

Questionnaire

Name: _____

Name of Parent/Guardian: _____ Relationship: _____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email of Parent/Guardian: _____

Date of Birth: _____ SSN: _____

List the names and addresses of any medical providers that have seen this child in relation to their claim:

List the names and addresses of schools attended, including current school:

Name and telephone number of someone, who does not live in your household, where we can leave a message for you:

Name Telephone Relationship

How did you hear about us? ☐ Friend/Family _____ ☐ Business Card/Pen

☐ Phone Book/Yellow Pages ☐ Commercial/Printed Advertisement ☐ Other _____

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, Shannon Fauver, 138 S. 3rd St. Louisville, KY 40202,
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title IV FMSHA (Black Lung) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I am appointing, or I now have, more than one representative. My main representative is _____
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part II ACCEPTANCE OF APPOINTMENT

I, Shannon Fauver, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

☒ I am an attorney. ☐ I am not an attorney. (Check one.)

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address <u>138 S. 3rd St. Louisville, KY 40202</u>	
Telephone Number (with Area Code) <u>502-569-7710</u>	Fax Number (with Area Code) <u>877-361-5200</u>	Date

Part III (Optional) WAIVER OF FEE

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date
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Part IV (Optional) ATTORNEY'S WAIVER OF DIRECT PAYMENT

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney Representative)	Date
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INFORMATION FOR CLAIMANTS

What A Representative May Do

We will work directly with your appointed representative unless he or she asks us to work directly with you. Your representative may:

- o get information from your claim(s) file;
- o give us evidence or information to support your claim;
- o come with you, or for you, to any interview, conference, or hearing you have with us;
- o request a reconsideration, hearing, or Appeals Council review; and
- o help you and your witnesses prepare for a hearing and question any witnesses.

Also, your representative will receive a copy of the decision(s) we make on your claim(s). We will rely on your representative to tell you about the status of your claim(s), but you still may call or visit us for information.

You and your representative(s) are responsible for giving Social Security accurate information. It is wrong to knowingly and willingly furnish false information. Doing so may result in criminal prosecution.

We usually continue to work with your representative until (1) you tell us that he or she no longer represents you; or (2) your representative tells us that he or she is withdrawing or indicates that his or her services have ended (for example, by filing a fee petition or not pursuing an appeal). We do not continue to work with someone who is suspended or disqualified from representing claimants.

What Your Representative(s) May Charge

Each representative you appoint can ask for a fee. To charge you a fee for services, your representative must get our approval. (Even when someone else will pay the fee for you, for example, an insurance company, your representative usually must get our approval.) One way is to file a fee petition. The other way is to file a fee agreement with us. In either case, your representative cannot charge you more than the fee amount we approve. If he or she does, promptly report this to your Social Security office.

o Filing A Fee Petition

Your representative may ask for approval of a fee by giving us a fee petition when his or her work on your claim(s) is complete. This written request describes in detail the amount of time he or she spent on each service provided you. The request also gives the amount of the fee the representative wants to charge for these services. Your representative must give you a copy of the fee petition and each attachment. If you disagree with the information shown in the fee petition, contact your Social Security office. Please do this within 20 days of receiving your copy of the petition.

We will review the petition and consider the reasonable value of the services provided. Then we will tell you in writing the amount of the fee we approve.

What Your Representative(s) May Charge, continued

o Filing A Fee Agreement

If you and your representative have a written fee agreement, one of you must give it to us before we decide your claim(s). We usually will approve the agreement if you both signed it; the fee you agreed on is no more than 25 percent of past-due benefits, or \$5,300 (or a higher amount we set and announced in the Federal Register), whichever is less; we approve your claim(s); and your claim results in past-due benefits. We will tell you in writing the amount of the fee your representative can charge based on the agreement.

If we do not approve the fee agreement, we will tell you and your representative in writing. Then your representative must file a fee petition to charge and collect a fee.

After we tell you the amount of the fee your representative can charge, you or your representative can ask us to look at it again if either or both of you disagree with the amount. (If we approved a fee agreement, the person who decided your claim(s) also may ask us to lower the amount.) Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

How Much You Pay

You never owe more than the fee we approve, except for:

- o any fee a Federal court allows for your representative's services before it; and
- o out-of-pocket expenses your representative incurs or expects to incur, for example, the cost of getting your doctor's or hospital records. Our approval is not needed for such expenses.

Your representative may accept money in advance as long as he or she holds it in a trust or escrow account. If an attorney represents you and your retirement, survivors, disability insurance, or black lung claim results in past-due benefits, we usually withhold 25 percent of your past-due benefits to pay toward the fee for you.

You must pay your representative directly:

- o the rest of the fee you owe
 - if the amount of the fee is more than any amount(s) your representative held for you in a trust or escrow account and we withheld and paid your attorney for you.
- o all of the fee you owe
 - if we did not withhold past-due benefits, for example, when your representative is not an attorney or the benefits are supplemental security income; or
 - if we withheld, but later paid you the money because your attorney did not either ask for our approval until after 60 days of the date of your notice of award or tell us on time that he or she planned to ask for a fee.

WHOSE Records to be DisclosedForm Approved
OMB No. 0960-0623

NAME (First Middle Last)

SSN

Birthday (mm/dd/yy)

SSA USE ONLY NUMBER HOLDER (If other than above)
NAME

SSN

**AUTHORIZATION TO DISCLOSE INFORMATION TO
THE SOCIAL SECURITY ADMINISTRATION (SSA)****** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - The information authorized for release may include records which may include the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV.
 - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:**TO WHOM****The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]**PURPOSE**Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)**EXPIRES WHEN** This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

*****PLEASE SIGN USING BLUE OR BLACK INK ONLY.****INDIVIDUAL** authorizing disclosure**SIGN** ►

IF not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)

(Parent/guardian/personal representative sign here if two signatures required by State law) ►

Date Signed

Street Address

Phone Number (with area code)

City

State

ZIP

WITNESS

I know the person signing this form or am satisfied of this person's identity:

SIGN ►IF needed, second witness sign here (e.g., if signed with "X" above)
SIGN ►

Phone Number (or Address)

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827,

"Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information SSA collects is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223 (d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs (VA));
3. For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions.

SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.*

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

TO:

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR ' 164.508, the provider listed above is hereby authorized to release to FAUVER LAW OFFICE, PLLC, or any of its representatives, all medical records, including but not limited to: office notes, history, physical, consultation notes, discharge summaries, order and progress notes, laboratory results, nurses notes, emergency room records, operative records, in-patient records and films of x-rays, MRIs or PET scans, pharmacy and drug records, medical bills and health insurance Medicaid or Medicare records, concerning any medical treatment that I have received from you, at your institution, as well as all such records which you keep in the regular course of business are found in my medical records file. I hereby authorize release of all records regarding mental health, psychiatric (other than psychotherapy notes which must be requested by separate authorization), chemical dependency or HIV. A photo static copy hereof shall be as valid as the original. I hereby authorize a free copy of my medical records pursuant to KRS 422.317 be sent, to the extent I have not already requested my one free copy.

The purpose of this authorization and request is to permit my attorney to obtain ALL medical information pertaining to my physical or mental condition. This authorization expires three (3) years from the date of the signature. The aforementioned expiration date has not passed, as this matter is ongoing.

