EDCS SSA-454 Form updates to EDCS screens

SSA-454 Adult form

R51.0

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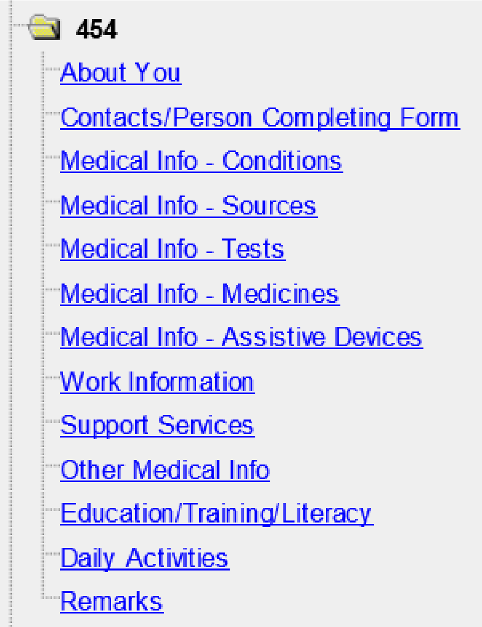
Background

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.

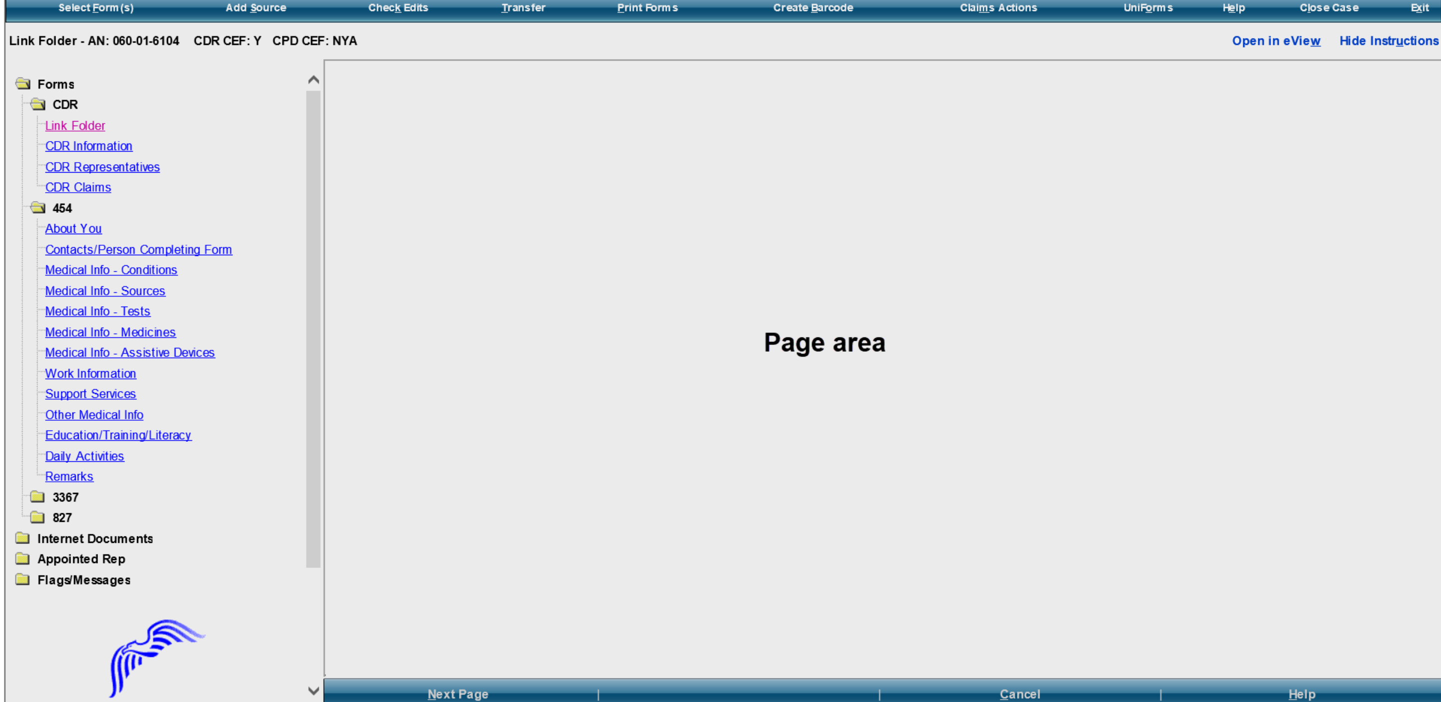
SSA - 454 Layout and Navigation

454 Left Navigation- used for all EDCS 454 pages



EDCS Frame

This screenshot shows the layout of all EDCS pages.

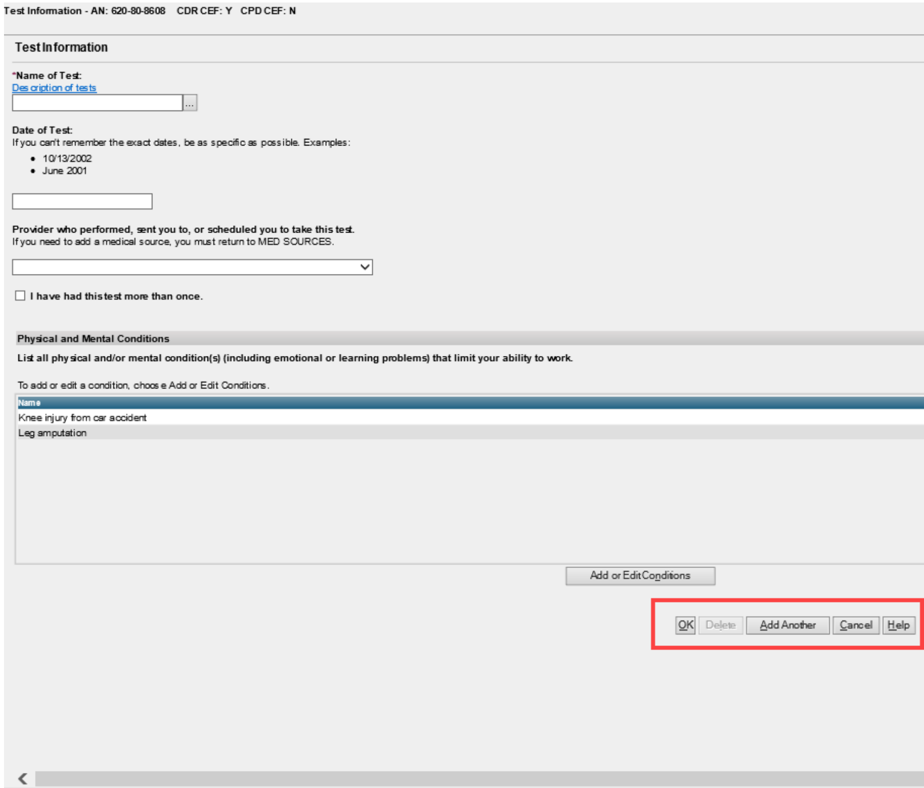


Things to note:

- 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 Adult EDCS Screenshots

SSA - 454 Section 1 – Information About You:

454 About You

Identification

Name: Zetti Marie Greene

Primary telephone number: 951-800-9659

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

Alternate telephone number: Ext:

E-mail address:

Your Language Information

Can you speak and understand English?

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

○ Yes ◉ No ○ Not yet answered

If NO, what language do you prefer? Other

Can you read and understand English?

○ Yes ◉ No ○ Not yet answered

Can you write more than your name in English?

