

# EDCS SSA-454 Form updates to EDCS screens

SSA-454 Adult form

## Contents

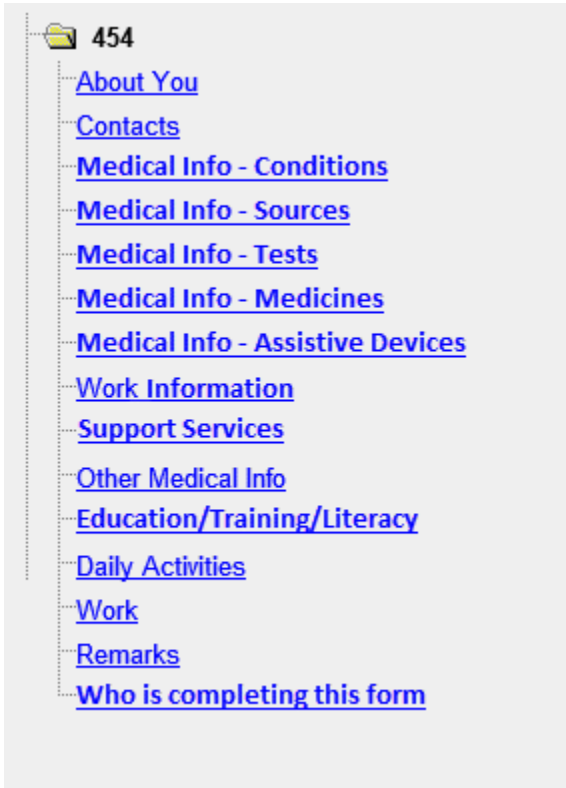
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## Background

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.

