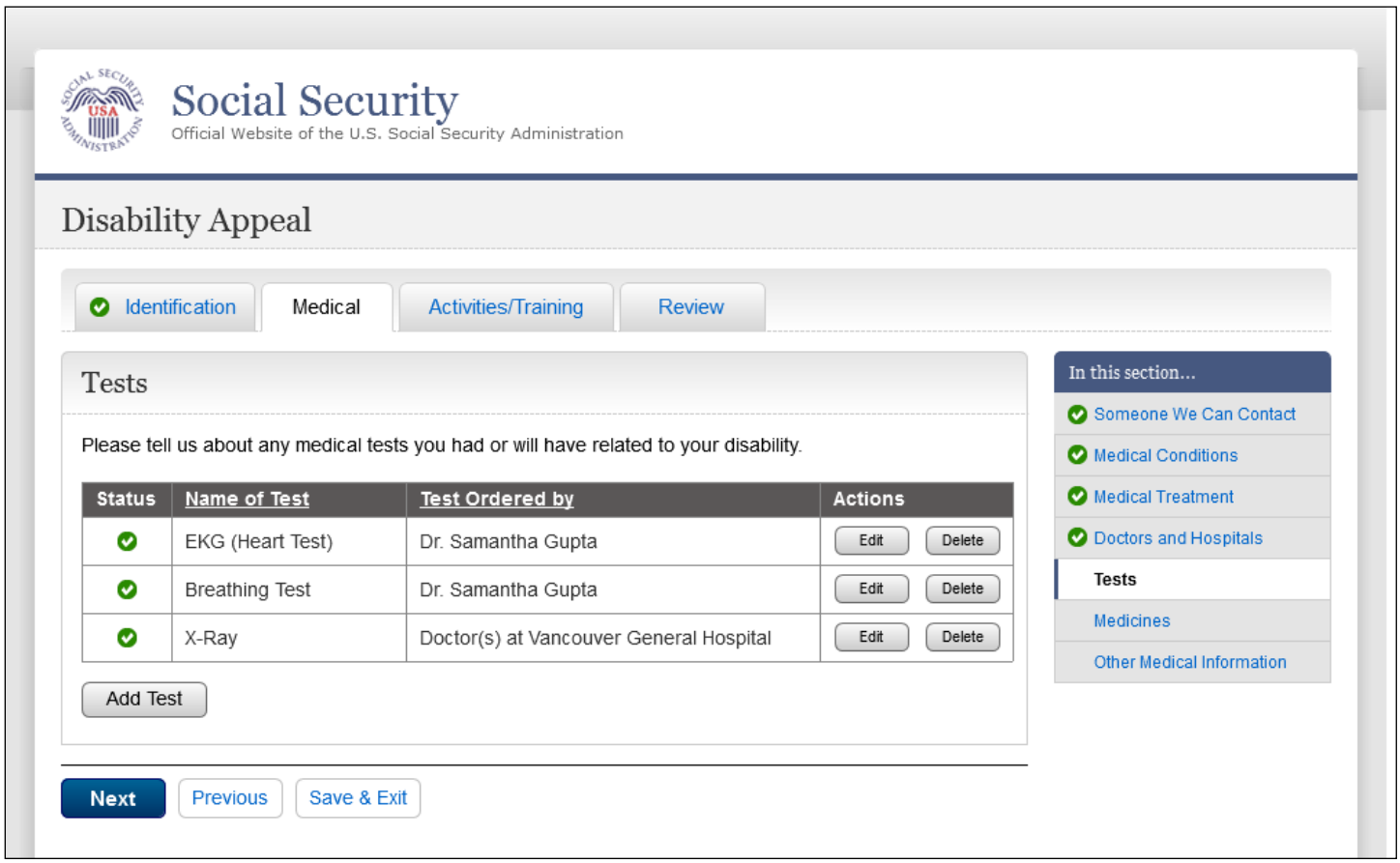
## 4.33. Add New Test – 1st Party: Other Hospital




United States or U.S. Territory
Street Address:
Street Line 1:
Street Line 2:
Add More Lines
City/Town:
State/Territory:
--
ZIP Code:
Patient ID Number, if known:
Treatment Dates at this Hospital or Clinic
Enter the closest date(s) you can remember. Examples: 6/2/2013; June 2013; Summer 2013.
Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?
Outpatient visit means you went home the same day. This does not include emergency room visits.
Yes
No
Did you have any emergency room (ER) visits at this hospital or clinic?
ER visit means you went to the ER and then went home.
Yes
No
Did you have any overnight stays at this hospital or clinic?
Yes
No
Medical Conditions Treated by this Hospital or Clinic
What medical conditions were treated or evaluated by this hospital or clinic?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)
Characters remaining: 1000

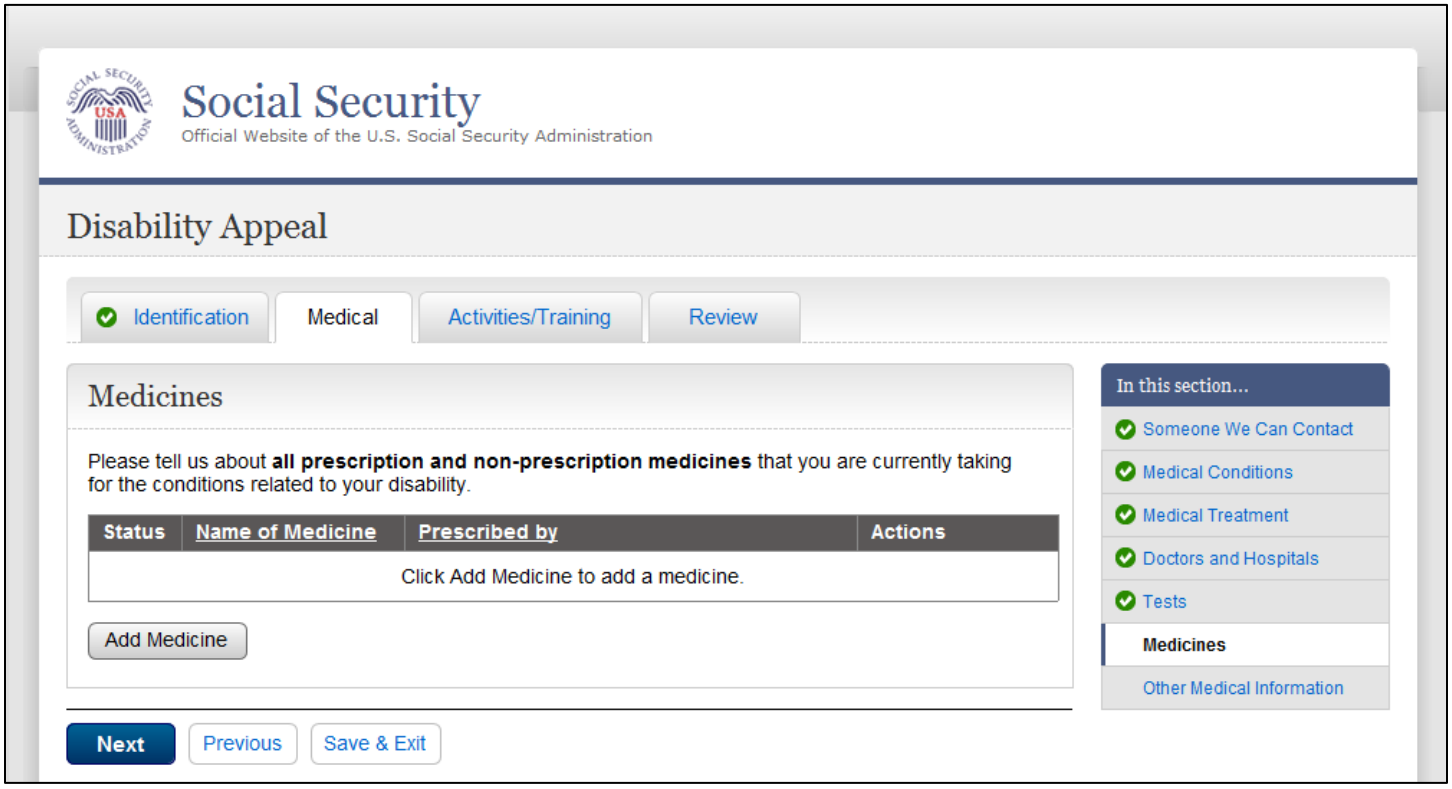

Treatment from this Hospital or Clinic
What treatment did you receive for the above conditions at this hospital or clinic?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)
Characters remaining: 1000
Medicines Recommended or Prescribed by this Hospital or Clinic
Please add all prescription and non-prescription medicines you are currently taking that this hospital or clinic recommended or prescribed.
Status
Medicine
Reason
Actions
Click Add Medicine to add a medicine.
Add Medicine
Save
Cancel

## 4.34. Tests – 1st Party: 3 Rows Filled

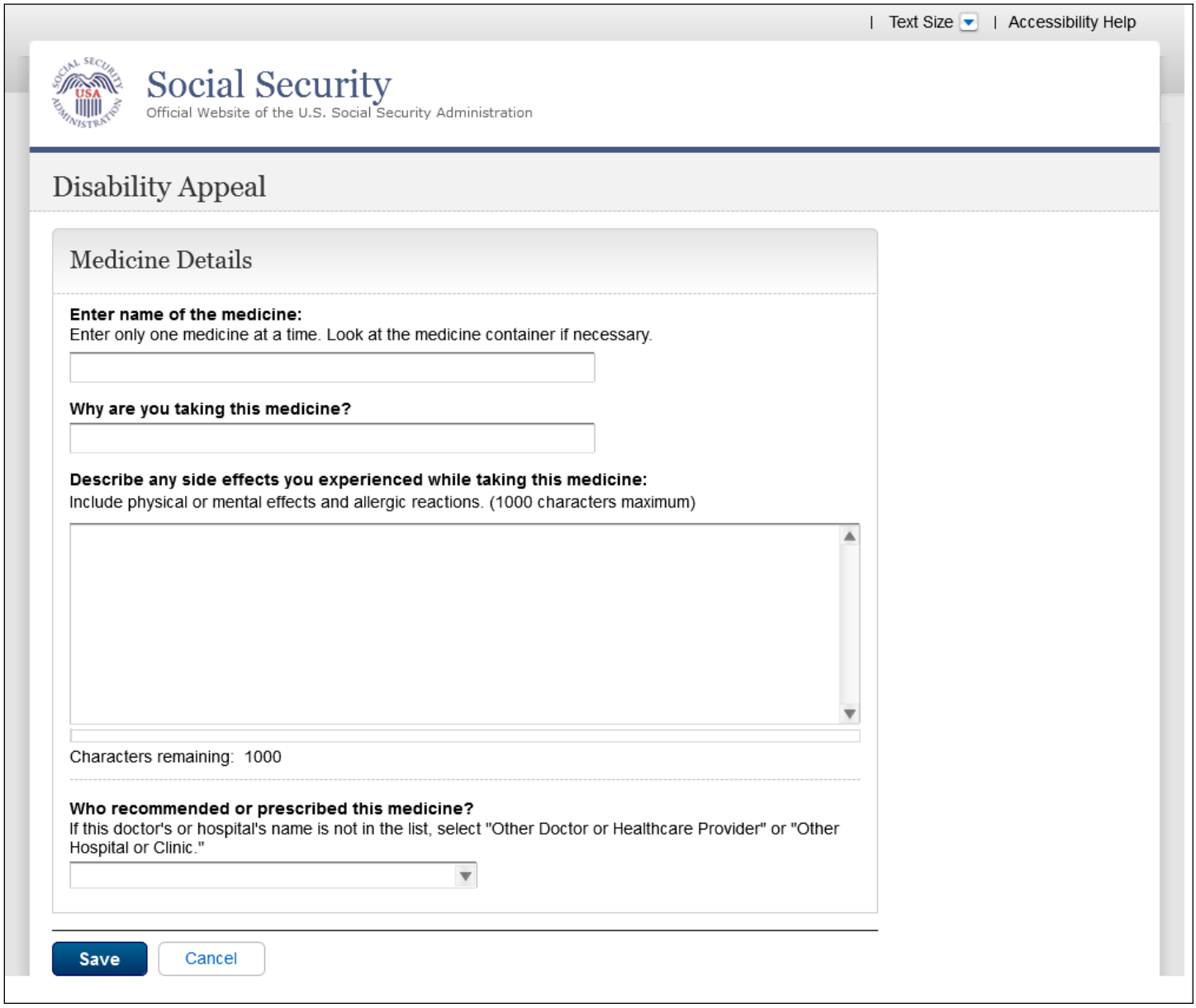


## 4.35. Medicines – 1st Party

Table will be prefilled with medicines previously entered in doctors/hospitals pages. No medicines has been provided yet in this example.



