EDCS SSA-454 Form updates to EDCS screens

SSA-454 Child form

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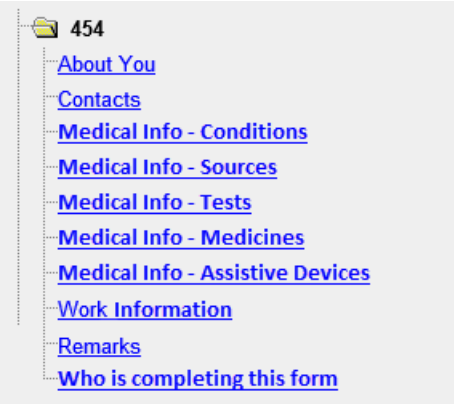
Background

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.

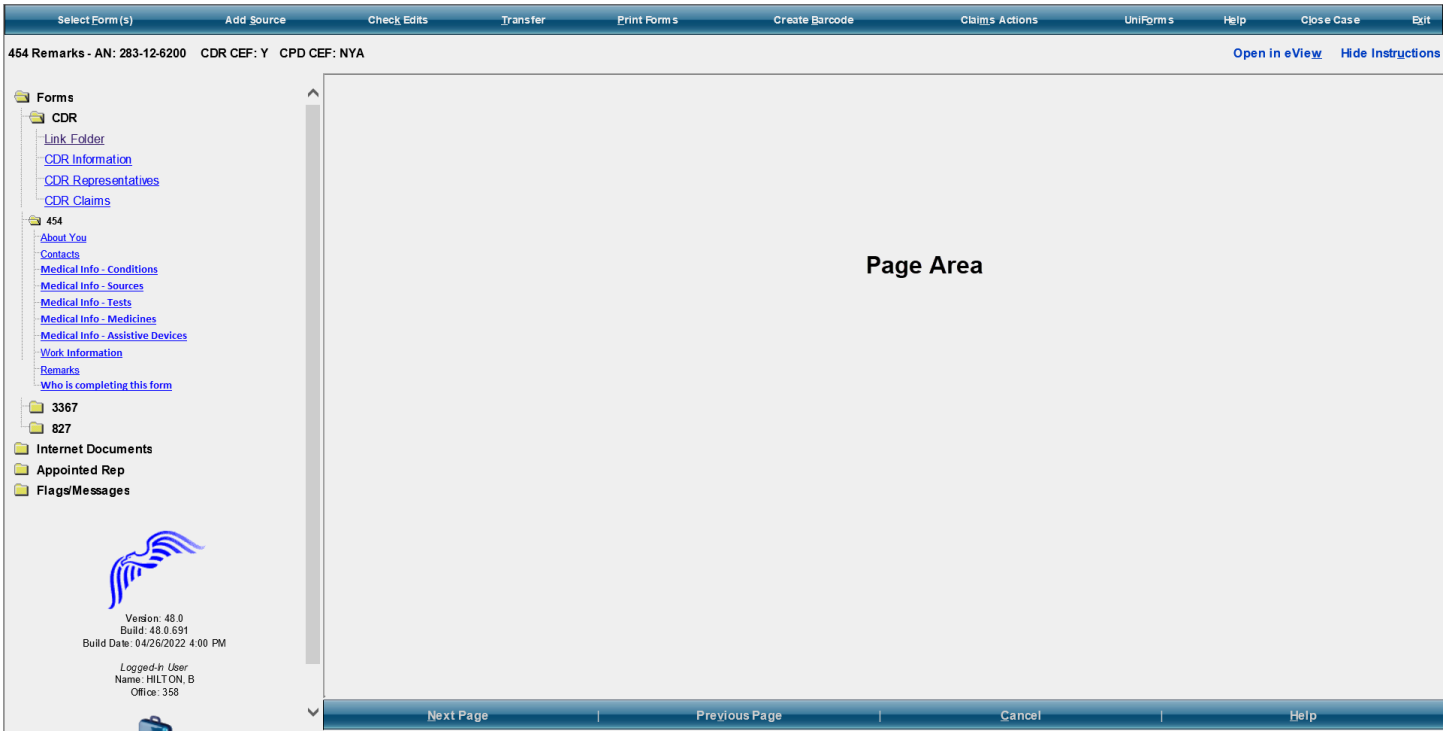
SSA - 454 Layout and Navigation

454 Left Navigation- used for all EDCS 454 pages



EDCS Frame

This screenshot shows the layout of all EDCS pages.

