Applying for Social Security

www.ssa.gov

SSA Phone Number: (800)772-1213

Applying for Social Security Disability Benefits or SSI

You can apply online at www.SSA.gov

Or you can call your local Social Security office and ask for an appointment to apply directly with them (this takes 30 days or more).

Information you need to apply:

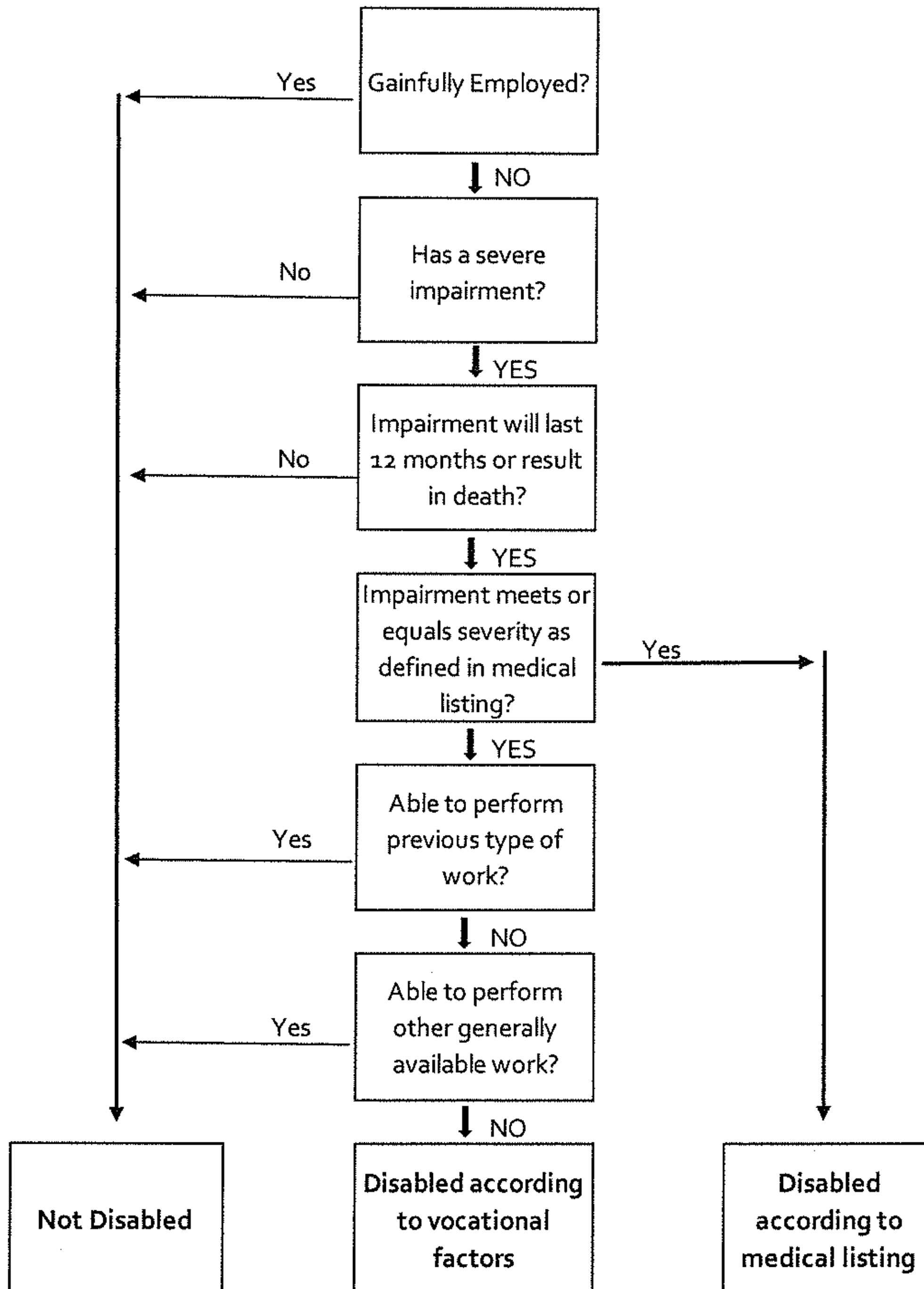
- All your doctors you are treating with including name, address, and what condition(s) they are treating you for.
- Names and dosages of all your prescribed medications.
- Dates of any medical testing you have had and address of where it was done (example MRI, blood test).
- Dates, names, and address of any hospitalizations.
- Dates of marriages, divorces, and date of death of in spouse (if any).
- Information on your spouse's birthday, social security number, and full name.
- Details on your employment for the past 15 years including name and address of employer, start and end date, hours per week you worked at each job, and pay per hour for each job.
- Bank account information if you would like direct deposit.

5 Step Sequential Evaluation

5 Step Sequential Evaluation Process

1	The claimant is not engaging in "substantial gainful activity" (SGA); *and*
2	The claimant has a "severe" impairment; *and*
3	The impairment meets or "equals" one of the impairments described in the Social Security regulations known as the "Listing of Impairments"; *or*
4	Considering the claimant's "residual functional capacity" (RFC), that is, what the claimant can still do even with his or her impairments, the claimant is unable to do "past relevant work" (PRW); *and*
5	Other work within the claimant's RFC, considering age, education and work experience, does not exist in the national economy in significant numbers.

Disability Decision and Sequential Evaluation Process



Application Forms

RSDI

(Retirement Survivors and Disability Insurance)

SSI

(Supplemental Security Insurance)

DISABILITY REPORT

SOCIAL SECURITY ADMINISTRATION ☐ TEL

Form Approved
OMS No. 0960-0444

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)
(Deferred or Abbreviated)

Do Not Write in This Space

☐ DEFERRED ☐ ABAP

☐ SNAP-SSA/APP ☐ SNAP-REFERRED

Filing Date (Month, Day, Year)

☐ Receipt ☐ Protective

Preferred Language:

Written:

Spoken:

I am/We are applying for Supplemental Security Income and any federally administered state supplementation under Title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under Title XIX of the Social Security Act.

TYPE OF CLAIM ☐ Individual ☐ Individual with Ineligible Spouse ☐ Couple ☐ Child ☐ Child with Parents

PART 1- BASIC ELIGIBILITY - Answer the questions below beginning with the first moment of the filing date month.