I hereby authorize attorneys of FAUVER LAW OFFICE, PLLC to speak to my healthcare professionals privately or to take testimony at deposition or trial as may be requested.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to FAUVER LAW OFFICE, PLLC. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Parent/Guardian Signature: _____

Patient/Guardian Printed Name: _____

Parent/Guardian of _____

Child's Address: _____

Date of Signature: _____

Child's Date of Birth: _____

Child's Social Security Number: _____

Witness Signature: _____

Witness Printed Name: _____

ESTABLISHING DISABILITY FOR YOUNG ADULTS

By Linda Landry, Staff Attorney at the Disability Law Center, Boston, Massachusetts and Thomas Yates, Staff Attorney at Health and Disability Advocates (formerly the SSI Coalition for a Responsible Safety Net), Chicago, Illinois

I. Introduction

Young adults (ages 18-25) face unique challenges in meeting the disability definition used for the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. In many ways for purposes of determining disability, young adults more closely resemble children than adults. Although young adults are measured under the adult disability standard, SSA decision makers often fail to identify evidence that shows functional limitations in young adults, particularly evidence from school-based settings. In addition, SSA decision makers fail to look at factors that may mask the true impact of a young adult's functional limitations. In many cases, the childhood disability regulations provide better guidance for assessing the functional limitations of a young adult than do the adult disability regulations. We discuss these factors below.

In the first section, we will explore how the childhood disability standard's focus on functioning in different areas or domains can be used to show limitations that would satisfy the adult disability standard. Second, we review the work rules for issues particularly relevant for young adults.

Generally speaking, young adults relying on or seeking SSI benefits fall into three categories:

- , 18-year-olds who are receiving SSI childhood disability benefits; at age 18 they must have their eligibility for SSI reassessed. When Social Security redetermines whether an 18-year-old is still disabled, it applies its adult disability rules.
- , Many young adults apply for SSI disability benefits for the first time at age 18. Because of Social Security rules that count parents' income until a child turns age 18, many children cannot qualify for SSI before they turn age 18. At age 18, however, Social Security no longer counts parents' income, even if the young adult is still living at home with his or her parents.
- , Young adults may seek Social Security Disability Insurance benefits on the earnings record of their parent, if that parent is retired, disabled, or deceased. To qualify, young adults must show that they have a disabling condition that began prior to turning age 22.

II. Factoring Childhood Functional Measures Into the Adult Disability Standard

Health & Disability Advocates
October 2003

A young adult must show that s/he is disabled using the adult SSI standard. The adult standard, which covers persons from age 18 until they turn age 65, is hard to meet; an individual age 18 or older must show that s/he is unable, due to a medical impairment or combination of medical impairments that have lasted, or are expected to last 12 months or result in death, to perform any jobs that exist in substantial numbers in the national or local economy. At a minimum, young adults must show the following to be found disabled under the adult disability standard:

- , be unable to meet the basic demands of at least sedentary work on a sustained basis; or
- , be unable to meet the basic mental demands of simple, unskilled work.

Showing that, however, can be difficult because much young adults do not have a longitudinal history of work history that can be used in assessing disability. Moreover, young adults are literally just kids—the standards they have been held to are child functioning standards.

SSA recognizes the difference between children and adults in its disability evaluation models; children are evaluated on a model that looks at functioning in a number of different areas while adults are assessed by how well they can do work-related activities.

A. Functional Capacity and the Childhood Disability Standard

1. The Sequential Evaluation Process for Children

SSA now uses a three-step sequential evaluation to determine childhood disability. 20 C.F.R. ' 416.924. It is set forth below:

1. Is the child working (engaging in substantial gainful activity)? (The SSA rules on substantial gainful activity are set forth at 20 C.F.R. ' ' 416.971-76). If yes, deny the claim. If no, go to step 2.
2. Does the child have a medically determinable impairment or combination of impairments that is severe? 20 C.F.R. ' 416.924(c). If no, deny the claim. If yes, go to step 3.
3. Does the child's impairment(s):
 - 1) meet the requirements of a listed impairment in the Listing of Impairments in 20 C.F.R. Part 404, Subpt. P, App. 1; or
 - 2) medically equal the requirements of a listed impairment in the Listing of Impairments in 20 C.F.R. Part 404, Subpt. P, App. 1; or

- 3) are the functional limitations caused by the impairment(s) the same as the disabling functional limitations of any listing, and therefore, functionally equivalent to that listing.

If yes, the child is disabled. If no, the child is not disabled.

2. Evaluating Functional Capacity

a. Functional Domains

In determining functional equivalence, SSA looks at six different domains, defined below. A child is considered disabled if s/he has marked limitations in two domains or an extreme limitation in one domain. The six domains are:

, **Acquiring and Using Information**

This domain is defined as how well a child acquires or learns information, and how well the child uses the information the child has learned. 20 C.F.R. ' 416.926a(g).

♦ **Attending and Completing Tasks**

This domain is defined as how well a child is able to focus and maintain his or her attention, and how well the child begins, carries through, and finishes his or her activities, including the pace at which the child performs activities and the ease with which the child changes them. 20 C.F.R. ' 416.926a(h).

, **Interacting and Relating With Others**

This domain is defined as how well a child initiates and sustains emotional connections with others, develops and uses the language of the child's community, cooperates with others, complies with rules, responds to criticism, and respects and takes care of the possessions of others. 20 C.F.R. ' 416.926a(i).

, **Moving About And Manipulating Objects**

This domain is defined as how a child moves his or her body from one place to another and how the child moves and manipulates things. Put another way, this domain assesses gross and fine motor skills. 20 C.F.R. ' 416.926a(j).

, **Caring For Yourself**

This domain is defined as how well a child maintains a healthy emotional and physical state, including how well the child gets his or her physical and emotional wants and needs met in

appropriate ways; how the child copes with stress and changes in his or her environment; and whether the child takes care of his or her own health, possessions, and living area. 20 C.F.R. ' 416.926a(k).

Health and Physical Well-Being

This domain is defined as the cumulative physical effects of physical or mental impairments and their associated treatments or therapies on the child's functioning that SSA did not consider in the domain of Moving about and manipulating objects. 20 C.F.R. ' 416.926a(l).

b. What Evidence Is Considered

The same general evidence gathering and weighing rules that apply in adult cases also apply in children's cases. *See* 20 C.F.R. ' ' 404.1527, 416.927. An Acceptable medical source@ is needed to establish a medically determinable impairment. 20 C.F.R. ' ' 404.1513, 416.913. Important to cases for both children and young adults, is the addition of the of the following Acceptable medical sources:@licensed or certified school psychologists for mental retardation, learning disabilities, and borderline intellectual functioning; and qualified speech and language pathologists for speech and language impairments. *Id.* Evidence of the functional severity of medically determinable impairments is not limited to that from acceptable medical sources, and can also come from other medical sources such as nurse practitioners and therapists, other professional sources such as counselors and teachers, and lay sources. 20 C.F.R. ' ' 404.1513, 416.913.

SSA has provided guidance to its decision makers about the gathering and evaluation of school evidence. The childhood regulations provide school evidence should be requested and evaluated. 20 C.F.R. ' 416.924a(a)(2)(iii). In addition, the regulation provides guidance on how to weigh evidence that a child is in a special education program or receives accommodations, 20 C.F.R. ' 416.924a(b)(7)(iv); and a child has medical impairments that limit his or her attendance and participation in school activities. 20 C.F.R. ' 416.924a(b)(7)(v).

c. How Evidence Is Considered

A feature of the childhood disability standard that is not nearly as uniformly present in the adult disability standard is the concept that SSA decision makers must consider, among other things, whether factors are present that either mask functional limitations, or cause or exacerbate the disabling functional limitations themselves.

For children, SSA decision makers must consider, in assessing the severity of functional limitations, the amount of help or adaptations a child requires and the impact of structured or supportive settings. In so doing, decision makers are to consider the following: a) the range of activities a child does; b) the child's ability to do them independently, including any prompting the child requires to begin, carry through, and complete those activities; c) the pace at which the

child does those activities; d) how much effort the child needs to do those activities; and e) how long the child is able to sustain such activities. 20 C.F.R. ' 416.924a(b)(5). Among the factors specifically considered are the following.

