SCREEN PACKAGE DOCUMENT

MEDICAL CONTINUING DISABILITY REVIEW APPLICATION OR I454

1. Screen Designs and Component Descriptions

1.1. My Social Security Landing Page

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

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

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.

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.

1.3.   Save and Exit

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

Save and Exit

The following confirmation message will display.

Save and Exit Confirmation

🛑 **You may return and continue where you left off.** Please submit your review on time to ensure your benefits are not interrupted.

Are you sure you want to save and exit?

Save and Exit   Cancel

cation records as well
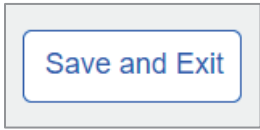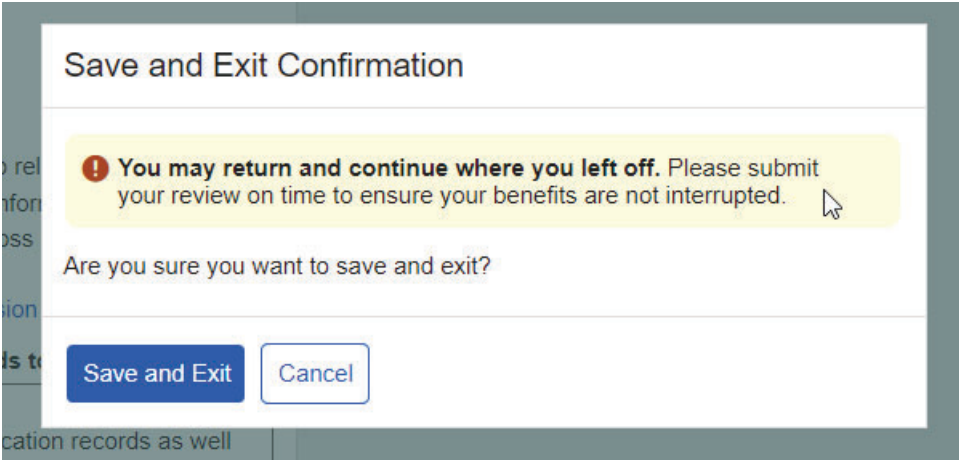
1.4. Instructions

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

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

[   ] [   ] [   ] [-- ▾]

➕ 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.

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.)?

Other ⌄

*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

[United States or U.S. Territory ▾]

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

[Next] [Previous] [Save and Exit]

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

*Relationship to You

-- ▼

--
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
Other

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

*Relationship to You

Other ▼

*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.

*Can this person speak and understand English?

○ Yes   ⦿ No

*What language do they prefer?

Spanish ▼

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

*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

[Feet, Inches ▾]   [   ]   [   ]

What is your weight?

Measurement Unit   Pounds

[Pounds   ▾]   [   ]

[Next]   [Previous]   [Save and Exit]

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.

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

Centennial Medical Group

Name of Doctor or Healthcare Professional

First	Middle	Last	Suffix
Mario	Ann	Hammond	-- ⌄

Phone Number

◉ U.S.   ○ International

*10-digit Number   Ext.

(410) 454-1012

Address

Country

United States or U.S. Territory ⌄

Street Address	Apartment, Suite, Building, Etc.
4500 Red Clay Lane	

City/Town	State/Territory	ZIP Code
Laurel	Maryland ⌄	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
-- ⌄	

☐ I don't remember

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

[Save] [Cancel]

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	Review Delete	Centennial Medical Group	Hammond, Marie Ann
NEEDS REVIEW	Review Delete	Riverside Medical Center	Sikorsky, Mark P.
NEEDS REVIEW	Review Delete	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.

Delete Medical Provider

Are you sure you want to delete Holy Cross Hospital?