1.	First Name, Middle Initial, Last Name	2. Sex ☐ Male ☐ Female	3. Birthdate (month, day, year)	4. Social Security Number
5.	Spouse's/Parent(s) Name(s)	6. Sex ☐ Male	7. Birthdate (month, day, year)	8. Social Security Number(s)
		☐ Female		
	Date of Marriage: (month, day, year)			
	Are you and your spouse living together? ☐ Yes ☐ No If no, date you began living apart:			
9.	Other Name(s) and Social Security Number(s) you, your spouse/parents used:			
	(a) Your Other Name(s) (including Maiden Name)	Your Other Social Security Number(s)		
	(b) Spouse's/Mother's Other Name(s) (including Maiden Name)	Spouse's/Mother's Other Social Security Number(s)		
	(c) Father's Other Name(s)	Father's Other Social Security Number(s)		

10. Your Place of Birth (City and State or Foreign Country)

11. Spouse's Place of Birth (City and State or Foreign Country)

12. If you are filing for yourself, go to (a); if you are filing for a child, go to (e).

	You		Your Spouse, if filing	
(a) Are you unable to work because of illnesses, injuries, or conditions?	☐ YES Go to (b)	☐ No Go to #13	☐ YES Go to (b)	☐ No Go to #13
(b) Enter the date you became unable to work.	(month, day, year) Go to (c)		(month, day, year) Go to (c)	
(c) What are your illnesses, injuries, or conditions?	(Brief Description) Go to (d)		(Brief Description) Go to (d)	
(d) If you were unable to work because of illnesses, injuries, or conditions before age 22, do you have a parent who is age 62 or older, unable to work because of illnesses, injuries, or conditions or deceased?	☐ YES Provide name(s) and Social Security Number(s) in Remarks. Go to #13		☐ NO Go to #13	

(e) When did the child become disabled? (month, day year)

Go to (f)

(f) What are the child's disabling illnesses, injuries, or conditions?

Go to (g)

(g) Does the child have a parent or stepparent who is 62 or older, unable to work because of illnesses, injuries, or conditions, or deceased?	☐ YES Provide name(s) and Social Security Number(s) in Remarks. Go to #13	☐ NO Go to #13

13. If you (and your spouse filing for benefits) were a United States citizen at birth, go to #'17; otherwise go to (a).

	You		Your Spouse, if filing	
(a) Are you a naturalized United States citizen?	☐ YES Go to #17	☐ No Goto(b)	☐ YES Go to #17	☐ NO Go to (b)
(b) Are you an American Indian born outside the United States?	☐ YES Go to (c)	☐ No Go to (d)	☐ YES Go to (c)	☐ No Go to (d)

(c) Check the block that shows your American Indian status.

You	Your Spouse, if filing
☐ American Indian born in Canada Goto#17	☐ American Indian born in Canada Goto#17
☐ Member of a Federally recognized Indian Tribe; Name of Tribe: Go to #17	☐ Member of a Federally recognized Indian Tribe; Name of Tribe: Go to #17
☐ Other American Indian Explain in Remarks, then Go to (d)	☐ Other American Indian Explain in Remarks, then Go to (d)

13\. (d) Check the block below that shows your current immigration status.

You	Your Spouse, if filing
☐ **Amerasian Immigrant** Go to #14	☐ **Amerasian Immigrant** Go to #14
☐ **Lawful Permanent Resident** Go to #14	☐ **Lawful Permanent Resident** Go to #14
☐ **Refugee** Date:t of entry (month, day, year): Go to #16	☐ **Refugee** Date of entry (month, day, year): Go to #16
☐ **Asylee** Date status granted (month, day, year): Goto#16	☐ **Asylee** Date status granted (month, day, year): Goto#16
☐ **Conditional Entrant** Date status granted (month, day, year): Goto#16	☐ **Conditional Entrant** Date status granted (month, day, year): Go to #16
☐ **Parolee for One Year** Go to #16	☐ **Parolee for One Year** Go to #16
☐ **Cuban/Haitian** Entrant Go to #16	☐ **Cuban/Haitian Entrant** Go to #16
☐ Deportation/Removal Withheld Date (month, day, year): Goto#16	☐ **Deportation/Removal Withheld** Date (month, day, year): Go to #16
☐ **Other** Explain in Remarks, then Go to (e)	☐ **Other** Explain in Remarks, then Go to (e)

(e) If you have status, or have applied for status, as the spouse, child, or parent of a child of a United States citizen, or a lawfully admitted permanent resident, Go to #"15; otherwise Go to #17.

14\.

(a) Date of admission:	You (month, day, year)	Your Spouse, if filing (month, day, year)

(b) Was your entry into the United States sponsored by any person or promoted by an institution or group?	☐ YES Go to (c)	☐ NO Go to (d)	☐ YES Go to (c)	☐ No Go to (d)

(c) Give the following information about the person, institution or group:

Name	Address	Telephone Number

(d) What was your immigration status, if any, before adjustment to lawful permanent resident?	You (month, day, year)	Your Spouse, if filing (month, day, year)
	From: ____________	From: ____________
	To: ____________	To: ____________

(e) If filing as an adult, did your parents ever work in the United States before you were 18?	☐ YES Go to (f)	☐ No Go to #16	☐ YES Go to (f)	☐ No Goto#16

(f) Name and Social Security Number of parent(s) who worked.

Name	Social Security Number
Name	Social Security Number

		You		Your Spouse, iffiling	
15.	(a) Have you, your child, or your parent, been subjected to battery or extreme cruelty while in the United States?	☐YES Goto(b)	☐No Go to #17	☐YES Goto(b)	☐No Go to #17
	(b) Have you, your child, or your parent filed a petition with the Department of Homeland Security for a change in immigration status because of being subjected to battery or extreme cruelty?	☐YES Go to #16	☐No Go to #17	☐YES Go to #16	☐No Go to #17
16.	Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	☐ YES Explain in Remarks, then Go to #17 ☐ NO Go to #17		☐ YES Explain in Remarks, then Go to #17 ☐ NO Go to #17	
17.	(a) When did you first make your home in the United States?	(month, day, year)		(month, day, year)	
	(b) Have you lived outside of the United States since then?	☐YES Go to (c)	☐No Go to #18	☐YES Go to (c)	☐No Go to #18
	(c) Give the date(s) of residence outside the United States.	(month, day, year) Date Left:		(month, day, year) Date Left:	
		(month, day, year) Date Returned:		(month, day, year) Date Returned:	
18.	(a) Have you been outside the United States (the 50 States, District of Columbia and Northern Mariana Islands) 30 days prior to the filing date?	☐YES Goto(b)	☐No Go to #19	☐YES Goto(b)	☐No Go to #19
	(b) Give the date (month, day, year) you left the United States and the date you returned to the United States.	(month, day, year) Date Left:		(month, day, year) Date Left:	
		(month, day, year) Date Returned:		(month, day, year) Date Returned:	

19. Claimant's Mailing Address (Number & Street, Apt. No., P.O. Box, or Rural Route)
651 Bensley Ave

City and State	ZIP Code	Name of County (if any) in which you live	Telephone Number
Calumet City, IL	60409-3823		(773)971-7458

20. **If you are blind or visually impaired, check the type of mail you want to receive from us**

☐ Standard notice First-Class ☐ Standard notice First-Class with a follow-up phone call

