



## SCREEN PACKAGE DOCUMENT

# MEDICAL CONTINUING DISABILITY REVIEW APPLICATION OR I454



# 1. Screen Designs and Component Descriptions

## 1.1. My Social Security Landing Page

The screenshot displays the 'my Social Security' user interface. At the top right, the user's name 'John Smith' and a 'Sign Out' link are visible. The navigation bar includes 'Home', 'Messages', and 'My Profile'. A welcome message for 'John!' is followed by the last sign-in time: 'January 22, 2022 at 3:36 PM ET.' Below this are four action cards: 'Your Social Security Statement and Fact Sheets', 'Your Benefit Verification Letter', 'Complete Your Continuing Disability Review' (with an 'ACTION REQUIRED' badge), and 'Replace Your Tax Form SSA-1099/SSA-1042S'. A 'Benefits and Payments' section is expanded, showing a 'Benefit Summary' of \$753 and a 'Social Security (Disability)' benefit of \$753, which is marked as 'Active'. The disability benefit section also lists the next payment date as April 15, 2022, and notes that payments are made on the 15th of every month via Direct Deposit.

A user can access the Continuing Disability Review application or i454 from their my Social Security homepage.

This is a close-up of the 'Complete Your Continuing Disability Review' button. It features a blue icon of a person with a plus sign, the text 'Complete Your Continuing Disability Review', and a yellow badge with the text 'ACTION REQUIRED'.

## 1.2. Permission to Release Records (SSA-827)

A user has an option to sign SSA-827 electronically and continue completing the i454 or complete both forms on paper and mail them to SSA.

Continuing Disability Review Report Messages 3 | Preferences

### Permission to Release Records

\*Indicates required information

In order to decide whether you are still disabled, we need to obtain your:

- Medical Records
- Education Records
- Other information related to your ability to perform tasks

We will request records with your permission. Providing your permission to release records is voluntary, but failing to do so, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim and could result in denial or loss of benefits.

You may review a blank form before making a selection below: [Permission to Release Records](#).

**\*Do you agree to electronically sign your permission to release records to SSA?**

**I agree to electronically sign the release form.**  
I voluntarily authorize and request disclosure of my medical and education records as well as other information related to my ability to perform tasks.

**I decline to electronically sign the release form. I will sign and mail the release form and the Continuing Disability Review form instead.**

[Next](#) [Save and Exit](#)

[OMB No. 0960-0072](#) [Privacy Policy](#) [Privacy Act Statement](#) [Accessibility Help](#)

NOTE: Upon accessing the Continuing Disability Review application, a footer as shown below will display.

[OMB No. 0960-0072](#) [Privacy Policy](#) [Privacy Act Statement](#) [Accessibility Help](#)

The “OMB No.0960-0072” is linked to the Paperwork Reduction Act. The user has the option to print the Paperwork Reduction Act and the Privacy Act Statement. The footer is persistent throughout the application and will not be shown on the upcoming pages.

If the user selects “I agree to electronically sign the release form,” an informational message appears below, letting the user know that they can print and/or save their electronically signed release form upon submission.

**\*Do you agree to electronically sign your permission to release records to SSA?**

**I agree to electronically sign the release form.**  
I voluntarily authorize and request disclosure of my medical and education records as well as other information related to my ability to perform tasks.

**I decline to electronically sign the release form. I will sign and mail the release form and the Continuing Disability Review form instead.**

**i** **Printing or Saving Your Electronically Signed Release Form**  
Upon submitting your medical review, you will be able to print or save your electronically signed release form should you like to keep it for your records.

**Next**

If the user selects “I decline to electronically sign the release form...,” a warning message appears below, letting the user know how to submit their review and the release form using paper forms. Links to the SSA-454 and SSA-827 forms are included.

**\*Do you agree to electronically sign your permission to release records to SSA?**

**I agree to electronically sign the release form.**  
I voluntarily authorize and request disclosure of my medical and education records as well as other information related to my ability to perform tasks.

**I decline to electronically sign the release form. I will sign and mail the release form and the Continuing Disability Review form instead.**

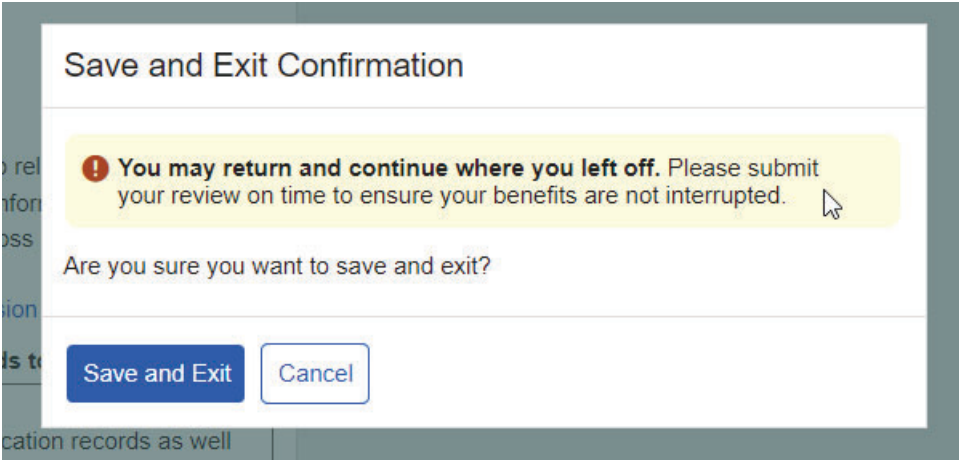
**!** **Declining to Electronically Sign Your Release Form**  
If you decline to electronically sign the release form, you can sign and mail the paper form instead. However, by doing so you will no longer be able to submit your medical review online.  
  
To complete your medical review on paper, you may access and print [Continuing Disability Review Report](#) and [Permission to Release Records](#). You can also use the forms we mailed to you. For further assistance, please call at 1-800-772-1213, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call TTY 1-800-325-0778.  
  
To electronically sign, please change your selection above.

### 1.3. Save and Exit

If the user decides to exit the application at any point, they can select the “Save and Exit” button.



The following confirmation message will display.



## 1.4. Instructions

The user can review what documents they need to have available for completing the i454.

### Instructions

The office that reviews your medical conditions will use the information in this report to decide whether you are still disabled. Please complete as much of the report as you can.

#### What You Need To Complete This Report

- Contact information of someone (other than your doctors) who we can contact about your case.
- Contact information of doctors, hospitals, and clinics you have visited in the last 12 months.
- Any prescription or non-prescription medicines you take or have taken in the last 12 months.
- Contact information of organizations that may have your medical records in the last 12 months. This includes social services, welfare agencies, attorneys, prisons, worker's compensation, or insurance companies who have paid you disability benefits.
- Information about any education, training, vocational rehabilitation, employment, or support services that may help you join the workforce since your last disability decision of 07/25/2022.

#### Your Medical Records

**You do not need to ask doctors or hospitals for any medical records that you do not already have. With your permission, we will request your records using the information you provide.**

#### If You Need Help

For help with completing this report, you can contact us at 1-800-772-1213, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call TTY 1-800-325-0778.

[Next](#) [Save and Exit](#)

### In This Section

- Instructions**
- [Information about You](#)
- [Someone We Can Contact](#)
- [Medical Conditions](#)
- [Medical Providers](#)
- [Tests](#)
- [Medicines](#)
- [Assistive Devices](#)
- [Other Medical Information](#)
- [Work](#)
- [Support Services](#)
- [Training](#)
- [Education](#)
- [Daily Activities](#)
- [Remarks](#)
- [Summary](#)

The side navigation on right displays on all screens within the application. Users can either go through the screens of the application in order or access any of the screens from the right navigation if they prefer. Green check marks indicate sections completed without errors.

The right navigation is persistent throughout the application and will not be shown in the upcoming screenshots.

## 1.5. Information about You

The user needs to respond to several questions about using other names as well as their ability to communicate. Since the user is authenticated to their my Social Security portal, their name, address, email, and phone do not need to be entered.

