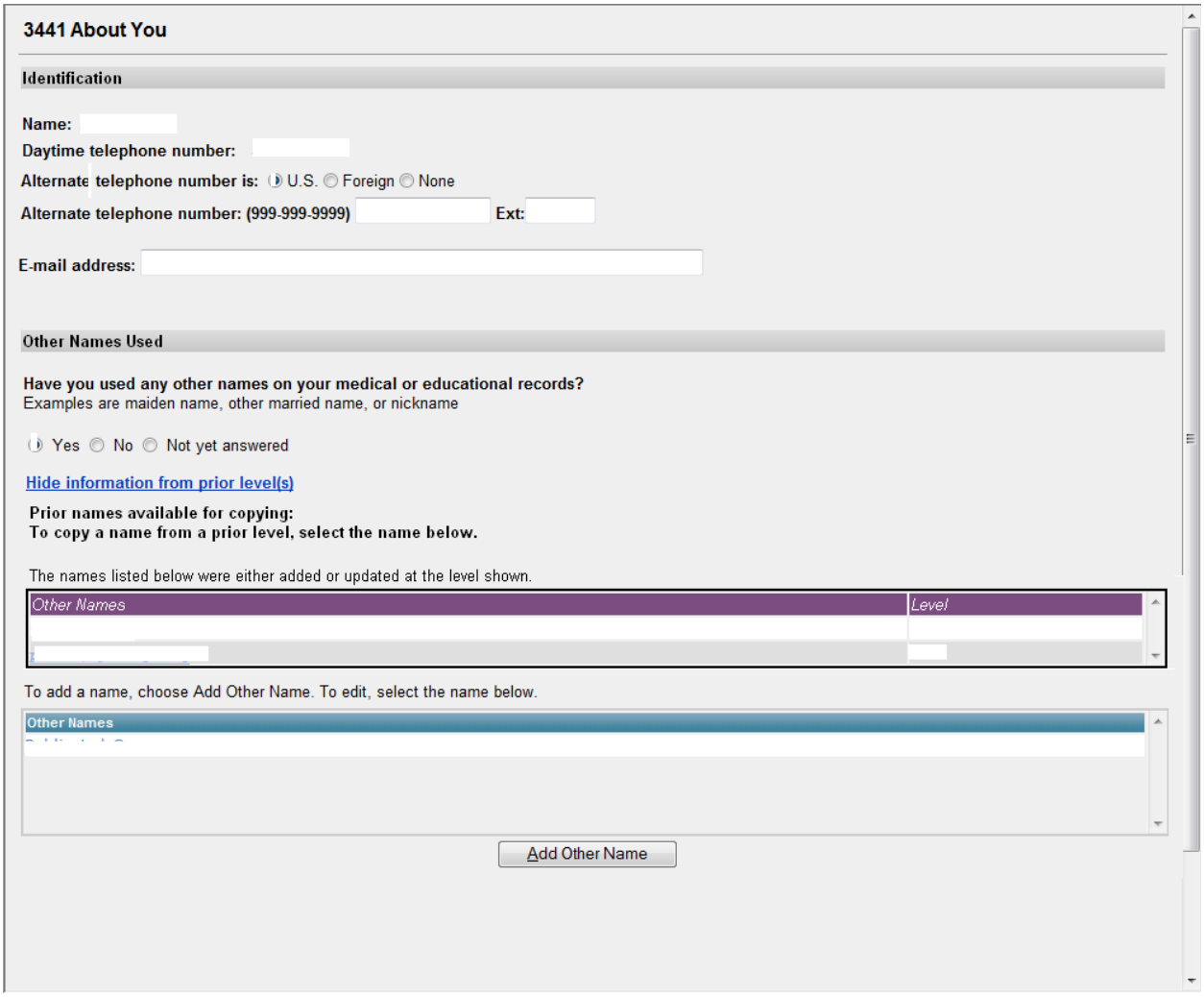
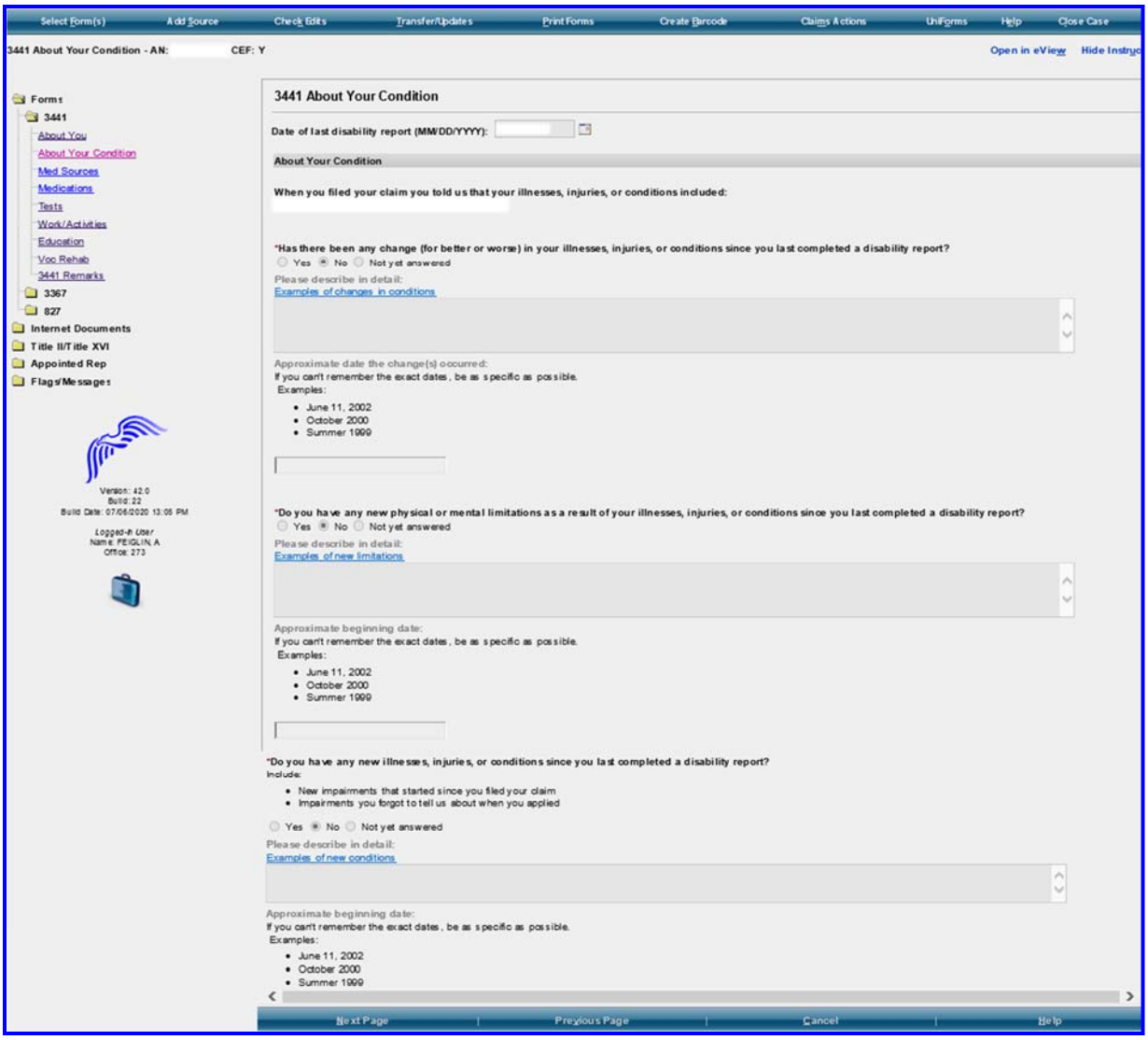
EDCS