Delete   Cancel
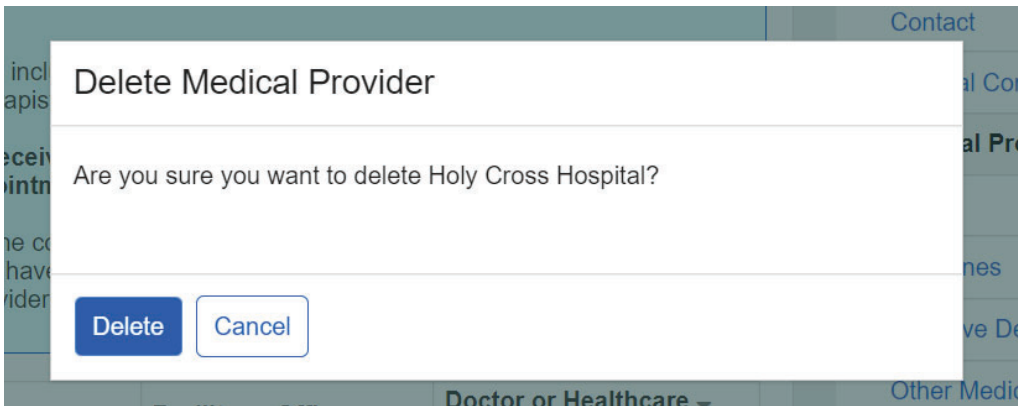
If the user needs to add a provider, they can select the "Add Medical Provider" button.

Test Details

*Indicates required information

ℹ️ **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	Review Delete	Centennial Medical Group	Hammond, Marie Ann
NEEDS REVIEW	Review Delete	Riverside Medical Center	Sikorsky, Mark P.
NEW	Review Delete	--	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.

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

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

ⓘ 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 P.
Summers, Claro
Other Medical Provider

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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	Review	Delete	X-Ray full body	Hammond, Marie 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.

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

ⓘ **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.

Cortizone

Reason for Medicine
(1000 characters maximum)

For pain

Characters remaining: 1000

Prescribed by:

Hammond, Marie Ann ⌄

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

Save   Cancel

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	Review	Delete	Cortizone	Hammond, Marie Ann
NEEDS REVIEW	Review	Delete	Aspirin	No one

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

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		Medicine	Prescribed by
REVIEWED	Review	Delete	Cortizone	Hammond, Marie Ann
NEEDS REVIEW	Review	Delete	Aspirin	No one
NEW	Review	Delete	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

ℹ️ **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:

--	⌄

Save   Cancel

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
- Canes
- Crutches
- Eyeglasses
- Hearing Aid
- Screen Reader
- Walker
- Wheelchair
- 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
- Hammond, Marie Ann
- Sikorsky, Mark P.
- Summers, Clara
- Other Medical Provider

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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.

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
[ ]	[ ]	[ ]	[-- ▼]

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
[ ]	[-- ▼]	[ ]

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

[-- ▼]   [   ]

☐ I don't remember

Reasons for Contact

(1000 characters maximum)

[   ]

Characters remaining: 1000

[Save] [Cancel]

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	Review Delete	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

[United States or U.S. Territory ⌄]

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

[Save] [Cancel]

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?

○ Yes, I am scheduled to complete it

○ No, I completed it

◉ 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

☐ Psychological/IQ Test

☐ Vision Test

☐ Hearing Test

☐ Work Classes

☐ Work Evaluation

☑ 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	Review Delete	Division of Rehabilitation Services	Norman, Ron

Add Plan or Program

Next   Previous   Save and Exit

1.15. Training

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

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

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

United States or U.S. Territory ⌄

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	Program
NEW	Review	Delete	--	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?

O Yes   O 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   O 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

United States or U.S. Territory ⌄

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

Save   Cancel

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	Review Delete	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

- ☐ Dressing
- ☐ Bathing
- ☐ Caring for Hair
- ☐ Taking Medicines
- ☐ Preparing Meals
- ☐ Feeding Self
- ☐ Doing Chores (inside/outside house)
- ☐ Driving or Using Public Transportation
- ☐ Shopping
- ☐ Managing Money
- ☐ Walking
- ☐ Standing
- ☐ Lifting Objects
- ☐ Using Arms
- ☐ Using Hands or Fingers
- ☐ Sitting
- ☐ Seeing, Hearing, or Speaking
- ☐ Concentrating
- ☐ Remembering
- ☐ Understanding or Following Directions
- ☐ Getting Along with People
- ☐ 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