○ Yes ◉ No ○ Not yet answered

Other Names Used

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

Examples are maiden name, other married name, or nickname

○ Yes ◉ No ○ Not yet answered

SSA - 454 Section 2 – Contacts/Person Completing Form

454 Someone we can contact

Alternate Contact Information

Is there someone (other than your doctors) we can contact who knows about your medical condition(s), and can help you with your case? Examples include a family member, friend, or neighbor.

(•) Yes ( ) No ( ) Not yet answered

Name of Alternate Contact

*First name: First | Middle name: | *Last name: Last | Suffix:

Relationship to Disabled Person:

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 phone number: (999-999-9999) Ext:

Preferred Language of Alternate Contact

Can this person speak and understand English?

( ) Yes (•) No ( ) Not yet answered

If "NO", what language is preferred?

Person Completing the Report

*Who is providing information?

( ) Aubrey Anna Birkhamshaw

( ) Alternate Contact listed above

(•) Someone else

Selecting the "Someone else" radio button will prompt Name of Person Completing this form fields.

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 phone number: (999-999-9999) Ext:

SSA - 454 Section 3 – Medical Info – Conditions

454 Medical Information - Medical Conditions

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.** High Blood Pressure

2. Lung Cancer 2

3. Low vision

4. Anxiety

5.

Check Spelling

Height and Weight

What is your height? feet: ____ **inches:** ____

What is your weight? pounds: ____

SSA - 454 Section 3 – Medical Info – Sources

Medical Sources Summary

454 Medical Information - Medical Sources

Comparison Point Decision Date: 11/20/2022

Doctors, Therapists, Hospital, Clinics

*__Within the last 12 months, have you seen or received treatment from a health care provider (doctor, hospital, clinic, psychiatrists, nurse practitioners, therapists, physical therapists, or other medical professionals)?__

(•) 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
DANA FABER CANCER INSTITUTE		450 BROOKLINE AVE
JEFFERSON, SHIRLEY ARLENE MD	*	PO BOX98

Add Doctor/Hospital/Etc.

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

Doctor/Therapist Information

Comparison Point Decision Date: 11/20/2022

Name: DANA FABER CANCER INSTITUTE [Replace Source]

Attention:

Address: 450 BROOKLINE AVE

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: 10/2022

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

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

- Physical therapy
- Counseling
- Heat treatments
- Medicines

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
Biopsy (lkn/lkn)	.,mlkmn.lm	DANA FABER CANCER INSTITUTE

[Add Test]

Medicines

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

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

Medicine	Prescribed By	Reason

[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
High Blood Pressure
Lung Cancer 2
Low vision
Anxiety

[Add or Edit Conditions]

Medical sources – Hospital/Clinic Information

Hospital/Clinic Information

Comparison Point Decision Date: 04/29/2005

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

Attention:

Address: P O BOX 631013

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

ED on call

Patient ID# (if known):

Dates at this Facility

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

- June 11, 2002
- October 2000
- Summer 1999

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

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

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

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

Conditions and Treatments

What medical conditions were treated or evaluated?
Examples:

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

Trauma to legs/knees

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

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

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

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

Tests

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

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

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

[Add Test]

Medicines

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

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

Medicine	Prescribed By	Reason
Metoprolol	GBMC/VASCULAR SURGERY	Heart palp
New Medicine (NOT IN LIST)	GBMC/VASCULAR SURGERY	Reasons here
Oxycodone	GBMC/VASCULAR SURGERY	Oxycodone
Vicodin	GBMC/VASCULAR SURGERY	Manage Pain

[Add Medicine]

Physical and Mental Conditions

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

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

Name
Knee injury from car accident
Leg amputation

[Add or Edit Conditions]

[OK] [Delete] [Add Another Source] [Cancel] [Help]