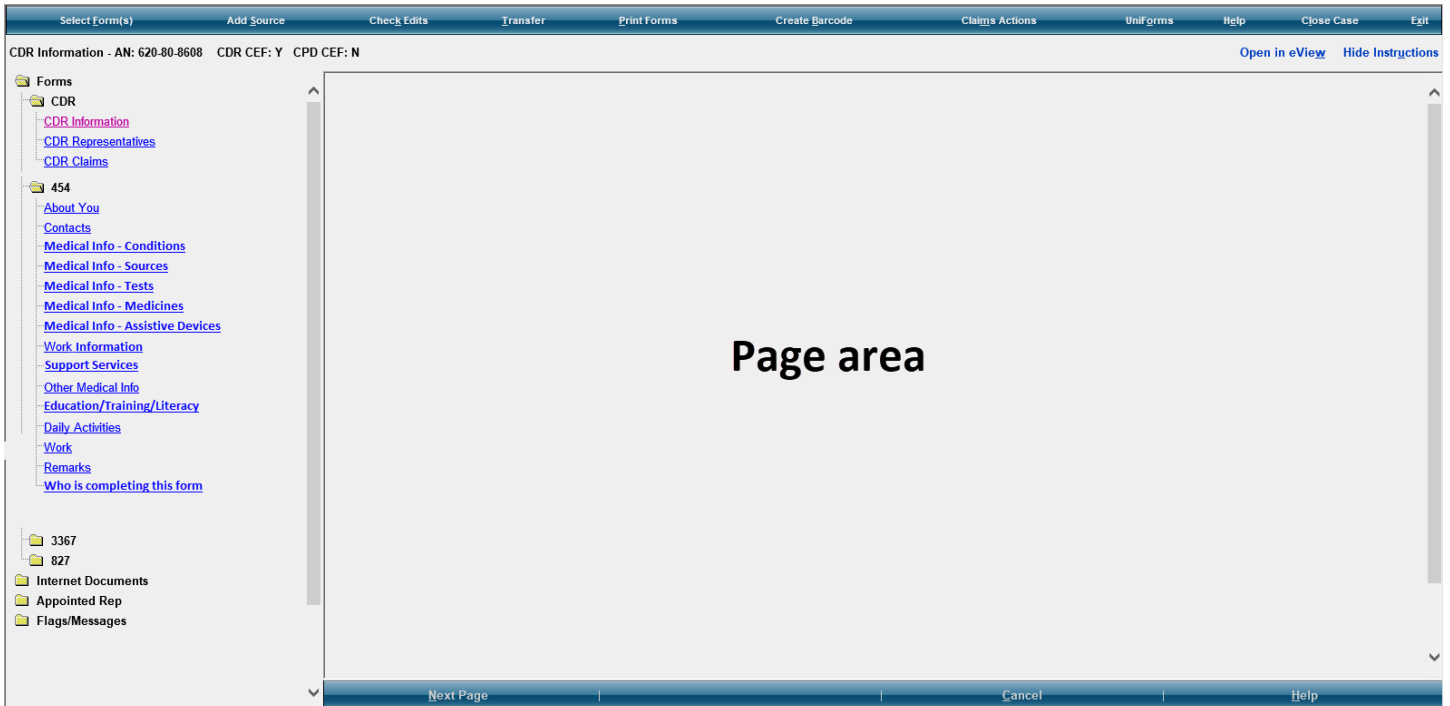
# SSA - 454 Layout and Navigation

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

Test Information - AN: 620-80-8608 CDR CEF: Y CPD CEF: N

---

**Test Information**

\*Name of Test:  
[Description of tests](#)

Date of Test:  
If you can't remember the exact dates, be as specific as possible. Examples:  
• 10/13/2002  
• June 2001

Provider who performed, sent you to, or scheduled you to take this test.  
If you need to add a medical source, you must return to 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 your ability to work.  
To add or edit a condition, choose Add or Edit Conditions.

Name
Knee injury from car accident
Leg amputation

<

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

## SSA - 454 Adult EDCS Screenshots

### SSA - 454 Section 1 – Information About You:

#### 454 About You

##### Identification

Name: [REDACTED]

Primary telephone number: [REDACTED]

Secondary telephone number is:  U.S.  Foreign  None

Alternate telephone number: [REDACTED] Ext: [REDACTED]

E-mail address: [REDACTED]

##### Your Language Information

Can you speak and understand English?

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

Yes  No  Not yet answered

If NO, what language do you prefer?

Can you read and understand English?

Yes  No  Not yet answered

Can you write more than your name in English?

Yes  No  Not yet answered

##### Other Names Used

In the last 12 months, have you used any other names on your medical or educational records?

Examples are maiden name, other married name, or nickname

Yes  No  Not yet answered

### 454 Contacts

#### Alternate Contact Information

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

Yes  No  Not yet answered

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

#### Name of Alternate Contact

\*First name:  Middle name:  \*Last name:  Suffix:

Relationship to Disabled Person:  ...

#### Address for Alternate Contact

Address is:  U.S.  Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City:  State:  ZIP Code:

#### Telephone for Alternate Contact

Telephone number is:  U.S.  Foreign  None

Daytime telephone number:  Ext:

#### Preferred Language of Alternate Contact

Can this person speak and understand English?

Yes  No  Not yet answered

If "NO", what language is preferred?

## 454 Medical Information - Medical Conditions

### Height and Weight

What is your height without shoes? feet:  inches:

What is your weight without shoes? pounds:

### Physical and Mental Conditions

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

Include:

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

Examples of conditions:

1. Back injury, 2. Arthritis, 3. Diabetes, 4. Glaucoma, 5. Depression, 6. Blindness

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

\*1.

2.

3.

# SSA - 454 Section 3 – Medical Info – Sources

## Medical Sources Summary

### 454 - Medical Information - Medical Sources

#### Doctors, Therapists, Hospital, Clinics

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

\*For any physical condition(s)

Yes  No  Not yet answered

\*For any mental condition(s) (including emotional or learning problems)

Yes  No  Not yet answered

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

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

Include:

- All types of providers (physicians, psychologists, optometrists, nurse practitioners, therapists, chiropractors, acupuncturists, 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
<a href="#">GBMC/VASCULAR SURGERY</a>	* P.O. BOX [REDACTED]
<a href="#">ORTHOPAEDIC ASSOCIATES</a>	* [REDACTED] BELLONA AVE #100

Add Doctor/Hospital/Etc.



