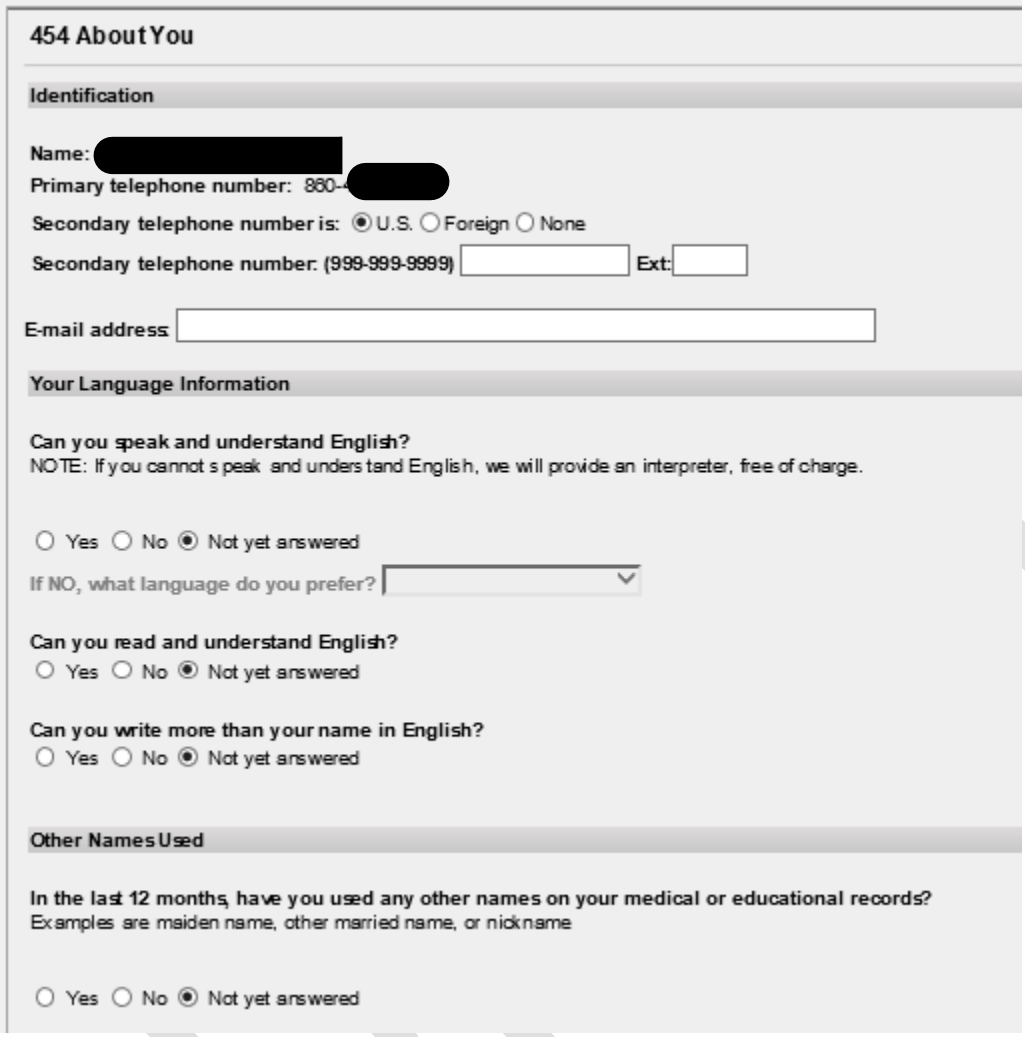
EDCS SSA-454 Adult Screenshots

About You: Section 1: Information About You



454 About You

Identification

Name: [redacted]

Primary telephone number: 860-[redacted]

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

Secondary 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

If NO, what language do you prefer?

Can you read and understand English?
○ Yes ○ No ◉ Not yet answered

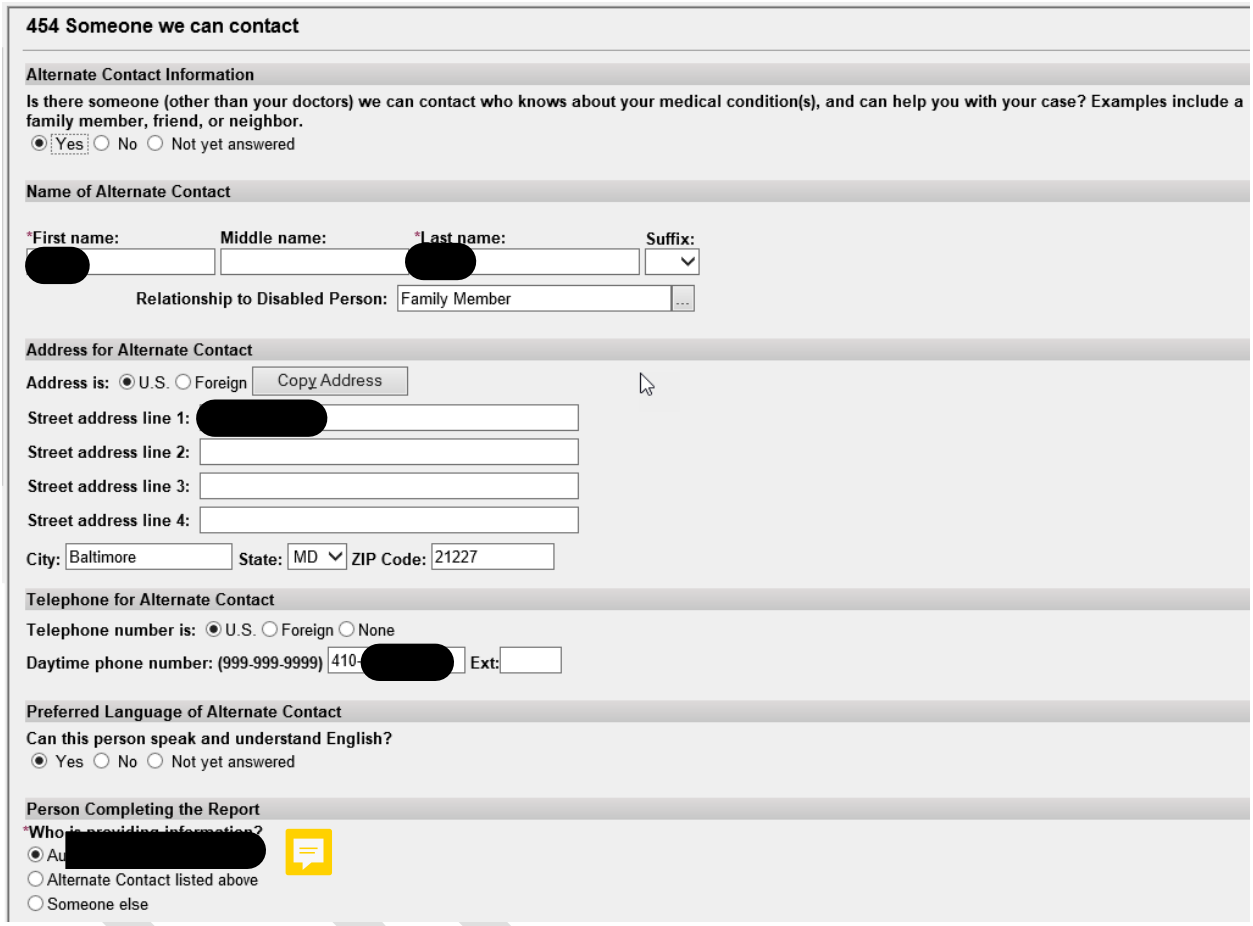
Can you write more than your name in English?
○ Yes ○ No ◉ Not yet answered

Other Names Used

In the last 12 months, have you used any other names on your medical or educational records?
Examples are maiden name, other married name, or nickname

○ Yes ○ No ◉ Not yet answered

SSA- 454 Section 2 – Contacts/Person Completing Form



454 Someone we can contact

Alternate Contact Information

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

(•) Yes ( ) No ( ) Not yet answered

Name of Alternate Contact

*First name: [redacted] Middle name: *Last name: [redacted] Suffix:

Relationship to Disabled Person: Family Member

Address for Alternate Contact

Address is: (•) U.S. ( ) Foreign Copy Address

Street address line 1: [redacted]

Street address line 2:

Street address line 3:

Street address line 4:

City: Baltimore State: MD ZIP Code: 21227

Telephone for Alternate Contact

Telephone number is: (•) U.S. ( ) Foreign ( ) None

Daytime phone number: (999-999-9999) 410-[redacted] Ext:

Preferred Language of Alternate Contact

Can this person speak and understand English?

(•) Yes ( ) No ( ) Not yet answered

Person Completing the Report

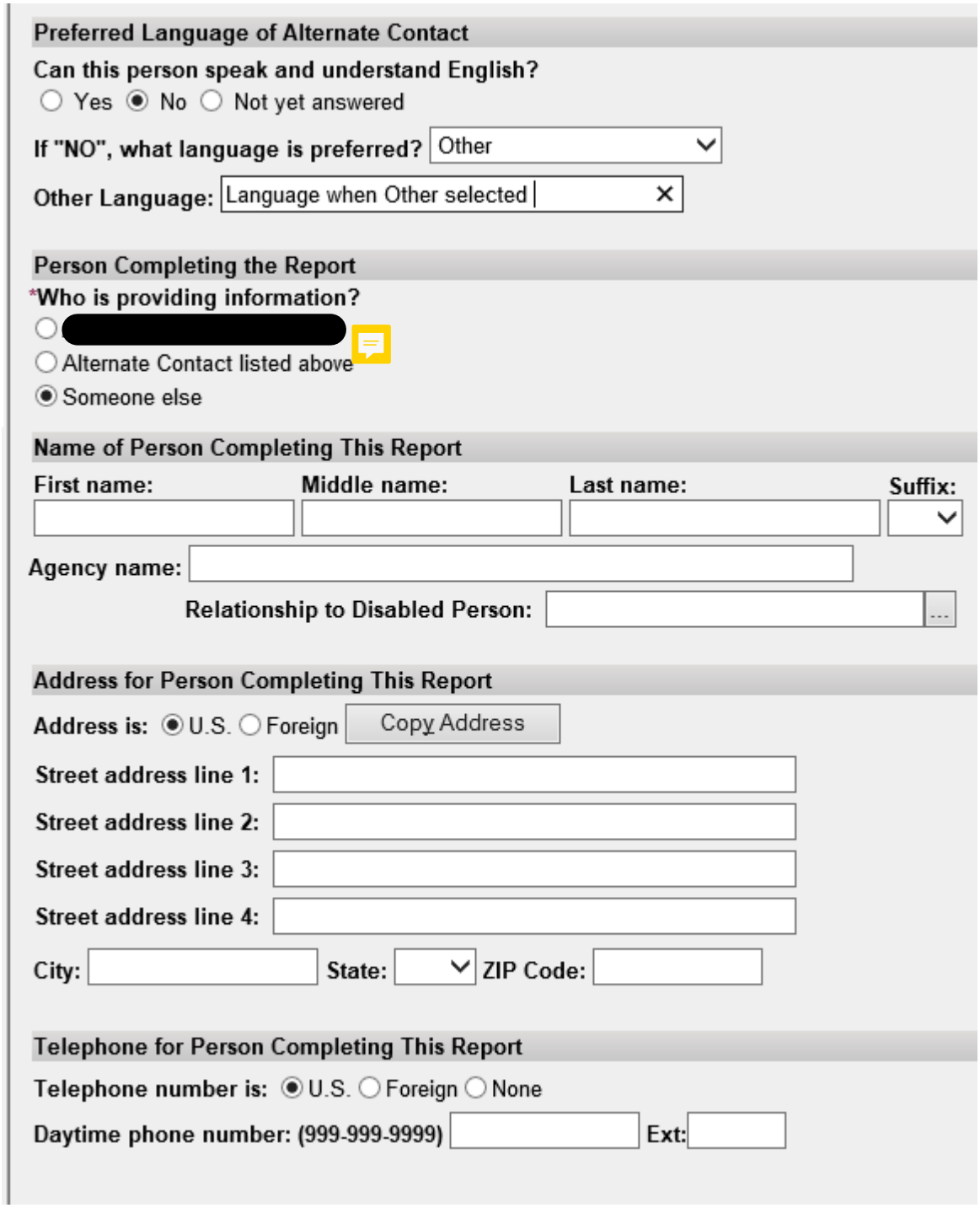
*Who is providing information?

(•) Au[redacted]

( ) Alternate Contact listed above

( ) Someone else

Expanded Version- Someone Else is Completing the Form



Preferred Language of Alternate Contact

Can this person speak and understand English?

○ Yes ◉ No ○ Not yet answered

If "NO", what language is preferred? Other

Other Language: Language when Other selected

Person Completing the Report

***Who is providing information?**

○ [redacted]

○ 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 Copy Address

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

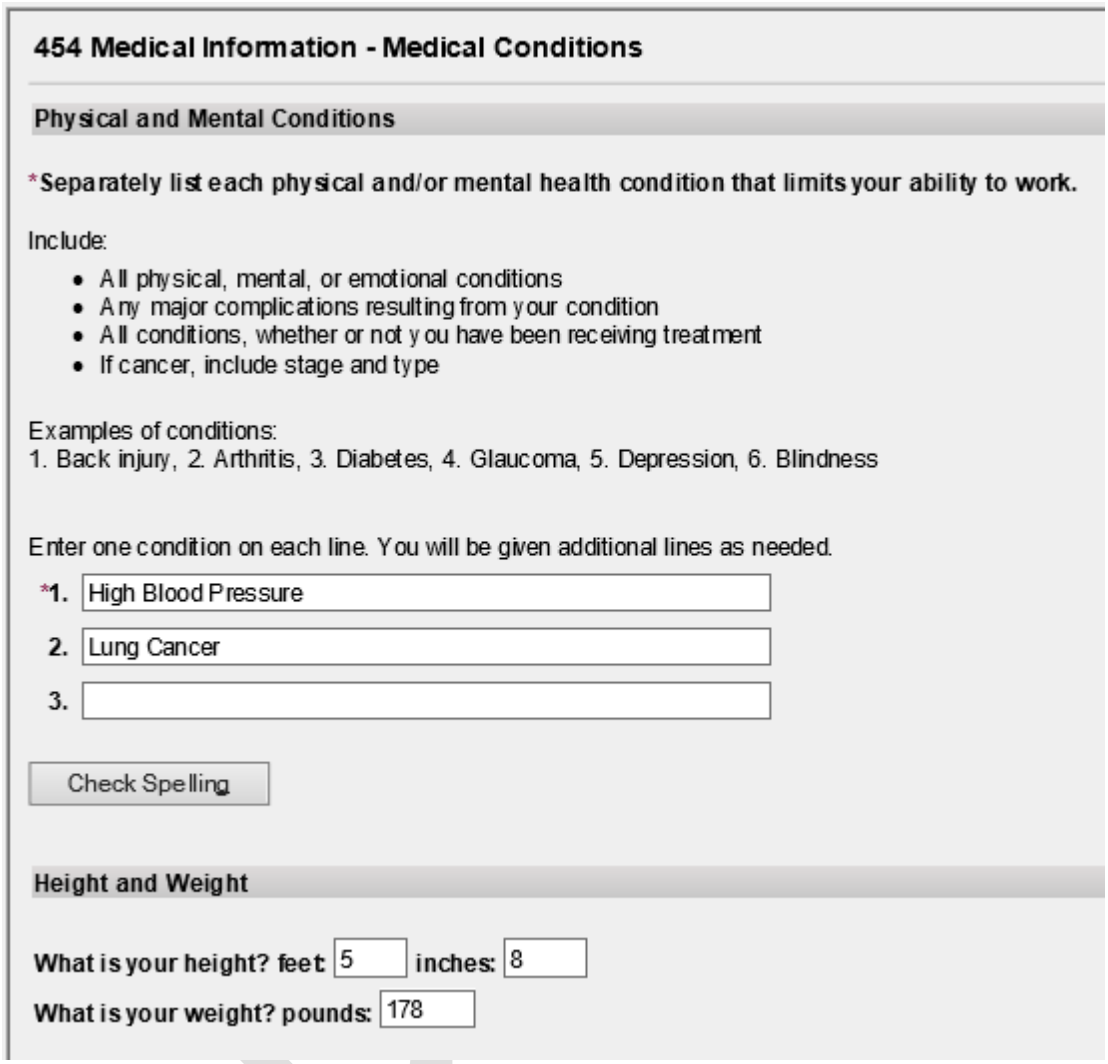
City: **State:** **ZIP Code:**

Telephone for Person Completing This Report

Telephone number is: ◉ U.S. ○ Foreign ○ None

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

SSA-454 Section 3- Medical Info- Conditions



454 Medical Information - Medical Conditions

Physical and Mental Conditions

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

Include:

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

Examples of conditions:
1. Back injury, 2. Arthritis, 3. Diabetes, 4. Glaucoma, 5. Depression, 6. Blindness

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

*1. High Blood Pressure
2. Lung Cancer
3.

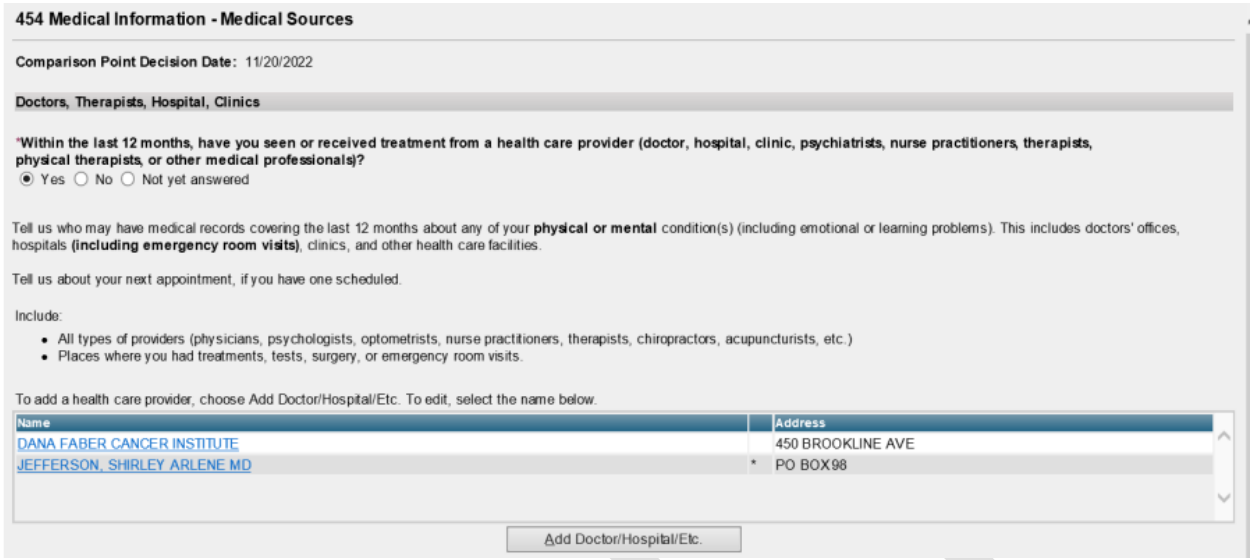
Check Spelling

Height and Weight

What is your height? feet: 5 **inches:** 8

What is your weight? pounds: 178

SSA-454 Section 3- Medical Info Sources



454 Medical Information - Medical Sources

Comparison Point Decision Date: 11/20/2022

Doctors, Therapists, Hospital, Clinics

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

(•) Yes ( ) No ( ) Not yet answered

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

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

Include:

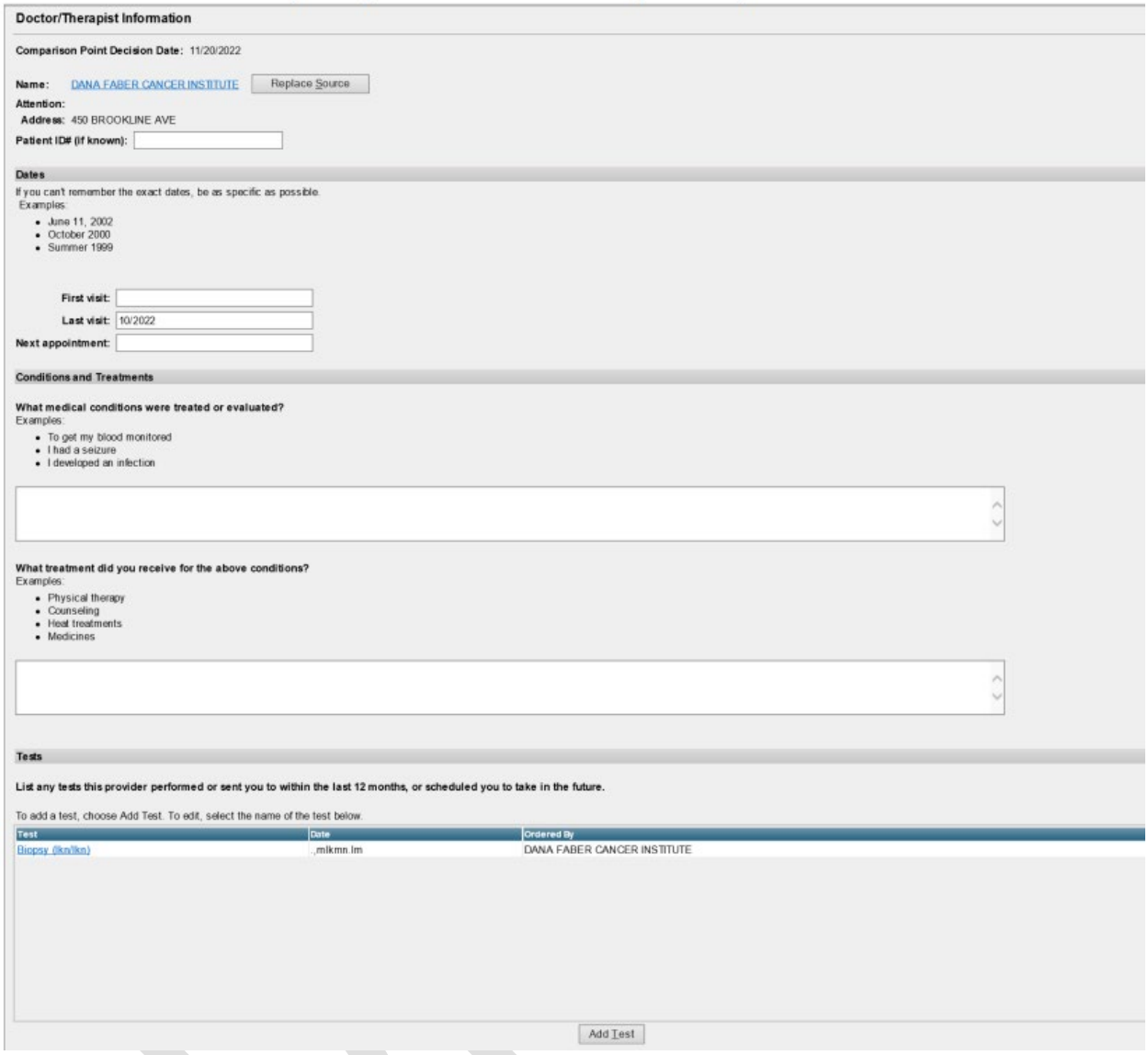
- All types of providers (physicians, psychologists, optometrists, nurse practitioners, therapists, chiropractors, acupuncturists, etc.)
- Places where you had treatments, tests, surgery, or emergency room visits.

To add a health care provider, choose Add Doctor/Hospital/Etc. To edit, select the name below.

Name		Address
DANA FABER CANCER INSTITUTE		450 BROOKLINE AVE
JEFFERSON, SHIRLEY ARLENE MD	*	PO BOX98

Add Doctor/Hospital/Etc.

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



Doctor/Therapist Information

Comparison Point Decision Date: 11/20/2022

Name: DANA FABER CANCER INSTITUTE Replace Source

Attention:

Address: 450 BROOKLINE AVE

Patient ID# (if known):

Dates

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

- June 11, 2002
- October 2000
- Summer 1999

First visit:

Last visit: 10/2022

Next appointment:

Conditions and Treatments

What medical conditions were treated or evaluated?
Examples:

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

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

- Physical therapy
- Counseling
- Heat treatments
- Medicines

Tests

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

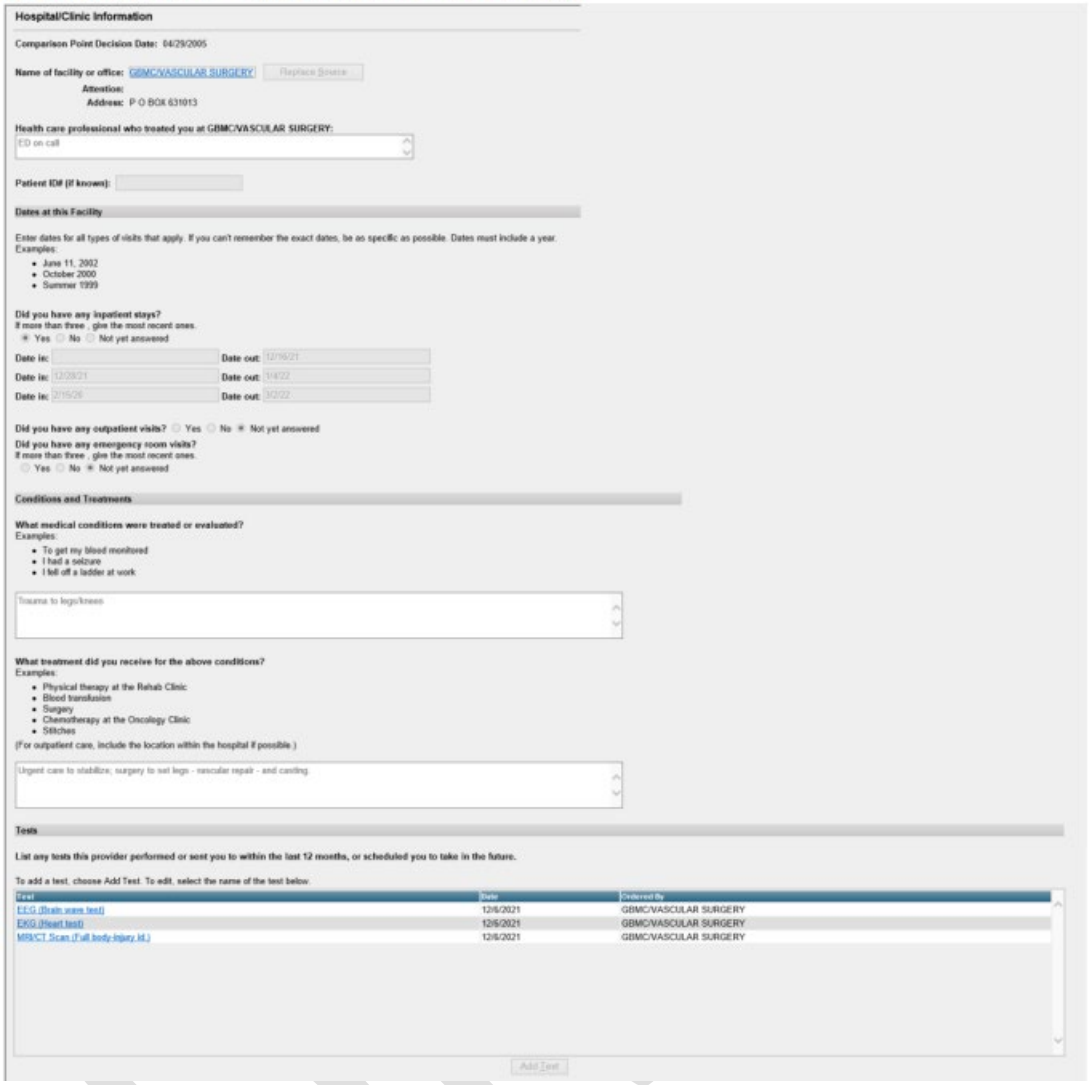
To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By
Biopsy (lkn/lkn)	,mlkmn lm	DANA FABER CANCER INSTITUTE

Add Test


Medicines
List all medicines you are now taking, or have you taken in the last 12 months, prescribed or suggested by this provider.
To add a medicine, choose Add Medicine. To edit, select the name of the medicine below.
Medicine
Prescribed By
Reason
Add Medicine
Physical and Mental Conditions
List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.
To add or edit a condition, choose Add or Edit Conditions.
Name
High Blood Pressure
Lung Cancer 2
Low vision
Anxiety
Add or Edit Conditions

Medical Sources – Hospital/Clinic Information



Hospital/Clinic Information

Comparison Point Decision Date: 04/29/2005

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

Attention:

Address: P O BOX 631013

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

ED on call

Patient ID# (if known):

Dates at this Facility

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

- June 11, 2002
- October 2000
- Summer 1999

Did you have any inpatient stays?
If more than three , give the most recent ones.

(•) Yes ( ) No ( ) Not yet answered

Date in:		**Date out:**	12/16/21
Date in:	12/28/21	**Date out:**	1/4/22
Date in:	2/15/25	**Date out:**	3/2/22

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

Did you have any emergency room visits?
If more than three , give the most recent ones.

( ) Yes ( ) No (•) Not yet answered

Conditions and Treatments

What medical conditions were treated or evaluated?
Examples:

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

Trauma to legs/knees

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

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

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

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

Tests

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

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

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

Add Test

Medicines

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

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

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

Add Medicine

Physical and Mental Conditions

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

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

Name
Knee injury from car accident
Leg amputation

Add or Edit Conditions

OK | Delete | Add Another Source | Cancel | Help

SSA-454 Section 3- Medical Info-Tests

454 Medical Information - Tests Summary

Within the last 12 months, did any of the providers you listed order any medical test for you? (Include tests performed and scheduled in the future, and the healthcare provider, or facility, that scheduled them.)

(•) 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 (Provider or Facility)
X-ray (legs)		*No Source*

Test Information

***Name of Test:**

Description of tests

[ ] [...]

Date of Test:

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

- 10/13/2002
- June 2001

[ ]

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

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

[ ]

[ ] **I have had this test more than once.**

Physical and Mental Conditions

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

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

Name
High Blood Pressure
Lung Cancer 2
Low vision

Add or Edit Conditions

OK | Delete | Add Another | Cancel | Help

SSA - 454 Section 3 – Medical Info – Medicines

Medicines Summary

454 Medical Information - Medicines Summary

Within the last 12 months, have you taken or are you now taking any prescription or non-prescription medicines?
(•) Yes ( ) No ( ) Not yet answered

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

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

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

Add Medicine

Medicines Detail (no edits)

Medicine Information

*Name of medicine: [ ] ...

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

[ ]

Reason for medicine:
Examples:

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

Physical and Mental Conditions

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

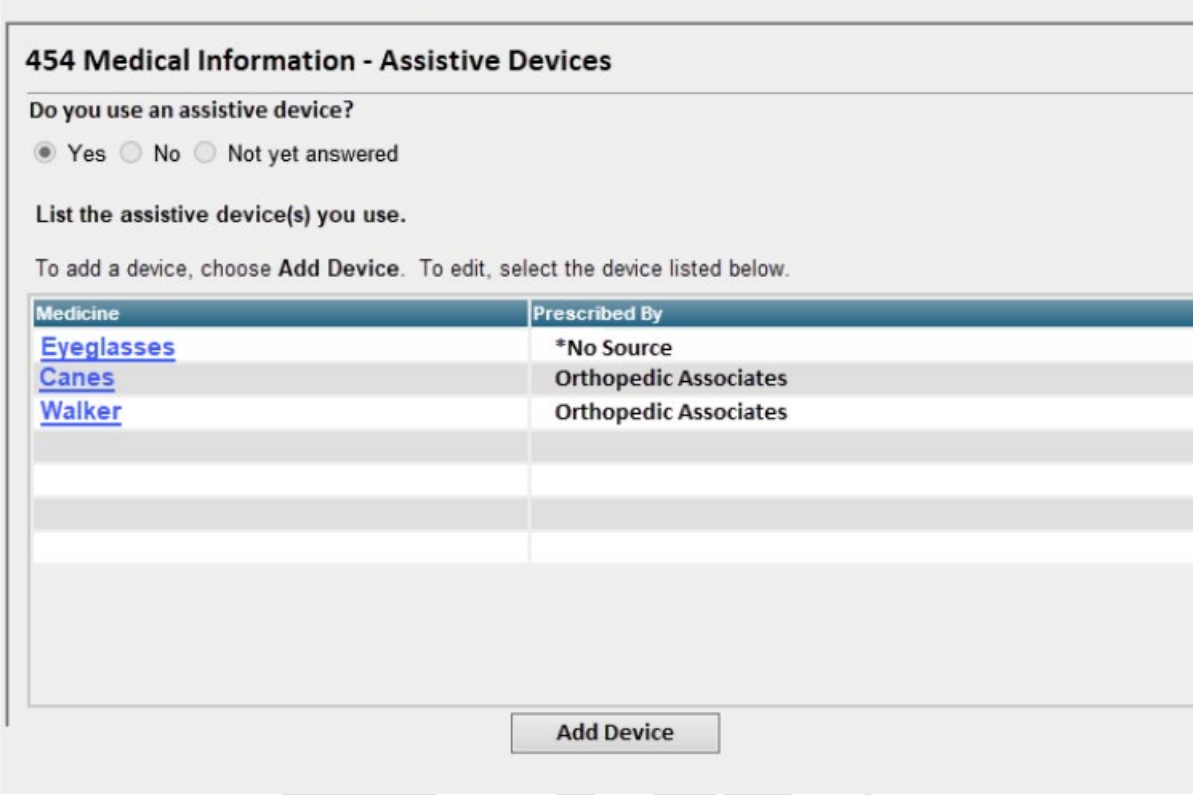
To add or edit a condition, choose Add or Edit Conditions.

Name
Knee injury from car accident
Leg amputation

Add or Edit Conditions

SSA - 454 Section 3 – Medical Info – Assistive Devices

Assistive Devices Summary (new)



454 Medical Information - Assistive Devices

Do you use an assistive device?

(•) Yes ( ) No ( ) Not yet answered

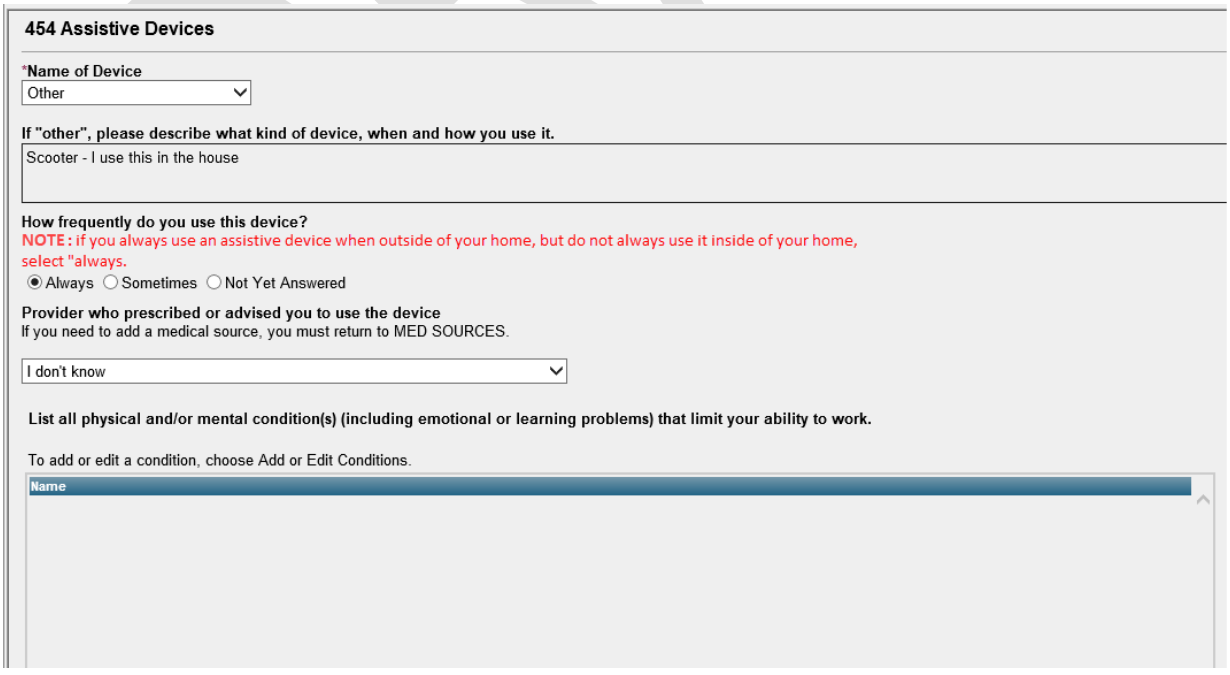
List the assistive device(s) you use.

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

Medicine	Prescribed By
Eyeglasses	*No Source
Canes	Orthopedic Associates
Walker	Orthopedic Associates

Add Device

Assistive Devices Detail (New)



454 Assistive Devices

*Name of Device

Other

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

Scooter - I use this in the house

How frequently do you use this device?

NOTE: if you always use an assistive device when outside of your home, but do not always use it inside of your home, select "always.

(•) Always ( ) Sometimes ( ) Not Yet Answered

Provider who prescribed or advised you to use the device

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

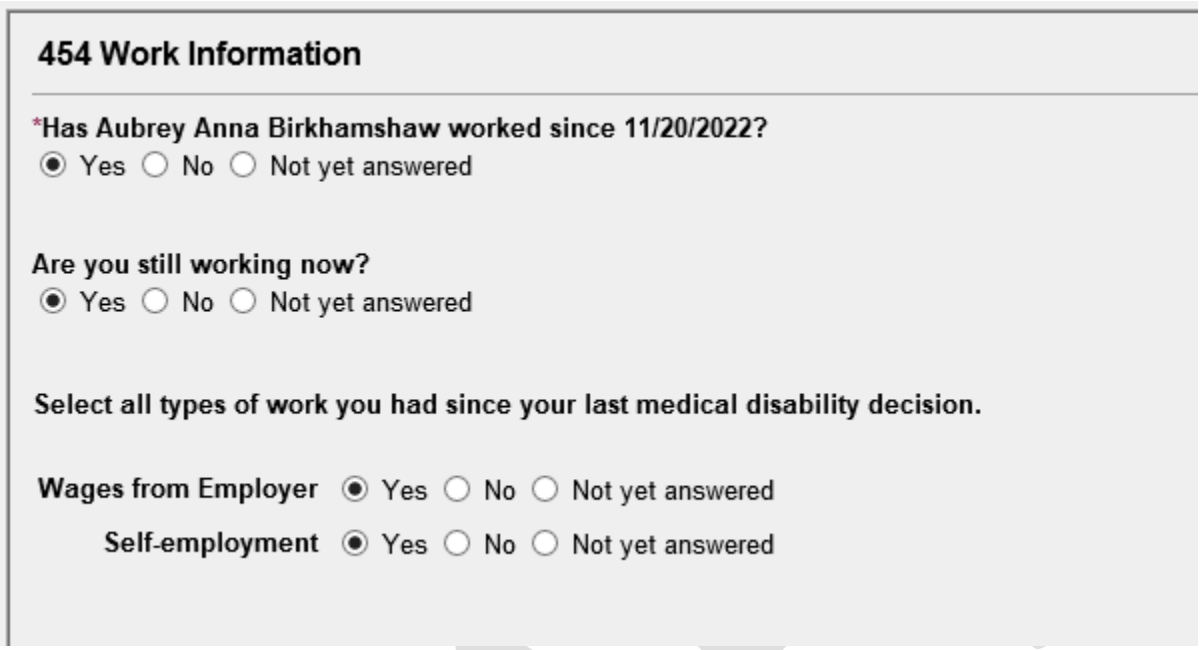
I don't know

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

SSA-454 Section 4- Work Information



454 Work Information

*Has Aubrey Anna Birkhamshaw worked since 11/20/2022?
(•) Yes ( ) No ( ) Not yet answered

Are you still working now?
(•) Yes ( ) No ( ) Not yet answered

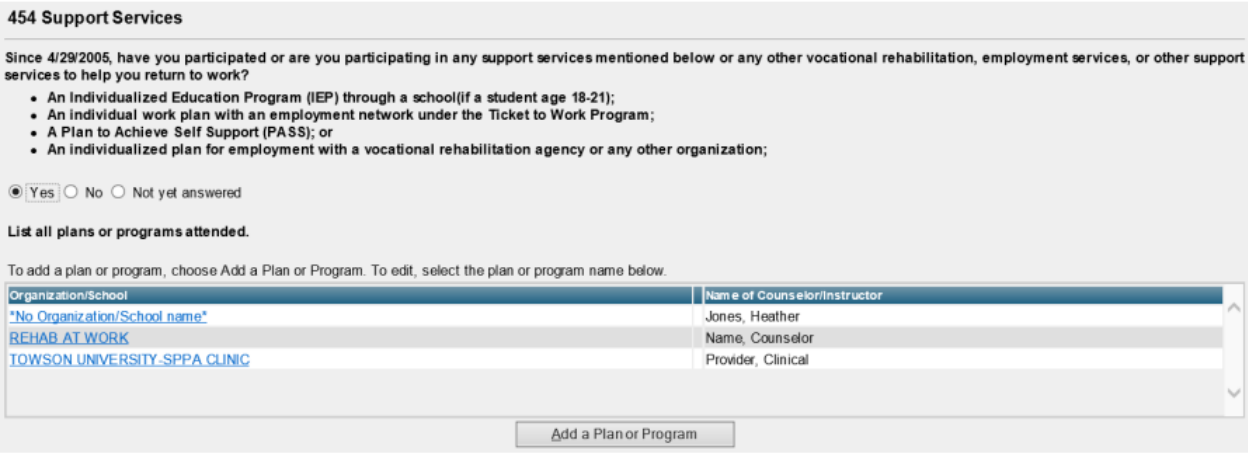
Select all types of work you had since your last medical disability decision.

Wages from Employer (•) Yes ( ) No ( ) Not yet answered

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

SSA - 454 Section 5 – Support Services

Support Services Summary



454 Support Services

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

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

(•) Yes ( ) No ( ) Not yet answered

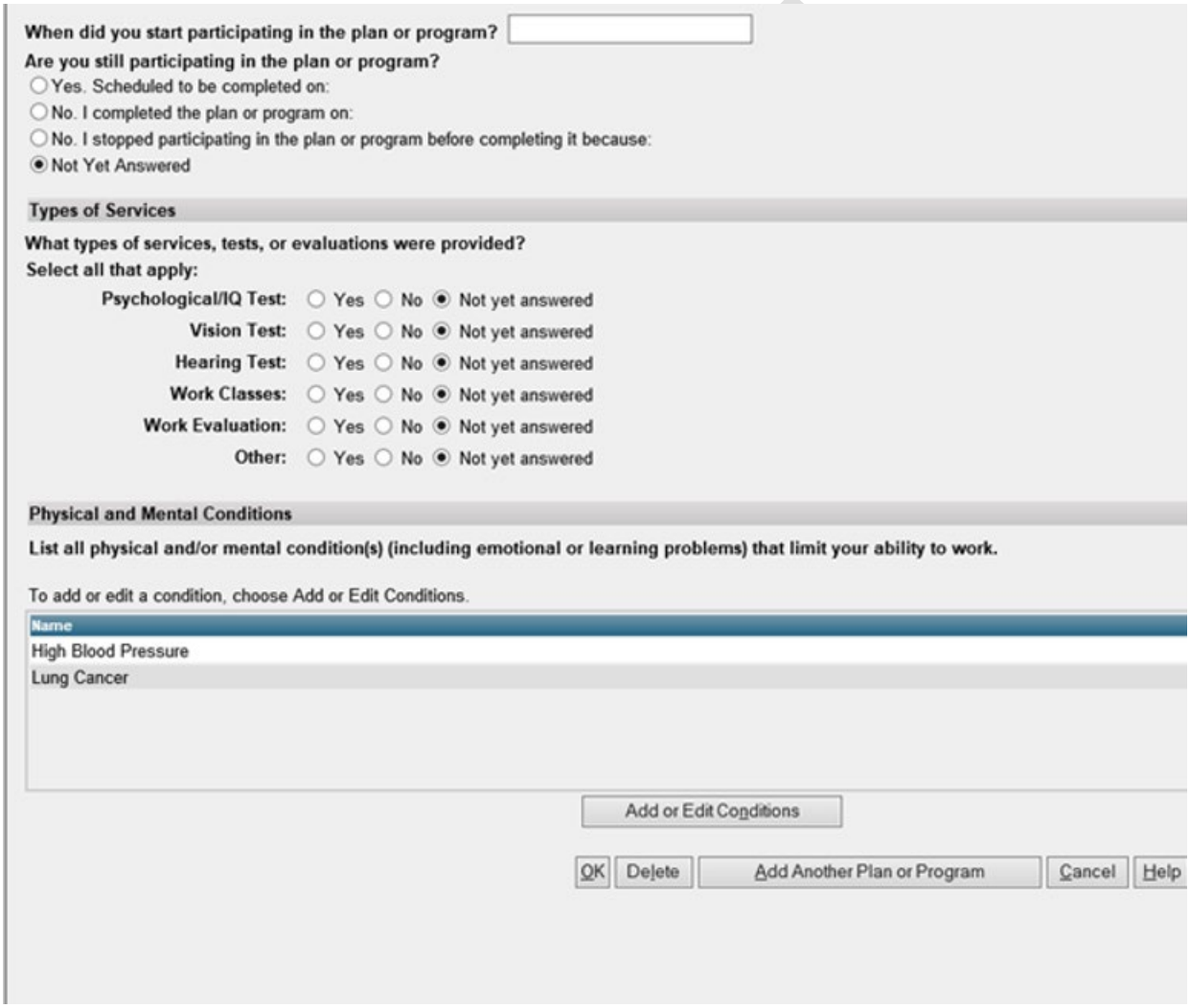
List all plans or programs attended.

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

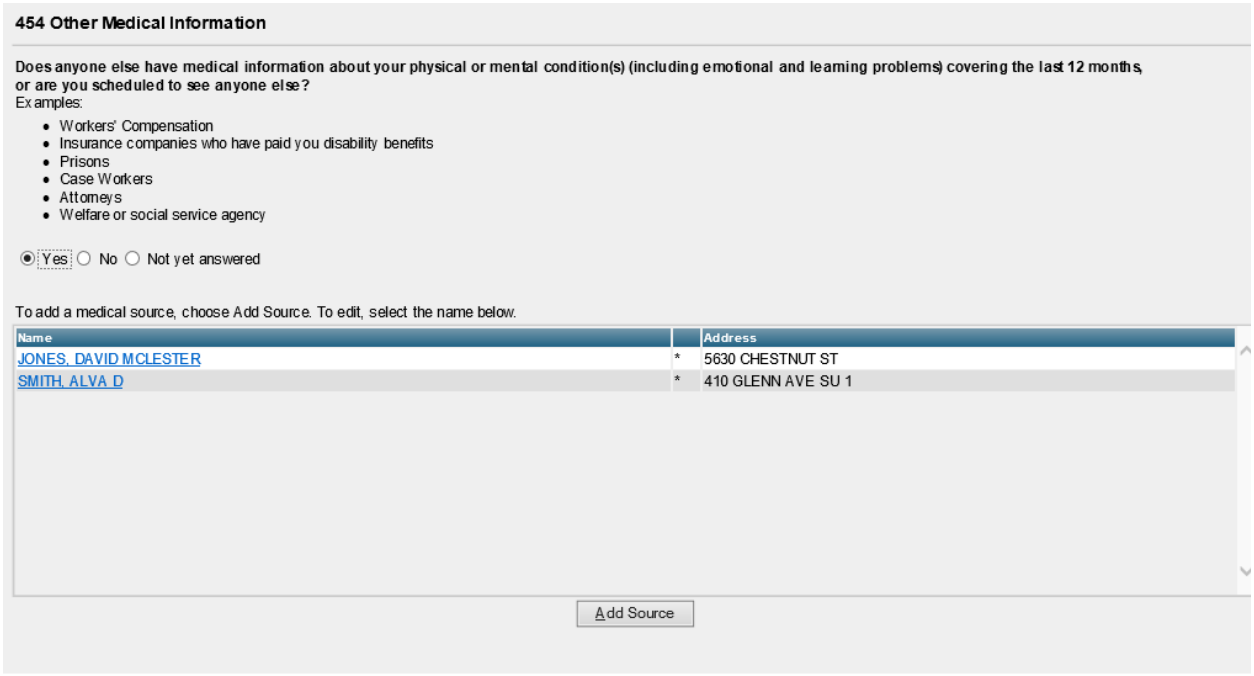
Organization/School	Name of Counselor/Instructor
No Organization/School name	Jones, Heather
REHAB AT WORK	Name, Counselor
TOWSON UNIVERSITY-SPPA CLINIC	Provider, Clinical

Add a Plan or Program

Support Services Detail



SSA-454Section 6- Other Medical Information



454 Other Medical Information

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

- Workers' Compensation
- Insurance companies who have paid you disability benefits
- Prisons
- Case Workers
- 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
JONES, DAVID MCLESTER	*	5630 CHESTNUT ST
SMITH, ALVA D	*	410 GLENN AVE SU 1

Add Source

SSA - 454 Section 7 – Education, Training and Literacy

454 Education, Training and Literacy

Education

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

Name of school: School Name

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

***Type of program or degree:**
The type of program or degree text box

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

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

Job Training or Vocational School

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

(•) Yes ( ) No ( ) Not yet answered

Name of training facility: Training Facility

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

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

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

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

Language Information

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

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

Other Language: Braille

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

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

SSA - 454 Section 8 – Daily Activities

454 Daily Activities

Do you ever have difficulty doing any of the following:

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

SSA - 454 Section 9 – Remarks

454 Remarks

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