### Information about You

\*Indicates required information

**\*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

**\*Can you speak and understand English?**  
If you cannot speak and understand English, we will provide an interpreter free of charge.

Yes  No

**\*Can you read and understand English?**

Yes  No

**\*Can you write more than your name in English?**

Yes  No

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

-- ▾

[Next](#) [Previous](#) [Save and Exit](#)

If the user selects “Yes” to the question about using other names on medical or educational records, the Name fields will display. The user can add more than one name, if needed.

**\*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

**Other Name 1**

*First	Middle	*Last	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="--"/>

[+ Add Another Name](#)



If the user selects “No” to the question “Can you speak and understand English?” they can select a language of their preference from the dropdown list.

**\*Can you speak and understand English?**  
If you cannot speak and understand English, we will provide an interpreter free of charge.

Yes  No

**\*What language do you prefer?**

--

**\*Can you read and understand English?**

Yes  No

**\*Can you write more than your name in English?**

Yes  No

--

- Spanish
- Alaska Native
- Albanian
- \* American Indian-Apache
- American Indian-Choctaw
- \* American Indian-Crow
- American Indian-Dakota
- American Indian-Lakota
- American Indian-Nakota
- American Indian-Navajo
- American Indian-Other
- American Indian-Zuni
- \* American Sign Language
- Amharic
- Arabic
- Armenian
- Assyrian
- \* Bengali
- \* Bosnian

--

ed any other names on your medical or educational

arried name, or nickname.

glish?

English, we will provide an interpreter free of charge.

The list of languages is coming from the Global Reference Table (GRT).

If the user cannot locate the language of their preference, they can select “Other” and specify in the field provided.

**\*Can you speak and understand English?**  
If you cannot speak and understand English, we will provide an interpreter free of charge.

Yes  No

**\*What language do you prefer?**

Other

**\*Please Specify**

If the user selects any language under the “What written language do you use every day in most situations (at home, work, school, in community, etc.)?” question, two additional questions about reading and writing will be displayed.

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

English

**Can you read a simple message in the language you identified above?**

Yes  No

**Can you write a simple message in the language you identified above?**

Yes  No

If the user cannot locate the language of their preference, they can select “Other” and specify in the field provided.

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

**\*Please Specify**

**Can you read a simple message in the language you identified above?**

Yes  No

**Can you write a simple message in the language you identified above?**

Yes  No

## 1.6. Someone We Can Contact

The user is asked to provide a contact person.

**Someone We Can Contact**

**\*Indicates required information**

**\* Is there someone we can contact who can help you with your case?**  
Please provide the name of someone (other than your doctors) who knows about your medical conditions, can help with your case, and can help us reach you if you become unavailable.

Yes  No

**Next** Previous Save and Exit

If the user answers “Yes” to the “Is there someone we can contact who can help with your case?” question, additional fields will appear below to capture details.

### Someone We Can Contact

**\*Indicates required information**

**\* Is there someone we can contact who can help you with your case?**  
Please provide the name of someone (other than your doctors) who knows about your medical conditions, can help with your case, and can help us reach you if you become unavailable.

Yes  No

**Contact's Name**

**\*First**  **Middle**  **\*Last**  **Suffix**

**\*Relationship to You**

**Mailing Address**

Country

Street Address  Apartment, Suite, Building, Etc.

City/Town  State/Territory  ZIP Code

**Phone Number**

U.S.  International

**\*10-digit Number**  **Ext.**

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

Yes  No

The user can select their relationship with the contact person from a list as shown below.

A screenshot of a web form showing a dropdown menu for the field labeled "\*Relationship to You". The dropdown is open, displaying a list of relationship options: Family Member, Attorney Representative, Non-Attorney Representative, Government Agency, Non-Profit Organization/Legal Aid Group, Case Manager, Health Service Agency/Hospital, Nursing Care Facility, Friend, and Other. A mouse cursor is pointing at the top of the dropdown menu.

If the user selects "Other" from the list, they can specify their relationship in the field provided.

A screenshot of the web form showing the "\*Relationship to You" dropdown menu with "Other" selected. Below the dropdown is a text input field labeled "\*Please Specify".

If the user answers "No" to their contact's ability to speak and understand English, they can select a language other than English from the list. The list of languages is coming from the GRT table.

A screenshot of the web form showing two sections. The first section is labeled "\*Can this person speak and understand English?" and has two radio buttons: "Yes" (unselected) and "No" (selected). The second section is labeled "\*What language do they prefer?" and has a dropdown menu with "Spanish" selected.

If the user selects “Other,” they can specify what language their contact prefers.



The screenshot shows a form with two main sections. The first section is titled "\*What language do they prefer?" and contains a dropdown menu with the word "Other" selected. The second section is titled "\*Please Specify" and contains an empty text input field. The form is enclosed in a light gray border.

**\*What language do they prefer?**

Other

**\*Please Specify**

## 1.7. Medical Conditions

The user can list their medical conditions as well as their height and weight.

### Medical Conditions

\* Indicates required information

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

Examples include back injury, arthritis, diabetes, glaucoma, depression, blindness. We will consider these conditions regardless of whether or not you have been receiving treatment.

In addition, please provide:

- Any major complications resulting from your condition
- If cancer, include stage and type

\* Medical Condition 1

Medical Condition 2

Medical Condition 3

+ Add Another Medical Condition

**What is your height?**

Measurement Unit   Feet                      Inches

**What is your weight?**

Measurement Unit   Pounds

The user can switch to the metric system when entering height and weight, if needed.

**What is your height?**  
Measurement Unit Centimeters

Centimeters

**What is your weight?**  
Measurement Unit Kilograms

Kilograms



## 1.8. Medical Providers

The system propagates medical providers from the user’s last review or initial application. The user must review and update medical providers they have seen in the last 12 months or have an upcoming appointment with.

### Medical Providers

\*Indicates required information

**i** During the last review of your case, you were treated by the medical providers displayed below.

Medical providers may include a doctor, hospital, clinic, psychiatrist, nurse practitioner, therapist, physical therapist, or other healthcare professional.

**If you have seen or received treatment from medical providers in the last 12 months or have a future appointment scheduled, you must:**

- Review and update the contact information for each provider
- Delete providers you have not seen in the last 12 months
- Add any medical providers you have seen in the last 12 months

Status	Actions	Facility or Office	<u>Doctor or Healthcare Professional</u>
NEEDS REVIEW	<a href="#">Review</a> <a href="#">Delete</a>	Centennial Medical Group	[REDACTED]
NEEDS REVIEW	<a href="#">Review</a> <a href="#">Delete</a>	Riverside Medical Center	[REDACTED]
NEEDS REVIEW	<a href="#">Review</a> <a href="#">Delete</a>	Holy Cross Hospital	--

[Add Medical Provider](#)

Next

Previous

Save and Exit

To update medical provider information, the user can select the “Review” button, which will take them to the Medical Provider Details page with certain data propagated from the last review.

### Medical Provider Details

**\*Indicates required information**

**i** Only include medical providers you visited in the last 12 months or are scheduled to visit in the future.

**Name of Facility or Office**

---

**Name of Doctor or Healthcare Professional**

First	Middle	Last	Suffix
<input type="text" value="Marie"/>	<input type="text" value="Ann"/>	<input type="text" value="Hammond"/>	<input type="text" value="--"/>

**Phone Number**

U.S.    International

**\*10-digit Number**   **Ext.**

<input type="text" value="(410) 454-1012"/>	<input type="text"/>
---	----------------------

**Address**

Country

Street Address      Apartment, Suite, Building, Etc.

