

# Disability Case Selection

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

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### Disability Case Selection

[Enable JAWS Mode](#)

**Search Criteria**

Client SSN:

Client Name. Last:  First:

**Search Results**

	Client Name	DSI	CEF	DOB	Estab Date	Level	Claim Type	Office Code	Office Type	Claim Status
<input type="radio"/>	<a href="#">Ovard, Joshua</a>	N	Y	06/01/1994	07/31/2005	Reconsideration	DC	X33	FO	Closed
<input type="radio"/>	<a href="#">Ovard, Joshua Q.</a>	N	Y	06/01/1994	01/15/2005	Initial	DC	C65	FO	Closed

# Select Case Level

Select Case Level -- Web Page Dialog

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

Initial Classification:

- Initial
- Reconsideration
- Hearing
- Appeals Council
- Federal Court

MCS Exclusion Claim

CDR Classification:

- CDR Initial
- CDR Reconsideration
- CDR Hearing

OK Cancel


# Confirm Case Creation

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

**Client Name:** Joshua Ovard  
**Date of Birth:** 06/01/1994

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

An Adult  
 A Child  
 An Age 18

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

Do you wish to create a case for this person?

# Form Selection

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

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

**Form(s) Selection**

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

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

# Link Folder

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

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

---

**Link Folder**

---

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

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

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

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

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

Yes    No    Not Yet Answered

# CDR Information, Part 1 of 2

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

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

Check Edits | Transfer | Print Forms | Create Barcode | Claims Actions | eForms | Help | Close Case | Exit

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  - [CDR Representatives](#)
  - [CDR Claims](#)
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**CDR Information**

**Client Identification**

**Name:** Joshua Ovard

**Date of birth:** 06/01/1994

**Mailing address:** 608 W. 100 STREET  
PROVO, UT 84601

**Residence address:** 608 W. 100 STREET  
PROVO, UT 84601

**Daytime telephone number:** 801-377-1373

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

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

**Alternate telephone number:**

**Other Names Used**

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

Yes  No  Not Yet Answered

# CDR Information, Part 2 of 2

Other Names = Yes, but no other names entered

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

Other Names

Add

**Your Language Information**

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

**Case Information**

\* CDR type:

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

Is DDS capability development needed?  Yes  No  Not Yet Answered

**Contact Information**




\* CR unit code:

\* First name:  \* Last name:

\* Telephone number:  Ext.

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# Other Names Used

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


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

Add each name that might appear on the child's medical or educational records.

\* First name:

Middle name:

\* Last name:

Suffix  



# CDR Information, Part 2 of 2

Other Names = Yes, with another name entered

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

**Other Names**

[Ovard, Josh](#)


Add

**Your Language Information**

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

**Case Information**

\* CDR type:

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

Is DDS capability development needed?  Yes  No  Not Yet Answered

**Contact Information**

\* CR unit code:

\* First name:  \* Last name:

\* Telephone number:  Ext.

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# CDR Representatives

Appointed Representative = No

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### CDR Representatives

**Representative Payee Information**

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

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

Name	Address	Claim Type
<a href="#">Ovard, Amanda</a>	608 W 100 St.	DC

**Appointed Representative Information**

Does the child have an appointed representative?

Yes  No  Not Yet Answered

|  |  |

# CDR Representatives, Part 1 of 2

## Appointed Representative = Yes

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**Flags/Messages**

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### CDR Representatives

#### Representative Payee Information

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

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

Name	Address	Claim Type
<a href="#">Ovard, Amanda</a>	608 W 100 St.	DC

#### Appointed Representative Information

Does the child have an appointed representative?

Yes  No  Not Yet Answered

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

#### Appointed Representative Address Information

# CDR Representatives, Part 2 of 2

## Appointed Representative = Yes

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**Appointed Representative Information**

Does the child have an appointed representative?  
 Yes  No  Not Yet Answered

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

**Appointed Representative Address Information**

Address is:  U.S.  Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City:  State:  Zip Code:

**Appointed Representative Telephone Information**

Telephone Number is:  U.S.  Foreign  None

Type:  Voice  Fax  TTY

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

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# CDR Claims

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**CDR Claims**

Select a claim type to view CDR claim information:

Claim Type	Claim Number	BIC
<a href="#">DC</a>	999-99-9992	

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# Contacts, Part 1 of 3

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**454 Contacts**

**Alternate Contact Information**

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

Yes  No  Not Yet Answered

**Name of Alternate Contact**

First name:  Middle Name:  Last name:  Suffix:

Relationship to Child:

**Address for Alternate Contact**

Mailing address is:  U.S.  Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

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# Contacts, Part 2 of 3

## Person Completing Report = Claimant

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Street address line 4:

City:  State:  Zip Code:

**Telephone for Alternate Contact**

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

Telephone Number is:  U.S.  Foreign  None

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

**Preferred Language of Alternate Contact**

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

**Person Completing the Report**

Who is providing information?