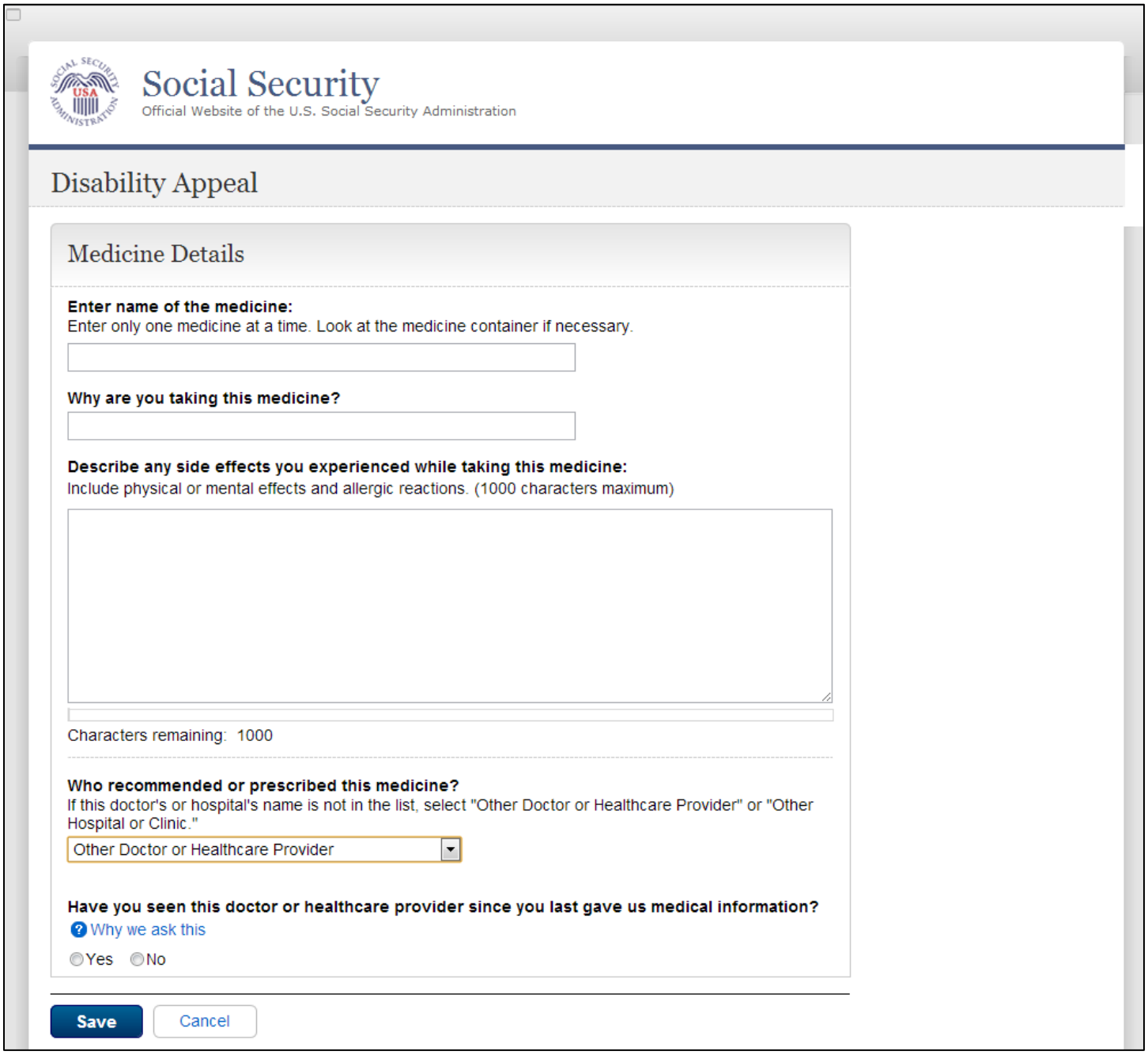
## 4.36. Add New Medicine – 1st Party



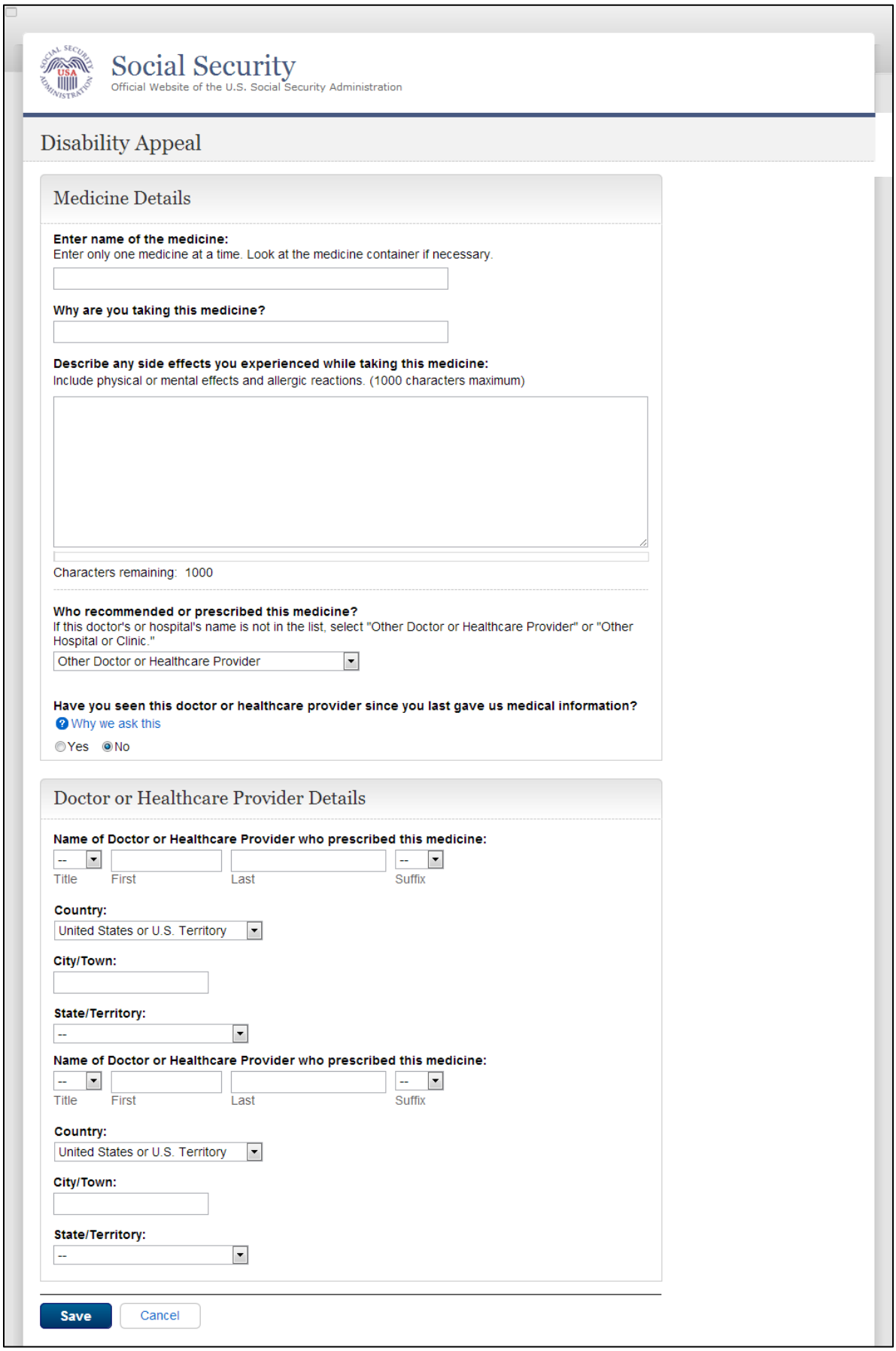

Contents of "Who ordered..." drop list:

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

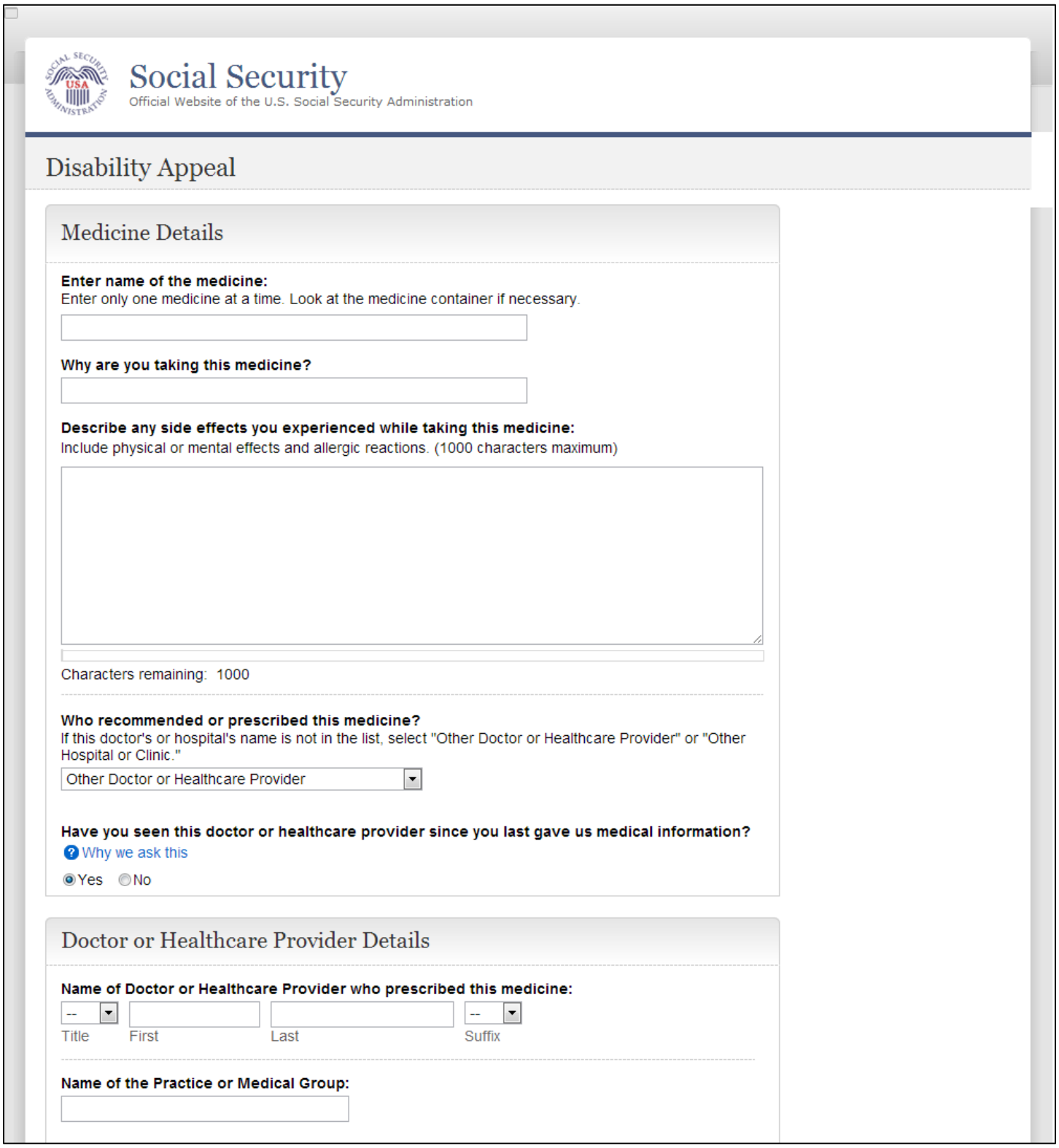
## 4.37. Add New Medicine – 1st Party: Other Doctor



## 4.38. Add New Medicine – 1st Party: Have not seen the doctor



## 4.39. Add New Medicine – 1st Party: Have seen the doctor



**Phone Number:**

U.S. International

10-digit Number Ext.

**Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

Street Line 2: Add More Lines

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

--

**Patient ID Number, if known:**

## Treatment Dates with this Doctor or Healthcare Provider

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

**First Visit:**

**Last Visit:**

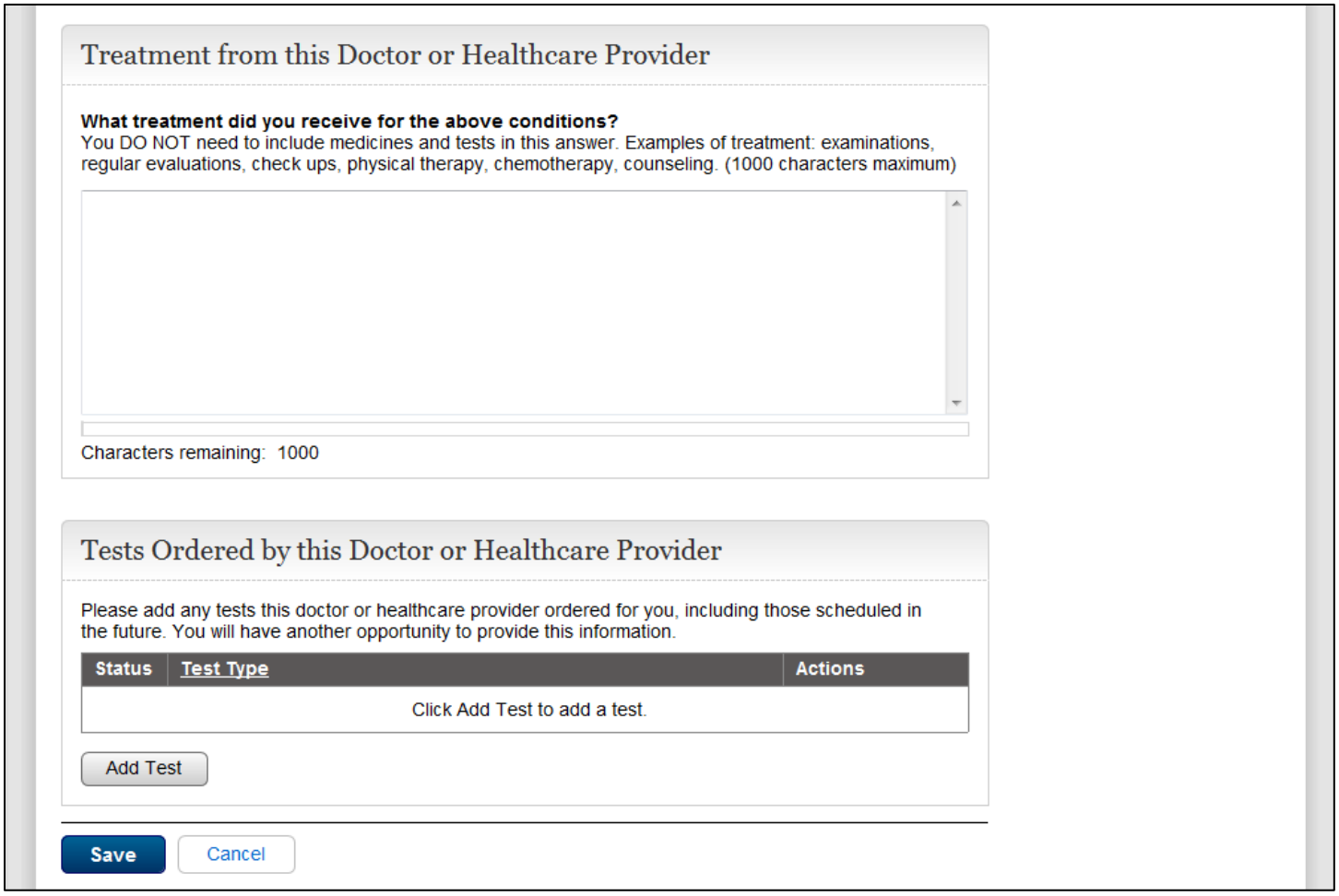
**Next Scheduled Appointment, if any:**

## Medical Conditions Treated by this Doctor or Healthcare Provider

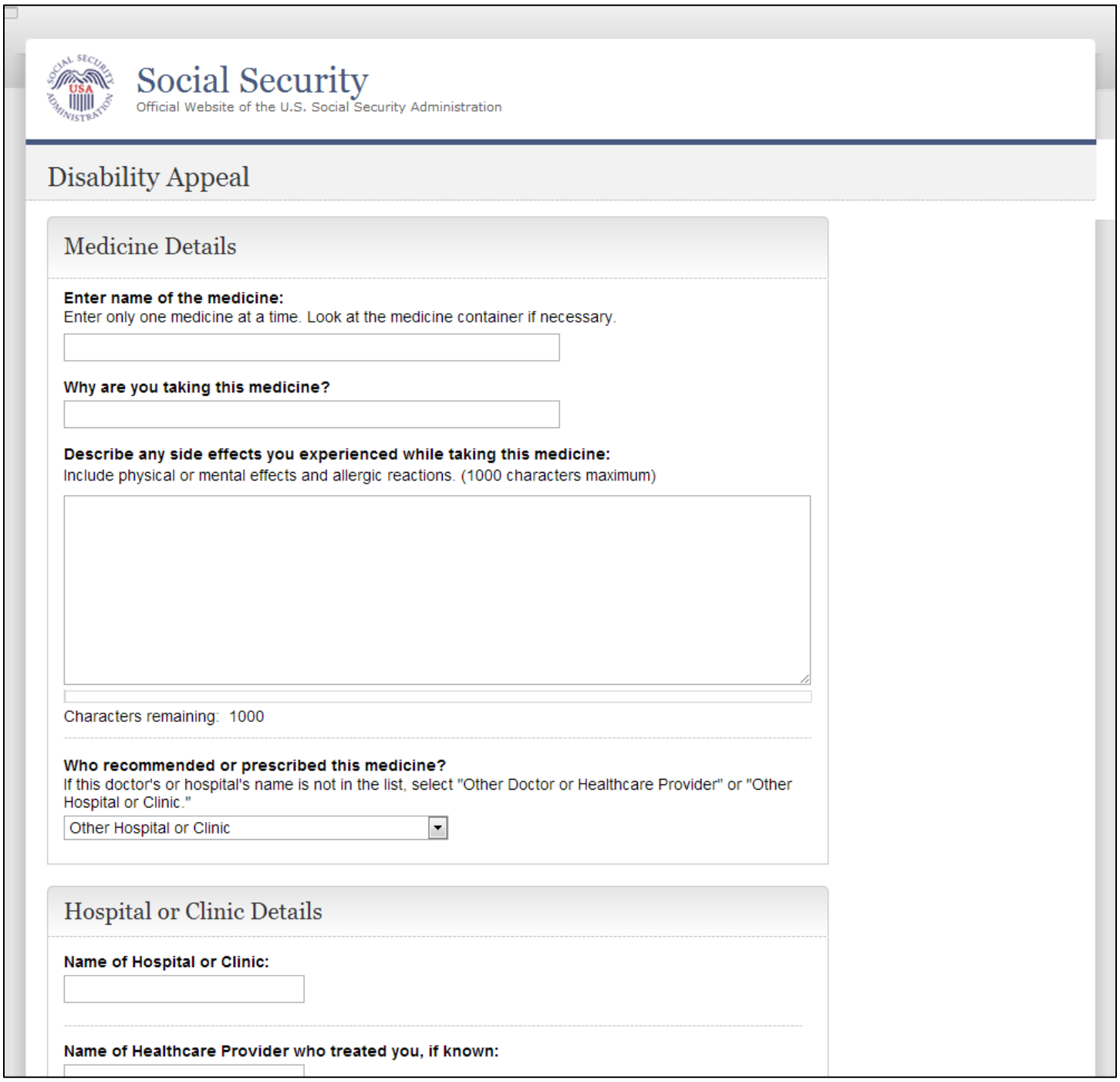
**What medical conditions were treated or evaluated?**

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

Characters remaining: 1000


Treatment from this Doctor or Healthcare Provider
What treatment did you receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)
Characters remaining: 1000
Tests Ordered by this Doctor or Healthcare Provider
Please add any tests this doctor or healthcare provider ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.
Status
Test Type
Actions
Click Add Test to add a test.
Add Test
Save
Cancel

## 4.40. Add New Medicine – 1st Party: Other Hospital



**Phone Number:**

U.S. International

10-digit Number Ext.

**Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

Street Line 2: Add More Lines

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

--

**Patient ID Number, if known:**

## Treatment Dates at this Hospital or Clinic

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

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

Yes No

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

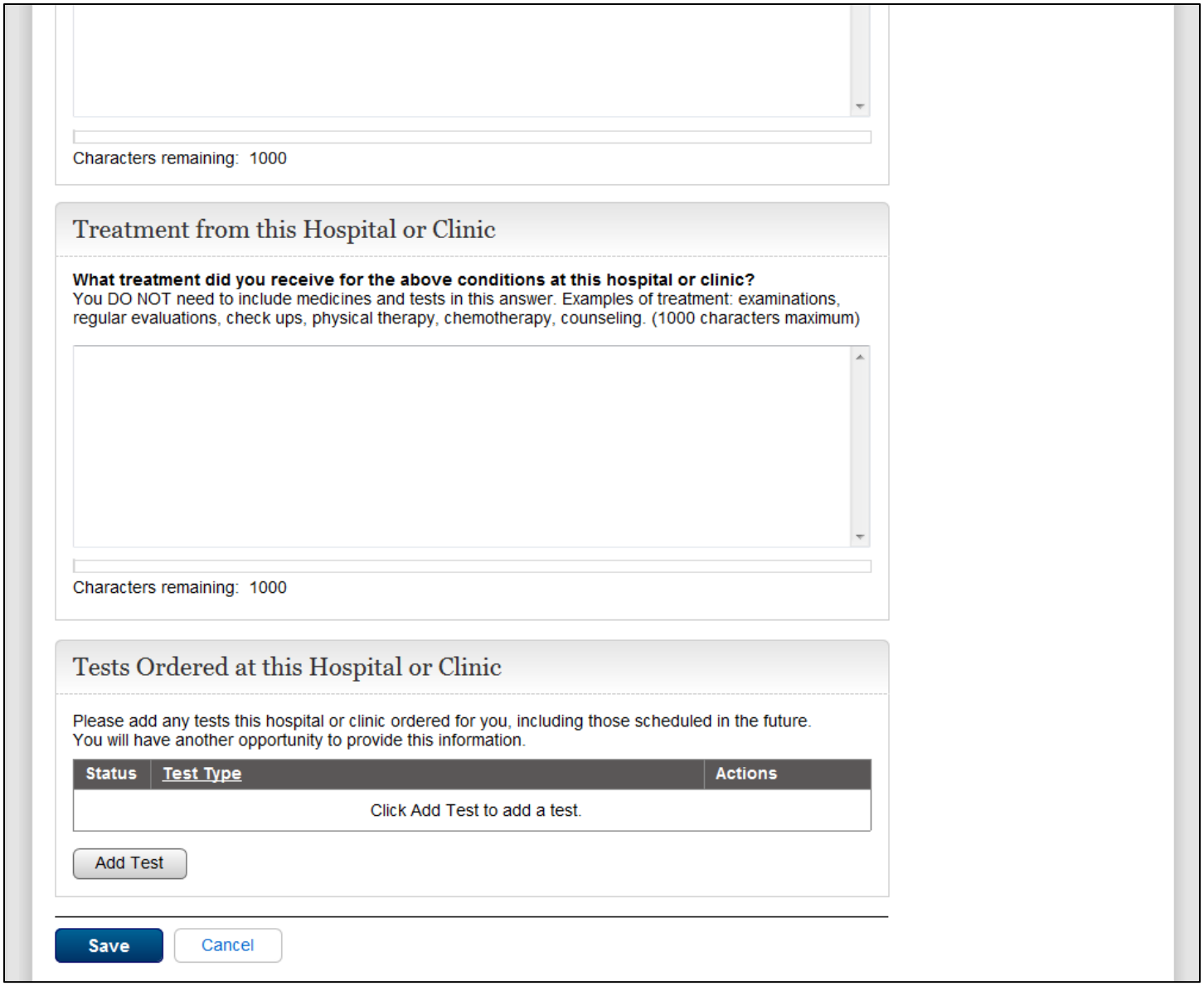
Yes No

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

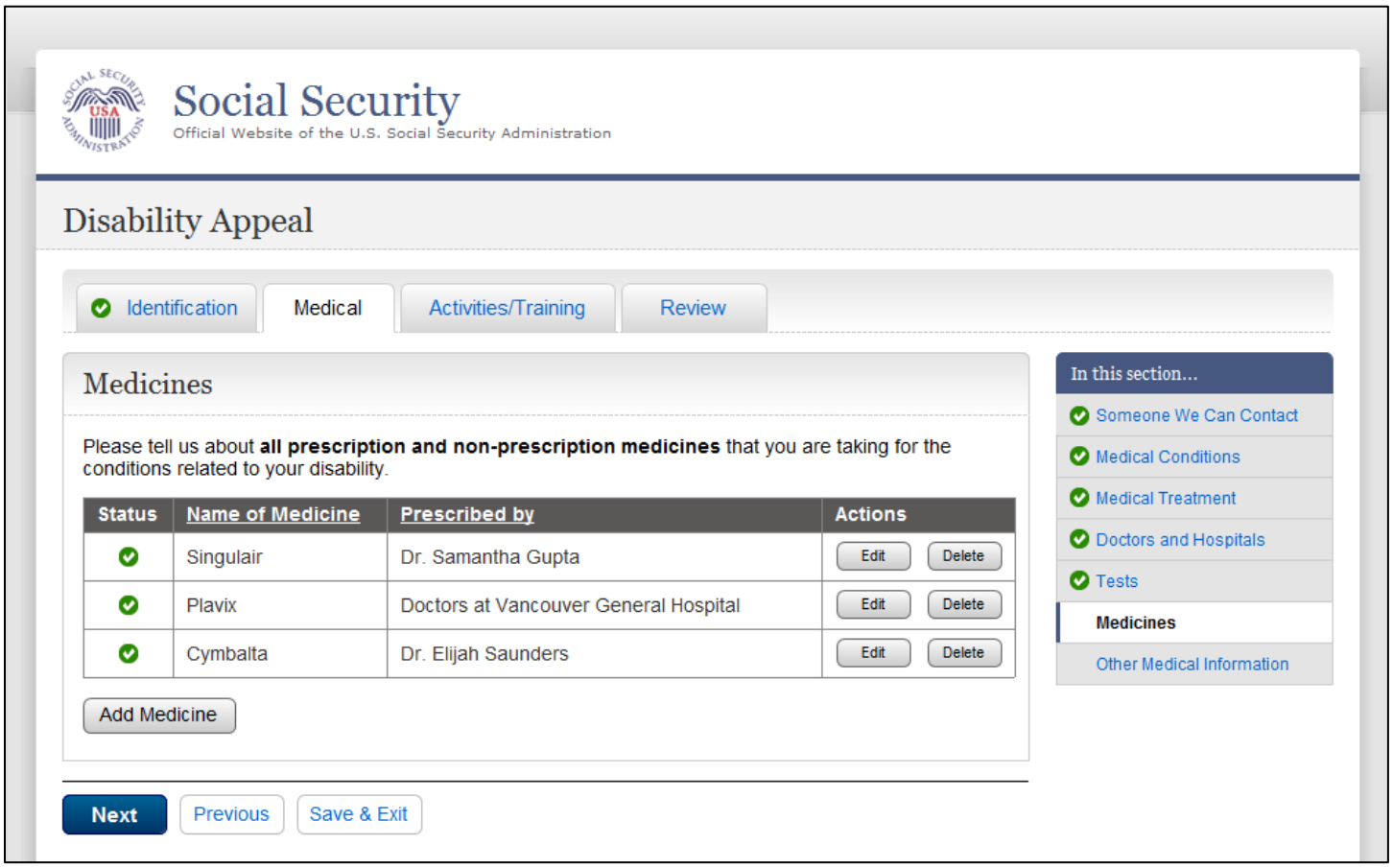
Yes No

## Medical Conditions Treated by this Hospital or Clinic

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


Characters remaining: 1000
Treatment from this Hospital or Clinic
What treatment did you receive for the above conditions at this hospital or clinic?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)
Characters remaining: 1000
Tests Ordered at this Hospital or Clinic
Please add any tests this hospital or clinic ordered for you, including those scheduled in the future.
You will have another opportunity to provide this information.
Status
Test Type
Actions
Click Add Test to add a test.
Add Test
Save
Cancel

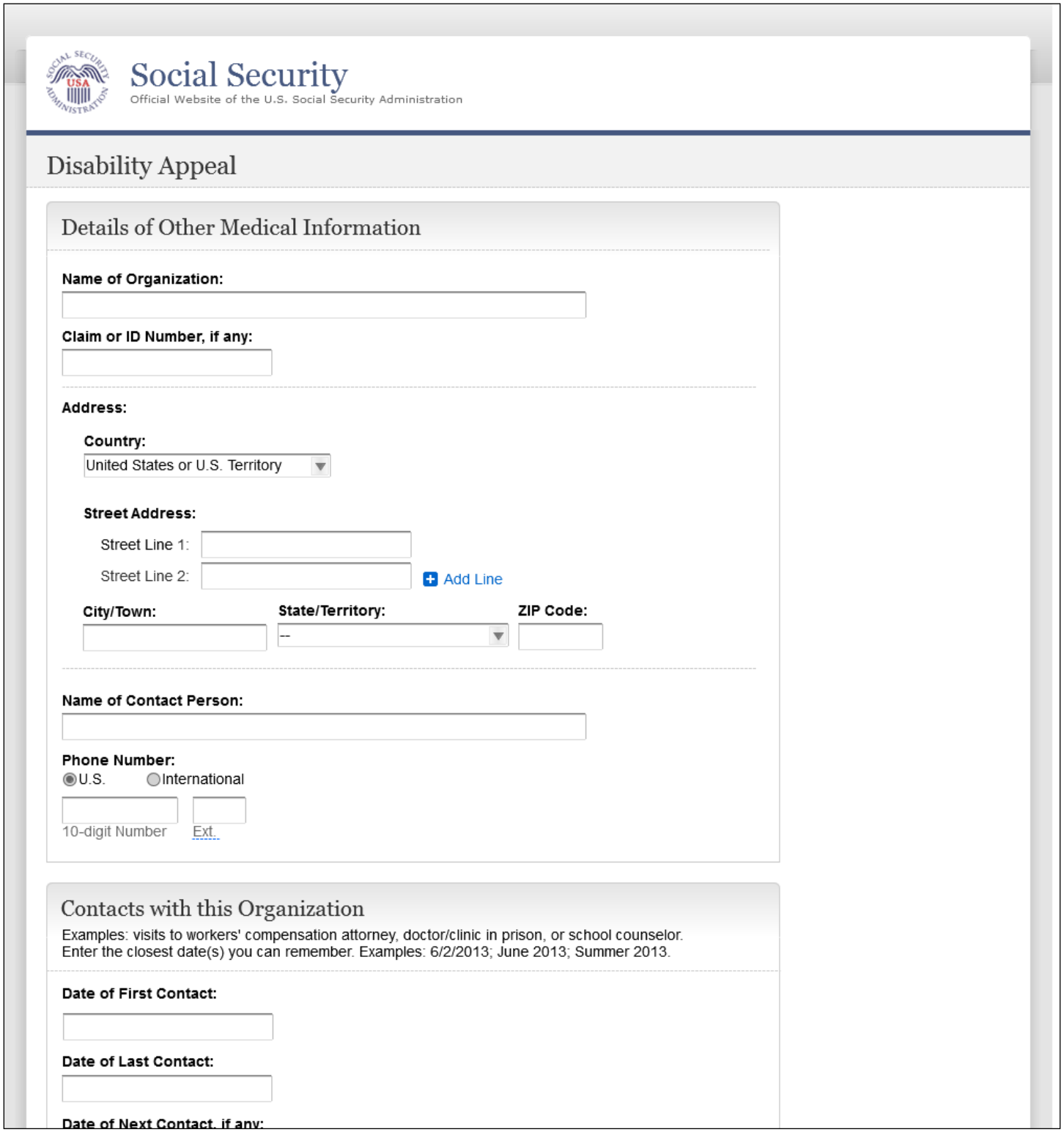
## 4.41. Medicines – 1st Party: 3 Rows Filled



## 4.42. Section5: Other Medical Info – 1st Party

## 4.43. Section5: Other Medical Info – 1st Party: Yes selected

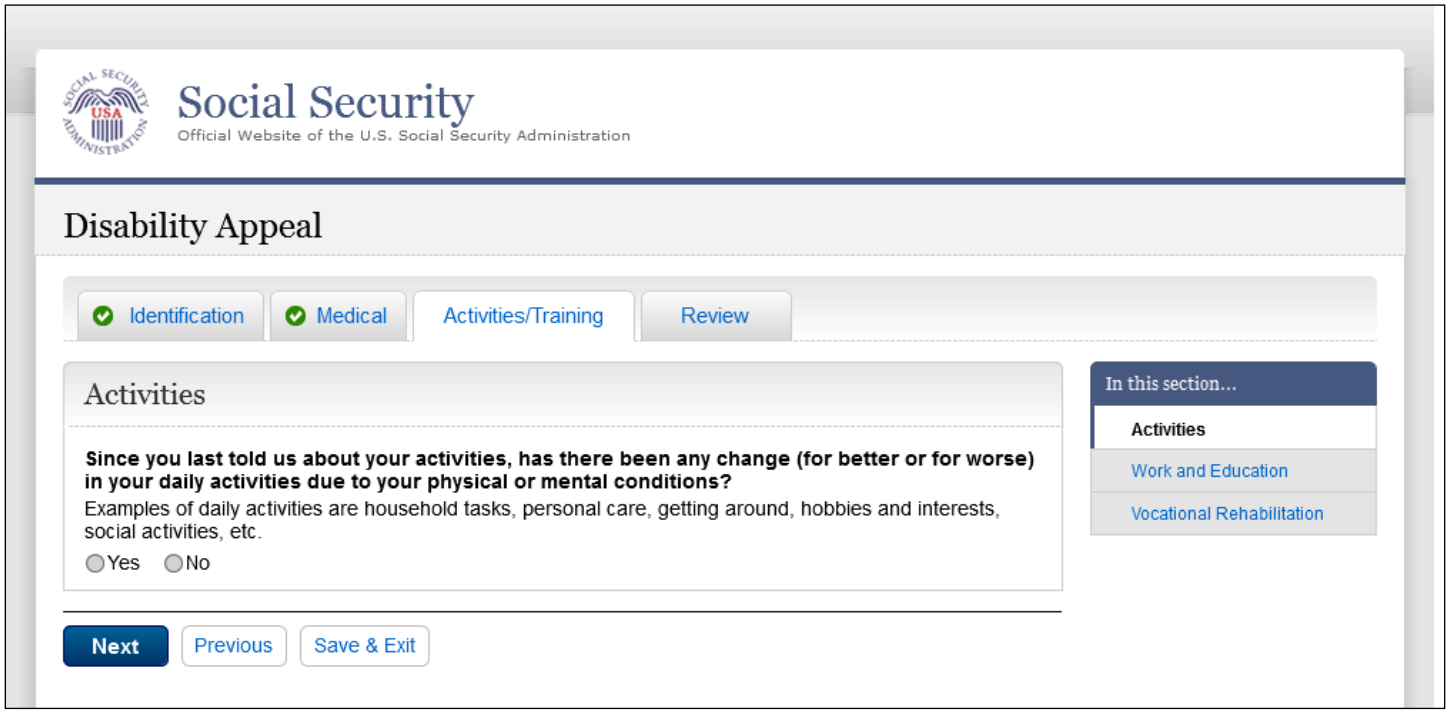
## 4.44. Add Other Medical Info – 1st Party: Details




Reasons for Contacts:
(1000 characters maximum)
Characters remaining: 1000
If you need more space, please continue in Remarks.
Save
Cancel