<input type="text" value="4500 Red Clay Lane"/>	<input type="text"/>
---	----------------------

City/Town      State/Territory      ZIP Code

<input type="text" value="Laurel"/>	<input type="text" value="Maryland"/>	<input type="text" value="20707"/>
-------------------------------------	---------------------------------------	------------------------------------

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

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

Characters remaining: 1000

**When did you last see this provider in the last 12 months? If you are scheduled to see them in the future, please provide that date.**

Month      Year

<input type="text" value="--"/>	<input type="text"/>
---------------------------------	----------------------

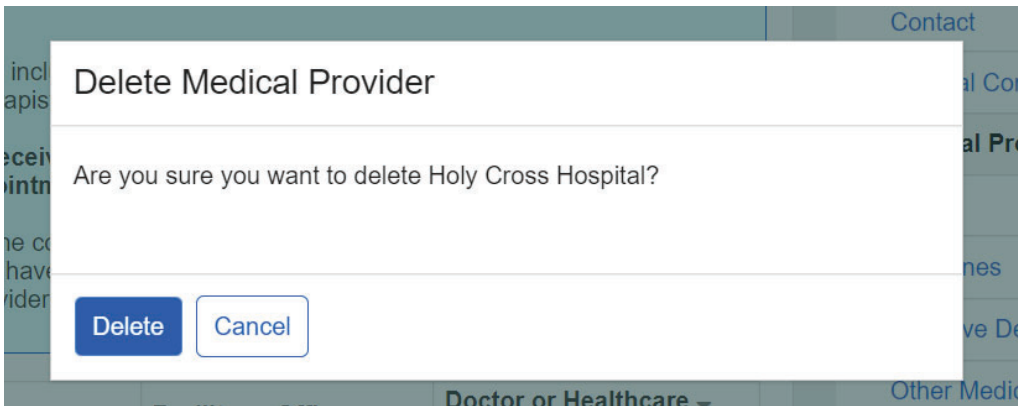
I don't remember

**i** Please select 'Save' to confirm that you have reviewed the above information and it is correct.

Upon saving, the user will be taken back to the Medical Providers page. The “NEEDS REVIEW” warning status badge will be replaced by the “REVIEWED” success badge.

Status	Actions	Facility or Office ▾	Doctor or Healthcare Professional ▾
REVIEWED	<a href="#">Review</a> <a href="#">Delete</a>	Centennial Medical Group	Hammond, Marie Ann
NEEDS REVIEW	<a href="#">Review</a> <a href="#">Delete</a>	Riverside Medical Center	Sikorsky, Mark P.
NEEDS REVIEW	<a href="#">Review</a> <a href="#">Delete</a>	Holy Cross Hospital	--

If the user needs to delete a provider, they can click the “Delete” button. Upon clicking on “Delete,” the following confirmation message will display.



If the user needs to add a provider, they can select the “Add Medical Provider” button.

### Test Details

**\*Indicates required information**

**i** Only include medical tests you had in the last 12 months or are scheduled to have.

**\*Test Type**

Treadmill (Exercise Test) ▾

**Ordered by**

Other Medical Provider ▾

**Name of Facility or Office**

\_\_\_\_\_

**Name of Doctor or Healthcare Professional**

First Middle Last Suffix

\_\_\_\_ ▾ \_\_\_\_ ▾ \_\_\_\_ ▾ -- ▾

**Phone Number**

U.S.  International

**\*10-digit Number** **Ext.**

\_\_\_\_

**Address**

Country

United States or U.S. Territory ▾

Street Address Apartment, Suite, Building, Etc.

\_\_\_\_\_

City/Town State/Territory ZIP Code

\_\_\_\_ -- ▾ \_\_\_\_

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

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

\_\_\_\_\_

Characters remaining: 1000

**When did you last see this provider in the last 12 months? If you are scheduled to see them in the future, please provide that date.**

Month Year

-- ▾ \_\_\_\_

I don't remember

**Save** **Cancel**

Upon saving, the user will be taken back to the Medical Providers page. The informational status badge “NEW” will be displayed against the provider added.

Status	Actions	Facility or Office	Doctor or Healthcare Professional
REVIEWED	<a href="#">Review</a> <a href="#">Delete</a>	Centennial Medical Group	Hammond, Marie Ann
NEEDS REVIEW	<a href="#">Review</a> <a href="#">Delete</a>	Riverside Medical Center	Gikorsky, Mark P.
NEW	<a href="#">Review</a> <a href="#">Delete</a>	--	Summers, Clare

If no medical providers were reported in the last review, the user will see a corresponding instructional message and a blank Medical Providers table.

### Medical Providers

\*Indicates required information

**i** Please add any medical providers that you have seen in the last 12 months or have future appointments with.

Medical providers may include a doctor, hospital, clinic, psychiatrist, nurse practitioner, therapist, physical therapist, or other healthcare professional.

Status	Actions	Facility or Office	Doctor or Healthcare Professional
No doctors or healthcare professionals have been entered yet.			

[Add Medical Provider](#)

Next

Previous

Save and Exit

## 1.9. Tests

The user can enter details of tests ordered by their providers in the last 12 months.

### Tests

\*Indicates required information

**\*In the last 12 months, have you had any medical tests ordered by your providers? Include tests scheduled for the future.**

Yes  No

**Next** Previous Save and Exit

When the user selects “Yes,” a blank Tests table will appear.

### Tests

\*Indicates required information

**\*In the last 12 months, have you had any medical tests ordered by your providers? Include tests scheduled for the future.**

Yes  No

Status	Actions	Test	Ordered by
No tests have been entered yet.			

Add Test

**Next** Previous Save and Exit

If the user selected the “Add Test” button, it will bring up the Test Details page where the user can enter test information.

**Test Details**

\*Indicates required information

**i** Only include medical tests you had in the last 12 months or are scheduled to have.

\***Test Type**

--

**Ordered by:**

--

Save Cancel

The user can select a test from the list “Test Type.”

\***Test Type**

--

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



If either Biopsy, MRI/CT Scan, or X-ray is selected from the Test Type dropdown list, the user has to provide the body part:

**Test Details**

\*Indicates required information

**i** Only include medical tests you had in the last 12 months or are scheduled to have.

\***Test Type**  
Biopsy

\***Body Part**  
left lung

If a test is not on the list, the user can select “Other” and specify.

\***Test Type**  
Other

\***Please Specify**

Then, the user can select a provider who ordered the test under “Ordered by.” The list will contain medical providers already entered as well as other options. If the provider is not on the list, the user can select “Other Medical Provider” and enter details as seen under the Medical Providers.

**Note:** the same interaction will take place when users are entering Medicines.

**Ordered by:**

--

No one  
I don't know  
Hammond, Marie Ann  
Sikorsky, Mark D.  
Summers, Clare  
Other Medical Provider

OMB No. 0960-0072 Privacy Policy Privacy

### Test Details

\*Indicates required information

**i** Only include medical tests you had in the last 12 months or are scheduled to have.

**\*Test Type**

Treadmill (Exercise Test) ▾

**Ordered by**

Other Medical Provider ▾

**Name of Facility or Office**

**Name of Doctor or Healthcare Professional**

First Middle Last Suffix  
-- ▾

**Phone Number**

U.S.  International

\*10-digit Number Ext.

**Address**

Country

United States or U.S. Territory ▾

Street Address

Apartment, Suite, Building, Etc.

City/Town

State/Territory

-- ▾

ZIP Code

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

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

Characters remaining: 1000

**When did you last see this provider in the last 12 months? If you are scheduled to see them in the future, please provide that date.**

Month Year  
-- ▾

I don't remember

Save Cancel

Upon saving test details, the user will be taken back to the Tests page where the table is populated with a new entry designated by the “NEW” information status badge.

### Tests

\*Indicates required information

\*In the last 12 months, have you had any medical tests ordered by your providers?  
Include tests scheduled for the future.

Yes  No

Status	Actions	Test	Ordered by
NEW	<a href="#">Review</a> <a href="#">Delete</a>	X-Ray full body	Hammond, Mark Ann

[Add Test](#)

[Next](#) [Previous](#) [Save and Exit](#)

## 1.10. Medicines

The system propagates medicines from the user’s last review or initial application. The user must review and update medicines, based on the last 12 months.