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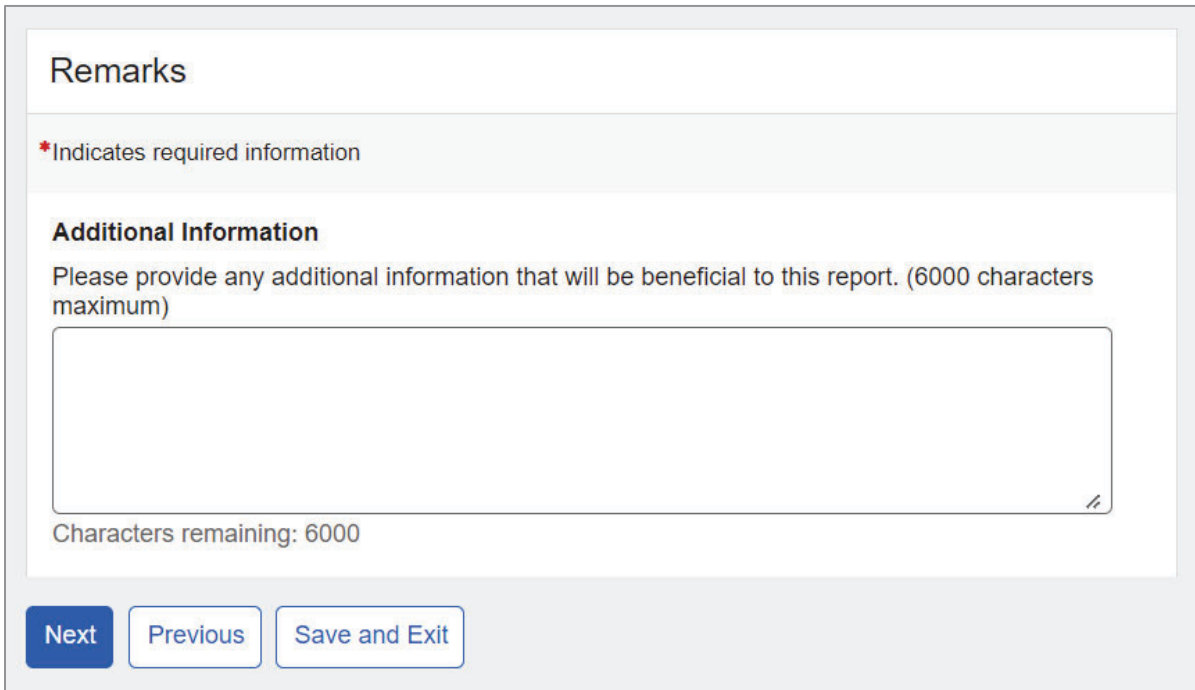- ☐ None of these apply to me

*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

ℹ️ **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: ███████████
Relationship to You: **Family Member**
Mailing Address: ███████████**t, Beltsville Maryland 20705**
Phone Number: **(410)**███████
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: ████████████████

Phone Number: **(410)** ████████

Address: ████████ **lay 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: ████████████████

Phone Number: **(410)** ████████

Address ████████ **verside 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: ████████████████

Phone Number: **(410)** ████████

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 ████████████████

✅ **MEDICINES** [Edit]