☐ Standard notice & data CD by First-Class ☐ Standard notice Certified

☐ Standard & Braille notices by First-Class ☐ Standard & large print notices ☐ Standard notice & audio CO

		You		Your Spouse, iffiling	
21.	(a) Do you have any unsatisfied felony warrants for your arrest?	☐YES Goto(b)	☐No Go to #22	☐YES Goto(b)	☐No Go to #22
	(b) In which State or country was the warrant issued?	Name of State/Country Go to (c)		Name of State/Country Go to (c)	
	(c) Was the warrant satisfied?	☐YES Go to (d)	☐No Go to #22	☐YES Go to (d)	☐No Go to #22
	(d) Date warrant satisfied:	(month, day, year)		(month, day, year)	

22.		You		Your Spouse, if filing	
	(a) Do you have any unsatisfied Federal or state warrants for violating the conditions of probation or parole?	☐YES Go to (b)	☐NO Go to #23	☐YES Go to (b)	☐NO Go to #23
	(b) In which State or country was the warrant issued?	Name of State/Country Go to (c)		Name of State/Country Go to (c)	
	(c) Was the warrant satisfied?	☐YES Go to (d)	☐NO Go to #23	☐YES Go to (d)	☐NO Go to #23
	(d) Date warrant satisfied:	(month, day, year)		(month, day, year)	

PART 2- LIVING ARRANGEMENT (Use "Remarks" to explain any change between the first moment of the filing date month and today.)

23. Claimant's Residence Address
651 Bensley Ave

City and State	ZIP Code	Name of County (if any) in which you live
Calumet City,IL	60409-3823	

24. (a) Mark the box that describes where you live.

☐ House, apartment, mobile home, houseboat

☐ Noninstitution (rest home, retirement home, foster home, or group home)

☐ Room in commercial establishment

☐ Institution (hospital, rehabilitation center, prison, or school)

☐ Room in private home

☐ Transient or homeless

(b) Date you began living there: (month, day, year)

25. Mark the box that describes with whom you live. If you live in a foster home, group home, or an institution, or if you are a transient or homeless, do not answer but explain in remarks.

☐ Alone ☐ Spouse/Parents and/or Children ☐ Other People

PART 3 - RESOURCES (Show resources as of the first moment of the filing date month. Use "Remarks" to explain any changes.)

26. If you own, or your name or your spouse's/parent's name(s) appear on any of the following items (either alone or with other people's name(s)), enter the total cash value of item(s) on each line.

	YES	NO	Description of Items Marked YES	Co-owned With Others Yes	Co-owned With Others No	Dollar Value You Own	Dollar Value Spouse or Parents Own
a. Vehicles (cars, trucks, boats, motorcycles). How many?						$	$
b. Insurance policies						$	$
c. Cash at home, with you, or anywhere else						$	$

26.	YES	NO	Description of Items Marked YES	Co-owned With Others Yes	No	Dollar Value You Own	Dollar Value Spouse or Parents Own
d. Savings, checking accounts, stocks, bonds						$	$
e. Trust(s)						$	$
f. Property other than the home you live in						$	$
g. Life estates or property you inherited						$	$
h. Other items that can be turned into cash						$	$

27. Are there any assets set aside to meet burial expenses for you or your spouse/parent(s)? (If "Yes" describe the item in "Remarks".)		
Your Answer	☐YES	☐NO
Spouse's Answer	☐YES	☐NO
Mother's Answer	☐YES	☐NO
Father's Answer	☐YES	☐NO

28.	You	Your Spouse
(a) Have you or your spouse sold, transferred title, disposed of or given away, any money or other property, including money or property in foreign countries, since the first moment of the filing date month or within the 36 months prior to the filing date month?	☐YES ☐NO	☐YES ☐NO
(b) If you co-owned any money or property with another person(s), did you or any co-owner sell, transfer, or give away any co-owned money or property within the 36 months prior to the filing date month?	☐YES ☐NO	☐YES ☐NO

IF YOU ANSWERED "YES" TO (a) OR (b), GO TO (c). IF "NO" TO BOTH, GO TO #29.

(c)	OWNER'S/CO-OWNER'S NAME	DESCRIPTION Of PROPERTY	DATE OF DISPOSAL
Item#1			
Item #2			
Item #3			

	NAME AND ADDRESS OF PURCHASER OR RECIPIENT	RELATIONSHIP TO OWNER	VALUE OF PROPERTY AND/ OR AMOUNT OF CASH GIFT
Item #1			$
Item #2			$
Item #3			$

28.

	SALE PRICE OR OTHER CONSIDERATION	ARE OTHER CONSIDERATIONS OR PROCEEDS EXPECTED? EXPLAIN	DO YOU STILL OWN PART OF THE PROPERTY?
Item #'l			☐YES ☐NO
Item #2			☐YES ☐NO
Item #3			☐YES ☐NO

	SOLD ON OPEN MARKET?	GIVEN AWAY?	TRADED FOR GOODS/ SERVICES?
Item #1	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
Item #2	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
Item #3	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO

29.	You	Your Spouse, if filing
Do you give us permission to obtain any financial records from any financial institution?	☐YES ☐NO	☐YES ☐NO

PART 4 - INCOME (List all income received since the first moment of the filing date month or expected in the next 3 months.) Include you, your spouse/parents.

30. List cash, checks, and direct payment to bank accounts you (your spouse/parents) received or expect to receive. Include income from wages, sick pay, self-employment, interest, social security, assistance based on need, VA, gifts, pensions, and any other type of income. Give date last paid if income will stop in the next 3 months.

Person Receiving Income	Type of Income	Amount	Frequency Received	Date Last Paid	Source of Income
		$			
		$			
		$			

Also, note here if anyone pays any bills for you directly or gives you money to pay them.

31.

(a) Does your spouse/parent pay court ordered child support?	☐YES Goto(b)	☐No Go to #32

(b) Give the amount and frequency of payment:

$

PART 5 - SUPPLEMENT NUTRITION ASSISTANCE PROGRAM (SNAP)

32.	You		Your Spouse, if filing	
(a) Are you currently receiving SNAP benefits (formerly food stamps?	☐YES Go to (b)	☐No Go to (c)	☐YES Goto(b)	☐No Go to (c)
(b) Have you received a recertification notice within the past 30 days?	☐YES Go to (e)	☐No Go to #33	☐YES Go to (e)	☐No Go to #33
(c) Have you filed for SNAP benefits in the last 60 days?	☐YES Go to (d)	☐No Go to (e)	☐YES Go to (d)	☐No Go to (e)

32.		You		Your Spouse, if filing	
	(d) Have you received a favorable decision?	☐YES Go to #33	☐No Go to (e)	☐YES Go to #33	☐No Go to (e)
	(e) May I take your SNAP application today?	☐YES Go to #33	☐No Explain in (f)	☐YES Go to #33	☐No Explain in (f)
	(f) Explanation:				

PART 6 – MISCELLANEOUS

ANSWER #33 ONLY IF YOU ARE REQUESTING BENEFITS ON BEHALF OF SOMEONE ELSE; OTHERWISE GO T0#34.

