EDCS SSA-454 Form updates to EDCS screens

SSA-454 Adult form

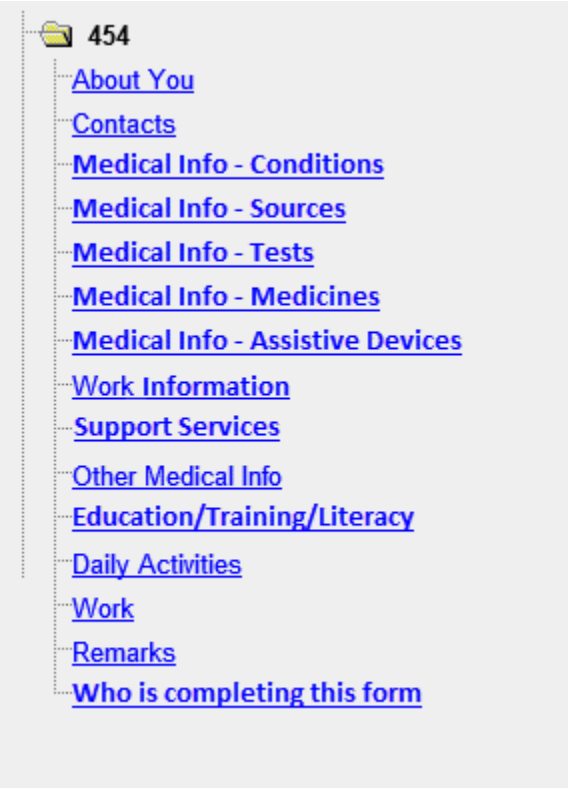
Contents

Background

The Electronic Disability Case Processing System (EDCS) is a mature software application that has been in production for over 20 years. Due to the age of the application, any updates triggered by the new, streamlined SSA-454 form will follow the existing design approach in EDCS. This will help ensure easy adoption of new content while limiting the need for separate training on the newly implemented features.

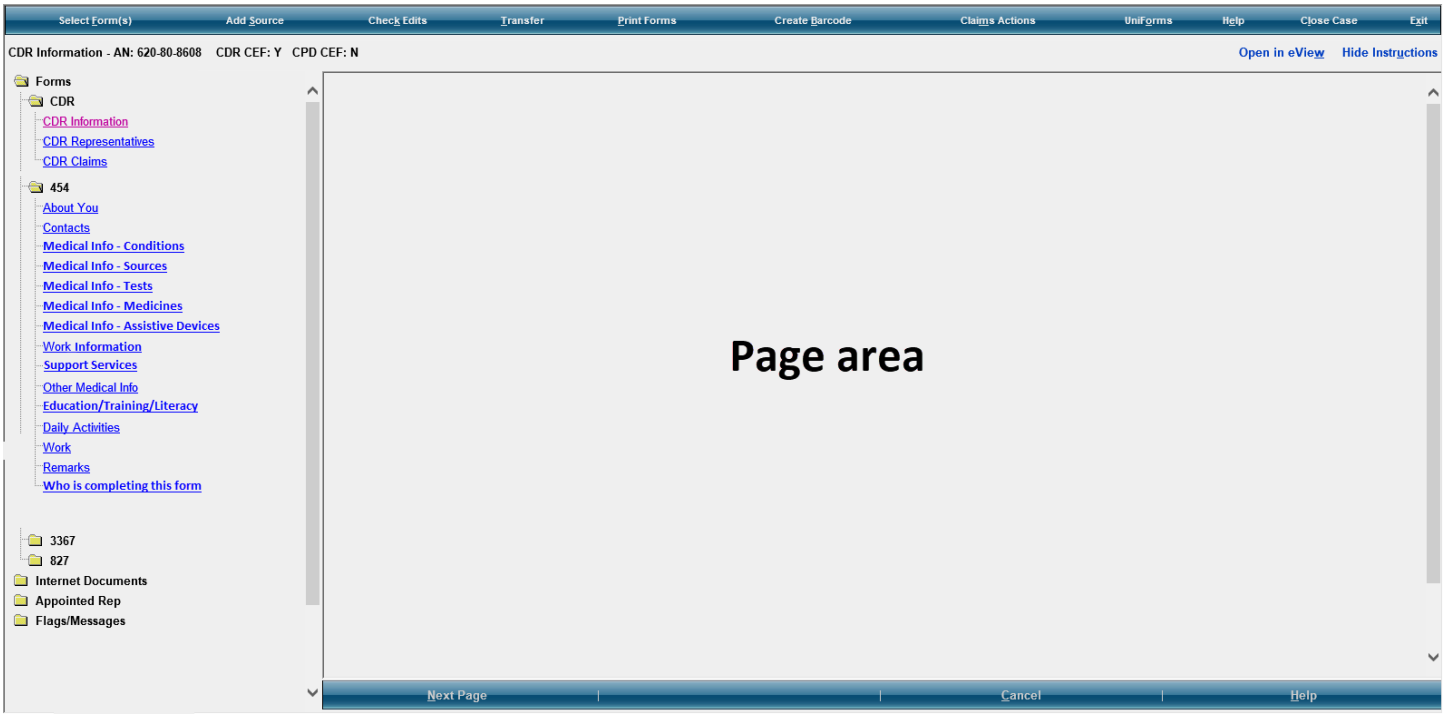
SSA - 454 Layout and Navigation

454 Left Navigation- used for all EDCS 454 pages



EDCS Frame

This screenshot shows the layout of all EDCS pages.

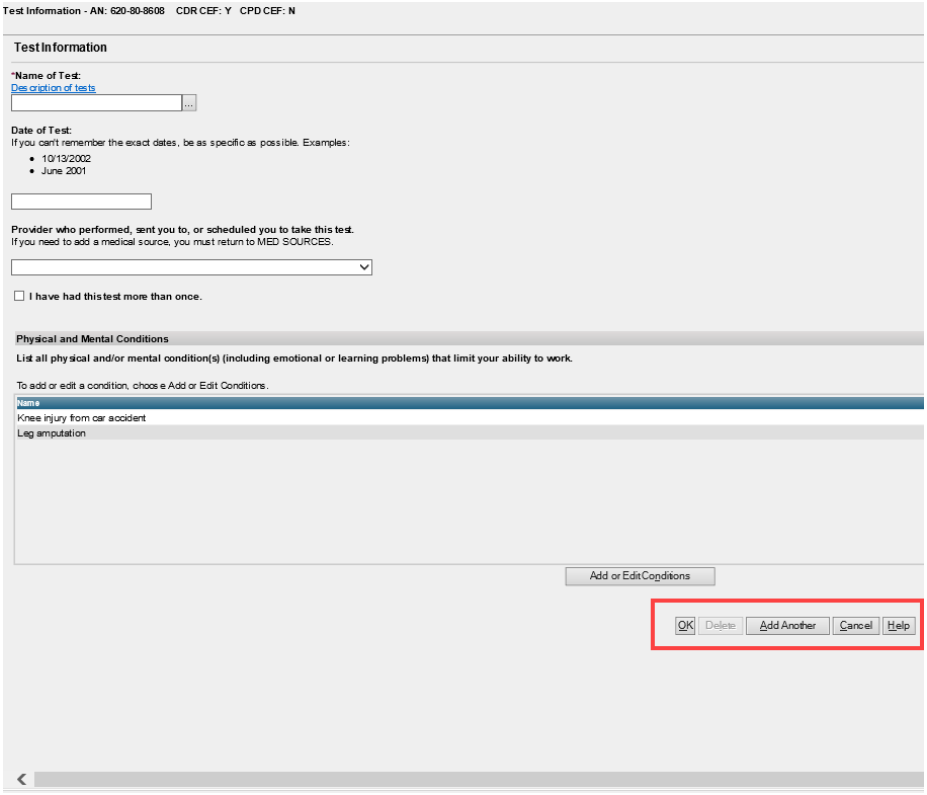


Things to note:

- The left-hand navigation tree displays links to each of the SSA-454 page screens.
- Individual page screens display in the Page Area
- Next/Previous buttons display at the bottom of the frame.
- To save space, the left nav and EDCS Frame content are not included in the SSA-454 screenshots depicting the updates

EDCS Modal windows

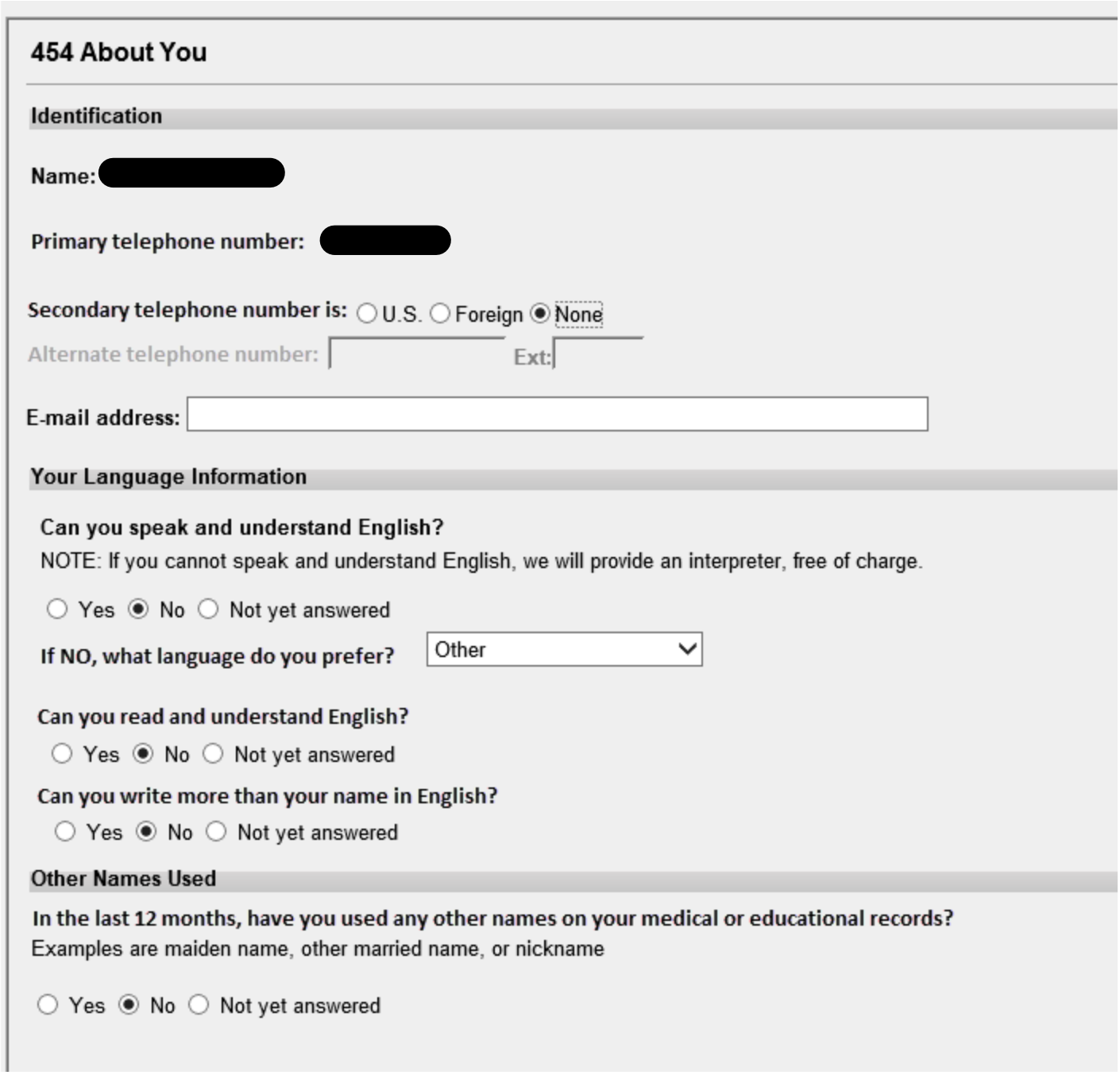
Sample



- *Some pages display as full-screen modal windows.*
- *These pages have navigation buttons at the bottom center of the page.*
- *To save space, these buttons are not included in the screenshots.*

SSA - 454 Adult EDCS Screenshots

SSA - 454 Section 1 – Information About You:



454 About You

Identification

Name: [redacted]

Primary telephone number: [redacted]

Secondary telephone number is: ○ U.S. ○ Foreign ◉ None

Alternate telephone number: Ext:

E-mail address:

Your Language Information

Can you speak and understand English?

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

○ Yes ◉ No ○ Not yet answered

If NO, what language do you prefer? Other

Can you read and understand English?

○ Yes ◉ No ○ Not yet answered

Can you write more than your name in English?

○ Yes ◉ No ○ Not yet answered

Other Names Used

In the last 12 months, 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

SSA - 454 Section 2 – Contacts

454 Contacts

Alternate Contact Information

Is there someone (other than your doctors) we can contact who can help you with your case?

(•) Yes ( ) No ( ) Not yet answered

Please provide the name of someone we can contact who knows about your medical conditions(s) and can help with your case and can help us reach you if you become unavailable. Examples include a family member, friend, or neighbor.

Name of Alternate Contact

*First name:	Middle name:	*Last name:	Suffix:
[redacted]		[redacted]	

Relationship to Disabled Person: daughter

Address for Alternate Contact

Address is: (•) U.S. ( ) Foreign [Copy Address]

Street address line 1: GENERAL DELIVERY

Street address line 2:

Street address line 3:

Street address line 4:

City: LAS VEGAS **State:** NV **ZIP Code:** 89165

Telephone for Alternate Contact

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

Daytime telephone number: **Ext:**

Preferred Language of Alternate Contact

Can this person speak and understand English?

( ) Yes (•) No ( ) Not yet answered

If "NO", what language is preferred?

SSA - 454 Section 3 – Medical Info – Conditions

454 Medical Information - Medical Conditions

Height and Weight

What is your height without shoes? feet: 5 **inches:** 6

What is your weight without shoes? pounds: 140

Physical and Mental Conditions

Separately list each physical and/or mental health condition that limits your ability to work.

Include:

- All physical, mental, or emotional conditions
- Any major complications resulting from your condition
- All conditions, whether or not you have been receiving treatment
- If cancer, include stage and type

Examples of conditions:
1. Back injury, 2. Arthritis, 3. Diabetes, 4. Glaucoma, 5. Depression, 6. Blindness