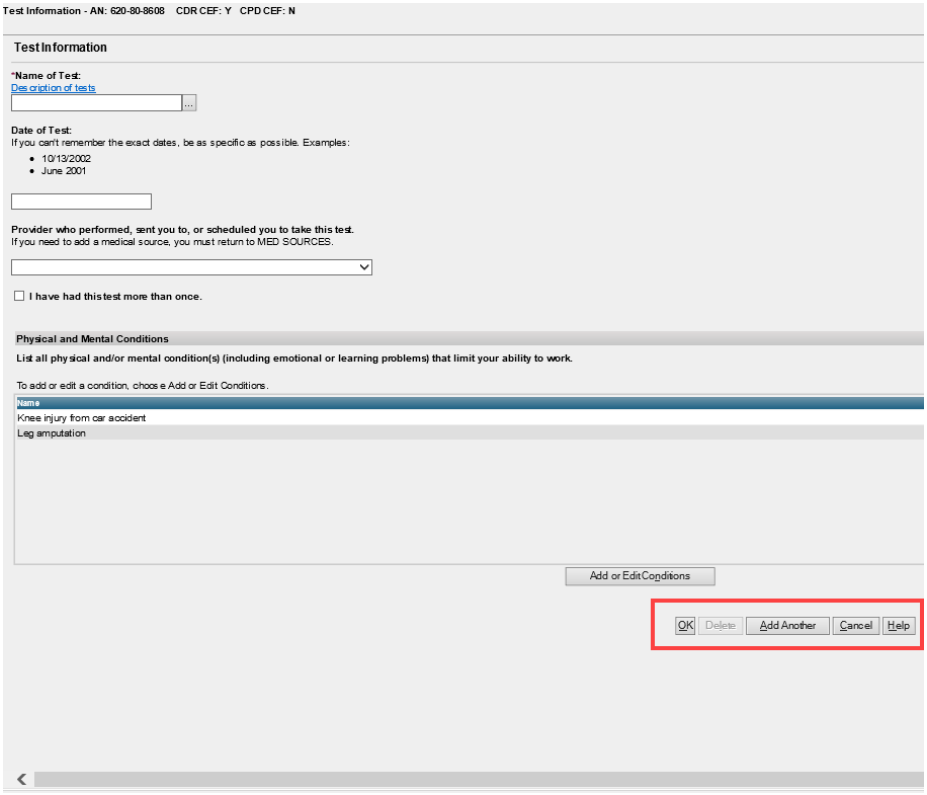


Things to note:

- 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 Child 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

Secondary telephone number: Ext:

E-mail address:

The Child's Language Information

Can the child 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 does the child prefer?

Can the child read and understand English?

◉ Yes ○ No ○ Not yet answered

Can the child write more than their name in English?

◉ Yes ○ No ○ Not yet answered

Other Names Used

In the last 12 months, has the child used any other names on his or her medical or educational records?

Examples are maiden name, other married name, or nickname

○ Yes ◉ No ○ Not yet answered

SSA - 454 Section 2 – Contacts

454 Someone we can Contact

Alternate Contact Information

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

(•) Yes ( ) No ( ) Not yet answered

Please give the name of a friend or relative (other than your doctors) we can contact who knows about the child's medical conditions, and can help with the child's case. Examples include a family member, friend, or neighbor.

Name of Alternate Contact

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

Relationship to Child: Grandparent

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

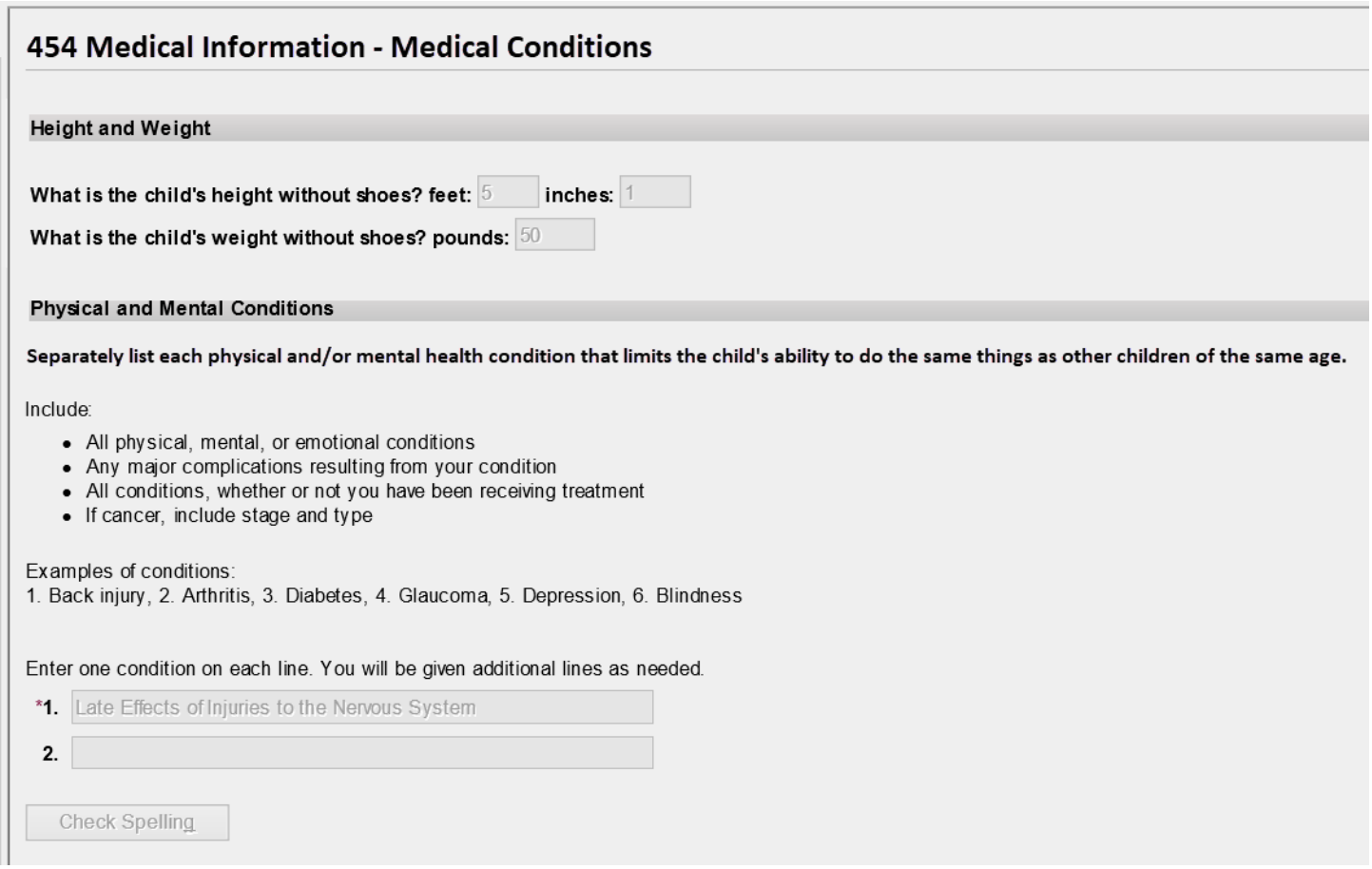
Daytime telephone number: (999-999-9999) [redacted] Ext:

Preferred Language of Alternate Contact

Can this person speak and understand English?