SSA- - 454 Section 3 – Medical Info – Tests

Test Summary

454 Medical Information - Tests Summary

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

(•) Yes ( ) No ( ) Not yet answered

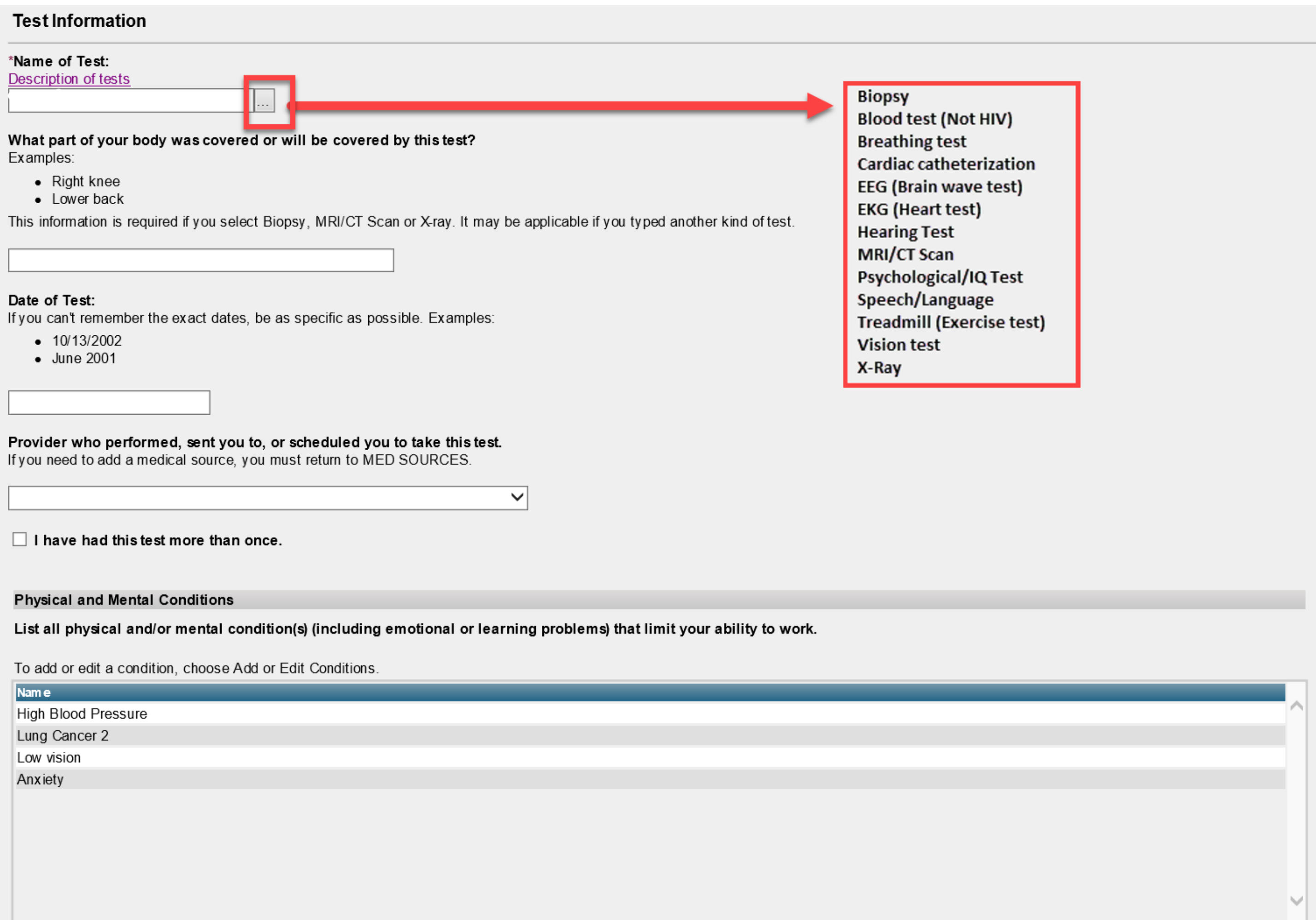
List all tests that you had or will have for your condition.

