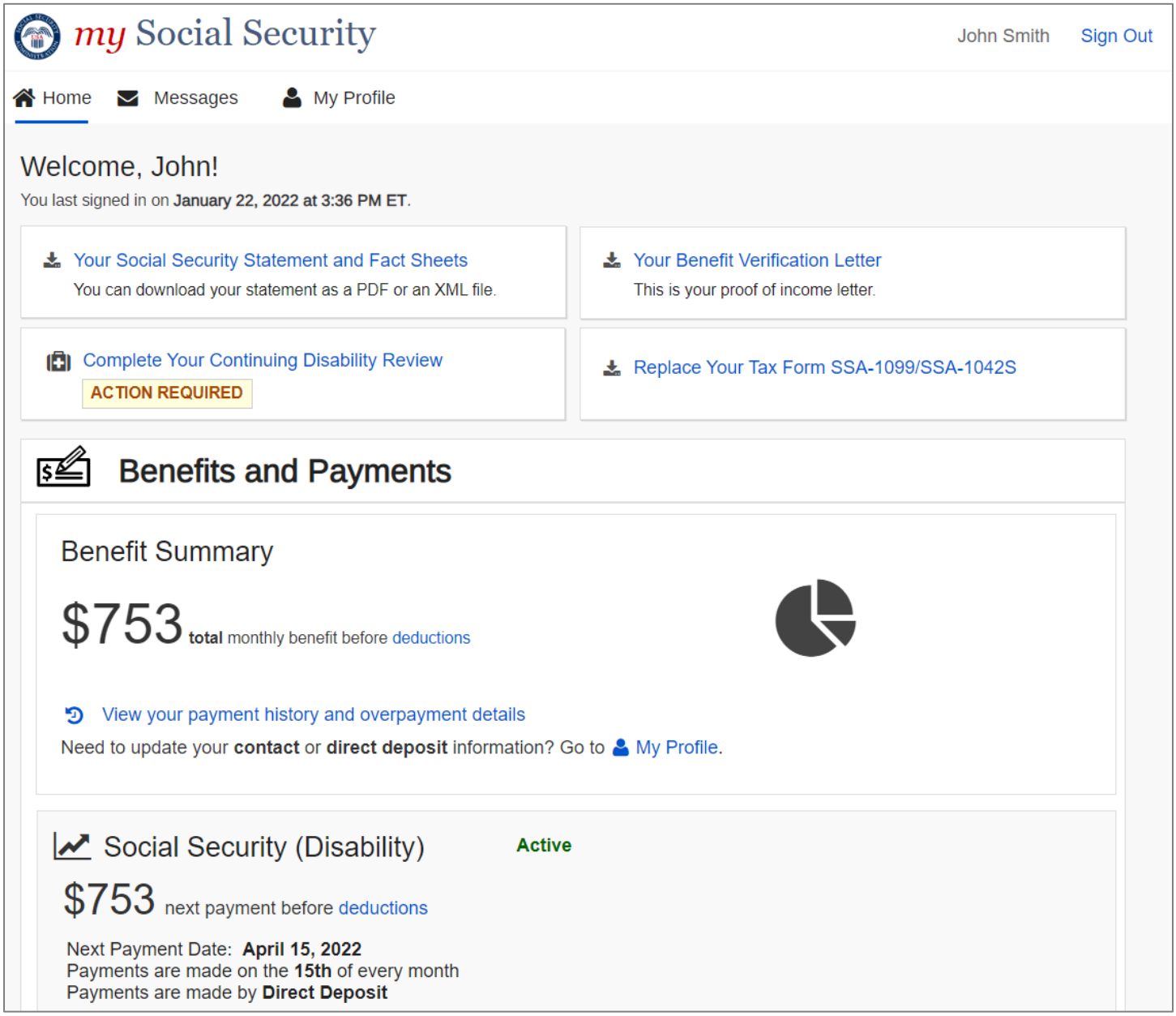
SCREEN PACKAGE DOCUMENT

MEDICAL CONTINUING DISABILITY REVIEW APPLICATION OR I454

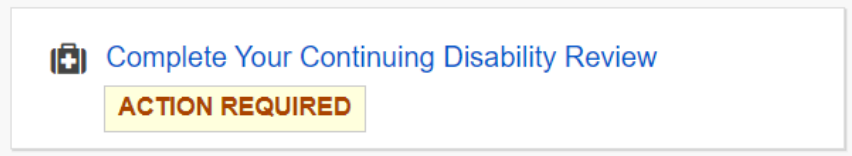
Table of Contents

1. Screen Designs and Component Descriptions

1.1. My Social Security Landing Page

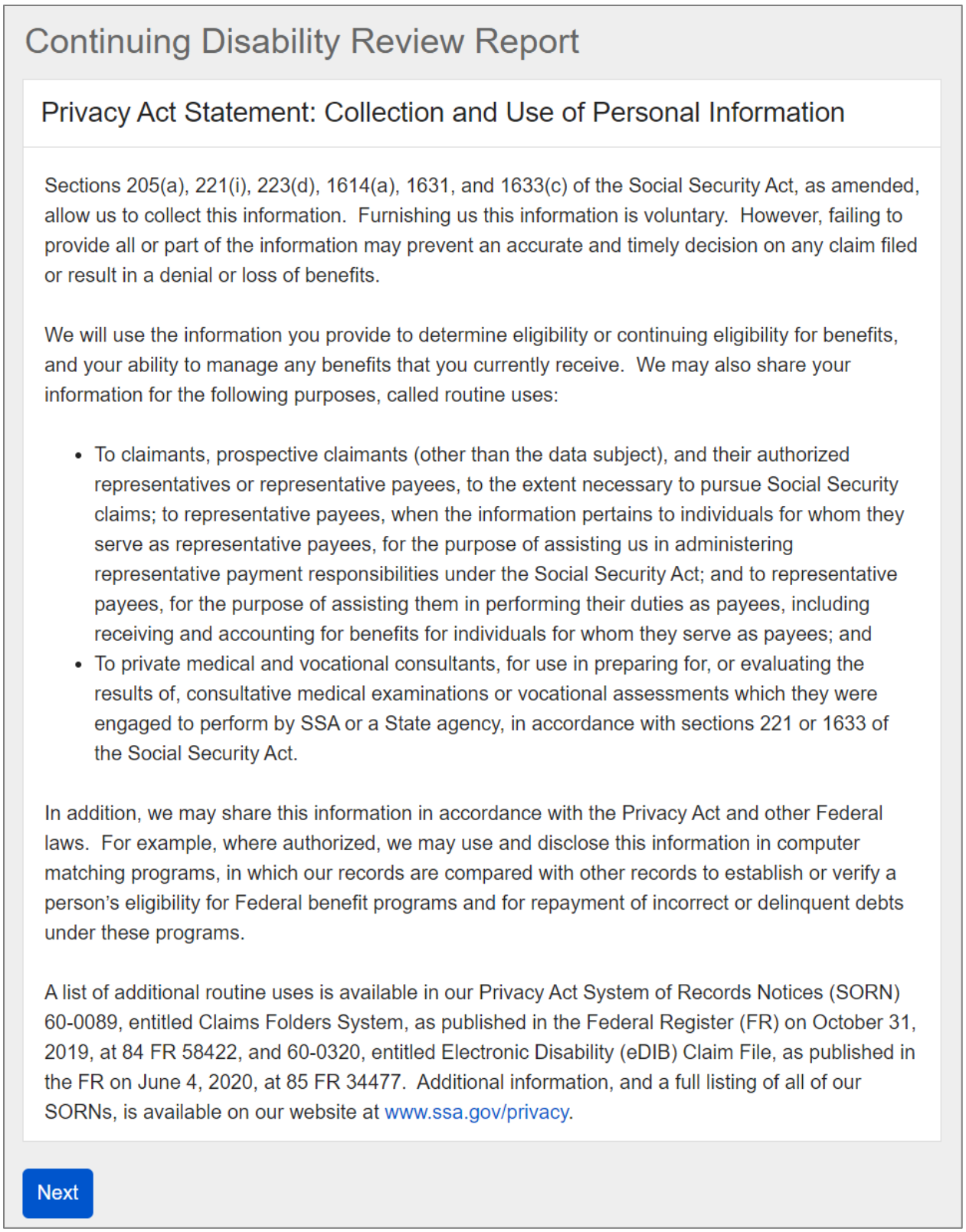


A user can access the Continuing Disability Review application or i454 from their my Social Security homepage.



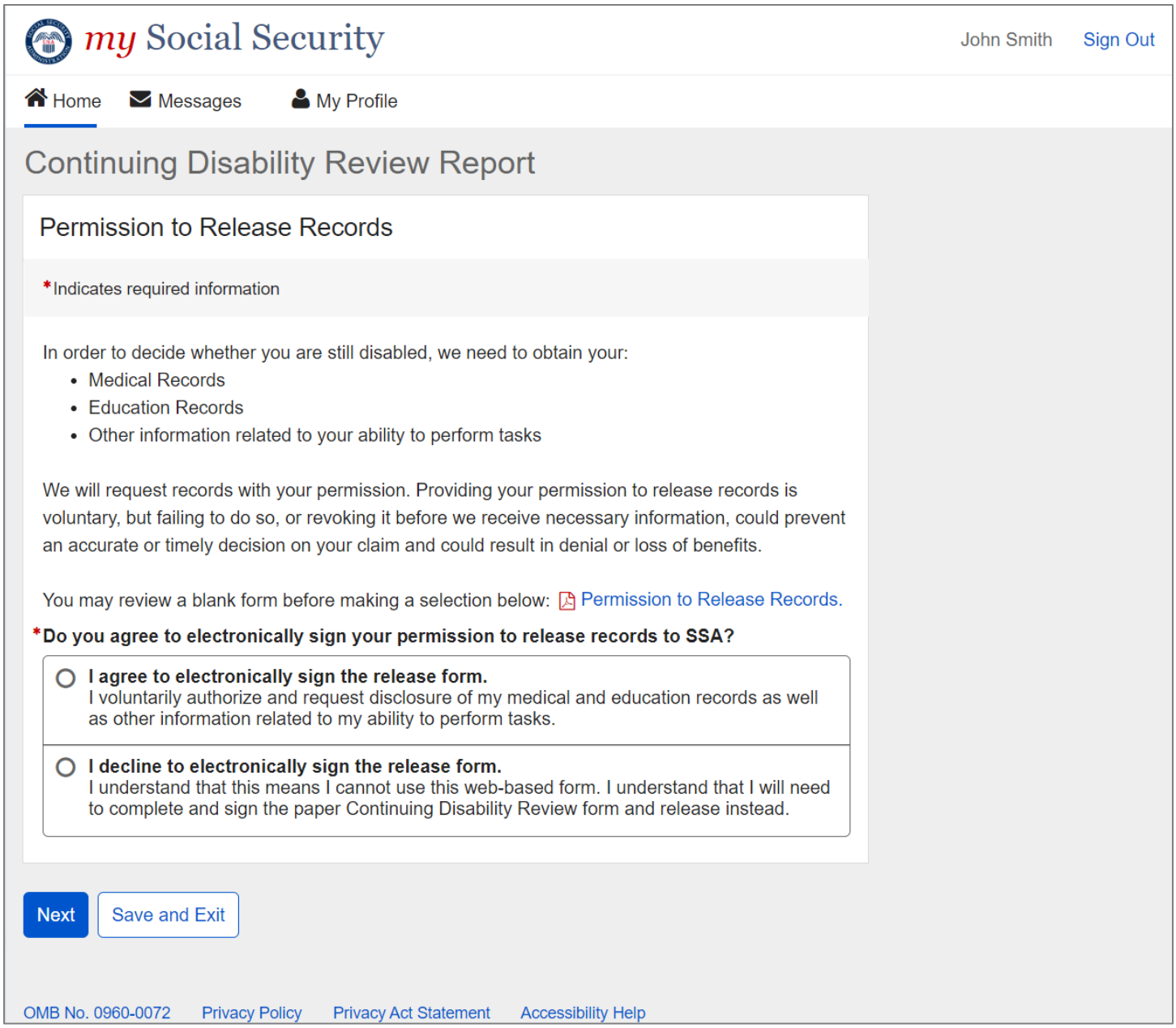
1.2. Privacy Act Statement: Collection and Use of Personal Information

A user is provided with the Privacy Act Statement before prior to completion of the i454.



1.3. Permission to Release Records (SSA-827)

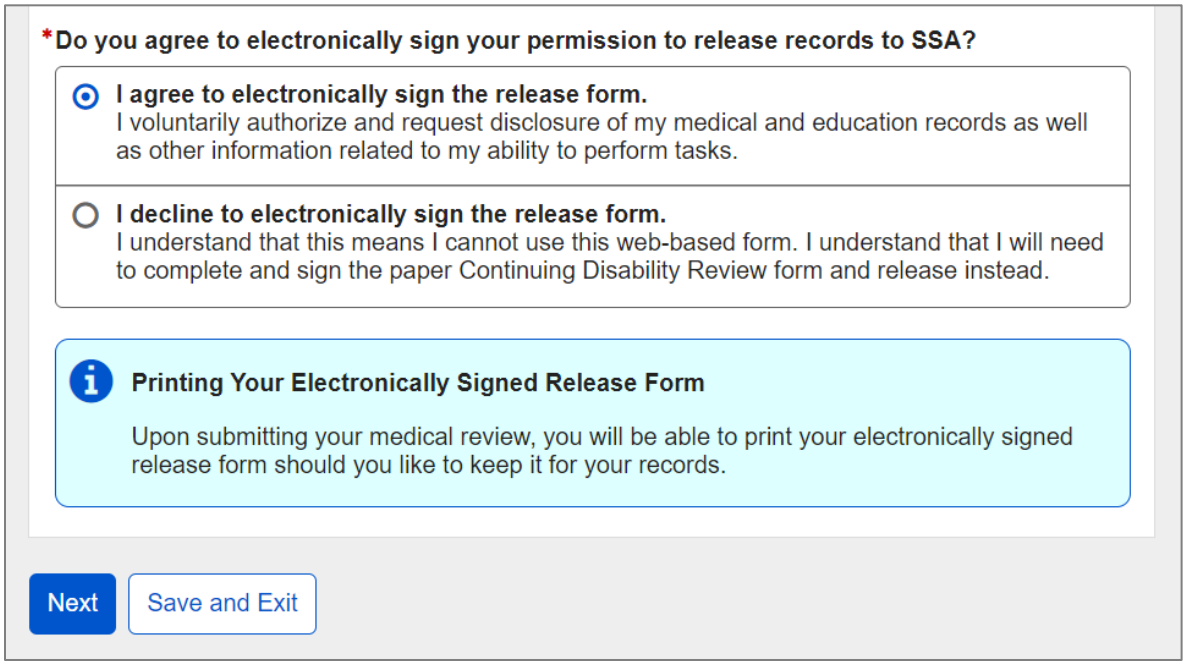
The user has an option to sign SSA-827 electronically and continue completing the i454 or complete both forms on paper and mail them to SSA.



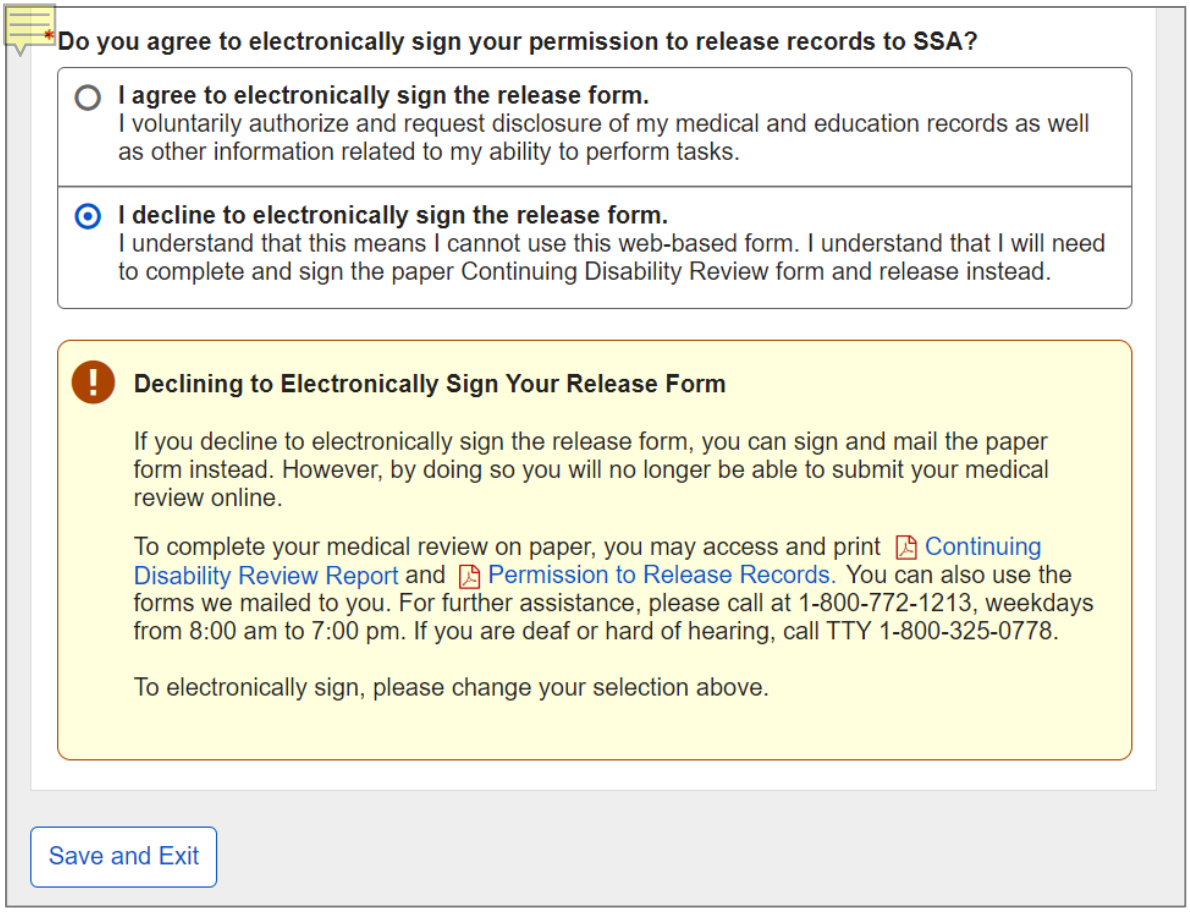
NOTE: Upon accessing the Continuing Disability Review application, a footer as shown below will display.

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.

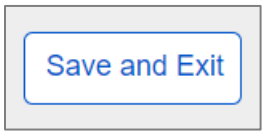


If the user selects "I decline to electronically sign the release form." a warning message appears below, letting the user know how to submit their review and the release form using paper forms. Links to the SSA-454 and SSA-827 forms are included.

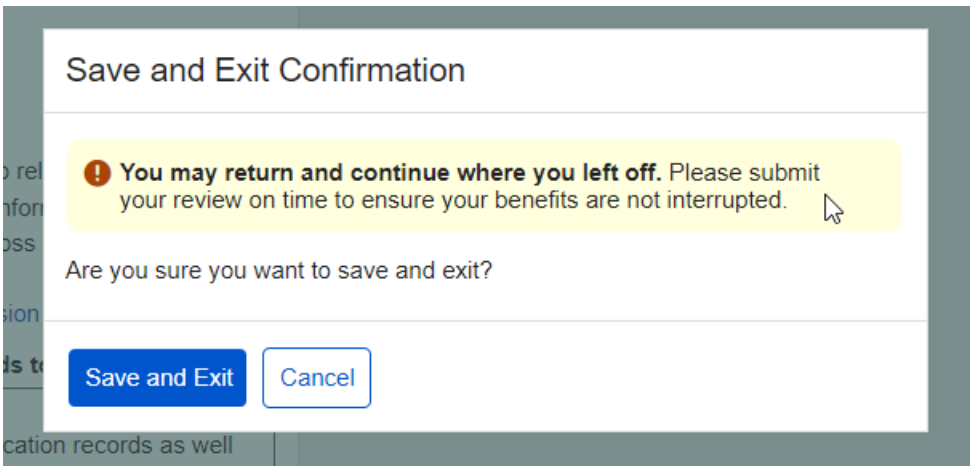


1.4. Save and Exit

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

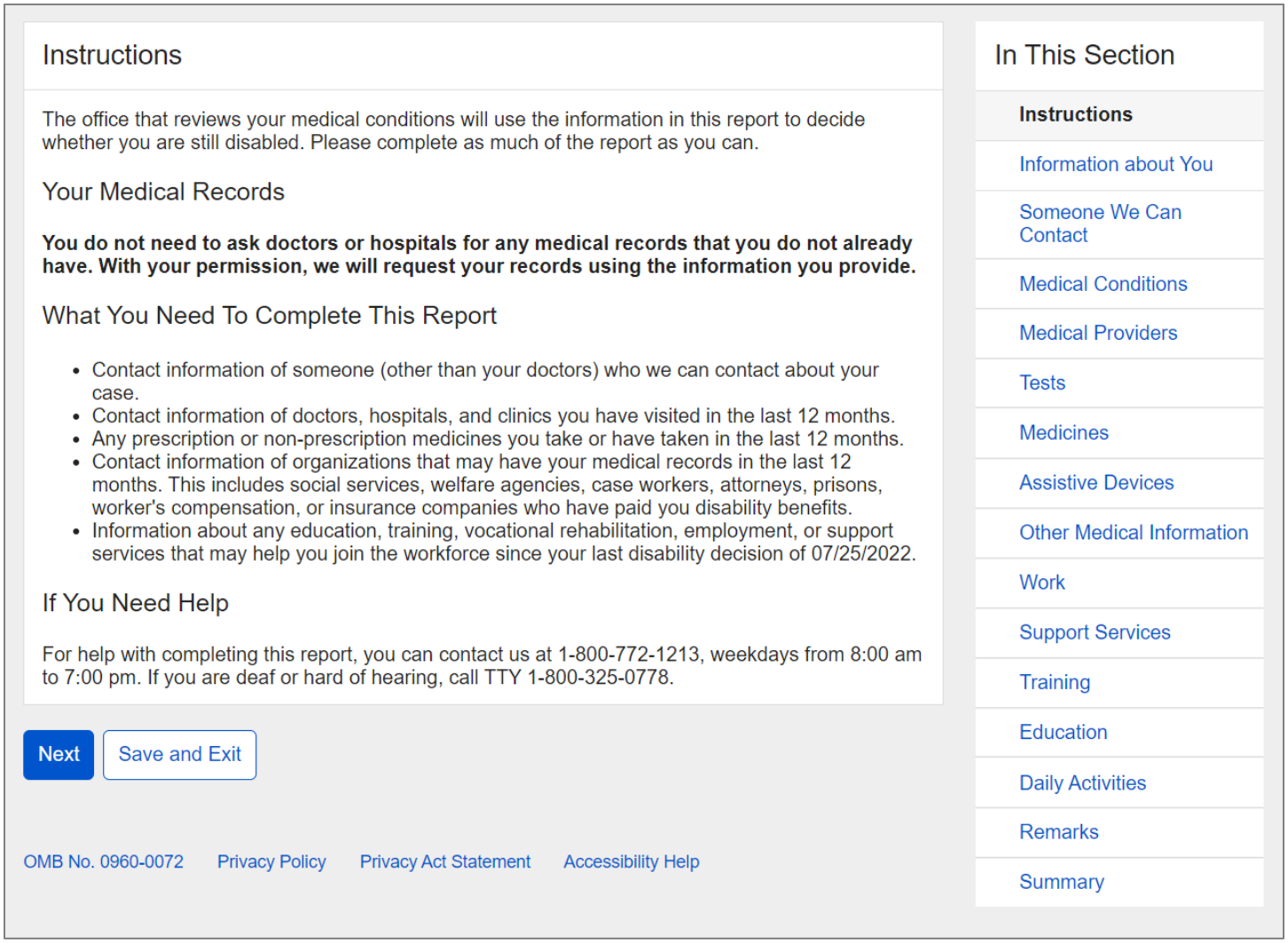


The following confirmation message will display.