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

## Doctor/Therapist Information

Comparison Point Decision Date: 04/29/2005

3.D.  
1-4

Name: [ORTHOPAEDIC ASSOCIATES](#)

Attention:

Address: 8522 BELLONA AVE #100

Patient ID# (if known):

### Dates

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

Examples:

- June 11, 2002
- October 2000
- Summer 1999

First visit:

Last visit:

Next appointment:

### Conditions and Treatments

What medical conditions were treated or evaluated?

Examples:

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

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

What treatment did you receive for the above conditions?

Examples:

- Physical therapy
- Counseling
- Heat treatments
- Medicines

Post amputation care and counseling.

### Tests

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

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

Test	Date	Ordered By
<a href="#">Blood test (Not HIV)</a>	12/2021	ORTHOPAEDIC ASSOCIATES
<a href="#">Fake Test</a>	Fake Date	ORTHOPAEDIC ASSOCIATES
<a href="#">MRI/CT Scan (1 Legs - looking for clots)</a>	12/2021	ORTHOPAEDIC ASSOCIATES

### Medicines

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

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

Medicine	Prescribed By	Reason
<a href="#">Flexeril</a>	ORTHOPAEDIC ASSOCIATES	Muscle tension in back and arms from wheelchair use
<a href="#">Oxycodone</a>	ORTHOPAEDIC ASSOCIATES	*No Reason*

### Physical and Mental Conditions

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

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

Name

Knee injury from car accident  
Leg amputation

# Medical sources – Hospital/Clinic Information

### Hospital/Clinic Information

Comparison Point Decision Date: 04/29/2005

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

Attention: P O BOX

Address: P O BOX

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

Patient ID# (if known):  

---

### Dates at this Facility

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

- June 11, 2002
- October 2000
- Summer 1999

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

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

---

### Conditions and Treatments

What medical conditions were treated or evaluated?  
 Examples:

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

Trauma to legs/knees

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

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

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

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

---

### Tests

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

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

Test	Date	Facility
<a href="#">ECG (Brain wave test)</a>	12/6/2021	GBMC/VASCULAR SURGERY
<a href="#">EKG (Heart test)</a>	12/6/2021	GBMC/VASCULAR SURGERY
<a href="#">MRI/CT Scan (Full body injury id.)</a>	12/6/2021	GBMC/VASCULAR SURGERY

Add Test

---

### Medicines

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

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

Medicine	Prescribed by	Reason
<a href="#">Metoprolol</a>	GBMC/VASCULAR SURGERY	Heart palp
<a href="#">New Medicine (NOT IN LIST)</a>	GBMC/VASCULAR SURGERY	Reasons here
<a href="#">Oxycodone</a>	GBMC/VASCULAR SURGERY	Oxycodone
<a href="#">Vicodin</a>	GBMC/VASCULAR SURGERY	Manage Pain

Add Medicine

---

### Physical and Mental Conditions

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

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

Name
<a href="#">Knee injury from car accident</a>
<a href="#">Leg amputation</a>

Add or Edit Conditions

OK
Delete
Add Another Source
Cancel
Help

# SSA- - 454 Section 3 – Medical Info – Tests

## Test Summary

### 454 Medical Information - Tests Summary

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

Yes  No  Not yet answered

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

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

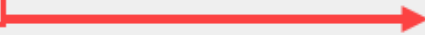
Test	Date	Ordered By
<a href="#">1234567890123456789012345678901234567890123456789012345678901234567890</a>		*No Source*
<a href="#">Blood test (Not HIV)</a>	12/2021	ORTHOPAEDIC ASSOCIATES
<a href="#">EEG (Brain wave test)</a>	12/6/2021	GBMC/VASCULAR SURGERY
<a href="#">EKG (Heart test)</a>	12/6/2021	GBMC/VASCULAR SURGERY
<a href="#">Fake Test</a>	Fake Date	ORTHOPAEDIC ASSOCIATES
<a href="#">MRI/CT Scan (Legs - looking for clots)</a>	12/2021	ORTHOPAEDIC ASSOCIATES
<a href="#">MRI/CT Scan (Full body-injury id.)</a>	12/6/2021	GBMC/VASCULAR SURGERY
<a href="#">new test</a>	date of new test	*No Source*

Add Test

### 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

Add description of test/body part tested.