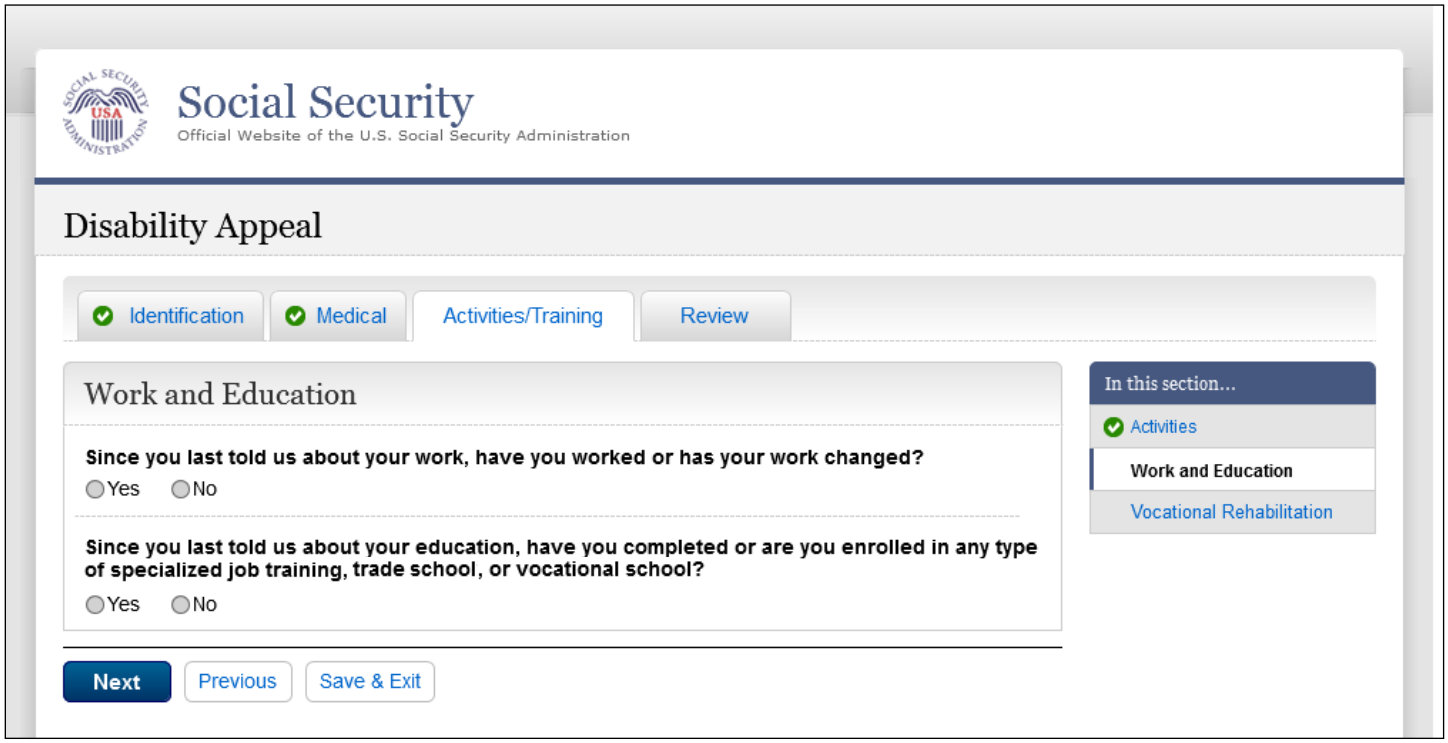
## 4.45. Added Other Medical Info – 1st Party: One Row Filled

## 4.46. Section7: Activities – 1st Party

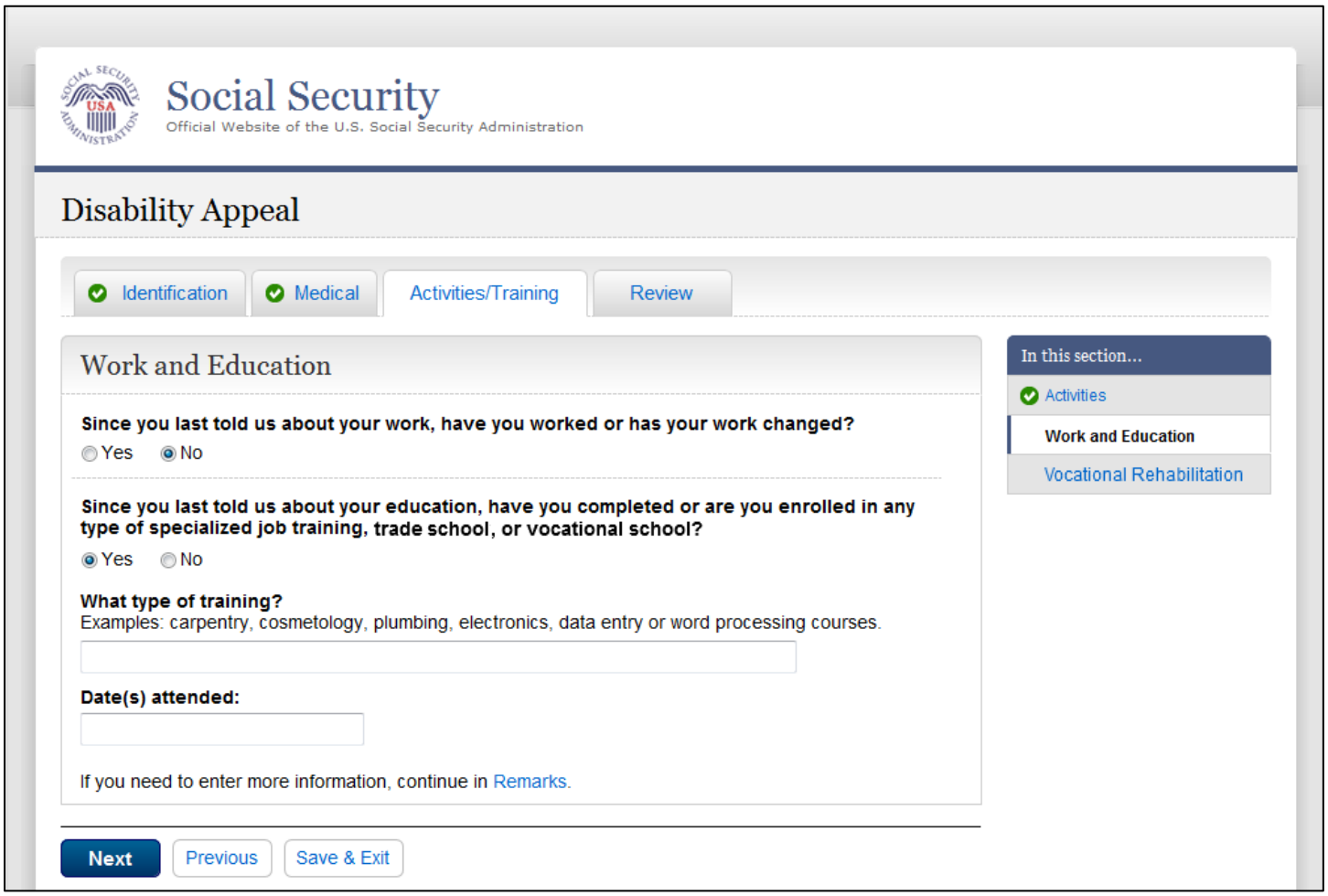


## 4.47. Section7: Activities – 1st Party: Follow up question

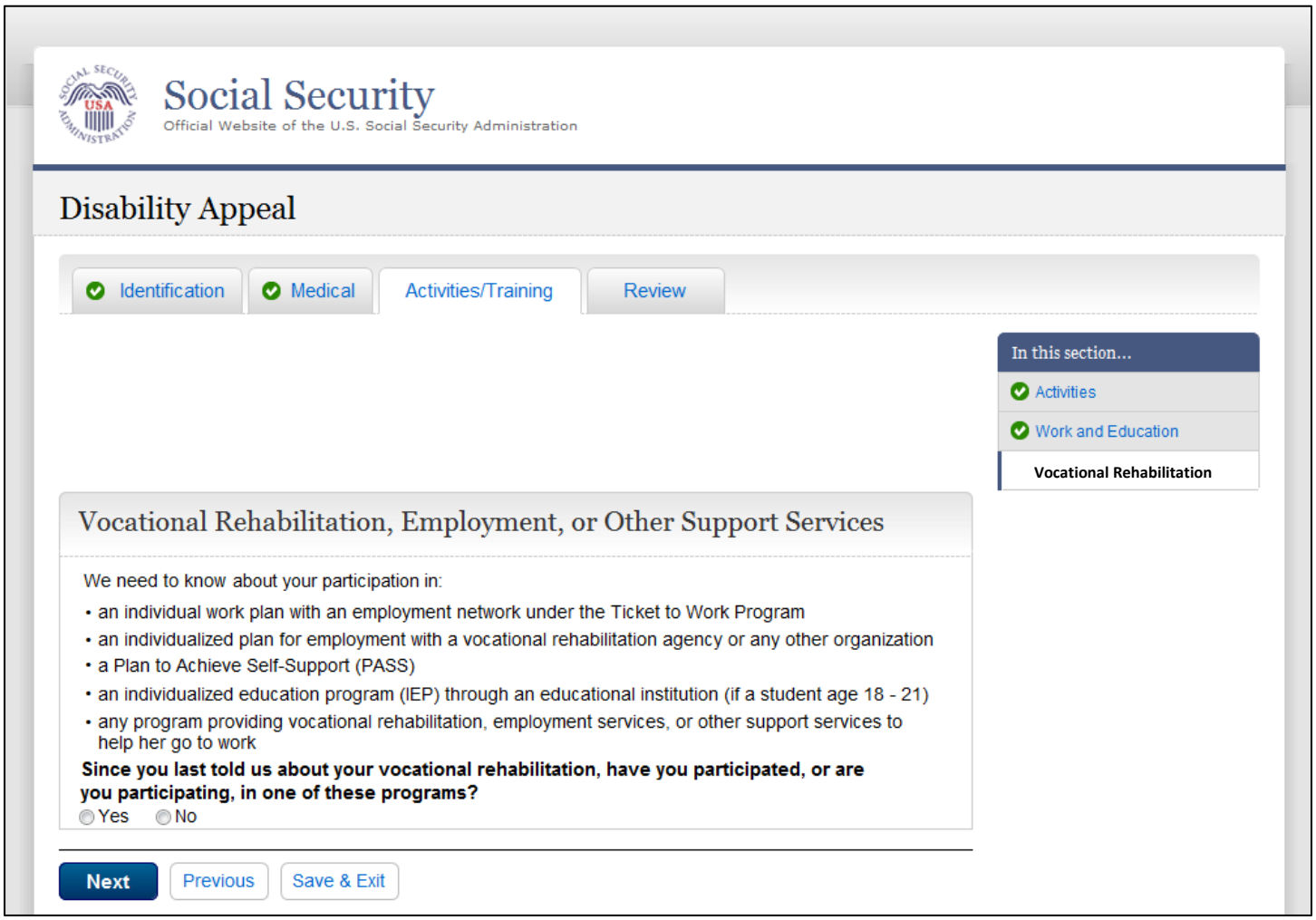
## 4.48. Section8: Work & Education – 1st Party



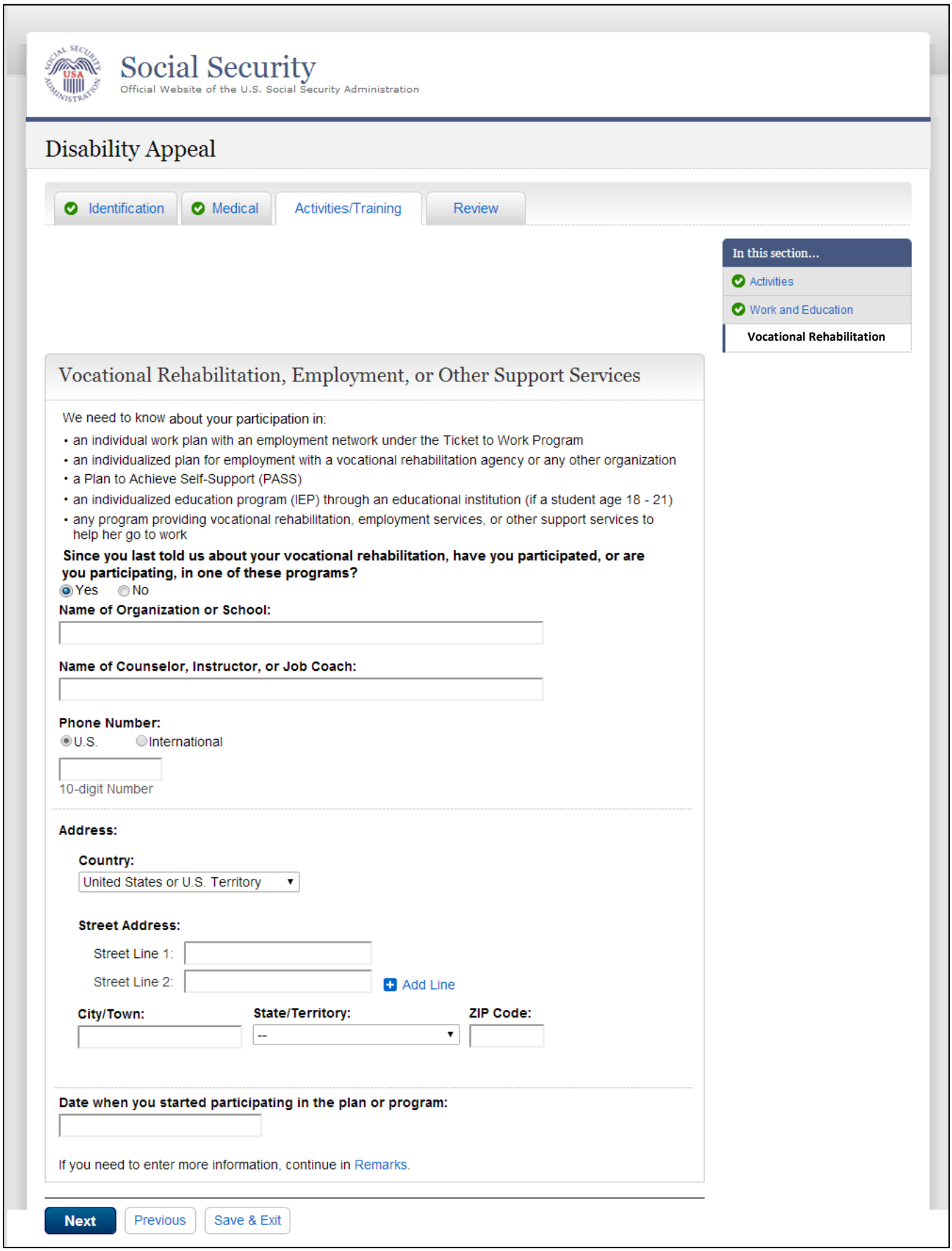
## 4.49. Section8: Work & Education – 1st Party: Follow up question