(•) Yes ( ) No ( ) Not yet answered

SSA - 454 Section 3 – Medical Info – Conditions



454 Medical Information - Medical Conditions

Height and Weight

What is the child's height without shoes? feet: 5 **inches:** 1

What is the child's weight without shoes? pounds: 50

Physical and Mental Conditions

Separately list each physical and/or mental health condition that limits the child's ability to do the same things as other children of the same age.

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.

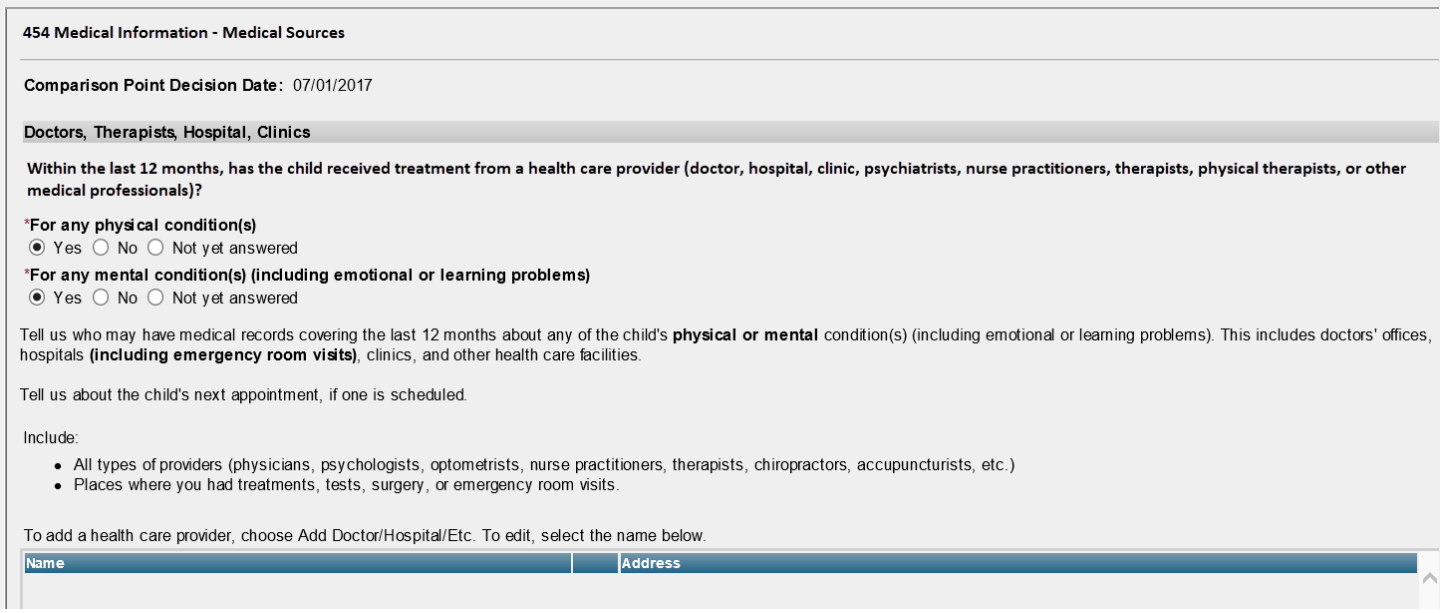
*1. Late Effects of Injuries to the Nervous System

2.

Check Spelling

SSA - 454 Section 3 – Medical Info – Sources

Medical Sources Summary



454 Medical Information - Medical Sources

Comparison Point Decision Date: 07/01/2017

Doctors, Therapists, Hospital, Clinics

Within the last 12 months, has the child received treatment from a health care provider (doctor, hospital, clinic, psychiatrists, nurse practitioners, therapists, physical therapists, or other medical professionals)?