33.	Name of Person Requesting Benefits	Relationship to Claimant	Your Social Security Number

PART 7 – REMARKS – (You may use this space for any explanations. Enter the item number before each explanation. If you need more space, use a signed form SSA-795.)

PART 8 – IMPORTANT INFORMATION – PLEASE READ CAREFULLY

34. The Social Security Administration will check your statements and compare its records with records from other state and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount. We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you or your spouse notify us in writing that you are cancelling your permission, (2) your application for SSI is denied in a final decision, (3) your eligibility for SSI terminates, or (4) we no longer consider your spouse's income and resources to be available to you. If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

PART 9 - SIGNATURES

35. 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. I understand that anyone who knowingly gives false information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

36. Your Signature (First name, middle initial, last name) (Write in ink.) | Date (Month, day, year)

37. Spouse's Signature (First name, middle initial, last name) (Write in ink.) (Sign only if applying for payments.)

WITNESSES

38. Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing, who know you, must sign below giving their full address.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and ZIP Code)	Address (Number and Street, City, State, and ZIP Code)

Financial Permission Statement

To be eligible for SSI benefits, you must provide us with permission to access your financial institution information. We are asking for your permission in order to help us determine whether you are eligible for SSI benefits.

- Read the two statements below and select one of them by marking it with a check mark
- Sign and date this letter and return it along with your SSI application

__X__ I give SSA permission to contact any financial institutions and request my financial records.

____ I do not give SSA permission to contact any financial institutions and request my financial records. I understand that refusing to give this permission will cause me to be ineligible for SSI benefits

Signature: ______________________________
Full Name: ______________________________
SSN: __________________________________
Date: ________________

What it Means to Give Permission to Contact Financial Institutions

We have asked you for permission to obtain, from any financial institution, any financial records about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs.

- You notify us in writing that you are canceling your permission,
- Your application for SSI is denied in a final decision, or
- Your eligibility for SSI terminates

If you do not give or cancel your permission you will not be eligible for SSI and we will deny your claim or stop your payments

SOCIAL SECURITY ADMINISTRATION ☐ TEL TOE 120/145 Form Approved OMB No. 0960-0618

(Do not write in this space)

APPLICATION FOR DISABILITY INSURANCE BENEFITS

I apply for a period of disability and/or all insurance benefits for which I am eligible under Title II and Part A of Title XVIII of the Social Security Act, as presently amended.

1.	**PRINT your name**	FIRST NAME, MIDDLE INITIAL, LAST NAME
2.	Enter your Social Security Number	
3.	Check (X) whether you are	☐ Female ☐ Male

Answer question 4 if English is not your preferred language. Otherwise, go to item 6.

4.	Enter the language you prefer to: Speak ________	Write ________
5.	(a) Enter your date of birth	MONTH, DAY, YEAR 12/5/1964
	(b) Enter name of city and state or foreign country where you were born.	
	(c) Was a public record of your birth made before you were age 5?	☐ Yes ☐ No ☐ Unknown
	(d) Was a religious record of your birth made before you were age 5?	☐ Yes ☐ No ☐ Unknown
6.	(a) Are you a U.S. citizen?	☐ Yes Go to item 7 ☐ No Go to item (b)
	(b) Are you an alien lawfully present in the U.S.?	☐ Yes Go to item (c) ☐ No Go to item 7
	(c) When were you lawfully admitted to the U.S.?	
7.	(a) Enter your name at birth if different from item (1)	
	(b) Have you used any other names?	☐ Yes Go to (c) ☐ No Go to item 8
	(c) Other name(s) used.	
8.	(a) Have you used any other Social Security number(s)?	☐ Yes Go to (b) ☐ No Go to item 9
	(b) Enter Social Security number(s) used.	
9.	When do you believe your conditions(s) became severe enough to keep you from working (even if you have never worked)?	
	(a) Have you (or has someone on your behalf) ever filed an application for Social Security Benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare?	☐ Yes ☐ No ☐ Unknown (If "Yes", answer (b) and (c)) (If "No", or "Unknown", go to item 11)
	(b) Enter name or person on whose Social Security record you filed the other application:	
	(c) Enter Social Security Number of person named in (b). *If unknown, check this block.* ☐	

11.	(a) Were you in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939 and before 1968?	☐ Yes (If "Yes", answer (b) and (c)) ☐ No (If "No", go to item 12)
	(b) Enter dates of service	FROM: (Month, Year) | TO: (Month, Year)
	(c) Have you *ever* been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (Include Veterans Administration benefits *only* if you waived military retirement pay.)	☐ Yes ☐ No
12.	Did you or your spouse (or prior spouse) worked in the railroad industry for 5 years or more?	☐ Yes ☐ No
13.	(a) Do you have Social Security credits (for example, based on work or residence) under another country's Social Security System?	☐ Yes (If "Yes", answer (b)) ☐ No (If "No", go to item 14)
	(b) List the country(ies):	
14.	(a) Are you entitled to, or do you expect to be entitled to, a pension or annuity (or a lump sum in place of a pension or annuity) based on your work after 1956 not covered by Social Security?	☐ Yes (If "Yes," answer (b) (and (c)) ☐ No (If "No," go on to item 12)
	(b) ☐ I became entitled, or expect to become entitled, beginning	MONTH | YEAR
	(c) ☐ I became eligible, or expect to become eligible, beginning	MONTH | YEAR

I AGREE TO PROMPTLY NOTIFY the Social Security Administration if I become entitled to a pension or annuity based on my employment after 1956 not covered by Social Security, or if such pension or annuity stops.

15\. (a) Have you ever been married? ☐ Yes Go to (b) ☐ No Go to item 16

(b) Give the following information about your current marriage. If not currently married, write "None". ________ Go on to item 15 (c)

Spouse's name (including maiden name)	When (Month, day, year)	Where (Name of City and State)
Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in Remarks)	Spouse's date of birth (or age)	Spouse's Social Security Number (if none or unknown, so indicate)

(c) Enter information about any other marriage if you:

- Had a marriage that lasted 10 years; or
- Had a marriage that ended due to the death of your spouse, regardless of duration; or
- Were divorced, remarried the same individual within the year immediately following the year of the divorce, and the combined period of marriage totaled 10 years or more. If none, write "None". ________ Go on to item 15 (d) if you have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22) and you are divorced from the child's other parent who is now deceased and the marriage lasted less than 10 years.