**Date of Test:**

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

- 10/13/2002
- June 2001

**Provider who performed, sent you to, or scheduled you to take this test.**

If you need to add a medical source, you must return to 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 your ability to work.

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

Name
Knee injury from car accident
Leg amputation

Add or Edit Conditions

Medicines Summary

**454 Medical Information - Medicines Summary**

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

Yes  No  Not yet answered

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

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

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

Add Medicine

### Medicine Information

\*Name of medicine:  ...

Who prescribed this medicine (if prescription)?

If you need to add a medical source, you must return to MED SOURCES.

Reason for medicine:

Examples:

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

### Physical and Mental Conditions

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

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

Name

Knee injury from car accident

Leg amputation

Add or Edit Conditions

### 454 Medical Information - Assistive Devices

Do you use an assistive device?

Yes  No  Not yet answered

List the assistive device(s) you use.

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

Medicine	Prescribed By
<a href="#">Eyeglasses</a>	*No Source
<a href="#">Canes</a>	Orthopedic Associates
<a href="#">Walker</a>	Orthopedic Associates

Add Device

## Assistive Devices Detail (new)

**454 Assistive Devices**

**\*Name of Device**

Select

If other, please describe what kind of device, when and how you use it.

500 Char (?) text field

How frequently do you use this device?

Always  Sometimes  Never  Not yet answered

Provider who prescribed or advised you to use the device.

If you need to add a medical source, you must return to MED SOURCES.

Other medical professional

Other Medical Professional:

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

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

Name
Knee injury from car accident
Leg amputation

**Braces**  
**Canes**  
**Crutches**  
**Eyeglasses**  
**Hearing aid**  
**Screen reader**  
**Walker**  
**Wheelchair**  
**Other**

JOHNSON, RICHARD SAMUEL MD, JOHN'S HOPKINS UNIVERSITY HOSPITAL  
ORTHOPAEDIC ASSOCIATES  
SCHOOL FOR THE ARTS IN LEARNING  
TECH, VO. ORG NAME FIELD  
THERAPY & SPORTS ASSESSMENT  
VOCA  
No one prescribed this  
I don't know  
Other medical professional

List built from providers on the claim

## SSA - 454 Section 4 – Work

**454 Work Information**

Has  worked since 04/29/2005?

Yes  No  Not yet answered

Are you still working now?

Yes  No  Not yet answered

Select all types of work you had since your last medical disability decision:

Wages from employer

Self-employment

(Yes answer triggers display of remaining questions)



## SSA - 454 Section 5 – Support Services

### Support Services Summary

#### 454- Support Services

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

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

Yes  No  Not yet answered

List all plans or programs attended.

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

Organization/School	Name of Counselor/Instructor
<a href="#">THERAPY &amp; SPORTS ASSESSMENT</a>	*No Counselor/Instructor name*
<a href="#">VOCA</a>	*No Counselor/Instructor name*

Add a Plan or Program

# Support Services Detail

## Support Services

Name: [Counselor FN](#) [Counselor MN](#) [Counselor LN](#), ERS Career Coaching

Attention:

Address: ● Unification Street

### Dates Seen

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

Examples:

- June 10, 2001
- February 1998
- Summer 1995

When did you start participating in the plan or program?

Are you still participating in the plan or program?

Yes. Scheduled to be completed on:

No. I completed the plan or program on:

No. I stopped participating in the plan or program before completing it

All selected radio buttons display a text box for dates.

because:

Not Yet Answered

### Types of Services

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

Select all that apply:

Psychological/IQ test:  Yes  No  Not yet answered

Vision test:  Yes  No  Not yet answered

Hearing test:  Yes  No  Not yet answered

Work classes:  Yes  No  Not yet answered

Work evaluation:  Yes  No  Not yet answered

Other:  Yes  No  Not yet answered

Please explain:

**NOTE: Yes answer opens "Please explain" box.**

### Physical and Mental Conditions

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

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

Name

Knee injury from car accident

Leg amputation

## SSA - 454 Section 6 – Other Medical Information

### 454 Other Medical Information

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

Examples:

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

Yes  No  Not yet answered

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

Name	Address
<a href="#">CENTER FOR PAIN MANAGEMENT</a>	[REDACTED] LE PIKE STE #505
<a href="#">JOHNSON, RICHARD SAMUEL MD, JOHNS HOPKINS UNIVERSITY HOSPITAL</a>	PO BOX [REDACTED]
<a href="#">SCHOOL FOR THE ARTS IN LEARNING</a>	[REDACTED] 6TH STREET NW

Add Source



## 454 Education, Training, and Literacy

### Education

Have you received any education since 04/29/2005?