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

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

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

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

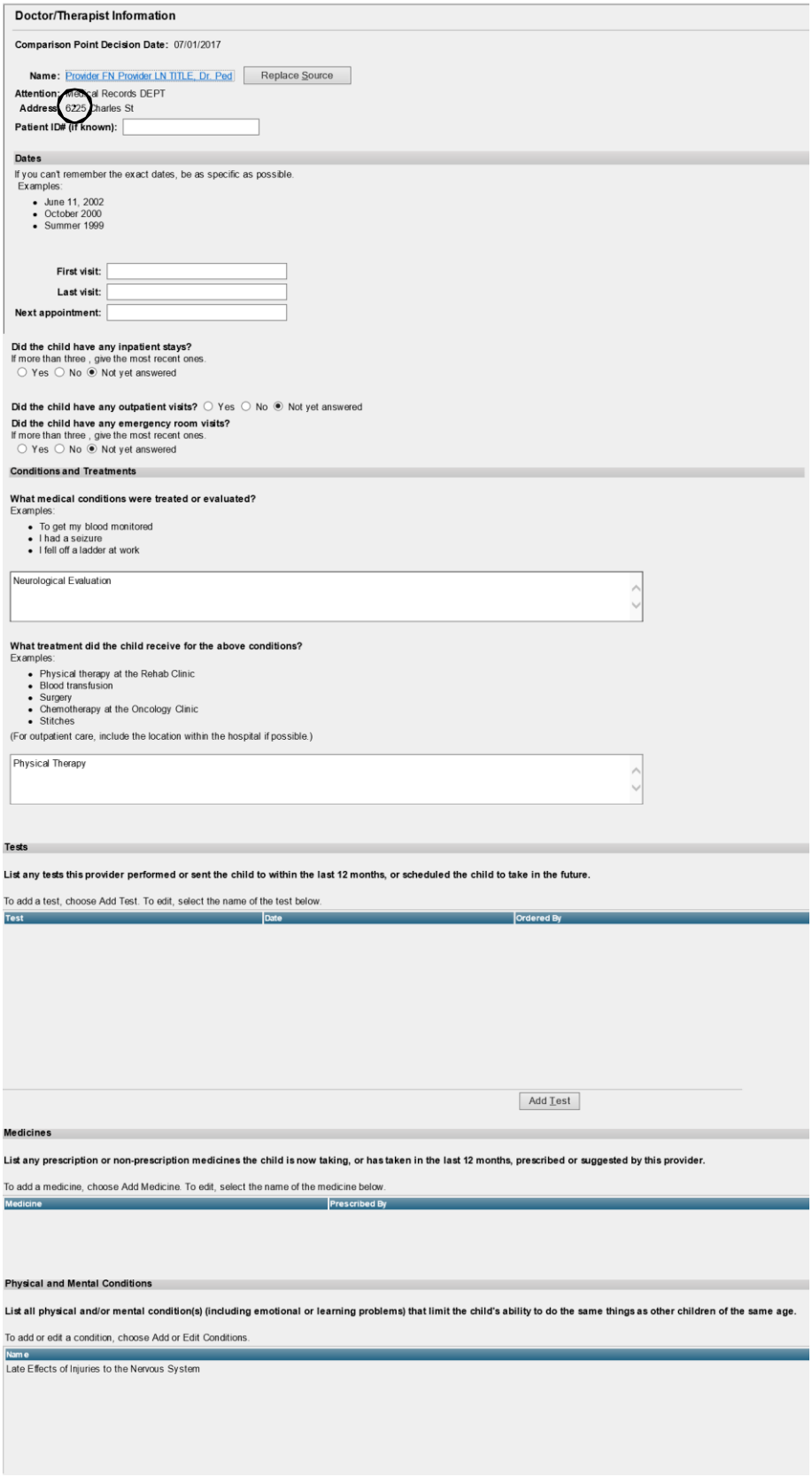
Include:

- 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

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



Doctor/Therapist Information

Comparison Point Decision Date: 07/01/2017

Name: Provider FN Provider LN TITLE, Dr. Ped Replace Source

Attention: Medical Records DEPT

Address: 6225 Charles St

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:

Last visit:

Next appointment:

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

Did the child have any outpatient visits? ○ Yes ○ No ◉ Not yet answered

Did the child 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

Neurological Evaluation

What treatment did the child 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.)