1.5. Instructions

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

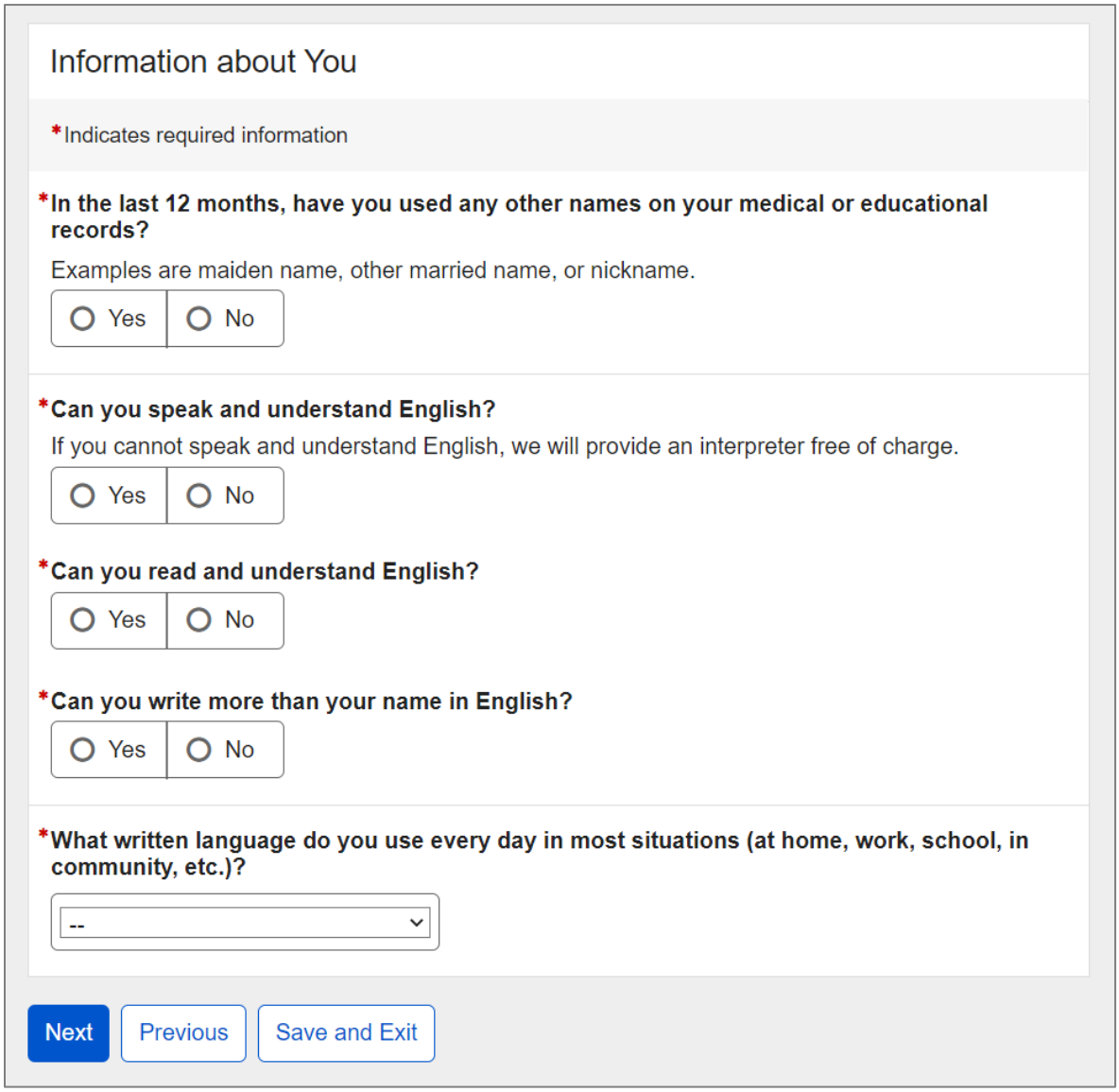


The side navigation on right displays on all screens within the application. Users can either go through the screens of the application in order or access any of the screens from the right navigation if they prefer. Green check marks indicate sections completed without errors.

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

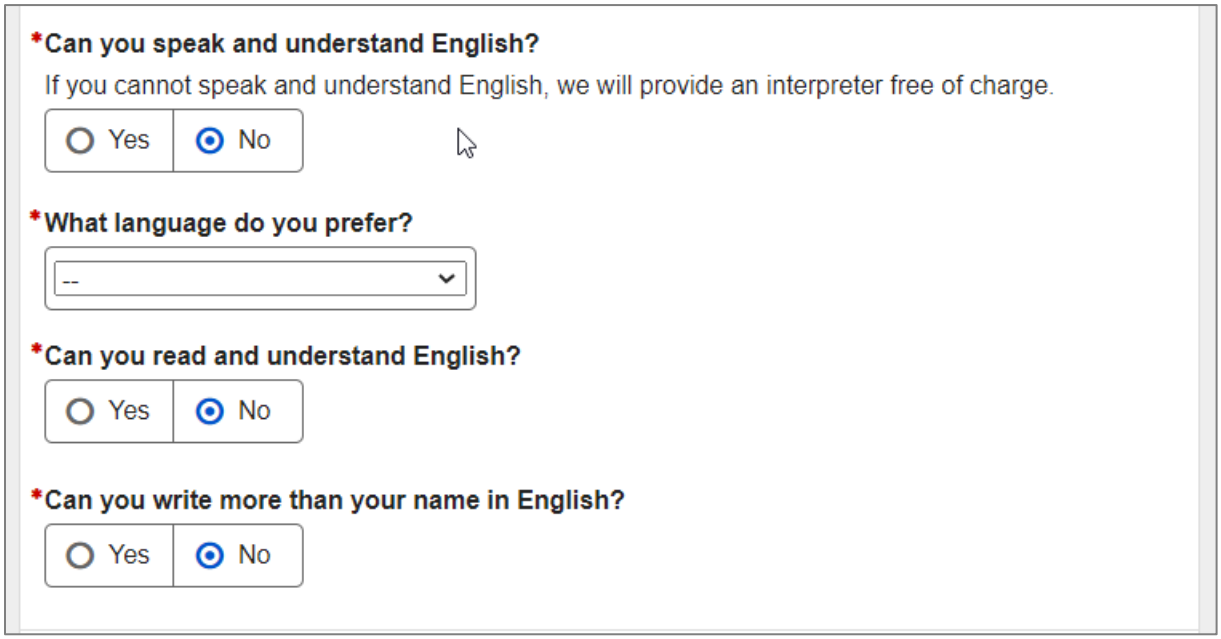
1.5. Information about You

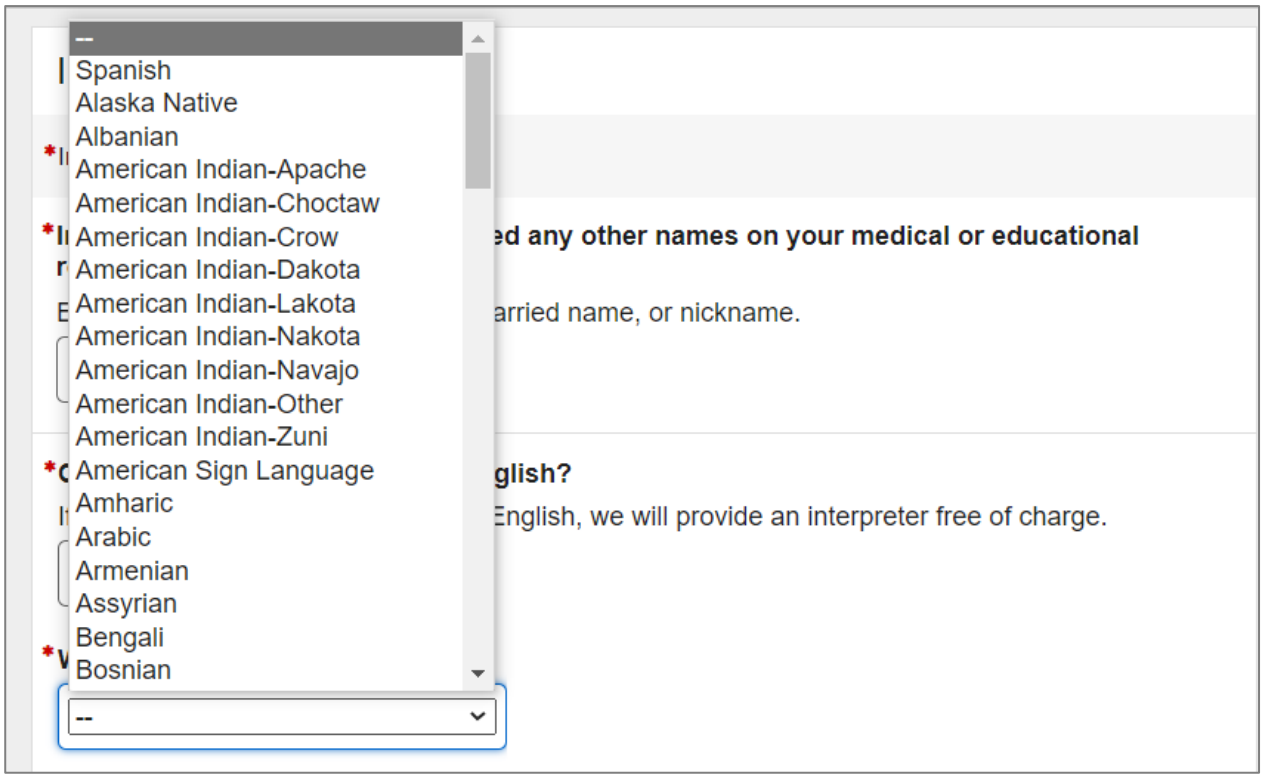
The user needs to respond to several questions about using other names as well as their ability to communicate. Since the user is authenticated to their my Social Security portal, their name, address, email, and phone do not need to be entered.



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.

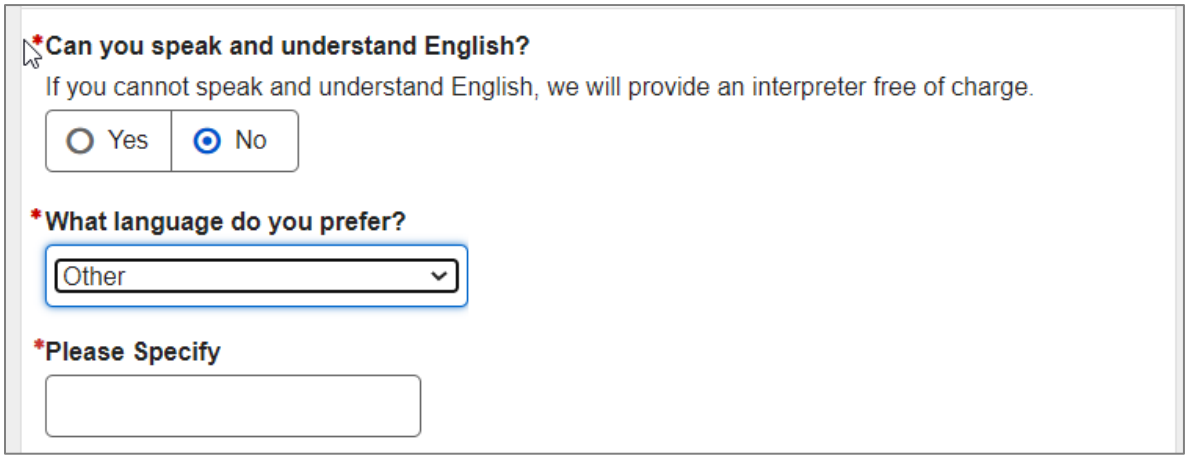
If the user selects “No” to the question “Can you speak and understand English?” they can select a language of their preference from the dropdown list.



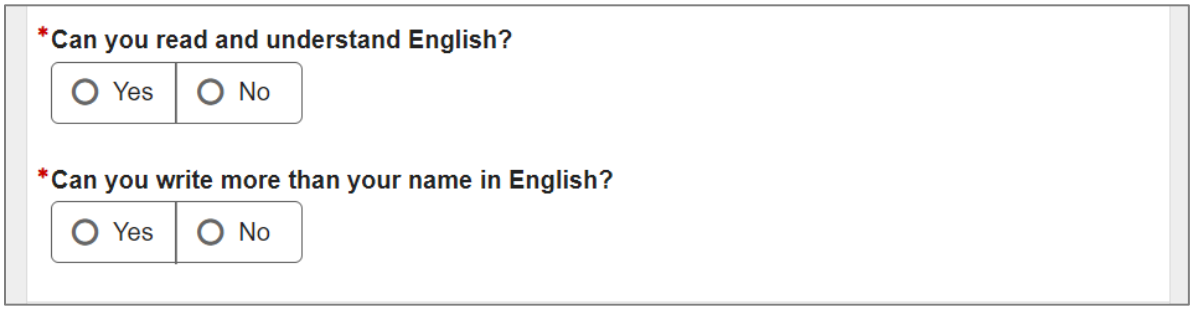


The list of languages is coming from the Global Reference Table (GRT).

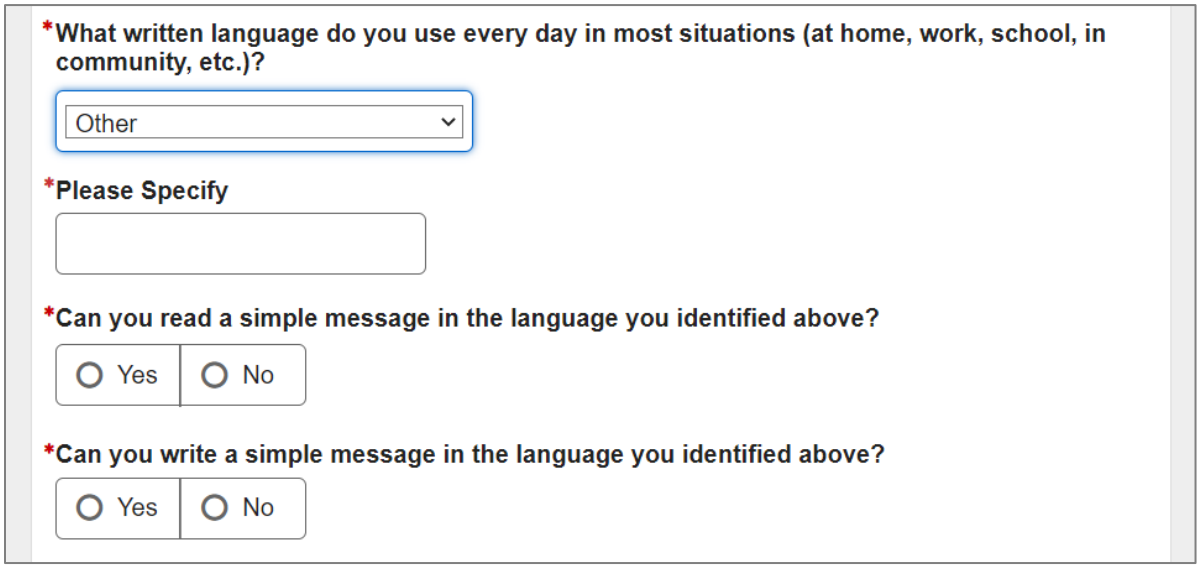
If the user cannot locate the language of their preference, they can select “Other” and specify in the field provided.



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.

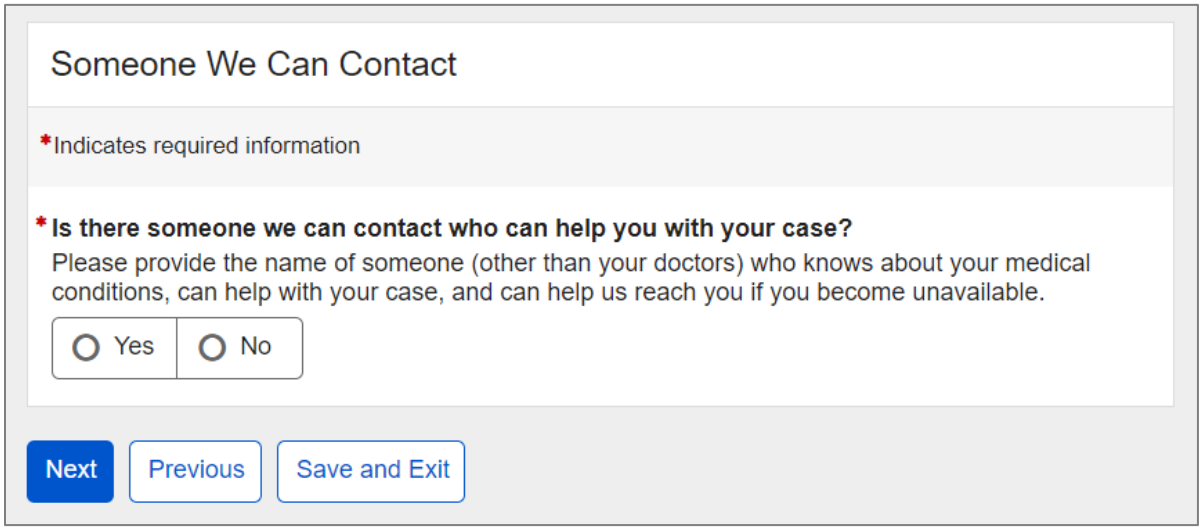


If the user cannot locate the language of their preference, they can select “Other” and specify in the field provided.

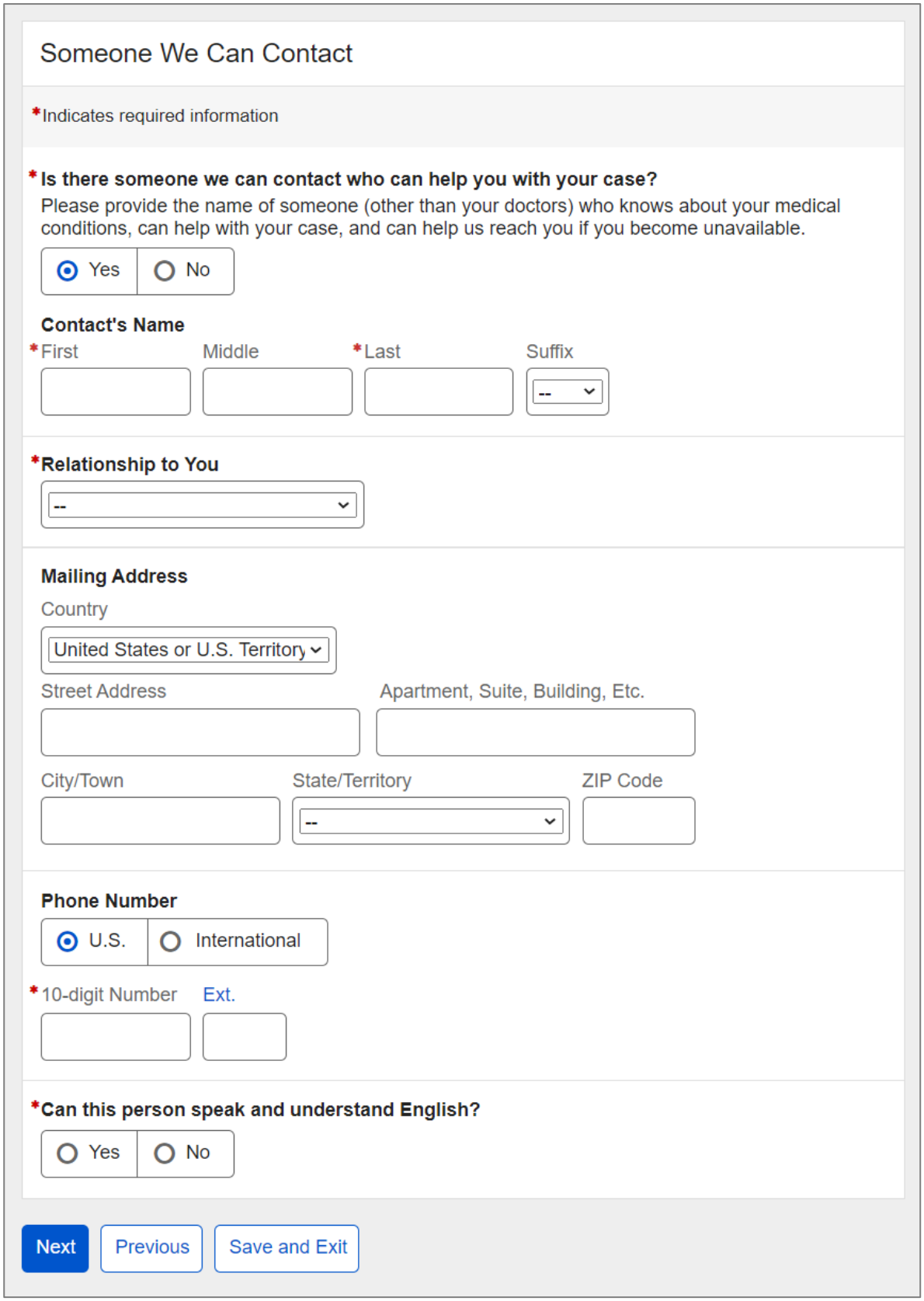


1.6. Someone We Can Contact

The user is asked to provide a contact person.

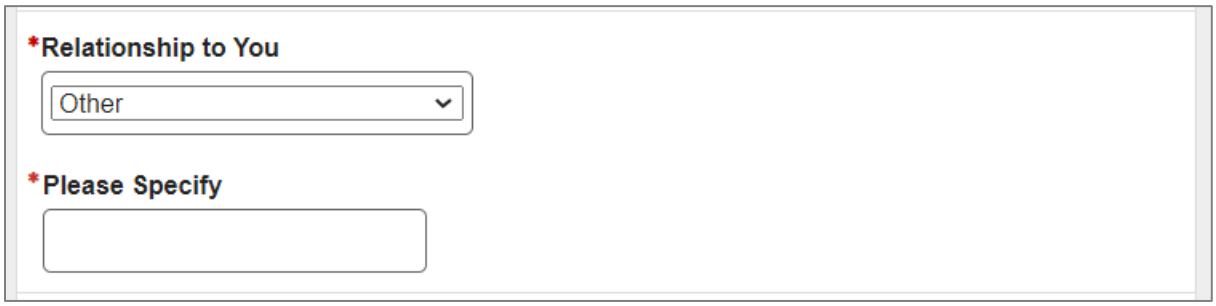


If the user answers “Yes” to the “Is there someone we can contact who can help with your case?” question, additional fields will appear below to capture details.



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

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

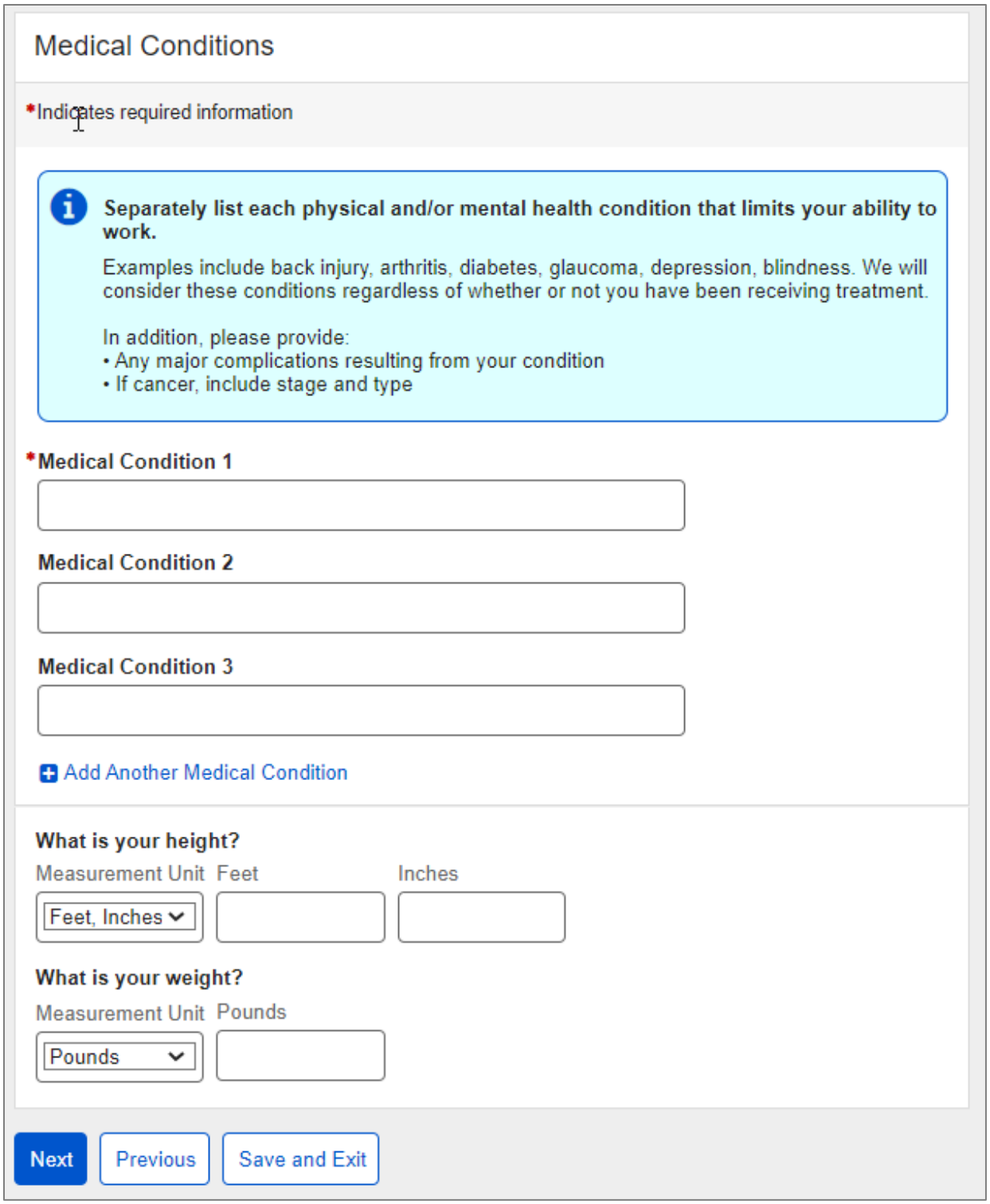


If the user answers “No” to their contact’s ability to speak and understand English, they can select a language other than English from the list. The list of languages is coming from the GRT table.