Medicine 1

Name of Medicine: **Cortizone**

Reason for Medicine: **For pain**

Prescribed by: ████████████████

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 ████████████████

✅ **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: ██████████████████

✅ 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: ██████████████
Phone Number: **(410)** ███████
Address: ███████, **Ellicot 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: ████████████
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)**▓▓▓▓▓
Address:▓▓▓▓▓▓ **ia 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: ▓▓▓▓▓▓ **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**
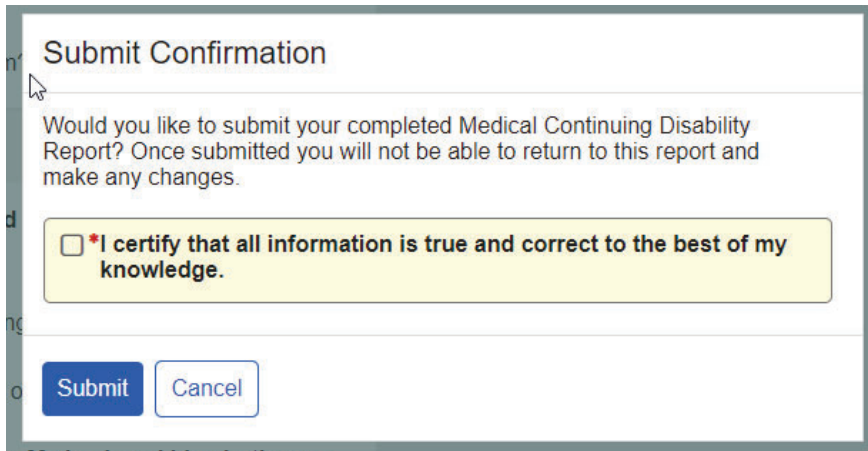Please select tasks that you need help with or have difficulty doing: **My back and hips bother me when standing for too long or doing chores like vacuuming.**

✓ REMARKS   [Edit]

Additional Information: *Not Answered*
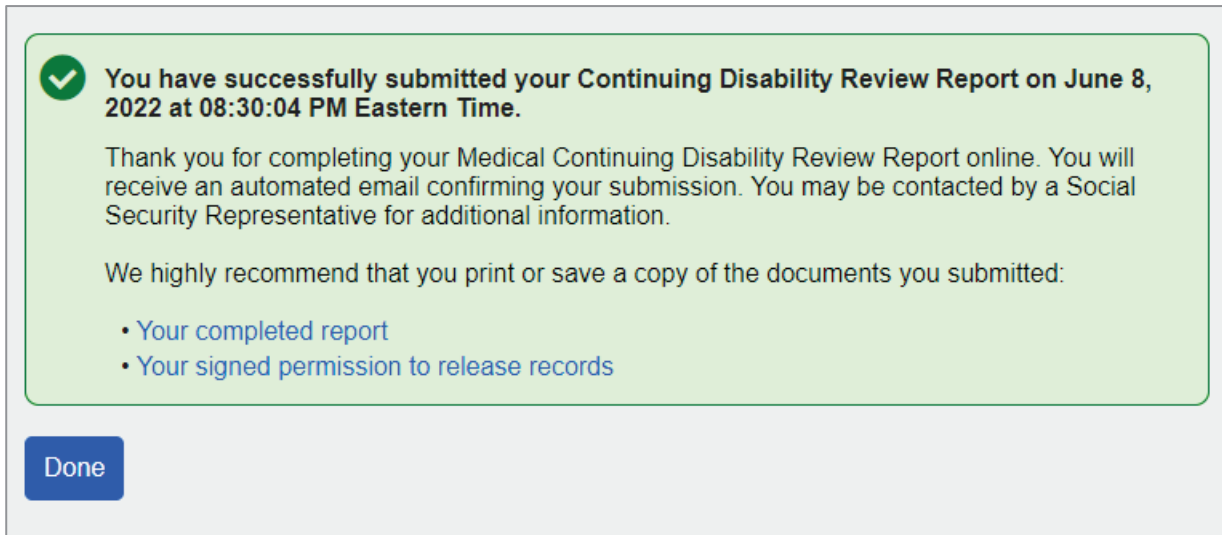
[Submit]   [Previous]   [Save and Exit]

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.

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.

Upon cliking "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: ███████████
Relationship to You: **Family Member**
Mailing Address: █████████ **Street, Beltsville Maryland 20705**
Phone Number: **(410)**███████
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 ████████████

Phone Number: **(410** ████████

Address: 4██████████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: ████████████

Phone Number: **(410)** ████████

Address: ██████████e **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: ████████████

Phone Number: **(410)** ████████

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: ████████████

MEDICINES

Medicine 1

Name of Medicine: **Cortizone**

Reason for Medicine: **For pain**

Prescribed by: ████████████

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: ████████████

ASSISTIVE DEVICES

65

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: ███████████

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: ███████████
Phone Number: **(410)** ███████████
Address: ███████████ llicot 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: ███████████
Phone Number: **(301** ███████████
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** ████████████

Address: ████████████ **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: ████████████ **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*