Physical Therapy

Tests

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

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

Test	Date	Ordered By

Add Test

Medicines

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

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

Medicine	Prescribed By

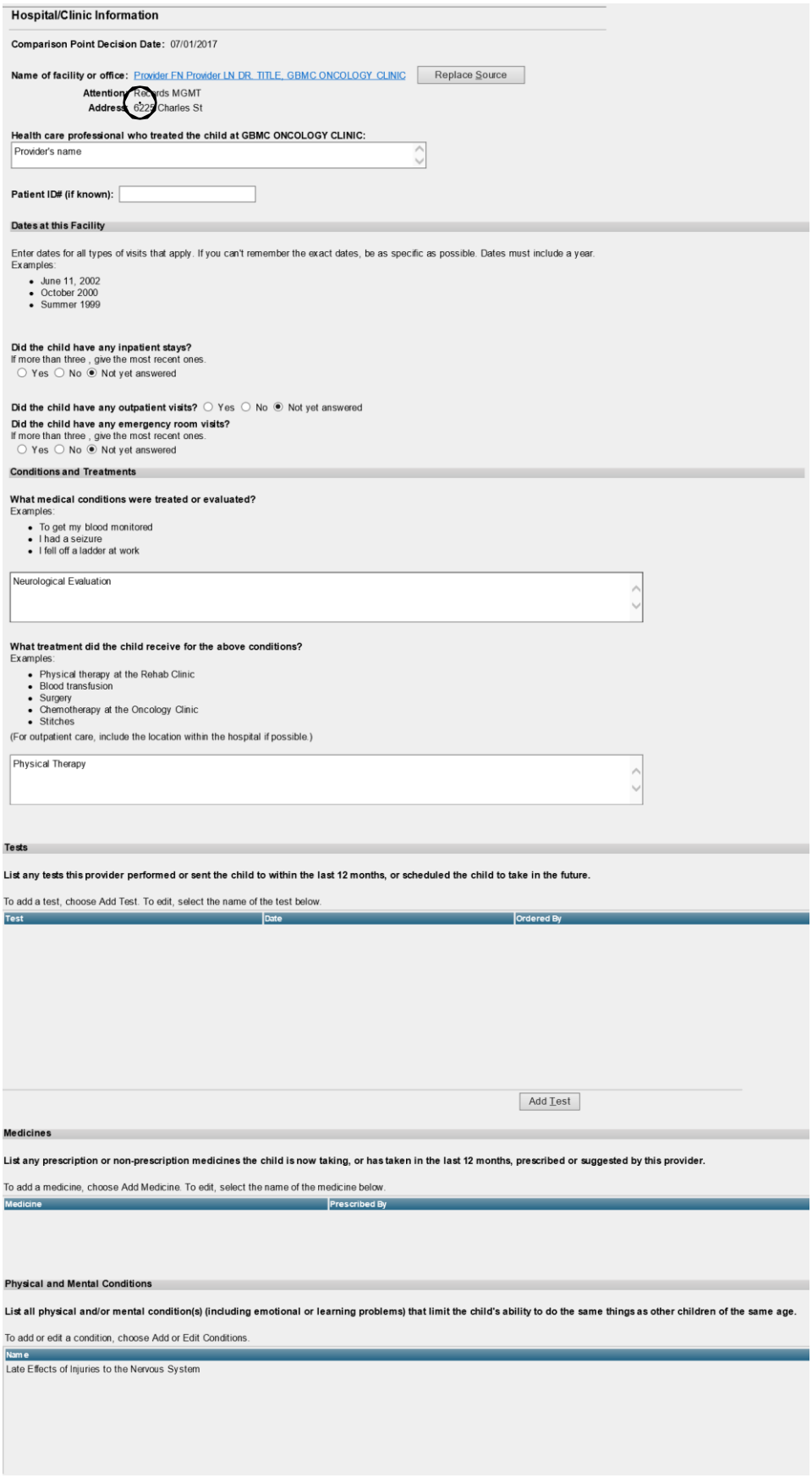
Physical and Mental Conditions

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

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

Name
Late Effects of Injuries to the Nervous System

Medical sources – Hospital/Clinic Information



Hospital/Clinic Information

Comparison Point Decision Date: 07/01/2017

Name of facility or office: Provider FN Provider LN DR. TITLE, GBMC ONCOLOGY CLINIC — Replace Source

Attention: Records MGMT
Address: 6225 Charles St

Health care professional who treated the child at GBMC ONCOLOGY CLINIC:

Provider's name

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

Did the child have any outpatient visits? ○ Yes ○ No ◉ Not yet answered

Did the child 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

Neurological Evaluation

What treatment did the child 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.)

Physical Therapy

Tests

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

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

Test	Date	Ordered By

Add Test

Medicines

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

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

Medicine	Prescribed By

Physical and Mental Conditions

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

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

Name
Late Effects of Injuries to the Nervous System

SSA- - 454 Section 3 – Medical Info – Tests

Test Summary

454 Tests Summary

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

(•) Yes ( ) No ( ) Not yet answered

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

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

Test	Date	Ordered By
IQ testing	Nov 2021	Other medical professional
Speech/Language	Oct 2021	Provider LN, Provider FN TITLE, Dr. Ped

Add Test

Tests detail

Test Information

***Name of Test:**
Description of tests

...

- Biopsy
- Blood test (Not HIV)
- Breathing test
- Cardiac catheterization
- EEG (Brain wave test)
- EKG (Heart test)
- Hearing Test
- MRI/CT Scan
- Psychological/IQ Test
- Speech/Language
- Treadmill (Exercise test)
- Vision test
- X-Ray

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

- 10/13/2002
- June 2001

Add a description of the test/body part tested:

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

[ ] **I have had this test more than once.**

Physical and Mental Conditions

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

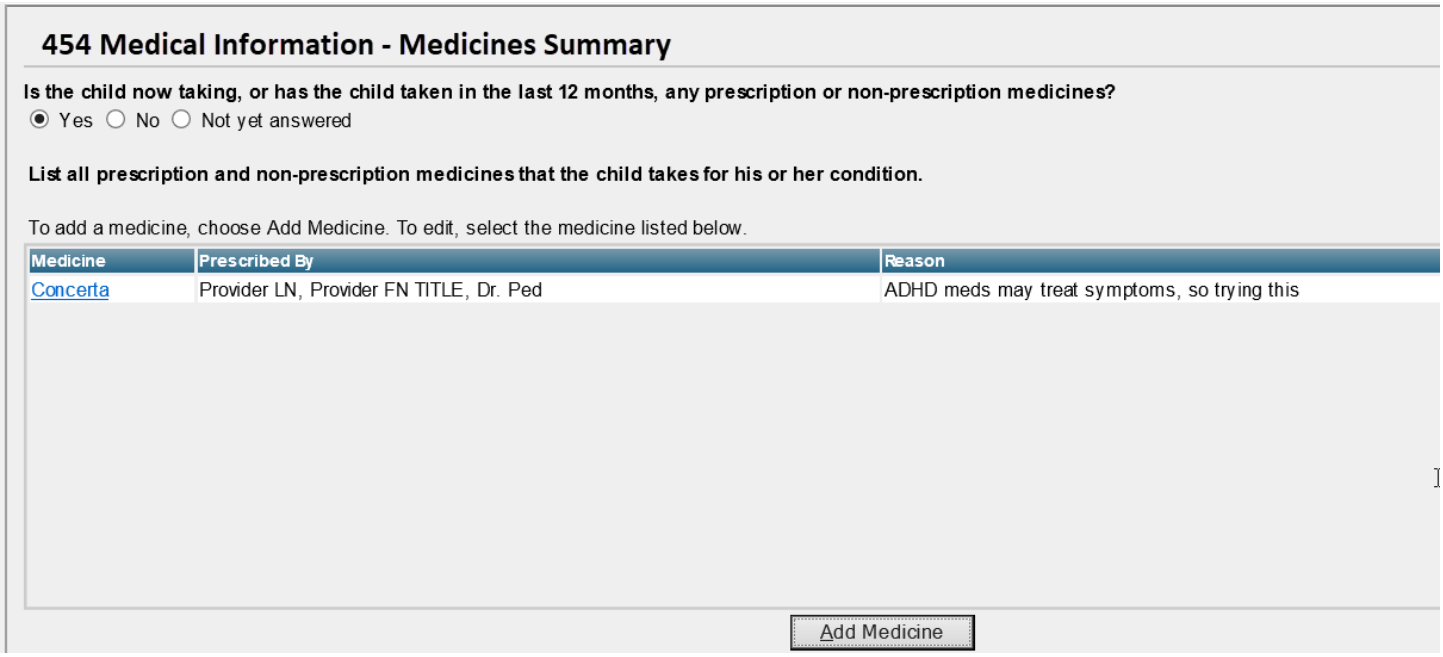
To add or edit a condition, choose Add or Edit Conditions.