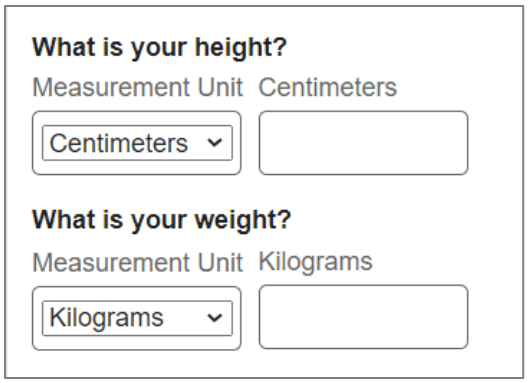
If the user selects “Other,” they can specify what language their contact prefers.

1.7. Medical Conditions

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

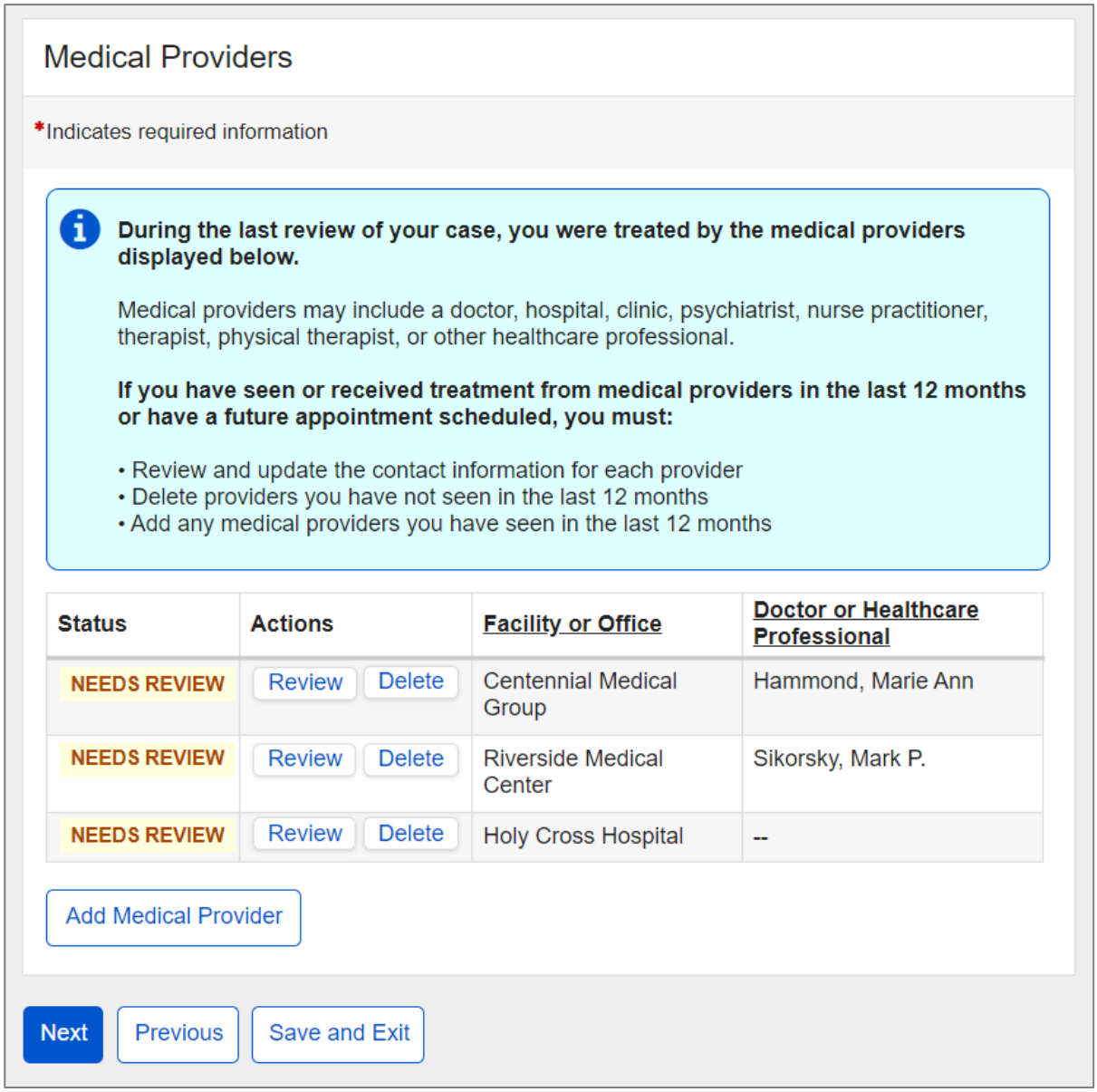


The user can switch to the metric system when entering height and weight, if needed.



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

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
Marie	Ann	Hammond	--

Phone Number

(•) U.S. ( ) International

*10-digit Number: (410) 454-1012 Ext.: 1001

Address

You may find this information on medical bills or the internet. If you don't have the full street address, please give as much information as you can remember. Example: On Main St. next to courthouse.

Country: United States or U.S. Territory

Street Address: 4500 Red Clay Lane

Apartment, Suite, Building, Etc.:

City/Town: Laurel

State/Territory: Maryland

ZIP Code: 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.**

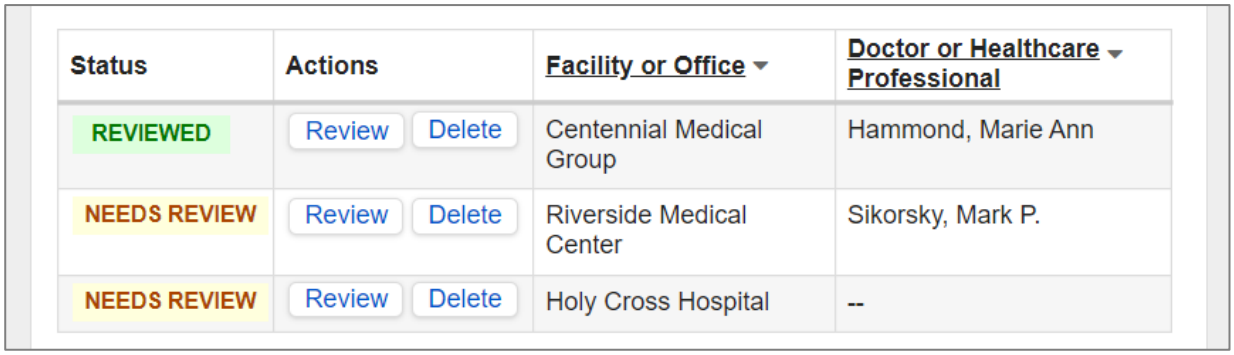
Month: -- Year:

[ ] I don't remember

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

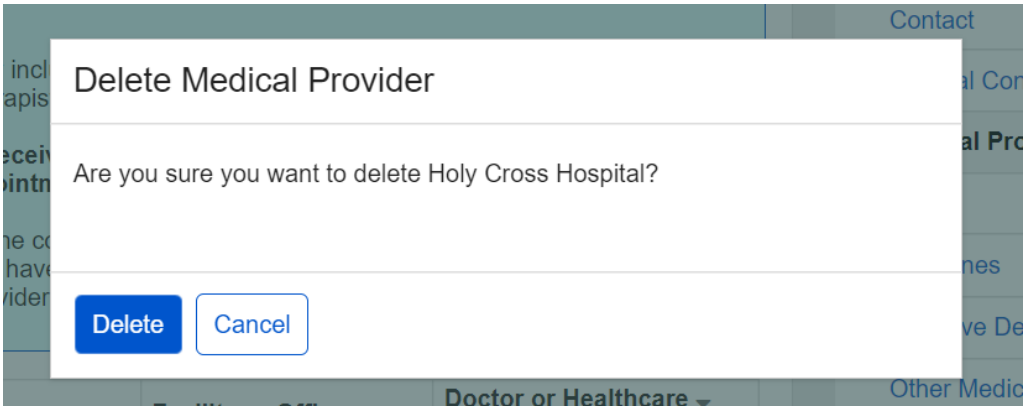
Save Cancel

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.

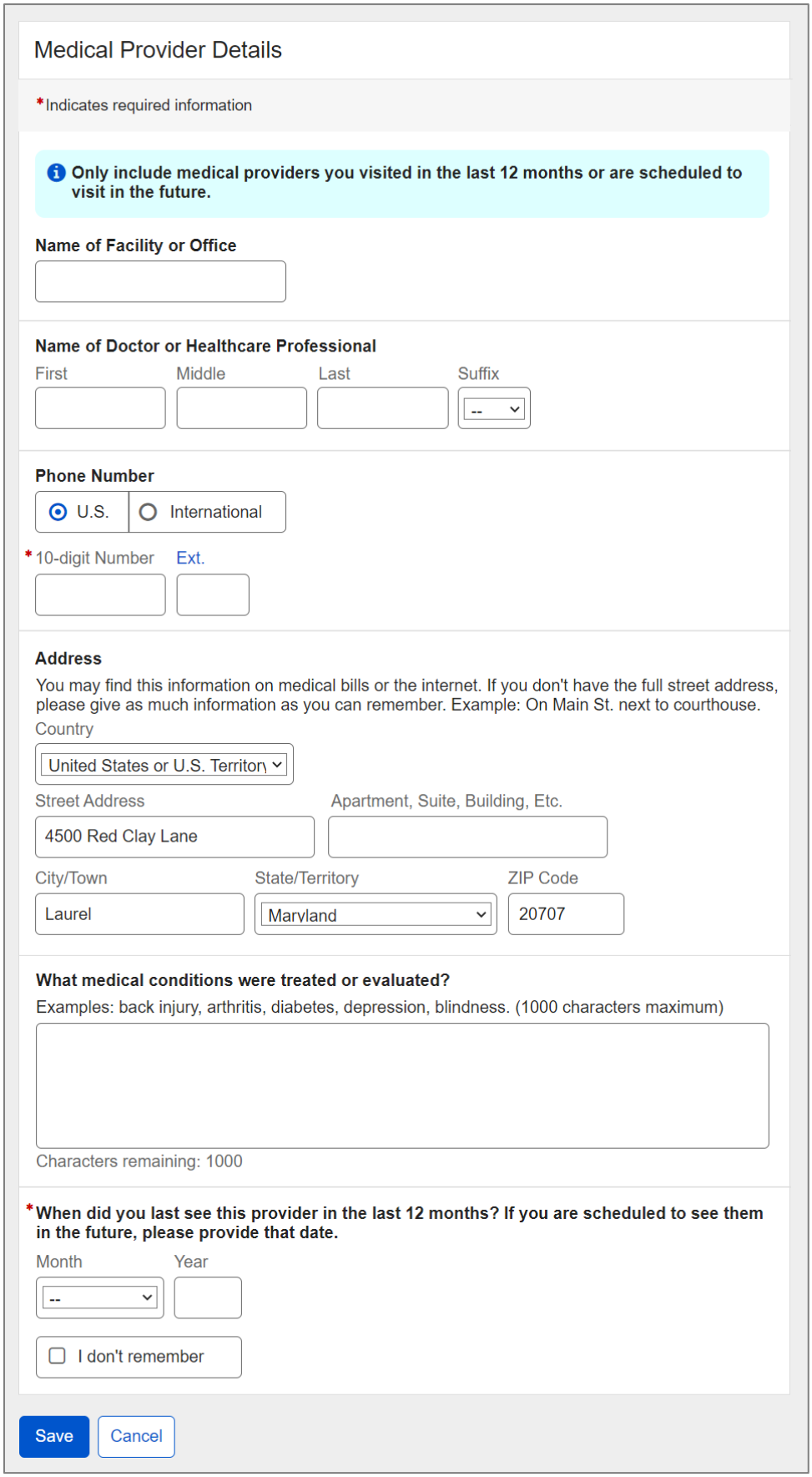


Status	Actions	Facility or Office	Doctor or Healthcare Professional
REVIEWED	Review Delete	Centennial Medical Group	Hammond, Marie Ann
NEEDS REVIEW	Review Delete	Riverside Medical Center	Sikorsky, Mark P.
NEEDS REVIEW	Review Delete	Holy Cross Hospital	--

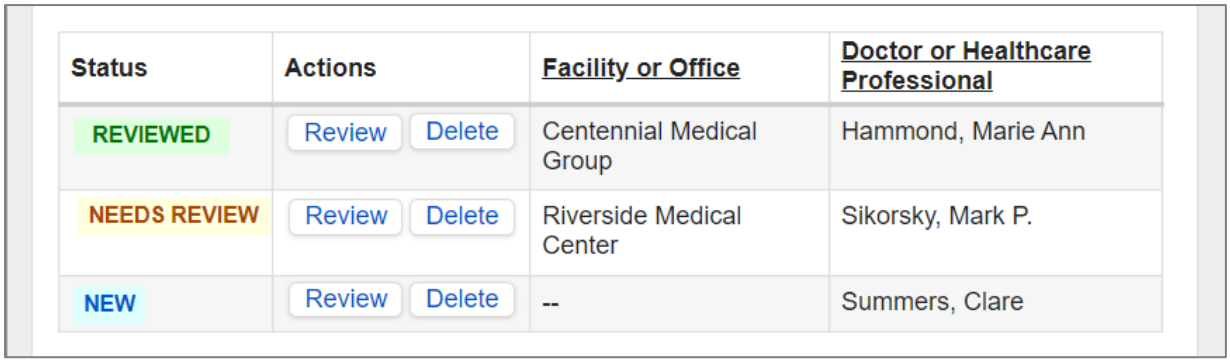
If the user needs to delete a provider, they can click the “Delete” button. Upon clicking on “Delete,” the following confirmation message will display.



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

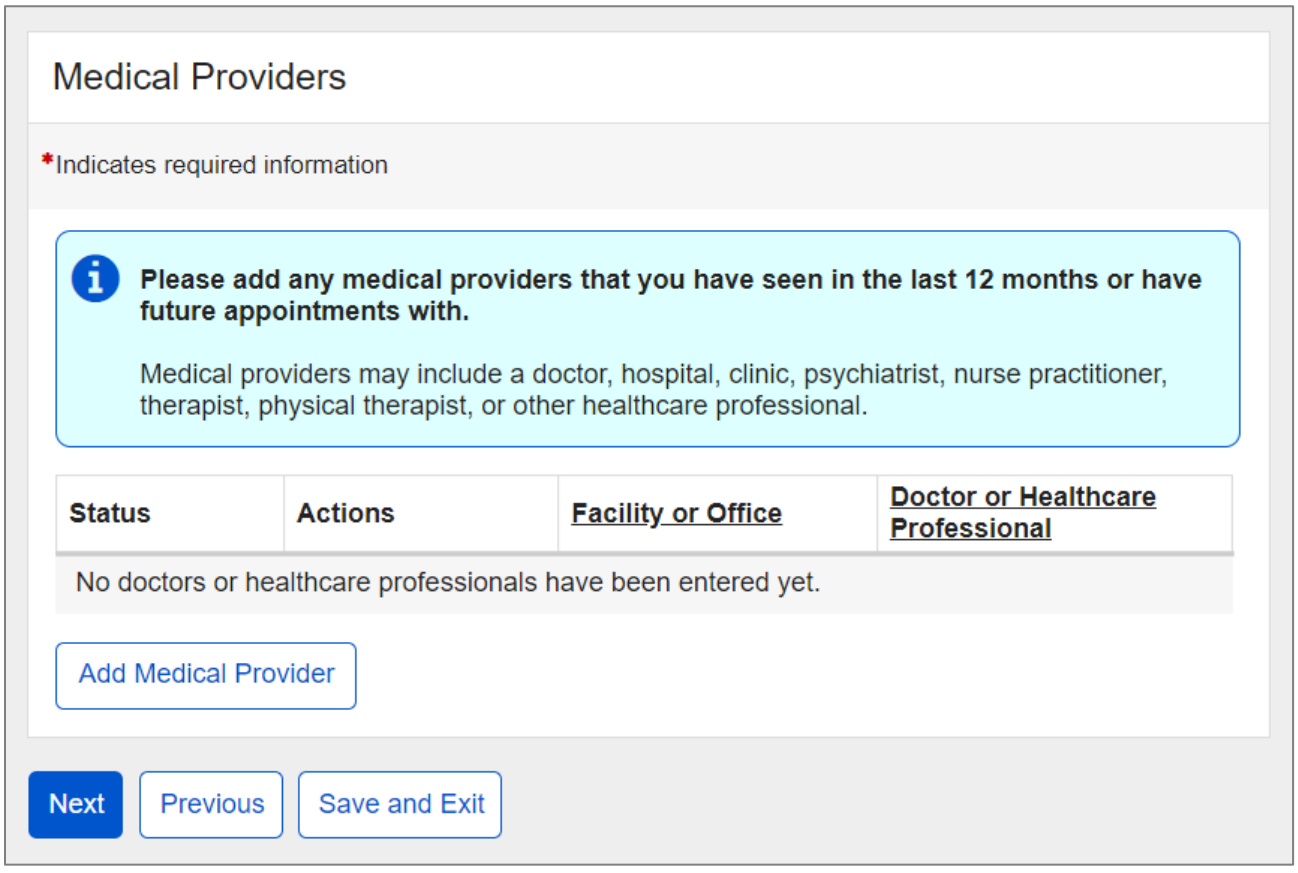


Upon saving, the user will be taken back to the Medical Providers page. The informational status badge “NEW” will be displayed against the provider added.



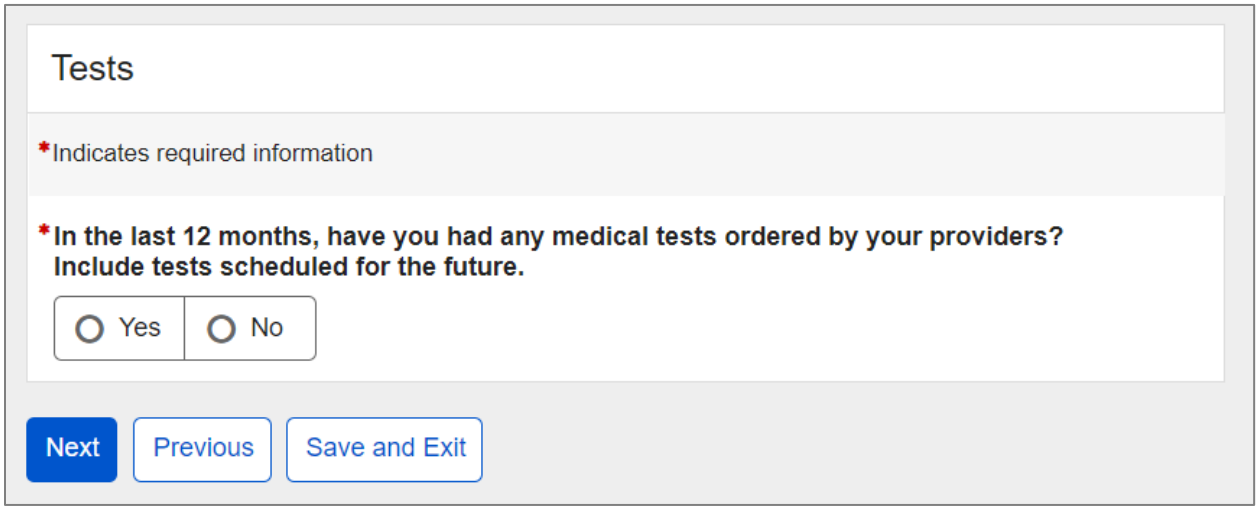
Status	Actions	Facility or Office	Doctor or Healthcare Professional
REVIEWED	Review Delete	Centennial Medical Group	Hammond, Marie Ann
NEEDS REVIEW	Review Delete	Riverside Medical Center	Sikorsky, Mark P.
NEW	Review Delete	--	Summers, Clare

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

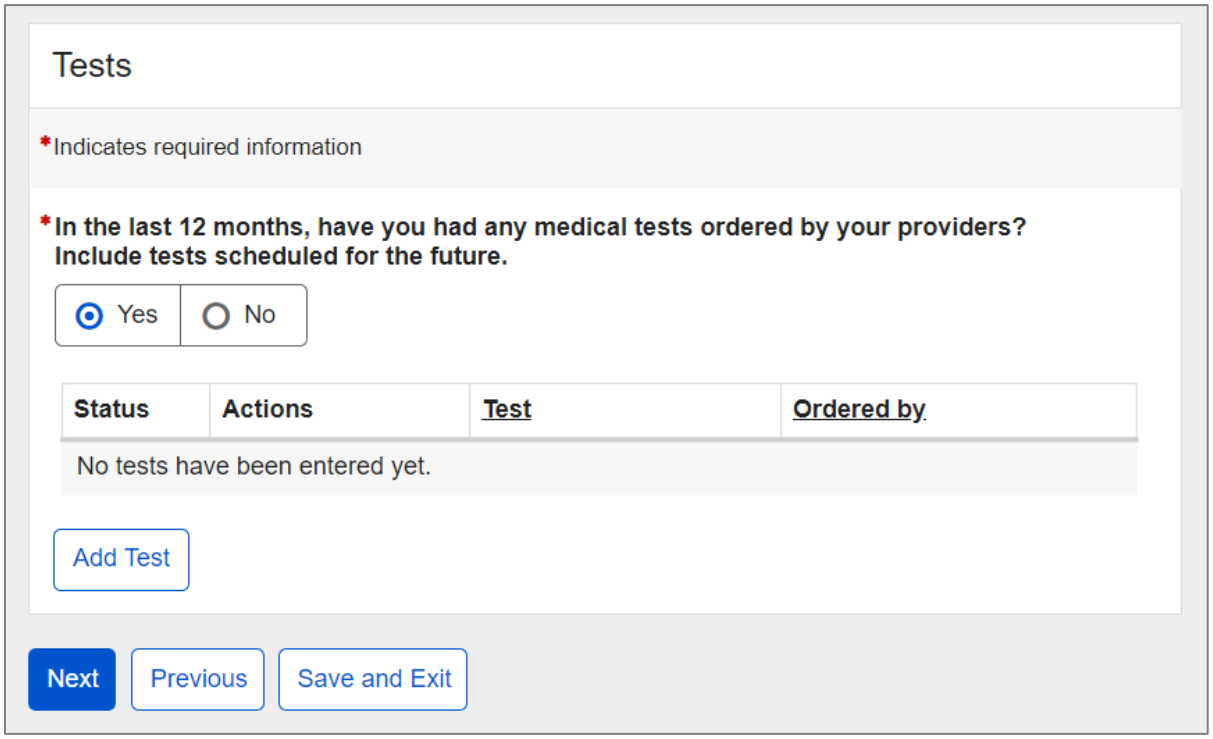


1.9. Tests

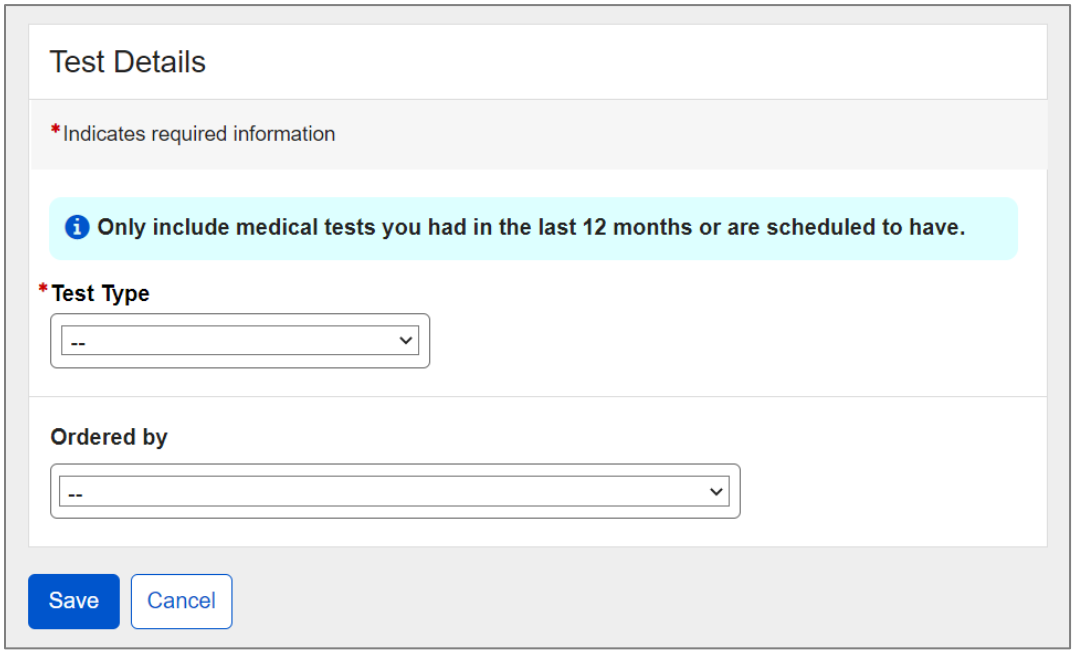
The user can enter details of tests ordered by their providers in the last 12 months.