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

*1. Knee injury from car accident ×

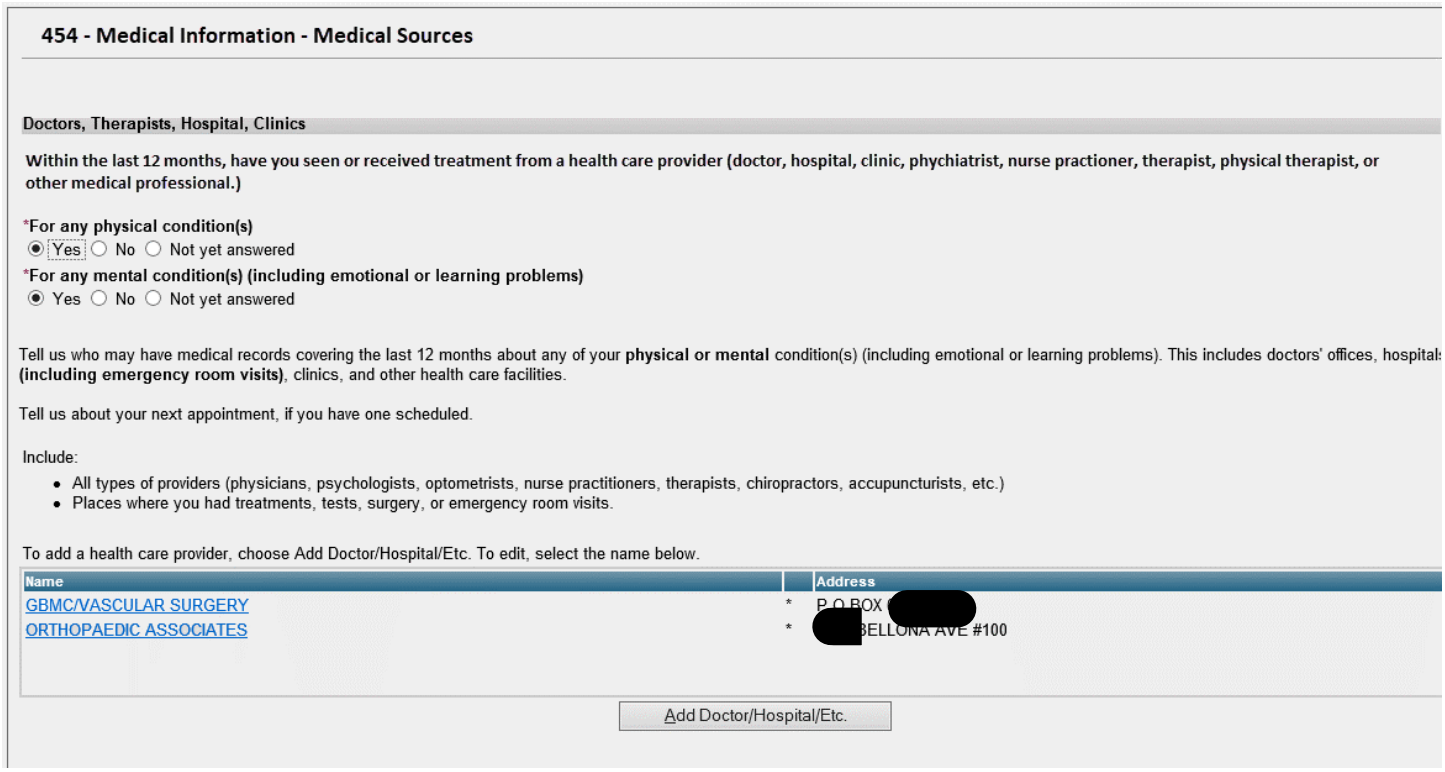
2. Leg amputation

3.

Check Spelling

SSA - 454 Section 3 – Medical Info – Sources

Medical Sources Summary



454 - Medical Information - Medical Sources

Doctors, Therapists, Hospital, Clinics

Within the last 12 months, have you seen or received treatment from a health care provider (doctor, hospital, clinic, phychiatrist, nurse practioner, therapist, physical therapist, or other medical professional.)

***For any physical condition(s)**
(•) Yes ( ) No ( ) Not yet answered

***For any mental condition(s) (including emotional or learning problems)**
(•) Yes ( ) No ( ) Not yet answered

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

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

Include:

- All types of providers (physicians, psychologists, optometrists, nurse practitioners, therapists, chiropractors, accupuncturists, etc.)
- Places where you had treatments, tests, surgery, or emergency room visits.

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

Name		Address
GBMC/VASCULAR SURGERY	*	P O BOX [redacted]
ORTHOPAEDIC ASSOCIATES	*	[redacted]BELLONA AVE #100

Add Doctor/Hospital/Etc.

Medical Sources – Doctor/Therapist Information DETAIL (no edits)

Doctor/Therapist Information

Comparison Point Decision Date: 04/29/2005

3.D. 1-4

Name: ORTHOPAEDIC ASSOCIATES Replace Source

Attention:

Address: 8522 BELLONA AVE #100

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: 12/6/2021

Last visit: 2/15/2022

Next appointment: 3/28/2022

Conditions and Treatments

What medical conditions were treated or evaluated?
Examples:

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

Post-ER treatment and casting prior to surgery; surgery and recasting; Xray monitoring of healing process via 2-week Xrays. Turns out the legs wer amputated, as the surgery didn't work.

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

- Physical therapy
- Counseling
- Heat treatments
- Medicines

Post amputation care and counseling.

Tests

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

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

Test	Date	Ordered By
Blood test (Not HIV)	12/2021	ORTHOPAEDIC ASSOCIATES
Fake Test	Fake Date	ORTHOPAEDIC ASSOCIATES
MRI/CT Scan (Legs - looking for clots)	12/2021	ORTHOPAEDIC ASSOCIATES

Add Test

Medicines

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

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

Medicine	Prescribed By	Reason
Flexeril	ORTHOPAEDIC ASSOCIATES	Muscle tension in back and arms from wheelchair use
Oxycodone	ORTHOPAEDIC ASSOCIATES	*No Reason*

Add Medicine

Physical and Mental Conditions

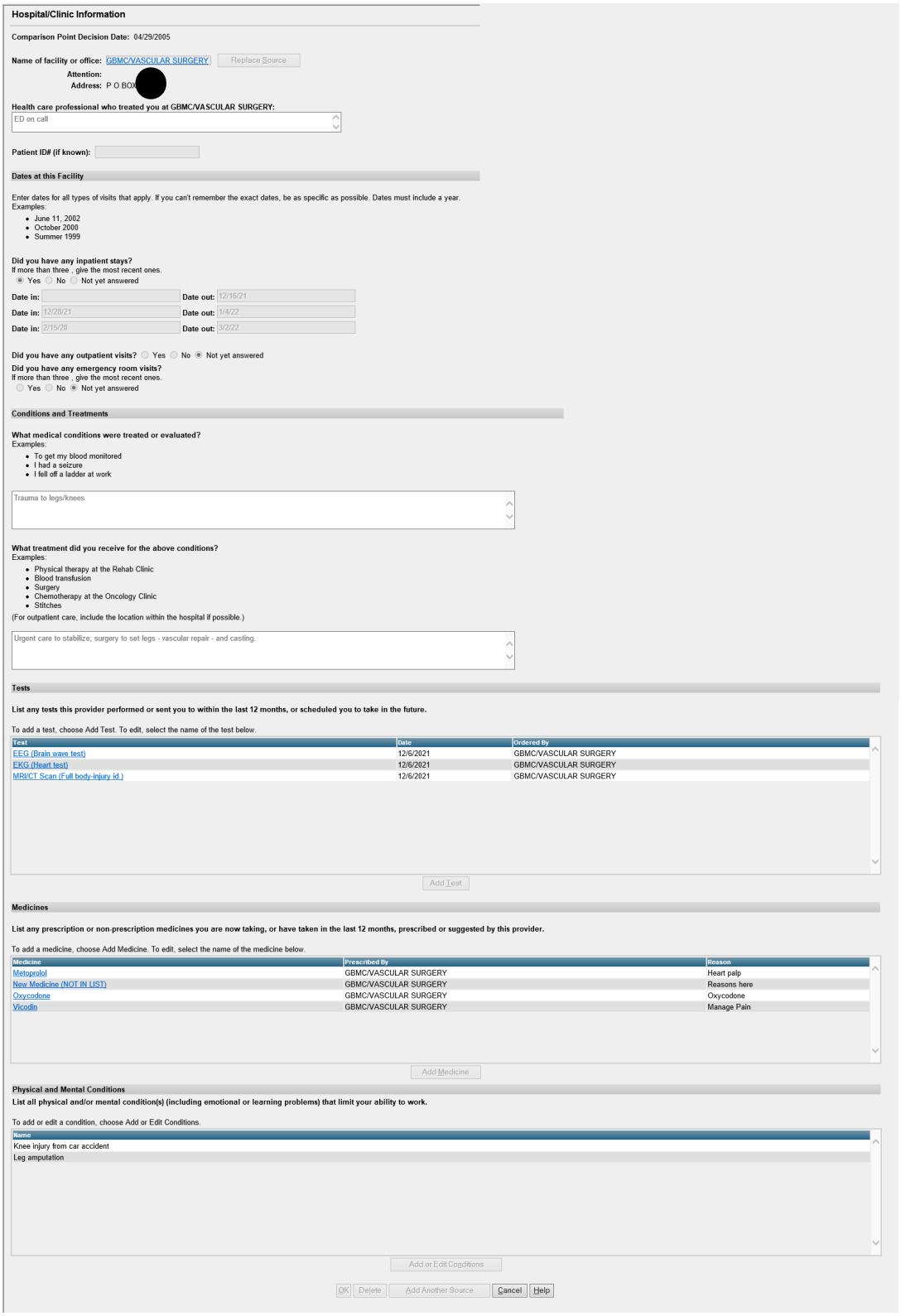
List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

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

Name
Knee injury from car accident
Leg amputation

Add or Edit Conditions

Medical sources – Hospital/Clinic Information



Hospital/Clinic Information

Comparison Point Decision Date: 04/29/2005

Name of facility or office: GBMC/VASCULAR SURGERY | Replace Source

Attention:

Address: P O BOX [redacted]

Health care professional who treated you at GBMC/VASCULAR SURGERY:

ED on call

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:**	12/16/21
Date in:	12/28/21	**Date out:**	1/4/22
Date in:	2/15/20	**Date out:**	3/2/22

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

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

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

Trauma to legs/knees

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.)

Urgent care to stabilize; surgery to set legs - vascular repair - and casting.

Tests

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

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

Test	Date	Ordered By
EEG (Brain wave test)	12/6/2021	GBMC/VASCULAR SURGERY
EKG (Heart test)	12/6/2021	GBMC/VASCULAR SURGERY
MRI/CT Scan (Full body-injury id.)	12/6/2021	GBMC/VASCULAR SURGERY

Add Test

Medicines

List any prescription or non-prescription medicines you are now taking, or have 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
Metoprolol	GBMC/VASCULAR SURGERY	Heart palp
New Medicine (NOT IN LIST)	GBMC/VASCULAR SURGERY	Reasons here
Oxycodone	GBMC/VASCULAR SURGERY	Oxycodone
Vicodin	GBMC/VASCULAR SURGERY	Manage Pain

Add Medicine

Physical and Mental Conditions

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

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

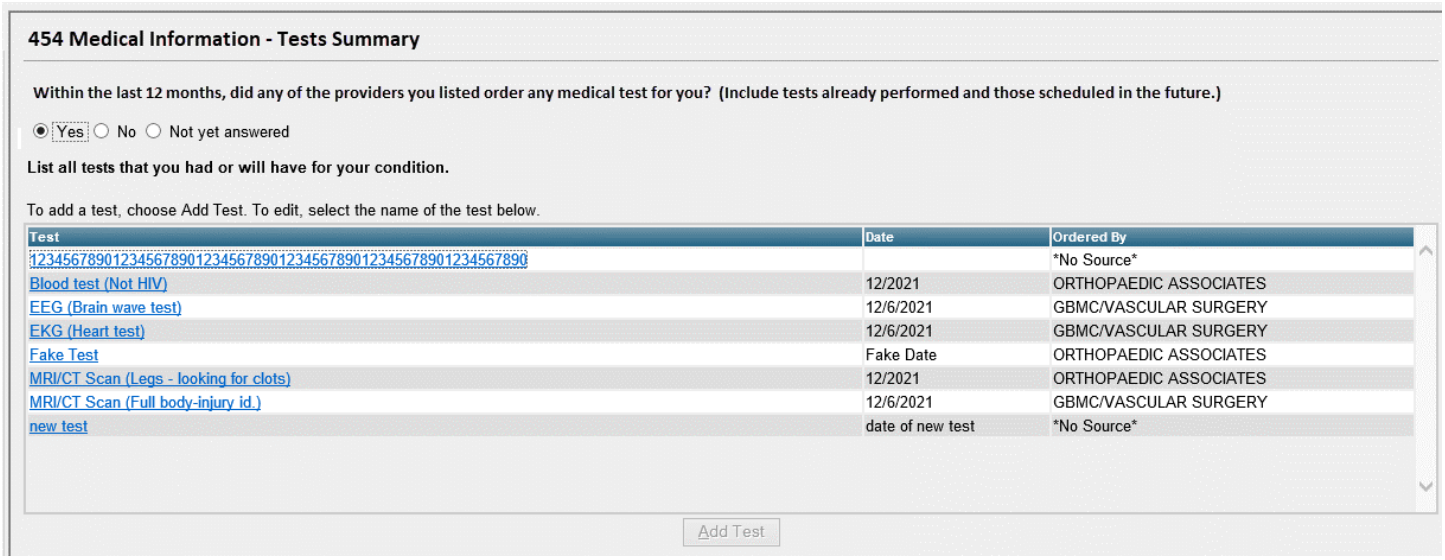
Name
Knee injury from car accident
Leg amputation

Add or Edit Conditions

OK | Delete | Add Another Source | Cancel | Help

SSA- - 454 Section 3 – Medical Info – Tests

Test Summary



454 Medical Information - Tests Summary

Within the last 12 months, did any of the providers you listed order any medical test for you? (Include tests already performed and those scheduled in the future.)

(•) Yes ( ) No ( ) Not yet answered

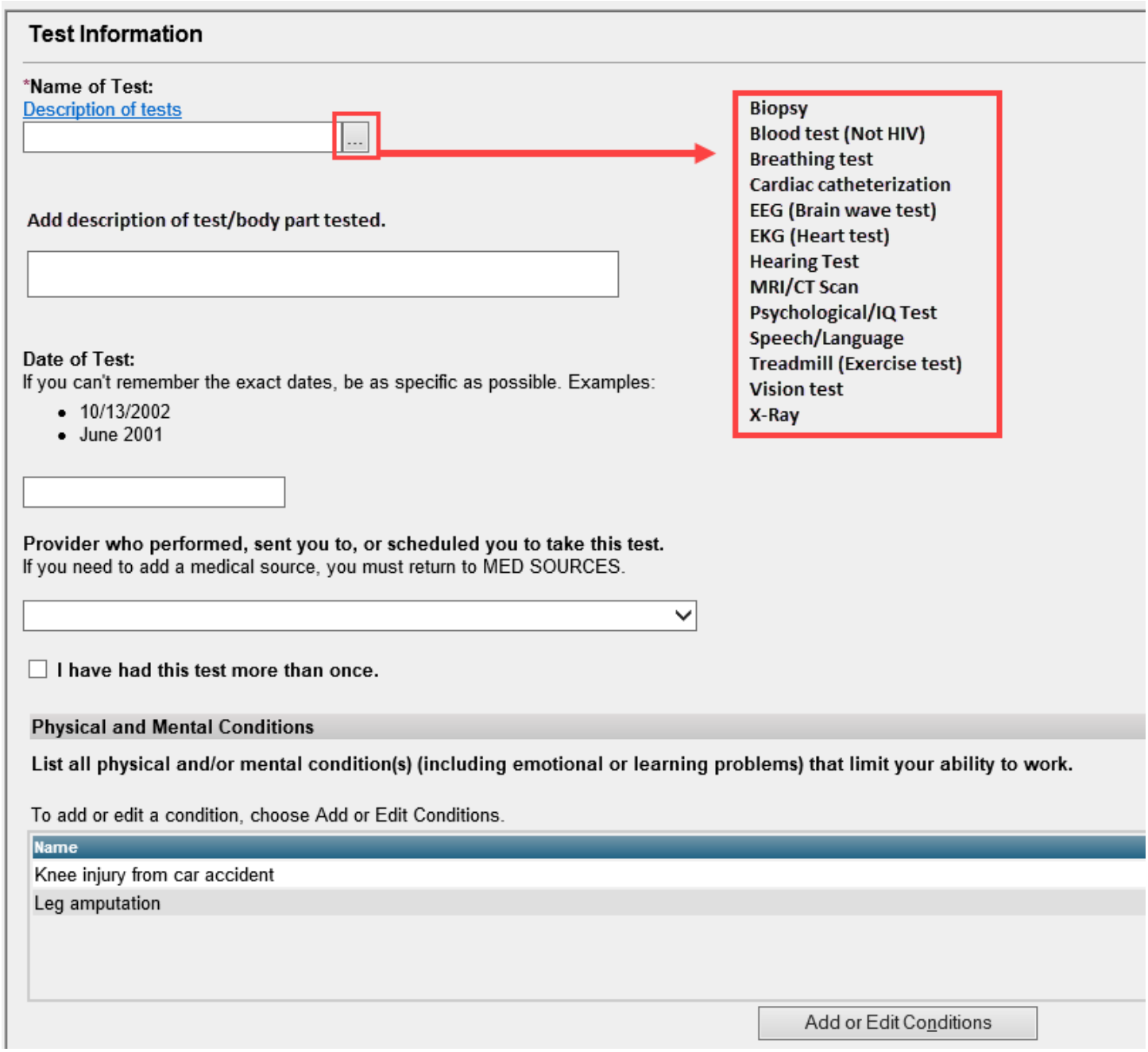
List all tests that you had or will have for your condition.