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

Test	Date	Ordered By
12345678901234567890123456789012345678901234567890123456789		*No Source*
Blood test (Not HIV)	12/2021	ORTHOPAEDIC ASSOCIATES
EEG (Brain wave test)	12/6/2021	GBMC/VASCULAR SURGERY
EKG (Heart test)	12/6/2021	GBMC/VASCULAR SURGERY
Fake Test	Fake Date	ORTHOPAEDIC ASSOCIATES
MRI/CT Scan (Legs - looking for clots)	12/2021	ORTHOPAEDIC ASSOCIATES
MRI/CT Scan (Full body-injury id.)	12/6/2021	GBMC/VASCULAR SURGERY
new test	date of new test	*No Source*

Add Test

Tests detail



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

What part of your body was covered or will be covered by this test?
Examples:

- Right knee
- Lower back

This information is required if you select Biopsy, MRI/CT Scan or X-ray. It may be applicable if you typed another kind of test.

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

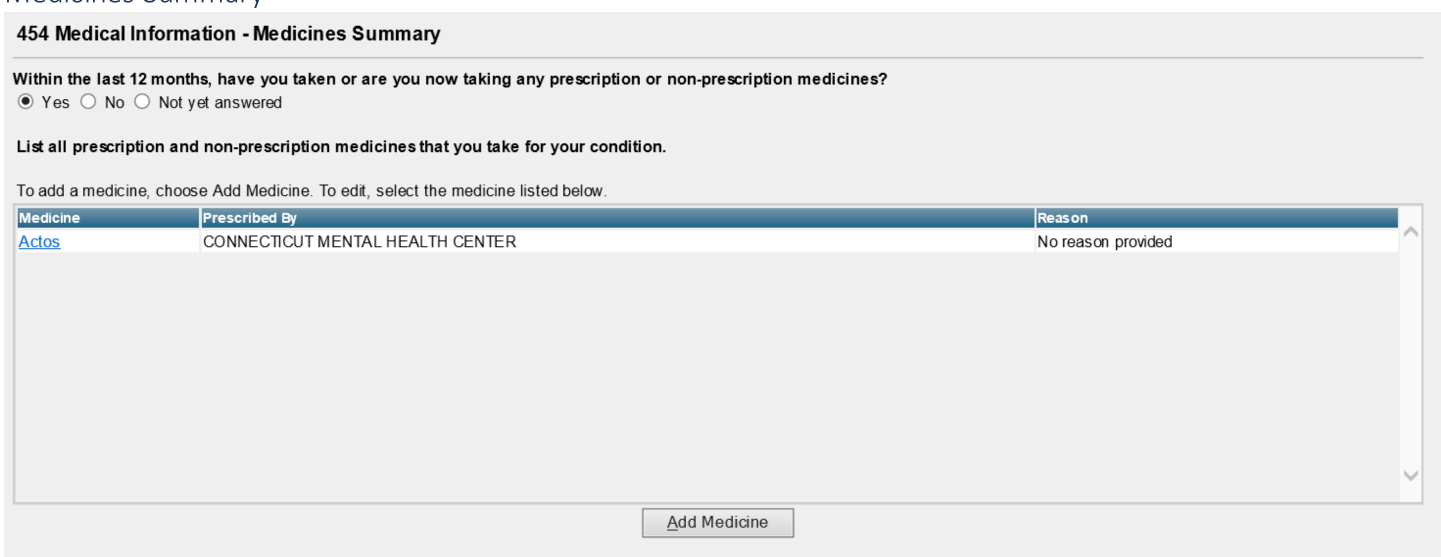
List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

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

Name
High Blood Pressure
Lung Cancer 2
Low vision
Anxiety

SSA - 454 Section 3 – Medical Info – Medicines

Medicines Summary



454 Medical Information - Medicines Summary

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

(•) Yes ( ) No ( ) Not yet answered

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

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

Medicine	Prescribed By	Reason
Actos	CONNECTICUT MENTAL HEALTH CENTER	No reason provided