Extra Help

SSA decision makers are required to consider any extra help that a child requires to do age-appropriate activities. 20 C.F.R. ' 416.924a(b)(5)(i). In making the disability determination or decision, the decision makers must assess how a child would function without the extra help. Extra help is more help than a child of the same age without an impairment would be expected to need. 20 C.F.R. ' 416.924a(b)(5)(ii).

Structured or Supportive Settings

A child with a serious impairment(s) may spend some or all of his or her time in a structured or supportive setting beyond what a child without such an impairment(s) normally requires. SSA decision makers must consider how that child would function outside of the structured or supportive setting because the structured or supportive setting may minimize signs and symptoms of the child's impairment(s) and help to improve his or her functioning while he or she is in it, even though the child's signs, symptoms, and functional limitations might worsen outside this type of setting. 20 C.F.R. ' 416.924a(b)(5)(iv).

Unusual Settings

SSA recognizes that children may behave differently in unusual settings and that behavior should not be relied upon in isolation in determining the severity of functional limitations. The final regulations state:

Children may function differently in unfamiliar or one-to-one settings than they do in their usual settings at home, at school, in childcare or in the community. You may appear more or less impaired on a single examination (such as a consultative examination) than indicated by the information covering a longer period. We will not draw inferences about your functioning in other situations based only on how you function in a one-to-one, new, or unusual situation.

20 C.F.R. ' 416.924a(b)(6).

Effects of Medications

In determining disability, SSA decision makers must consider how a child functions with the benefit of prescribed medications. 20 C.F.R. ' 416.924a(b)(9). The final regulations state that if a child's symptoms or signs are reduced by medications, SSA must still consider, among

other things, whether the medications create side effects that cause or contribute to the child's functional limitations. 20 C.F.R. ' 416.924a(b)(9)(i)(A)-(E).

Treatment Effects

The effects of treatment must also be considered in determining disability. 20 C.F.R. ' 416.924a(b)(9)(ii). Treatment includes occupational, physical, speech, and language therapy, psychotherapy and psychosocial counseling. The final regulations provide that frequent therapy may also interfere with a child's functioning. Therefore, decision makers must consider the frequency of therapy; how long the child has received therapy or will need it; whether the therapy interferes with the child's participation in activities typical of children of that age without impairments, such as attending school or classes or socializing with peers; and the length and frequency of hospitalizations. 20 C.F.R. ' 416.924a(b)(9)(ii).

2. The Adult Disability Standard

For adults, people age 18 and older, SSA defines disability as the inability to engage in any substantial gainful activity by reason of medically determinable physical and/or mental impairment(s) which can be expected to last for a continuous period of not less than 12 months or result in death. 20 C.F.R. ' ' 404.1505, 416.905. SSA uses a five step sequential analysis to determine disability under this standard. See 20 C.F.R. ' ' 404.1520, 416.920.

1. Is the applicant engaging in Substantial Gainful Activity (SGA)? If yes, the application is denied. If no, the application proceeds to Step 2.
2. Does the applicant have a severe impairment or combination of impairments that are severe? If no, the application is denied. If yes, the application proceeds to Step 3.
3. Does the applicant have an impairment which meets or equals the severity of a listed impairment? If yes, the application is approved. If no, the application proceeds to Step 4.
4. Does the applicant have the residual functional capacity (RFC) to perform his/her past relevant work (work performed in the last 15 years)? If yes, the application is denied. If no, the application proceeds to Step 5.
5. Does the claimant have the RFC to perform any other work that exists in significant numbers in the national economy? SSA considers factors such as the applicant's age, education, work history (skilled or unskilled), and ability to communicate in English, are considered when determining if there is other work the claimant can perform. If no, the application is approved. If yes, the application is denied.

C. Finding Common Ground Between The Childhood and Adult Disability Standard

1. What Evidence Is Relevant

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The regulations provide, at 20 C.F.R. ' 416.913(e), that information from non-medical sources is important in determining how medical impairments affect the ability to work. It lists the following sources as relevant:

- , public and private social welfare agencies and social workers;
- , observations by people who know you (for example, spouses, parents and other caregivers, siblings, other relatives, friends or neighbors, clergy);
- , other medical practitioners (for example, nurse practitioners and physicians= assistants, naturopaths, and chiropractors);
- , therapists (for example, physical, occupational, or speech and language therapists); and
- , educational agencies and personnel (for example, school teachers, school psychologists who are not acceptable medical sources, and school counselors.

20 C.F.R. ' 416.913(e).

2. Evaluating Function at Step ThreeBThe Listings

As described above, an adult is disabled if s/he meets or medically equals a listing in the Listings of Impairments. Most of the listings do not incorporate function. However, SSA has been making some effort, as it updates the listings for physical impairments, to incorporate functional measures.

The mental impairment listings do incorporate functional measures in the AB@and AC@ criteria. The AB@and AC@of the adult mental impairment listings should be advocates=main focus. The AA@criteria fulfill the statutory requirement that a person have a medically determinable impairment or impairments to be found disabled. The AB@and AC@criteria Adescribe impairment-related functional limitations that are incompatible with the ability to work The criteria included in paragraphs B and C of the listings for mental disorders have been chosen because they represent functional areas deemed essential to work.@ 20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.A.

i. The AB@Criteria and AC@Criteria

The AB@criteria considered are as follows:

Activities of Daily Living, refers to daily adaptive activities such as:

- , cleaning;
- , shopping;
- , cooking;
- , taking public transportation;
- , paying bills;

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- , maintaining a residence;
- , caring appropriately for one's grooming and hygiene;
- , using telephones and directories; and
- , using a post office.

20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.C.1.

In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness and effectiveness. It is necessary to define the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

Social functioning refers to your capacity to interact independently, appropriately, effectively, and on a sustained basis with other individuals. Social functioning includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. You may demonstrate impaired social functioning by, for example, a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. You may exhibit strength in social functioning by such things as your ability to initiate social contacts with others, communicate clearly with others, or interact and actively participate in group activities. We also need to consider cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority (*e.g.*, supervisors), or cooperative behaviors involving coworkers. 20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.C.2.

Concentration, persistence, or pace refers to the ability to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings. Limitations in concentration, persistence, or pace are best observed in work settings, but may also be reflected by limitations in other settings. In addition, major limitations in this area can often be assessed through clinical examination or psychological testing. Wherever possible, however, a mental status examination or psychological test data should be supplemented by other available evidence. 20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.C.3.

On mental status examinations, concentration is assessed by tasks such as having you subtract serial sevens or serial threes from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits.

In work evaluations, concentration, persistence, or pace is assessed by testing your ability to sustain work using appropriate production standards, in either real or simulated work tasks (*e.g.*, filing index cards, locating telephone numbers, or disassembling and reassembling objects). Strengths and weaknesses in areas of concentration and attention can be discussed in

terms of your ability to work at a consistent pace for acceptable periods of time and until a task is completed, and your ability to repeat sequences of action to achieve a goal or an objective.

Episodes of decompensation are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two). Episodes of decompensation may be inferred from medical records showing significant alteration in medication; or documentation of the need for a more structured psychological support system (e.g., hospitalizations, placement in a halfway house, or a highly structured and directing household); or other relevant information in the record about the existence, severity, and duration of the episode. 20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.C.4.

The term *repeated episodes of decompensation, each of extended duration* in these listings means three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks. If you have experienced more frequent episodes of shorter duration or less frequent episodes of longer duration, we must use judgment to determine if the duration and functional effects of the episodes are of equal severity and may be used to substitute for the listed finding in a determination of equivalence.

If the AB@criteria are not met, SSA looks at additional functional criteria (paragraph C criteria) in 12.02, 12.03, 12.04, and 12.06. These criteria do the same thing as the other factors discussed above for children (structured settings, etc.).

ii. Special Factors in Weighing Evidence in Adult Claims

As set forth above, the childhood regulations provide specific guidance in assessing the severity of functional limitations about the impact of the amount of help or adaptations a child requires and the impact of structured or supportive settings. The same points are made in the adult mental impairment listings. However, they are not as clearly set out. These factors are discussed below.