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

Test	Date	Ordered By
12345678901234567890123456789012345678901234567890123456789012345678901234567890		*No Source*
Blood test (Not HIV)	12/2021	ORTHOPAEDIC ASSOCIATES
EEG (Brain wave test)	12/6/2021	GBMC/VASCULAR SURGERY
EKG (Heart test)	12/6/2021	GBMC/VASCULAR SURGERY
Fake Test	Fake Date	ORTHOPAEDIC ASSOCIATES
MRI/CT Scan (Legs - looking for clots)	12/2021	ORTHOPAEDIC ASSOCIATES
MRI/CT Scan (Full body-injury id.)	12/6/2021	GBMC/VASCULAR SURGERY
new test	date of new test	*No Source*

Add Test

Tests detail



SSA - 454 Section 3 – Medical Info – Medicines

Medicines Summary

454 Medical Information - Medicines Summary

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

(•) Yes ( ) No ( ) Not yet answered

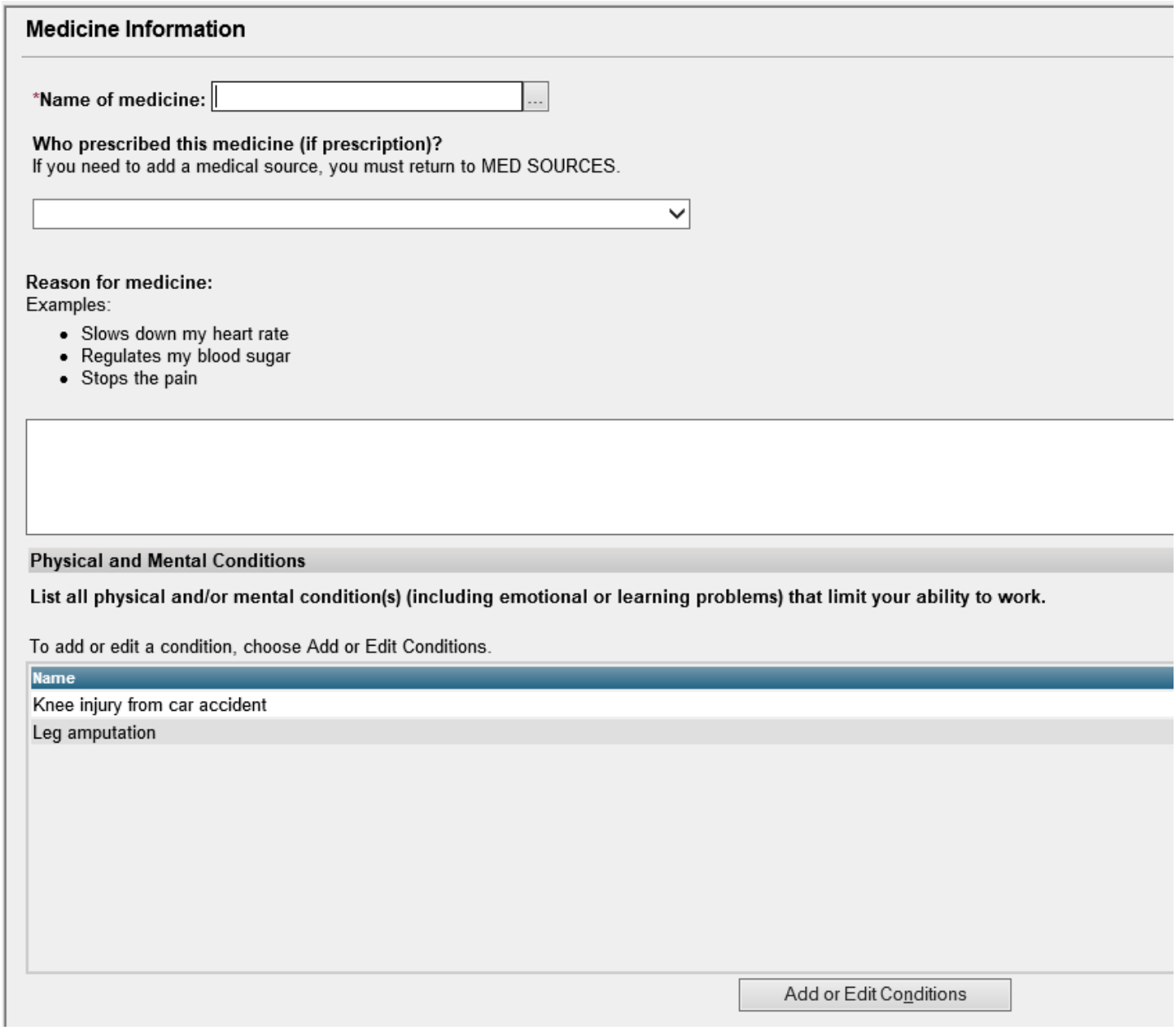
List all prescription and non-prescription medicines that you take for your condition.

