
SSA HIV LISTING OF IMPAIRMENTS FOR ADULTS

Text (including explanation of the diseases) reproduced from Social Security Administration's regulation. Citations refer to 20 C.F.R. Part 404, Subpart P, Appendix 1.

Human immunodeficiency virus (HIV) may be characterized by increased susceptibility to common infections as well as opportunistic infections, cancers, or other conditions listed in 14.11.

A. "STAND ALONES"

- ***Multicentric (not localized or unicentric) Castleman disease affecting multiple groups of lymph nodes or organs containing lymphoid tissue*** [14.11A]

  Multicentric (not localized or unicentric) Castleman disease (MCD) affects multiple groups of lymph nodes and organs containing lymphoid tissue. This widespread involvement distinguishes MCD from localized (or unicentric) Castleman disease, which affects only a single set of lymph nodes. While not a cancer, MCD is known as a lymphoproliferative disorder. Its clinical presentation and progression is similar to that of lymphoma, and its treatment may include radiation or chemotherapy. [SSA] requires characteristic findings on microscopic examination of the biopsied lymph nodes or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis. Localized (or unicentric) Castleman disease does not meet or medically equal the criterion in 14.11A, but [SSA] may evaluate it under the criteria in 14.11H or 14.11I.

- ***Primary central nervous system lymphoma*** [14.11B]
  Primary central nervous system lymphoma (PCNSL) originates in the brain, spinal cord, meninges, or eye. Imaging tests (for example, MRI) of the brain, while not diagnostic, may show a single lesion or multiple lesions in the white matter of the brain. [SSA] requires characteristic findings on microscopic examination of the cerebral spinal fluid or of the biopsied brain tissue, or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

- ***Primary effusion lymphoma*** [14.11C]
  Primary effusion lymphoma (PEL) is also known as body cavity lymphoma. [SSA] requires characteristic findings on microscopic examination of the effusion fluid or of the biopsied tissue from the affected internal organ, or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

- **Progressive multifocal leukoencephalopathy** [14.11D]
  Progressive multifocal leukoencephalopathy (PMD) is a progressive neurological degenerative syndrome caused by the John Cunningham (JC) virus in immunosuppressed individuals. Clinical findings of PML include clumsiness, progressive weakness, and visual and speech changes. Personality and cognitive changes may also occur. [SSA] requires appropriate clinical findings, characteristic white matter lesions on MRI, and a positive PCR test for the JC virus in the cerebrospinal fluid to establish the diagnosis. [SSA] also accepts a positive brain biopsy for JC virus or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

- ***Pulmonary Kaposi sarcoma*** [14.11E]
  Pulmonary Kaposi sarcoma (Kaposi sarcoma in the lung) is the most serious form of Kaposi sarcoma (KS). Other internal KS tumors (for example, tumors of the gastrointestinal tract) have a more variable prognosis. [SSA] requires characteristic findings on microscopic examination of the induced sputum, bronchoalveolar lavage washings, or of the biopsied transbronchial tissue, or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

B. CONDITIONS RELATING TO CD4 COUNTS

- ***Absolute CD4 count of 50 cells/mm3 or less*** [14.11F]
  CD4 measurement: To evaluate [applicant's] HIV infection under 14.11F, [SSA] requires one measurement of [applicant's] absolute CD4 count (also known as CD4 count or CD4+ T-helper lymphocyte count). This measurement must occur within the period [SSA] is considering in connection with [applicant's] application or continuing disability review. If [applicant's] has more than one measurement of absolute CD4 count within this period, [SSA] we will use [the] lowest absolute CD4 count.

- ***Absolute CD4 count of less than 200 cells/mm3 or CD4 percentage of less than 14 percent, and <u>one</u> of the following*** *(values do not have to be measured on the same date)* [14.11G]
  1. BMI measurement of less than 18.5; <u>or</u>

  2. Hemoglobin measurement of less than 8.0 grams per deciliter (g/dL).

C. CONDITIONS THAT REQUIRE HOSPITALIZATION [14.11H]

- Complication(s) of HIV infection requiring at least three hospitalizations within a 12-month period and at least 30 days apart. Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

D. **"CATCH_ALL": REPEATED MANIFESTATIONS OF HIV ILLNESS LINKED WITH FUCTIONAL LIMITATION REQUIREMENT [14.11I]** ***Repeated manifestations of HIV infection***, include:

- ✓ Manifestations of the five (5) "**STAND ALONES**" disorders described at "A" above but without the requisite findings for those listings
- ✓ Manifestations of the disease' progression to "**AIDS**" as described in "B" above without the requisite findings for those listings
- ✓ **OTHER MANFESTATIONS**, including, but not limited to,
    - Cardiovascular disease (including myocarditis, pericardial effusion, pericarditis, endocarditis, or pulmonary arteritis)
    - Diarrhea
    - Distal sensory polyneuropathy
    - Glucose intolerance
    - Gynecologic conditions (including cervical cancer or pelvic inflammatory disease)
    - Hepatitis
    - HIV-associated dementia
    - Immune reconstitution inflammatory syndrome (IRIS)
    - Infections (bacterial, fungal, parasitic, or viral)
    - Lipodystrophy (lipoatrophy or lipohypertrophy)
    - Malnutrition
    - Muscle weakness
    - Myositis (neurocognitive or other mental limitations)
    - Oral hairy leukoplakia
    - Osteoporosis
    - Pancreatitis
    - Peripheral neuropathy

resulting in significant, documented symptoms or signs, [including], but not limited to:

- Fever
- Headaches
- Insomnia
- involuntary weight loss
- malaise
- nausea
- night sweats
- pain
- severe fatigue
- vomiting)

and **ONE** of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

(emphasis and formatting above by AIDS Law Project)

SSA DEFINITIONS

"***Repeated***" [14.00I3] means that

- the manifestations occur ***on an average of three times a year***, or ***once every 4 months, each lasting 2 weeks or more***; OR
- the manifestations ***do not last for 2 weeks but occur substantially more frequently than three times in a year*** or once every 4 months; OR
- they occur ***less frequently than an average of three times a year*** or once every 4 months but last substantially longer than 2 weeks.

Claimant's impairment will satisfy this criterion regardless of whether s/he has the same kind of manifestation repeatedly, all different manifestations, or any other combination of manifestations; for example, two of the same kind of manifestation and a different one. Claimant must have the required number of manifestations with the frequency and duration required in this section. Also, the manifestations must occur within the period covered by the claim.

"***Activities of daily living***" [14.00I6] include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, or paying bills. We will find that you have a "marked" limitation of activities of daily living if you have a serious limitation in your ability to maintain a household or take public transportation because of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, caused by your immune system disorder (including manifestations of the disorder) or its treatment, even if you are able to perform some self-care activities.

"Social functioning" [14.00I7] includes the capacity to interact independently, appropriately, effectively, and on a sustained basis with others. It includes the ability to communicate effectively with others. We will find that you have a "marked" limitation in maintaining social functioning if you have a serious limitation in social interaction on a sustained basis because of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, or a pattern of exacerbation and remission, caused by your immune system disorder (including manifestations of the disorder) or its treatment, even if you are able to communicate with close friends or relatives.

"Completing tasks in a timely manner" [14.00I3] involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings. We will find that you have a "marked" limitation in completing tasks if you have a serious limitation in your ability to sustain concentration or pace adequate to complete work-related tasks because

of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, caused by your immune system disorder (including manifestations of the disorder) or its treatment, even if you are able to do some routine activities of daily living.

"***Persistent***" [14.00C9] means that a sign(s) or symptom(s) has continued over time. The precise meaning will depend on the specific immune system disorder, the usual course of the disorder, and the other circumstances of your clinical course.

"***Recurrent***" [14.00C10] means that a condition that previously responded adequately to an appropriate course of treatment returns after a period of remission or regression. The precise meaning, such as the extent of response or remission and the time periods involved, will depend on the specific disease or condition you have, the body system affected, the usual course of the disorder and its treatment, and the other facts of your particular case.

"Resistant" [14.0011] to treatment means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate or a course of treatment is appropriate will depend on the specific disease or condition you have, the body system affected, the usual course of the disorder and its treatment, and the other facts of your particular case.

CLIENT ACTIVITY LOG

Client: _____

Address: _____

_____

SSN: _____

The purpose of the Client Activity Log is to document and describe symptoms of physical and mental conditions you experience in relation to HIV disease and other diagnoses. You should include all symptoms even if they are not new to you. You should keep this diary daily. The page for each day is divided up into Morning, Afternoon, and Evening so that you can make several smaller entries during different times of the day. The instructions below give you a general guideline of the types of things to include in your diary. A good rule of thumb is that if you're not sure whether to include something, go ahead and include it. Feel free to add more pages if you need to, just be sure to put the date on every additional entry. Keep this diary. You will either be instructed to mail it in or bring it to our office on your next visit.

THINGS TO KEEP IN MIND

1. If you need someone else to help you keep the diary, that's fine.

2. If you are ever too exhausted or ill to make an entry in your diary, that's OK. You need to take care of yourself first. When you have enough energy again, just make a note of how many days you were unable to make entries and why, and then go back to making daily entries.

3. Although it may seem repetitive to keep mentioning certain illnesses or fatigue, it's important that you continue documenting them.

4. Often, people neglect to tell their doctors about certain conditions, many times because they think it's not important, or they've become so used to it that they don't think of it. Keep in mind that telling your doctor not only makes it easier to diagnose and treat you, but also makes it easier for us to document your illnesses and disabilities.

YOU SHOULD INCLUDE ALL CONDITIONS WHETHER OR NOT THEY ARE RELATED TO HIV. IT WILL HELP US TO DEMONSTRATE DISABILITY.

While it is helpful for us to know about conditions that your doctor has diagnosed, we really need you to tell us how those conditions affect your day-to-day life. We also especially need you to tell us how your everyday life is affected by things that reoccur so frequently that you don't mention them to your doctor anymore or things that occur between visits to your doctor.

IF YOU HAVE ANY OF THESE TYPES OF CONDITIONS, YOU SHOULD INCLUDE THEM IN YOUR DIARY AND DESCRIBE HOW THEY ARE AFFECTING YOU:

recurrent infections candidiasis (thrush, yeast infections) rashes excessively dry skin severe itching lesions on the skin or mouth eczema psoriasis genital ulcers weight loss diarrhea weakness Fever/chills sinusitis upper respiratory infections (cold) anemia kidney problems	frequent urination fatigue depression weight loss pain night sweats vomiting nausea tremors stiffness dizziness confusion tingling in your arms, legs, hands and/or feet seizures memory loss any other condition affecting you

WHAT YOU SHOULD DESCRIBE ABOUT YOUR CONDITION(S)

1. You should indicate what area of the body a given condition affects.

Examples: "I have thrush in my mouth."
"The psoriasis is on the back of my thigh and seems to be spreading toward the front."
"My sinusitis is making it difficult to breath and is causing headaches."

2. You should describe any pain, discomfort or other physical manifestations your condition causes.

Examples: "My throat is sore from the thrush. I couldn't even eat this morning."
"The trembling in my hands got so bad today that I couldn't button my sweater."

3. Be sure to describe how conditions interfere with your normal living, including regular day-to-day activities, social functioning, and completing tasks.

Examples: "I was planning to go to the store this afternoon, but the diarrhea got so bad that I knew I couldn't."
"I was vacuuming the living room and I had to take a break half way through because I was so exhausted." "My sister was going to come visit, but I told her not to because I knew I wouldn't be able to stay awake." "I tried to go to work today, but I couldn't get anything done because I kept putting things down and forgetting where I had put them."

4. Include information about any side effects of your medication.

Example: "I'm taking fluconazol for my esophageal thrush.I think it's making me nauseous, though." "I am taking over the counter immodium for diarrhea"

5. Remember to describe things like your sleep patterns, eating habits, mental state, and related conditions such as fatigue and/or weight loss.

Examples: "I woke up several times during the night. One of the times I was up for two hours. I finally got back to sleep, but I wasn't able to get out of bed again until 11 a.m. Early in the afternoon I had to take a 3 hour nap."
"My doctor told me that I should eat as often as possible, but I just didn't get hungry. All I could eat was part of a sandwich in the afternoon."
"I feel tired all of the time. I have to rest and nap a lot. But I still have trouble sleeping straight through the night."
"I got on the scale today. I lost 2 pounds since last week."
"Today I just felt so depressed. All I could do was sit in front of the TV."

6. Don't forget to include information about any symptoms that are related to physical and mental conditions other than living with HIV.

Examples: "I tried to open a jar, but my hands hurt so much from arthritis that I couldn't do it."
"I got suddenly dizzy today. That usually happens when my blood pressure gets especially high."

7. Don't exaggerate. The most important thing is to be truthful.

8. Add the following statement to the bottom of your client activity log.

I swear/ affirm that the above client activity log is a true and accurate representation of the physical and mental symptoms that I have experienced in my normal daily activities on (**date**) through (**date**).

_____

Signature of Claimant

January 1, 2020

Clerk of the Master Docket
Social Security Administration
Office of Hearings Operations
1601 Market Street, 21st Floor
Philadelphia, PA 19103

Re: John Doe
Claim No: XXX-XX-XXXX
REQUEST FOR DECISION-ON-THE-RECORD

To the Clerk of the Master Docket:

This is a claim for benefits under Title II of the Social Security Act. I am writing to request that Mr. John Doe's claim be granted by a Decision-on-the-Record.

Mr. Doe suffers with the severe impairment of HIV disease. The record exhibits in this case establish that he meets the listing at 14.11-I for repeated manifestations of HIV infection resulting in restriction of activities of daily living, difficulties in maintaining social functioning, and difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Specifically, Mr. Doe suffers from the following manifestations of HIV disease and side effects from HIV medications:

- •Weight loss: (Jonathan Lax Treatment Center Progress Notes dated 05/27/18, 07/26/18, 08/17/18, 12/12/18, 05/26/19, 06/17/19, 03/27/19)
- •Fatigue: (Jonathan Lax Treatment Center Progress Notes dated 05/27/18, 06/01/18, 07/26/18, 08/17/18, 11/27/18, 12/12/18, 02/13/19, 05/26/19, 06/17/19, 07/21/19, and also Activities of Daily Living dates 08/19/18-page 7)
- •Night Sweats: (Jonathan Lax Treatment Center Progress Notes dated 06/01/18, 07/26/18, 12/12/18, 02/13/19, 05/26/19, 06/17/19, 07/21/19, 04/10/19)
- •Cough: (Jonathan Lax Treatment Center Progress Notes dated 05/27/18, 06/01/18, 11/27/18, 12/12/18, 02/13/19, 07/21/19, 04/10/19)
- •Loss of Appetite (Jonathan Lax Treatment Center Progress Notes dated 05/26/19, 06/17/19, 3/27/19)
- •Nausea & Vomiting: (Jonathan Lax Treatment Center Progress Notes dated 05/27/18, 07/26/18, 08/17/18, 12/12/18, 05/26/19, 06/17/19, 3/27/19)
- •HIV related Depression:(Jonathan Lax Treatment Center Progress Notes dated 05/27/18, 06/01/18, 11/27/18, 12/12/18, 02/13/19, 07/21/19, 04/10/19)

Mr. Doe is 57 years old with an eleventh grade education, and closely approaching retirement age. He left his employment in March 2018 due to excessive fatigue (Jonathan Lax

Treatment Center Progress Notes dated 5/27/18 and Activities of Daily Living pages 5, 6), chronic weight loss and pain that he experienced in his arms and legs (Disability Report-Adult-Form SSA-3368 page 2).

Mr. Doe is unable to perform the tasks that he performed in the last fifteen years because of excess fatigue and overall pain in his body. In the Activities of Daily Living form filed of record Mr. Doe states that he has to take 15-minute breaks every half hour between activities and had to stop walking and standing long periods of time. He also claims that he can walk only three blocks before he takes a break.

In addition, Dr. Joe Smith, who has been Mr. Doe's medical provider for the past six years, believes that Mr. Doe cannot stand or walk for more than 2 hours and cannot sit for more than 6 hours and needs to nap at least once in an 8 hour working day due to ongoing fatigue. Dr. Smith is also of the opinion that Mr. Doe lacks the ability to conform to the demands of a full-time 8-hour work schedule due to ongoing HIV related fatigue and wasting. Mr. Doe also suffers from GERD, HIV related depression and hypogonadism (See attached Interrogatories).

Although the Social Security Administration has identified Mr. Doe's past relevant work as a Certified Nursing Assistant and has assessed him as having the capacity to perform past relevant work, a combination of the aforesaid impairments and restrictions exclude Mr. Doe from engaging in any substantial gainful activity. Mr. Doe has not returned to work since he applied for social security benefits in 2018.

The evidence establishes that Mr. Doe's symptoms from HIV disease and the side effects of HIV medications cause functional limitations and restrictions having more than a minimal effect on his ability to perform basic work activities. He is unable to engage in even sedentary activity on a full-time basis that is sustainable.

Based on the foregoing, we request that Your Honor find that Mr. Doe meets the listing at 14.11-I (1), (2) and (3), and grant his social security disability claim.

Respectfully submitted,

SOCIAL SECURITY CLIENT INTERVIEW FORM*

Date: _____ Intake completed by: _____

Client name: _____ Phone#: _____

A. Personal

1. Age: _____ D.O.B.: _____ SS#: _____

2. Current weight: _____ Normal weight: _____

3. Marital status:
   Date of marriage(s):

4. Date of divorce(s):

5. Names and ages of children:

6. With whom does each minor child live?

   Do you have contact with him/her?

7. Sources of income (if any)

   a. Employment:
   b. VA benefits:
   c. Disability:
   d. Workers' Compensation:
   e. Cash Assistance (GA/TANF)
   f. Other:

8. How many other people live in your household?

9. How are they related to you (i.e., friends, relatives, roommates, etc.)?

10. Do you rent or own?

11. How many floors, steps?

B. Education

1. Last grade completed:

2. GED? (Where and when?)

3. Vocational/technical training? (Specify program and skills.)

4. Any college/graduate/professional degrees? (Include course work not leading to a degree.)

C. Military

1. Have you ever served in the military?

2. What branch? Rank when discharged?

3. Did you receive any training/schooling?

4. What kind of work did you do?

5. Were you ever in combat? Where? When?

6. What kind of discharge did you receive? When?

7. Do you receive any VA benefits (pension or medical)?

D. Employment

1. What was your last steady job?

2. Job title: _____ Number of years at that job: _____

3. Name, address, and telephone number of employer:

_____

_____

4. Name of supervisor?

5. How was your relationship with him/her?

6. What did you do at this job? (Describe skills required.)

7. Did you have any specialized skills? (Describe any special training.)

8. Describe all the different tasks, duties, and responsibilities involved in your job.

9. To what extent were you able to perform each task, duty, or responsibility before you became ill?

10. For each task, duty, or responsibility:

    How often did you do it? How long did it take?
    Did it involve reading?
    Did it involve making calculations?
    Did it involve reading instruments?
    Did it involve using your memory?
    Did it involve walking?
    Did it involve operating machinery, using tools? What kind?
    How much did you have to concentrate on what you were doing?
    Could you do the task now? If not, why not?
    Did it involve lifting?
    Did it involve sitting?
    Standing?
    Walking?
    Lifting?
    Pushing?
    Pulling?
    Reading?
    Hearing?
    Understanding?
    Following instructions? (Written or Oral)
    Responding to supervision?
    Supervising others?

11. How much did you interact with other people in your job? Who were the people you interacted with? (Supervisors, co-workers, clients, the general public?)

12. How much stress/pressure did it involve?

13. When did you leave this job? Why?

14. Before you left this job, were you having difficulty performing? (Get specific details.)

15. Were you able to work every day? If not, why not?

16. Were you taking an unusual amount of time off? Why? How much?

17. Had you ever taken a leave of absence?

18. Have you looked for work since you left your last job?

    a. What kind of work?
    b. Did you get a job?
    c. If not, why not?
    d. If yes, what happened?

19. Is there any job you believe you could do?

20. Do you do any volunteer work?

21. How do you feel about not working?

22. If you could work, would you like to?

23. List other jobs held in the past 10 years.

    a. Employer name and address:
    b. Job title/nature of work:
    c. Details, if job involved different skills than described:

24. Could you do that job now? If not, why not?

E. Daily Activities

I. Describe how you spent a typical weekday/weekend day *before* you became ill:

    a. Hobbies:

    b. Community activities:

    c. Athletics/sports:

    d. Religious activities:

    e. Social interaction:

    f. Household responsibilities/chores:

    g. Work:

    h. Reading:

    i. Personal care:

    j. Finances

2. Describe how you spend a typical weekday/weekend day now:

    a. Which former activities do you still participate in?

    b. Do you need help in doing some or all? Which ones? Why?

    c. Who helps you?

d. Have you quit doing some or all?

e. If so, which ones? Why?

f. When did you begin to experience difficulty with each activity?

g. Do you spend more time in bed than you used to? Why? How much time do you spend in bed?

h. Do you go outdoors? How often?

i. Do you need frequent access to the bathroom?

F. Medical

1. What symptoms/physical difficulties are you experiencing today?

2. What symptoms/physical difficulties have you experienced in the last week? The last month? As of your onset date?

3. What medications have you taken in the last month?

4. List all health care providers client has seen since onset:

   a. Name:

   b. Dates:

   c. Location:

   d. Diagnosis/symptoms:

   e. Treatment:

   f. Lab work:

   g. Medication prescribed:

   h. Type of provider:

5. List all hospitalizations:

   a. Date(s):

   b. Hospital:

   c. Reason admitted:

d. Diagnosis:

e. Treating provider:

f. Treatment:

g. Length of stay:

h. Surgery:

G. Ability to Perform Basic Work Activities

1. Do you have any trouble performing the following basic physical activities:
   a. Sitting?
   b. Standing?
   c. Walking?
   d. Lifting?
   e. Pushing?
   f. Pulling?
   g. Reaching?
   h. Hearing?
   i. Understanding?
   j. Remembering?
   k. Following instructions?
   l. Responding to supervision?
   m. Relating and interact with co-workers?
   n. Relating and interact with supervisors?
   o. Tolerating work pressures?
   p. Maintaining social functioning?
   q. Completing tasks in a timely manner due to deficiencies in concentration, persistence or pace?

2. Do you have any of the following impairments or restrictions:

   a. Sensory problems (hearing, smelling, tasting, touching, seeing)?
   b. Postural limitations?
   c. Inability to use your hands?
   d. Inability to use your legs?
   e. Trouble working in different environments (outside, inside, up high, in noisy area, etc.)?
   f. Any other conditions that do not affect your strength to perform the physical functions to work, but which limit your ability to work in other ways?

H. Mental/Emotional Health

1. How is your mood today?

2. How has living with HIV affected your psychological/emotional state?

3. Have you experienced any of the following (note duration, frequency of occurrence, onset, etc.):

   a. Feelings of depression, sadness, blueness, or hopelessness?
   b. Feelings of irritability?
   c. Poor appetite?
   d. Significantly increased appetite?
   e. Insomnia?
   f. Trouble sleeping too much?
   g. Loss of energy, fatigue?
   h. Feelings of worthlessness, self-reproach, (excessive) guilt?
   1. Physical agitation?
   J. Loss of interest, pleasure in activities you used to enjoy?
   k. Difficulty thinking or concentrating?
   1. Difficulty in making decisions?
   m. Difficulty remembering things (give examples)?
   n. Thoughts of suicide/suicide attempt?
   o. Tearfulness?
   p. Difficulty interacting with other people?

4. Do you currently use alcohol or recreational drugs? How often? How much?

5. Do you have or have you ever had a problem with drugs or alcohol? (Get details)

6. Have you ever received treatment for a drug or alcohol addiction? Are you in a drug and alcohol program now?

7. If not using drugs now, how long have you been sober?

8. Do you ever see a therapist now? (Name and address)

9. How long have you been seeing him them? How often?

10. Have you ever seen a therapist since the onset of your physical difficulties? (Name, address, details)

11. Do you attend group therapy or participate in a support group, etc.? (Get details)

BUREAU OF DISABILITY DETERMINATION
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
POST OFFICE BOX 8229
HARRISBURG, PENNSYLVANIA 17105

DIAL TOLL FREE
LOCAL TELEPHONE NUMBER:
FROM OTHER AREAS CALL: 800-
TT #: 717-7

EXT. 325

DATE: 10/13/00

SSN:

DEAR.

The Bureau of Disability Determination is evaluating your eligibility for disability benefits. We need some additional information to help us make a correct decision.

We would like you to give us more information about your impairment and how it limits your ability to work. We have enclosed questions for you to answer. Please be detailed in answering them, and return all the forms as soon as you can.

If you have any questions or would like to talk to someone about the information we are requesting, please call me at the toll-free number listed above. The best time to call is between 9 a.m. and 3 p.m.

At the bottom of this letter is an official statement about the way this information will be used. Please be sure to read it before completing the form.

Sincerely,

Disability Claims Adjudicator

The information requested on this form is authorized by Title 20 CFR 404.1512 and Title 20 CFR 416.912. The information provided will be used to further document your eligibility for benefits. Information requested on this questionnaire is voluntary, but failure to provide all or any part of the requested information may affect the determination. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between Social Security and another agency.

ENCLOSURE Daily Activities Questionnaire, Return Envelope

It is very important that you provide as much detail as possible when answering the following questions. Detailed information will enable us to fully consider all the limitations your impairments cause on a daily basis. If you need additional space for your answers, you may write on the back of the form or attach additional paper.

The following questions are about your daily activities:

Where do you currently live?

___ Home (1 story -or- 2 story)

___ Apartment

___ Nursing home

___ Other Please describe.

Do you live alone? Yes ___ No ___
If no, who lives with you?

Have you made any changes to your home because of your condition?
Yes ___No ___ If yes, please explain.

Please describe your usual daily activities, commenting on things such as household chores, shopping, errands, walking, driving, yard work, hobbies, washing the car, doing small repairs, etc. If you need assistance in any of these areas, please describe.

If on a particular day you do more than usual, what problems, if any, do you have?

Who is dependent upon you for care (spouse, children, parents, pets, etc.)?

What assistance do you give them?

Are you limited in doing activities which you were able to-manage in the past? Yes _____ No _____
If yes, please explain your limitations in the following areas:

Cooking

Yard Work

Child Care

Shopping

House Cleaning

Laundry

Driving

Home Maintenance

Care of Pets

Do you need to take rests between activities? Yes____ No____
If yes, how often and how long must you rest?

What activities have you had to stop?

Do you have any problems with personal care, such as bathing, dressing, shaving, doing your hair, etc.? Yes___ No ___
If yes, please describe them.

Do you drive? Yes____ No ____
If yes, how often and for how long?

Please describe any modifications that have been made to your car.

_____

If you don't drive, please explain.

Can you take public transportation alone? Yes____ No ____
If no, please explain.

Do you pay your own bills? Yes____ No ____
If no, please explain.

How far you can walk on level ground without stopping? _____
What causes you to stop?

How far can you walk uphill?

Do you mow the lawn? Yes___ No ___

What kind of mower do you use (push mower, riding mower, etc.)?

Do you do yard work or gardening? Yes____ No ____
If yes, please describe.

Can you dress yourself without resting? Yes____ No ____
If no, please explain.

Can you shower without resting? Yes____ No ____
If no, please explain.

Can you change and make a bed without stopping? Yes____ No ____
If no, please explain.

Can you take out the trash? Yes____ No ____
If no, please explain.

Do you have any problems in preparing food and cooking a meal?

If no, please explain. Yes____ No ____

Can you use the vacuum? Yes____ No ____
If no, please explain.

Please tell us about any housework and home repairs that you do that have not already been described.

Can you use a knife and fork? Yes____ No ____
If no, please explain.

Can you dial a telephone? Yes____ No ____
If no, please explain.

Can you use a TV remote? Yes____ No ____

Do you do your own grocery shopping? Yes____ No ____
If no, please explain.

How many bags can you carry at once?

Do you rest while shopping? Yes____ No ____
If no, please explain.

What time do you go to bed? _____ What time do you get up? _____

Do you take naps during the day? Yes____ No ____
If yes, how frequently?

If yes, how long?
How many steps can you climb without stopping to rest?
What causes you to stop?

How frequently are you able to climb a flight of steps?

How much can you lift and carry?
What causes you to stop?

Please describe any hobbies or things you do for enjoyment.

Do you need any special help or reminders to take care of your personal needs (washing, bathing, dressing, etc)? Yes____ No ____
If yes, please describe.

Do you have any problems getting along with family, friends, neighbors, etc.? Yes____ No ____
If yes, please explain and give examples.

Describe what activities you participate in with relatives & friends.

How often do you participate in these activities?

How well do you get along with people in authority (doctors, supervisors, police officers, etc.?)
Please explain.

How well do you respond to criticism?
Please explain.

Do you have difficulty when you go out in public? Yes____ No ____
If yes, please describe.

Do you belong to any groups or clubs? Yes____ No ____
If yes, please describe.

Have you ever been in fights, evicted, fired, etc.? Yes____ No ____
If yes, please describe.

Are you able to start and complete projects or activities such as reading a book, putting a puzzle together, sewing/needlepoint, fixing things around the house, etc.? Yes____No ____
Please describe and give examples.

Are you able to plan each day such as when to get up, start meals, finish household chores, go to appointments, etc.? Yes____ No ____
If no, please give examples.

Do you have trouble understanding instructions and carrying them out? Yes____ No ____
If yes, please give examples.

What happens when you are faced with changes such as a change in daily schedule, change in living arrangements, change in doctors, etc.?

What happens when you have a disagreement with someone?

Can you make decisions on your own? Yes____ No ____
If no, who helps you make decisions?

Do you take medications for your condition? Yes____ No ____
Please list the medicine and amounts.

Do you need help taking medication? Yes____ No ____
If yes, who helps you?

IF YOU WORKED IN THE PAST, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Did you usually report to work on time? Yes____ No ____
If no, please explain.

Did you have good attendance? Yes____ No ____
If no, please explain.

Were you usually able to keep up with your work? Yes____ No ____
If no, please explain.

Were you able to concentrate on your work for extended periods of time? Yes____ No ____
If no, please explain.

Did you have trouble getting along with your supervisors and/or coworkers? Yes____ No ____
If yes, please explain.

When changes were made at work that affected your job, were you able to accept these changes? Yes____ No ____
If no, please explain.

The following questions concern fatigue you have been experiencing:

When did you begin to experience fatigue?

Was the fatigue associated with the onset of an illness?
Yes____ No ____ If yes, please explain.

Has your level of fatigue remained the same since it began?
Yes____ No ____ Please describe the changes.

Is your fatigue worse at certain times of the day?
Yes____ No ____ If yes, please explain.

How often do you experience fatigue?

How long does it last?

What helps to relieve the fatigue?

Do you take medication? Yes____ No ____
If yes, please list all the medications that you are taking.

If you are taking medication, does it have any effect on your fatigue?
Yes____ No ____ If yes, please describe the effect.

The following questions concern the pain you have been experiencing:

When did your pain begin?

What caused you to start having pain?

Describe your pain.

Has the nature of your pain changed since it began? Yes____ No ____
If yes, please explain.

Where is your pain located?

Where does it spread?

What activities cause you to have pain (bending, standing, walking, temperature extremes, etc.)?

Is your pain worse at certain times of the day? Yes____ No ____
If yes, please describe.

How often does your pain occur?

How long does your pain last?

Does pain disturb your sleep? Yes____ No ____
If yes, please describe how your sleep habits have changed.

How often do you have sleep problems? Regularly____ Occasionally____

Have your eating habits changed because of your pain?
Yes____ No ____

Have you lost weight? Yes____ No ____
If yes, how much?

Have you gained weight? Yes____ No ____
If yes, how much?

If there has been a weight change in either direction, were you trying to change your weight? Yes____ No ____

Has pain affected your ability to think and concentrated?
Yes____ No ____ If yes, please explain.

Do you take pain medicine? Yes____ No ____
If yes, please provide the following information:

NAME OF MEDICATION DOSAGE AND FREQUENCY TAKEN DATE STARTED

Does the medicine relieve the pain? Yes____ No ____
Is yes, how soon and for how long?

Does the medicine cause any side effects? Yes____No ____
If yes, what are these side effects?

Do you wear or use any devices such as a brace or TENS to relieve the pain? Yes____ No ____
If yes, please describe.

Do you need to use an assistive device to walk (cane, crutch, walker, brace)? Yes____ No ____
If yes, how far and for how long can you walk?

Please describe any other things done to relieve the pain (physical therapy, biofeedback, hot showers, etc.).

Have you ever attended physical therapy? Yes____ No ____
If yes, please provide the name and address of the treatment facility and the dates of your treatment.

Have you been referred to a psychologist/psychiatrist to help cope with pain? Yes____ No ____
If yes, please provide the name, address, and telephone number of the doctor and the dates of your treatment.

Please provide any additional comments regarding how your impairment or pain limits your ability to work. You may write on the back of the form or attach additional pages, if necessary.

Name of person completing this form: _____

Signature: _____ Date: _____

Relationship (if other than the claimant): _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____
(Patient's Name) **(DOB)** **(Social Security Number)**

Authorize _____
to disclose the information identified below to the following individual or organization

Name: _____

Address:_____

□ All Medical Records. **This authorization includes HIV-Related Information and Treatment Records protected by the Pennsylvania Confidentiality of HIV-Related Information Act 35 P.S. § 7607. HIV is the virus that causes or indicates AIDS or HIV infection. HIV-related information is information which concerns whether a person has been tested for HIV or has AIDS or an HIV-related illness or could reasonably identify the person as having one or more of these conditions.**

□ Substance Use Disorder Records and Drug and Alcohol Treatment Records including substance use history summaries, lab tests, medications and dosages, inpatient and outpatient treatment records, clinical charts and progress notes. **I understand these records are protected by Pennsylvania Drug and Alcohol Abuse Control Act 71 P.S. §1690.108 and Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2 and Heath Insurance Portability and Accountability Act of 1996, 45 C.F.R parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations.**

□ Mental Health Records including Comprehensive Bio-Psycho Social Evaluations, mental health history summaries, assessments, diagnoses, treatment plans, progress notes, test results, medications and dosages. **I understand these records are protected by the Mental Health Procedures Act 50 P.S. § 7111 and I have a right subject to 55 Pa. Code § 5100.33 to inspect the material to be released.**

□ Other _____

Purpose of Release of Information: _____

Dates of Service: From _____ to _____

This Authorization expires on: _____

Statement of Authorization

This Authorization is voluntary. I understand that I may revoke this Authorization at any time by notifying my provider in writing or by notifying the provider or entity that is authorized to receive these records. I understand that my revocation will not have any effect on actions taken prior to the revocation and based on the Authorization. I understand that, if the organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations. I understand that this information may be re-released by the recipient and no longer protected by 45 C.F.R. Pt. 164. I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. By signing below, I certify that I understand the nature of this Authorization. I authorize all health care providers or other covered entities to disclose information, oral or written, regarding my physical or mental health, including but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations promulgated thereunder. This Authorization must be signed and dated. HIPAA requires that I be offered a copy of this Authorization. Photocopies/facsimiles of this Authorization shall have the same authority as the original.

_____ _____
Signature of Patient **Date**

BUREAU OF DISABILITY DETERMINATION
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
1171 SOUTH CAMERON STREET ROOM 200
HARRISBURG, PENNSYLVANIA 17104-2594

FROM HARRISBURG CALL: 783-3620
FROM OTHER AREAS CALL: 800-932-0701
HARRISBURG AREA FAX: 800-582-8051
TT #: 717-772-1741

DATE:
SSN:
NAME:
ADDRESS:

BIRTH DATE:

Dear Doctor:

The Bureau of Disability Determination (BDD) is evaluating your patient's eligibility for disability benefits under the Social Security Act. The claimant has listed you as a source of medical treatment between and .

We are requesting medical evidence from your records to help us establish the onset, severity and duration of any impairment(s). Your medical report should include medical history, clinical findings, laboratory findings, diagnosis, and treatment. Please complete the Medical Source Statement of Claimant's Ability to Perform Work-Related Activities, if one is enclosed. If you charge a fee for preparing this information, BDD can reimburse you up to $30.00 for completing the enclosed forms or providing a narrative report. Reimbursement of up to $19.00 can be authorized if you choose to provide photocopied records in lieu of an original abstract. Complete the enclosed Professional Service Invoice and submit it with your report. **THIS AUTHORIZATION AUTOMATICALLY EXPIRES 90 DAYS FROM THE DATE OF THIS LETTER. PAYMENT WILL NOT BE AUTHORIZED FOR RECORDS RECEIVED AFTER THAT DATE.**

We welcome telephone or fax responses. You can fax to the number above at any time, or you can dial the above toll free number any working day between 8:00 a.m. and 4:30 p.m. The claims adjudicator whose name appears below will take your report. For best service, please call between 9:00 a.m. and 3:00 p.m.

YOU MIGHT FIND IT MOST CONVENIENT TO USE OUR 24 HOUR TELERECORDING SERVICE. CALL THIS TOLL FREE NUMBER: 800+492-2514 (TOUCH TONE) OR 800-492-2528 (ROTARY), ANY DAY, AT ANY TIME, TO DICTATE YOUR REPORT. A copy of any medical information you provide via telephone will be sent to you for verification and signature.
Please try to complete this request within 10 days to help us process your patient's claim promptly. This is a request for information from existing records only.

Please try to complete this request within 10 days to help us process your patient’s claim promptly. This is a request for information from existing records only.

Sincerely,

Disability Claims Adjudicator Reviewing Physician

ENCLOSURE: Medical Release Authorization, Return Envelope, Professional Service Invoice

Date First Seen _____ Date Last Seen _____

Frequency of Visits:

Current height (without shoes) _____ Current weight _____

Diagnosis and Onset Date:

History and Clinical Course:

The following questions relate to the allegation of AIDS or HIV infection:

Indicate if any of the following have been performed and provide the results. Include a copy of the report or indicate where it can be obtained.

	NOT PERFORMED	PERFORMED (DATE)	RESULT
ELISA (HIV Antibody Screen)	_____	_____	_____
HIV Serum Antigen	_____	_____	_____
Western Blot	_____	_____	_____
Absolute Lymphocyte Count	_____	_____	_____
CD4 (T-helper) Lymphocyte Count	_____	_____	_____
CD4/CDB Ratio	_____	_____	_____
Immunofluorescent Assay	_____	_____	_____
Other (Please specify)			
_____	_____	_____	_____

Provide results of laboratory findings covering at least a three-month period, if done, or specify where they can be obtained.

	RESULT/DATE	RESULT/DATE	RESULT/DATE
Hemoglobin/Hematocrit	_____/_____	_____/_____	_____/_____
Platelet Count	_____/_____	_____/_____	_____/_____
Absolute Neutrophil Count	_____/_____	_____/_____	_____/_____

Is there evidence of opportunistic infection or indicator diseases?

Yes _____ No _____

If yes, provide results of histology or cytology, if available. Include a copy of the report or indicate where it can be obtained.

Result _____

Date _____

Is there evidence of candidiasis of:

Esophagus? Yes _____ No _____
Trachea? Yes _____ No _____
Bronchi? Yes _____ No _____
Lungs? Yes _____ No _____

If yes, provide gross description of lesion with date of inspection.

Was gross inspection done by endoscopy_____, autopsy_____, or microscopy (either histology or cytology)? _____

Was the specimen obtained directly from the affected tissue (including scrapings from the mucosal surface)? Yes _____ No _____

If no, describe diagnostic method.

Did the patient experience retrosternal pain on swallowing prior to?
diagnosis? Yes _____ No _____ Onset _____

Is there evidence of:

Extrapulmonary cryptococcosis? Yes _____ No _____
Histoplasmosis, disseminated? Yes _____ No _____
Site: _____

If yes, provide results of the following studies, if available.

Include a copy of the report or indicate where it can be obtained.

	DATE	RESULT
Culture	_____	_____
Antigen in specimen	_____	_____
India-ink prep. of CSF	_____	_____

Is there evidence of:

Cryptosporidiosis? Yes _____ No _____
Isosporiasis? Yes _____ No _____

If yes, provide results of fecal microscopy, if available. Include a copy of the report or indicate where it can be obtained.

Has the patient had diarrhea persisting over one month?
Yes _____ No _____ Onset _____

Is there evidence of cytomegalovirus? Yes _____No _____
If yes, please indicate which body organs are involved.

If cytomegalovirus retinitis is present, please provide a description of ophthalmoscopic findings and visual acuity with best correction on each ophthalmoscopic examination since onset.

DATE OF EXAMINATION	VISUAL ACUITY	FINDINGS
_____	___OD_/_OS___	_____
_____	_____/_____	_____
_____	_____/_____	_____

Is there evidence of herpes simplex virus? Yes _____ No _____

If yes:
Has the patient had any of the following attributable to this virus?

	YES	NO
Disseminated infection?	_____	_____
Encephalitis?	_____	_____
Mucocutaneous ulcer persisting for longer than one month?	_____	_____
Involvement of the pulmonary or gastrointestinal tract?	_____	_____

Provide the results of the following, if performed. Include a copy of the report or indicate where it can be obtained.

	DATE	RESULT
Culture	_____	_____
Antigen in specimen	_____	_____

Is there evidence of primary lymphoma of the brain? Yes _____ No _____

Is there evidence of:
M. avium complex? Yes _____ No _____
M. Kansasii disease, disseminated? Yes _____ No _____
If yes, provide the following:
Site(s) of infection _____
Culture results (include copy or indicate where it can be obtained.)

Date of culture _____

Is there evidence of Pneumocystis carinii pneumonia? Yes _____ No _____
If yes, and the diagnosis was not established by histology or cytology, how was the diagnosis made?

Has bacterial pneumonia been ruled out? Yes _____ No _____

If any of the following have been performed, provide the results. Include a copy of the report or indicate where it can be obtained.

	DATE	RESULT
Chest X-ray	_____	_____
Gallium scan	_____	_____
Arterial blood gas	_____	_____

Is there evidence of progressive multifocal leukoencephalopathy?
Yes _____ No _____

Is there evidence of coccidioidomycosis, disseminated? Yes _____ No _____
If yes, please specify sites.

Provide the results of the following, if performed. Include a copy of the report or indicate where it can be obtained.

	DATE	RESULT
Culture	_____	_____
Antigen in specimen	_____	_____

Is there evidence of:
Disseminated mycobacterial disease? Yes _____ No _____ Site:_____

Extrapulmonary M. tuberculosis? Yes _____ No _____ Site:_____
Recurrent salmonella
(non-typhoid) Septicemia? Yes _____ No _____ Site:_____
Other bacterial infection? Yes _____ No _____
If yes, please describe.

Provide culture results. Include copy of report or indicate where it can be obtained.

Date of culture _____

Is there evidence of HIV Wasting Syndrome? Yes _____ No _____ If yes:
Has there been profound involuntary weight loss? Yes _____ No _____

If yes, please provide serial weights.
Weight _____/_____/_____/_____/_____/_____
Date _____/_____/_____/_____/_____/_____
Baseline weight _____ Date _____

Has there been chronic diarrhea? Yes _____ No _____
If yes, how often per day does diarrhea occur and how long has diarrhea persisted?

Has there been chronic weakness? Yes _____ No _____

Has there been documented fever? Yes _____ No _____
If yes, provide the following
Temperature _____/_____/_____/_____/_____/_____
Date _____/_____/_____/_____/_____/_____

Have other concurrent illnesses been excluded? Yes _____ No _____

Is there evidence of:
Lymphoma? Yes _____ No _____
Immunoblastic sarcoma? Yes _____ No _____

Is there evidence of nocardiosis? Yes _____ No _____

Is there evidence of extra-intestinal strongyloidiasis? Yes _____ No _____

Is there evidence of anal squamous cell carcinoma? Yes _____ No _____

Is there evidence of cardiomyopathy? Yes _____ No _____

Is there evidence of nephropathy? Yes _____ No _____

Have any of the following conditions been present and persistent and/or resistant to therapy?

Pneumonia? Yes _____ No _____
Pulmonary tuberculosis? Yes _____ No _____
Bacterial or fungal sepsis? Yes _____ No _____
Meningitis? Yes _____ No _____
Septic arthritis? Yes _____ No _____
Endocarditis? Yes _____ No _____
Peripheral neuropathy Yes _____ No _____
Kaposi's sarcoma? Yes _____ No _____
If yes, describe treatment and response.

Have any of the following been present and persistent over a two-month period?

Mucosal candidiasis? Yes _____ No _____
Oral hairy leukoplakia? Yes _____ No _____
Chronic/recurrent herpes zoster? Yes _____ No _____
Dermatologic conditions such as
Eczema, or psoriasis? Yes _____ No _____
Persistent or recurrent sinusitis? Yes _____ No _____
(if documented radiographically
Include x-ray reports)
If yes, describe treatment and response.

For female patients, is there evidence of any of the following gynecologic manifestations of HIV infection:

Invasive carcinoma of the cervix? Yes _____ No _____
If yes, provide FIGO state.

Pelvic inflammatory disease? Yes _____ No _____
If yes, describe frequency of recurrence and response to treatment.

Chronic or recurrent vulvovaginal candidiasis? Yes _____ No _____
If yes, describe frequency of recurrence and response to treatment.

Genital herpes? Yes _____ No _____
If yes, describe extent of lesions, response to treatment, and frequency of recurrence.

Is there evidence of toxoplasmosis of the brain or other organ(s)?
Yes _____ No _____ If yes, specify _____,
And provide the following information if diagnosis was not established by histology or cytology:
Has there been a recent onset of focal neurologic abnormality consistent with intracranial disease? Yes _____ No _____
If yes, describe.

Is there a reduced level of consciousness? Yes _____ No _____
If yes, describe.

Provide the results of the following, if performed. Include a copy of the report or indicate where it can be obtained.

	DATE	RESULT
CRT scan	_____	_____
MRI	_____	_____
Serum antibody test	_____	_____

Is there evidence of HIV encephalopathy (dementia)? Yes _____ No _____
If yes, describe.

Provide the results of the following, if performed. Include a copy of the report or indicate where it can be obtained.

	DATE	RESULT
CRT scan	_____	_____
MRI	_____	_____
Cerebrospinal fluid exam	_____	_____

Is there evidence of any other mental impairment related to the patient's HIV disorder? Yes _____ No _____

If yes, describe the symptoms.

Have you ever prescribed any medication for this patient's mental condition? Yes _____ No _____

If yes, give the type, dose and date it was first prescribed.

Are you currently prescribing it? Yes _____ No _____

What has the response been to medication?

Have you referred the patient to a mental health professional?

Yes _____ No _____

If yes, provide the name of doctor or agency and date of referral.

MEDICAL SOURCE STATEMENT OF CLAIMANT'S ABILITY TO PERFORM WORK-RELATED PHYSICAL ACTIVITIES

NAME: **S.S. NO.:**

Doctor: Please assess the claimant's ability to engage in full-time employment in a regular work setting. You should consider the combined effects of all impairments / the side effects of any medication / and the effects of symptoms (e.g. pain, fatigue, etc.). THE ASSESSMENT SHOULD REFLECT MAXIMUM SUSTAINABLE PHYSICAL CAPACITY, not a median or minimum. Your opinion should be based on clinical signs and laboratory findings, NOT ON THE INDIVIDUAL'S STATEMENTS.

DEFINITIONS: **Occasional** – from very little up to 1/3 of an hour a day **Frequent** – from 1/3 to 2/3 of an 8-hour day
Capacity – Maximum Sustainable Capacity

LIFTING

No Limitation ☐

Capacity:	Frequent	Occasional
2-3 pounds	☐	☐
10 pounds	☐	☐
20 pounds	☐	☐
25 pounds	☐	☐
50 pounds	☐	☐
100 pounds	☐	☐

CARRYING

No Limitation ☐

Capacity:	Frequent	Occasional
2-3 pounds	☐	☐
10 pounds	☐	☐
20 pounds	☐	☐
25 pounds	☐	☐
50 pounds	☐	☐
100 pounds	☐	☐

Supportive medical findings, if not otherwise included in report:

_____

_____

STANDING AND WALKING

No Limitation ☐

Capacity (cumulative in 8-hour day):

- ☐ 1 hour or less
- ☐ 1 to 2 Hours
- ☐ More than 2 Hours but less than 6 Hours; How many? _____
- ☐ Hand-held assistive device required for: ☐ balance; ☐ ambulation; ☐ other _____

Supportive medical findings, if not otherwise included in report:

_____

_____

SITTING

No Limitation ☐

Capacity (cumulative in 8-hour day):

- ☐ Sit less than 6 hours. How many? _____
- ☐ Sit 6 hours.
- ☐ 8 Hours with alternating sit/stand at his/her option.

Supportive medical findings, if not otherwise included in report:

_____

_____

PUSHING AND PULLING

No Limitation ☐

Consider operation of hand and/or foot controls.

☐ Unlimited, other than shown under lifting and carrying

☐ Limited in upper extremity (describe nature and degree) _____

☐ Limited in lower extremity (describe nature and degree) _____

Supportive medical findings, if not otherwise included in report:

_____

_____

POSTURAL ACTIVITIES

No Limitation ☐

Are the following affected by the impairment(s)? Please specify the nature and degree of any limitation.

	Frequent	Occasional	Never	Comments
Bending	☐	☐	☐	
Kneeling	☐	☐	☐	
Stooping	☐	☐	☐	
Crouching	☐	☐	☐	
Balancing	☐	☐	☐	
Climbing	☐	☐	☐	

Supportive medical findings, if not otherwise included in report:

_____

_____

OTHER PHYSICAL FUNCTIONS

No Limitation ☐

Are the following affected by the impairment(s)? Please specify the nature and degree of any limitation.

	No	Yes	Comments
Reaching	☐	☐	
Handling	☐	☐	
Fingering	☐	☐	
Feeling	☐	☐	
Seeing	☐	☐	
Hearing	☐	☐	
Speaking	☐	☐	
Tasting/Smelling	☐	☐	
Continence	☐	☐	

Supportive medical findings, if not otherwise included in report:

_____

_____

ENVIRONMENTAL RESTRICTIONS

No Limitation ☐

Are the following affected by the impairment(s)? Please specify the nature and degree of any limitation.

		Comments
☐	Poor Ventilation	_____
☐	Heights	_____
☐	Moving Machinery	_____
☐	Vibration	_____
☐	Temperature Extremes	_____
☐	Wetness	_____
☐	Dust	_____
☐	Noise	_____
☐	Fumes, Odors, Gases	_____
☐	Humidity	_____
☐	Chemical	_____
	(please specify)	_____
☐	Other	_____
	(please specify)	_____

Supportive medical findings, if not otherwise included in report:

_____

_____

_____

_____ Date Last Seen: _____

Physician's Name (PLEASE PRINT)

_____ _____

Physician's Signature Date

CLAIMANT NAME:

SSN:

MEDICAL ASSESSMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES

(MENTAL)

To determine this individual's ability to do work-related activities on a day-to-day basis in a regular work setting, please give us an assessment -- BASED ON YOUR EXAMINATION -- of how the individual's physical mental/emotional capabilities are affected by the impairment(s). Consider the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not the individual's age, sex, or work experience.

For each activity shown below:

(1) **Describe the individual's ability to perform the activity according to the following terms:**

Unlimited or Very Good - Ability to function in this area is more than satisfactory.

Good - Ability to function in this area is limited but satisfactory.

Fair - Ability to function in this area is seriously limited, but not precluded.

Poor or None - No useful ability to function in this area.

(2) Identify the particular medical or clinical findings (i.e., mental status examination, behavior, intelligence test results, symptoms) which support your assessment of any limitations.

IT IS IMPORTANT THAT YOU RELATE PARTICULAR MEDICAL FINDINGS TO ANY ASSESSED LIMITATION IN CAPACITY; THE USEFULNESS OF YOUR ASSESSMENT DEPENDS ON THE EXTENT TO WHICH YOU DO THIS.

CLAIMANT NAME:
SSN:

I. MAKING ADJUSTMENTS

Check the blocks representing the individual's ability to adjust to a job, and complete Item 9.

	Unlimited/ Very Good	Good	Fair	Poor/ None
1. Follow Work Rules	_____	_____	_____	_____
2. Relate to Co-workers	_____	_____	_____	_____
3. Deal with the public	_____	_____	_____	_____
4. Use Judgment	_____	_____	_____	_____
5. Interact with Supervisor(s)	_____	_____	_____	_____
6. Deal with Work Stresses	_____	_____	_____	_____
7. Function Independently	_____	_____	_____	_____
8. Maintain Attention/ Concentration	_____	_____	_____	_____

9. Describe any limitations and include the medical/clinical findings that support this assessment.

II. MAKING PERFORMANCE ADJUSTMENTS

Check the blocks representing the individual's ability to adjust to a job, and

	Unlimited/ Very Good	Good	Fair	Poor/ None
1. Understand, remember and carry out complex job instructions	_____	_____	_____	_____

complete Item 4.

2. Understand, remember and carry out detailed, but not complex job instructions _____ _____ _____ _____

3. Understand, remember and carry out simple job instructions _____ _____ _____ _____

4. Describe any limitations and include the medical/clinical findings that support this assessment; e.g., intellectual ability, thought organization, memory, comprehension, etc.

CLAIMANT NAME:
SSN:

III. MAKING PERSONAL-SOCIAL ADJUSTMENTS

Check the blocks representing the individual's ability to adjust personally and socially and complete Item 5.

	Unlimited/ Very Good	Good	Fair	Poor/ None
1. Maintain personal appearance	_____	_____	_____	_____
2. Behave in an emotionally stable manner	_____	_____	_____	_____
3. Relate predictably in social situations	_____	_____	_____	_____
4. Demonstrate reliability	_____	_____	_____	_____

5. Describe any limitations and include the medical/clinical findings that support that assessment.

IV. OTHER WORK RELATED ACTIVITIES

State any other work-related activities which are affected by the impairment, and indicate how the activities are affected. What are the medical/clinical findings that support this assessment?

V. CAPABILITY TO MANAGE BENEFITS

Can the individual manage benefits in his or her own best interest?

YES _____ NO _____

_____ _____

Signature/Title Date

Via Certified Mail/ Fax

January 1, 2020

The District Manager
Social Security Administration
2929 North Broad Street
Philadelphia, PA 19132

Re: John Doe
SSN: XXX-XX-XXXX
Request for Administrative Waiver

Dear Sir/Madam:

We are writing in response to your letter dated December 30, 2019 to Mr. John Doe informing him that he was overpaid 4,500.00 in disability benefits, and that his benefits will be discontinued to recover this overpayment. Mr. Doe denies the overpayment and has sought the assistance of this office to contest the alleged overpayment. Enclosed, please find an Appointment of Representative Form (Form SSA 1696), and a Request for Reconsideration (Form SSA-561-U2).

As this appeal is filed within 10 days of the receipt of the notice, Mr. Doe is entitled to a continuation of his benefits until a decision is made on this Request.

Mr. Doe denies that he was incarcerated from March 2017 through October 2017, during which time the Administration claims the overpayment occurred. Mr. Doe was residing at his apartment at 450 Park Lane, Philadelphia, PA 19107 at the relevant period of time. We attach to this appeal, a sworn statement from Mr. Doe and letters from his landlord and his neighbors verifying that he was in fact residing at the above address March 2017 through October 2017. Mr. Doe is due the Social Security Disability benefits from March 2017 through October 2017.

We, therefore, request that the Administration find that Mr. Doe was not overpaid and rescind the notice dated December 30,2019.

Should you have any questions, please contact me at (215) 587-9377.

Sincerely,

Staff Attorney

cc: Mr. John Doe

Via Certified Mail/ Fax

January 1, 2020

The District Manager
Social Security Administration
2929 North Broad Street
Philadelphia, PA 19132

Re: John Doe
SSN: XXX-XX-XXXX
Request for Administrative Waiver

Dear Sir/Madam:

This office represents Mr. John Doe in his efforts to resolve an alleged overpayment issue. Enclosed, please find an Appointment of Representative Form (Form SSA-1696) and a Request for Waiver of Overpayment Recovery (Form SSA-632), both signed by Mr. Doe.

Please stop collection on the alleged overpayment until a decision is made on this Request for Waiver (POMS sections GN 02210.220)

Please grant a personal conference to Mr. Doe to discuss his Request for Waiver.

Should you have any questions, please contact me at (215) 587-9377.

Sincerely,

Staff Attorney

cc: Mr. John Doe

Via Certified Mail/ Fax

January 1, 2020

The District Manager
Social Security Administration
2929 North Broad Street
Philadelphia, PA 19132

Re: John Doe
SSN: XXX-XX-XXXX
Request for Administrative Waiver

Dear Sir/Madam:

We write in response to a notice received by Mr. John Doe dated November 27, 2019 informing him of an overpayment of $980.00.

This office represents Mr. Doe in his efforts to have the recovery of the overpaid amount waived. Enclosed, please find an Appointment of Representative Form (Form SSA-1696) signed by Mr. Doe.

On behalf of Mr. Doe, we request that an Administrative Waiver (POMS SI 02260.030, B.2) be granted.

Should you have any questions, please contact me at (215) 587-9377.

Sincerely,

Staff Attorney

cc: Mr. John Doe

SGA and TWP Table for NONBLIND INDIVIDUALS ONLY

Trial Work Period

You can work and earn over the SGA level during a Trial Work Period month without worrying about losing your SSDI benefits. SSA defines Trial Work Period (TWP) as 9 months in any rolling 5-year period when you try out working by performing services while retaining your disability status. If an amount of gross net earnings per month is at or above the Trial Work Period Amount listed below, then those earnings indicate services, and therefore the use of a TWP month. At the end of your 9th TWP month, SSA will

For Month(s):	Trial Work Period Amount and/or Trial Work Period (Self-Employment) ("Services")	"Countable earnings" of employees indicate SGA and "countable income" of the self-employed is "substantial" if the amount averages more per month than the (primary) amount of:
In calendar year 2010	$720 or 40 hours	$1000
In calendar year 2011	$720 or 40 hours	$1000
In calendar year 2012	$720 or 80 hours	$1010
In calendar year 2013	$750 or 80 hours	$1040
In calendar year 2014	$770 or 80 hours	$1070
In calendar year 2015	$780 or 80 hours	$1090
In calendar year 2016	$810 or 80 hours	$1130
In calendar year 2017	$840 or 80 hours	$1170
In calendar year 2018	$850 or 80 hours	$1180
In calendar year 2019	$880 or 80 hours	$1220
In calendar year 2020	$920 or 80 hours	$1260

review your earnings to see if they represent SGA overall. If earnings are below the Trial Work Period amount for any given month, they do not count as "services" and thus that month is not counted as a Trial Work Period month. Current Trial Work Period amounts are here https://www.ssa.gov/oact/cola/twp.html; SGA amounts are here: https://www.ssa.gov/oact/cola/sga.html

SSI CALCULATION SHEET

STEP	CALCULATIONS
Unearned Income	
General Income Exclusion (GIE)	-
Countable Unearned Income	=
Gross Earned Income	
Student Earned Income Exclusion	-
Remainder	
GIE (if not used above)	-
Remainder	
Impairment Related Work Expense (IRWE)	-
Remainder	
Divide by 2	
Blind Work Expenses (BWE)	-
Total Countable Earned Income	=
Total Countable Unearned Income	
Total Countable Earned Income	+
PASS Deduction	-
Total Countable Income	=
Base SSI Rate (check for VTR or PMV)	
Total Countable Income	-
Adjusted SSI Payment	=