Joshua Ovard  
 Alternate Contact listed above  
 Someone else

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# Contacts, Part 3 of 3

## Person Completing Report = Someone Else

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**Flags/Messages**

Someone else

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

Relationship to Disabled Person:

**Address for Person Completing This Report**

Mailing address is:  U.S.  Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City:  State:  Zip Code:

**Telephone for Person Completing This Report**

Telephone Number is:  U.S.  Foreign  None

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



# Medical Conditions

Medical Conditions Propagated from mainframe, no new conditions entered

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### 454 Medical Conditions

#### Physical and Mental Conditions

\* List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.

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

1.

2.

#### Height and Weight

What is the child's height without shoes? feet:  inches:

What is the child's weight without shoes? pounds:

|  |  |

# Medical Conditions

Medical Conditions Propagated from mainframe, plus one new conditions entered

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### 454 Medical Conditions

#### Physical and Mental Conditions

\* List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.

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

1.

2.

3.

#### Height and Weight

What is the child's height without shoes? feet:  inches:

What is the child's weight without shoes? pounds:

|  |  |

# Medical Sources

Initial view

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**454 Medical Sources**

**Doctors, Therapists, Hospital, Clinics**

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

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

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

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# Medical Sources

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

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### 454 Medical Sources

Doctors, Therapists, Hospital, Clinics

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

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

Yes    No    Not Yet Answered

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

Yes    No    Not Yet Answered

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




Tell us about the child's **next appointment**, if one is scheduled.

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

Name	Address

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# Add Doctor/Therapist, Part 1 of 2

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

**Doctor/Therapist Information** Source to Merge

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

**Attention:**

**Address:** 147 West 400 North

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

**Dates**

**First visit:**

**Last visit:**

**Next appointment:**

**Conditions and Treatments**

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

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

## Add Doctor/Therapist, Part 2 of 2

### Tests

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

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

Test	Date	Ordered By

Add Test

### Medicines

List all medicines the child is now taking, or has taken **in the last 12 months**, prescribed or suggested **by this provider**.

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

Medicine	Prescribed By	Reason

Add Medicine

### Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.

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

Name
Fatigue, Fibromyalgia
Migraines

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

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# Medical Sources

User has indicated claimant has medical sources and entered a doctor

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### 454 Medical Sources

Doctors, Therapists, Hospital, Clinics

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

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

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

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

Tell us about the child's **next appointment**, if one is scheduled.

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

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

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# Add Hospital/Clinic, Part 1 of 3

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

### Hospital/Clinic Information

Name of facility or office: [Utah General Hospital](#)  
Attention:  
Address: 6701 Main Street

Health care professional who treated the child at Utah General Hospital:

Patient ID# (if known):

### Dates at this Facility

Did the child have any inpatient stays?  Yes  No  Not Yet Answered

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

Did the child have any outpatient visits?  Yes  No  Not Yet Answered

First visit:   
Last visit:   
Next appointment:



## Add Hospital/Clinic, Part 2 of 3

Did the child have any emergency room visits?  Yes  No  Not Yet Answered

Date of visit:

Date of visit:

Date of visit:

### Conditions and Treatments

What medical conditions were treated or evaluated?

What treatment did the child receive for the above conditions?

### Tests

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

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

Test	Date	Ordered By

Add Test

## Add Hospital/Clinic, Part 3 of 3

### Medicines

List any prescription or non-prescription medicines the child is now taking, or has taken in the last 12 months, prescribed or suggested by this provider.

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

Medicine	Prescribed By	Reason

Add Medicine

### Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.

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

Name
Fatigue, Fibromyalgia
Migraines

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

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# Tests Summary

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### 454 Tests Summary

Has the child had any medical tests, or does the child have any tests scheduled for his or her condition?

Yes  No  Not Yet Answered

List all tests that child had or will have for his or her condition.




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

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

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# Test Information

No body part involved

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

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

\*Name of Test:

Date of Test:

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

**Physical and Mental Conditions**

List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.  
To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines

# Test Information

Body part involved

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

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

\*Name of Test: X-Ray (body part) ▼

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

Date of Test:

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

**Physical and Mental Conditions**

List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.  
To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines

# Physical and Mental Condition Information – Plan A

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




## Physical and Mental Condition Information

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

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

1.
2.
3.

# Physical and Mental Condition Information – Plan B

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

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

**\*Enter a physical and/or mental condition (including emotional or learning problems) that limits the child's ability to do the same things as other children of the same age.**

# Medicines Summary

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### 454 Medicines Summary

Is the child now taking, or has the child taken in the last 12 months, any prescription or non-prescription medicines?

Yes  No  Not Yet Answered

List all prescription and non-prescription medicines that the child takes for his or her condition.

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

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

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# Medicine Information

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

**\*Name of Medicine:**

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

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

**Physical and Mental Conditions**

List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.  
To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

# Work

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**454 Work**

Has Joshua Ovard worked since 10/16/2008?

Yes    No

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# Remarks

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**454 Remarks**

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

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

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

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

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

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

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

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

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

**Paperwork Reduction Act Statement** - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-0001.***