### Medicines

\*Indicates required information

**i** During the last review of your case, you were taking the medicines displayed below.

If you are currently taking or have taken in the last 12 months any prescription or non-prescription medicines, you must:

- Review and update each medicine
- Delete medicines you are no longer taking
- Add any medicines prescribed or suggested by providers in the last 12 months

Status	Actions	Medicine	Prescribed by
NEEDS REVIEW	<input type="button" value="Review"/> <input type="button" value="Delete"/>	Cortizone	Hammond, Marie Ann
NEEDS REVIEW	<input type="button" value="Review"/> <input type="button" value="Delete"/>	Aspirin	No one

The user can update a medicine by selecting the “Review” button. The “Review” button brings up a page titled “Medicine Details” with data propagated from the last review. The user can review and update details, as needed. The “Prescribed by” dropdown includes providers already entered as well as the “Other Medical Provider” option.

### Medicine Details

**\*Indicates required information**

**i** Only include medicines you have taken in the last 12 months.

**\*Name of Medicine**  
 Enter one medicine at a time. Look at the medicine container, if necessary.

**Reason for Medicine**  
 (1000 characters maximum)

For pain

Characters remaining: 1000

**Prescribed by:**

Hammond, Marie Ann

**i** Please select 'Save' to confirm that you have reviewed the above information and it is correct.

Upon saving, the user will be taken back to the Medicines page. The “NEEDS REVIEW” warning status badge will be replaced by the “REVIEWED” success badge.

Status	Actions	Medicine	Prescribed by
REVIEWED	<input type="button" value="Review"/> <input type="button" value="Delete"/>	Cortizone	<span style="background-color: #ccc; border-radius: 3px; padding: 2px 5px;">Hammond, Marie Ann</span>
NEEDS REVIEW	<input type="button" value="Review"/> <input type="button" value="Delete"/>	Aspirin	No one

If the “Add Medicine” button is selected, the Medicine Details page will display.

### Medicine Details

\*Indicates required information

**i** Only include medicines you have taken in the last 12 months.

**\* Name of Medicine**  
 Enter one medicine at a time. Look at the medicine container, if necessary.

**Reason for Medicine**  
 (1000 characters maximum)

Characters remaining: 1000

**Prescribed by:**

-- v

Save
Cancel

Upon saving medicine details, the user will return to Medicines page where the table is populated with a new entry designated by the “NEW” information status badge.

Status	Actions	<u>Medicine</u>	<u>Prescribed by</u>
REVIEWED	<span style="border: 1px solid #004a99; padding: 2px 5px; margin-right: 5px;">Review</span> <span style="border: 1px solid #004a99; padding: 2px 5px;">Delete</span>	Cortizone	Hammond, Marie Ann
NEEDS REVIEW	<span style="border: 1px solid #004a99; padding: 2px 5px; margin-right: 5px;">Review</span> <span style="border: 1px solid #004a99; padding: 2px 5px;">Delete</span>	Aspirin	No one
NEW	<span style="border: 1px solid #004a99; padding: 2px 5px; margin-right: 5px;">Review</span> <span style="border: 1px solid #004a99; padding: 2px 5px;">Delete</span>	Vitamin D3	Summers, Clare

If no medicines were reported in the last review, the user will see a corresponding informational message and a blank Medicines table.

## Medicines

\*Indicates required information

**i** Please add any prescription or non-prescription medicines that you are currently taking or have taken in the last 12 months.

Status	Actions	Medicine	Prescribed by
No medicines have been entered yet.			

Add Medicine

Next Previous Save and Exit

## 1.11. Assistive Devices

The user can add assistive devices they are using.

### Assistive Devices

\*Indicates required information

**\* Do you use an assistive device?**  
Examples include braces, canes, crutches, eyeglasses, hearing aid, screen reader, walker, wheelchair.

Yes  No

**Next** Previous Save and Exit

If the user selects “Yes,” a blank Assistive Devices table will appear below.

### Assistive Devices

\*Indicates required information

**\* Do you use an assistive device?**  
Examples include braces, canes, crutches, eyeglasses, hearing aid, screen reader, walker, wheelchair.

Yes  No

Status	Actions	Assistive Device	Prescribed by
No assistive devices have been entered yet.			

Add Assistive Device

**Next** Previous Save and Exit



If the “Add Assistive Device” button is selected, then the Assistive Device Details page will display.

### Assistive Device Details

\*Indicates required information

**\*Name of Assistive Device**

**\*How often do you use it?**

Always

Sometimes

**Prescribed by:**

The user can select an assistive device from the list. If the assistive device is not listed, the user can select “Other” and specify.

**\*Name of Assistive Device**

--

- Braces
- H Canes
- Crutches
- Eyeglasses
- Hearing Aid
- Screen Reader
- Walker
- Wheelchair
- F Other

**\*Name of Assistive Device**

Other

**\*Please Specify**

Then, the user can select a provider who prescribed the device under “Prescribed by.” The list will contain medical providers already entered as well as other options. If the provider is not on the list, the user can select “Other Medical Provider” and enter Medical Provider’s Name or Facility.

**Prescribed by:**

No one

- 
- No one
- I don't know
- S Hammond, Marie Ann
- Sikorsky, Mark P.
- Summers, Clare
- Other Medical Provider

OMB No. 0960-0072 Privacy Policy Priv

**Prescribed by:**

Other Medical Provider

**\*Medical Provider's Name or Facility**  
Include providers you may not have seen recently.

Upon saving, the user returns to the Assistive Devices page where the table is populated with a new entry designated by the “NEW” information status badge.

### Assistive Devices

\*Indicates required information

**\*Do you use an assistive device?**  
Examples include braces, canes, crutches, eyeglasses, hearing aid, screen reader, walker, wheelchair.

Yes  No

Status	Actions	Assistive Device	Prescribed by
NEW	<a href="#">Review</a> <a href="#">Delete</a>	Braces	Hammond, Mark Ann

[Add Assistive Device](#)

[Next](#) [Previous](#) [Save and Exit](#)

## 1.12. Other Medical Information

The user is asked to list organizations other than their providers that may have their medical records based on the last 12 months.

### Other Medical Information

\*Indicates required information

**\*Does anyone else (other than your medical providers) have medical information about your physical or mental health conditions? Include organizations you have seen in the last 12 months or have future appointments with.**

Examples include places like social services agencies, welfare agencies, attorneys, prisons, workers' compensation, or insurance companies who have paid you disability benefits.

Yes
  No

Next
Previous
Save and Exit

If the user selects “Yes,” a blank Organizations table will appear below.

### Other Medical Information

\*Indicates required information

**\*Does anyone else (other than your medical providers) have medical information about your physical or mental health conditions? Include organizations you have seen in the last 12 months or have future appointments with.**

Examples include places like social services agencies, welfare agencies, attorneys, prisons, workers' compensation, or insurance companies who have paid you disability benefits.

Yes
  No

Status	Actions	Organization	Contact Person
No organizations have been entered yet.			

Add Organization

Next
Previous
Save and Exit

If the “Add Organization” button is selected, the Organization Details page will display.

### Organization Details

\*Indicates required information

**i** Only include organizations you visited in the last 12 months or are scheduled to visit in the future.

**\*Name of Organization**

**Name of Contact Person**

First	Middle	Last	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="--"/>

**Phone Number**

U.S.  International

\*10-digit Number  Ext.

**Address**

Country

Street Address	Apartment, Suite, Building, Etc.
<input type="text"/>	<input type="text"/>

City/Town	State/Territory	ZIP Code
<input type="text"/>	<input type="text" value="--"/>	<input type="text"/>

**Claim Number (if any)**

**When did you last see this organization in the last 12 months? If you are scheduled to see them in the future, please provide that date.**

Month	Year
<input type="text" value="--"/>	<input type="text"/>

I don't remember

**Reasons for Contact**  
(1000 characters maximum)

Characters remaining: 1000

Upon saving, the user returns to the Other Medical Information page where the table is populated with a new entry designated by the “NEW” information status badge.

### Other Medical Information

\*Indicates required information

**\*Does anyone else (other than your medical providers) have medical information about your physical or mental health conditions? Include organizations you have seen in the last 12 months or have future appointments with.**

Examples include places like social services agencies, welfare agencies, attorneys, prisons, workers' compensation, or insurance companies who have paid you disability benefits.