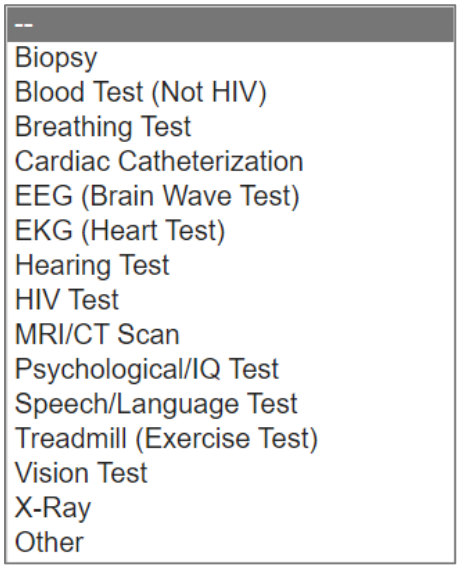
When the user selects "Yes," a blank Tests table will appear.



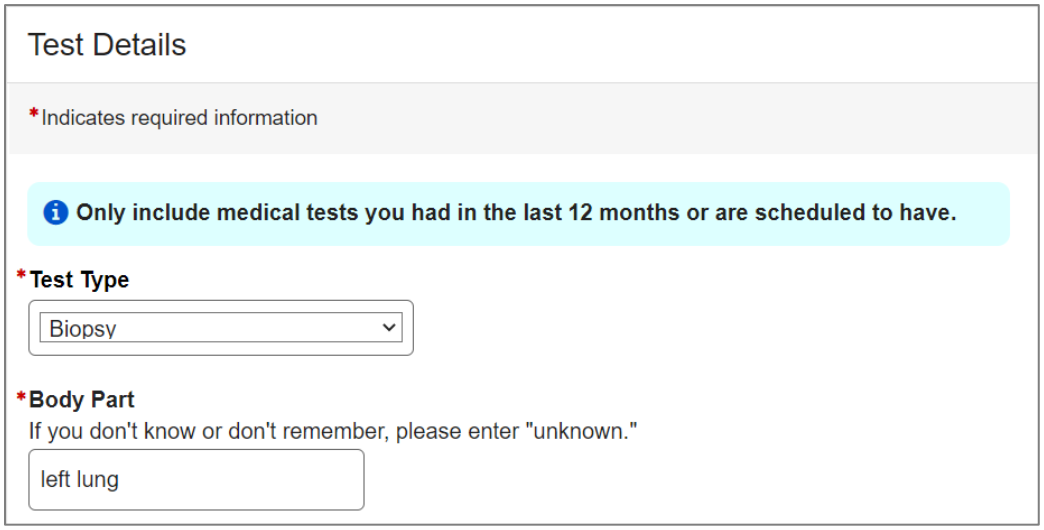
If the user selected the "Add Test" button, it will bring up the Test Details page where the user can enter test information.



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



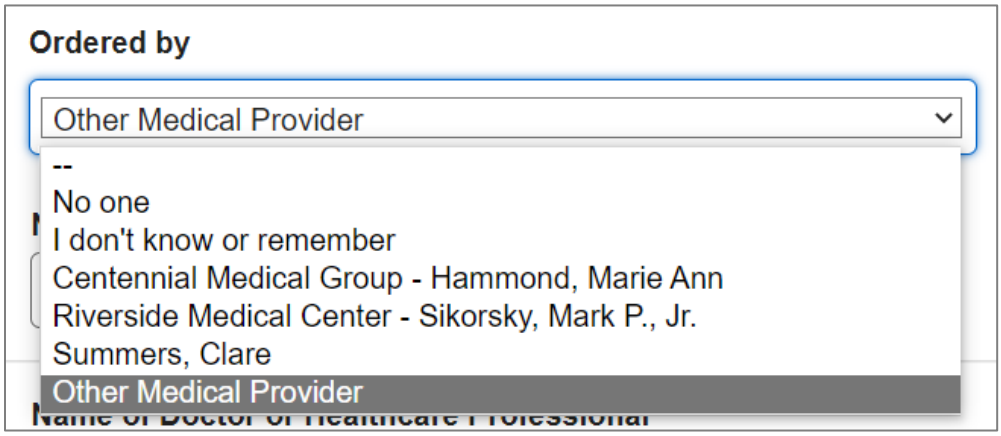
If either Biopsy, MRI/CT Scan, or X-ray is selected from the Test Type dropdown list, the user has to provide the body part:



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



Test Details

*Indicates required information

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

You may find this information on medical bills or the internet. If you don't have the full street address, please give as much information as you can remember. Example On Main St. next to courthouse.

Country: United States or U.S. Territory

Street Address: 4500 Red Clay Lane

Apartment, Suite, Building, Etc.

City/Town: Laurel

State/Territory: Maryland

ZIP Code: 20707

What medical conditions were treated or evaluated?

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

Characters remaining: 1000

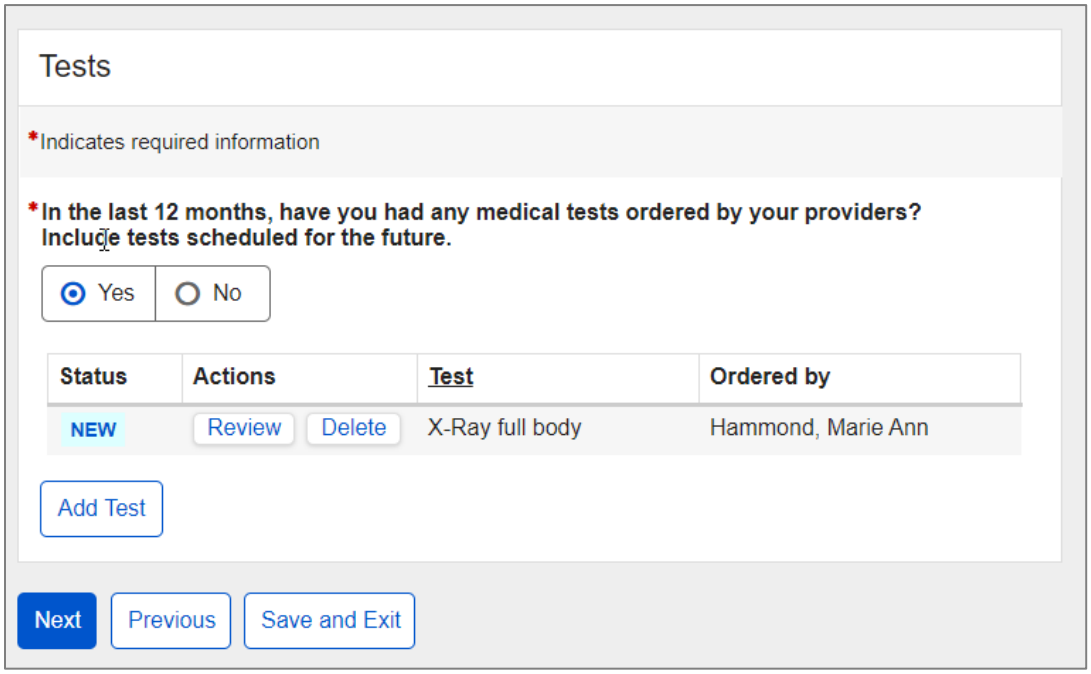
***When did you last see this provider in the last 12 months? If you are scheduled to see them in the future, please provide that date.**

Month | Year

I don't remember

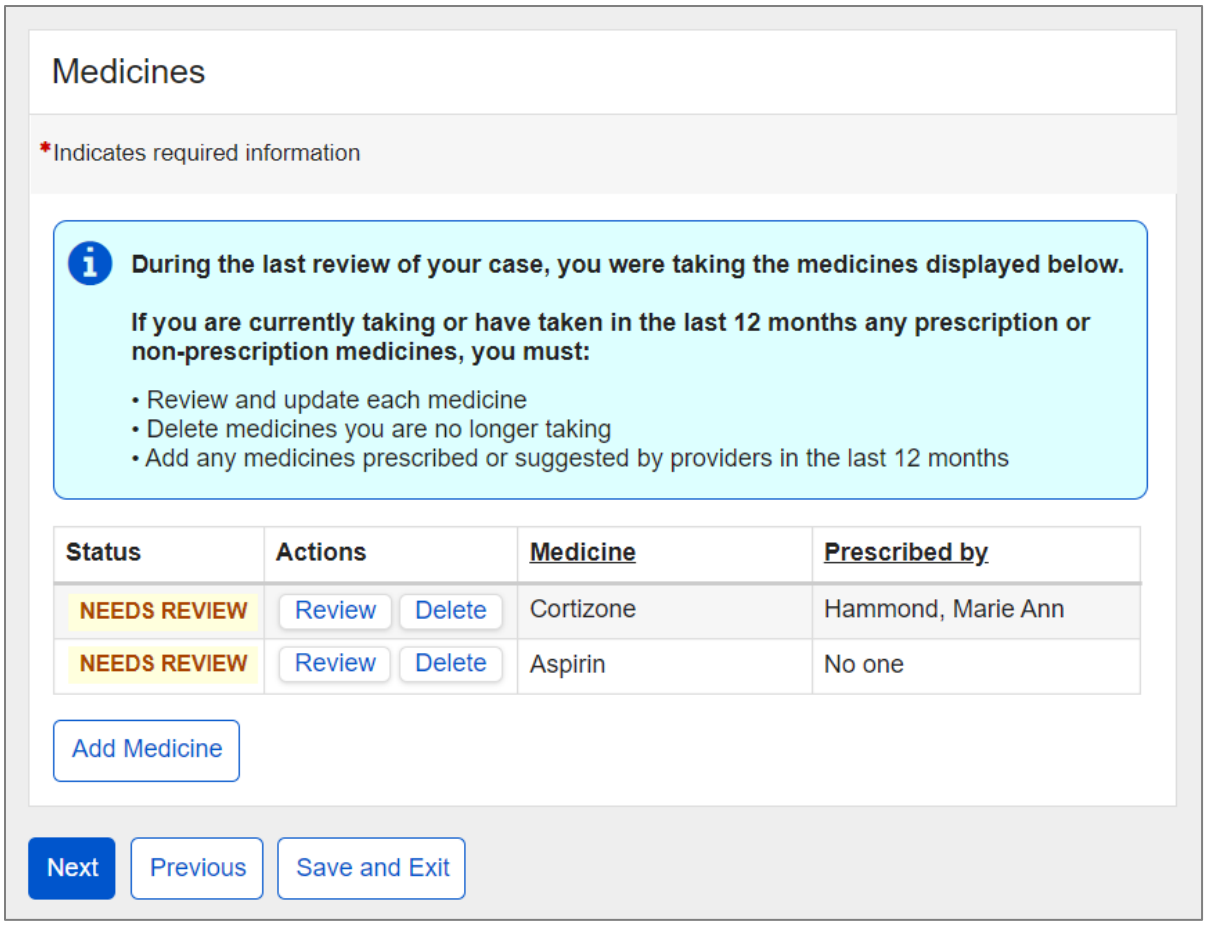
Save | Cancel

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.

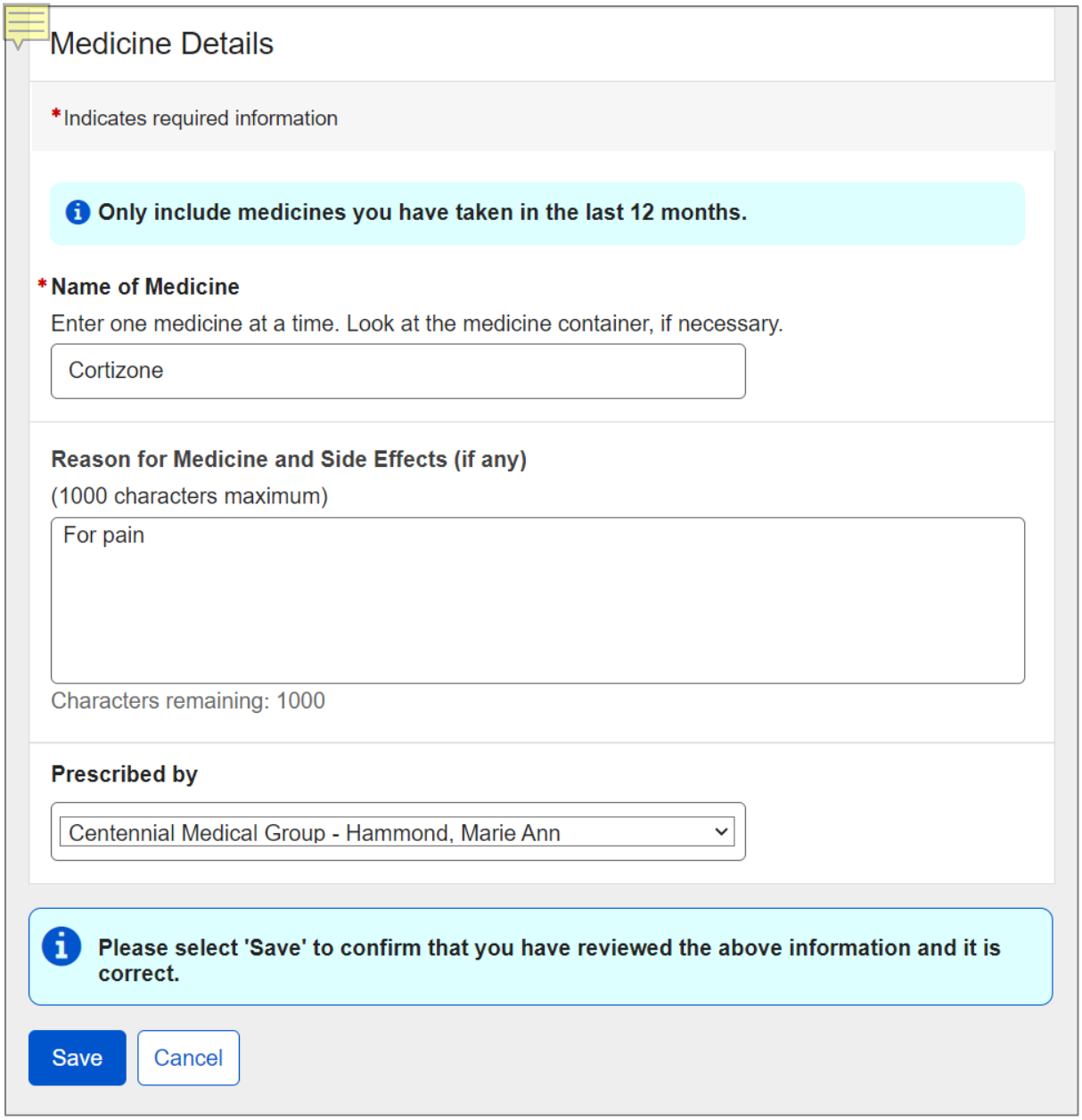


1.10. Medicines

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.



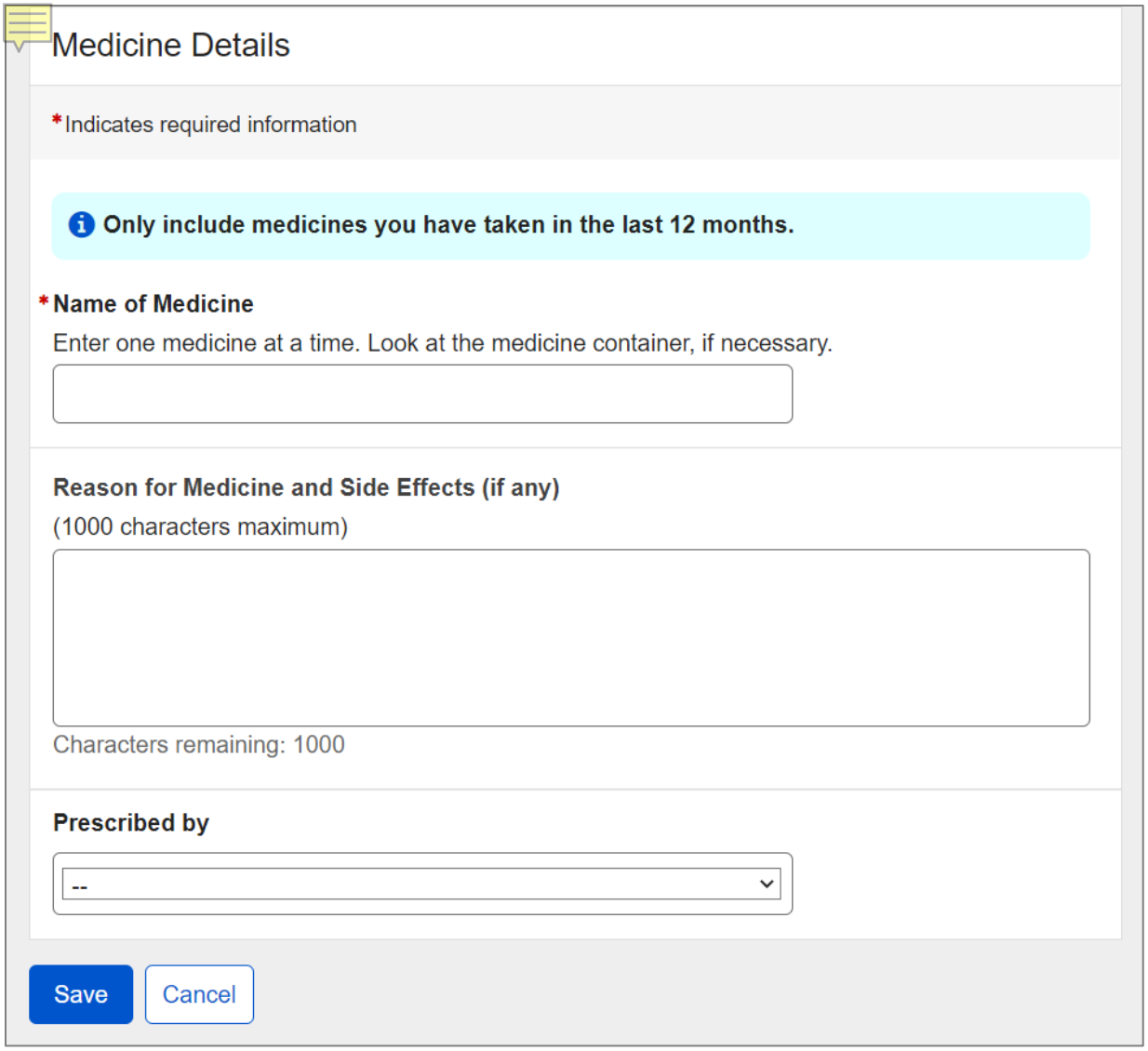
The user can update a medicine by selecting the "Review" button. The "Review" button brings up a page titled "Medicine Details" with data propagated from the last review. The user can review and update details, as needed. The "Prescribed by" dropdown includes providers already entered as well as the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



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

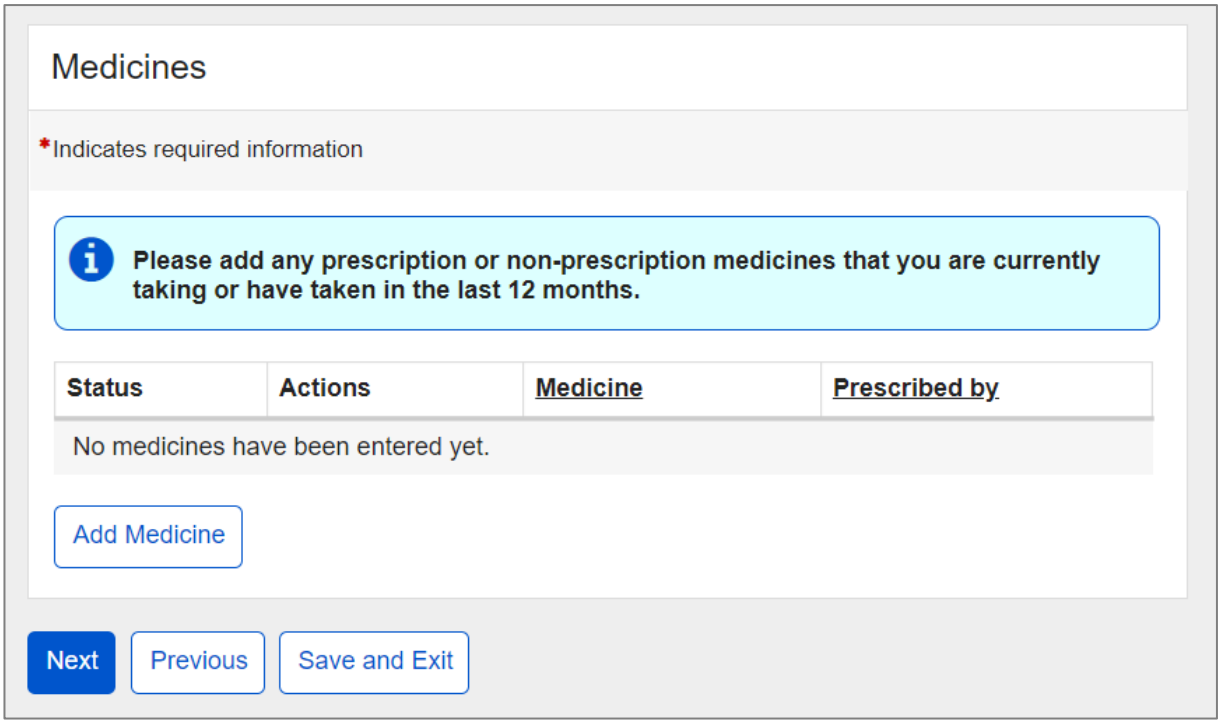
If the “Add Medicine” button is selected, the Medicine Details page will display.



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.