Name
Late Effects of Injuries to the Nervous System

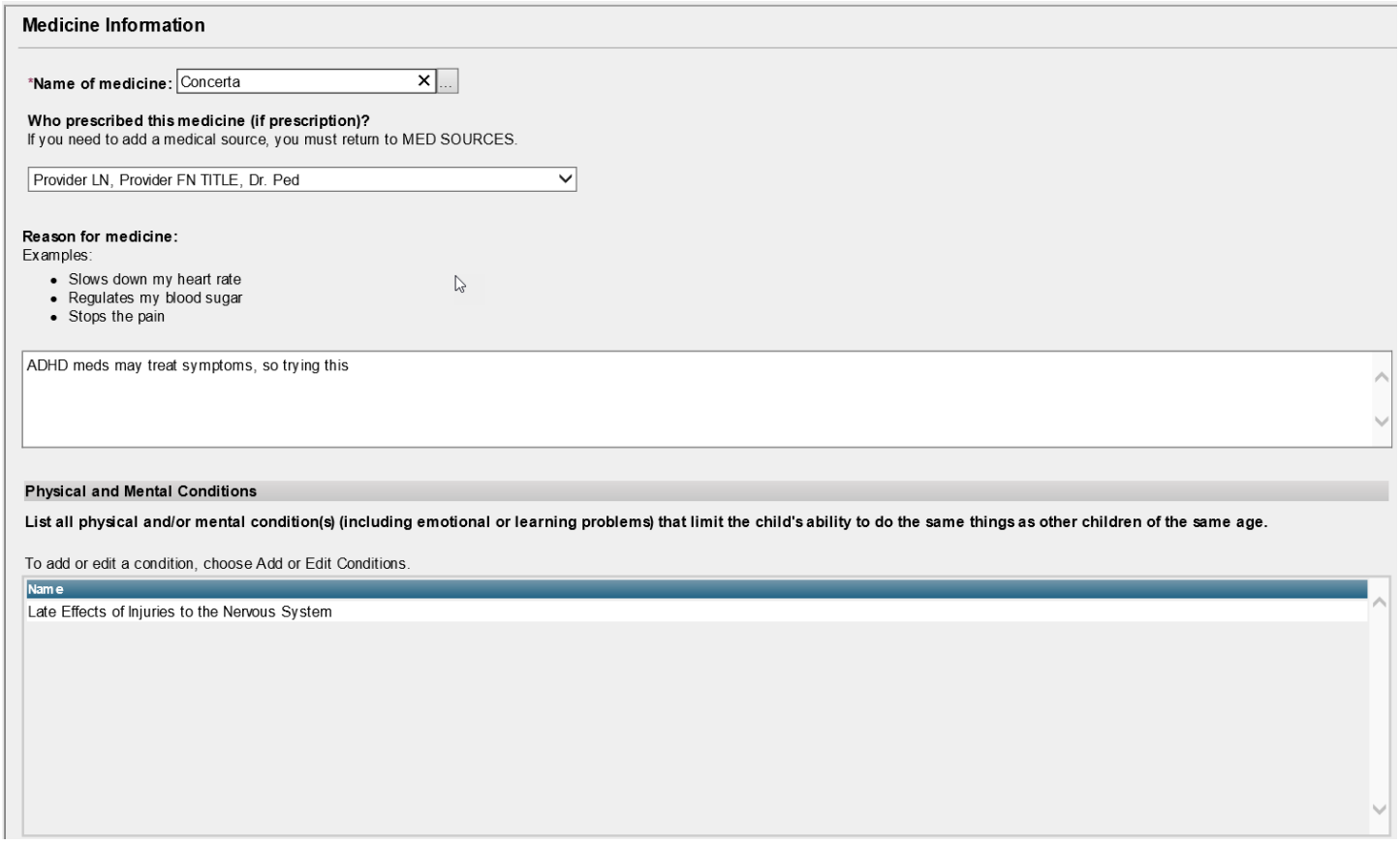
Add or Edit Conditions

SSA - 454 Section 3 – Medical Info – Medicines

Medicines Summary

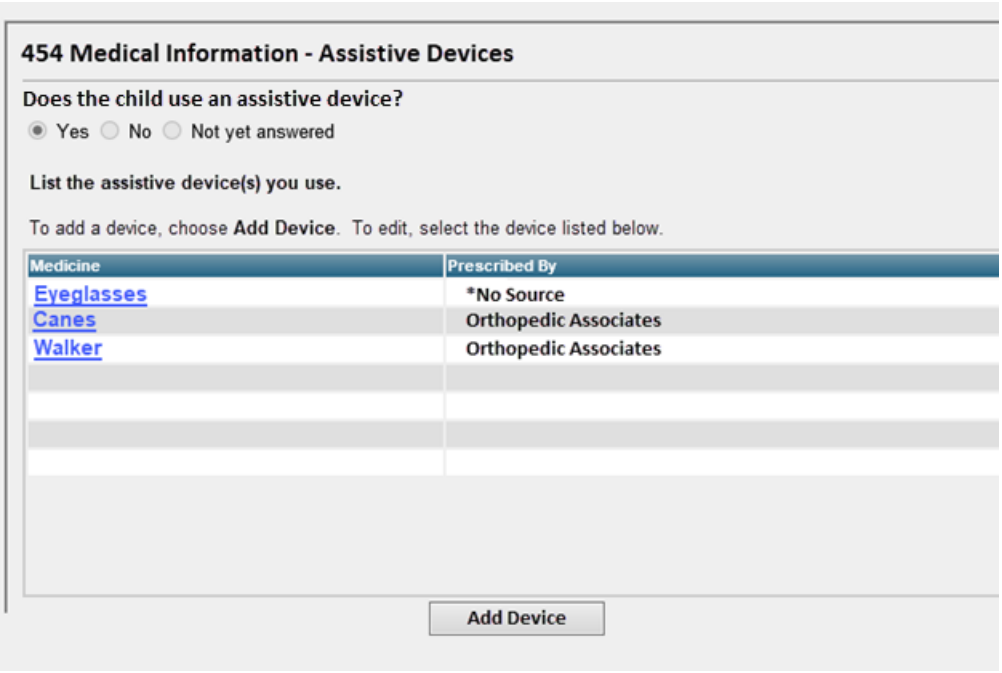


