



Select Form(s) | Add Source | Check Entry | Transfer | Print Form(s) | Create Record | Design Actions | of forms | Help | Close Case | Exit

3368 About You - AN | 019: N | CEF: NYA | [Open in eView](#) | [Hide Instructions](#)

**Forms**

- 3368
  - About You
  - Contacts
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  - Work and Contact
  - Job History
  - Medical Sources
  - Tests
  - Medicines
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- Flags/Messages

  
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### 3368 About You

**Identification**

Name:

Daytime telephone number:

Telephone number is:  U.S.  Foreign  None

Alternate telephone number: (999-999-9999)  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 are maiden name, other married name, or nickname

Yes  No  Not yet answered

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Version: 24.0  
Build: 16  
Build Date: 04/08/2012 07:02 PM

Logged-In User  
Name: GEDA, V  
Office: 267



### 3368 Contacts

#### Alternate Contact Information

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:

#### 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  
If "NO", what language is preferred? OTHER   
Other Language:

#### Person Completing the Report

Who is providing information?  
 Jill Renee Bahmann  
 Alternate Contact listed above  
 Someone else

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

## 3368 Medical Conditions

Alleged onset date: ( )

### Physical and Mental Conditions

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

Include:

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

Examples of conditions:

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

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

- \*1.
2.
3.
4.
5.
6.

Do your conditions cause you pain or other symptoms?

Yes  No  Not yet answered

### Height and Weight

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Select [Form(s)] | Add Source | Check/Edits | Transfer | Print Form(s) | Create Barcode | Change Actions | eForms | Help | Close Case | Exit


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Version: 17.0  
Build: 318  
Build Date: 10/28/2009 09:38 AM



### 3368 Work and Onset

Alleged onset date from the mainframe is: 01/01/2009

**\*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 caused you to make changes in your work activity?**  
 Yes  No  Not yet answered

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


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### 3368 Work and Onset

Alleged onset date from the mainframe is: 01/01/2009

**\*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 caused you to make changes in your work activity?**  
 Yes  No  Not yet answered


**When did your condition first start bothering you?**  
 01/01/2009 [Where did this data come from?](#)

Select Form(s) | Add Source | Check/Edit | Transfer | Print Forms | Create Barcode | Check Actions | eForms | Help | Close Case | Exit


3368 Work and Onset - AN: DSI: N CEF: NYA Open in eView | Hide Instructions

**Forms**

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  - Contacts
  - Medical Conditions
  - Work and Onset**
  - Job History
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Version: 17.0  
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### 3368 Work and Onset

Alleged onset date from the mainframe is: 01/01/2009

**'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)? 01/01/2009 [Where did this date come from?](#)


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Select Form(s) | Add Source | Check/Edit | Transfer | Print Forms | Create Barcode | Check Actions | eForms | Help | Close Case | Exit


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**Forms**

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Version: 17.0  
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### 3368 Work and Onset

Alleged onset date from the mainframe is: 01/01/2009

**'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

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):

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

Yes  No  Not yet answered

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

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## Section 5-Education and Training Form/3368 Education EDCS

**3368 Education and Training**

**Education**

Alleged onset date:

What is the highest grade of school that you completed?   
(Select 12, if you have education equivalent to high school from another country.)

**Special Education**

Did you receive special education, such as through an Individualized Education Plan (IEP) or equivalent education?  
 Yes  No  Not yet answered

**Job Training or Vocational School**

Have you completed any type of specialized job training, trade, or vocational school?  
 Yes  No  Not yet answered

**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.

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

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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### Still receiving special education-

This screenshot reflects the question “Still receiving special education”. This question is not on the paper form. This field is required in EDCS for the user to navigate through the form.

**3368 Education and Training**

**Education**

Alleged onset date:

What is the highest grade of school that you completed?   
(Select 12, if you have education equivalent to high school from another country.)

Approximate date completed (MM/YYYY):

Name of school:

Address is:  U.S.  Foreign

City:  State:

**Special Education**

Did you receive special education, such as through an Individualized Education Plan (IEP) or equivalent education?  
 Yes  No  Not yet answered

Still receiving special education

From (MM/YYYY):

What is the last grade you received special education?

Reason(s) for IEP or equivalent education:

Is the school listed above where you last received special education?  
 Yes  No  Not yet answered

Name of school:

Address is:  U.S.  Foreign

City:  State:

Add School | Copy from Prior


### Still receiving special education at a different school


This screenshot reflects the question “Still receiving special education at a different school”. This question is not on the paper form. This field is required in EDCS for the user to navigate through the form when they are receiving special education at a school other than the last school where they received special education.