Effects of Structured Settings

SSA recognizes that overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, halfway house, board and care facility, or other environment (including one's home) that provides similar structure in cases involving chronic mental disorders. Such settings may greatly reduce the mental demands placed on a person. With lowered mental demands, overt symptoms and signs of the underlying mental disorder may be minimized. At the same time, however, the person's ability to function outside of such a structured or supportive setting may not have changed. If someone's symptomatology

is controlled or attenuated by psychosocial factors, SSA must consider your ability to function outside of such structured settings. 20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.F. See also SSR 85-15(discussing stress and mental illness).

Effects of Medication

SSA recognizes that medication effects a person's symptoms, signs, and ability to function. While drugs used to modify psychological functions and mental states may control certain primary manifestations of a mental disorder, *e.g.*, hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may not affect all functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the use of such drugs, particular attention must be focused on the functional limitations that may persist.

The introductory language to the Listings recognizes that drugs used in the treatment of some mental illnesses may cause drowsiness, blunted effect, or other side effects involving other body systems. Those symptoms must be considered in evaluating the overall severity of someone's impairment. Where adverse effects of medications contribute to the impairment severity and the impairment(s) neither meets nor is equivalent in severity to any listing but is nonetheless severe, SSA considers such adverse effects in the RFC assessment. 20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.G.

Effects of Treatment

With adequate treatment some individuals with chronic mental disorders not only have their symptoms and signs ameliorated, but they also return to a level of function close to the level of function they had before they developed symptoms or signs of their mental disorders. Treatment may or may not assist in the achievement of a level of adaptation adequate to perform sustained SGA. 20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.H.

Unusual Settings

Unlike the childhood disability regulations, the adult mental impairment standard does not specifically recognize unusual settings. In the childhood context, the unusual settings language is intended in large part to instruct decision makers that reliance on evidence generated from one-on-one encounters such as consultative examinations is often misplaced because such reliance ignores that many children do not exhibit the symptoms of their mental impairments in such settings. Similar language is contained in the adult mental impairment listings, although it is not separately set forth.

In discussing the B criteria of concentration, persistence, or pace, the listings state:

We must exercise great care in reaching conclusions about your ability or inability to complete tasks under the stresses of employment during a normal workday or work week

based on a time-limited mental status examination or psychological testing by a clinician, or based on your ability to complete tasks in other settings that are less demanding, highly structured, or more supportive. We must assess your ability to complete tasks by evaluating all the evidence, with an emphasis on how independently, appropriately, and effectively you are able to complete tasks on a sustained basis.

20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.C.3. In addition, the mental impairment listings stress the need for longitudinal evidence, recognizing that a person's level of functioning may vary considerably over time. A proper evaluation of your impairment(s) must take into account any variations in the level of your functioning in arriving at a determination of severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication to establish your impairment severity. @20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.D.2.

3. Evaluating Function at Steps Four and Five-Residual Functional Capacity

At steps four and five in the adult sequential evaluation, SSA assesses how an adult functions in determining disability. The adult assessment is residual functional capacity (RFC). RFC is what the person can still do despite the functional limitations imposed by all of his or her impairments. See 20 CFR ' ' 404.1545, 416.945. Put another way, RFC is:

a multidimensional description of the work-related activities [that a person] retain[s] in spite of ... medical impairments. An assessment of ... RFC complements the functional evaluation necessary for the paragraphs B and C of the listings by requiring consideration of an expanded list of work-related capacities that may be affected by mental disorders
....

20 C.F.R. Part 404, Subpt. P, App. 1, ' 12.00.A.

An RFC includes both exertional and nonexertional functional capacities:

- , Exertional functional capacity includes the ability to walk, stand, sit, lift, push, pull, reach, carry, and handle items.
- , Nonexertional functional capacity includes the ability to see, hear, speak, to tolerate fumes, dust, heat and cold understand, and to carry out, and remember simple instructions, use judgment, respond appropriately to supervision, co-workers, and usual work situations, and deal with changes in a routine work setting.

When SSA considers the individual functional limitations of claimants with mental impairments at steps four and five of the sequential analysis, it is not unusual to see SSA find

claimants with quite severe mental impairments capable of unskilled work. This is especially true for younger claimants. However, the basic mental demands of even unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, co-workers, and usual work situations; and to deal with changes in a routine work setting and customary work pressures. *See* Social Security Ruling 85-15 and 85-16.

The introductory materials (20 CFR Part 404, Subpt. P, App.1, 12.00) to the mental impairment listings, as discussed earlier, contain language that is useful to the evaluation of mental impairments throughout the sequential analysis, i.e., the need for a longitudinal assessment; the importance of lay evidence in completing the assessment of functional limitations; and the need to consider the effects of structured settings to accurately assess the ability to function in a work setting. *See* 20 C.F.R. ' ' 404.1520a(c), 416.920a(c).

a. Evaluating the Impact of Stress and the Need for Structured Settings

SSR 85-15 contains helpful language about the impact of stress on persons with mental impairments, mirroring substantially, the language about the impact of structured settings in the childhood disability regulation and the adult mental impairment listings:

Stress and Mental Illness -- Since mental illness is defined and characterized by maladaptive behavior, it is not unusual that the mentally impaired have difficulty accommodating to the demands of work and work-like settings. Determining whether these individuals will be able to adapt to the demands or "stress" of the workplace is often extremely difficult. This section is not intended to set out any presumptive limitations for disorders, but to emphasize the importance of thoroughness in evaluation on an individualized basis.

Individuals with mental disorders often adopt a highly restricted and/or inflexible lifestyle within which they appear to function will. Good mental health services and care may enable chronic patients to function adequately in the community by lowering psychological pressures, by medication, and by support from services such as outpatient facilities, day care programs, social work programs and similar assistance.

The reaction to the demands of work (stress) is highly individualized, and mental illness is characterized by adverse responses to seemingly trivial circumstances. The mentally impaired may cease to function effectively when facing such demands as getting to work regularly, having their performance supervised, and remaining in the workplace for a full day. A person may become panicked and develop palpitations, shortness of breath, or feel faint while riding in an elevator; another may experience terror and begin to hallucinate when approached by a stranger asking a question. Thus, the mentally impaired may have difficulty meeting the requirement of even so-called "low stress" jobs.

Because response to the demands of work is highly individualized, the skill level of a position is not necessarily related to the difficulty an individual will have in meeting the demands of the job. A claimant's condition may make performance of an unskilled job as difficult as an objectively more demanding job, for example, a busboy need only clear dishes from tables. But an individual with a severe mental disorder may find unmanageable the demand of making sure that he removes all the dishes, does not drop them, and gets the table cleared promptly for the waiter or waitress. Similarly, an individual who cannot tolerate being supervised may be not able to work even in the absence of close supervision; the *knowledge* that one's work is being judged and evaluated, even when the supervision is remote or indirect, can be intolerable for some mentally impaired persons. Any impairment-related limitations created by an individual's response to demands of work, however, must be reflected in the RFC assessment.

b. Incorporating School Evidence Into The RFC Determination

Often, SSA decision makers fail to focus on evidence that shows the inability to do simple, unskilled work on a sustained basis.

Among other things, SSR 85-16 provides that the following types of evidence should be considered in determining RFC:

- , Reports of the individual's activities of daily living and work activity, as well as testimony of third parties about the individual's performance and behavior.
- , Reports from workshops, group homes, or similar assistive entities.