Yes     No

Status	Actions	Organization	Contact Person
NEW	<a href="#">Review</a> <a href="#">Delete</a>	United Way of Central MD	Martin, Veronique

[Add Organization](#)

[Next](#)    [Previous](#)    [Save and Exit](#)

### 1.13. Work

The user is asked to answer if they ever worked since the date of their last disability decision.

Work

\*Indicates required information

**\*Have you worked since your last disability decision of 07/25/2019?**

Yes  No

[Next](#) [Previous](#) [Save and Exit](#)

Upon selecting “Yes,” additional fields will appear below.

Work

\*Indicates required information

**\*Have you worked since your last disability decision of 07/25/2019?**

Yes  No

**\*What type of wages have you received or are still receiving?**  
Select all that apply

Wages from employer

Self-employment

**\*Are you currently working?**

Yes  No

## 1.14. Support Services

The user is asked to list support services that they participated in since the date of their last disability decision.

### Support Services

\*Indicates required information

**\*Since your last disability decision of 07/25/2019, have you participated or are you participating in any vocational rehabilitation, employment, or other support services to help you return to work?**

Examples of support services include:

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

Yes  No

[Next](#) [Previous](#) [Save and Exit](#)



If the user selects “Yes,” a blank Support Services table will appear below.

### Support Services

\*Indicates required information

**\*Since your last disability decision of 07/25/2019, have you participated or are you participating in any vocational rehabilitation, employment, or other support services to help you return to work?**

Examples of support services include:

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

Yes    No

Status	Actions	Plan or Program	Counselor, Instructor, or Job Coach
No plans or programs have been entered yet.			

[Add Plan or Program](#)

[Next](#)   [Previous](#)   [Save and Exit](#)

If the “Add Organization” button is selected, the Plan or Program Details page will display.

### Plan or Program Details

\*Indicates required information

**\*Name of Plan or Program**

---

**Name of Counselor, Instructor, or Job Coach**

First  Middle  Last  Suffix

---

**Phone Number**

U.S.  International

\*10-digit Number  Ext.

---

**Address**

Country

Street Address  Apartment, Suite, Building, Etc.

City/Town  State/Territory  ZIP Code

---

**When did you start participating in the plan or program?**

Month  Year

I don't remember

---

**Are you still participating in the plan or program?**

Yes, I am scheduled to complete it

No, I completed it

No, I stopped participating before completing it

---

**What types of services, tests, or evaluations were provided?**

Please select all that apply

Psychological/IQ Test

Vision Test

Hearing Test

Work Classes

Work Evaluation

Other

---

If user selects “Yes, I’m scheduled to completed it,” they can provide ‘Date to be Completed.’

**Are you still participating in the plan or program?**

Yes, I am scheduled to complete it

No, I completed it

No, I stopped participating before completing it

**Date to be Completed**

Month                      Year

I don't remember

If user selects “No, I completed it,” they can provide ‘Date Completed.’

**Are you still participating in the plan or program?**

Yes, I am scheduled to complete it

No, I completed it

No, I stopped participating before completing it

**Date Completed**

Month                      Year

I don't remember

If the user selects “No, I stopped participating before completing it,” they can provide a reason for ending their participation.

**Are you still participating in the plan or program?**

<input type="radio"/> Yes, I am scheduled to complete it
<input type="radio"/> No, I completed it
<input checked="" type="radio"/> No, I stopped participating before completing it

**Reason for Ending Participation**  
(1000 characters maximum)

Characters remaining: 1000

The user can select services, tests, or evaluations from the checklist. If a service, test, or evaluation is not on the list, the user can select “Other” and provide details.

**What types of services, tests, or evaluations were provided?**  
Please select all that apply

<input type="checkbox"/> Psychological/IQ Test
<input type="checkbox"/> Vision Test
<input type="checkbox"/> Hearing Test
<input type="checkbox"/> Work Classes
<input type="checkbox"/> Work Evaluation
<input checked="" type="checkbox"/> Other

**\*Please Specify**

Upon saving, the user returns to the Support Services page where the table is populated with a new entry designated by the “NEW” information status badge.

## Support Services

**\*Indicates required information**

**\*Since your last disability decision of 07/25/2019, have you participated or are you participating in any vocational rehabilitation, employment, or other support services to help you return to work?**

Examples of support services include:

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

Yes
  No

Status	Actions	Plan or Program	Counselor, Instructor, or Job Coach
NEW	<input type="button" value="Review"/> <input type="button" value="Delete"/>	Division of Rehabilitation Services	Norman, Ron

## 1.15. Training

The user is asked to list trainings that they participated in since the date of their last disability decision.

### Training

\*Indicates required information

**\*Have you received any type of specialized job, trade, or vocational training since your last disability decision of 07/25/2019?**

Yes  No

**Next** Previous Save and Exit

If the user selects “Yes,” a blank Training table will appear below.

### Training

\*Indicates required information

**\*Have you received any type of specialized job, trade, or vocational training since your last disability decision of 07/25/2019?**

Yes  No

Status	Actions	Training Facility	Program
No training programs have been entered yet.			

Add Training

**Next** Previous Save and Exit

If the “Add Training” button is selected, the Training Details page will display.

### Training Details

**\*Indicates required information**

**Name of Training Facility**

  
**Phone Number**

U.S.    International

**\*10-digit Number**   **Ext.**

     
**Address**

Country

  
Street Address   Apartment, Suite, Building, Etc.     
City/Town   State/Territory   ZIP Code        
**\*Type of Program**  
**When did you complete or are scheduled to complete this program?**

Month   Year

     
 I don't remember

**Save**   **Cancel**

Upon saving, the user returns to the Training page where the table is populated with a new entry designated by the “NEW” information status badge.

### Training

\*Indicates required information

**\*Have you received any type of specialized job, trade, or vocational training since your last disability decision of 07/25/2019?**

Yes  No

Status	Actions	Training Facility	<u>Program</u>
NEW	<a href="#">Review</a> <a href="#">Delete</a>	--	Electrical Engineering Workshop

[Add Training](#)

[Next](#) [Previous](#) [Save and Exit](#)



## 1.16. Education

The user is asked to list education that they received since the date of their last disability decision.

### Education

\*Indicates required information

**\*Have you received any education since your last disability decision of 07/25/2019?**

Yes  No

**Next** Previous Save and Exit

If the user selects “Yes,” a blank Education table will appear below.

### Education

\*Indicates required information

**\*Have you received any education since your last disability decision of 07/25/2019?**

Yes  No

Status	Actions	School	Program or Degree
No educational programs have been entered yet.			

Add Education

**Next** Previous Save and Exit

If the “Add Education” button is selected, the Education Details page will display.

### Education Details

**\*Indicates required information**

**Name of School**

---

**Address**

Country

Street Address  Apartment, Suite, Building, Etc.

City/Town  State/Territory   ZIP Code

---

**\*Type of Program or Degree**

---

**When did you start attending this program?**

Month   Year

I don't remember

---

**When did you complete or are scheduled to complete this program?**

Month   Year

I don't remember

---

Upon saving, the user returns to the Education page where the table is populated with a new entry designated by the “NEW” information status badge.

### Education

\*Indicates required information

**\*Have you received any education since your last disability decision of 07/25/2019?**

Yes  No

Status	Actions	School	Program or Degree
NEW	<a href="#">Review</a> <a href="#">Delete</a>	Lincoln School of Technology	Electrical Engineering

[Add Education](#)

[Next](#) [Previous](#) [Save and Exit](#)

## **1.17. Daily Activities**

The user must document details of their daily life as well as describe difficulty doing any of the activities listed.