## 4.50. Section9: Voc Rehab – 1st Party: First follow up question

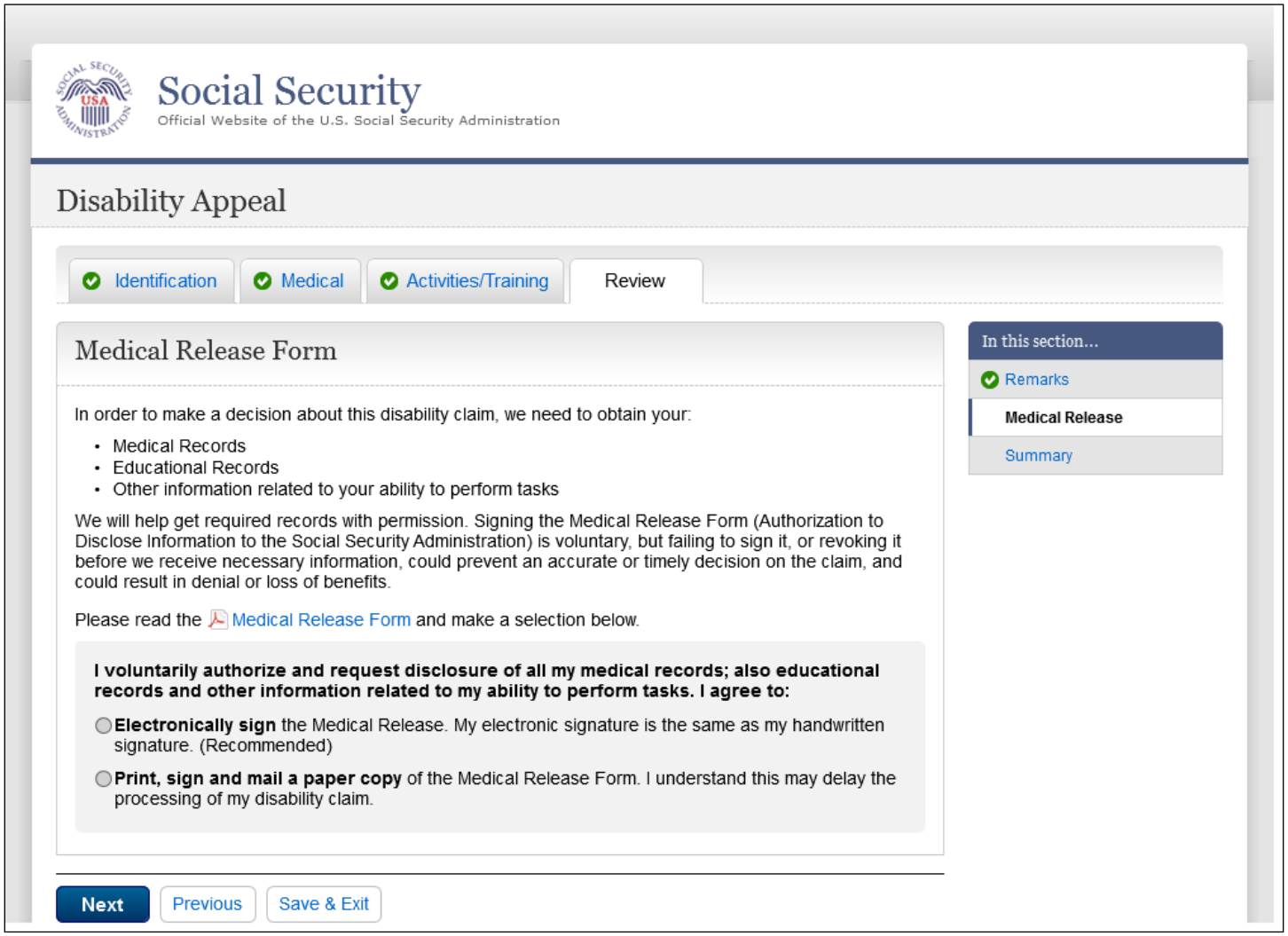


## 4.51. Section9: Voc Rehab – 1st Party: Second follow up questions



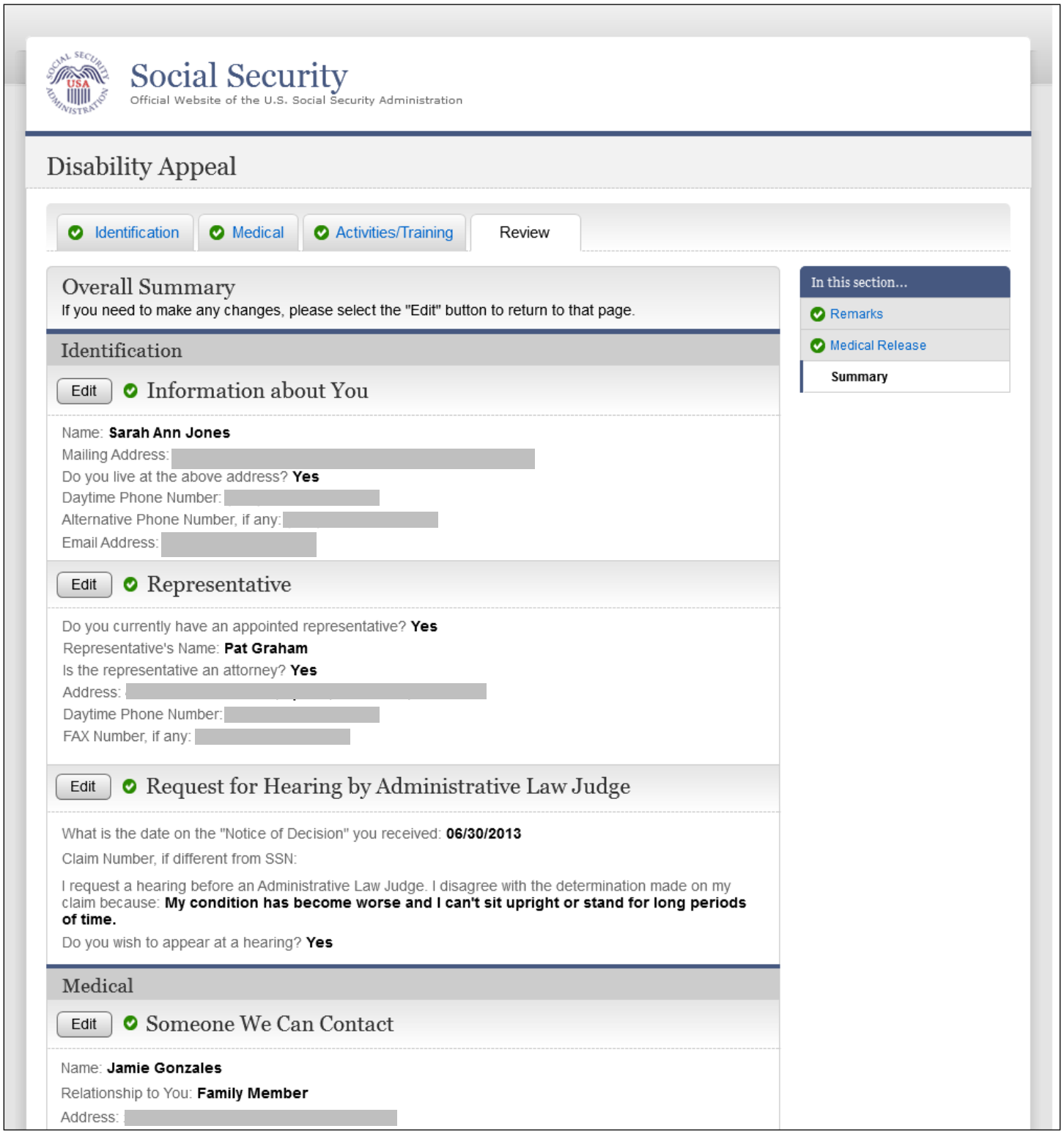
## 4.52. Remarks – 1st Party

## 4.54. Medical Release – 1st Party



## 4.55. Overall Summary – 1st Party

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



Daytime Phone Number:

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

Edit

## Medical Conditions

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? **Yes**

Date the change(s) occurred: **early January 2013**

Please describe in detail: **My condition is worse and I can't or stand for long periods of time. I get dizzy.**

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? **Yes**

Date when the new condition(s) began: **July**

Please describe your new condition(s) in detail: **I am being treated for a heart condition. When I have difficulty breathing, I have to use a nebulizer.**

Edit

## Medical Treatment

Have you used any other names on your medical or educational records? **Yes**

Other Name 1: **Sarah Smith**

Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled? **Yes**

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

Edit

## Doctors and Hospitals

**Doctor or Healthcare Provider 1**

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

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

Phone Number:

Address:

First Visit: **Sometime in 1999**

Last Visit: **June 6, 2013**

Patient ID Number, if known:

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

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

Treatments Received: **Examinations**

**Doctor or Healthcare Provider 2**

Name: **Dr. Elijah Saunders**

Address: **Baltimore, MD**

**Hospital or Clinic 1**

Name of Hospital or Clinic: **Vancouver General Hospital**

Name of Healthcare Provider who treated you, if known:

Phone Number:

Address:

Patient ID Number, if known:

Emergency Room Visits: **Yes**
Emergency Room Visit 1 : **June 2013**
Overnight Stays: **No**
Outpatient Visits: **No**
Medical conditions treated: **Heart attack**
Treatment Received:

Edit ✔ Tests

**Test 1**
Test Type: **EKG (Heart Test)**
Date(s) of Test: **June 2013**
Who ordered this test? **Dr. Samantha Gupta**

**Test 2**
Test Type: **X-ray Chest**
Date(s) of Test: **June 2013**
Who ordered this test? **Doctor(s) at Vancouver General Hospital**

**Test 3**
Test Type: **Breathing Test**
Date(s) of Test: **June 2013**
Who ordered this test? **Dr. Samantha Gupta**

Edit ✔ Medicines

**Medicine 1**
Medicine Name: **Singulair**
Reason: **Asthma**
Side Effects:
Prescribed by: **Dr. Samantha Gupta**

**Medicine 2**
Medicine Name: **Plavix**
Reason: **Heart Disease**
Side Effects:
Prescribed by: **Doctors at Vancouver General Hospital**

**Medicine 3**
Medicine Name: **Cymbalta**
Reason: **Depression and Pain Management**
Side Effects:
Prescribed by: **Dr. Elijah Saunders**

**Medicine 4**
Medicine Name: **Tylenol**
Reason: **Headaches**
Side Effects:
Prescribed by: **No one prescribed this medicine**

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

Edit ● Other Medical Information

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

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

Claim or ID Number, if any:

Address:

Name of Contact Person:

Phone Number:

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

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

Date of Next Contact, if any:

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

## Activities/Training

Edit ● Activities

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

Please describe the changes in your daily activities in detail: **I often become dizzy and have trouble breathing.**

Edit ● Work and Education

Since you last told us about your work, have you worked or has your work changed? **No**

Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

What type of training? **Computer training**

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

Edit ● Vocational Rehabilitation, Employment, or Other Support

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs? **No**

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

Name of Counselor, Instructor, or Job Coach:

Phone Number:

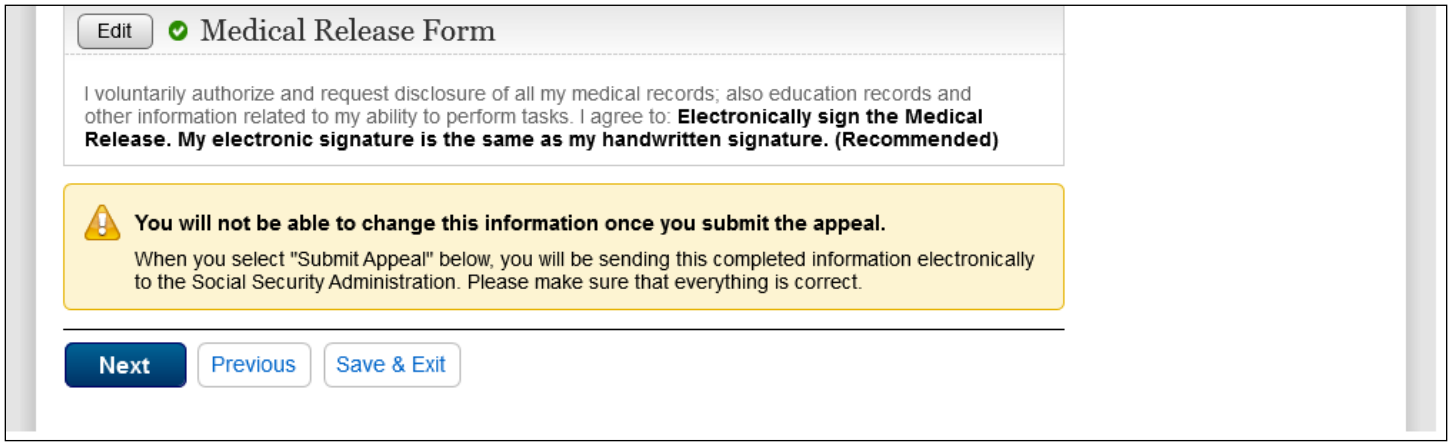
Address:

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

## Review

Edit ● Remarks

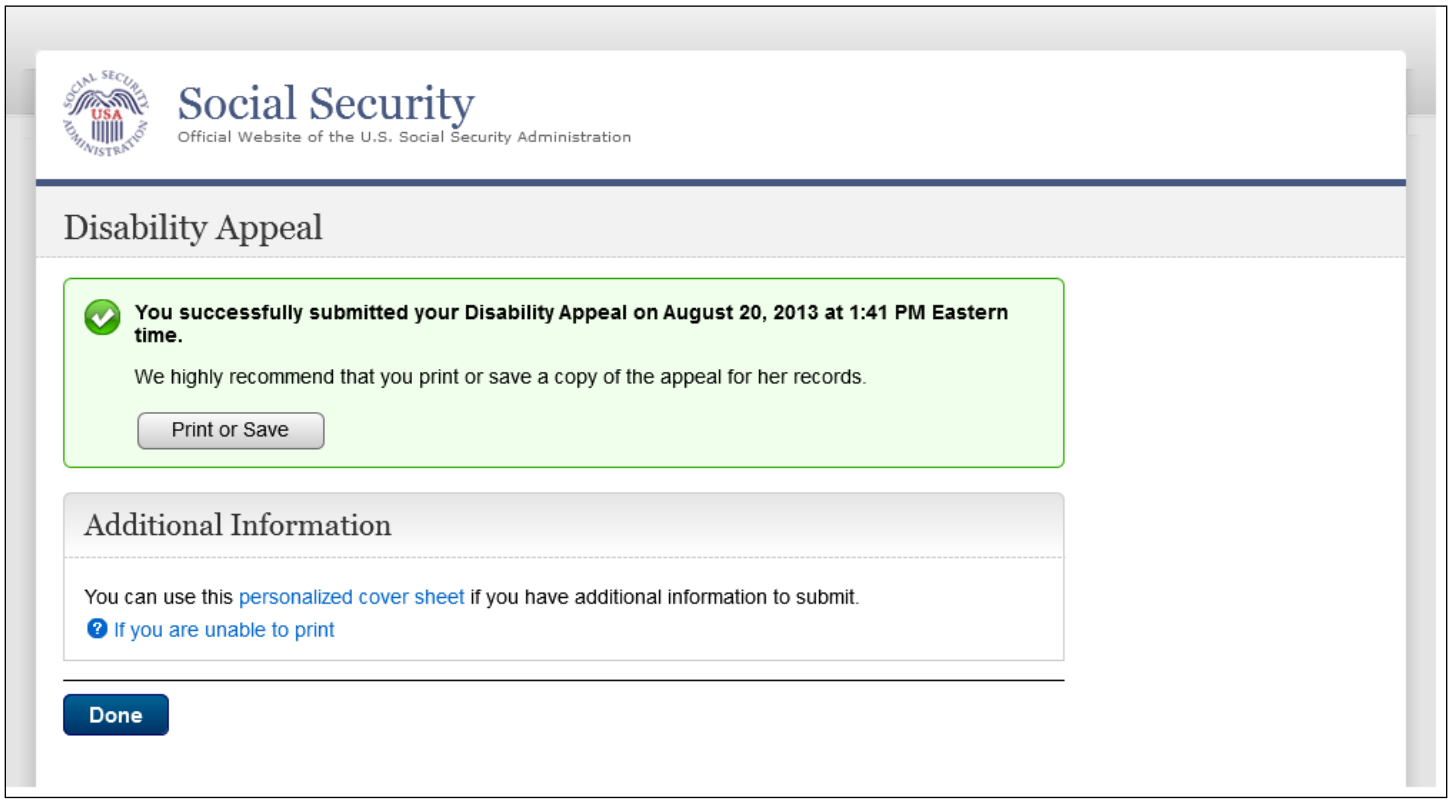
Remarks: **I cannot work. I have trouble breathing and chest pain every day.**


Edit
Medical Release Form
I voluntarily authorize and request disclosure of all my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Electronically sign the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)**
**You will not be able to change this information once you submit the appeal.**
When you select "Submit Appeal" below, you will be sending this completed information electronically to the Social Security Administration. Please make sure that everything is correct.
Next
Previous
Save & Exit

## 4.57. Attach Files: No Files Attached

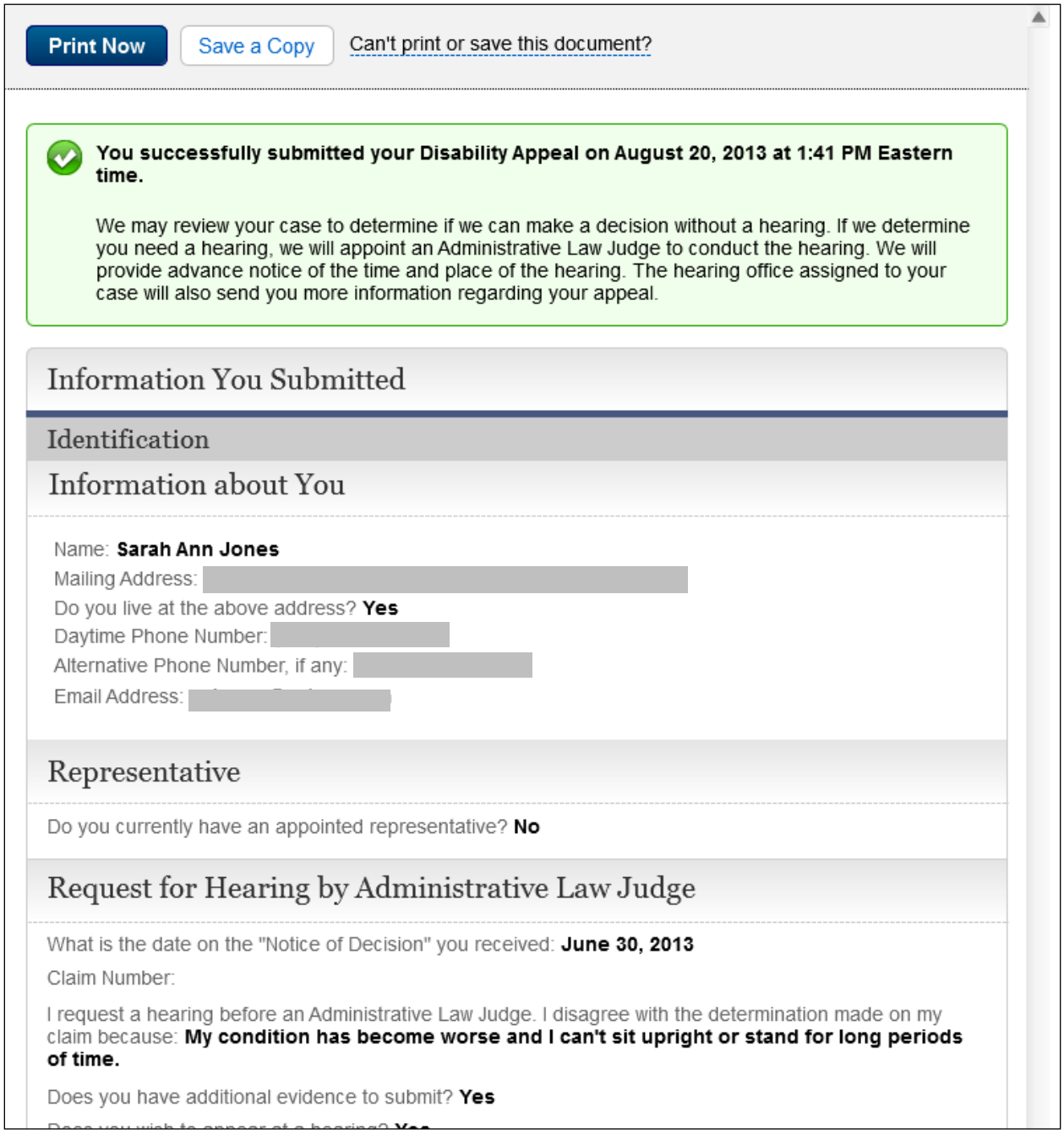
## 4.58. Confirmation – 1st Party

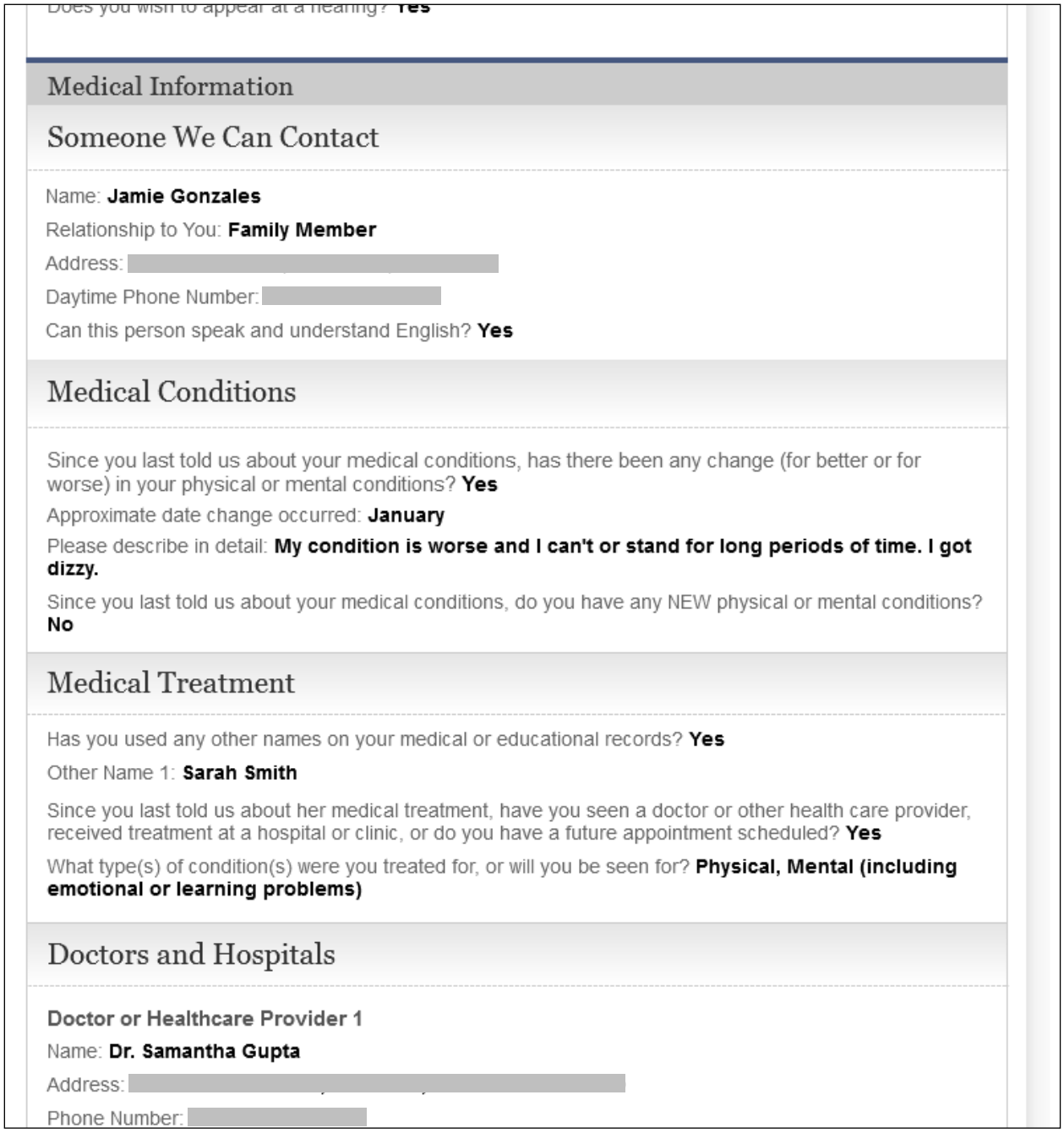
This is a sample of a confirmation for a request for Reconsideration.