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

Medicine	Prescribed By	Reason
Actos	VOCA	*No Reason*
Flexeril	ORTHOPAEDIC ASSOCIATES	Muscle tension in back and arms from wheelchair use
Metoprolol	GBMC/VASCULAR SURGERY	Heart palp
New Medicine (NOT IN LIST)	GBMC/VASCULAR SURGERY	Reasons here
Oxycodone	GBMC/VASCULAR SURGERY	Oxycodone
Oxycodone	ORTHOPAEDIC ASSOCIATES	*No Reason*
Vicodin	GBMC/VASCULAR SURGERY	Manage Pain

Add Medicine

Medicines Detail (no edits)



Medicine Information

*Name of medicine:

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

Reason for medicine:
Examples:

- Slows down my heart rate
- Regulates my blood sugar
- Stops the pain

Physical and Mental Conditions

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

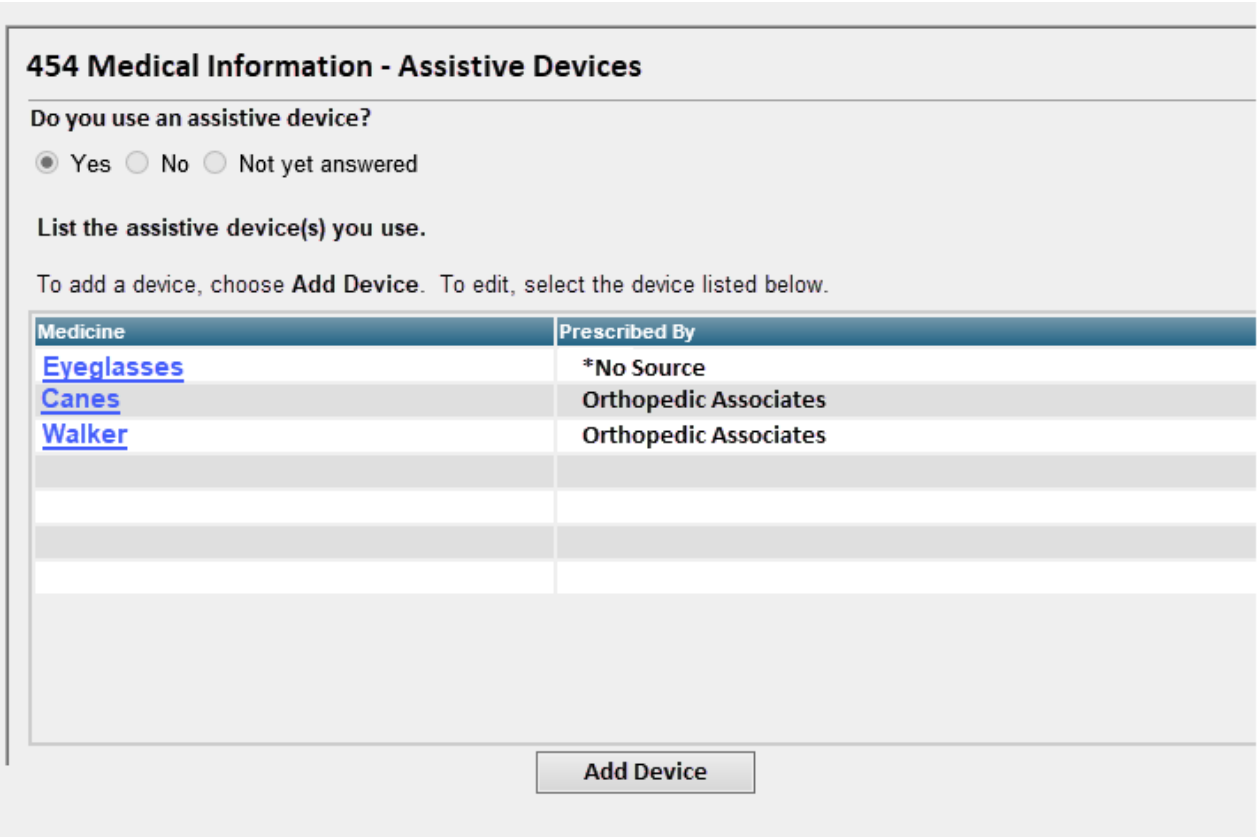
To add or edit a condition, choose Add or Edit Conditions.

Name
Knee injury from car accident
Leg amputation

Add or Edit Conditions

SSA - 454 Section 3 – Medical Info – Assistive Devices

Assistive Devices Summary (new)



454 Medical Information - Assistive Devices

Do you use an assistive device?

(•) Yes ( ) No ( ) Not yet answered

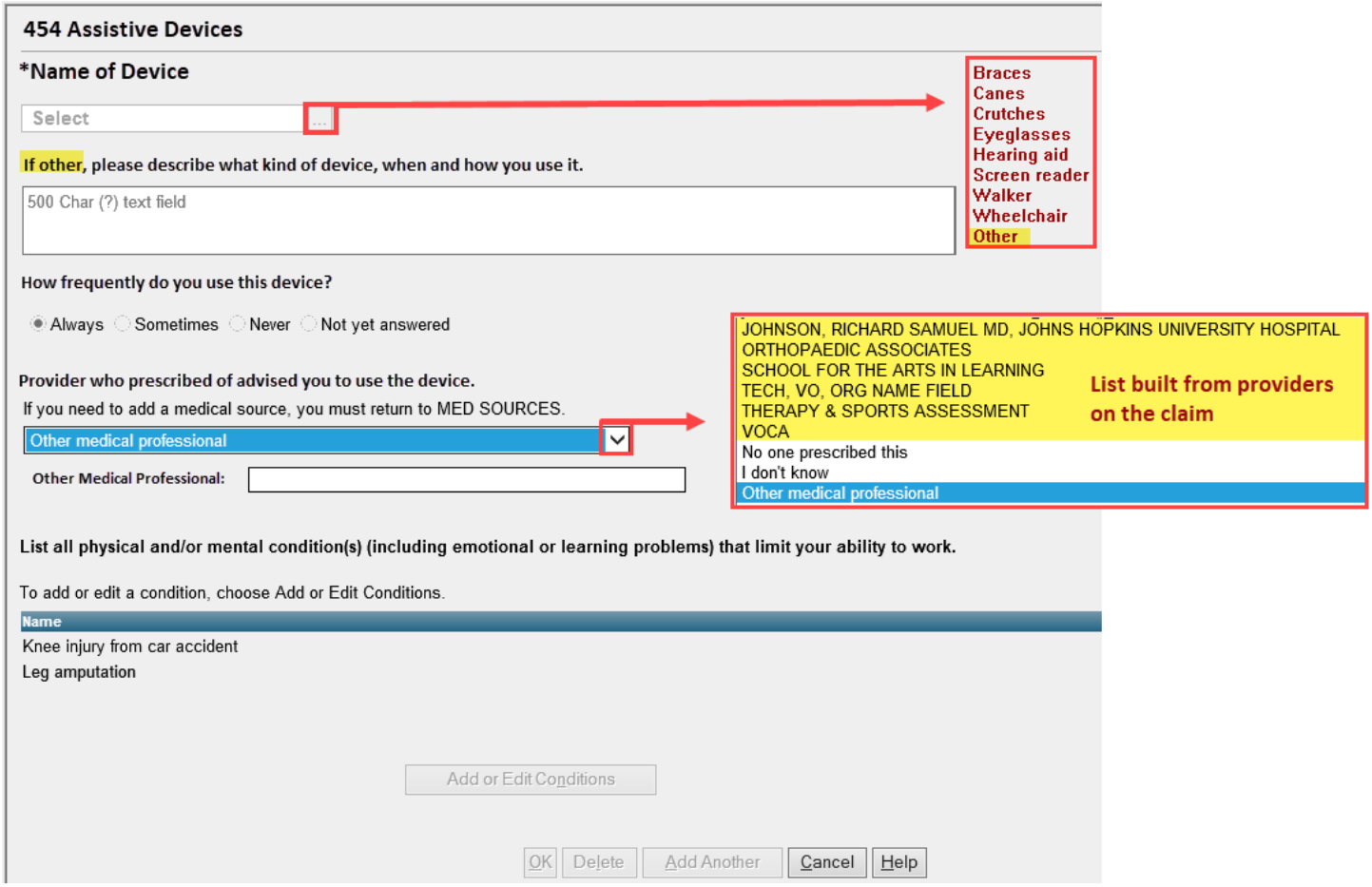
List the assistive device(s) you use.

To add a device, choose **Add Device**. To edit, select the device listed below.