## Daily Activities

\*Indicates required information

### \*Describe what you do in a typical day

Provide details of how you spend most of your days. Please focus on how your medical conditions affect your daily activities. (2000 characters maximum)

Characters remaining: 2000

### \*Do you have hobbies or interests?

Yes  No

### \*Do your medical conditions cause you to have difficulty doing any of the following?

Please select tasks that you need help with or have difficulty doing

<input type="checkbox"/> Dressing
<input type="checkbox"/> Bathing
<input type="checkbox"/> Caring for Hair
<input type="checkbox"/> Taking Medicines
<input type="checkbox"/> Preparing Meals
<input type="checkbox"/> Feeding Self
<input type="checkbox"/> Doing Chores (inside/outside house)
<input type="checkbox"/> Driving or Using Public Transportation
<input type="checkbox"/> Shopping
<input type="checkbox"/> Managing Money
<input type="checkbox"/> Walking
<input type="checkbox"/> Standing
<input type="checkbox"/> Lifting Objects
<input type="checkbox"/> Using Arms
<input type="checkbox"/> Using Hands or Fingers
<input type="checkbox"/> Sitting
<input type="checkbox"/> Seeing, Hearing, or Speaking
<input type="checkbox"/> Concentrating
<input type="checkbox"/> Remembering
<input type="checkbox"/> Understanding or Following Directions
<input type="checkbox"/> Getting Along with People
<input type="checkbox"/> None of these apply to me

[Next](#) [Previous](#) [Save and Exit](#)

If user selects 'Yes' to "Do you have hobbies or interests?" question, they have to describe hobbies and how much time they spend doing them.

**\*Do you have hobbies or interests?**

Yes  No

**\*Please describe what they are and how much time you spend doing them**  
(1000 characters maximum)

Characters remaining: 1000

Upon selecting one or several activities, the user will have to provide an explanation.

**\*Do your medical conditions cause you to have difficulty doing any of the following?**

Please select tasks that you need help with or have difficulty doing

<input checked="" type="checkbox"/> Dressing
<input checked="" type="checkbox"/> Bathing
<input type="checkbox"/> Caring for Hair
<input checked="" type="checkbox"/> Taking Medicines
<input type="checkbox"/> Preparing Meals
<input type="checkbox"/> Feeding Self
<input type="checkbox"/> Doing Chores (inside/outside house)
<input type="checkbox"/> Driving or Using Public Transportation
<input type="checkbox"/> Shopping
<input type="checkbox"/> Managing Money
<input checked="" type="checkbox"/> Standing
<input checked="" type="checkbox"/> Lifting Objects
<input type="checkbox"/> Using Arms
<input checked="" type="checkbox"/> Using Hands or Fingers
<input checked="" type="checkbox"/> Sitting
<input type="checkbox"/> Seeing, Hearing, or Speaking
<input type="checkbox"/> Concentrating
<input checked="" type="checkbox"/> Remembering
<input type="checkbox"/> Understanding or Following Directions
<input type="checkbox"/> Getting Along with People
<input type="checkbox"/> None of these apply to me

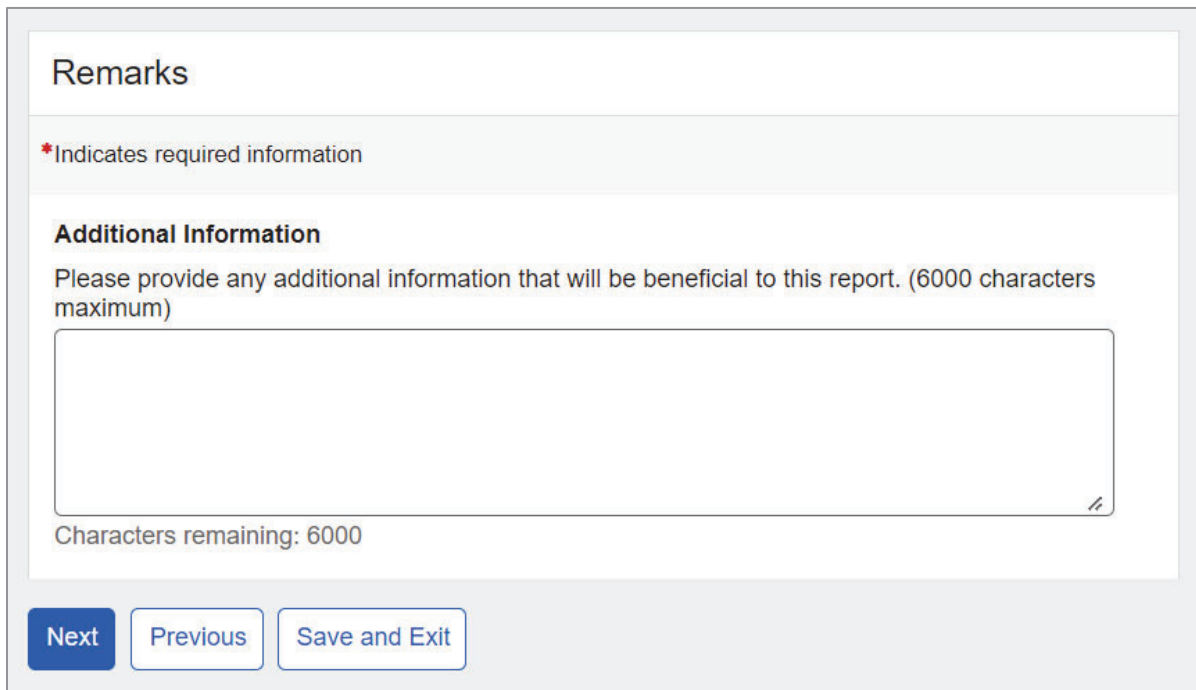
**\*Please explain anything you need help with or have difficulty doing**

(5000 characters maximum)

Characters remaining: 5000

## 1.18. Remarks

The user can provide additional information on the Remarks page.



Remarks

\*Indicates required information

**Additional Information**

Please provide any additional information that will be beneficial to this report. (6000 characters maximum)

Characters remaining: 6000

Next Previous Save and Exit

## 1.19. Summary

The user will be able to review all entered information on the Summary page.



## Continuing Disability Review Report

**i Please review the following information carefully.**

This page provides a summary of all information you entered. Please review your answers for accuracy. If you need to make any changes, please select 'Edit' to return to that part of the application.

By selecting 'Submit' at the end of this page, you agree to the release of your electronically signed Permission to Release Records.

### Summary

**✓ PERMISSION TO RELEASE RECORDS**

Do you agree to electronically sign your permission to release records to SSA?: **I agree to electronically sign the release form.**

**✓ INFORMATION ABOUT YOU**

[Edit](#)

In the last 12 months, have you used any other names on your medical or educational records?: **No**

Can you speak and understand English?: **Yes**

Can you read and understand English?: **Yes**

Can you write more than your name in English?: **Yes**

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

Can you read a simple message in the language you identified above?: **Yes**

Can you write a simple message in the language you identified above?: **Yes**

**✓ SOMEONE WE CAN CONTACT**

[Edit](#)

Is there someone we can contact who can help you with your case?: **Yes**

Contact's Name: **[REDACTED]**

Relationship to You: **Family Member**

Mailing Address: **[REDACTED] St, Beltsville Maryland 20705**

Phone Number: **(410) [REDACTED]**

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

**✓ MEDICAL CONDITIONS**

[Edit](#)

Medical Condition 1: **Arthritis**

Medical Condition 2: **Back pain**

What is your height? Feet: **5** Inches: **11**

What is your weight? Pounds: **190**

**✓ MEDICAL PROVIDERS**

[Edit](#)

**Medical Provider 1**

**Medical Provider 1**

Name of Facility or Office: **Centennial Medical Group**  
Name of Doctor or Healthcare Professional: [Redacted]  
Phone Number: (410) [Redacted]  
Address: [Redacted] **Way Lane, Laurel Maryland 20707**  
What medical conditions were treated or evaluated?: **Arthritis**  
When did you last see this provider in the last 12 months?: **November 2021**

**Medical Provider 2**

Name of Facility or Office: **Riverside Medical Center**  
Name of Doctor or Healthcare Professional: [Redacted]  
Phone Number: (410) [Redacted]  
Address: [Redacted] **riverside Drive, Laurel Maryland 20707**  
What medical conditions were treated or evaluated?: **Back pain**  
When did you last see this provider in the last 12 months?: **I don't remember**