In analyzing the evidence, it is necessary to draw meaningful inferences and allow reasonable conclusions about the individual's strengths and weaknesses. Consideration should be given to factors such as:

- , Quality of daily activities, both in occupational and social spheres (see Listing 12.00, Introduction), as well as of the individual's actions with respect to a medical examination.
- , Ability to sustain activities, interests, and relate to others *over a period of time*. The frequency, appropriateness, and independence of the activities must also be considered.
- , Level of intellectual functioning.
- , Ability to function in a work-like situation.

Many young adults have school-based evidence, including evidence of academic work and school-based vocational program work, that addresses these issues.

The regulations provide that evidence from teachers and school psychologists, or physical, occupational, or speech-language therapists shall be considered. 20 C.F.R. ' 416.913(e). The childhood disability regulations explain that relevant school evidence includes:

- , Evidence from teachers about the child's performance in activities throughout the school day;
- , Special education services including information in Individualized Education Program (IEP) plans;
- , Special education or accommodationsBAWe will consider the circumstances of your school attendance, such as your ability to function in a regular classroom or preschool setting with children your age who do not have impairments. Similarly, we will consider that good performance in a special education setting does not mean that you are functioning at the same level as other children your age who do not have impairments.@
- , Attendance and participationBAWe will also consider factors affecting your ability to participate in your education program. You may be unable to participate on a regular basis because of the chronic or episodic nature of your impairment(s) or your need for therapy or treatment.@

20 C.F.R. ' 416.924a(b)(7).

Advocates should look to school evidence for the following in determining whether young adults can work:

- , A young adult's ability to understand, carry out, and remember simple instructions and work-like procedures in the classroom is evidence of his or her ability to do these things in a job.
- , A young adult's ability to communicate spontaneously, interactively, and age-appropriately in the classroom is evidence of ability to do these things in a job.
- , A young adult's ability to maintain attention for extended periods of time and to sustain an ordinary daily routine without special supervision is evidence of ability to do these things in a job.
- , A young adult's ability to work with authority figures and to follow direction in school, responding appropriately to correction or criticism, is evidence of ability to deal with supervision in a job.

- , A young adult's ability to interact with peers in school, school-related activities, and other age-appropriate environments is evidence of ability to relate to co-workers in a job.
- , A young adult's ability to regulate mood and behavior in various school settings is evidence of ability to deal with change in the work setting.
- , A young adult's ability to engage in physical activities both in and out of school is evidence of ability to perform the physical demands of work.
- , A young adult's skills derived from specific vocational education and/or part-time employment are evidence of ability to use those skills in a job.

III. How Work Affects SSI and SSDI Eligibility for Young Adults

Many young adults are working, or want to go to work. However, wages will affect income eligibility for SSI, and the ability to do some work may be used by SSA to show that a young adult is not disabled because of the way that SSA evaluates work activity. SSA looks primarily at the wages that a young adult earns at work to decide whether that work shows that he or she is not disabled. Generally speaking, a young adult will be considered to be working and not disabled if he or she is employed and earning more than \$780 per month (in 2002). There are exceptions, however.

A. Wages and SSI Income Eligibility

Virtually all wages earned by an SSI recipient are countable after certain deductions. The SSI earned income deduction is \$65 plus half of the remainder. 20 C.F.R. ' 416.1112(c)(5) & (7). For example, \$565 in gross monthly wages results in \$250 in countable income for SSI purposes. In addition, the \$20 general income deduction can be used if it has not been used up against unearned income. 20 C.F.R. ' 416.1112(c)(4). Impairment Related Work Expenses (IRWEs) and wages set aside in a Plan to Achieve Self Support (PASS) are also excluded from countable income. 20 C.F.R. ' 416.1112(c)(6) & (9) (see below for more information on PASS & IRWEs). Finally, students under age 22 who are regularly attending school can exclude up to \$1,320 per month but not more than \$5340 in calendar year 2002. 20 C.F.R. ' 416.1112(c)(3). POMS SI 00820.510. This amount is indexed to the yearly COLA.

B. Substantial Gainful Activity

The definition of disability for both SSI and SSDI requires that the claimant be "unable to engage in any substantial gainful activity" (SGA). 20 CFR ' 404.1505, 416.905. SGA involves the performance of significant physical or mental duties productive in nature. It is not necessary that the work be full-time to be substantial; part-time work may be sufficient. Gainful activity is activity for remuneration or profit or intended for profit whether or not it's realized. Work performed in self-care or one's own household tasks, and non-remunerative work on hobbies, institutional therapy or training, school attendance, clubs, social programs, etc. does not constitute SGA in and of itself. However, SSA may look to these to see if the claimant has the ability to do SGA.

SSA has developed a complex set of rules for evaluating when work activity should be considered SGA. See 20 C.F.R. ' 404.1571 et seq., 20 C.F.R. ' 416.971. The primary consideration for employees is the amount of gross monthly wages. For the self-employed, SSA considers not only wages but also the value of the activity to the business. In addition, there are several factors that may be applied to reduce earnings below the SGA level. These factors are seldom adequately developed, so it is important to be aware of them and investigate them where appropriate. See the SGA evaluation rules at 20 CFR ' 404.1571 et seq., 20 CFR ' 416.971.

1. Presumed SGA Wages

In general, for calendar year 2002, SSA will presume that any employee who earns more than \$780 a month in gross wages is engaging in SGA. The SGA amount has been indexed to the yearly COLA since 2001. Prior SGA amounts include the following: \$740 for 2001; \$700 for 7/99 - 12/00; and \$500 for 1/90 - 6/99.

The presumption of SGA can be rebutted though the exceptions to SGA, as follows: 1) the earnings include a subsidy reducing the true earnings below the SGA level (20 CFR ' 416.974(a)(2), 65 Fed. Reg. 42789(7/11/00)); 2) the work involves special circumstances such that it should not be considered SGA (20 CFR ' 416.973(c), 65 Fed. Reg. 42788 (7/11/00)); 3) the individual's impairment forces him/her to quit working within a short period of time (3 - 6 months), constituting what is called an unsuccessful work attempt (20 CFR ' 416.974 (c), Id.); and 4) the claimant has impairment related work expenses that reduce monthly wages below the SGA level (20 CFR ' 416.976).

2. Presumed Non-SGA Wages

A claimant earning less than \$300 a month in gross wages, in the absence of evidence to the contrary, will not be considered engaging in SGA. Exceptions to this rule would be individuals doing volunteer work or work with little remuneration, which nevertheless is comparable to those engaged in SGA.

3. No Presumption Wages

For work performed in or after January 2001, SSA is not required to investigate whether these mid level earnings should be considered SGA. Instead, SSA will generally not consider other evidence to determine whether mid level wages show the ability to do SGA, unless there is evidence of SGA or evidence of wage suppression. See 20 CFR ' 416.974(6), 65 Fed. Reg. 82905, 82912 (12/29/00). However, for work performed prior to January 2001, SSA is required to investigate whether earnings between \$300 and SGA level earnings should be considered engaging in SGA. See the considerations laid out in 20 C.F.R. ' 416.974(6).

B. Factors That May Show Inability To Do SGA

The following factors may be used to rebut the presumption created by earnings at the SGA level.

1. Unsuccessful Work Attempts

This factor should be developed when the young adult has either stopped working or lost a job due to impairment related reasons. Work that constitutes an Unsuccessful Work Attempt (UWA) is not SGA. A UWA is a short, failed to work.. To be considered a UWA, the work attempt must be terminated because of an impairment related inability to perform the work activity. As a general rule, SSA will consider a work attempt terminated in less than three months to be a UWA. Work attempts lasting between 3-6 months require more evidence showing disability related problems and termination. A UWA should not result in a determination that the claimant is able to engage in SGA. SSA will not consider the work activity or wages earned by the claimant during the UWA as evidence of ability to perform SGA. *See* 20 C.F.R.' ' 4041574(a)(1), 416.974(a)(1), as published at 65 Fed. Reg. 42771 (7/11/00) and Social Security Ruling 84-25 for more information on UWAs.