Spouse's name (including maiden name)		When (Month, day, year)	Where (Name of City and State)
How marriage ended		When (Month, day, year)	Where (Name of City and State)
Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in Remarks)	Spouse's date of birth (or age)	Date of spouse's death	Spouse's Social Security Number (If none or unknown, so indicate)

(d) Enter information about any other marriage if you:

- Have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22) and;
- Were married for less than 10 years to the child's mother or father, who is now deceased; and
- The marriage ended in divorce

If none, write "None." ________

Spouse's name (including maiden name)		When (Month, day, year)	Where (Name of City and State)
Date of Divorce (Month,day, year)		Where (Name of City and State)	
Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in Remarks)	Spouse's date of birth (or age)	Date of spouse's death	Spouse's Social Security Number (If none or unknown, so indicate)

Use the "REMARKS" space on page 5 for marriage continuation or explanation

16\. If your claim for disability benefits is approved, your children (including adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) may be eligible for benefits based on your earnings record.

List below: FULL NAME OF ALL such children who are now or were in the past 12 months UNMARRIED and:

- UNDER AGE 18
- AGE 18 TO 19 AND ATTENDING ELEMENTARY OR SECONDARY SCHOOL FULL-TIME
- DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)

17\. (a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year?

☐ Yes (If "Yes", go to item 18) ☐ No (If "No", answer (b))

(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.

18\. Enter below the names and addresses of all the persons, companies, or Government agencies for whom you have worked this year and last year. IF NONE, WRITE "NONE" BELOW AND GO ON TO ITEM 19.

NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer)	Work Began		Work Ended (If still working show "Not Ended")	
	MONTH	YEAR	MONTH	YEAR

(If you need more space, use "Remarks".)

19\. May the Social Security Administration or the State agency reviewing your case ask your employers for information needed to process the claim? ☐ Yes ☐ No

20\. Complete item 20 even if you were an employee.

(a) Were you self-employed this year or last year? ☐ Yes Go to (b) ☐ No Go to item 21

(b) Check the year (or years) you were self-employed	In what kind of trade or business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from your trade or business $400 or more? (Check "Yes" or "No")
☐ This year		
☐ Last year		☐ Yes ☐ No

21\. (a) How much were your total earnings last year? (Count both wages and self-employment income. If none, write "None".) Amount $

(b) How much have you earned so far this year? (If none, write "None".) Amount $

22.	(a) Are you still unable to work because of your illnesses, injuries, or conditions?	☐ Yes ☐ No (If "Yes", go to item 23) (If "No", answer (b))
	(b) Enter the date you became able to work.	MONTH, DAY, YEAR
23.	Are your illnesses, injuries, or conditions related to your work in any way?	☐ Yes ☐ No
24.	(a) Have you filed, or do you intend to file, for any other public disabilty Benefits (including workers' compensation, Black Lung benefits and SSI)?	☐ Yes Go to (b) ☐ No Go to item 25
	(b) The other public disability benefit(s) you have filed for (or intend to file) for is (Check as many as apply): ☐ Veterans Administration Benefits ☐ Welfare ☐ Supplemental Security Income (SSI) ☐ Other (if "Other", complete a Workers' Compensation/Public Disability Benefit Questionnaire)	
25.	(a) Did you receive any money from an employer(s) on or after the date in item 9 when you became unable to work because of your illnesses, injuries, or conditions? (If "Yes", give the amounts and explain in "Remarks".)	☐ Yes ☐ No Amount $
	(b) Do you expect to receive any additional money from an employer such as sick pay, vacation pay, other special pay? (If "Yes", please give amounts and explain in "Remarks".)	☐ Yes ☐ No Amount $
26.	Do you, or did you, have a child under age 3 (your own or your spouse's) living with you in one or more calendar years when you had no earnings?	☐ Yes ☐ No
27.	Do you have a dependent parent who was receiving at least one-half support from you when you became unable to work because of your disability? If "Yes", enter the parent's name and address and social security number, if known, in "Remarks".	☐ Yes ☐ No
28.	If you were unable to work before age 22 because of an illness, injury or condition, do you have a parent (including adoptive or stepparent) or grandparent who is receiving social security retirement or disability benefits or who is decesased? If yes, enter the name(s) and social security number, if known, in "Remarks" (if unknown, write "Unknown.")	☐ Yes ☐ No

REMARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

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

SIGNATURE OF APPLICANT	Date (Month, day, year)
Signature (First name, middle initial, last name((Write in ink)	Telephone Number(s) at which you may be contacted during the day. (Include the area code)

DIRECT DEPOSIT PAYMENT INFORMATION (FINANCIAL INSTITUTION)

Routing Transit Number	Account Number	☐ Checking ☐ Saving	☐ Enroll in Direct Express ☐ Direct Deposit Refused

Applicant's Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks", if different.)*

City and State	ZIP Code	County *(if any)* in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in Signature block.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State and ZIP Code)*	Address *(Number and street, City, State and ZIP Code)*

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT	**For SSA Use Only – Do not write in this box.** **Related SSN** ________ **Number Holder** ________

If you are filling out the report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 – INFORMATION ABOUT THE DISABLED PERSON

1. A. Name (First, Middle Initial, Last)	**1. B.** Social Security Number

1. C. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (if not USA)

1. D. Email Address

1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada.

Phone number ________

☐ Check this box if you do not have a phone or a number where we can leave a message.

1.F. Alternate Phone Number – another number where we may reach you, if any.

Alternate phone number ________

1.G. Can you speak and understand English? ☐ Yes ☐ No

If no, what language do you prefer? ________

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

1.H. Can you read and understand English? ☐ Yes ☐ No

1.I. Can you write more than your name in English? ☐ Yes ☐ No

1.J. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname. ☐ Yes ☐ No

If yes, please list them here:

SECTION 2 – CONTACTS

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

2.A. Name (First, Middle Initial, Last)	**2.B.** Relationship to you

2.C. Daytime Phone Number (as described in 1.E. above)

2.D. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (if not USA)

2.E. Can this person speak and understand English? ☐ Yes ☐ No

If no, what language is preferred? ________

SECTION 2 – CONTACTS (continued)

2.F. Who is completing this report?

- ☐ The person who is applying for disability (Go to Section 3 – Medical Conditions)
- ☐ The person listed in 2.A. (Go to Section 3 – Medical Conditions)
- ☐ Someone else (Complete the rest of Section 2 below)

2.G. Name (First, Middle Initial, Last)

2.H. Relationship to Person Applying

2.I. Daytime Phone Number

2.J. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.

City | State/Province | ZIP/Postal Code | Country (if not USA)

SECTION 3 – MEDICAL CONDITIONS

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1.
2.
3.
4.
5.

If you need more space, go to Section 11 - Remarks on the last page.

3.B. What is your height without shoes? ______ feet ______ inches OR ______ centimeters (if outside USA)

3.C. What is your weight without shoes? ______ pounds OR ______ KILOGRAMS (IF OUTSIDE THE USA)

3.D. Do your conditions cause you pain or other symptoms? ☐ Yes ☐ No

SECTION 4 – WORK ACTIVITY

4.A. Are you currently working?

- ☐ No, I have never worked (Go to question **4.B.** below)
- ☐ No, I have stopped working (Go to question **4.C.** below)
- ☐ Yes, I am currently working (Go to question **4.F.** on page 3)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked? (month/day/year) ____________ (Go to Section 5 on Page 3)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year) ____________

Why did you stop working?

- ☐ Because of my condition(s).
- ☐ Because of other reasons. Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed)

____

____

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

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours or rate of pay)

- ☐ No (Go to Section 5 – Education and Training on page 3)
- ☐ Yes When did you make changes? (month/day/year) ____________

SECTION 4 – WORK HISTORY (continued)

4.E. Since the date in 4.D. above, have you had gross earnings greater than $1010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No (Go to Section 5) ☐ Yes (Go to Section 5)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

☐ No When did your condition(s) first start bothering you? (month/day/year) ________

☐ Yes When did you make changes? (month/day/year) ________

4.G. Since your condition(s) first bothered you, have you had gross earnings greater than $1010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for further information.)

☐ NO ☐ YES

SECTION 5 – EDUCATION AND TRAINING

5.A. Check the highest grade of school completed.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Date completed: ________

5.B. Did you attend special education classes? ☐ Yes ☐ No (Go to 5.C.)

Name of school ________

City ________ State/Province ________ Country (if not USA) ________

Dates attended special education classes: from ________ to ________

5.C. Have you completed any type of specialized job training, trade, or vocational school? ☐ Yes ☐ No

If "Yes", what type? ________ Date completed ________

If you need to list or education or training use Section 11 – Remarks on the last page.

SECTION 6 – JOB HISTORY

6.A. List the jobs (up to 5) that you have had in the last 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

☐ Check here and go to Section 7 on page 5 if you did not work at all in the last 15 years before you became unable to work.

	Job Title	Type of Business	Dates Worked		Hours Per Day	Days Per Week	Rate of Pay	
			From MM/YY	To MM/YY			Amount	Frequency
1.							$	
2.							$	
3.							$	
4.							$	
5.							$	

SECTION 6 – JOB HISTORY (continued)

Check the box that applies to you.

☐ I had **only one job** in the last 15 years before I became unable to work. Answer the questions below.

☐ I had **more than one job** in the last 15 years before I became unable to work. Do **not** answer the questions on this page; go to Section 7 on page 5. (We may contact you for more information.)

Do not complete this page if you had **more than one job** in the last 15 years before you became unable to work.

6.B. Describe this job. What did you do all day? ______________________

____

____

(If you need more space, use Section 11 – Remarks on the last page.)

6.C. In this job, did you:

Use machines, tools, equipment? ☐ Yes ☐ No

Use technical knowledge or skills? ☐ Yes ☐ No

Do any writing, complete reports, or perform any duties like this? ☐ Yes ☐ No

6.D. In this job, how many total hours each day did you do each of the tasks listed:

Task	Hours	Task	Hours	Task	Hours
Walk		Stoop *(Bend down & forward at the waist.)*		Handle large objects	
Stand		Kneel *(Bend legs to rest on knees.)*		Write, type or handle small objects	
Sit		Crouch *(Bend legs & back down & forward.)*		Reach	
Climb		Crawl *(Move on hands & knees.)*			

6.E. Lifting and carrying *(Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job):* ______________________

____

____

____

6.F. Check the **heaviest** weight lifted:
☐ Less than 10 lbs. ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other ______

6.G. Check the **frequently** lifted: *(by frequently, we mean from 1/3 to 2/3 of the workday.)*
☐ Less than 10 lbs. ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other ______

6.H. Did you supervise other people in this job? ☐ Yes (Complete items below.) ☐ No (if No, go to **6.I.**)

How many people did you supervise? ______

What part of your time did you spend supervising people? ______

Did you hire and fire employees? ☐ Yes ☐ No

6.I. Were you a lead worker? ☐ Yes ☐ No

SECTION 7 – MEDICINES

7. Are you taking any medicines (prescription or non-prescription)?

☐ Yes (Give the information requested below. You may need to look at your medicine containers.)
☐ No (Go to Section 8 – Medical Treatment)

Name of Medicine	If prescribed, give name of doctor	Reason for medicine

If you need to list other medicines use Section 11 – Remarks on the last page.

SECTION 8 – MEDICAL TREATMENT

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled**?

8.A. For any **physical** condition(s)?

☐ YES ☐ NO

8.B. For any **mental** condition(s) (**including emotional or learning problems**)?

☐ YES ☐ NO

If you answered "No" to both 8.A. and 8.B., go to Section 9 – Other Medical Information on page 11.

SECTION 8 – MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first
First Visit ______	A. ______	A. Date in ______ Date out ______
Last Visit ______	B. ______	B. Date in ______ Date out ______
Next scheduled appointment (if any) ______	C. ______	C. Date in ______ Date out ______

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 – Remarks on the Last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) ______		☐ X-Ray (list body part) ______	
☐ Hearing Test		☐ MRI/CT Scan (list body part) ______	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) ______	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 – MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.D. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits

First Visit ____________

Last Visit ____________

Next scheduled appointment (if any)

____

2. Emergency Room visits
List the most recent date first

A. ____________

B. ____________

C. ____________

3. Overnight hospital stays
List the most recent date first

A. Date in ________ Date out ________

B. Date in ________ Date out ________

C. Date in ________ Date out ________

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 – Remarks on the last page.

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☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) ____________		☐ X-Ray (list body part) ____________	
☐ Hearing Test		☐ MRI/CT Scan (list body part) ____________	
☐ Speech/Language Test		☐ Other (please describe) ____________	
☐ Vision Test			
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 – MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.E. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first
First Visit ______	A. ______	A. Date in ______ Date out ______
Last Visit ______	B. ______	B. Date in ______ Date out ______
Next scheduled appointment (if any) ______	C. ______	C. Date in ______ Date out ______

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 – Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	**Kind of Test**	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) ______		☐ X-Ray (list body part) ______	
☐ Hearing Test		☐ MRI/CT Scan (list body part) ______	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) ______	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 – MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.F. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first
First Visit ________	A. ________	A. Date in ______ Date out ______
Last Visit ________	B. ________	B. Date in ______ Date out ______
Next scheduled appointment (if any) ________	C. ________	C. Date in ______ Date out ______

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 – Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	**Kind of Test**	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) ________		☐ X-Ray (list body part) ________	
☐ Hearing Test		☐ MRI/CT Scan (list body part) ________	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) ________	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 – MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.G. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first
First Visit ______	A. ______	A. Date in ______ Date out ______
Last Visit ______	B. ______	B. Date in ______ Date out ______
Next scheduled appointment (if any) ______	C. ______	C. Date in ______ Date out ______

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 – Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	**Kind of Test**	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) ______		☐ X-Ray (list body part) ______	
☐ Hearing Test		☐ MRI/CT Scan (list body part) ______	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) ______	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 9 – OTHER MEDICAL INFORMATION

9. Does **anyone else** have medical information about your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

☐ YES (Please complete information below.)