3441 About You
Identification
Name:
Daytime telephone number:
Alternate telephone number is: U.S. Foreign None
Alternate telephone number: (999-999-9999) 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
Hide information from prior level(s)
Prior names available for copying:
To copy a name from a prior level, select the name below.
The names listed below were either added or updated at the level shown.
Other Names
Level
To add a name, choose Add Other Name. To edit, select the name below.
Other Names
Add Other Name


Select Form(s)
Add Source
Check Edits
Transfer/Updates
Print Forms
Create Barcode
Claims Actions
UniForms
Help
Close Case
3441 About Your Condition - AN:
CEF: Y
Open in eView
Hide Instruc
Forms
3441
About You
About Your Condition
Med Sources
Medications
Tests
Work/Activities
Education
Voc Rehab
3441 Remarks
3367
827
Internet Documents
Title II/Title XVI
Appointed Rep
Flags/Messages
Version: 42.0
Build: 22
Build Date: 07/06/2020 13:05 PM
Logged-In User
Name: FEIGLIN, A
Office: 273
3441 About Your Condition
Date of last disability report (MM/DD/YYYY):
About Your Condition
When you filed your claim you told us that your illnesses, injuries, or conditions included:
*Has there been any change (for better or worse) in your illnesses, injuries, or conditions since you last completed a disability report?
Yes
No
Not yet answered
Please describe in detail:
Examples of changes in conditions
Approximate date the change(s) occurred:
If you can't remember the exact dates, be as specific as possible.
Examples:
June 11, 2002
October 2000
Summer 1999
*Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions since you last completed a disability report?
Yes
No
Not yet answered
Please describe in detail:
Examples of new limitations
Approximate beginning date:
If you can't remember the exact dates, be as specific as possible.
Examples:
June 11, 2002
October 2000
Summer 1999
*Do you have any new illnesses, injuries, or conditions since you last completed a disability report?
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
Next Page
Previous Page
Cancel
Help

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 daily activities due to 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 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

Copy from Prior Level

Name of Alternate Contact

*First name: | Middle name: | *Last name: | Suffix:

Relationship to disabled person:

Address for Alternate Contact

Address is: ( ) U.S. ( ) Foreign Copy Address

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City: State: ZIP Code:

Telephone for Alternate Contact

Telephone number is: ( ) U.S. ( ) Foreign ( ) None

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

Preferred Language for Alternate Contact

Can this person speak and understand English?