2. Subsidies and Special Conditions

Some young adults will have participated in work programs that may or may not have had reduced expectations and production requirements. In these cases, the possibility that the work was subsidized or performed under special circumstances should be investigated. Subsidized work and work performed under special circumstances may show that the individual does not have the ability to perform SGA, even if the individual's wages are at or above the SGA level. *See* 20 CFR ' ' 404.1573, 404.1574, 416.973, 416.974, published at 65 Fed. Reg. 42771 (7/11/00). A subsidy exists when an employer pays an employee more than the reasonable value of his/her services. The amount of the subsidy is determined by comparing the time, energy, skill, and responsibility involved in the individual's services with the same elements involved in the performance of similar work by **individuals without impairments**. For example, an employee who produces 50% of the production requirement and is paid the same as those expected to meet the production requirement receives a 50% subsidy. Evidence that a subsidy exists includes marked lack of productivity, necessity for an unusual amount of supervision and assistance, or marked slowness and inefficiency.

Work performed under special circumstances may also show that the individual does not have the ability to do SGA. Special circumstances should be investigated whenever the employee

- , receives special assistance from other employees;
- , works irregular hours or takes frequent rest periods;
- , works under specially arranged circumstances;
- , has lower standard of productivity or efficiency; and
- , has family relationships or past association with the employer.

See 20 CFR 404.1573(c), 416.973(c), as published at 65 Fed. Reg. 42771, 42783 (7/11/00). An example of work performed under special circumstances could include a young adult who earns SGA level wages but who does so only with significant services from a job coach provided by a social service agency.

3. Impairment-Related Work Expenses

Some young adults may be earning SGA level wages but spending significant unreimbursed amounts on Impairment Related Work Expenses (IRWEs). The value of any such (IRWEs) can be deducted from monthly earnings, and may reduce those earnings below the SGA level. An IRWE is a disability related expense that helps the employee function at work. The cost of an IRWE must be paid by the recipient and must not be reimbursed by any source. 20 CFR ' ' 404.1576(b)(3), 416.976(b)(3). Verified IRWE costs must be deducted from monthly gross earnings before SSA makes an SGA determination. Significant IRWEs can reduce gross earnings below the SGA level. For example, a recipient who earns \$900 in gross monthly wages in 2002 but who has \$200 per month in out of pocket expenses for prescription medication for his mental impairment is not performing SGA. Other IRWE deductions may include unreimbursable claimant paid costs for items and/or services necessary to the claimant's ability work, such as wheelchairs, assistive technology, counseling services, specially adapted vehicles, etc.

4. Plans for Achieving Self-Support

A plan for achieving self-support (PASS) allows claimants to set aside income and/or resources for a specified time for a vocationally achievable work goal. A young adult could set aside money to pay expenses for education, vocational training, adaptive equipment, job coaching, or starting a business as long as the expenses are related to achieving the work goal. POMS SI 00870.000 et seq. SSA does not count the income set aside under the PASS when computing the SSI payment amount. 20 C.F.R. ' 416.1112(c)(9). Further, SSA does not count the resources set aside under the PASS to determine resource eligibility for SSI. 20 C.F.R. ' 416.1225. This means that a PASS can help establish or maintain SSI eligibility and can increase the SSI payment amount.

A PASS must

- , be designed especially for the claimant;
- , be in writing (preferably on form SSA-545-BK);
- , state a specific work goal the claimant is capable of performing;
- , state a specific time frame for reaching the work goal;
- , show what money and other resources will be used to reach the goal;
- , show how the funds will be used to reach the goal;
- , include a detailed business plan if the goal is self-employment;
- , show how the set aside funds will be kept identifiable from other funds;
- , be approved by SSA; and
- , be reviewed by SSA periodically to assure the plan is actually helping achieve progress.

20 C.F.R. ' ' 416.1181, 416.1126. POMS SI 00870.006.

C. Work Incentives

Both the SSI and the SSDI programs include work incentive rules that permit claimants to test their abilities to work without immediate loss of benefits and related health insurance. These work incentive rules can help a young adult with disabilities transition from school to work.

1. SSI Work Incentive Program.

SSI recipients who work at the SGA level are eligible for the 1619 program. 20 CFR ' ' 416.2.60 -.267. Recipients who have earnings above the SGA level can continue to receive cash payments under the 1619(a) program (special SSI payments for people who work) as long they remain medical disabled and meet all other eligibility requirements. The recipient's financial eligibility and payment amount will be calculated in the same way as for someone who is not working at the SGA level. Medicaid eligibility also continues with 1619(a) eligibility.

When earnings become too high to allow for a cash payment, the recipient may be eligible for 1619(b) (continued Medicaid eligibility). 20 CFR ' ' 416.268 - .269. In order to qualify, the recipient must:

- , have been eligible for an SSI cash payment for at least one month;
- , still meet the disability definition;
- , still meet other non-disability requirements;
- , need Medicaid in order to work; and
- , have gross earned income insufficient to replace SSI and Medicaid.

POMS SI 02302.010.

Individuals who remain medically disabled can move between SSI, 1619(a) and 1619(b) without a new application, as their circumstances change.

3. SSDI Work Incentive Programs

SSDI recipients are entitled to a 9 month trial work period during which benefits are not affected. 20 CFR ' 404.1592. A trial work month is a month in which the recipient earns more than **\$560 in gross wages (in 2002)** in work that is not training or therapy. Recipients continue to receive their full SSDI benefit during the trial work months, no matter how much they earn. The 9 months do not have to be consecutive. The trial work period is completed when the recipient has had 9 trial work months in a rolling 60 month period. When the 9 month trial work period is complete, SSA will review the work to determine whether the recipient is performing substantial gainful activity. SSA should also conduct a continuing disability review to see whether the recipient remains medically disabled.

If the individual is no longer medically disabled, benefits will cease.

Recipients who remain medically disabled begin the extended period of eligibility (EPE). 20 CFR ' 404.1592a. The EPE is a consecutive 36 month period that begins the month following the end of the trial work period. During the EPE, recipients are not eligible for a cash benefit for months in which they work at the substantial gainful (SGA) activity level. However, as long as the recipient remains medically disabled, benefits can be reinstated during the EPE without a new application for any month in which the person does not work at the SGA level. Medicare benefits continue during the EPE regardless of whether the recipient is eligible for a cash benefit. Eligibility will cease at the end of the 36 months if the recipient is performing work at the SGA level. If the recipient is not working at the SGA level, eligibility will cease with first month the recipient does perform SGA.

Although SSA can look at any work to see if it shows the ability to perform substantial gainful activity (SGA), SSA presumes that work resulting in gross wages at or above the SGA level constitutes SGA. The regulations at 20 CFR' 404.1574, provides a useful chart indicating the SGA level applicable to various time periods. Any special circumstances and the monthly value of any subsidies or impairment related work expenses (IRWEs) should be deducted from monthly gross wages before deciding whether the wages show SGA.

QUESTIONNAIRE FOR CHILDREN CLAIMING SSI BENEFITS

Please print, type, or write clearly and answer all items to the best of your ability. If you need help completing any part of this form, we will help you. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. If you do not know the answer, enter "unknown." If the question does not apply, enter "N/A." If you need more space to answer any of the questions, please use "REMARKS" and enter the number of the question next to your answer.

Child's Full Name		Social Security Number	Date (month, day, year)
Informant's Name		Relationship to Child	Daytime Telephone Number (including Area Code)
1.	Is (was) the child cared for by a baby sitter? Does (did) the child attend any type of preschool, daycare and/or after school program? If so, please specify. If more than one of the above, use the "REMARKS" section.		
	Name	Address (Number, Street, City, State, Zip Code)	
	Telephone Number (including Area Code)	Dates Attended	
2.	a. Is (was) the child in school? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If "yes," and the school was not listed in Item 12A of the SSA-3820-F6, please show it here. (If more than one, use the "REMARKS" section.)		
	Name	Address (Number, Street, City, State, Zip Code)	
	Telephone Number (including Area Code)	Dates Attended	
	Grade Level Completed	Last Teacher's Name	

2.	b. Is the child in a special education program? —————→	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	c. Does the school make any special accommodations for the child; e.g., adaptive furniture, wheelchair ramps, extra assistance or attention? —————→	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
	If "yes" in 2.b. or 2.c., indicate type of program and/or accommodations:	Specify number of hours per week the child is in special education program:
	d. Do you have a copy of the child's individual education plan (IEP), the report in which the teacher outlines the child's problems and lists the plans for correcting them? —————→ If "yes," please provide a copy.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Does the child receive any special counseling or tutoring? a. In school —————→ b. Outside school —————→	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes," in 3.a. or 3.b., please indicate: (If more than one, use the "REMARKS" section.)		
Type of Counseling, Tutoring		
Date Began and Ended (If completed)		Frequency of Visits
Counselor's or Tutor's Name		Telephone Number (including Area Code)
Address (Number and Street, City, State and Zip Code)		
4.	Does the child or family have a child welfare, social services or early intervention caseworker? —————→	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes," please provide the following information: (If more than one, use the "REMARKS" section.)		
Caseworker's Name		Organization
Address (Number and Street, City, State and Zip Code)		Telephone Number (including Area Code)
File or Record Number		Date First Saw/Last Saw Caseworker

5. Has the child ever been tested or evaluated by any of the following agencies or organizations?

If "yes," indicate in the space provided below the agency name, address, telephone number, record number, and the type and date of test or evaluation performed (e.g., vision, hearing, speech, physical).

- | | | | |
|--|--------|------------------------------|-----------------------------|
| a. Public/Community Health Department | _____→ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Child Welfare/Social Services Agency | _____→ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Developmental Evaluation Center | _____→ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Mental Health/Mental Retardation Center | _____→ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Special Needs/Crippled Children Agency | _____→ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Speech and Hearing Center | _____→ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Women, Infants and Children (WIC) Program | _____→ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Use the letter designation (5a, 5b, etc.) to identify the agency.

If additional space is needed, use "REMARKS" section.

6. Does (did) the child receive any special therapy (physical, speech and language, occupational), exercises, or any other services for his/her impairments? _____ →

☐ Yes ☐ No

Include information about any therapy or exercises the parent, guardian or caregiver provides the child.

If "yes," indicate below the therapist's name, the name of the person who PRESCRIBED AND/OR DESIGNED the therapy program, the type(s) and frequency of treatment, when treatment began and ended (if completed), and where treatment was received (*e.g., home, hospital, therapist's office, clinic.*)

Therapist's Name

Telephone No. (including Area Code)

Address (Number and Street, City, State and Zip Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

Therapist's Name

Telephone No. (including Area Code)

Address (Number and Street, City, State and Zip Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

7.	Does (did) the child receive vocational rehabilitation services? → If "yes," describe services received below the rehabilitation counselor's information. Include dates and record number.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Rehabilitation Counselor's Name	Telephone No. (including Area Code)
Address (Number and Street, City, State and Zip Code)		
Services received:		
(If additional space is needed, use "REMARKS" section.)		

8.	NOTE: PROVIDING INFORMATION ABOUT THE CHILD'S INVOLVEMENT WITH THE COURT SYSTEM IS OPTIONAL	
	Has the child ever been involved with the court system other than in custody proceedings? → If "yes," please explain involvement, including testing and evaluation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Youth Development Center's Name		
Address (Number and Street, City, State and Zip Code)		
	Probation or Parole Officer's Name	Telephone No. (including Area Code)
Address (Number and Street, City, State and Zip Code)		
Involvement including any testing and evaluation:		

9. Does (did) the child participate in any community or school activities, such as choir, Special Olympics, Boy's/Girl's Club, Scouts, or sports?

☐ Yes ☐ No

If "yes," describe involvement, amount of time spent in activity, and level of participation. Provide name, address, and telephone number of individual who supervises the activity. Include dates of involvement. If involvement ended, explain why.

10. If the child takes any medication on an ongoing basis, please indicate the following:

MEDICATION DOSAGE/FREQUENCY	PRESCRIBED BY (NAME)	REASON FOR MEDICATION	DESCRIBE ANY SIDE EFFECTS

How well does the medication(s) work? Please explain:

11.

a. If you are unable to give us information we need about the child, is there someone else who helps care for the child and, knows of the child's impairment who can help us get the information we need, and, if necessary, bring the child to a consultative examination?

☐ Yes ☐ No

b. If "yes," please provide the following information about this person

Name

Address (Number and Street, City, State and ZIP Code)

Daytime telephone number (including Area Code)

Relationship (*e.g., relative, neighbor, family friend*) to the child?

REMARKS:

REMARKS (continued):

PRIVACY ACT: The information requested on this form is authorized by Section 223 and Section 1632 of the Social Security Act. The information provided will be used in making a decision on your claim. While completion of this form is voluntary, failure to provide all or part of the requested information could prevent an accurate and timely decision on your claim and could result in the loss of benefits. 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 law requiring the exchange of information between Social Security and another agency.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT: This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213. You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.**

DISABILITY REPORT - CHILD - Form SSA-3820-BK
READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM
THIS IS NOT AN APPLICATION

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Fill out as much of this form as you can before your interview appointment.
- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/OTHER/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use Section 10, "DATE AND REMARKS," on Pages 11 and 12, and show the number of the question being answered.

ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records
- Copies of the child's prescriptions or medicine containers
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and medicine containers.

The Privacy and Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security Office.

PAPERWORK REDUCTION ACT: This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

DISABILITY REPORT - CHILD

SECTION 1 -- INFORMATION ABOUT THE CHILD		
A. CHILD'S NAME <i>(First, Middle Initial, Last)</i>	B. CHILD'S SOCIAL SECURITY NUMBER	
C. YOUR NAME <i>(If agency, provide name of agency and contact person)</i>		
YOUR MAILING ADDRESS <i>(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)</i>		
CITY	STATE	ZIP CODE
YOUR EMAIL ADDRESS (Optional)		
D. YOUR DAYTIME PHONE NUMBER <div style="text-align: right; font-size: small; margin-top: 5px;"> <i>(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)</i> </div> <div style="margin-top: 10px;"> <div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="text-align: center;"> <div style="border-bottom: 1px solid black; width: 100px;"></div> <div style="font-size: x-small; margin-top: 2px;">Area Code</div> </div> <div style="text-align: center;"> <div style="border-bottom: 1px solid black; width: 150px;"></div> <div style="font-size: x-small; margin-top: 2px;">Number</div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="checkbox"/> Your Number <input type="checkbox"/> Message Number <input type="checkbox"/> None </div> </div>		

E. What is **your relationship to the child**? _____

F. Can you **speak and understand English**? ☐ YES ☐ NO

If "NO", what is your preferred language? _____

NOTE: If you cannot speak and understand English, we will provide you an interpreter, free of charge.

If you cannot speak and understand English, is there someone we may contact who speaks and understands English and will give you messages?