☐ NO (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 – Vocational Rehabilitation; if not, go to Section 11 on the last page.)

Name of Organization			Phone Number
Mailing Address			
City	State/Province	ZIP/Postal Code	Country (if not USA)
Name of Contact Person		Claim or ID Number (if any)	
Date of First Contact	Date of Last Contact		Date of Next Contact (if any)
Reason for Contacts			

If you need to list other people or organizations use Section 11 – Remarks on the last page and give the same detailed information as above for each one you list.

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.
SECTION 10 – VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

10.A. Have you participated, or are you participating in:

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

☐ YES (Complete the following information) ☐ NO (Go to Section 11)

10.B. Name of Organization or School			
Name of Counselor, Instructor, or Job Coach			Phone Number
Mailing Address			
City	State/Province	ZIP/Postal Code	Country (if not USA)

10.C. When did you start participating in the plan or program? ______________________

SECTION 10 – VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES (continued)

10.D. Are you still participating in the plan or program?

- ☐ Yes. I am scheduled to complete the plan or program on: ____________________
- ☐ No. I completed the plan or program on: ____________________
- ☐ No. I stopped participating in the plan or program before completing it because:

____

____

10.E. List the types of services, tests, or evaluations that you received (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluations, or classes).

____

____

If you need to list another plan or program use Section 11 – Remarks and give the same detailed information as above.

SECTION 11 - REMARKS

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us additional information requested in those sections. Be sure to show the section to which you are referring.

Date Report Completed	____/____/____ month, day, year

Medical Source Statements

Social Security
Connective Tissue Disorder Medical Source Statement

Patient Name:

Social Security No.:

Relevant Dates:

Provider Name:

1. **Diagnosis** of the condition(s) for which you have treated the above patient:
   ____
   ____
   ____
   ____

2. When did you begin treating this patient? ______________________

3. When was the patient last seen? ______________________

4. Prognosis: ______________________

   Describe type of treatment offered and response. ______________________
   ____
   ____

5. Does the patient have any of the following associated with his/her connective tissue disorder?

   _____ Hypermobility of joints
   _____ Fatigue
   _____ Scoliosis
   _____ Arthritis
   _____ Muscle weakness
   _____ Joint swelling
   _____ Skin discoloration
   _____ Skin texture changes
   _____ Arterial ruptures

5a. Is significant pain a reasonably expected result of hypermobility and arthritic components? yes______ no______

5b. Please describe the extent of joint involvement______________________________
____

5c. Please describe the extent of muscle involvement___________________________
____

6. If your patient reports experiencing weakness, pain, fatigue, or other subjective symptoms, can the medical condition(s) which have been diagnosed be reasonably expected to produce that type of symptom or complaint? yes ________ no ________

7. Please identify your clinical findings and objective signs of the conditions that have diagnosed____
____
____
____

8. Have your patient's impairments lasted or can they be expected to last at least twelve months? yes ________ no __________

9. How often are your patient's pain, symptoms or medication side-effects severe enough to interfere with attention and concentration?

_____ Never
_____ Seldom (up to 25% of the day)
_____ Often (up to 50% of the day)
_____ Frequently (up to 75% of the day)
_____ Constantly (up to 100% of the day)

11. While engaging in occasional standing or walking, does the patient need to use a cane or other assistive device? yes ______ no ______

12. Is the patient currently taking any prescription medications? If so, what medication and dosage:
____
____
____
____

13. In your opinion, based upon the diagnosis and symptoms of the patient and any other diagnosed impairments of which you are aware, is it reasonable to describe the patient as lacking the ability to consistently perform competitive employment on an 8 hour per day, 5 day per week basis?

yes____ no____

14. In your opinion, is the patient capable of functioning on a part-time basis in a competitive work setting? yes _____ no _____

If yes, ______ hours per day and ______ days per week

15. In your opinion, to what degree do the patient's symptoms impair his/her ability to perform activities of daily living?

_____ none _____ slight _____moderate _____marked

17. Is it medically reasonable to expect that the patient may need to lie down or recline periodically throughout the day to relieve or reduce the symptoms of their impairments? yes _____ no _____

18. If the patient became employed full-time, would it be reasonable to expect that the patient would miss at least two or three days of work per month due to symptoms related to his/her physical impairments?

yes_____ no______

19. Is it reasonable to expect the patient to experience fatigue from the conditions which he/she is being treated for? yes _______ no _________.

If yes, to what degree does such fatigue impair the patient's ability to work?

none _____ slight _______ moderate _______ severe _______

20. In an eight (8) hour work day, would this patient require breaks or rest periods in addition to the standard two (2) breaks and lunch break. yes ______ no ______. If yes, what would be the frequency and duration of the additional required breaks?

number of breaks: ______________________
duration of breaks: _____________________

Would such breaks be able to be scheduled? yes ______ no _______

21. Additional limitations and restrictions.

a. How much weight can the patient lift and carry in a competitive work situation?

	never	occasionally	frequently
less than 10 lbs.	______	______	______
10 lbs.	______	______	______
20 lbs.	______	______	______
50 lbs.	______	______	______

b. How many city blocks can your patient walk without rest or severe pain?

____

c. How long can your patient sit and stand continuously at one time:
sit for _________ minutes
stand for ________ minutes

d. Would your patient need a job which would permit her/him to change positions at will from sitting, standing or walking? yes _____ no ______

If yes, please estimate how often your patient would need to change positions: every ________ minutes

e. Please rate the frequency with which your patient can perform the following physical activities:

	never	occasionally	frequently
bending	________	________	_______
twisting	________	________	_______
stooping	________	________	_______
climbing	________	________	_______
kneeling	________	________	_______
crouching	________	________	_______
crawling	________	________	_______
reaching	________	________	_______
pulling	________	________	_______
pushing	________	________	_______
firm grasping(left)	________	________	_______
fine grasping(left)	________	________	_______
firm grasping(right)	________	________	_______
fine grasping(right)	________	________	_______
overhead work	________	________	_______
static neck flexion	________	________	_______
frequent neck rotation	________	________	_______
walking up incline	________	________	_______

f. Can the patient perform repetitive employment tasks involving his/her hands, arms, upper extremities? yes _______ no _________

Does the patient have good use of both hands and fingers for bilateral manual dexterity? yes _______ no _________

Does the patient have good use of the hands and fingers for repetitive hand-finger actions? yes _______ no _________

Does the patient have a significant limitation of his/her ability to manipulate, handle, and work with small objects with both hands? yes _____ no ______

g. In an eight hour day, what is the total amount of time the patient can:

sitting
______ less than 2 hours
______ about 2 hours
______ about 4 hours
______ about 6 hours

stand/walk
______ less than 2 hours
______ about 2 hours
______ about 4 hours
______ about 6 hours

22. Do you have any additional comments that bear on this patient's capacity for performing work activities?

____
____
____
____

The above opinions are based upon my training and experience, my findings on examination, as well as all lab or diagnostic test results and other medical records/reports reviewed by me, as well as the history and symptoms reported by the patient, and they relate to the patient's condition during the time period that is noted above.