( ) Yes ( ) No ( ) Not yet answered

If "NO", what language is preferred?

Person Completing the Report

*Who is providing information?

( )

( ) Alternate Contact listed above

( ) Someone else

Copy from Prior Level

Name of Person Completing This Report

First name: | Middle name: | Last name: | Suffix:

Agency name:

Relationship to disabled person:

Address for Person Completing This Report

Address is: ( ) U.S. ( ) Foreign Copy Address

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:

Doctor/Therapist Information

Name: Replace Source

Attention:

Address:

Patient ID# (if known):

Dates

If you can't remember the exact dates, be as specific as possible.
Examples:

- June 11, 2002
- October 2000
- Summer 1999

First visit:

Previous last visit:

Last visit:

Next appointment:

Conditions and Treatments

What medical conditions were treated or evaluated?
Examples:

- To get my blood monitored
- I had a seizure
- I developed an infection

What treatment did you receive for the above conditions?
Examples:

- Physical therapy
- Counseling
- Heat treatments
- Medicines

Tests

List any tests this provider performed, sent you to, or scheduled you to take in the future.

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

Test	Date	Ordered By

Add Test

Medicines

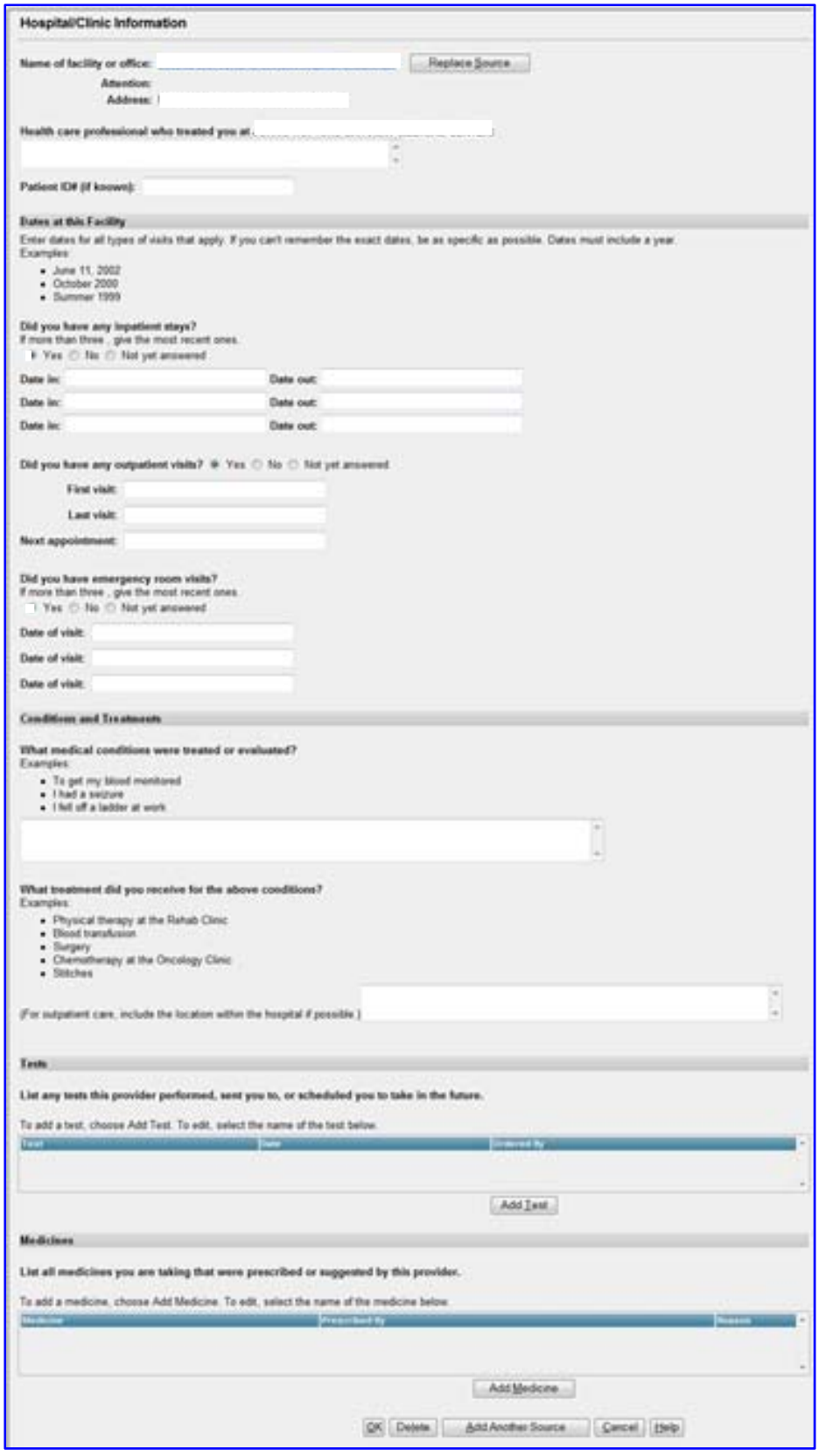
List all medicines you are taking that were prescribed or suggested by this provider.