## 4.59. Receipt Pop up – 1st Party

In the green Confirmation notice, the paragraph beginning "an Administrative Law Judge" is only displayed for a request for hearing, not reconsideration.





Does you wish to appeal at a hearing? **Yes**

## Medical Information

### Someone We Can Contact

Name: **Jamie Gonzales**

Relationship to You: **Family Member**

Address:

Daytime Phone Number:

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

### Medical Conditions

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

Approximate date change occurred: **January**

Please describe in detail: **My condition is worse and I can't or stand for long periods of time. I got dizzy.**

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? **No**

### Medical Treatment

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

Other Name 1: **Sarah Smith**

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

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

### Doctors and Hospitals

**Doctor or Healthcare Provider 1**

Name: **Dr. Samantha Gupta**

Address:

Phone Number:

First Visit: **Sometime in 1999**
Last Visit: **June 6, 2013**
Next Scheduled Appointment: **August 1, 2013**
Medical conditions treated: **Diabetes, Heart Disease, Asthma**
Treatments Received:

**Doctor or Healthcare Provider 2**
Name: **Dr. Elijah Saunders**
Address:

**Hospital or Clinic 1**
Name: **Vancouver General Hospital**
Address:
Phone Number:
Emergency Room Visits: **Yes**
Emergency Room Visit 1 : **June 2013**
Inpatient Stays: **No**
Outpatient Visits: **No**
Medical conditions treated: **Heart attack**
Treatment Received:

## Tests

**Test 1**
Kind of test: **EKG (Heart Test)**
Date of Test: **June 2013**
Sent for test by: **Dr. Samantha Gupta**

**Test 2**
Kind of test: **X-ray Chest**
Date of Test: **June 2013**
Sent for test by: **Doctor(s) at Vancouver General Hospital**

**Test 3**
Kind of test: **Breathing Test**
Date of Test: **June 2013**

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

## Medicines

**Medicine 1**
Medicine: **Singulair**
Reason: **Asthma**
Side Effects:
Prescribed by: **Dr. Samantha Gupta**

**Medicine 2**
Medicine: **Plavix**
Reason: **Heart Disease**
Side Effects:
Prescribed by: **Doctors at Vancouver General Hospital**

**Medicine 3**
Medicine: **Cymbalta**
Reason: **Depression and Pain Management**
Side Effects:
Prescribed by: **Dr. Elijah Saunders**

**Medicine 4**
Medicine: **Tylenol**
Reason: **Headache**
Side Effects:
Prescribed by: **No one prescribed this medicine**

## Other Medical Information

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

Name of Organization: **Workers' Insurance, Inc.**
Claim or ID Number, if any:
Address: [redacted]

Name of Contact Person:

Phone Number:

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

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

Date of Next Contact, if any:

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

## Activities/Training

### Activities

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

Please describe in detail the changes in your daily activities. **I often becomes dizzy and have trouble breathing so I can no longer drive a car or go anywhere alone.**

### Work and Education

Since you last told us about your work, have you worked or has your work changed? **No**

Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school? **Yes**

### Vocational Rehabilitation, Employment, or Other Support

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs? **No**

## Review

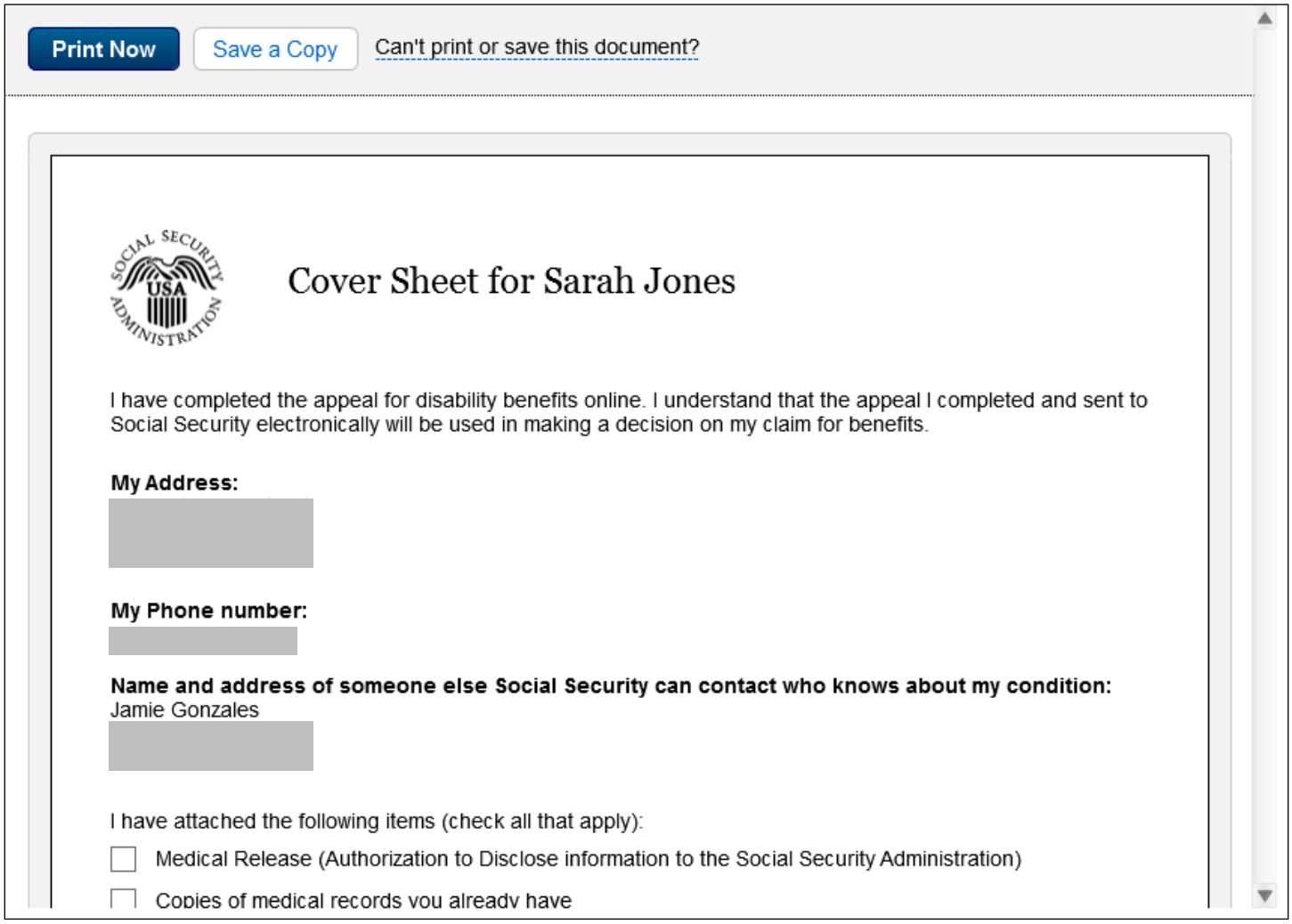
### Remarks

Remarks: **I cannot work. I have trouble breathing and chest pain every day.**

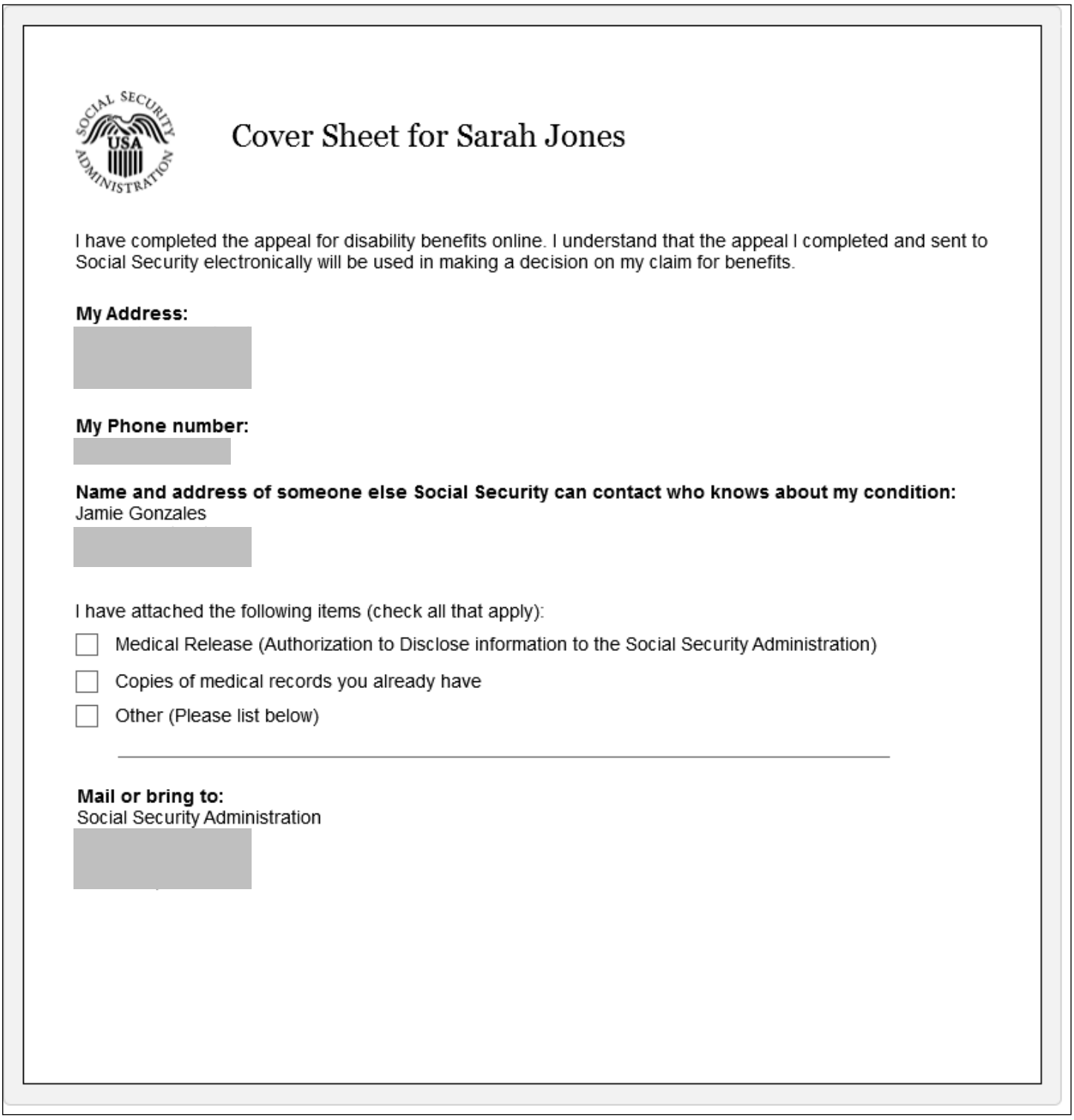
### Medical Release Form

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

## 4.60. Cover Sheet Popup – 1st Party



## 4.61. Cover Sheet Content – 1st Party



Cover Sheet for Sarah Jones

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

**My Address:**

**My Phone number:**

**Name and address of someone else Social Security can contact who knows about my condition:**
Jamie Gonzales

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

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

_____

**Mail or bring to:**
Social Security Administration