**3368 Education and Training**

**Education**


Alleged onset date:

What is the highest grade of school that you completed?    
(Select 12, if you have education equivalent to high school from another country.)

Approximate date completed (MM/YYYY):  

Name of school:


Address is:  U.S.  Foreign


City:  State:  

**Special Education**

Did you receive special education, such as through an Individualized Education Plan (IEP) or equivalent education?  
 Yes  No  Not yet answered

Still receiving special education

From (MM/YYYY):  

What is the last grade you received special education?  


Reason(s) for IEP or equivalent education:

Is the school listed above where you last received special education?  
 Yes  No  Not yet answered

If no, select the 'Add School' button below to add the school where you last received special education.

Name of school:

Address is:  U.S.  Foreign

City:  State:  

## Job Training

**Job Training or Vocational School**

Have you completed any type of specialized job training, trade, or vocational school?

Yes  No  Not yet answered

**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.

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

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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## Section 6-Job History

Select Form(s) | Add Source | Check/Edits | Transfer | Print Forms | Create Barcode | Display Actions | eForms | Help | Close Case | Exit

3368 Job History - AN: -SI: N CEF: NYA Open in eView Show Instructions

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  - Job History**
  - Medical Sources
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- Authorized Rep
- Flags/Messages



### 3368 Job History

Alleged onset date:

How many jobs did you have in the 15 years before you became unable to work because of your physical or mental conditions?

0  
 1  
 2-5  
 6 or more  
 Not yet answered

List the most recent job(s) (up to 5).

Job Title	Start	End
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**What did you do all day in this job?**

We need to know about the type of job skills and physical tasks you had during a typical workday in your longest job.

- What were your main responsibilities?
- What did you do during a normal workday?

**Daily duties included:**

[Examples of daily duties](#)

**In this job, did you:**

**Use machines, tools, or equipment?**

Examples:

- Carpenters may use tools like power saws and nail guns
- Secretaries may use a computer

Yes  No  Not yet answered

**Use technical knowledge or skills?**

Examples:

- Electricians may use a computer
- Teachers know the subjects they teach

Yes  No  Not yet answered

**Do any writing, complete forms, or perform duties like this?**

Examples:

- Waitresses write customers' orders
- Bookkeepers complete reports
- Truck drivers complete trip logs

Yes  No  Not yet answered

**In this job, how many hours a day did you do these activities?**

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?**

**Stand?**

**Sit?**

**Climb?**   
(stairs, ladders, etc.)

**Stoop?**   
(bend down and forward at waist)

**Kneel?**   
(bend legs and rest on knees)

**Crouch?**   
(bend legs and back down and forward)

**Crawl?**   
(move on hands and knees)

**Handle, grab, or grasp big objects?**

Examples:

- Lift a box
- Move a lever such as a gear shift

**Reach?**

**What did you do all day in this job?**

We need to know about the type of job skills and physical tasks you had during a typical workday in your longest job.

- What were your main responsibilities?
- What did you do during a normal workday?

**Daily duties included:**

[Examples of daily duties](#)

<pre> weee wwwwwww ww ww </pre>	<input type="text"/> <input type="text"/> <input type="text"/>
---	--

**In this job, did you:**

**Use machines, tools, or equipment?**

Examples:

- Carpenters may use tools like power saws and nail guns
- Secretaries may use a computer

Yes  No  Not yet answered

**Use technical knowledge or skills?**

Examples:

- Electricians may use a computer
- Teachers know the subjects they teach

Yes  No  Not yet answered

**Do any writing, complete forms, or perform duties like this?**

Examples:

- Waitresses write customers' orders
- Bookkeepers complete reports
- Truck drivers complete trip logs

Yes  No  Not yet answered

**In this job, how many hours a day did you do these activities?**

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?**

**Stand?**

**Sit?**

**Climb?**   
(stairs, ladders, etc.)

**Stoop?**   
(bend down and forward at waist)

**Kneel?**   
(bend legs and rest on knees)

**Crouch?**   
(bend legs and back down and forward)

**Crawl?**   
(move on hands and knees)

**Handle, grab, or grasp big objects?**

Examples:

- Lift a box
- Move a lever such as a gear shift

**Reach?**

reach:

**Write, type, or handle small objects?**

Examples:

- Write on a pad
- Enter numbers in a calculator
- Sort objects by hand

**Physical Activities: Lifting and Carrying**

**Describe what you lifted, how far you carried it, and how often you lifted it.**

[Examples of lifting and carrying](#)

**What is the heaviest weight you lifted?**

**How much weight did you lift frequently (from 1/3 to 2/3 of your workday)?**

reach:

**Write, type, or handle small objects?**

Examples:

- Write on a pad
- Enter numbers in a calculator
- Sort objects by hand

**Physical Activities: Lifting and Carrying**

**Describe what you lifted, how far you carried it, and how often you lifted it.**

[Examples of lifting and carrying](#)

**What is the heaviest weight you lifted?**

**How much weight did you lift frequently (from 1/3 to 2/3 of your workday)?**

**What is the heaviest weight you lifted?**

**How much weight did you lift frequently (from 1/3 to 2/3 of your workday)?**

Example: A gallon of milk weighs 8 pounds

**Supervisory Duties**

**In this job, did you supervise other people?**

Yes  No  Not yet answered

**How many people did you supervise?**

**What part of your time was spent supervising people?**

**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

Section 7 – Medicines

Select Form(s)   Add Source   Check Edits   Transfer   Print Forms   Create Barcode   Claims Actions   UniForms   Help   Close Case   Exit

3368 Medicines Summary - AN:   CEF:   [Open in eView](#)   [Hide Instructions](#)

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- Title II/Title XVI
- Appointed Rep
- Flags/Messages

### 3368 Medicines Summary

Are you 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

  |      |      |  

Medicine Information - AN:   CEF:   [Open in eView](#)   [Hide Instructions](#)

### 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

Section 8- Tests

Select Form(s) | Add Source | Check Edits | Transfer | Print Forms | Create Barcode | Claims Actions | Uniforms | Help | Close Case | Exit

3368 Tests Summary - AN: CEF:  [Open in eView](#) [Hide Instructions](#)

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### 3368 Tests Summary

Have you had any medical tests, or do you have any tests scheduled for your condition?  
 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

| 
  | 
  |

Test Information - AN:  CDR CEF: Y CPD CEF: NYA [Open in eView](#) [Hide Instructions](#)

### Test Information

\*Name 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

## Section 8: Medical Treatment

Disability Case Process 800-78-0845 Dale Andrew Jones - Windows Internet Explorer

Other Source Information - AN: [ ] DSI: N CEF: Y [Open in eView](#) [Hide Instructions](#)

### Other Source Information

Alleged onset date: [ ]

Name: [ ] [Replace Source](#)

Attention:  
Address: 11809 rt 6

Your case/claim number, if known: [ ]

### Dates

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

- June 11, 2002
- October 2000
- Summer 1999

First visit: [ ]

Last visit: [ ]

Next appointment: [ ]

### Reasons for Visits

Why have you been seeing this organization?

[ ]

List and describe all of the illnesses, injuries, or conditions that limit 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](#)

[ ]

[Check Spelling](#)

p weatherbee, tioga county assistance office Local Intranet 100%

## Section 9: Other Medical Sources



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

Select Form(s) | Add Source | Check Edits | Transfer | Print Forms | Create Barcode | Claims Actions | UnForms | Help | Close Case | Exit


3368 Medical Sources - AN:      CEF:      [Open in eView](#) [Hide Instructions](#)

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**Internet Documents**

- Title II/Title XVI
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- Flags/Messages



Version: 42.0  
Build: 22  
Build Date: 07/08/2020 13:05 PM  
Name: HIRULIN, A  
Office: 013

### 3368 Medical Sources

Alleged onset date:

**Doctors, Therapists, Hospitals, Clinics**

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)**  
 Yes  No  Not yet answered

**\*For any mental condition(s) (including emotional or learning problems)**  
 Yes  No  Not yet answered

Tell us who may have medical records 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:

- All types of providers (physicians, psychologists, optometrists, nurse practitioners, therapists, chiropractors, accupuncturists, 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

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Disability Case Process | Windows Internet Explorer

Select Form(s) | Add Source | Check Edits | Transfer | Print Forms | Create Barcode | Claims Actions | eForms | Help | Close Case | Exit

3368 Other Medical Information - AN:      : N CEF: NYA      [Open in eView](#) [Hide Instructions](#)

**Forms**

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### 3368 Other Medical Information

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

Examples:

- Worker's Compensation
  - Vocational rehabilitation
  - 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

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

### Other Medical Information

Alleged onset date:

Name:

Attention:

Address:

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

Section 10

Vocational Rehabilitation, Employment , or Other Services Information - AN: CDR CEF: CPD CEF: I [Open in eView](#) [Hide Instructions](#)

---

**Vocational Rehabilitation, Employment , or Other Services Information**

**Name:**

**Attention:**

**Address:**

**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

**Types of Services**

**What types of services, tests, or evaluations were provided?**  
Examples:

- Workshops
- Job coaching
- Job placement
- Tuition assistance
- Aptitude testing
- Classes

**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
<input type="text"/>