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

Medicine	Prescribed By	Reason

Add Medicine

OK Delete Add Another Source Cancel Help



Hospital/Clinic Information

Name of facility or office: Replace Source

Attention:

Address:

Health care professional who treated you at:

Patient ID# (if known):

Dates at this Facility

Enter dates for all types of visits that apply. If you can't remember the exact dates, be as specific as possible. Dates must include a year.
Examples:

- June 11, 2002
- October 2000
- Summer 1999

Did you have any inpatient stays?
If more than three , give the most recent ones.
Yes No Not yet answered

Date in: Date out:

Date in: Date out:

Date in: Date out:

Did you have any outpatient visits? Yes No Not yet answered

First visit:

Last visit:

Next appointment:

Did you have emergency room visits?
If more than three , give the most recent ones.
Yes No Not yet answered

Date of visit:

Date of visit:

Date of visit:

Conditions and Treatments

What medical conditions were treated or evaluated?
Examples:

- To get my blood monitored
- I had a seizure
- I fell off a ladder at work

What treatment did you receive for the above conditions?
Examples:

- Physical therapy at the Rehab Clinic
- Blood transfusion
- Surgery
- Chemotherapy at the Oncology Clinic
- Stitches

(For outpatient care, include the location within the hospital if possible.)

Tests

List any tests this provider performed, sent you to, or scheduled you to take in the future.

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

Test | Date | Ordered By

Add Test

Medicines

List all medicines you are taking that were 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

OK Delete Add Another Source Cancel Help

3441 Medical Conditions

Date of last disability report (MM/DD/YYYY):

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

Please describe in detail:

Examples of change in conditions

Approximate date the change(s) occurred:

If you can't remember the exact dates, be as specific as possible.

Examples:

- June 11, 2002
- October 2000
- Summer 1999

***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:

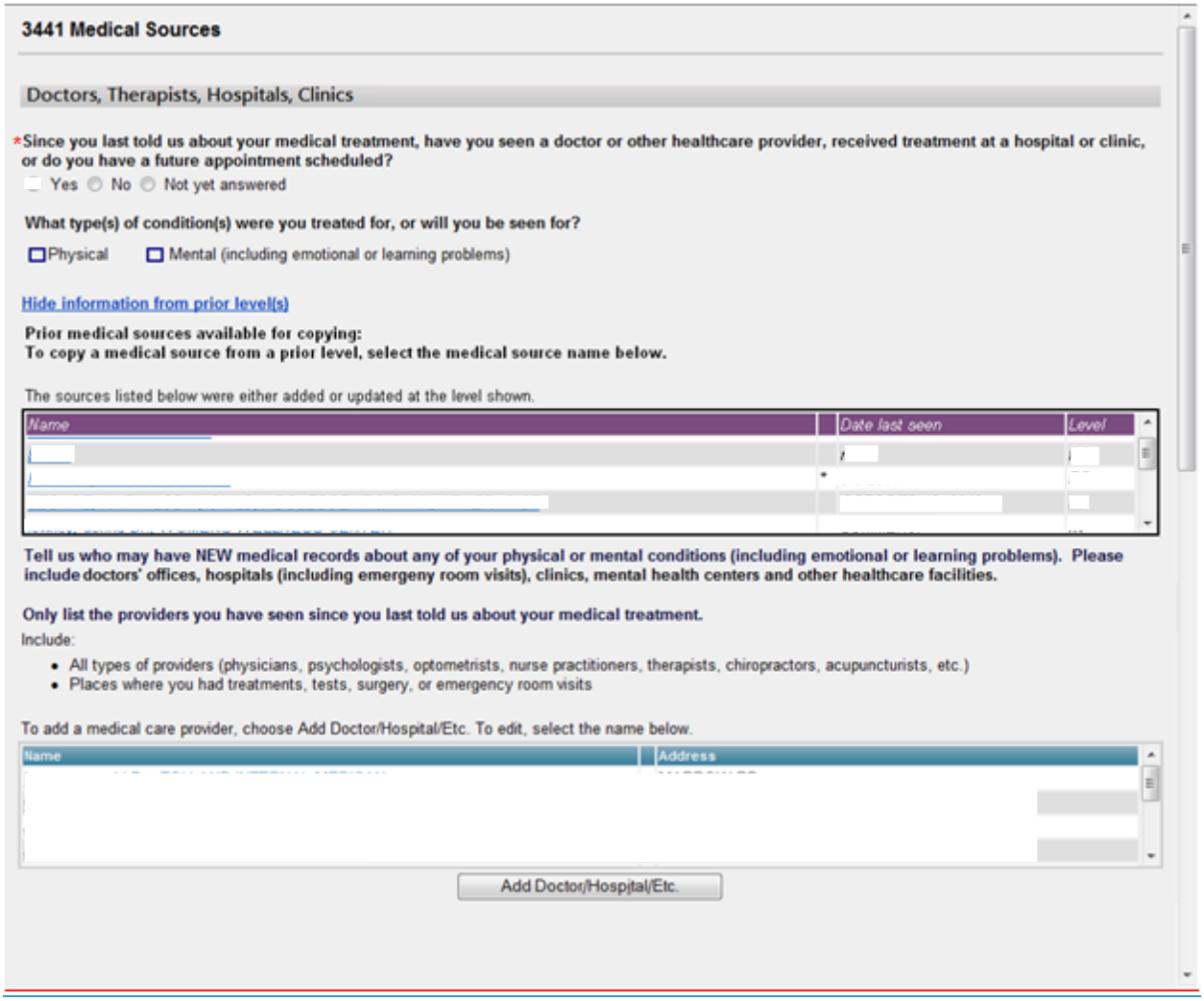
Examples of new conditions

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 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)

Hide information from prior level(s)

Prior medical sources available for copying:
To copy a medical source from a prior level, select the medical source name below.

The sources listed below were either added or updated at the level shown.

Name	Date last seen	Level

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 emergeny 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.

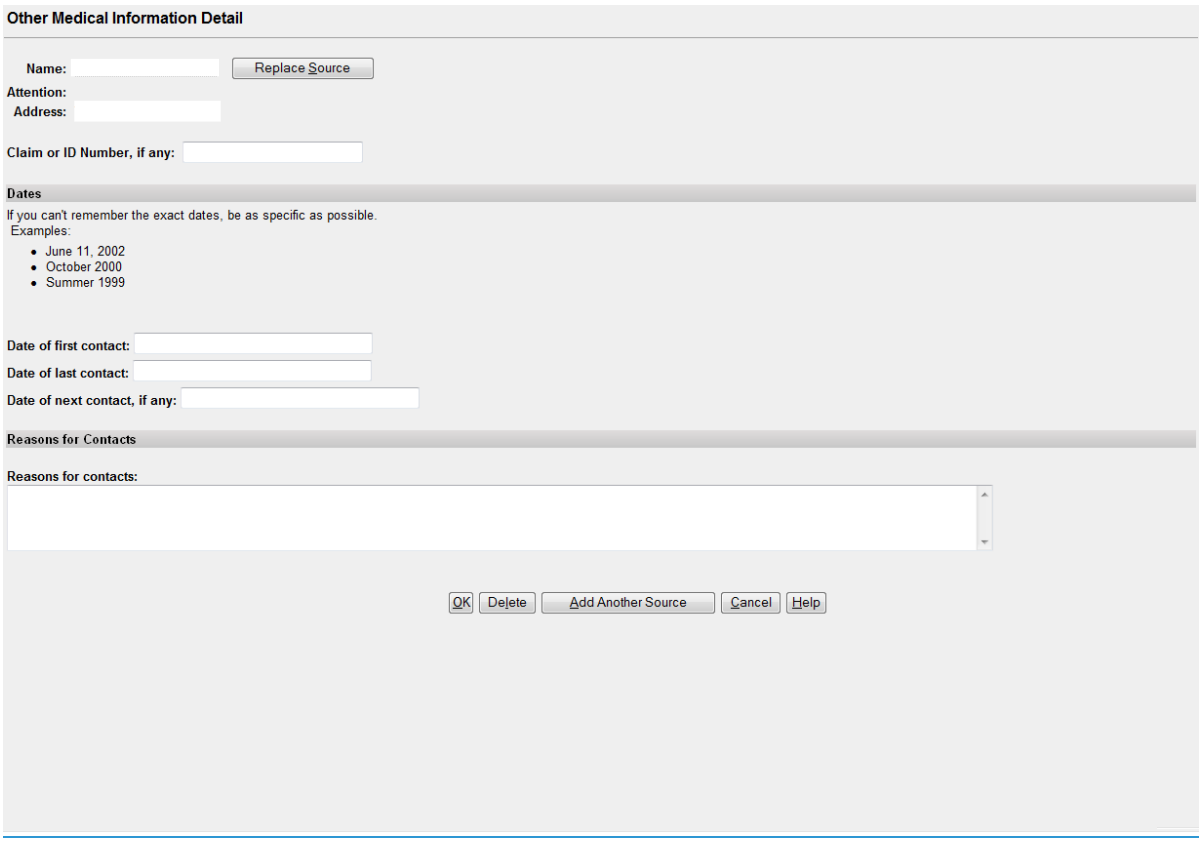
Include:

- 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

Add Doctor/Hospital/Etc.