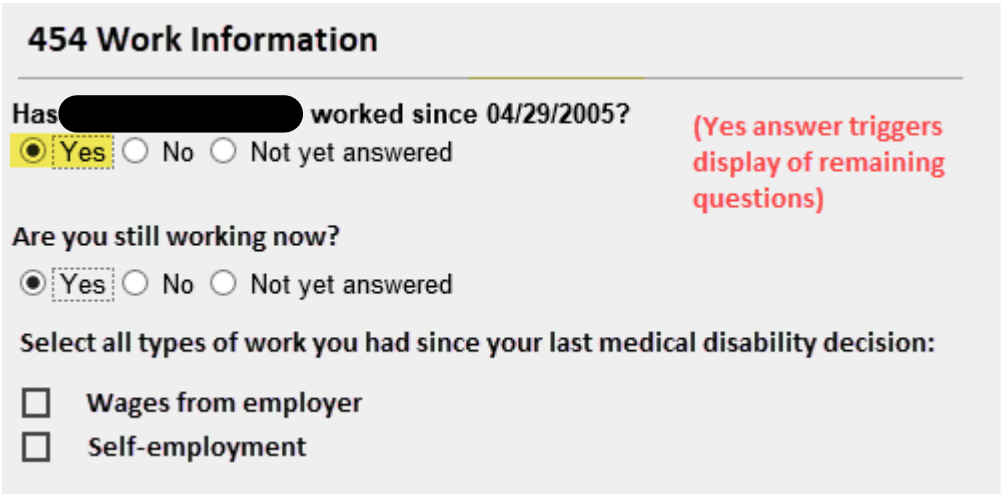
Medicine	Prescribed By
Eyeglasses	*No Source
Canes	Orthopedic Associates
Walker	Orthopedic Associates

Add Device

Assistive Devices Detail (new)



SSA - 454 Section 4 – Work



SSA - 454 Section 5 – Support Services

Support Services Summary

454· Support Services

Since 4/29/2005, have you participated or are you participating in any support services mentioned above or any other vocational rehabilitation, employment services, or other support services to help you return to work?

- **An Individualized Education Program (IEP) through a school(if a student age 18-21); or**
- **An individual work plan with an employment network under the Ticket to Work Program;**
- **A Plan to Achieve Self Support (PASS);**
- **An individualized plan for employment with a vocational rehabilitation agency or any other organization;**

(•) Yes ( ) No ( ) Not yet answered

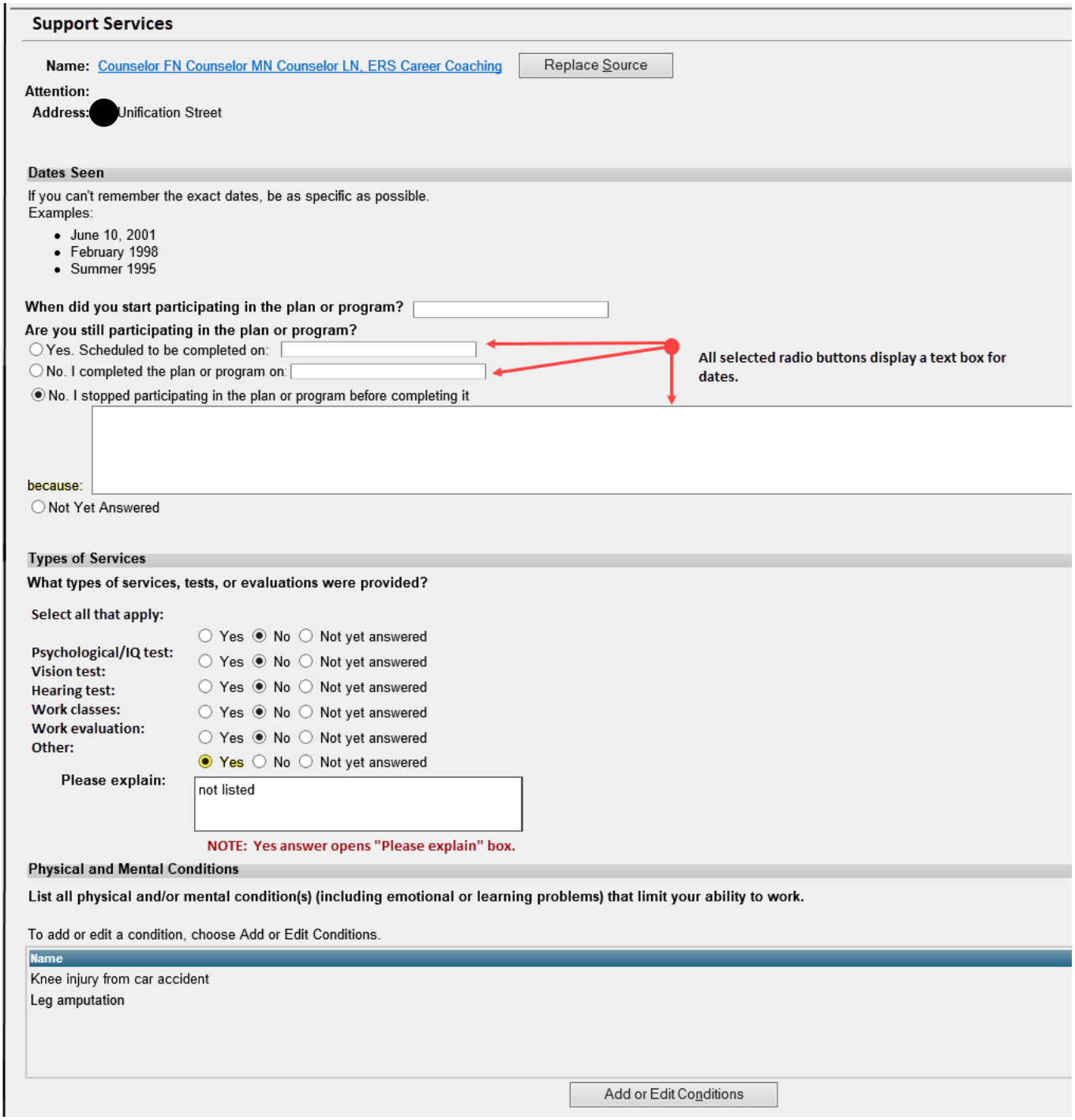
List all plans or programs attended.