Yes  No  Not yet answered

Name of school:

Dates of attendance:

From:

To:

Address is:  U.S.  Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City:

State:

ZIP Code:

Telephone number is:  U.S.  Foreign  None

Telephone number is: (999-999-9999)

Ext:

\*Type of Program:

Approximate Date Completed (or scheduled to be completed):

### Job Training or Vocational School

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

Yes  No  Not yet answered

Name of training facility:

Dates of attendance:

From:

To:

Address is:  U.S.  Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City:

State:

ZIP Code:

Telephone number is:  U.S.  Foreign  None

Telephone number is: (999-999-9999)

Ext:

\*Type of Program:

Approximate Date Completed (or scheduled to be completed):

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

READING - In the language you identified above, can you read a simple message, such as a shopping list or short and simple notes?

Yes  No  Not yet answered

WRITING - In the language you identified above, can you write a simple message, such as a shopping list or short and simple notes?

Yes  No  Not yet answered

**454 Daily Activities**

**Claims Specialists will mention to respondents that this question is optional**

**Describe what you do in a typical day:**

For example: I get up around 7 A.M., take a shower, eat breakfast, etc.

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

**Do you have hobbies or interests?**

Yes  No  Not yet answered

**Claims Specialists will mention to respondents that this question is optional**

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

I read books and take care of my children.

**Do you ever have difficulty doing any of the following:**

**Dressing:**  Yes  No  Not yet answered

**Bathing:**  Yes  No  Not yet answered

**Caring for hair:**  Yes  No  Not yet answered

**Taking medicines:**  Yes  No  Not yet answered

**Preparing meals:**  Yes  No  Not yet answered

**Claims Specialists will mention to respondents that this question is optional**

**Doing chores (inside/outside house):**  Yes  No  Not yet answered

**Driving or using public transportation:**  Yes  No  Not yet answered

**Please explain:**

not listed

**Shopping:**  Yes  No  Not yet answered

**Managing money:**  Yes  No  Not yet answered

**Walking:**  Yes  No  Not yet answered

**Standing:**  Yes  No  Not yet answered

**Lifting objects:**  Yes  No  Not yet answered

**Using arms:**  Yes  No  Not yet answered

**Using hands or fingers:**  Yes  No  Not yet answered

**Sitting:**  Yes  No  Not yet answered

**Seeing, hearing, or speaking:**  Yes  No  Not yet answered

**Concentrating:**  Yes  No  Not yet answered

**Please explain:**

**Remembering:**  Yes  No  Not yet answered

**Understanding or following directions:**  Yes  No  Not yet answered

**Getting along with people:**  Yes  No  Not yet answered

## SSA - 454 Section 9 – Remarks

454 Remarks
Please provide any additional information you did not give in earlier parts of this report.

## SSA - 454 Section 10 – Who is completing this form

454 Who is completing this report
<b>Name of Person Completing This Report</b>
First name: <input type="text"/> Middle name: <input type="text"/> Last name: <input type="text"/> Suffix: <input type="text" value="v"/>
Agency name: <input type="text"/>
Relationship to Disabled Person: <input type="text" value="..."/>
<b>Address for Person Completing This Report</b>
Address is: <input checked="" type="radio"/> U.S. <input type="radio"/> Foreign <input type="button" value="Copy Address"/>
Street address line 1: <input type="text"/>
Street address line 2: <input type="text"/>
Street address line 3: <input type="text"/>
Street address line 4: <input type="text"/>
City: <input type="text"/> State: <input type="text" value="v"/> ZIP Code: <input type="text"/>
<b>Telephone for Person Completing This Report</b>
Telephone number is: <input checked="" type="radio"/> U.S. <input type="radio"/> Foreign <input type="radio"/> None
Daytime telephone number: (999-999-9999) <input type="text"/> Ext: <input type="text"/>