Add Medicine

Medicines Detail (no edits)

Medicine Information

***Name of medicine:** [ ] ...

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

Reason for medicine:
Examples:

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

Physical and Mental Conditions

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

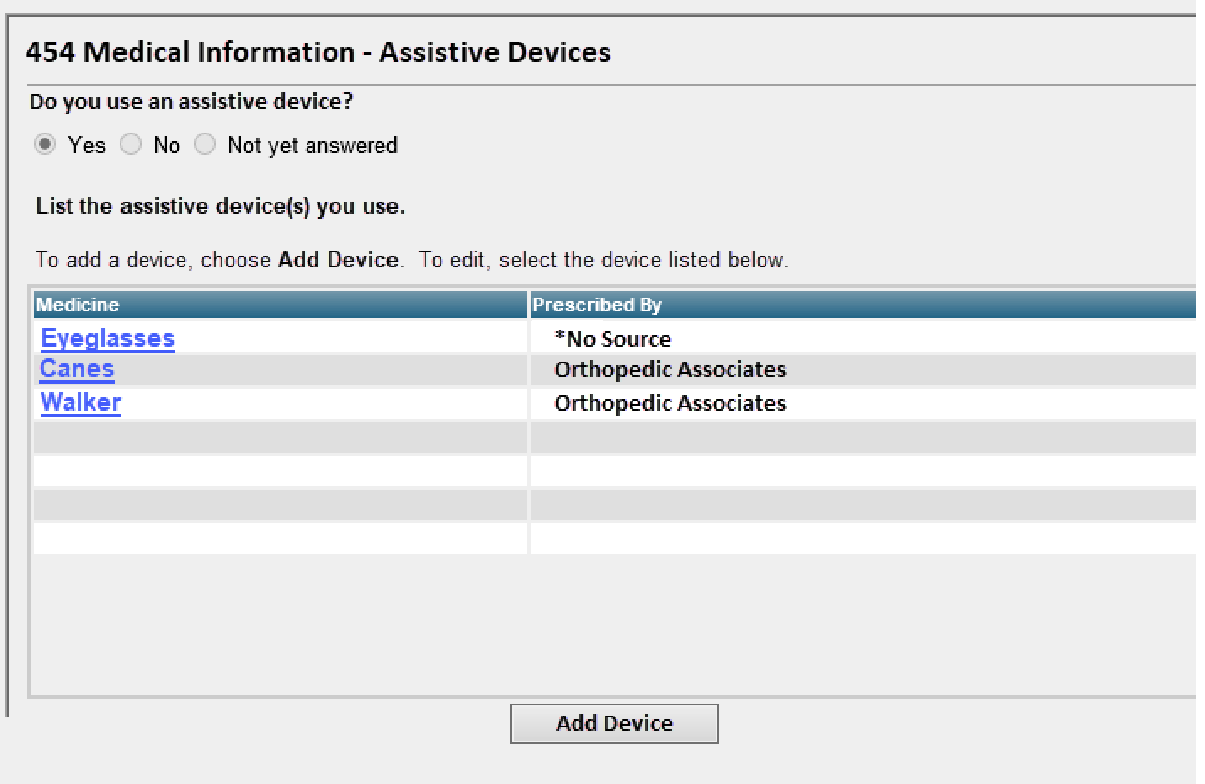
To add or edit a condition, choose Add or Edit Conditions.