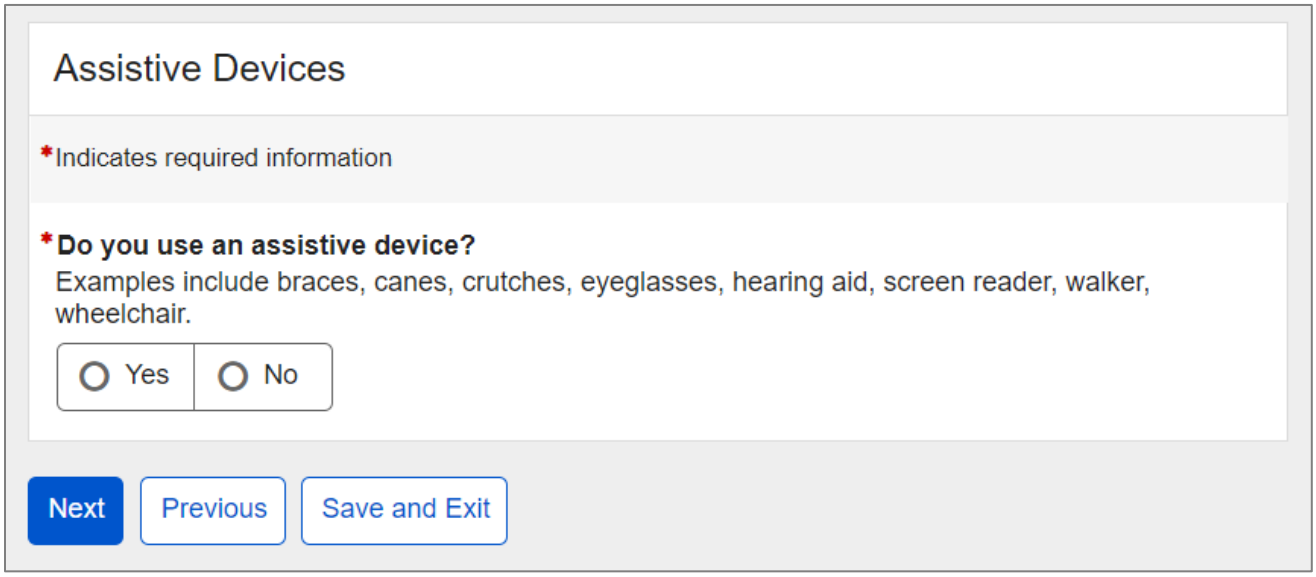
Status	Actions	Medicine	Prescribed by
REVIEWED	Review Delete	Cortizone	Hammond, Marie Ann
NEEDS REVIEW	Review Delete	Aspirin	No one
NEW	Review Delete	Vitamin D3	Summers, Clare

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

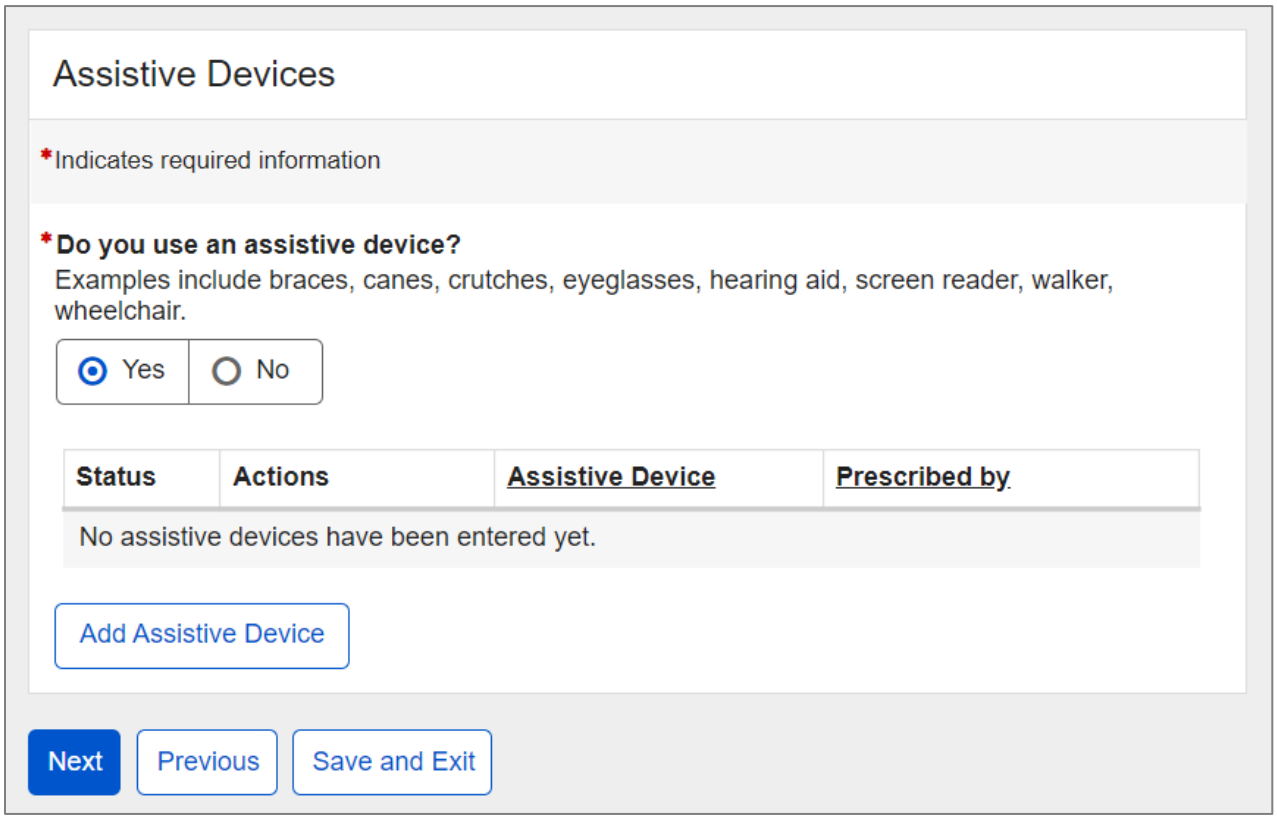


1.11. Assistive Devices

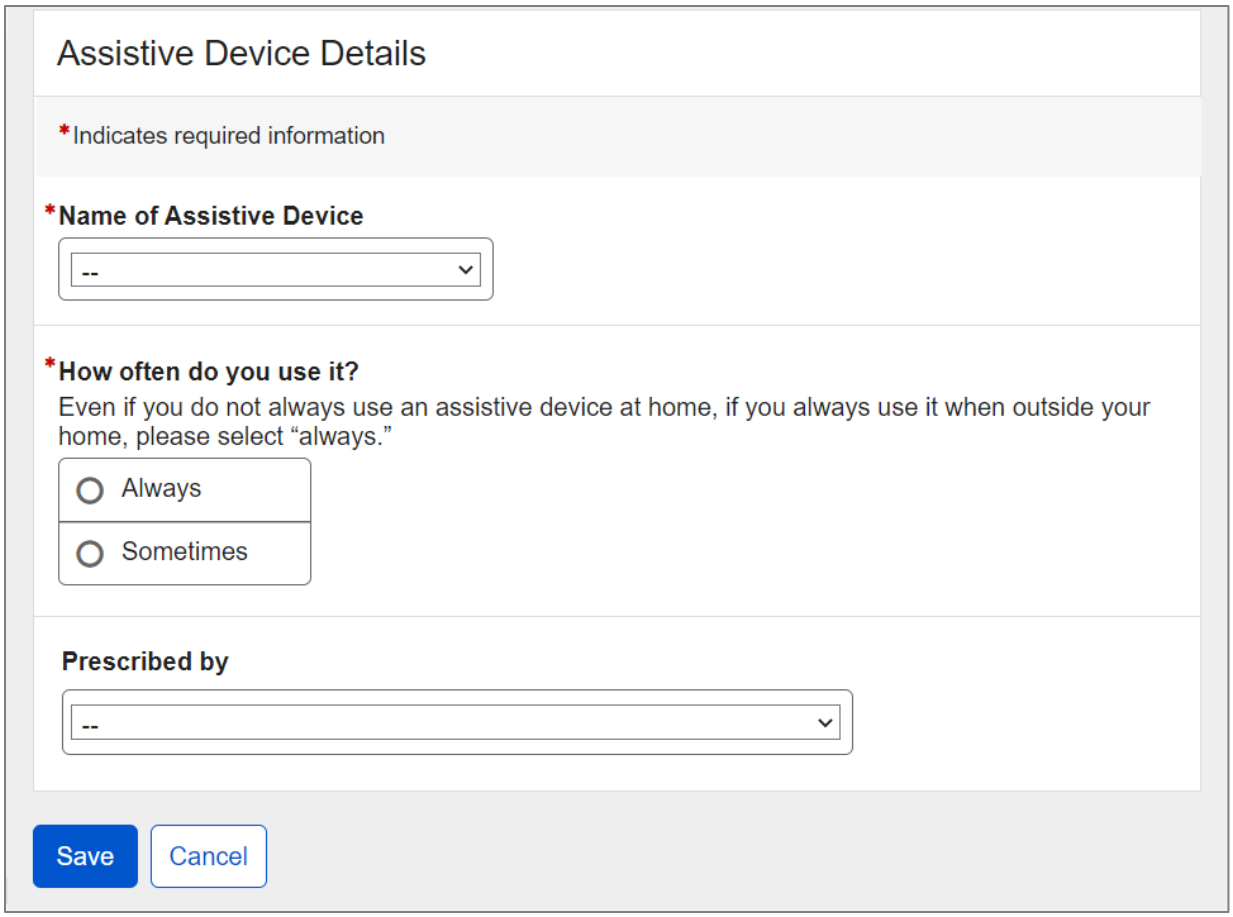
The user can add assistive devices they are using.



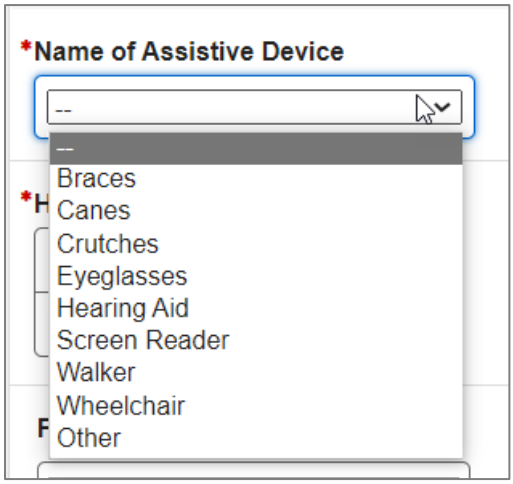
If the user selects "Yes," a blank Assistive Devices table will appear below.

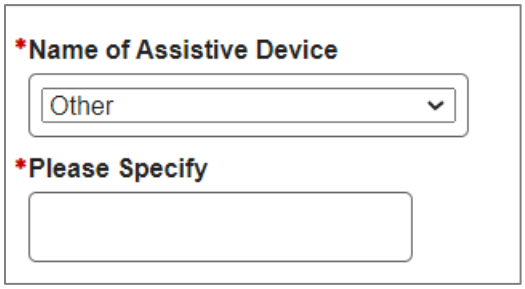


If the "Add Assistive Device" button is selected, then the Assistive Device Details page will display.

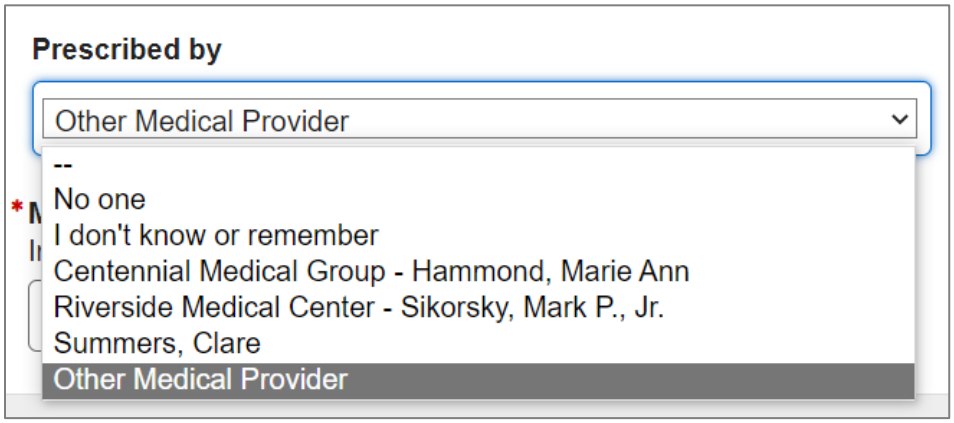


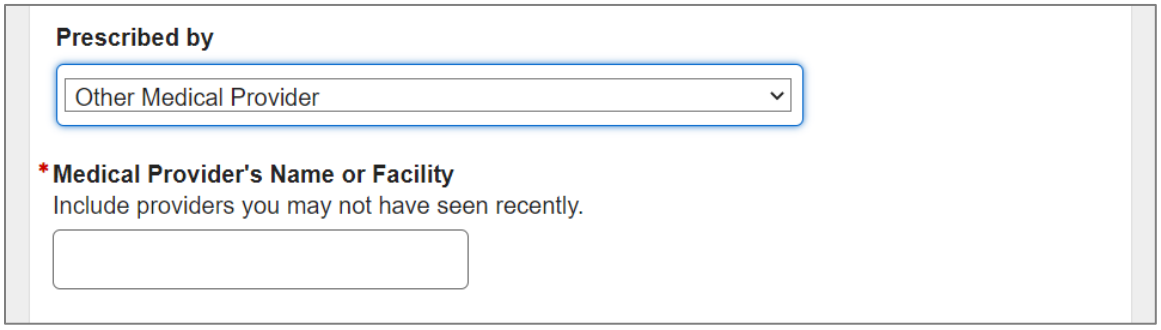
The user can select an assistive device from the list. If the assistive device is not listed, the user can select "Other" and specify.



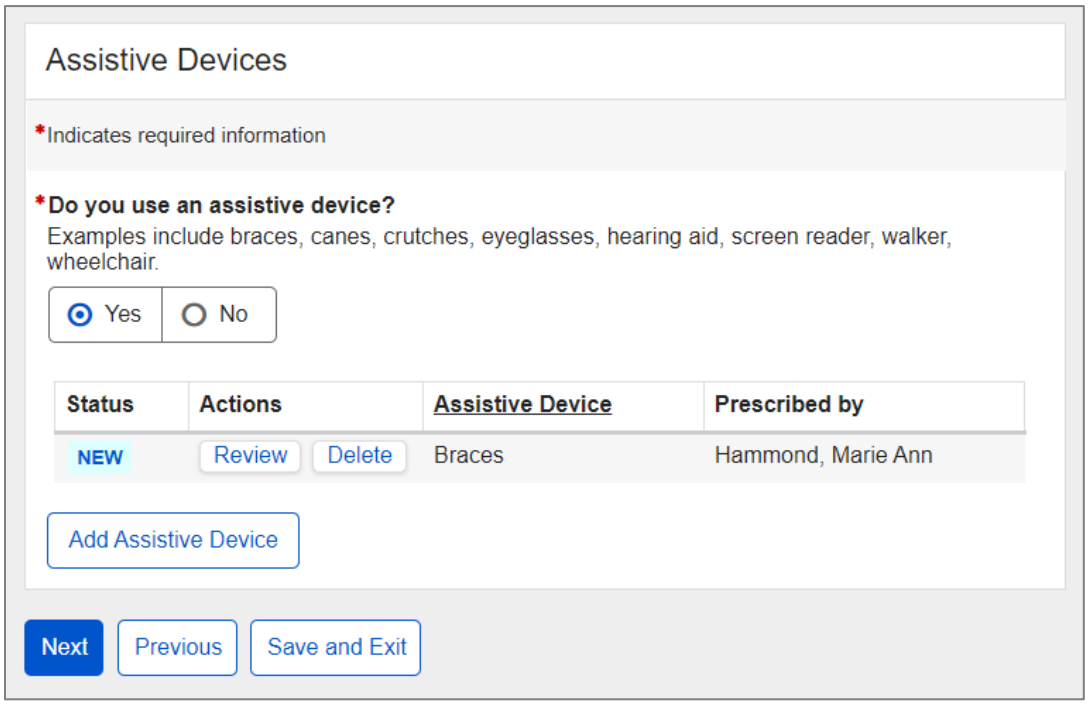


Then, the user can select a provider who prescribed the device under "Prescribed by." The list will contain medical providers already entered as well as other options. If the provider is not on the list, the user can select "Other Medical Provider" and enter Medical Provider's Name or Facility.



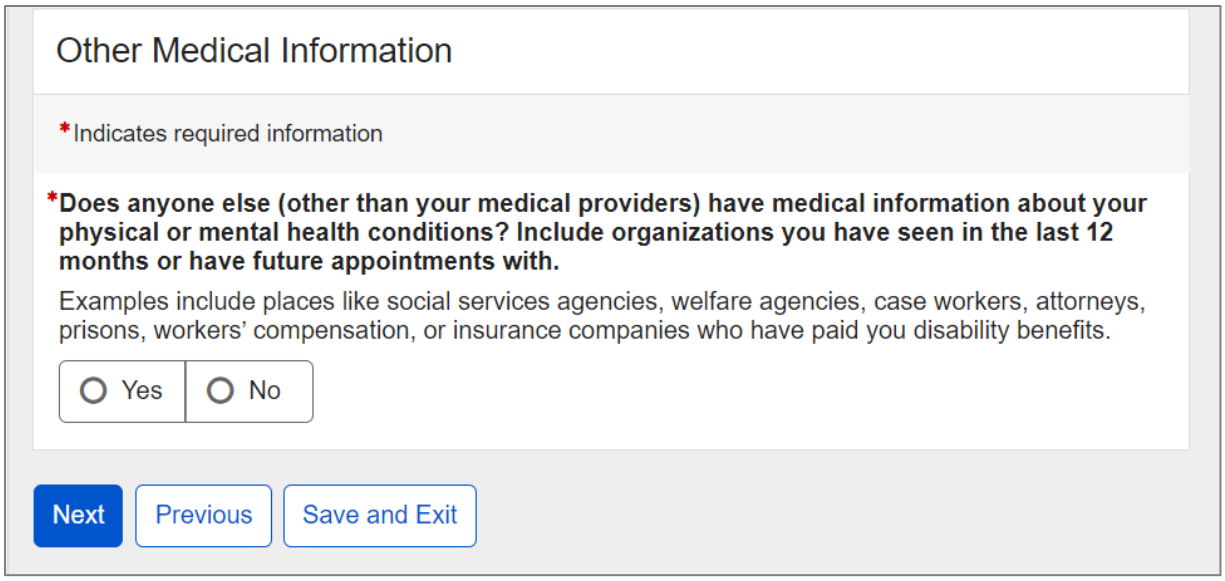


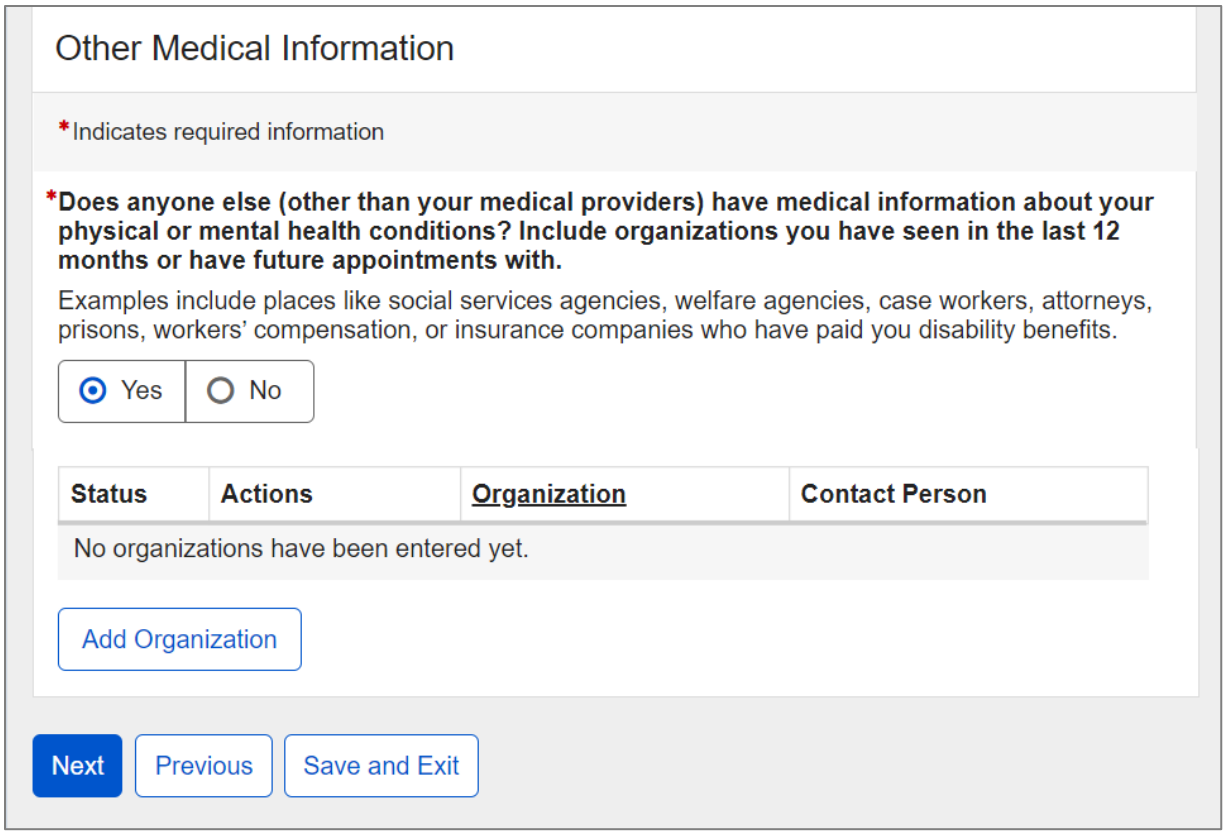
Upon saving, the user returns to the Assistive Devices page where the table is populated with a new entry designated by the "NEW" information status badge.



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.