☐ YES (Enter name, address, phone number, relationship) ☐ NO

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

DAYTIME PHONE

Area Code

Number

Can you **read and understand English**? ☐ YES ☐ NO

G. Does the child live with you? ☐ YES ☐ NO If "NO", with whom does the child live?

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

DAYTIME PHONE

Area Code

Number

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

SECTION 1 - INFORMATION ABOUT THE CHILD

H. Can the child speak and understand English?

☐ YES

☐ NO

If "NO," what languages can the child speak? _____

If the child understands any other languages, list them here: _____

I. What is the child's height (*without shoes*)? _____

What is the child's weight (*without shoes*)? _____

J. Does the child have a **medical assistance** card? (for example Medicaid, Medi-Cal)

☐ YES

☐ NO

If "YES", show the **number** here: _____

SECTION 2 - CONTACT INFORMATION

A. Does the child have a legal guardian or custodian other than you?

☐ YES (*Enter name, address, phone number, relationship*)

☐ NO

NAME _____

ADDRESS _____

(*Number, Street, Apt. No. (if any), P.O. Box, or Rural Route*)

City

State

ZIP

DAYTIME PHONE NUMBER

Area Code

Number

RELATIONSHIP TO CHILD _____

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

B. Is there another adult who helps care for the child and can help us get information about the child if necessary?

☐ YES (*Enter name, address, phone number, relationship*)

☐ NO

NAME OF CONTACT _____

ADDRESS _____

(*Number, Street, Apt. No. (if any), P.O. Box, or Rural Route*)

City

State

ZIP

DAYTIME PHONE NUMBER

Area Code

Number

RELATIONSHIP TO CHILD _____

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

**SECTION 3 - THE CHILD'S ILLNESSES, INJURIES OR
CONDITIONS AND HOW THEY AFFECT HIM/HER**

A. What are the child's disabling **illnesses, injuries, or conditions**?

B. When did the child become disabled?

<i>Month</i>	<i>Day</i>	<i>Year</i>
--------------	------------	-------------

C. Do the child's illnesses, injuries or conditions cause **pain**
or other symptoms?

☐ YES

☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the
illnesses, injuries or conditions?

☐ YES

☐ NO

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or
mental problems?

☐ YES

☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each DOCTOR/HMO/THERAPIST/OTHER**. Include the child's **next appointment**.

1. NAME		DATES
STREET ADDRESS		FIRST VISIT
CITY	STATE ZIP	LAST VISIT
PHONE _____ <small>Area Code Number</small>	Patient ID # (If known)	NEXT APPOINTMENT
REASONS FOR VISITS		
WHAT TREATMENT WAS RECEIVED?		

2. NAME		DATES
STREET ADDRESS		FIRST VISIT
CITY	STATE ZIP	LAST SEEN
PHONE _____ <small>Area Code Number</small>	Patient ID # (If known)	NEXT APPOINTMENT
REASONS FOR VISITS		
WHAT TREATMENT WAS RECEIVED?		

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3.	NAME	DATES
	STREET ADDRESS	FIRST VISIT
	CITY STATE ZIP	LAST VISIT
	PHONE _____ <small>Area Code Number</small>	Patient ID # (If known) NEXT APPOINTMENT
REASONS FOR VISITS		
WHAT TREATMENT WAS RECEIVED?		

If you need more space, use Section 10.

D. List each **HOSPITAL/CLINIC**. Include the child's **next appointment**.

1. HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
NAME <hr/> STREET ADDRESS <hr/> CITY _____ STATE _____ ZIP _____ PHONE _____ <small>Area Code Number</small>	<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT
	<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
	<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	

Next appointment _____ **The child's hospital/clinic number** _____

Reasons for visits

What treatment did the child receive?

What doctors does the child see at this hospital/clinic on a regular basis?

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC	TYPE OF VISIT	DATES		
NAME <hr/> STREET ADDRESS <hr/> CITY <hr/> STATE <hr/> ZIP <hr/> PHONE <hr/> <div style="display: flex; justify-content: space-between; font-size: small;"> Area Code Number </div>	<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT	
		<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
		<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	

Next **appointment** _____ The child's hospital/clinic **number** _____

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

If you need more space, use Section 10.

E. Does anyone else have medical records or information about the child's illnesses, injuries or conditions (Workers' Compensation, insurance companies, counselors, detention centers, attorneys, and/or tutors), or is the child scheduled to see anyone else?

☐ **YES** *(If "YES," complete information below.)*

☐ **NO**

NAME	DATES
ADDRESS	FIRST VISIT
CITY <hr/> STATE <hr/> ZIP <hr/>	LAST SEEN
PHONE <hr/> <div style="display: flex; justify-content: space-between; font-size: small;"> Area Code Number </div>	NEXT APPOINTMENT
CLAIM NUMBER (If any) _____ REASONS FOR VISITS _____ <hr/> <hr/>	

If you need more space, use Section 10.

SECTION 5 - MEDICATIONS

Does the child currently take any **medications** for illnesses, injuries or conditions? ☐ YES
 If "YES", tell us the following: *(Look at the child's medicine containers, if necessary.)* ☐ NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

If you need more space, use Section 10.

SECTION 6 - TESTS

Has the child had, or will he/she have, any **medical tests** for illnesses, injuries or conditions? ☐ YES ☐ NO If "YES", tell us the following (give approximate dates, if necessary).

KIND OF TEST	WHEN WAS/WILL TESTS BE DONE? <i>(Month, day, year)</i>	WHERE DONE <i>(Name of Facility)</i>	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part			
SPEECH/LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part			
MRI/CAT SCAN - Name of body part			

If the child has had other tests, list them in Section 10.

SECTION 7 - ADDITIONAL INFORMATION

A. Has the child been **tested or examined** by any of the following?

Headstart (Title V)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Public or Community Health Department	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Child Welfare or Social Service Agency	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Women, Infant and Children (WIC) Program	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Program for Children with Special Health Care Needs	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Mental Health/Mental Retardation Center	<input type="checkbox"/> YES	<input type="checkbox"/> NO

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work?

☐ YES ☐ NO

If you answered "YES" to any of the above in A. or B., please complete C. below:

C. 1. NAME OF AGENCY _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

PHONE NUMBER _____

Area Code

Number

TYPE OF TEST _____

WHEN DONE _____

TYPE OF TEST _____

WHEN DONE _____

FILE OR RECORD NUMBER _____

2. NAME OF AGENCY _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

PHONE NUMBER _____

Area Code

Number

TYPE OF TEST _____

WHEN DONE _____

TYPE OF TEST _____

WHEN DONE _____

FILE OR RECORD NUMBER _____

If there are any other agencies, show them in Section 10.

SECTION 8 - EDUCATION

A. What is the child's **current grade** in school or the **highest grade** completed?

B. Is the child currently attending school (*other than summer school*)? ☐ YES ☐ NO

If "NO", explain why the child is not attending school.

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL

ADDRESS

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City County State ZIP

PHONE NUMBER

Area Code Number

DATES ATTENDED

TEACHER'S NAME

Has the child been tested for behavioral or learning problems? ☐ YES ☐ NO

If "YES", complete the following:

TYPE OF TEST

WHEN DONE

TYPE OF TEST

WHEN DONE

Is the child in special education? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER

Is the child in speech therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH THERAPIST

SECTION 8 - EDUCATION

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

County

State

ZIP

PHONE NUMBER _____

Area Code

Number

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems?

☐

YES

☐

NO

If "YES", complete the following:

TYPE OF TEST _____

WHEN DONE _____

TYPE OF TEST _____

WHEN DONE _____

Was the child in special education?

☐

YES

☐

NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech therapy?

☐

YES

☐

NO

If "YES", and different from above, give:

NAME OF SPEECH THERAPIST _____

If there are other schools, show them in Section 10.

E. Is the child attending Daycare/Preschool?

☐

YES

☐

NO

If "YES", complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

County

State

ZIP

PHONE NUMBER _____

Area Code

Number

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

SECTION 9 - WORK HISTORY

A. Has the child ever worked (including sheltered

☐ YES ☐ NO

If "YES", complete the following:

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

PHONE NUMBER

Area Code

Number

NAME OF SUPERVISOR _____

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

SECTION 10 - DATE AND REMARKS

Please give the date you filled out this disability report.

Date (MM/DD/YYYY) / /

Use this section for any additional information about your child.

SECTION 10 - REMARKS