Name
Knee injury from car accident
Leg amputation

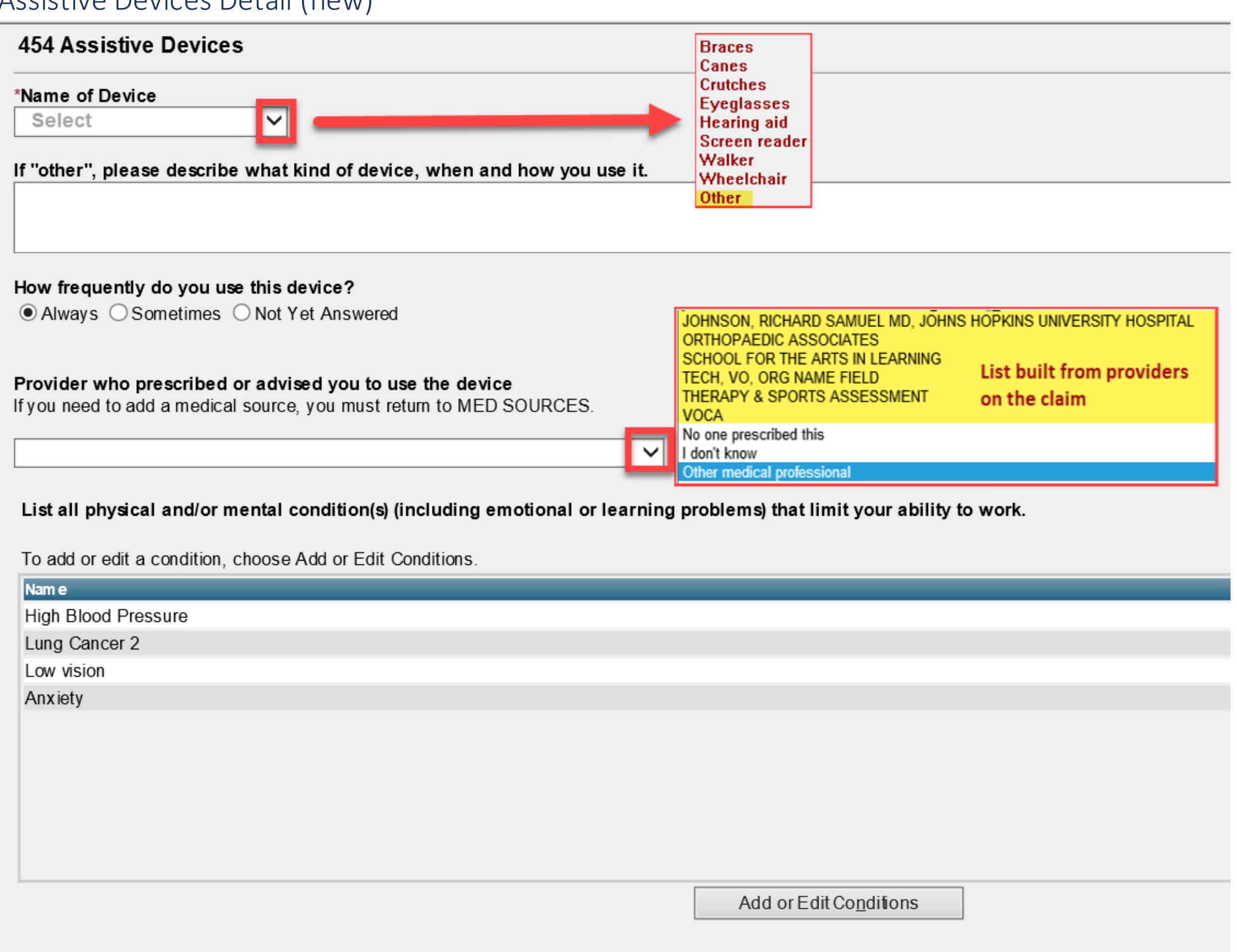
Add or Edit Conditions

SSA - 454 Section 3 – Medical Info – Assistive Devices

Assistive Devices Summary (new)



Assistive Devices Detail (new)



SSA - 454 Section 4 – Work Information

454 Work Information

*Has Aubrey Anna Birkhamshaw worked since 11/20/2022?