**Medical Provider 3**

Name of Facility or Office: **Not Answered**  
Name of Doctor or Healthcare Professional: [Redacted]  
Phone Number: (410) [Redacted]  
Address: **Columbia Maryland**  
What medical conditions were treated or evaluated?: **arthritis and back injury**  
When did you last see this provider in the last 12 months?: **February 2022**

**TESTS**

[Edit](#)

In the last 12 months, have you had any medical tests ordered by your providers? Include tests scheduled for the future.: **Yes**

**Test 1**

Test Type: **X-Ray**  
Body Part: **full body**  
Ordered by: [Redacted]

**MEDICINES**

[Edit](#)

**Medicine 1**

Name of Medicine: **Cortizone**  
Reason for Medicine: **For pain**  
Prescribed by: [Redacted]

**Medicine 2**

Name of Medicine: **Aspirin**  
Reason for Medicine: **to help with joints pain in the fall and spring**  
Prescribed by: **No one**

**Medicine 3**

Name of Medicine: **Vitamin D3**  
Reason for Medicine: **To improve bone health**  
Prescribed by: [Redacted]

**ASSISTIVE DEVICES**

[Edit](#)

**✓ ASSISTIVE DEVICES** Edit

Do you use an assistive device?: **Yes**

**Assistive Device 1**

Name of Assistive Device: **Braces**  
How often do you use it?: **Sometimes**  
Prescribed by: **Marie Ann Hammond**

**✓ OTHER MEDICAL INFORMATION** Edit

Does anyone else (other than your medical providers) have medical information about your physical or mental health conditions? Include organizations you have seen in the last 12 months or have future appointments with.: **Yes**

**Organization 1**

Organization: **United Way of Central MD**  
Name of Contact Person: **Veronique Martin**  
Phone Number: **(410) 423-4500**  
Address: **500 E. 11th St., Ellicott City Maryland 21043**  
Claim Number (if any): **Not Answered**  
When did you last see this provider in the last 12 months?: **I don't remember**  
Reasons for Contact: **Not Answered**

**✓ WORK** Edit

Have you worked since your last disability decision of 07/25/2019?: **Yes**  
What type of wages have you received or are still receiving?: **Wages from employer**  
Are you currently working?: **No**

**✓ SUPPORT SERVICES** Edit

Since your last medical disability decision of 07/25/2019, have you participated or are you participating in any vocational rehabilitation, employment, or other support services to help you return to work?: **Yes**

**Plan or Program 1**

Name of Plan or Program: **Division of Rehabilitation Services**  
Name of Counselor, Instructor, or Job Coach: **Tom Roman**  
Phone Number: **(301) 436-4040**  
Address: **Not Answered**  
When did you start participating in the plan or program?: **March 2022**  
Are you still participating in the plan or program?: **Yes, I am scheduled to complete it**  
Date to be Completed: **May 2022**  
What types of services, tests, or evaluations were provided?: **Work Evaluation**

**✓ TRAINING** Edit

**✓ TRAINING** Edit

Have you received any type of specialized job, trade, or vocational training since your last disability decision of 07/25/2019?: **Yes**

**Training 1**

---

Name of Training Facility: **Not Answered**

Phone Number: **(443) [REDACTED]**

Address: **[REDACTED] Gateway Drive, Suite 100, Columbia MD 21046**

Type of Program or Degree: **Electrical Engineering Workshop**

When did you complete or are scheduled to complete this program?: **I don't remember**

**✓ EDUCATION** Edit

Have you received any education since your last disability decision of 07/25/2019?: **Yes**

**Education 1**

---

Name of School: **Lincoln School of Technology**

Address: **[REDACTED] River Pkwy, Columbia MD 21046**

Type of Program or Degree: **Electrical and Electronic Systems Technology**

When did you start attending this program?: **July 2021**

When did you complete or are scheduled to complete this program?: **I don't remember**

**✓ DAILY ACTIVITIES** Edit

Describe what you do in a typical day: **Most days I get up around noon because my pain really bothers me. I watch news, rest, make a frozen dinner.**

Do you have hobbies or interests?: **Yes**

Please describe what they are and how much time you spend doing them: **I like to read but sometimes it is difficult to focus.**

Do your medical conditions cause you to have difficulty doing any of the following?: **Preparing Meals, Doing Chores (inside/outside house), Standing**

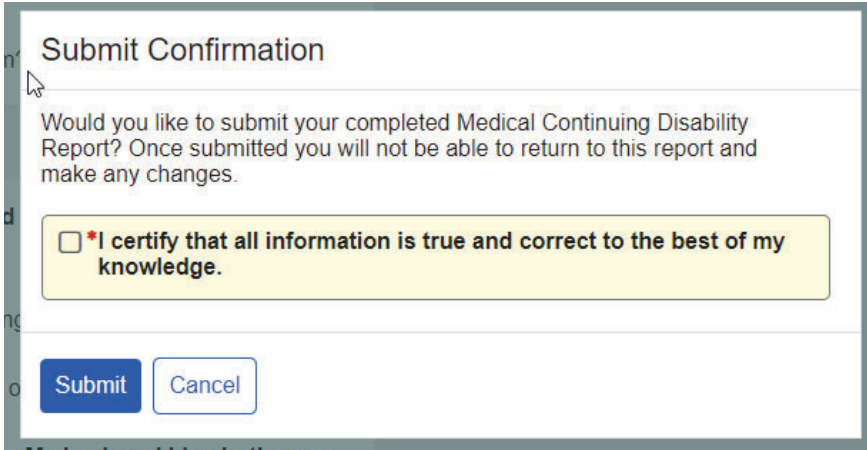
Please select tasks that you need help with or have difficulty doing: **My back and hips bother me when standing for too long or doing chores like vacuuming.**

**✓ REMARKS** Edit

Additional Information: **Not Answered**

**Submit** Previous Save and Exit

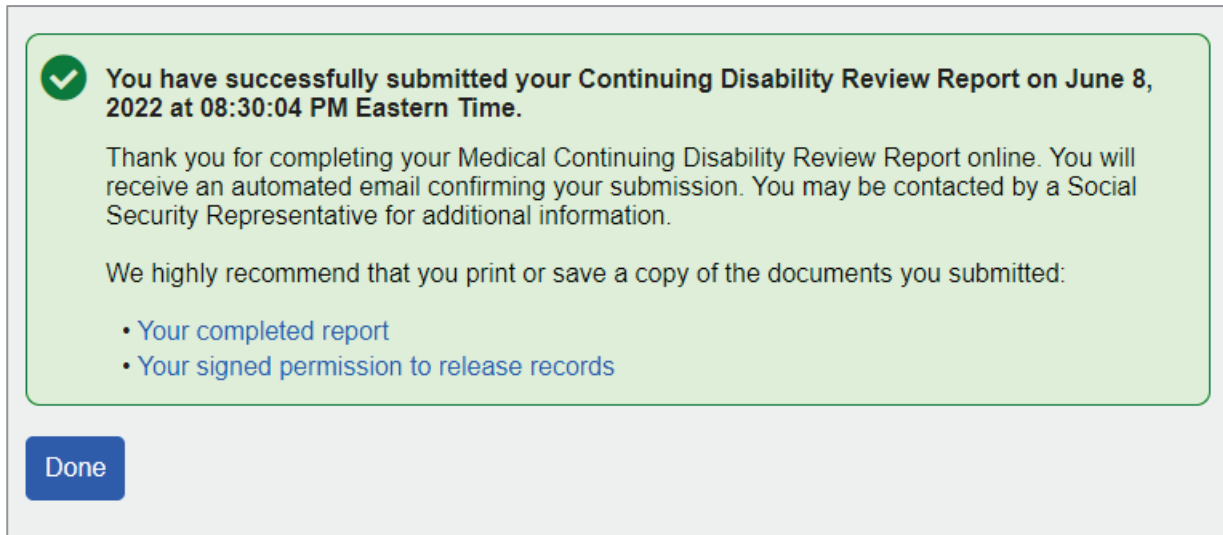
Upon pressing the “Submit” button on the Summary page, the confirmation message will display, where user must acknowledge that all information provided is true and correct.