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

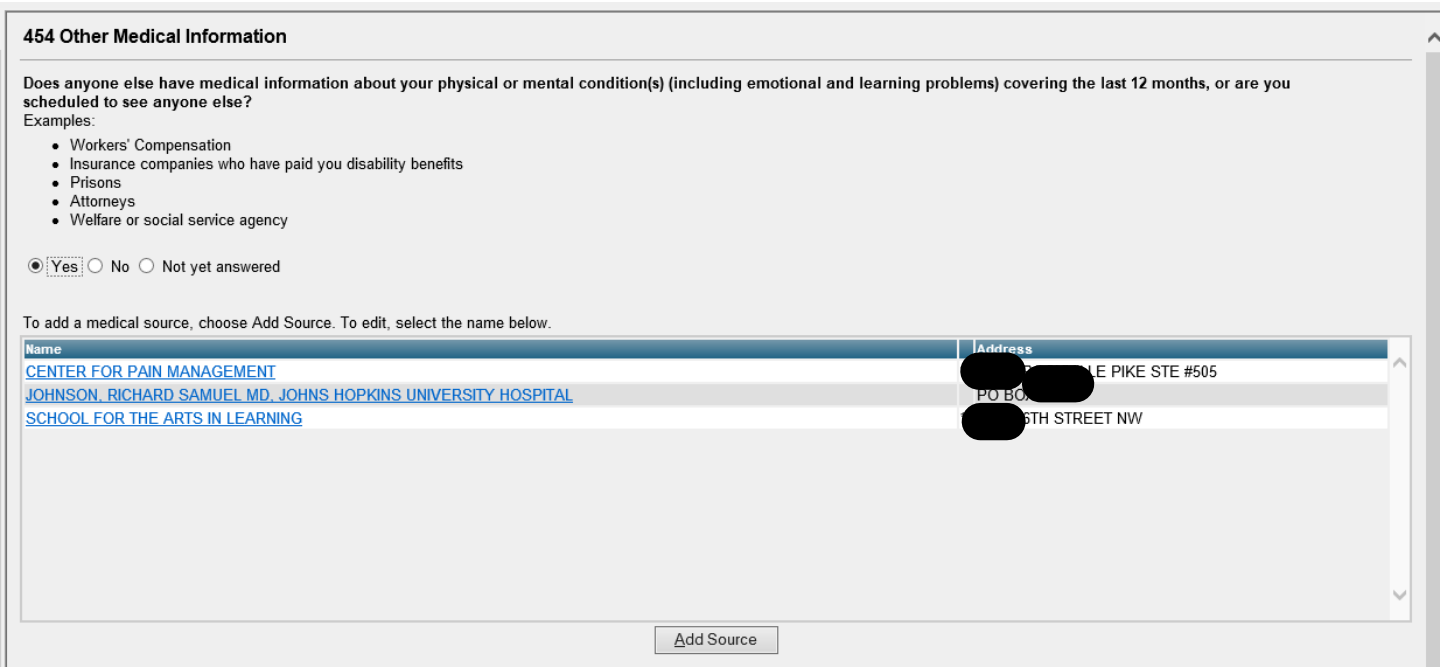
Organization/School		Name of Counselor/Instructor
THERAPY & SPORTS ASSESSMENT	*	*No Counselor/Instructor name*
VOCA	*	*No Counselor/Instructor name*

Add a Plan or Program

Support Services Detail



SSA - 454 Section 6 – Other Medical Information



454 Other Medical Information

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

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

(•) Yes ( ) No ( ) Not yet answered

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

Name	Address
CENTER FOR PAIN MANAGEMENT	[redacted]LE PIKE STE #505
JOHNSON, RICHARD SAMUEL MD, JOHNS HOPKINS UNIVERSITY HOSPITAL	PO BO[redacted]
SCHOOL FOR THE ARTS IN LEARNING	[redacted]6TH STREET NW

Add Source

454 Education, Training, and Literacy

Education

Have you received any education since 04/29/2005?
(•) Yes ( ) No ( ) Not yet answered

Name of school:

Dates of attendance:

From: **To:**

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 number is: (•) U.S. ( ) Foreign ( ) None
Telephone number is: (999-999-9999) **Ext:**

*Type of Program:

Approximate Date Completed (or scheduled to be completed):

Job Training or Vocational School

Have you received any type of specialized job, trade, or vocational training since 04/29/2005?

(•) Yes ( ) No ( ) Not yet answered

Name of training facility:

Dates of attendance:

From: **To:**

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 number is: (•) U.S. ( ) Foreign ( ) None
Telephone number is: (999-999-9999) **Ext:**

*Type of Program:

Approximate Date Completed (or scheduled to be completed):

What written language do you use every day in most situations (at home, work, school, in community, etc.)?

READING - In the language you identified above, can you read a simple message, such as a shopping list or short and simple notes?
(•) Yes ( ) No ( ) Not yet answered

WRITING - In the language you identified above, can you write a simple message, such as a shopping list or short and simple notes?
(•) Yes ( ) No ( ) Not yet answered

SSA - 454 Section 8 – Daily Activities

454 Daily Activities

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

Cook, clean, dress myself and my children, help my girls with homework after school and read to them.

Do you have hobbies or interests?

(•) Yes ( ) No ( ) Not yet answered

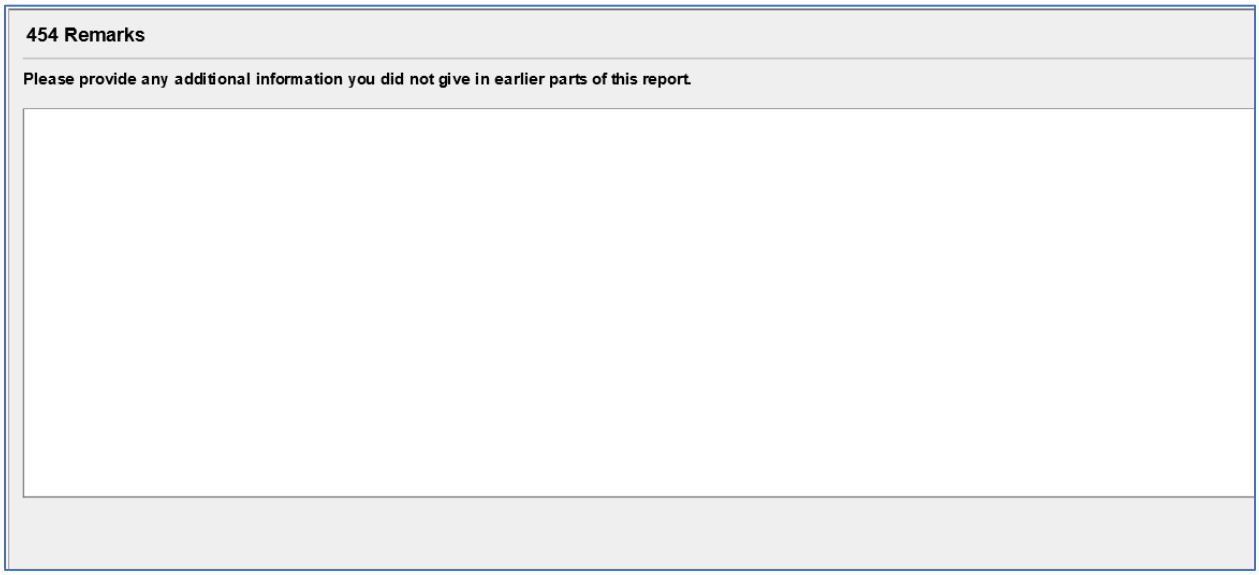
Please describe what they are and how much time you spend doing them.

I read books and take care of my children.

Do you ever have difficulty doing any of the following:

Dressing:	( ) Yes (•) No ( ) Not yet answered
Bathing:	( ) Yes (•) No ( ) Not yet answered
Caring for hair:	( ) Yes (•) No ( ) Not yet answered
Taking medicines:	( ) Yes (•) No ( ) Not yet answered
Preparing meals:	( ) Yes (•) No ( ) Not yet answered
Feeding self:	( ) Yes (•) No ( ) Not yet answered
Doing chores (inside/outside house):	( ) Yes (•) No ( ) Not yet answered
Driving or using public transportation:	(•) Yes ( ) No ( ) Not yet answered
Please explain:	not listed
Shopping:	( ) Yes (•) No ( ) Not yet answered
Managing money:	( ) Yes (•) No ( ) Not yet answered
Walking:	( ) Yes (•) No ( ) Not yet answered
Standing:	( ) Yes (•) No ( ) Not yet answered
Lifting objects:	( ) Yes (•) No ( ) Not yet answered
Using arms:	( ) Yes (•) No ( ) Not yet answered
Using hands or fingers:	( ) Yes (•) No ( ) Not yet answered
Sitting:	( ) Yes (•) No ( ) Not yet answered
Seeing, hearing, or speaking:	( ) Yes (•) No ( ) Not yet answered
Concentrating:	(•) Yes ( ) No ( ) Not yet answered
Please explain:	
Remembering:	( ) Yes (•) No ( ) Not yet answered
Understanding or following directions:	( ) Yes (•) No ( ) Not yet answered
Getting along with people:	( ) Yes (•) No ( ) Not yet answered

SSA - 454 Section 9 – Remarks



SSA - 454 Section 10 – Who is completing this form