(•) Yes ( ) No ( ) Not yet answered

(Yes answer triggers display of remaining questions)

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 ( ) Yes ( ) No (•) Not yet answered

Self-employment ( ) Yes ( ) No (•) Not yet answered

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 below 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);**
- **An individual work plan with an employment network under the Ticket to Work Program;**
- **A Plan to Achieve Self Support (PASS); or**
- **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
No Organization/School name	Jones, Heather
REHAB AT WORK	Name, Counselor
TOWSON UNIVERSITY-SPPA CLINIC	Provider, Clinical

Add a Plan or Program

Support Services Detail

Support Services

Name: Heather Jones [Replace Source]

Attention:

Address: 234 Main 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 because:

[ ]

( ) Not Yet Answered

All selected radio buttons display a text box for dates.

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: [ ]

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
High Blood Pressure
Lung Cancer 2
Low vision
Anxiety

[Add or Edit Conditions]

SSA - 454 Section 6 – Other Medical Information

454 Other Medical Information

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

Examples:

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

(•) Yes ( ) No ( ) Not yet answered

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

Name		Address
CENTER FOR PAIN MANAGEMENT	*	11921 ROCKVILLE PIKE STE #505
JOHNSON, RICHARD SAMUEL MD, JOHNS HOPKINS UNIVERSITY HOSPITAL		PO BOX 64896
SCHOOL FOR THE ARTS IN LEARNING	*	1100 16TH STREET NW

Add Source

SSA - 454 Section 7 – Education, Training and Literacy

454 Education, Training and Literacy

Education

Have you received any education since 11/20/2022?
(●) Yes ( ) No ( ) Not yet answered

Name of school: School Name

Address is: (●) U.S. ( ) Foreign
Street address line 1: Address Line 1
Street address line 2: Address Line 2
Street address line 3: Address LIne 3
Street address line 4: Address Line 4
City: City **State:** MD **ZIP Code:** 12345

*__Type of program or degree:__
The type of program or degree text box

Date(s) of attendance (MM/YYYY): from 09/2019 **to** 05/2021

Date completed (or scheduled to be completed) (MM/YYYY): 05/2021

Job Training or Vocational School

Have you received any type of specialized job, trade, or vocational training since 11/20/2022?

(●) Yes ( ) No ( ) Not yet answered

Name of training facility: Training Facility

Address is: (●) U.S. ( ) Foreign
Street address line 1: Address Line 1
Street address line 2: Address Line 2
Street address line 3: Address Line 3
Street address line 4: Address Line 4
City: City **State:** MD **ZIP Code:** 12345

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

*__Type of Program:__
Type of program for training facility goes here

Date completed (or scheduled to be completed) (MM/YYYY): 05/2023

Language Information

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

If the language is not listed, please select 'Other' and provide the language below. If 'Other' is selected, please specify language.

Other Language: Braille

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

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

SSA - 454 Section 8 – Daily Activities

454 Daily Activities

Do you ever have difficulty doing any of the following:

Activity	Answer (options: Yes / No / Not yet answered)
Dressing:	No
Bathing:	No
Caring for hair:	Yes
Please explain:	Can't lift arms above my shoulder
Taking medicines:	No
Preparing meals:	Yes
Please explain:	Cannot reach in cabinets
Feeding self:	No
Doing chores (inside/outside house):	No
Driving or using public transportation:	No
Shopping:	Yes
Please explain:	cannot reach for items on shelves, cannot lift
Managing money:	No
Walking:	No
Standing:	No
Lifting objects:	Yes
Please explain:	cannot lift over 5 lbs.
Using arms:	No
Using hands or fingers:	No
Sitting:	No
Seeing, hearing, or speaking:	No
Concentrating:	No
Remembering:	No
Understanding or following directions:	No
Getting along with people:	No

SSA - 454 Section 9 – Remarks

454 Remarks

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