

EDCS 3441 Screenshots (as of 4/25/2018)

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Manually Created T16 Information

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Title II/Title XVI  
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Build: 39  
Build Date: 04/10/2018 09:42 AM  
Logged-in User  
Name: SHERROD, L  
Office: 273

**3441 About You**

**Identification**

Name: Samantha Chou  
Daytime telephone number: 410-555-1247  
Alternate telephone number is:  U.S.  Foreign  None  
Alternate telephone number:  Ext:   
E-mail address:

**Other Names Used**

Have you used any other names on your medical or educational records?  
Examples are maiden name, other married name, or nickname

Yes  No  Not yet answered

There is no information of this type in prior level(s).  
To add a name, choose Add Other Name. To edit, select the name below.

**Other Names**

<a href="#">Tulsa, Howard Ray II</a>
<a href="#">Wilson, Samuel Allen VII</a>

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### 3441 Contacts

**Alternate Contact Information**

Is there someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your claim? (e.g., friend or relative)

Yes    No    Not yet answered

**Person Completing the Report**

Who is providing information?

Samantha Chou

Alternate Contact listed above

Someone else

**Name of Person Completing This Report**

First name:	Middle name:	Last name:	Suffix:
<input type="text" value="m"/>	<input type="text" value="l"/>	<input type="text" value="l"/>	<input type="text"/>

Agency name:

Relationship to disabled person:

**Address for Person Completing This Report**

Address is:  U.S.    Foreign  

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City:    State:    ZIP Code:

**Telephone for Person Completing This Report**

Telephone number is:  U.S.    Foreign    None

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

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### 3441 Medical Conditions

Date of last disability report (MM/DD/YYYY): [06/07/2017 X] [ ]

**Medical Conditions**

When you filed your claim you told us that your physical or mental conditions included:

\* Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your physical or mental conditions?  
 Yes  No  Not yet answered

\* Since you last told us about your medical conditions, do you have any NEW physical or mental conditions?  
 Include:  
 • New impairments that started since you filed your claim  
 • Impairments you forgot to tell us about when you applied

Yes  No  Not yet answered

Please describe in detail:  
[Examples of new conditions](#)

Approximate beginning date:  
 If you can't remember the exact dates, be as specific as possible.  
 Examples:  
 • June 11, 2002  
 • October 2000  
 • Summer 1999

3441 Medical Conditons

**Commented [KB1]:** Add "previously described." The sentence should read:

"Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your previously described physical or mental conditions."

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### 3441 Medical Sources

**Doctors, Therapists, Hospitals, Clinics**

\* Since you last told us about your medical treatment, have you seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled?  
 Yes  No  Not yet answered

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

There is no information of this type in prior level(s).  
 Tell us who may have NEW medical records about any of your physical or mental conditions (including emotional or learning problems). Please include doctors' offices, hospitals (including emergency room visits), clinics, mental health centers and other healthcare facilities.

Only list the providers you have seen since you last told us about your medical treatment.  
 Include:  
 • All types of providers (physicians, psychologists, optometrists, nurse practitioners, therapists, chiropractors, acupuncturists, etc.)  
 • Places where you had treatments, tests, surgery, or emergency room visits

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

Name	Address
Jan_Farhana_Beth Israel Deaconess Medical Center	330 Brookline Ave
PULIN, JAMES M. D.	* ORTHOPAEDIC TRAUMA & RECONSTRUCT.
TALLMAN, DR. CARTER M. D.	* ONE PARKWAY
TORRISI & TORRISI, L.	* C/O MICHAEL A. TORRISI, ESQ.

Add Doctor/Hospital/Etc.

3441 Medical Sources

**Commented [KB2]:** Add "or updated." The sentence should read:

"Tell us who may have NEW OR UPDATED medical records about any of your physical or mental conditions (including emotional or learning problems)..."

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### 3441 Tests Summary

Since you last told us about your tests, have you had any medical tests or do you have any tests scheduled in the future?

Yes  No  Not yet answered

There is no information of this type in prior level(s).

List all tests that you had or are scheduled to have since you last told us about your tests.

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

Test	Date	Ordered By
Breathing test	121286	Jan, Farhana, Beth Israel Deaconess Medical Center

[Add Test](#)

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### 3441 Other Medical Information

**Other Medical Sources**

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

Examples:

- Worker's Compensation
- Vocational rehabilitation services
- Insurance companies who have paid you disability benefits
- Prisons and correctional facilities
- Attorneys
- Social service agencies
- Welfare agencies
- School/education records

Yes  No  Not yet answered

There is no information of this type in prior level(s).

List any other people or places that may have your medical information or records since you last told us about your other medical information.

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

Name	Address
ORLANDO B. CONANAN MD	7501 LIBERTY RD
WACHTEL, MITCHELL DPM	451 ANDOVER STREET

[Add Source](#)

### 3441 Other Medical Information

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### 3441 Medicines Summary

Are you currently taking any medicines (prescription or non-prescription)?

Yes  No  Not yet answered

There is no information of this type in prior level(s).

List all prescription and non-prescription medicines that you are currently taking for your condition.

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

Medicine	Prescribed by	Reason
Acetaminophen	Jan, Fahana, Beth Israel Deaconess Medical Center	For me

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### 3441 Activities

**Information About Your Activities**

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

Examples:

- Household tasks
- Personal care
- Getting around
- Hobbies and interests
- Social activities

Yes  No  Not yet answered

Describe in detail.

3441 Activities

**Commented [KB3]:** Add "previously described." The sentence should read:

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

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### 3441 Work and Education

**Work Information**

Since you last told us about your work, have you worked or has your work changed?  
If yes, you will be asked to provide additional information.

Yes  No  Not yet answered

**Education Information**

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  No  Not yet answered

Describe what type:

Date(s) attended:

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### 3441 Vocational Rehabilitation, Employment, or Other Support Services

Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

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

Yes  No  Not yet answered

There is no information of this type in prior level(s).

List all plans or programs attended since you last told us about your vocational rehabilitation.  
To add a plan or program, choose Add a Plan or Program. To edit, select the plan or program name below.

Organization/School	Name of Counselor/Instructor
MARYLAND GENERAL HOS	*No Counselor/Instructor name*
MATER DOLOROSA SCHOOL	*No Counselor/Instructor name*

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### 3441 Remarks

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about.

**3441 Remarks**