The image shows a 'Submit Confirmation' dialog box. It has a title bar with the text 'Submit Confirmation'. Below the title bar is a message: 'Would you like to submit your completed Medical Continuing Disability Report? Once submitted you will not be able to return to this report and make any changes.' Below the message is a yellow highlighted box containing a checkbox and the text '\*I certify that all information is true and correct to the best of my knowledge.' At the bottom of the dialog box are two buttons: 'Submit' (a solid blue button) and 'Cancel' (a white button with a blue border).

## 1.20. Receipt

Once submitted, the user will be taken to the Receipt page where they can print and/or download/save their completed continuing disability review report as well as their electronically signed permission to release records.

A screenshot of a receipt confirmation screen. It features a light green rounded rectangular box containing a green checkmark icon, a bold confirmation message with a timestamp, a thank-you message, a recommendation to print or save documents, and a bulleted list of submitted items. Below the green box is a blue button labeled "Done".

**✓ You have successfully submitted your Continuing Disability Review Report on June 8, 2022 at 08:30:04 PM Eastern Time.**

Thank you for completing your Medical Continuing Disability Review Report online. You will receive an automated email confirming your submission. You may be contacted by a Social Security Representative for additional information.

We highly recommend that you print or save a copy of the documents you submitted:

- Your completed report
- Your signed permission to release records

Done

Upon clicking “Done,” the user will be taken to their mySSA homepage. The option to access their Continuing Disability Review will no longer be available.

The receipt, which is a read-only copy of the Summary, is shown below.

### Continuing Disability Review Report for John Smith ✕

[Print](#) [Save](#)

✓ Your information was received on June 8, 2022 at 08:30:04 PM Eastern Time.

#### PERMISSION TO RELEASE RECORDS

Do you agree to electronically sign your permission to release records to SSA?: **I agree to electronically sign the release form.**

#### INFORMATION ABOUT YOU

In the last 12 months, have you used any other names on your medical or educational records?: **No**

Can you speak and understand English?: **Yes**  
Can you read and understand English?: **Yes**  
Can you write more than your name in English?: **Yes**

What written language do you use every day in most situations (at home, work, school, in community, etc.): **German**  
Can you read a simple message in the language you identified above?: **Yes**  
Can you write a simple message in the language you identified above?: **Yes**

#### SOMEONE WE CAN CONTACT

Is there someone we can contact who can help you with your case?: **Yes**  
Contact's Name: [REDACTED]  
Relationship to You: **Family Member**  
Mailing Address: [REDACTED] **Street, Beltsville Maryland 20705**  
Phone Number: (410) [REDACTED]  
Can this person speak and understand English?: **Yes**

#### MEDICAL CONDITIONS

Medical Condition 1: **Arthritis**  
Medical Condition 2: **Back pain**

What is your height? Feet: **5** Inches: **11**  
What is your weight? Pounds: **190**

#### MEDICAL PROVIDERS

Medical Provider 1

**Medical Provider 1**

---

Name of Facility or Office: **Centennial Medical Group**  
Name of Doctor or Healthcare Professional: [REDACTED]  
Phone Number: (410) [REDACTED]  
Address: 4 [REDACTED] Lane, Laurel Maryland 20707  
What medical conditions were treated or evaluated?: **Arthritis**  
When did you last see this provider in the last 12 months?: **November 2021**

**Medical Provider 2**

---

Name of Facility or Office: **Riverside Medical Center**  
Name of Doctor or Healthcare Professional: [REDACTED]  
Phone Number: (410) [REDACTED]  
Address: [REDACTED] Drive, Laurel Maryland 20707  
What medical conditions were treated or evaluated?: **Back pain**  
When did you last see this provider in the last 12 months?: **I don't remember**

**Medical Provider 3**

---

Name of Facility or Office: **Not Answered**  
Name of Doctor or Healthcare Professional: [REDACTED]  
Phone Number: (410) [REDACTED]  
Address: **Columbia Maryland**  
What medical conditions were treated or evaluated?: **arthritis and back injury**  
When did you last see this provider in the last 12 months?: **February 2022**

**TESTS**

In the last 12 months, have you had any medical tests ordered by your providers? Include tests scheduled for the future.: **Yes**

**Test 1**

---

Test Type: **X-Ray**  
Body Part: **full body**  
Ordered by: [REDACTED]

**MEDICINES**

**Medicine 1**

---

Name of Medicine: **Cortizone**  
Reason for Medicine: **For pain**  
Prescribed by: [REDACTED]

**Medicine 2**

---

Name of Medicine: **Aspirin**  
Reason for Medicine: **to help with joints pain in the fall and spring**  
Prescribed by: **No one**

**Medicine 3**

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Name of Medicine: **Vitamin D3**  
Reason for Medicine: **To improve bone health**  
Prescribed by: [REDACTED]

**ASSISTIVE DEVICES**



**ASSISTIVE DEVICES**

Do you use an assistive device?: **Yes**

**Assistive Device 1**

Name of Assistive Device: **Braces**

How often do you use it?: **Sometimes**

Prescribed by: [REDACTED]

**OTHER MEDICAL INFORMATION**

Does anyone else (other than your medical providers) have medical information about your physical or mental health conditions? Include organizations you have seen in the last 12 months or have future appointments with.: **Yes**

**Organization 1**

Organization: **United Way of Central MD**

Name of Contact Person: [REDACTED]

Phone Number: **(410)** [REDACTED]

Address: [REDACTED] **ilicot City Maryland 21043**

Claim Number (if any): **Not Answered**

When did you last see this provider in the last 12 months?: **I don't remember**

Reasons for Contact: **Not Answered**

**WORK**

Have you worked since your last disability decision of 07/25/2019?: **Yes**

What type of wages have you received or are still receiving?: **Wages from employer**

Are you currently working?: **No**

**SUPPORT SERVICES**

Since your last medical disability decision of 07/25/2019, have you participated or are you participating in any vocational rehabilitation, employment, or other support services to help you return to work?: **Yes**

**Plan or Program 1**

Name of Plan or Program: **Division of Rehabilitation Services**

Name of Counselor, Instructor, or Job Coach: [REDACTED]

Phone Number: **(301)** [REDACTED]

Address: **Not Answered**

When did you start participating in the plan or program?: **March 2022**

Are you still participating in the plan or program?: **Yes, I am scheduled to complete it**

Date to be Completed: **May 2022**

What types of services, tests, or evaluations were provided?: **Work Evaluation**

**TRAINING**

**TRAINING**

Have you received any type of specialized job, trade, or vocational training since your last disability decision of 07/25/2019?: **Yes**

**Training 1**

Name of Training Facility: **Not Answered**

Phone Number: (443) [REDACTED]

Address: [REDACTED] Gateway Drive, Suite 100, Columbia MD 21046

Type of Program or Degree: **Electrical Engineering Workshop**

When did you complete or are scheduled to complete this program?: **I don't remember**

**EDUCATION**

Have you received any education since your last disability decision of 07/25/2019?: **Yes**

**Education 1**

Name of School: **Lincoln School of Technology**

Address: [REDACTED] River Pkwy, Columbia MD 21046

Type of Program or Degree: **Electrical and Electronic Systems Technology**

When did you start attending this program?: **July 2021**

When did you complete or are scheduled to complete this program?: **I don't remember**

**DAILY ACTIVITIES**

Describe what you do in a typical day: **Most days I get up around noon because my pain really bothers me. I watch news, rest, make a frozen dinner.**

Do you have hobbies or interests?: **Yes**

Please describe what they are and how much time you spend doing them: **I like to read but sometimes it is difficult to focus.**

Do your medical conditions cause you to have difficulty doing any of the following?: **Preparing Meals, Doing Chores (inside/outside house), Standing**

Please select tasks that you need help with or have difficulty doing: **My back and hips bother me when standing for too long or doing chores like vacuuming.**

**REMARKS**

Additional Information: **Not Answered**