Medicines Detail (no edits)

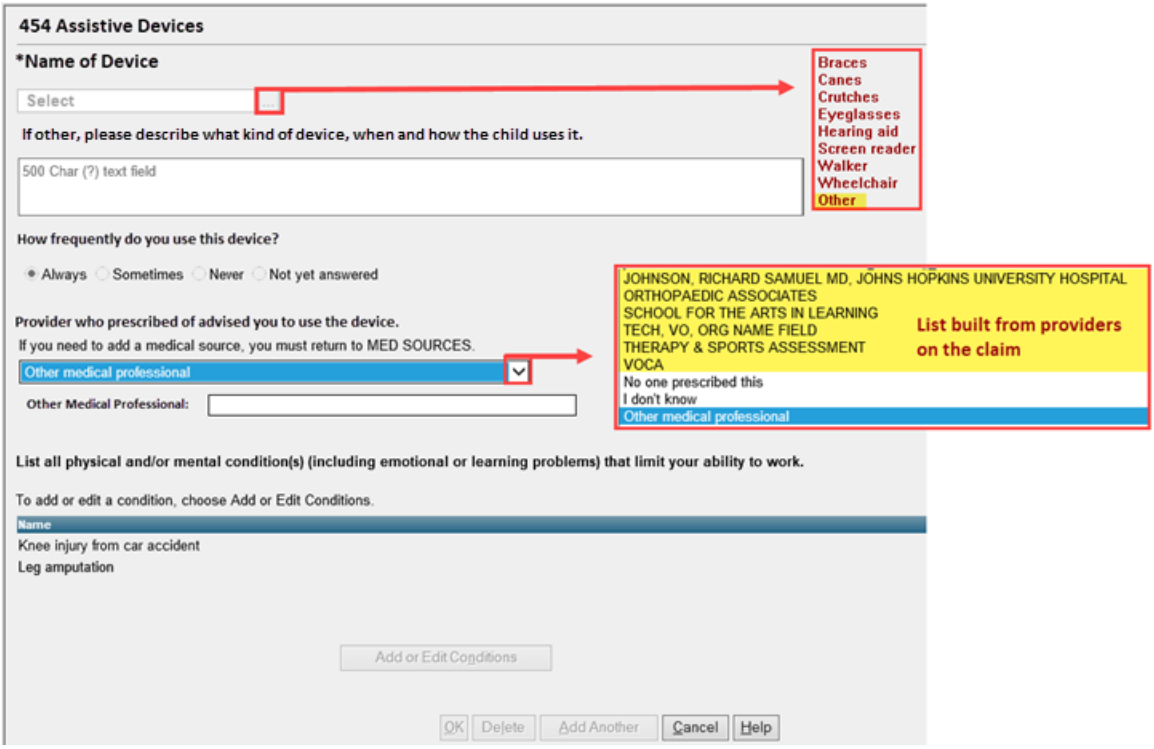


SSA - 454 Section 3 – Medical Info – Assistive Devices

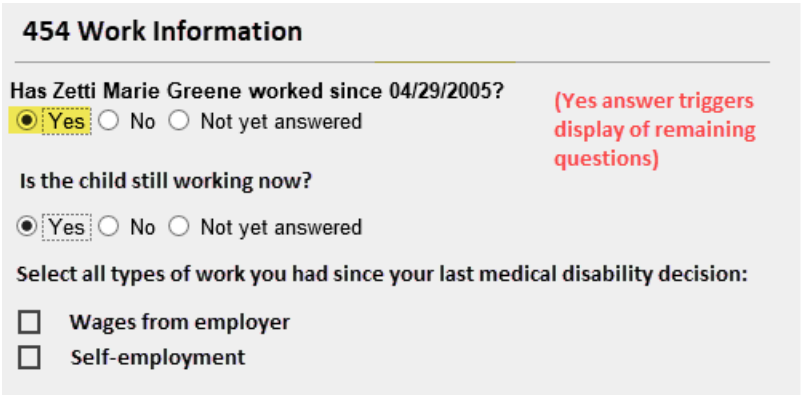
Assistive Devices Summary (new)