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

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

Organization Details

*Indicates required information

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

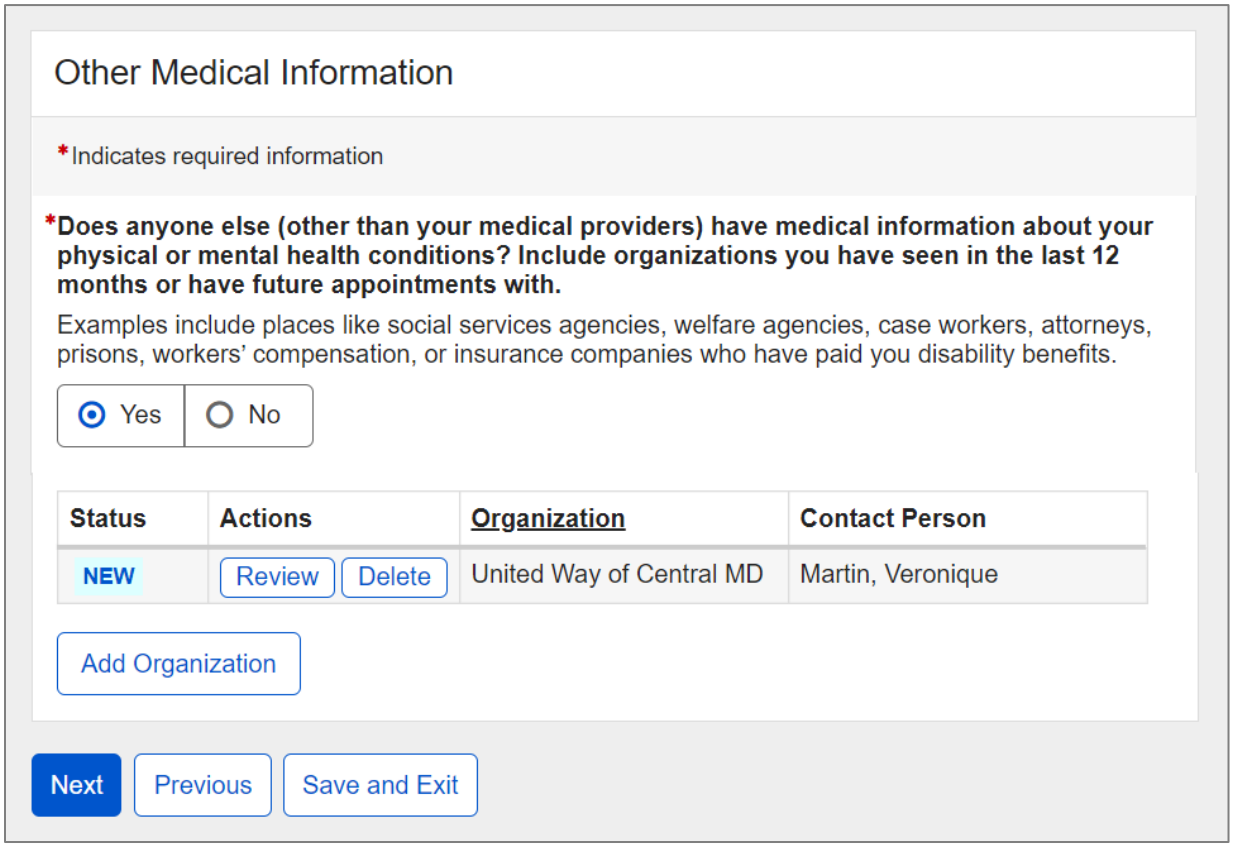
Reasons for Contact

(1000 characters maximum)

Characters remaining: 1000

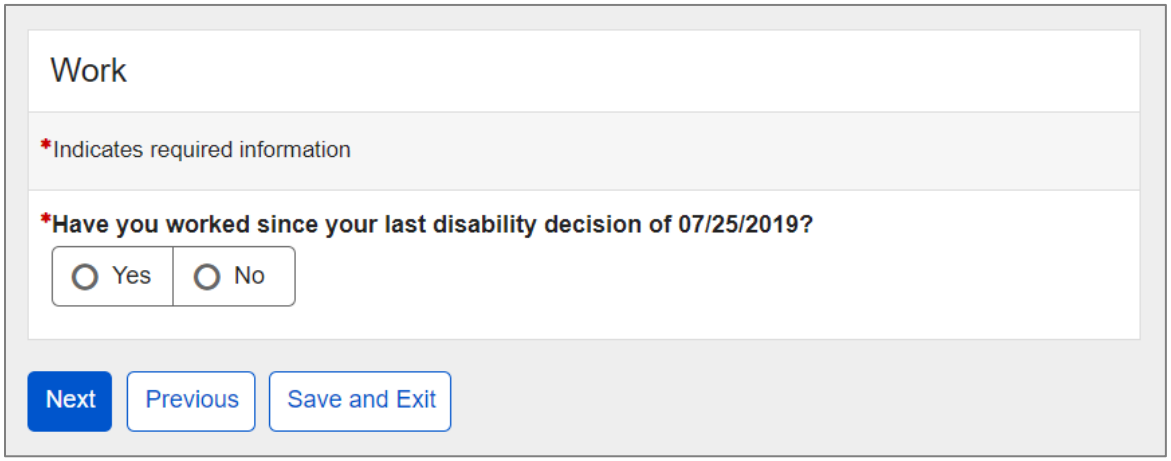
Save | Cancel

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.

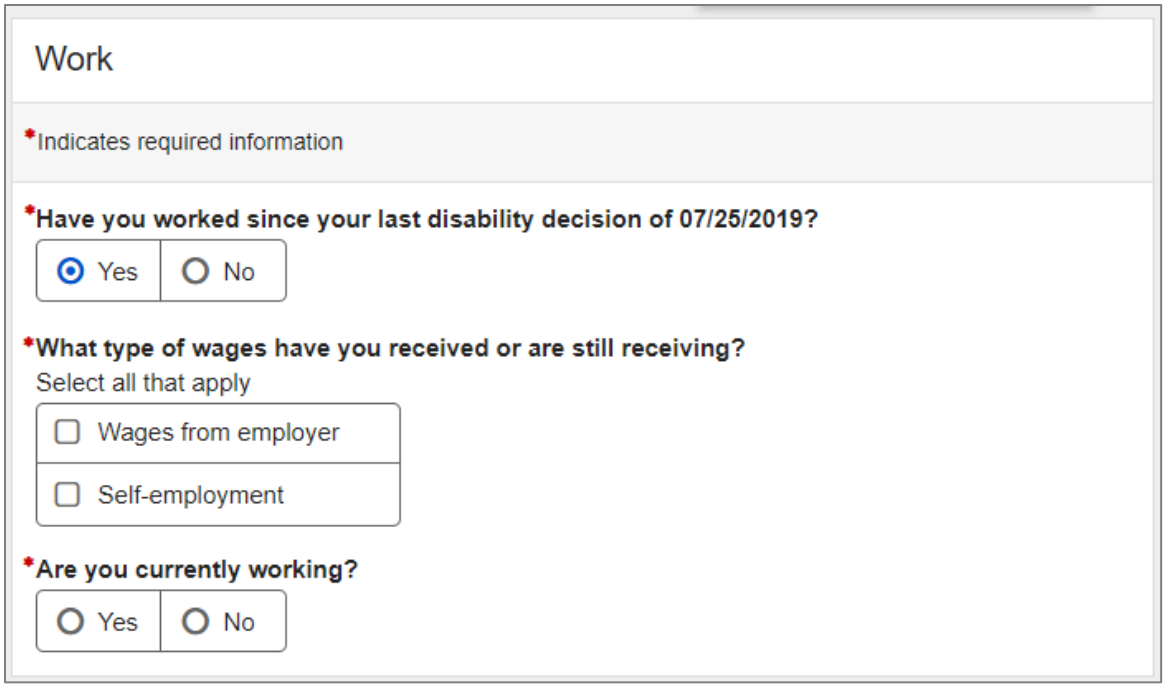


1.13. Work

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

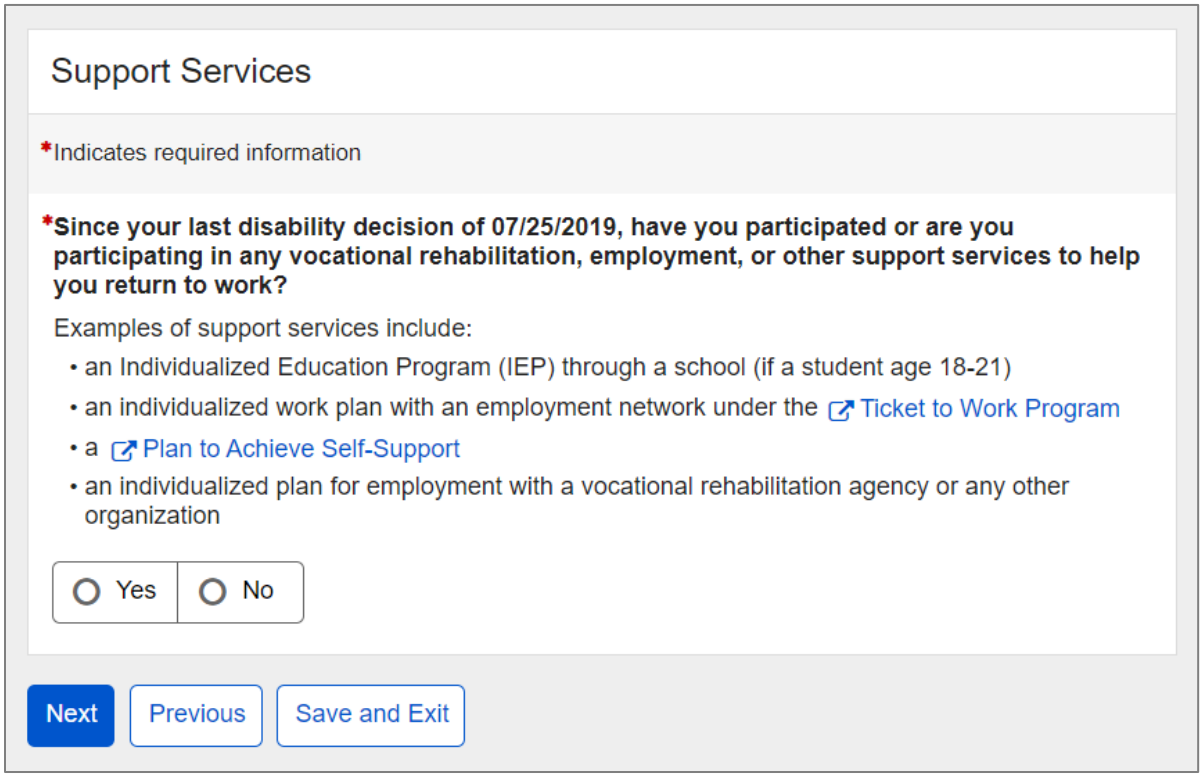


Upon selecting "Yes," additional fields will appear below.

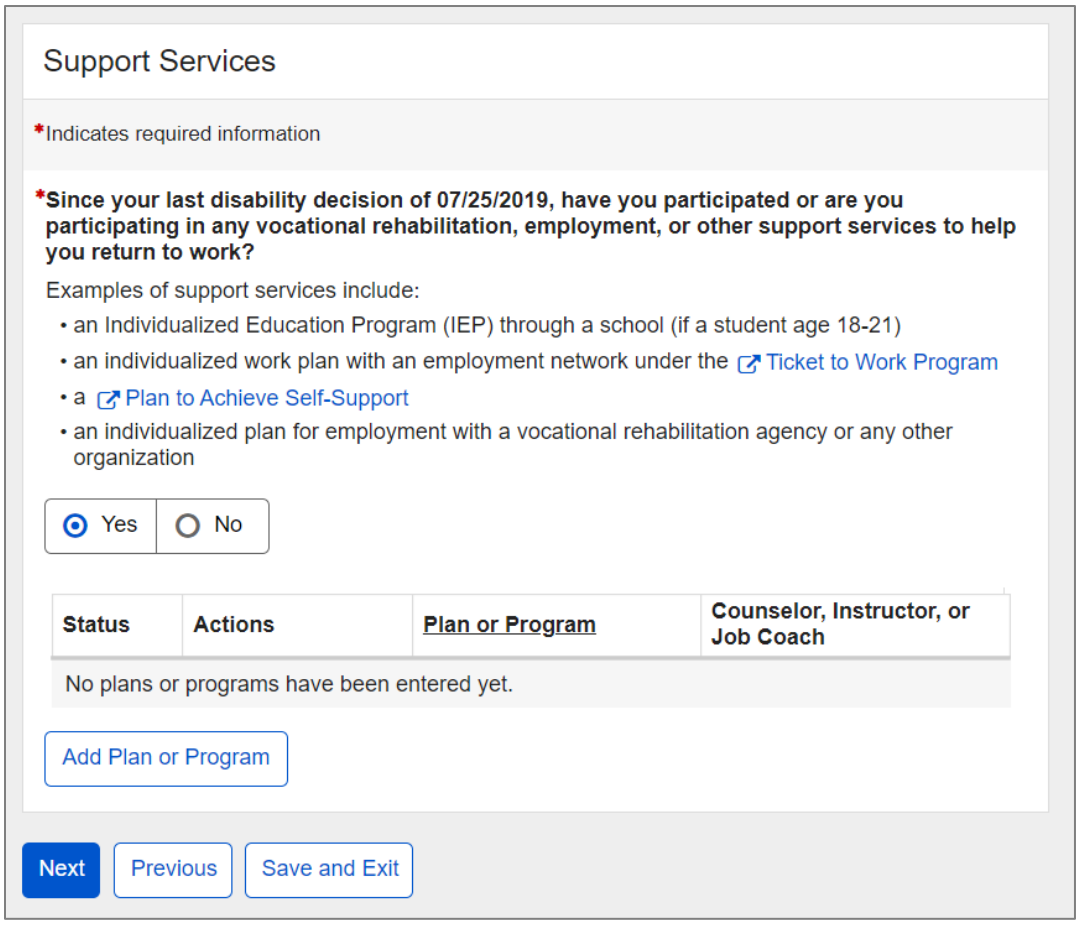


1.14. Support Services

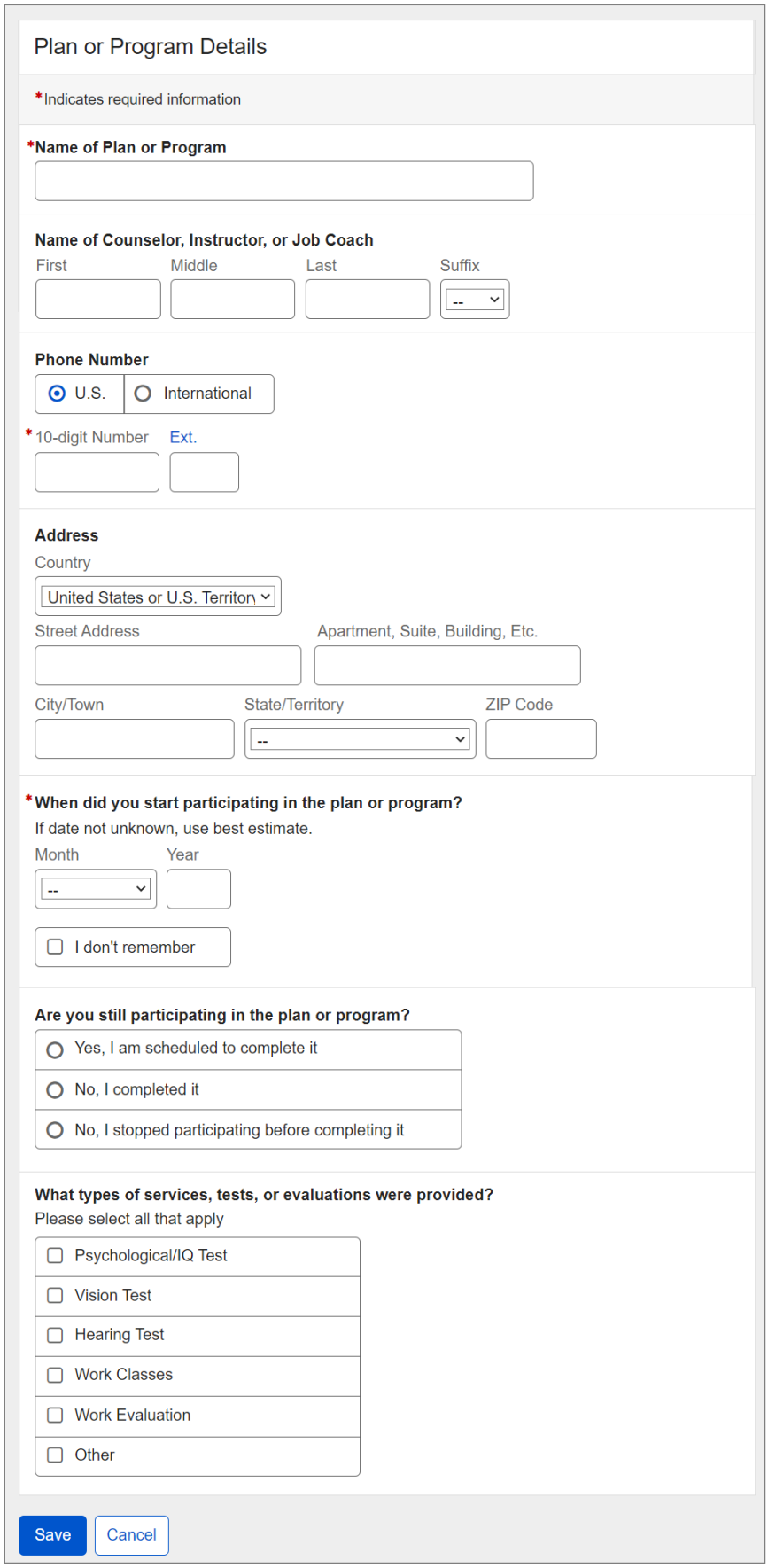
The user is asked to list support services that they participated in since the date of their last disability decision.



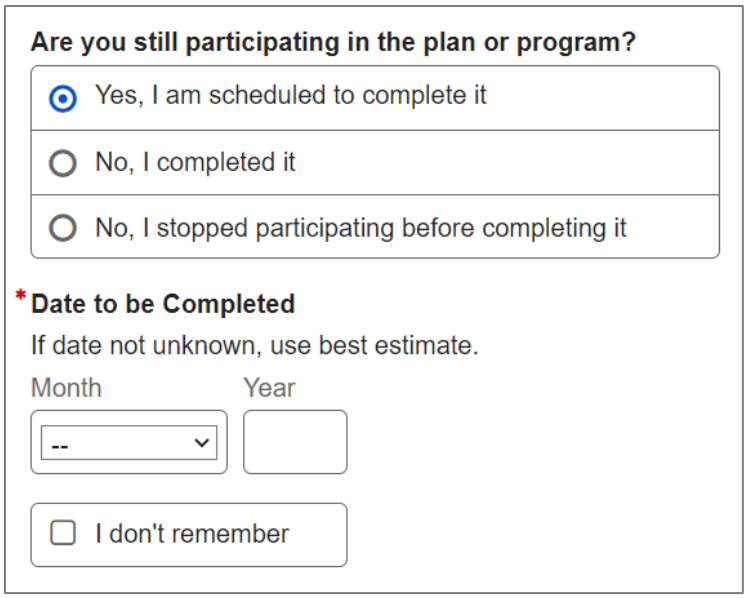
If the user selects “Yes,” a blank Support Services table will appear below.



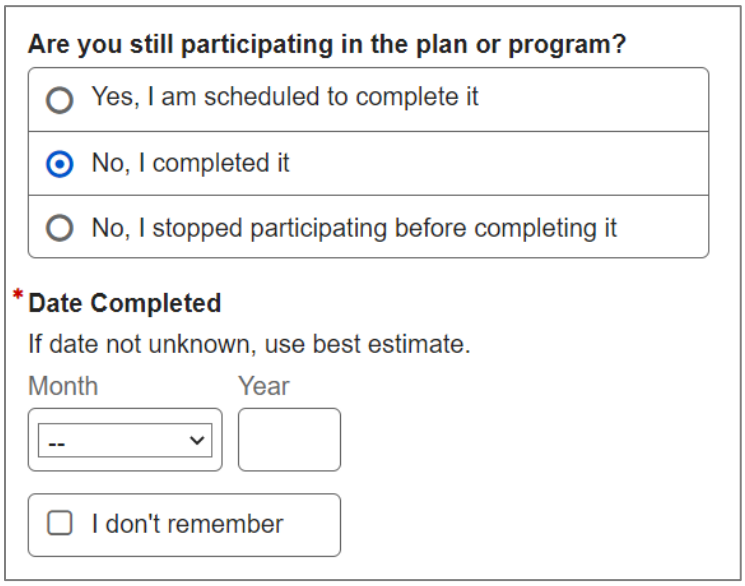
If the "Add Organization" button is selected, the Plan or Program Details page will display.



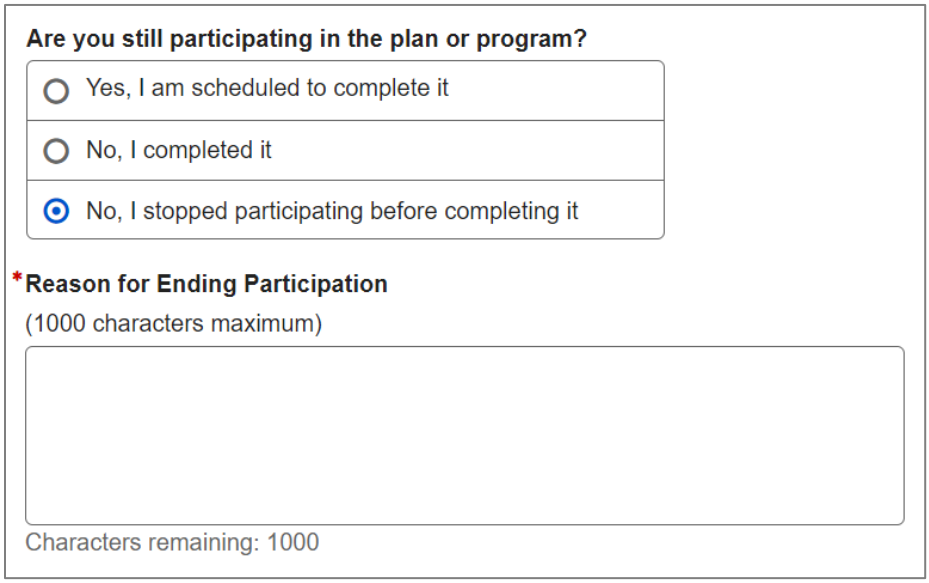
If user selects “Yes, I’m scheduled to completed it,” they can provide ‘Date to be Completed.’



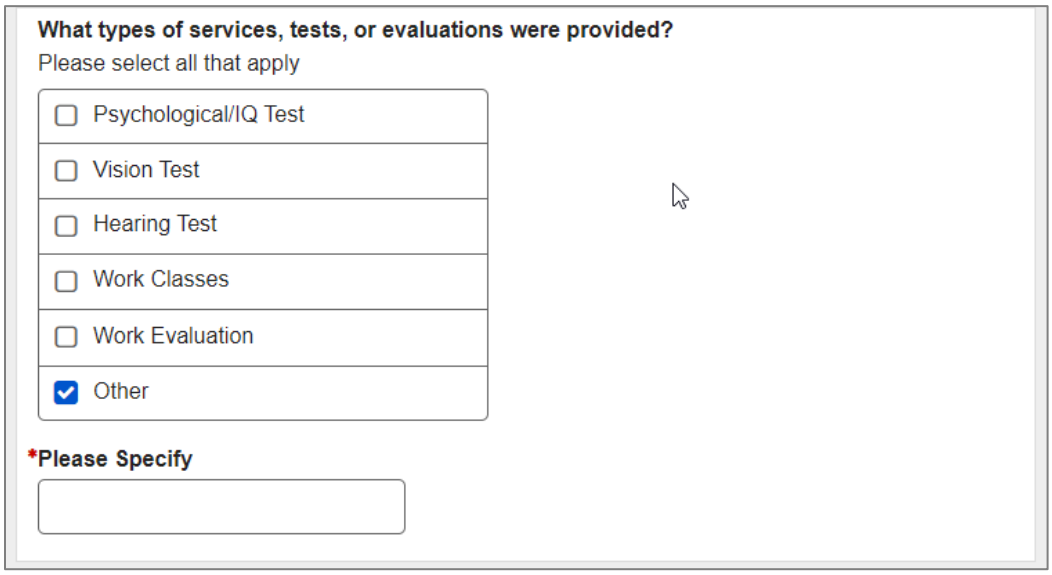
If user selects “No, I completed it,” they can provide ‘Date Completed.’



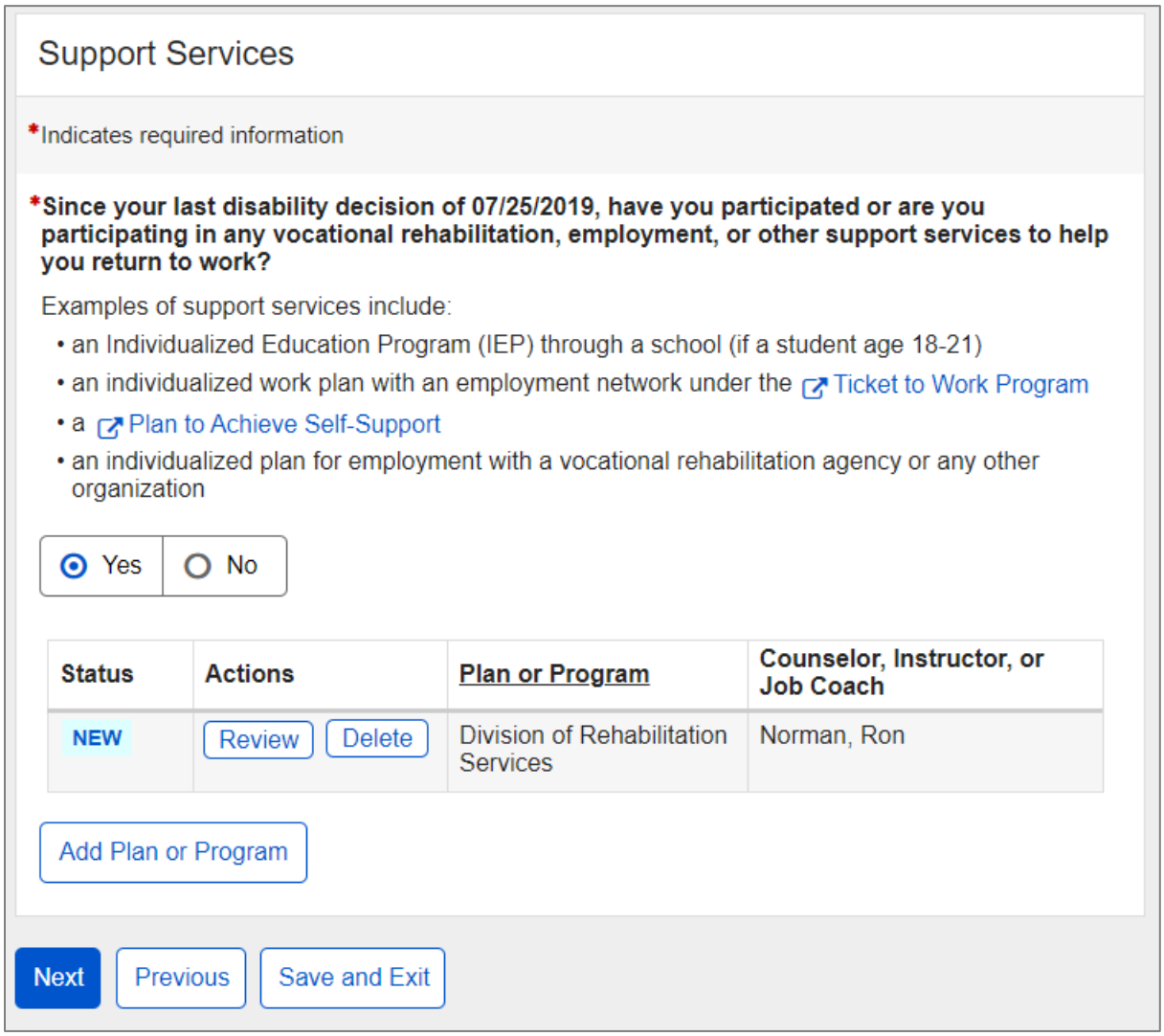
If the user selects “No, I stopped participating before completing it,” they can provide a reason for ending their participation.



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.

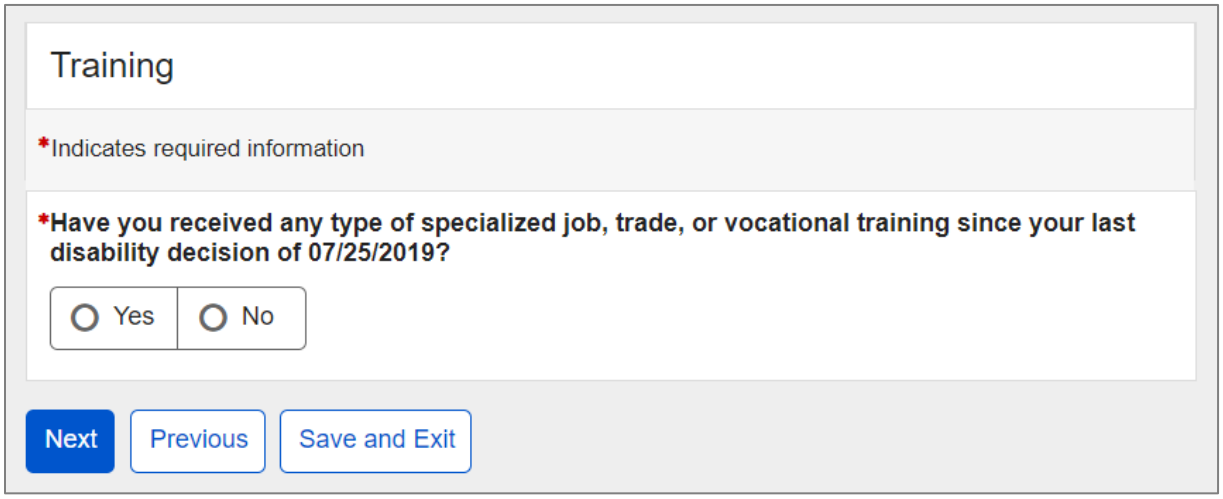


Upon saving, the user returns to the Support Services page where the table is populated with a new entry designated by the “NEW” information status badge.

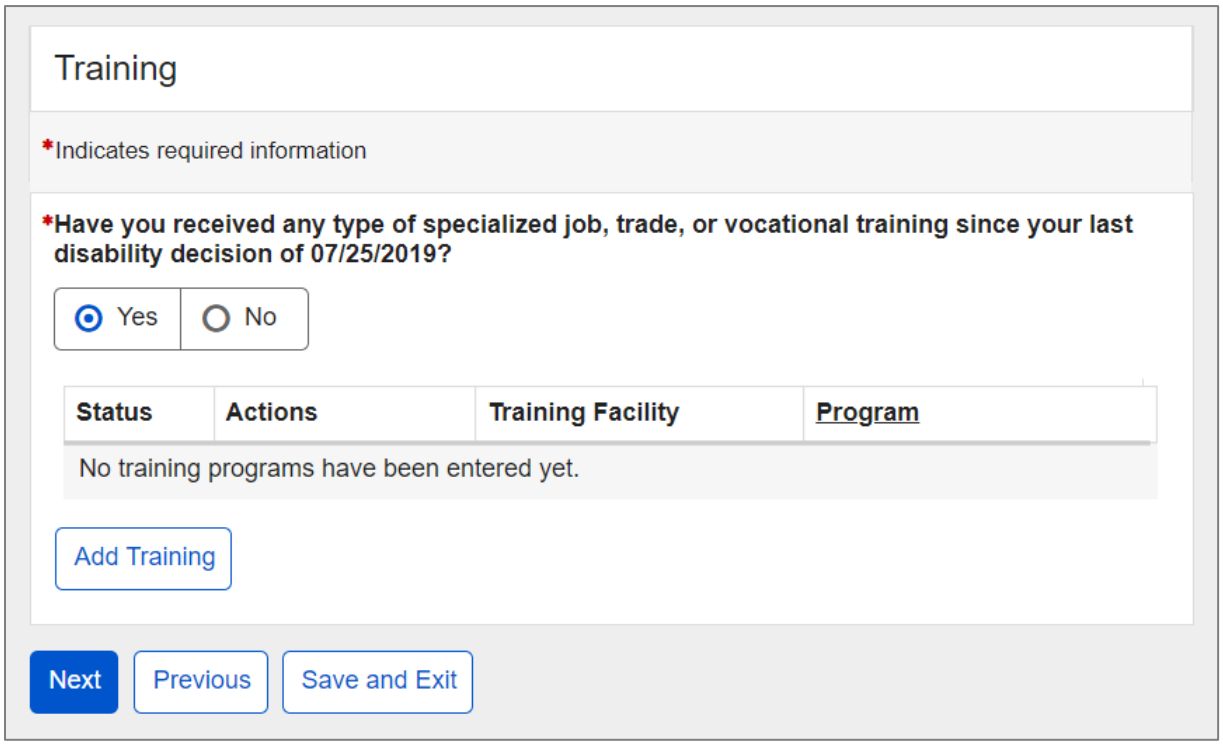


1.15. Training

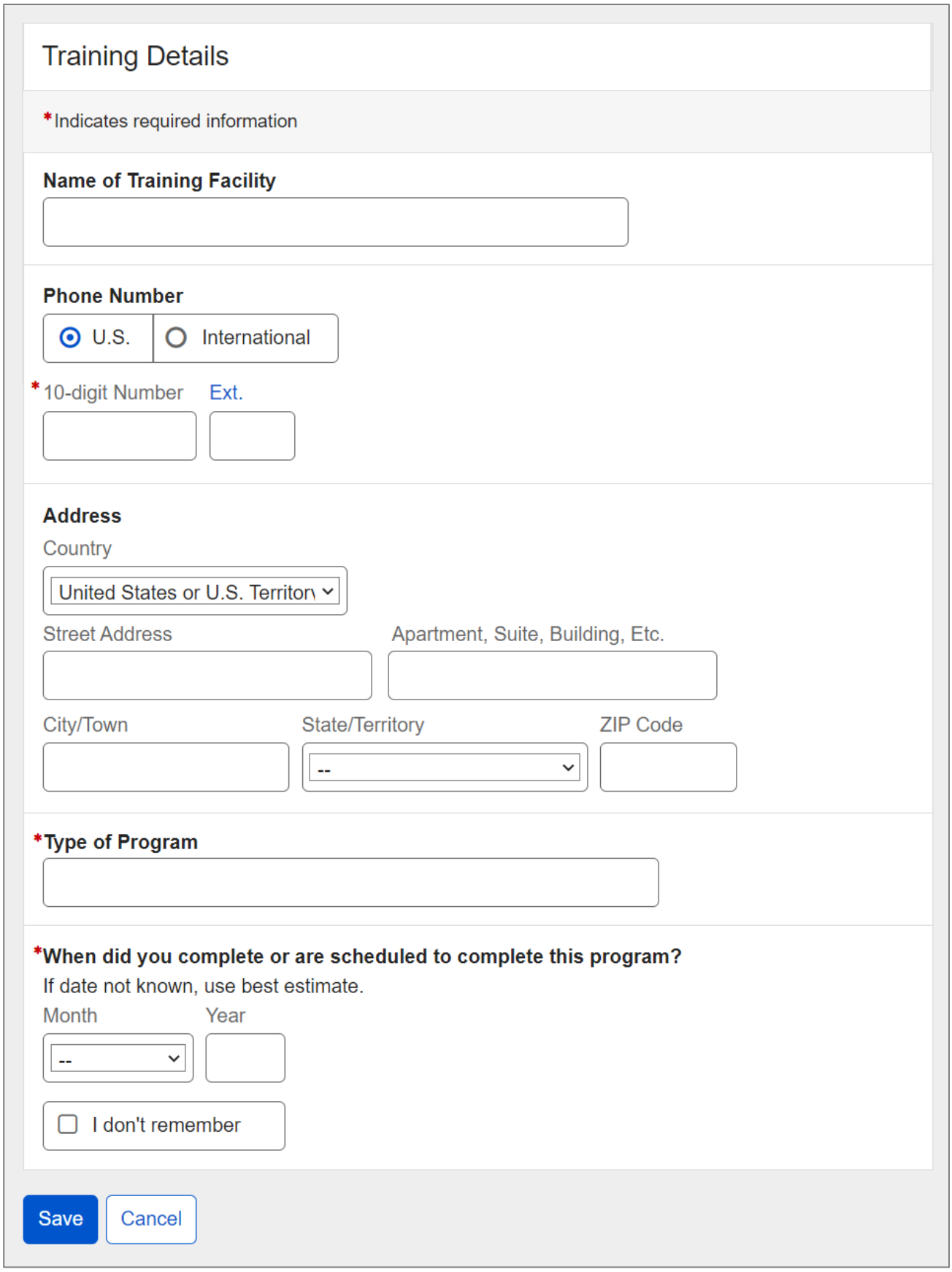
The user is asked to list trainings that they participated in since the date of their last disability decision.



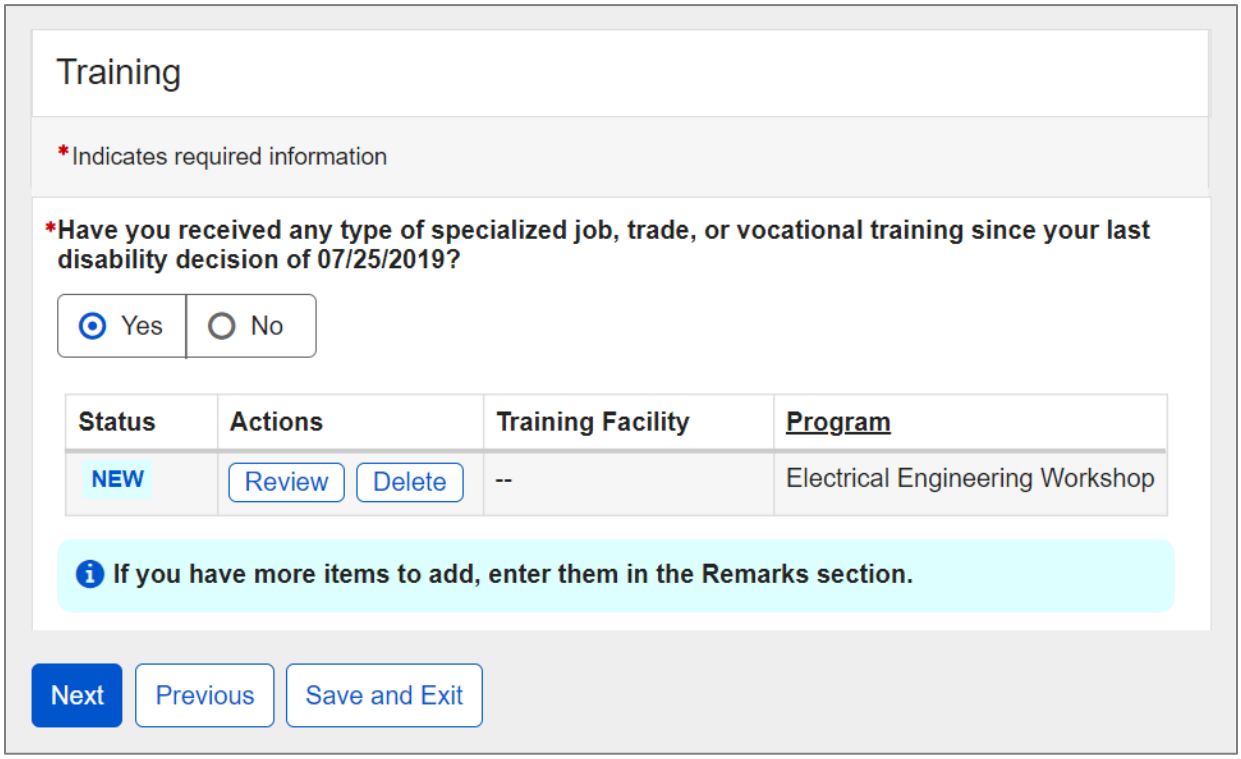
If the user selects "Yes," a blank Training table will appear below.



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

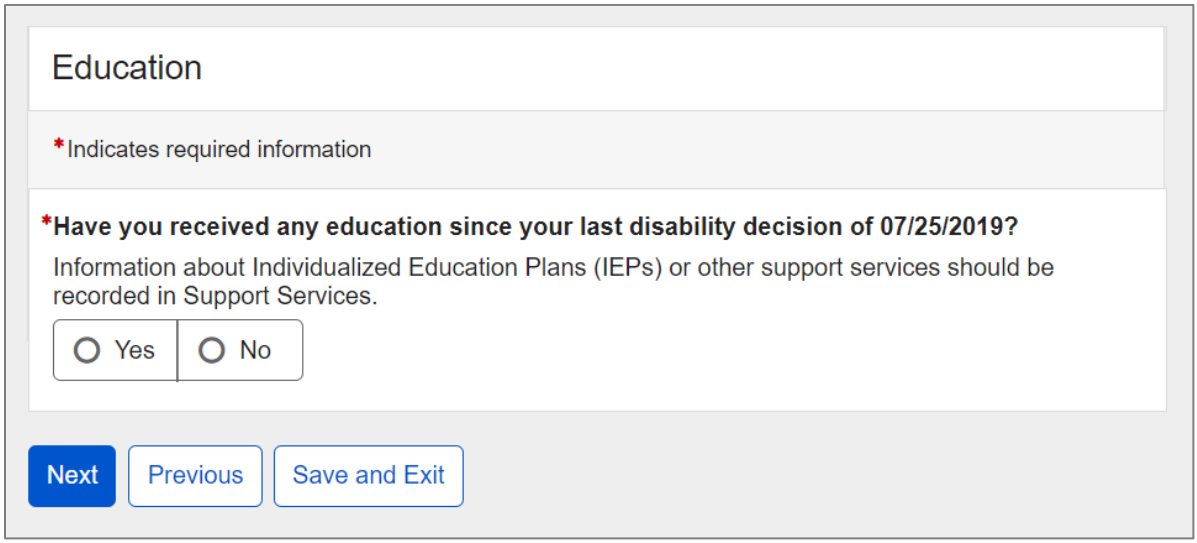


Upon saving, the user returns to the Training page where the table is populated with a new entry designated by the “NEW” information status badge.

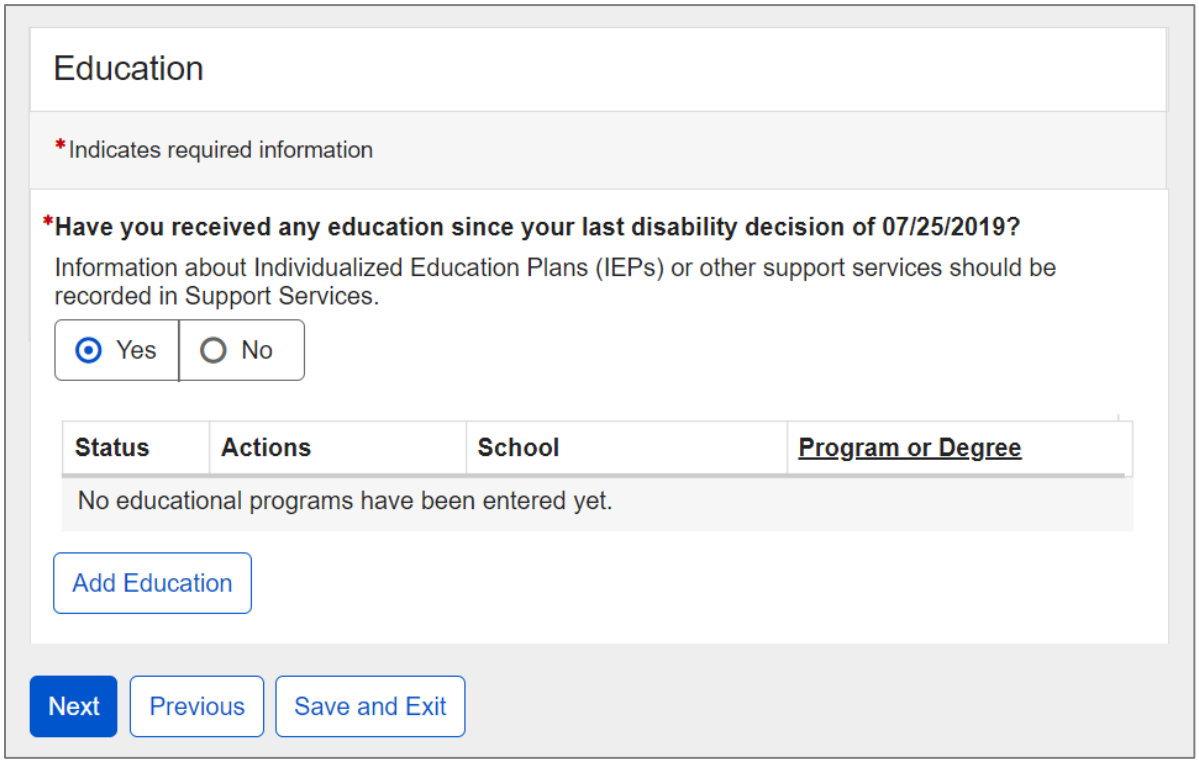


1.16. Education

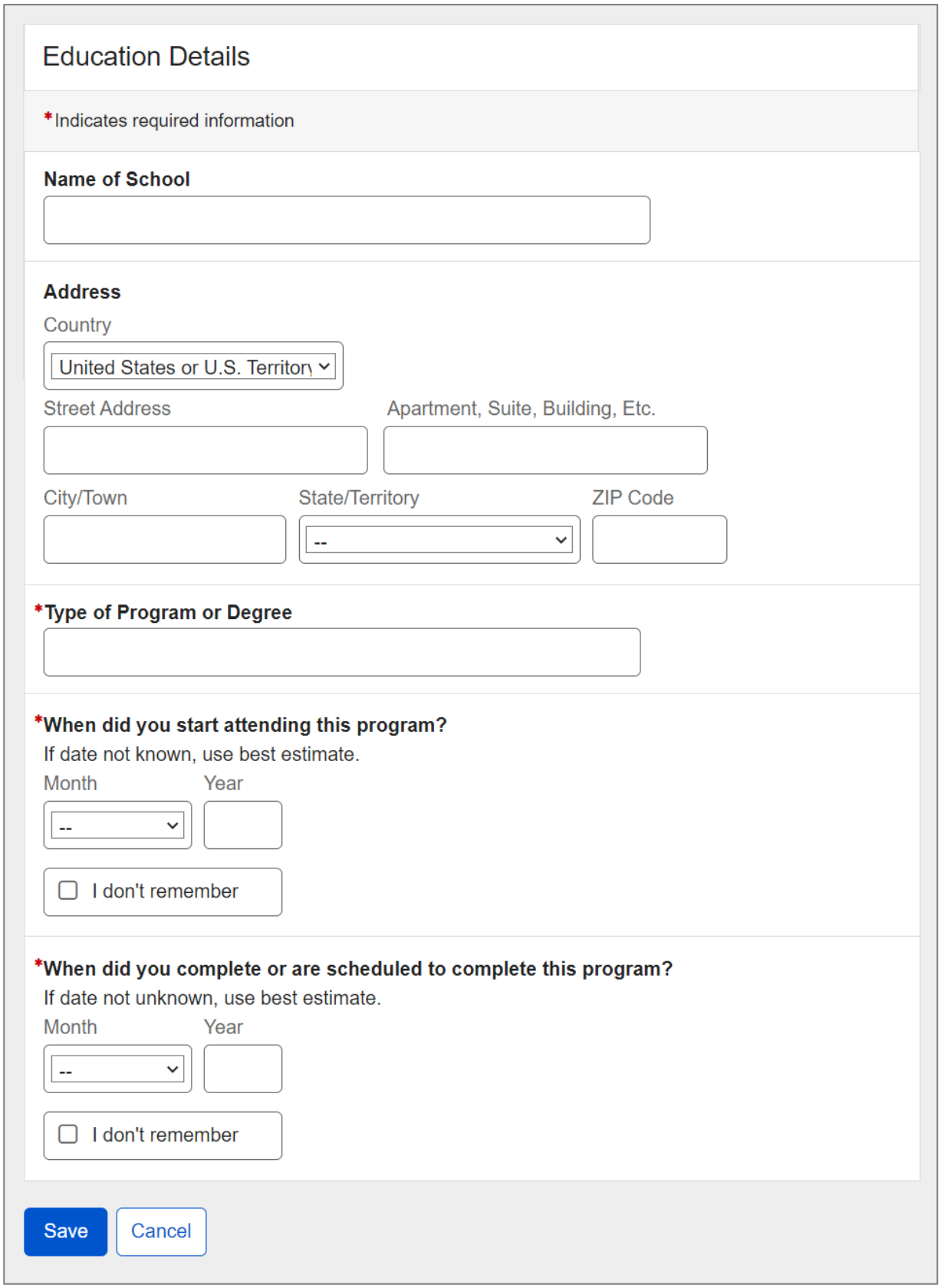
The user is asked to list education that they received since the date of their last disability decision.



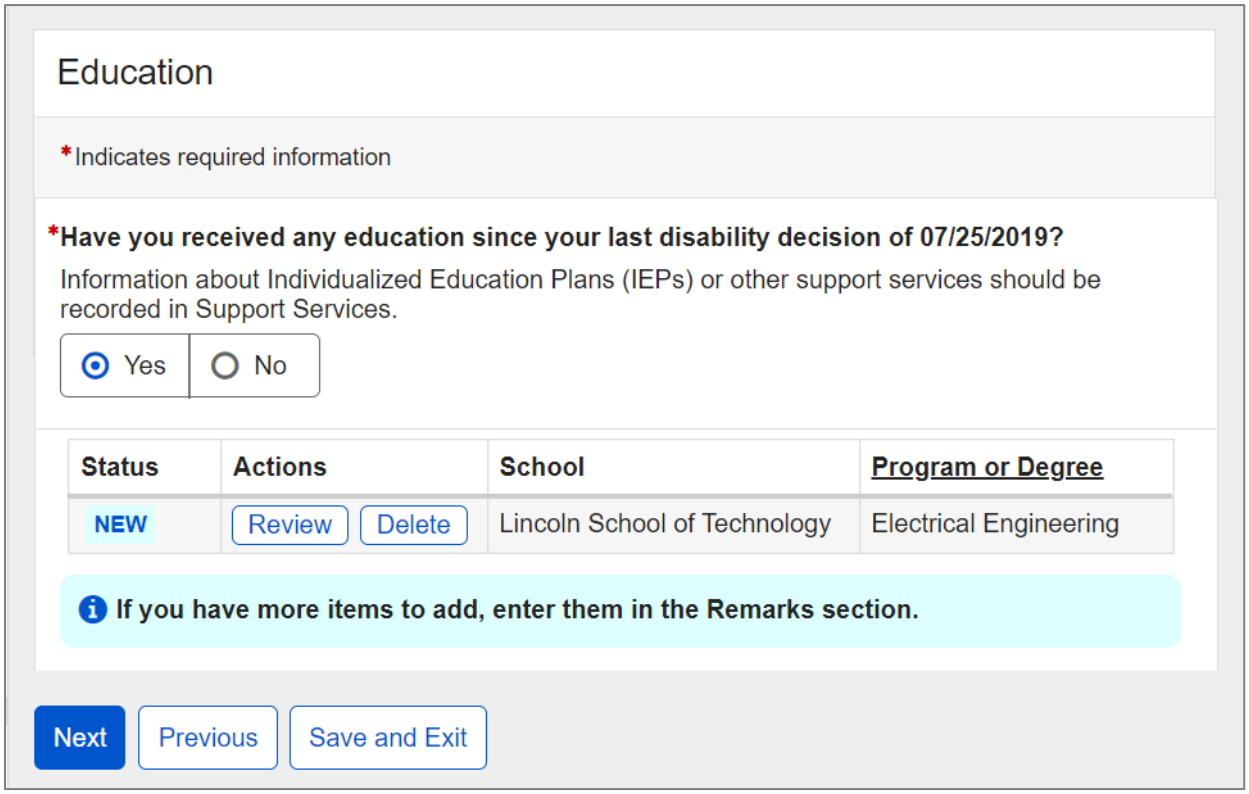
If the user selects "Yes," a blank Education table will appear below.



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

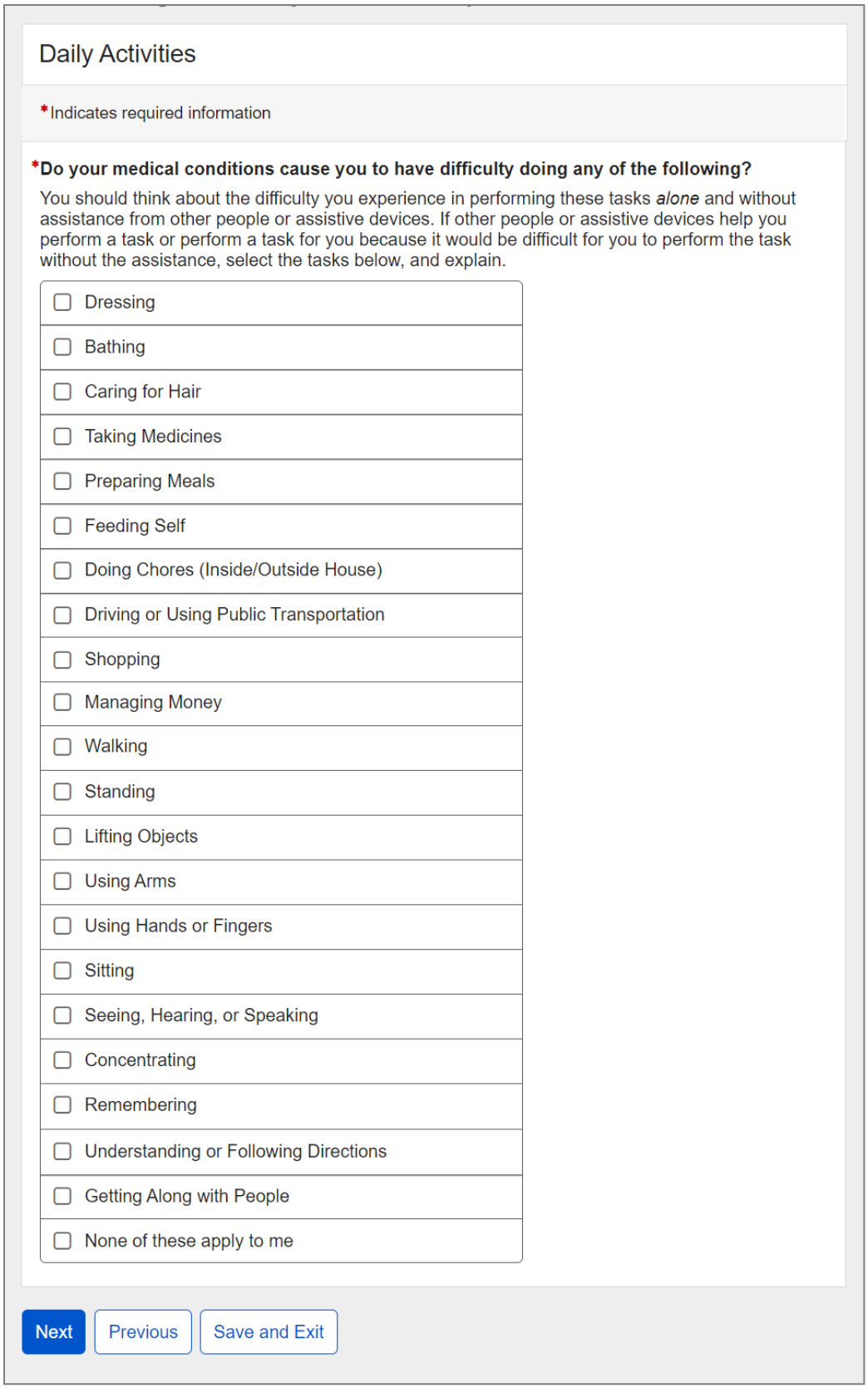


Upon saving, the user returns to the Education page where the table is populated with a new entry designated by the “NEW” information status badge.



1.17. Daily Activities

The user is asked to describe difficulty doing various activities listed.



Daily Activities

*Indicates required information

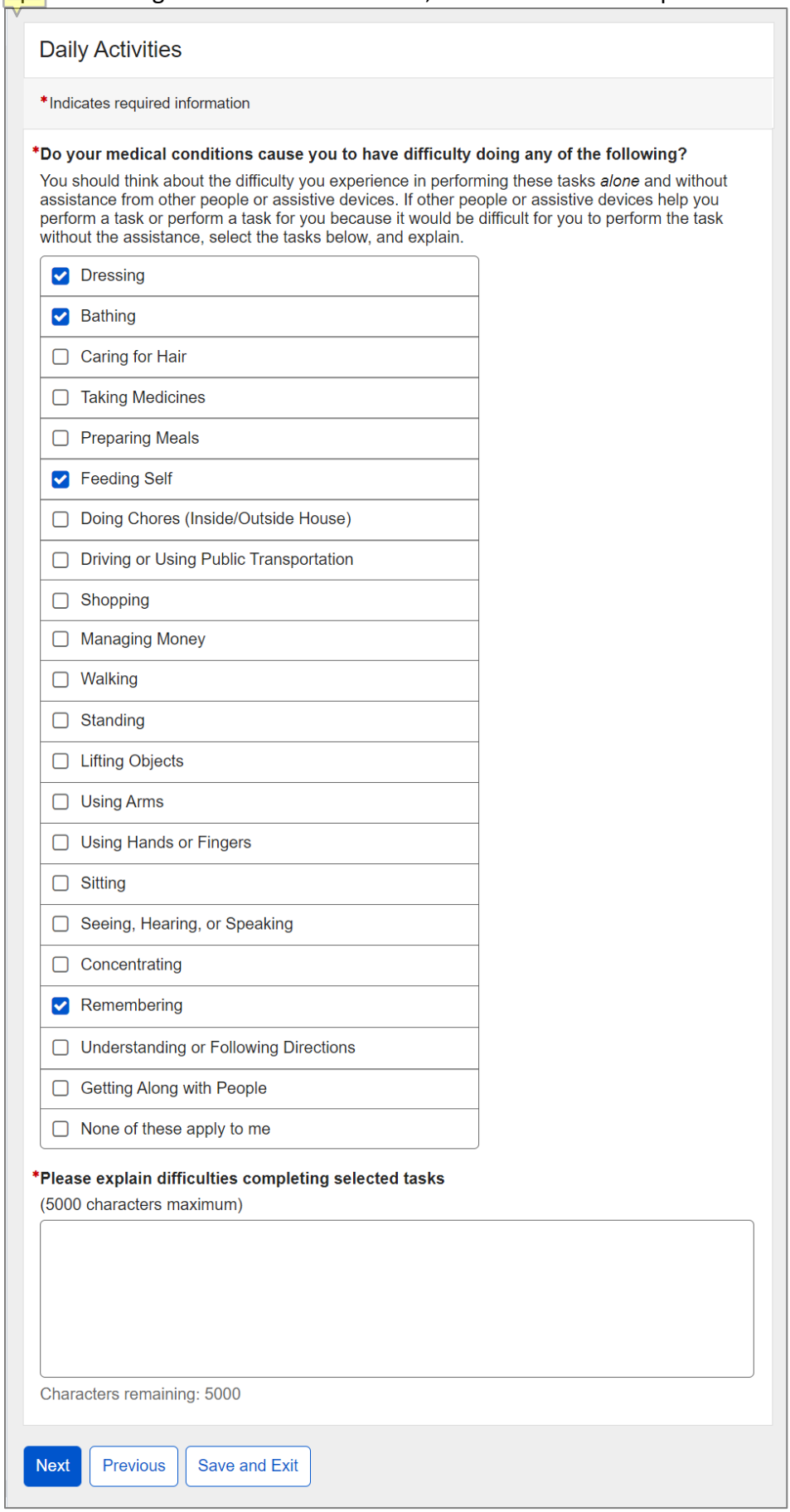
***Do your medical conditions cause you to have difficulty doing any of the following?**

You should think about the difficulty you experience in performing these tasks *alone* and without assistance from other people or assistive devices. If other people or assistive devices help you perform a task or perform a task for you because it would be difficult for you to perform the task without the assistance, select the tasks below, and explain.

- ☐ 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

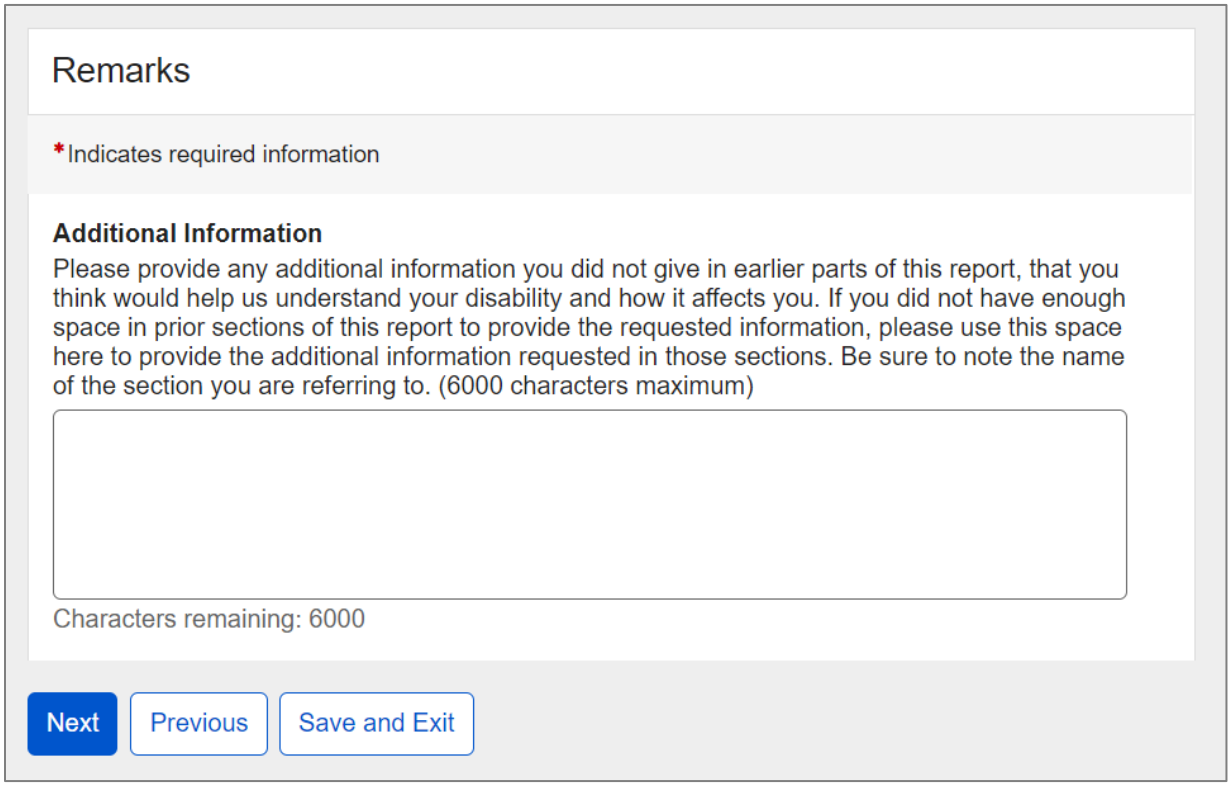
Next | Previous | Save and Exit

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



1.18. Remarks

The user can provide additional information on the Remarks page.



1.19. Summary

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

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: **Alan Smith**
Relationship to You: **Family Member**
Mailing Address: **4513 Tonquil Street, Beltsville Maryland 20705**
Phone Number: **(410) 415-0405**
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 PROVIDERS

Edit

Medical Provider 1

Name of Facility or Office: **Centennial Medical Group**
Name of Doctor or Healthcare Professional: **Marie Ann Hammond**
Phone Number: **(410) 454-1012 ext. 1001**
Address: **4500 Red Clay 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: **Mark P. Sikorsky Jr.**
Phone Number: **(410) 304-4444**
Address: **3210 Riverside Drive, Laurel Maryland 20707**
What medical conditions were treated or evaluated?: **Back pain**
When did you last see this provider in the last 12 months?: **I don't remember**

Medical Provider 3

Name of Facility or Office: ***Not Answered***
Name of Doctor or Healthcare Professional: **Clare Summers**
Phone Number: **(410) 412-0606**
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: **spine**
Ordered by: **Centennial Medical Group - Marie Ann Hammond**

MEDICINES

Edit

Medicine 1

Name of Medicine: **Cortizone**
Reason for Medicine and Side Effects (if any): **For pain**
Prescribed by: **Centennial Medical Group - Marie Ann Hammond**

Medicine 2

Name of Medicine: **Aspirin**
Reason for Medicine and Side Effects (if any): **to help with joints pain in the fall and spring**
Prescribed by: **No one**

Medicine 3

Name of Medicine: **Vitamin D3**
Reason for Medicine and Side Effects (if any): **To improve bone health**
Prescribed by: **Clare Summers**

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: **Centennial Medical Group - Marie Ann Hammond**

OTHER MEDICAL INFORMATION

Edit

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

Organization 1

Organization: **United Way of Central MD**
Name of Contact Person: **Veronique Martin**
Phone Number: **(410) 123-4560**
Address: **500 Ridge Rd, 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: **Ron Norman**
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) 692-6600**

Address: **6996 Columbia 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: **9325 Snowden 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

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

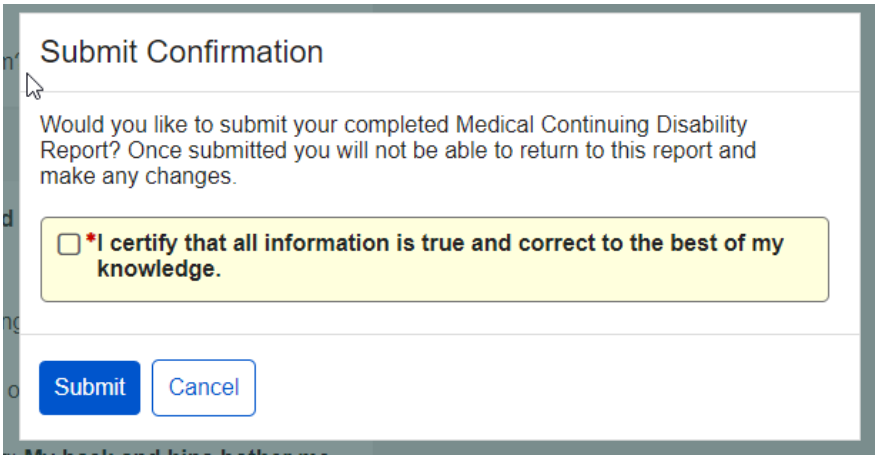
Please explain difficulties completing selected tasks: **My back and hips bother me when standing for too long or doing chores like vacuuming.**

REMARKS Edit

Additional Information: ***Not Answered***

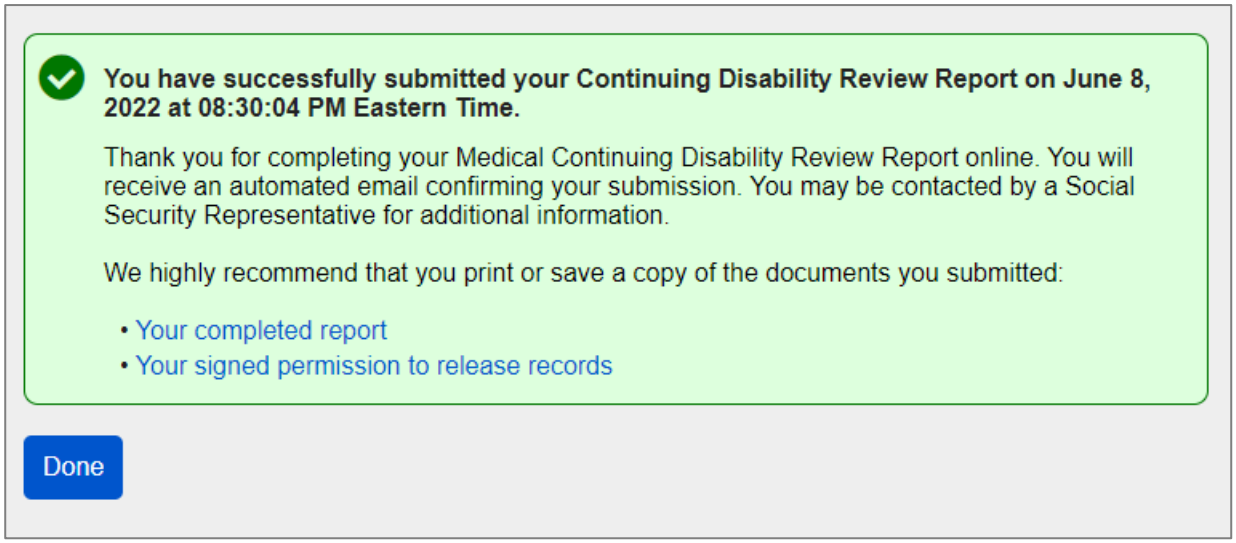
Submit Previous Save and Exit

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.



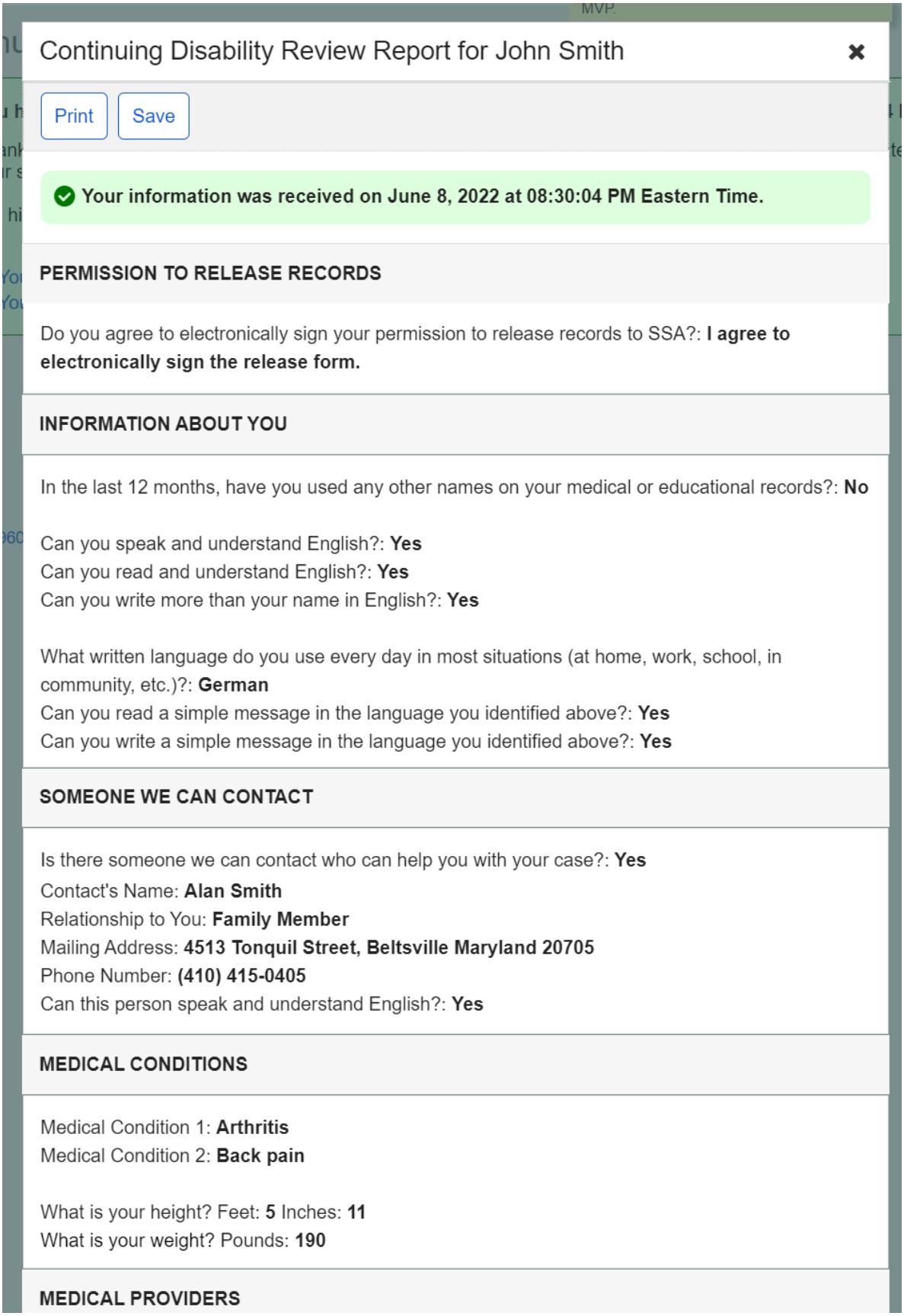
1.20. Receipt

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: **Alan Smith**
Relationship to You: **Family Member**
Mailing Address: **4513 Tonquil Street, Beltsville Maryland 20705**
Phone Number: **(410) 415-0405**
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 PROVIDERS

Medical Provider 1

Name of Facility or Office: **Centennial Medical Group**
Name of Doctor or Healthcare Professional: **Marie Ann Hammond**
Phone Number: **(410) 454-1012 ext. 1001**
Address: **4500 Red Clay 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: **Mark P. Sikorsky Jr.**
Phone Number: **(410) 304-4444**
Address: **3210 Riverside Drive, Laurel Maryland 20707**
What medical conditions were treated or evaluated?: **Back pain**
When did you last see this provider in the last 12 months?: **I don't remember**

Medical Provider 3

Name of Facility or Office: ***Not Answered***
Name of Doctor or Healthcare Professional: **Clare Summers**
Phone Number: **(410) 412-0606**
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: **spine**
Ordered by: **Centennial Medical Group - Marie Ann Hammond**

MEDICINES

Medicine 1

Name of Medicine: **Cortizone**
Reason for Medicine and Side Effects (if any): **For pain**
Prescribed by: **Centennial Medical Group - Marie Ann Hammond**

Medicine 2

Name of Medicine: **Aspirin**
Reason for Medicine and Side Effects (if any): **to help with joints pain in the fall and spring**
Prescribed by: **No one**

Medicine 3

Name of Medicine: **Vitamin D3**
Reason for Medicine and Side Effects (if any): **To improve bone health**
Prescribed by: **Clare Summers**

ASSISTIVE DEVICES

ASSISTIVE DEVICES

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

Assistive Device 1

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

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: **Veronique Martin**
Phone Number: **(410) 123-4560**
Address: **500 Ridge Rd, 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

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: **Ron Norman**
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

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) 692-6600**

Address: **6996 Columbia 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: **9325 Snowden 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

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

Please explain difficulties completing selected tasks: **My back and hips bother me when standing for too long or doing chores like vacuuming.**

REMARKS

Additional Information: ***Not Answered***