Other Medical Information Detail
Name:
Replace Source
Attention:
Address:
Claim or ID Number, if any:
Dates
If you can't remember the exact dates, be as specific as possible.
Examples:
June 11, 2002
October 2000
Summer 1999
Date of first contact:
Date of last contact:
Date of next contact, if any:
Reasons for Contacts
Reasons for contacts:
OK
Delete
Add Another Source
Cancel
Help

3441 Other Medical Information

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

Add Source

Other Names Used

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

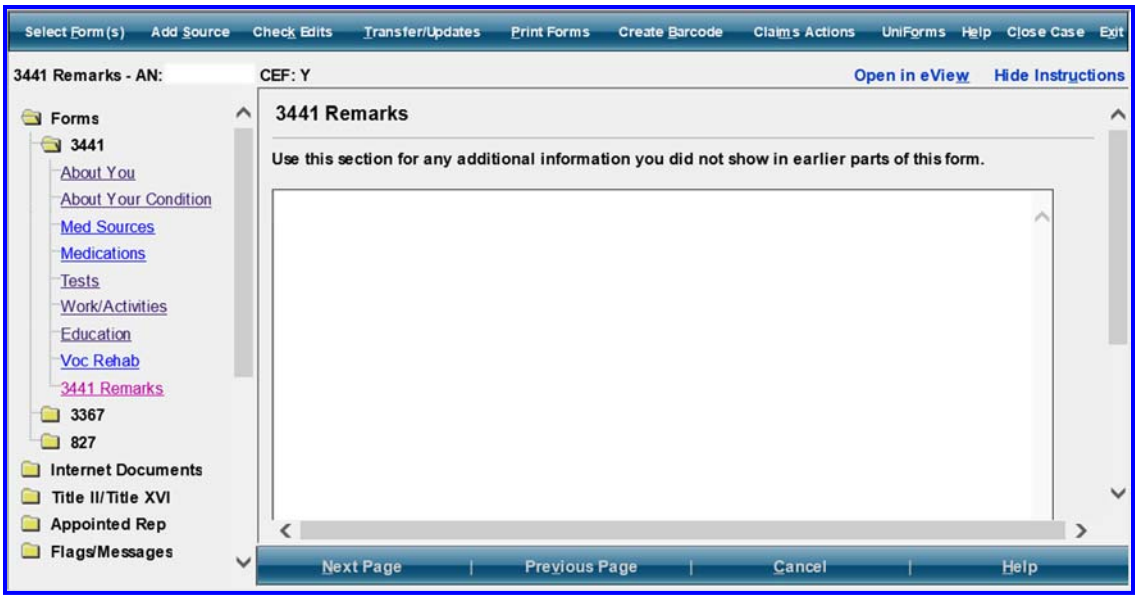
*First name:

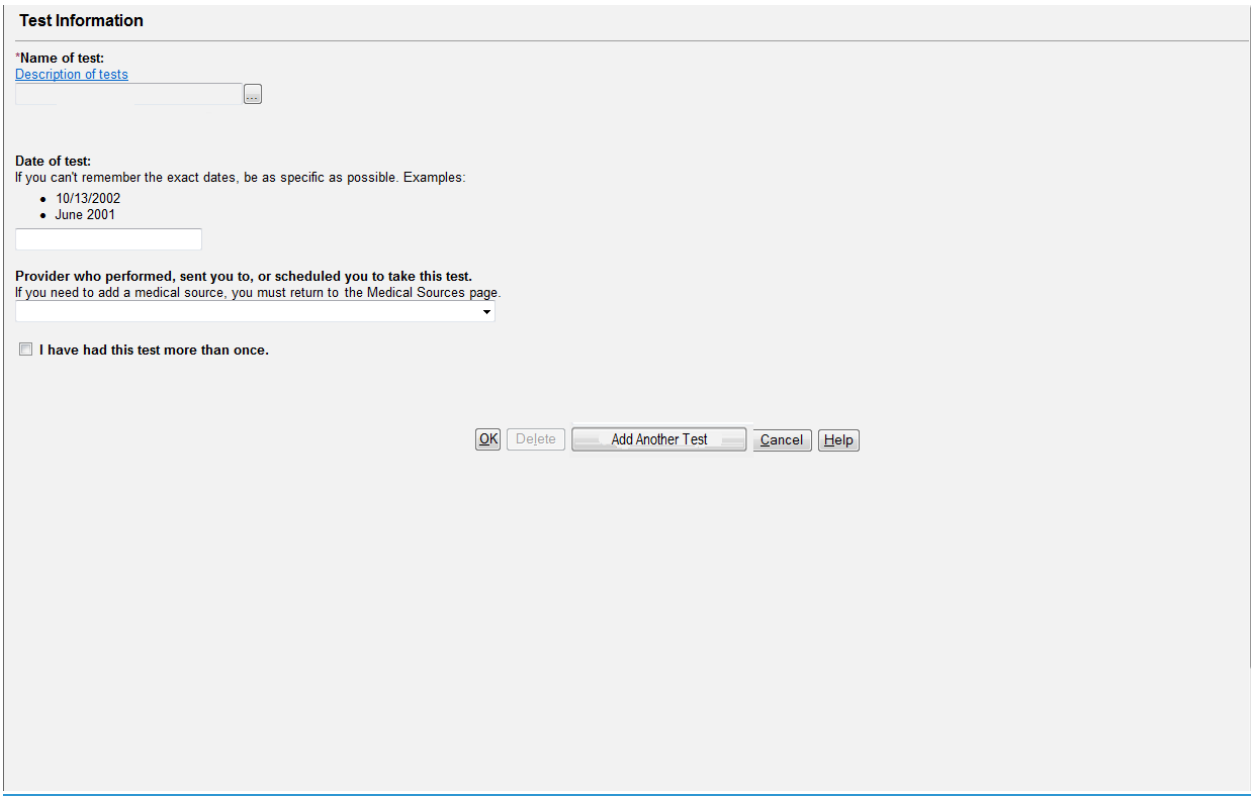
Middle name:

*Last name:

Suffix:

OK Delete Add Another Name Cancel Help


Select Form(s)
Add Source
Check Edits
Transfer/Updates
Print Forms
Create Barcode
Claims Actions
UniForms
Help
Close Case
Exit
3441 Remarks - AN:
CEF: Y
Open in eView
Hide Instructions
Forms
3441
About You
About Your Condition
Med Sources
Medications
Tests
Work/Activities
Education
Voc Rehab
3441 Remarks
3367
827
Internet Documents
Title II/Title XVI
Appointed Rep
Flags/Messages
3441 Remarks
Use this section for any additional information you did not show in earlier parts of this form.
Next Page
Previous Page
Cancel
Help


Test Information
*Name of test:
Description of tests
Date of test:
If you can't remember the exact dates, be as specific as possible. Examples:
10/13/2002
June 2001
Provider who performed, sent you to, or scheduled you to take this test.
If you need to add a medical source, you must return to the Medical Sources page.
I have had this test more than once.
OK
Delete
Add Another Test
Cancel
Help

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

Add Test

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

Add a Plan or Program

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 GED classes, specialized job training, trade school, vocational school, or college classes?

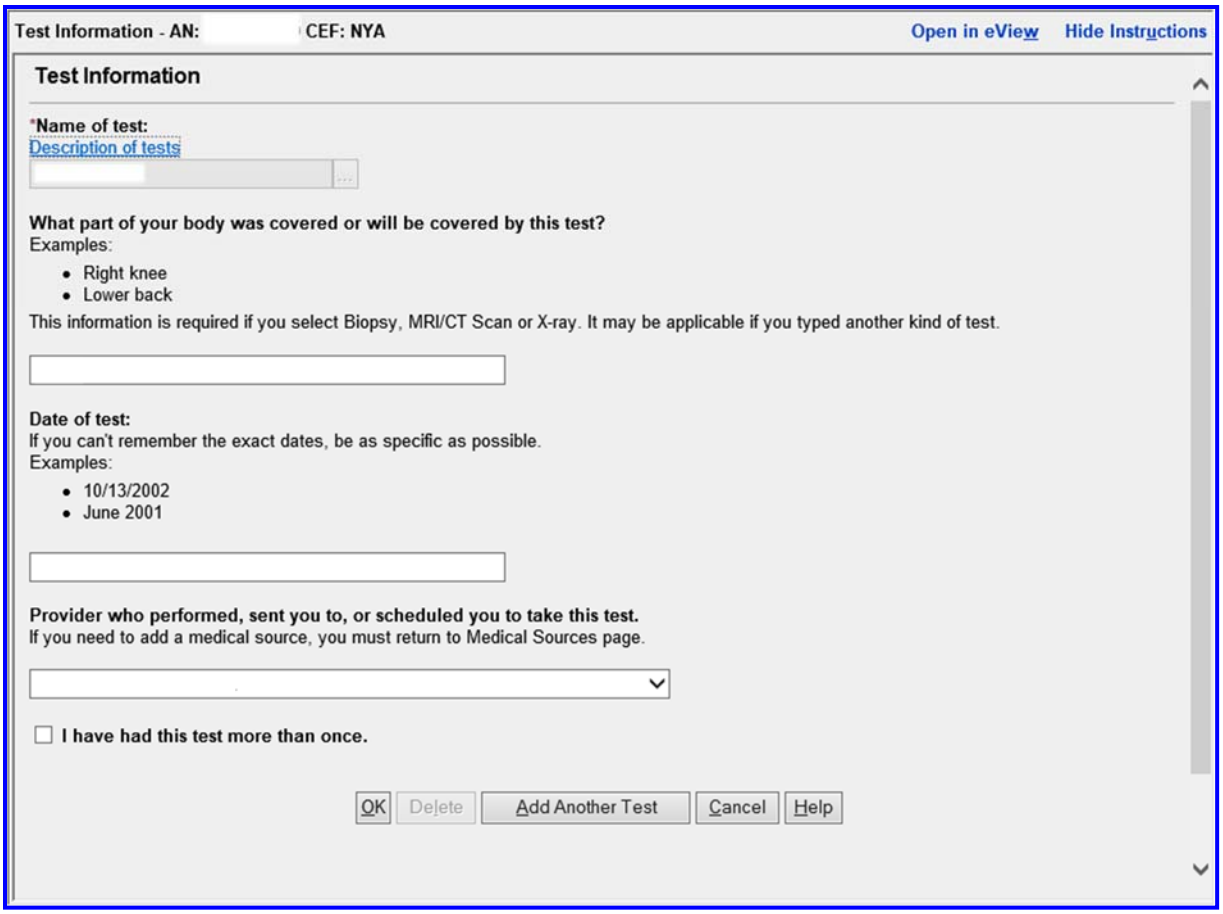
○ Yes ○ No ○ Not yet answered

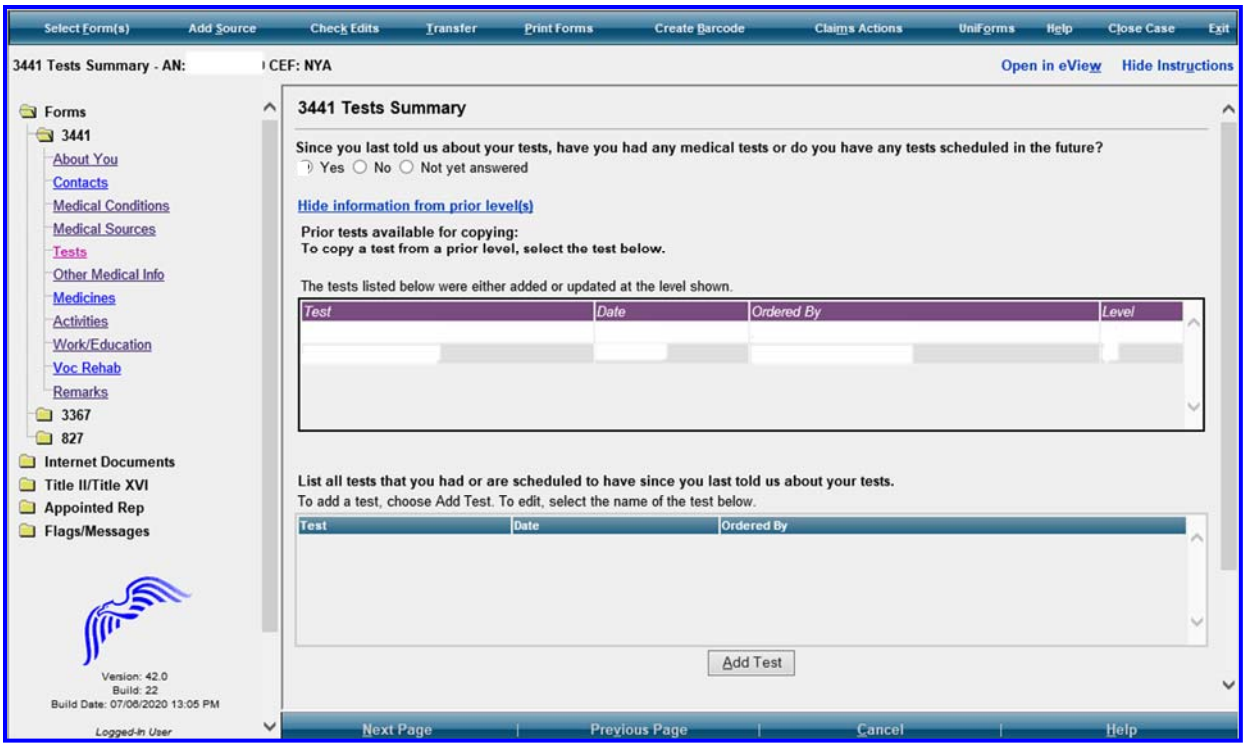
Describe what type:

Date(s) attended:

Degree(s) attained, if any:

Date of attainment (MM/YYYY):


Test Information - AN:
CEF: NYA
Open in eView
Hide Instructions
Test Information
*Name of test:
Description of tests
What part of your body was covered or will be covered by this test?
Examples:
Right knee
Lower back
This information is required if you select Biopsy, MRI/CT Scan or X-ray. It may be applicable if you typed another kind of test.
Date of test:
If you can't remember the exact dates, be as specific as possible.
Examples:
10/13/2002
June 2001
Provider who performed, sent you to, or scheduled you to take this test.
If you need to add a medical source, you must return to Medical Sources page.
I have had this test more than once.
OK
Delete
Add Another Test
Cancel
Help


Select Form(s)
Add Source
Check Edits
Transfer
Print Forms
Create Barcode
Claims Actions
UniForms
Help
Close Case
Exit
3441 Tests Summary - AN:
CEF: NYA
Open in eView
Hide Instructions
Forms
3441
About You
Contacts
Medical Conditions
Medical Sources
Tests
Other Medical Info
Medicines
Activities
Work/Education
Voc Rehab
Remarks
3367
827
Internet Documents
Title II/Title XVI
Appointed Rep
Flags/Messages
Version: 42.0
Build: 22
Build Date: 07/06/2020 13:05 PM
Logged-In User
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
Hide information from prior level(s)
Prior tests available for copying:
To copy a test from a prior level, select the test below.
The tests listed below were either added or updated at the level shown.
Test
Date
Ordered By
Level
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
Add Test
Next Page
Previous Page
Cancel
Help