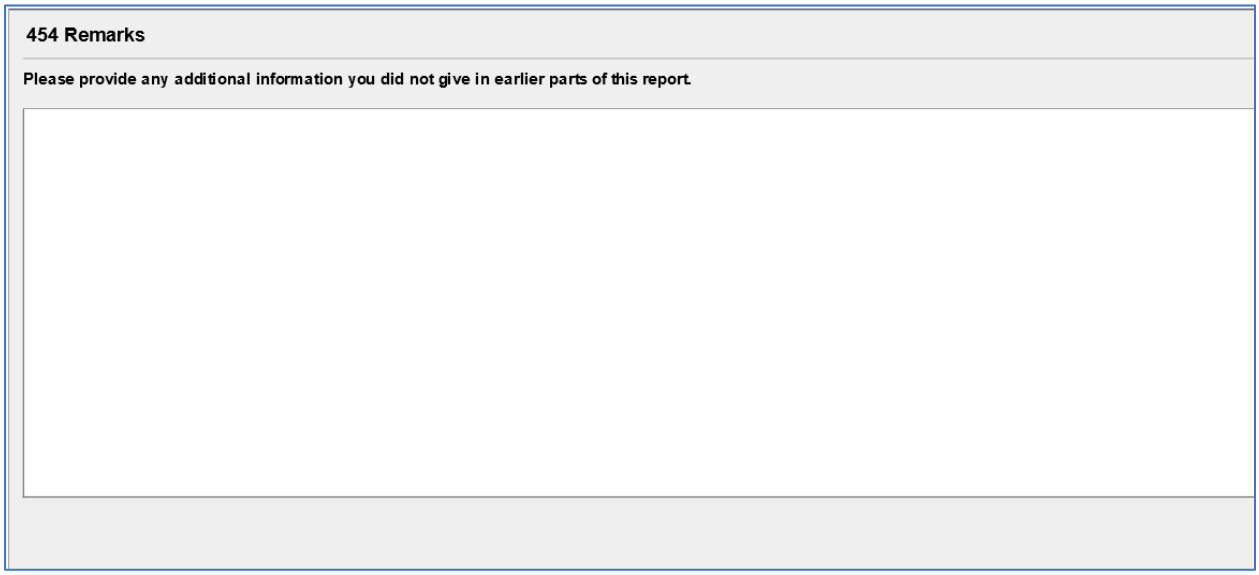
Assistive Devices Detail (new)



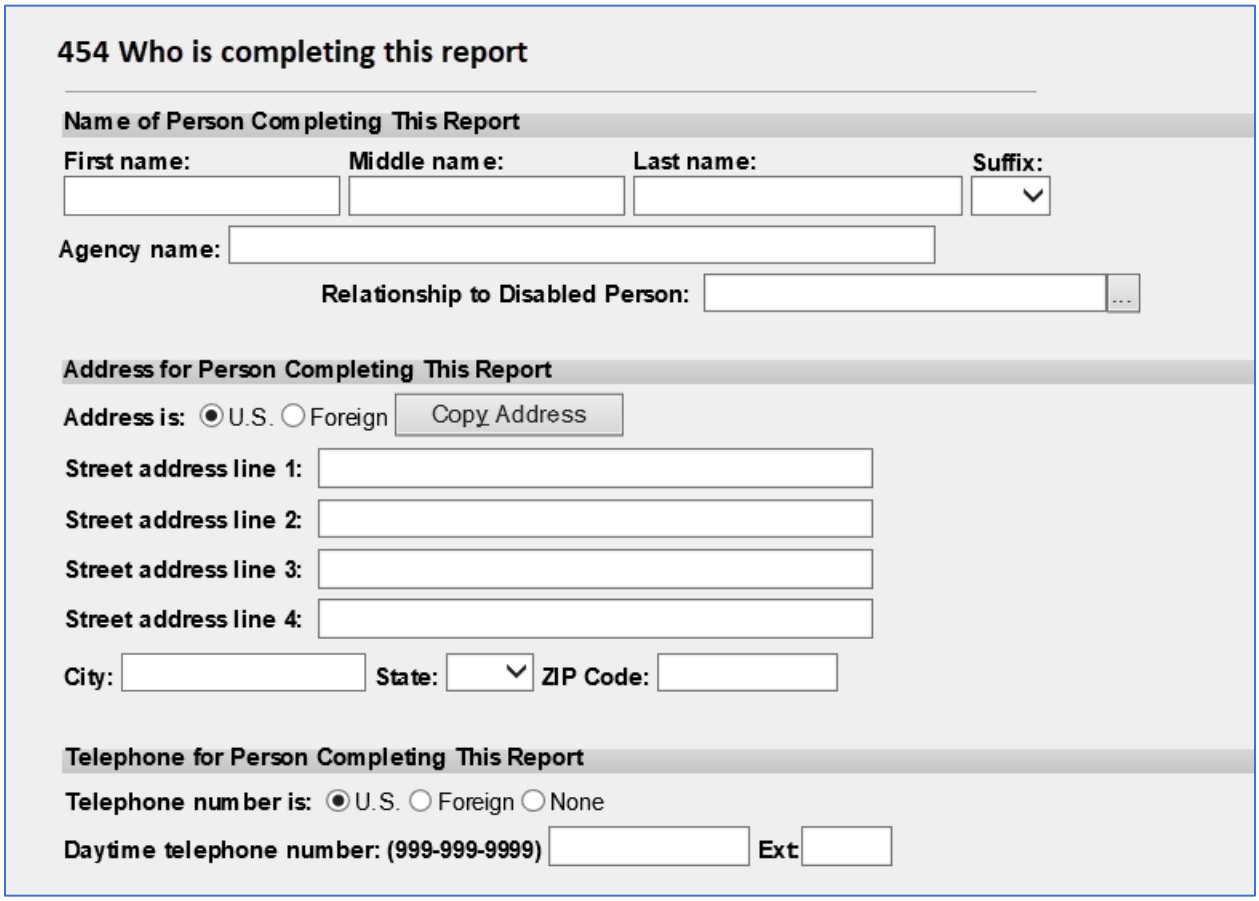
SSA - 454 Section 4 – Work



SSA - 454 Section 9 – Remarks



SSA - 454 Section 10 – Who is completing this form



454 Who is completing this report

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: