

EDCS SSA-3368 Form updates to EDCS screens

SSA-3368 form

R56.0

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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 SSA-3368 form will follow the existing design approach in EDCS. This will help ensure easy adoption of new or updated content while limiting the need for separate training on the implemented features.

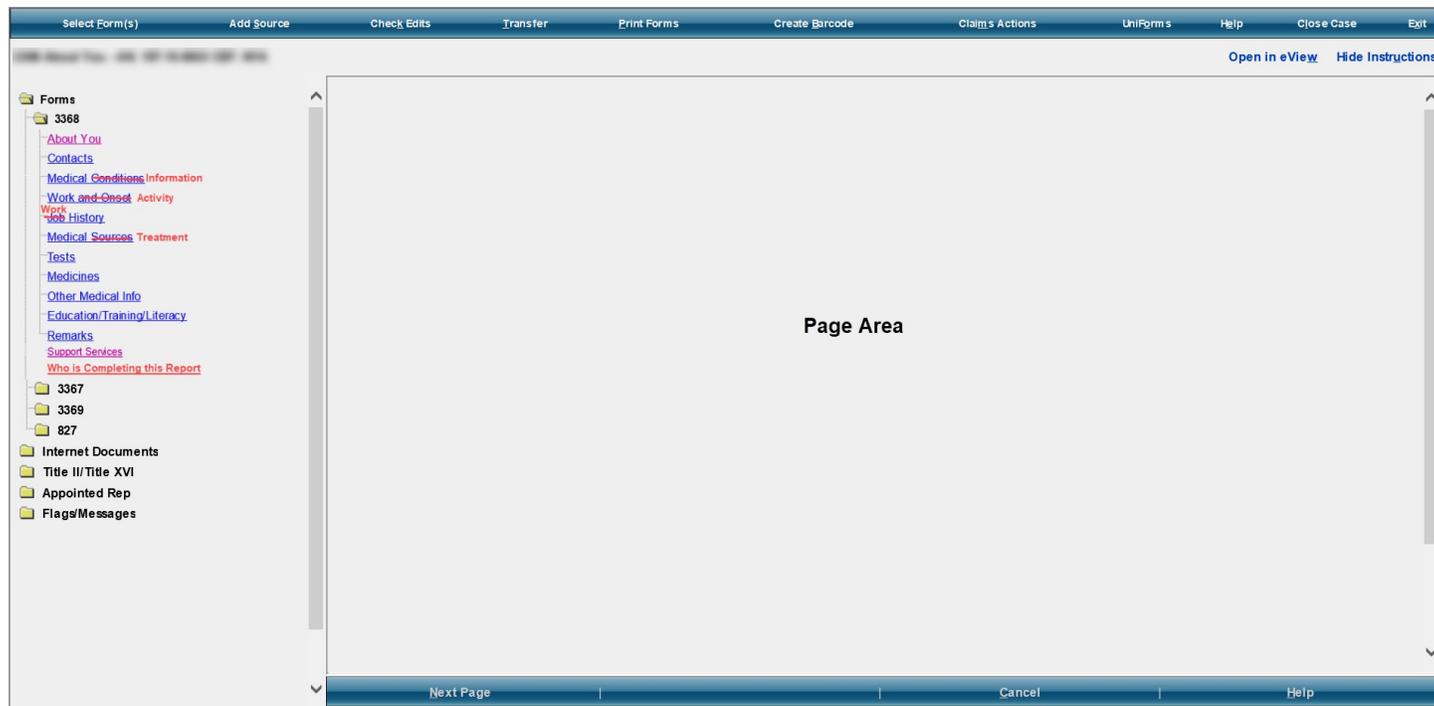
SSA-3368 Layout and Navigation

3368 Left Navigation- used for all EDCS 3368 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-3368 page screens.
- Individual page screens display in the Page Area
- Next/Previous buttons display at the bottom of the frame.

SSA-3368 Adult EDCS Screenshots

SSA-3368 Section 1 - Information About You:

3368 About You

Identification

Name: James Henry Lawson
Primary telephone number: 5210030498061
Secondary telephone number is: U.S. Foreign None
Secondary 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

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

Have you used any other names on your medical or educational records?
Examples include maiden name, other married names, other names, or nickname.
 Yes No Not yet answered

[Next Page](#) | [Cancel](#) | [Help](#)

SSA-3368 Section 2 - Contacts

Contacts Summary page

3368 Contacts

Alternate Contact Information

Is there someone we can contact who can help with your claim, if needed? Examples include a family member, friend, or neighbor.

- Yes Please provide the names of two people (other than your doctors) we can contact who know about your medical condition(s), and can help you with your claim and can help us reach you if you become unavailable.
- No We recommend that you provide at least one contact, if available. Providing the name of someone who knows you may help us to make a quicker decision on your claim.
- Not yet answered

~~Is there someone (other than your doctors) we can contact who knows about your medical conditions and can help you with your case?~~

- ~~Yes No Not yet answered~~

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:

Fields come off the Contact page, and go on the new Contacts INFORMATION page

Telephone for Alternate Contact

Telephone number is: U.S. Foreign None

Daytime telephone number: (999-999-9999) Ext:

Preferred Language for Alternate Contact

Can this person speak and understand English?

Yes No Not yet answered

To add a contact click on **Add Contact**. To edit, select the contact listed below.

Contact Name	Address	Phone Number	Speaks English?

~~Person Completing the Report~~

~~*Who is providing information?~~

- Gregory Allen Marks
- Alternate Contact listed above
- Someone else

Moves to Sec 12 - Who is completing...

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Contact Information

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: (999-999-9999) Ext:

As described in 1.E. above.

Preferred Language for Alternate Contact

Can this person speak and understand English?
 Yes No Not yet answered
If "NO", what language is preferred?

SSA-3368 Section 3 – Medical Information

3368 Medical Conditions Information

Alleged onset date: 02/01/2023

Physical and Mental Conditions

Separately list each physical and/or mental 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

AFTER

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.

Do your conditions cause you pain or other symptoms?

Yes No Not yet answered

Height and Weight

Even though your height and weight may be in your medical records, what you tell us can show whether the records are up-to-date.

What is your height **without shoes**? feet: inches:

What is your weight **without shoes**? pounds:

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[Cancel](#)

[Help](#)

SSA-3368 Section 4 – Work Activity

INITIAL PAGE - Title change

3368 Work and Onset **Work Activity**

Alleged onset date: 11/25/2018

***Are you currently working?**

- No, I have never worked
- No, I have stopped working
- Yes, I am currently working
- Not yet answered

Claimant has never worked

Alleged onset date: 01/01/2018

***Are you currently working?**

- No, I have never worked
- No, I have stopped working
- Yes, I am currently working
- Not yet answered

Never Worked Information

When do you believe your condition became severe enough to keep you from working (even though you have never worked)? 01/01/2018 [Where did this date come from?](#)

condition(s)

Claimant has stopped working

Because of my condition(s)

3368 Work and Onset

Alleged onset date: 01/01/2018

***Are you currently working?**

- No, I have never worked
- No, I have stopped working
- Yes, I am currently working
- Not yet answered

Stopped Working Information

When did you stop working? (MM/DD/YYYY):

***Why did you stop working?**

- Because of my condition(s)
- Because of other reasons
- Because of my condition(s) and other reasons
- Not yet answered

~~Did your condition(s) cause you or your employer to make changes in your work activity?~~
~~Did your condition(s) cause you to make changes in your work activity before you stopped working?~~
Examples include job duties, hours, or rate of pay.

Yes No Not yet answered

***When did you make changes? (MM/DD/YYYY):**

Because of other reasons

and/or

Because of my condition(s) and other reasons

Stopped Working Information

When did you stop working? (MM/DD/YYYY):

*Why did you stop working?

Because of my condition(s)

Because of other reasons

Because of my condition(s) and other reasons

Not yet answered

Same page for either answer.

Please explain why you stopped working.

[Examples of stopping work](#)

~~When do you believe that your condition became severe enough to keep you from returning to work? (MM/DD/YYYY):~~

Even though you stopped working for other reasons, when do you believe your condition(s) became severe enough to keep you from working?

~~Did your condition(s) cause you or your employer to make changes in your work activity?~~

~~Did your condition(s) cause you to make changes in your work activity before you stopped working?~~

Examples include job duties, hours, or rate of pay.

Yes No Not yet answered

*When did you make changes? (MM/DD/YYYY):

Claimant is still working

3368 Work and Onset

Alleged onset date: 11/25/2018

*Are you currently working?

No, I have never worked

No, I have stopped working

Yes, I am currently working

Not yet answered

Currently Working Information

Has your condition(s) caused you or your employer to make changes in your work activity? Examples include job duties, hours, or rate of pay.

~~*Has your condition caused you to make changes in your work activity?~~

Yes No Not yet answered

*When did you make changes? (MM/DD/YYYY):

SSA-3368 Section 5 – Education, Training, and Literacy

3368 Education, Training, and Literacy

Education

Alleged onset date: 01/01/2018

What is the highest grade of school that you completed?

(Select the highest level of school completed, including homeschooling, online education, and education received in another country.)

Special Education

Were you in special education?

Yes No Not yet answered

Job Training or Vocational School

Have you received any type of training (specialized job, trade, or vocational training)?

Yes No Not yet answered

Name of training facility:

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

[Next Page](#)

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[Cancel](#)

[Help](#)

City: State: ZIP Code:

Telephone number is: U.S. Foreign None

Telephone number is: (999-999-9999) Ext:

*Type of Program:

Approximate date completed (MM/YYYY):

Language Information

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

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

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

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[Cancel](#)

[Help](#)

SSA-3368 Section 6 – Work History

3368 Work History

Alleged onset date: 11/20/2014

Since 11/20/2014 have you had gross earnings greater than \$1070 in any month? Do not count sick leave, vacation, or disability pay. [Where did this date come from?](#)

Nonblind SGA and Blind SGA amounts

See [DI 10501 015](#) - Tables of SGA Earnings Guidelines and Effective Dates Based on Years of Work Activity.

Yes No Not yet answered

How many jobs have you had in the 5 years before you became unable to work because of your medical conditions?

0

1

2 or more

6 or more

Not yet answered

List your most recent job first.

To add a job, choose Add Job. To edit, select a job title below. ← (Keep as 1st line of instructional text)

List all job titles even if they were for the same employer. (Add 4 more lines of instructional text)

Do not include jobs you held less than 30 calendar days.

Include self-employment (e.g., rideshare driver, hair stylist).

Include work in a foreign country.

Job Title	From	To
test 1	01/01/2022	02/01/2022

Add Job

Work Information - AN: ████████ CEF: NYA

Work Information

*Occupation or job title:

Examples:

- Short-order cook, not just cook
- Elementary school teacher, not just teacher
- Long-haul truck driver, not just driver

cook

Type of business:

Do not give the employer's name.

Examples:

- Restaurant
- Large hotel chain
- Elementary school

elementary school

Dates Worked

If you can't remember the exact dates, be as specific as possible (month or season and year). If you are currently working in this job, enter "Present" in the To: input field.

From: 2001 To: 2003

Most Recent Hours and Pay

Hours per day:

Days per week:

Rate of pay:

If you did "piece work," give the average amount you earned per day. If you were on commission, give the average amount per month.

\$ Per:

(New section with new and modified fields)

Information about your work

For the job you titled (job title from above field) describe in detail the tasks you did in a typical workday. Examples of tasks include stocking shelves, greeting customers, scheduling appointments, or maintaining records.

^
v

If any of the tasks listed above involved writing or completing reports, describe the type of report you wrote or completed and how much time you spent on it per workday or workweek.

^
v

If any of the tasks listed above involved supervising others, describe who or what you supervised and what supervisory duties you had. Examples of supervisory duties include evaluating employee job performance, making schedules, or maintaining time records.

^
v

List the machines, tools, and equipment you used regularly when doing this job, and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.

^
v

List the machines, tools, and equipment you used regularly when doing this job, and explain what you used them for. Examples of equipment include computer, telephone, forklift, air compressor, or meat slicer.

^
v

Did your job require you to interact with coworkers, the general public, or anyone else?

- Yes No Not yet answered

Describe who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek.

Examples include answering customer questions on the telephone for 5 hours per day or showing clients properties for sale in person for 4 hours per day."

^
v

Physical and environmental requirements of your work Modified header label AFTER

~~In this job, how many hours a day did you do each of these tasks listed?~~
~~The following numbers do not have to add up to the total "Average hours per day" listed above because you may be performing more than one activity at a time. For example, you may be standing and lifting or sitting and typing simultaneously.~~

Walk? Two fields deleted Updated Instructional Text to read: Tell us how much time you spent doing the following physical activities in a typical workday. The total hours/minutes for standing, walking, and sitting should equal the **Hours per day**.

Stand? New field

Standing and walking (combined) New field

Sitting New field

Climb? (stairs, ladders, etc.) Field deleted

Stoop? (bend down and forward at waist) New field

Kneeling? (bend legs and rest on knees) New field

Crouching? (bend legs and back down and forward) New field

Crawling? (move on hands and knees) New field

Handle large objects? New field

Write, type, or handle small objects? New field

Reach? New field

Using fingers to touch, pick, or pinch New field and new instructional text

Using hands to seize, hold, grasp, or turn New field and new instructional text

Reaching at or below the shoulder: New field

Reaching overhead (above the shoulder): New field

Climbing stairs or ramps New field

Climbing ladders, ropes, or scaffolds New field

All of these fields are reused with modified labels, collected in Hours and Minutes, with modified instructional text

These three fields are deleted along with the instructional text

Physical Activities: Lifting and Carrying

~~Describe what you lifted, how far you carried it, and how often you did this in your job.~~ Modified field label Remove hyperlink and examples

Select the heaviest weight you lifted. For the drop down selections, add this as a new selection and list it first. Less than 1 lb.

Select the weight frequently lifted (By frequently we mean from 1/3 to 2/3 of the workday) For the drop down selections, add this as a new selection and list it first. Less than 1 lb.

Supervisory Duties Remove Supervisory Duties section

Did you supervise other people in this job?
 Yes No Not yet answered

How many people did you supervise?

What part of your time did you spend supervising?

Did you hire and fire employees?
 Yes No Not yet answered

Were you a lead worker?
 Examples:
 Foreman
 Chief Electrician

Yes No Not yet answered

Did this job expose you to any of the following? Check all that apply.

Outdoors Extreme heat (non-weather related) Extreme cold (non-weather related)

Wetness Humidity Hazardous substances

Moving mechanical parts High, exposed places Heavy vibrations New field with several options

Loud noises Other

If one or more boxes are checked, tell us about the exposure(s) and how often you were exposed. New field

Explain how your medical conditions would affect your ability to do this job. New field

SSA-3368 Section 7 - Medicines

3368 Medicines Summary

Are you **currently** taking any prescription or non-prescription medicine(s)?
 Yes No Not yet answered

AFTER

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
Acetaminophen	test	Stops the pain

Add Medicine

Next Page

Previous Page

Cancel

Help

SSA-3368 Section 8 – Medical Treatment

Summary Page

3368 Medical Sources Treatment			
Alleged onset date: 11/25/2018			
Doctors, Therapists, Hospitals, Clinics			
Have you seen or received treatment from a healthcare provider (doctor, hospital, clinic, psychiatrist, nurse practitioner, therapist, physical therapist, or other medical professional), or do you have a future appointment scheduled?			
Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:			
For any physical condition(s)			
<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not yet answered			
For any mental condition(s) (including emotional or learning problems)			
<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not yet answered			
You may find this information on medical bills, online medical chart, or the internet. If you don't have the full access			
Tell us who may have medical records about any of your physical or mental condition(s) (including emotional or learning problems) that limit your ability to work. 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:			
<ul style="list-style-type: none">• 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.			
<input type="text" value="Name"/>	<input type="text" value="Address"/>		
Next Page	Previous Page	Cancel	Help

Dr/Therapist Information page

Hospital/Clinic Information

Alleged onset date: 11/25/2018

Name of facility or office: [SMITH FEDELER SMITH AND MILES PA](#)

Replace Source

Attention: ATTN: MEDICAL RECORDS

Address: 832 S FLORIDA AV STE 1

Health care professional who treated you at :

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 in 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~~

Remove

~~Did you have any outpatient visits? Yes No Not yet answered~~

Remove Y/N/NYA question - date fields remain static on the page

~~Date first seen:~~

~~First visit:~~

~~Date last seen:~~

~~Last visit:~~

~~Next appointment:~~

~~Date of next appointment, if known:~~

~~Did you have emergency room visits?~~

~~If more than three, give the most recent ones.~~

~~Yes No Not yet answered~~

Remove

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

~~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.)~~

Remove

Hospital/Clinic Information Page

Doctor/Therapist Information

Alleged onset date: 11/25/2018

Name: ERIC JACKSON MD

Replace Source

Attention:

Address: 16 -18 RIDGE RD

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

Date first seen:

~~First visit:~~

~~Last visit:~~

Date last seen:

~~Next appointment:~~

Date of next appointment (if known):

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~~

Remove.

Bottom of both the Dr/Therapist and Hospital/Clinic Information pages - (no changes)

Tests

List any tests this provider performed, sent you to, 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
------	------	------------

Add Test

Medicines

List all medicines you are taking that were 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

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

Help

Test Summary Page

(3368) Section 2 - Contacts

Is there someone we can contact who can help with your claim, if needed? Examples include a family member, friend, or neighbor.

~~Give the name of someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your claim.~~

YES Please provide the names of two people (other than your doctors) we can contact who know about your medical condition(s) and can help you with your claim and can help us reach you if you become unavailable.

OR

NO We recommend that you provide at least one contact, if available. Providing the name of someone who knows you may help us to make a quicker decision on your claim.

2.A. Name (First, Middle Initial, Last)	First Middle Last Jr
2.B. Relationship to you:	Neighbor
2.C. Daytime Phone Number (as described in 1.E. above)	112-388-9972
2.D. Mailing Address (Street or PO Box) Include apartment number or unit if applicable, City, State/Province, Zip/Postal Code, Country (if not USA)	99 Street Road Baltimore, MD 21212

2.E. Can this person speak and understand English? **Yes**

If no, what language is preferred?

2.F. Name (First, Middle Initial, Last)	
2.G. Relationship to you:	
2.H. Daytime Phone Number (as described in 1.E. above)	
2.I. Mailing Address (Street or PO Box) Include apartment number or unit if applicable, City, State/Province, Zip/Postal Code, Country (if not USA)	

Add questions 2.F. thru 2.J. for the

2.J. Can this person speak and understand English?

If no, what language is preferred?

~~2.F. Who is completing this report? Someone else (Please complete the rest of Section 2 below)~~

2.G. Name (First, Middle Initial, Last)	OTHER First OTHER Middle OTHER Last
2.H. Relationship to Person Applying:	TYPED INTO THE FIELD
2.I. Daytime Phone Number	882-996-3338
2.J. Mailing Address (Street or PO Box) Include apartment number or unit if applicable, City, State/Province, Zip/Postal Code, Country (if not USA)	88 Infinity Way TOWNLY, MA 87214

Moves to section 12

SSA-3368 Section 9 - Other Medical Information Detail Page

Other Medical Information Detail

Alleged onset date: 11/25/2018

Name: [JOSEPH TESTA MD](#)

Attention: AFTER

Address: 1265 VISCAYA PARKWAY

Claim or ID Number, if any:

Dates

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

- June 11, 2002
- October 2000
- Summer 1999

Date of first contact:

Date of last contact:

Date of next contact, if any:

Reasons for Contacts

Reasons for contacts:

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

Date of next contact, if any:

Reasons for Contacts

Reasons for contacts:

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

AFTER (continued) - NO CHANGES

SSA-3368 Section 9 – Other Medical Information Summary Page

3368 Other Medical Information

Does anyone else (other than your healthcare providers) have your medical information?

Examples:

- Worker's Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency
- Department of Veterans Affairs

Yes No Not yet answered

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

Name	Address
SMITH, ALFRED MD, Test Services	6201 SW 70 ST
TESTA, JOSEPH MD, Medical Corp.	1265 VISCAYA PARKWAY

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AFTER

SSA-3368 Section 10 – Support Services Support Services Summary Page

3368 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	* HACKNEY, DAVID T. MD
No Organization/School name	name, test
Walmart	name, test m Coach
WALMART	PETERSON, STEPHEN MD

Support Services Information page

Support Services - AN: [] CDR CEF: Y CPD CEF: NYA

Support Services

Name: [test m name Coach, Walmart](#)

Attention:

Address: 1234 security blvd

Dates Seen

If date not known, use best estimate.
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

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

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
test 454

SSA-3368 Section 11 - Remarks (no changes)

3368 Remarks

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

| | |

SSA-3368 Section 12 - Who Is Completing this Report

3368 Who Is Completing This Report

Name of Person Completing This Report

- Joanne Allen
- Maria Vasquez
- Juan Ramirez
- Someone else (complete the section below)

Upon selecting the "Someone else" radio button a new section labeled "Name of Person Completing This Report" should expand.



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

Mailing Address line 1:

Mailing Address line 2:

Mailing Address line 3:

Mailing 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:

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