Date:________________________ Signature:____________________________

Area of Specialty:____

If you are board certified in that specialty, please check here: ___ Board Certified

AUTO IMMUNE DISORDER
MEDICAL ASSESSMENT FORM

TO: Dr.________________________

Re: ________________________

SSN: ________________________

Please answer all the following questions concerning your patient's auto immune and other health problems. *Attach all relevant treatment notes, laboratory and test results which have not been provided previously to the Social Security Administration.*

1. Date began treatment:_______________ Frequency of tx: __________________

2. Does your patient have an auto immune disorder? ☐ Yes ☐ No

   If yes, if possible, identify the type of auto immune disorder: ____________________

   ____

   Other diagnoses: ____

3. Identify any test results, symptoms or signs that your patient exhibits due to his/her impairment (or adverse effects of treatments):

☐ bladder infections	☐ yeast infections	☐ oral ulcers
☐ urinary urgency or incontinence	☐ headaches	☐ low grade fever
☐ chronic sinusitis	☐ recurrent bronchitis	☐ weight loss
☐ Raynaud's phenomenon	☐ anxiety	☐ depression
☐ peritonitis	☐ disturbed sleep	☐ candida
☐ aspergillus	☐ herpes complex	☐ vertigo
☐ recurrent sore throat	☐ septic arthritis	☐ neuropathy
☐ endocarditis	☐ chronic diarrhea	☐ chronic fatigue
☐ night sweats	☐ renal involvement	☐ hemolytic anemia
☐ lypophopenia	☐ nausea/vomiting	☐ severe malaise
☐ abdominal cramping/pain	☐ visual disturbances	☐ lymph node enlargement

☐ other: ____

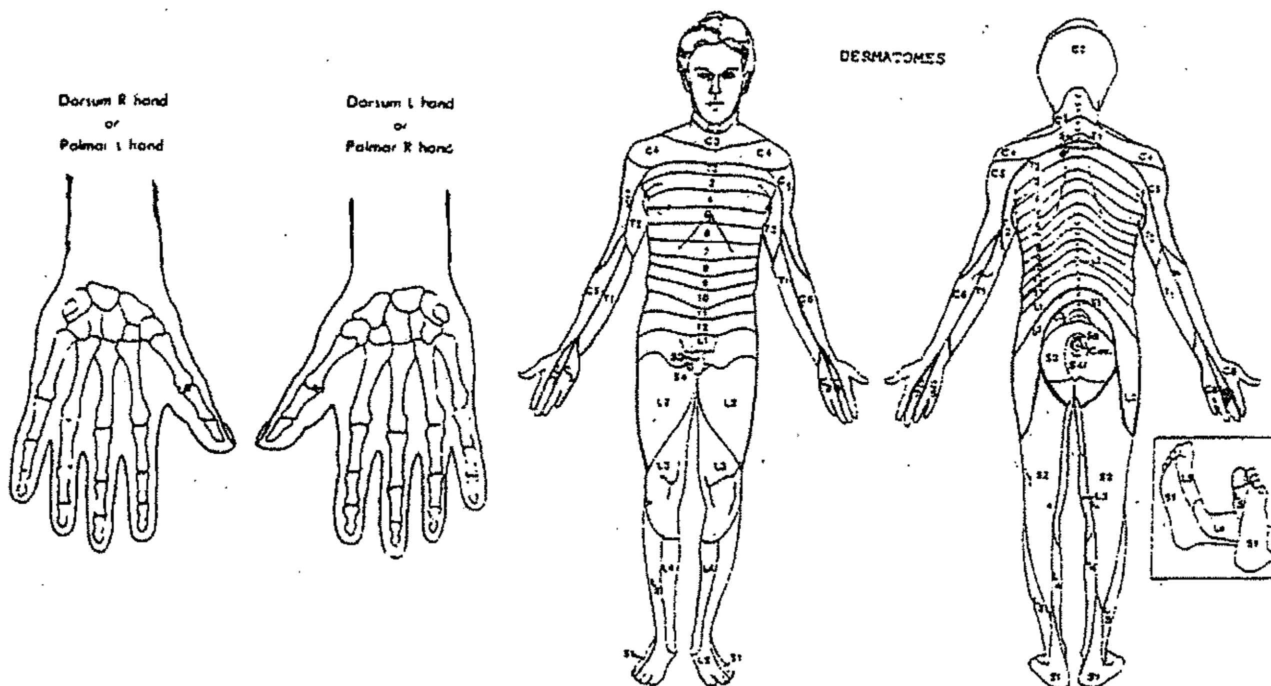
____

4. Identify and positive clinical findings and test results (e.g., granulocytopenia, T and B cell deficiency, hypogammaglobulinemia, positive ANA etc.):

   ____

   ____

5. Identify the location and frequency of pain/paresthesia by shading the relevant body portions and labeling as constant (C), frequent (F), intermittent (I):



6. Does your patient experience symptoms which interfere with the attention and concentration needed to perform even simple work tasks, so that if your patient was working s/he would likely be "off task" at least 15% of the time? ☐ yes ☐ no

7. If your patient was placed in a competitive job, identify those aspects of workplace stress that your patient would be unable to perform or be exposed to:

- ☐ routine, repetitive tasks at consistent pace
- ☐ detailed or complicated tasks
- ☐ frequent interaction with coworkers/supervisors/public
- ☐ fast paced tasks (e.g., production line)

8. Identify any side effects of any medications which may have implications for working:

☐ drowsiness/sedation ☐ other: ______________________________

9. As a result of your patient's impairment(s), estimate your patient's functional limitations assuming your patient was placed in a competitive work situation on an ongoing basis:

A. How many city blocks can the patient **walk** without rest or severe pain? _________

B. Please circle the hours and/or minutes that your patient can *continuously* **sit and stand** *at one time:*

1. **Sit:** 0 5 10 15 20 30 45 Minutes 1 2. More than 2 Hours

What must your patient usually do after sitting this long?
☐ walk ☐ stand ☐ lie down ☐ other: ____________________

2. **Stand:** 0 5 10 20 30 45 Minutes 1 2, More than 2 Hours

What must your patient usually do after standing this long?
☐ walk ☐ sit ☐ lie down ☐ other: ___________________________

C. Please indicate how long your patient can sit and stand/walk *total in an eight hour work day* (with normal breaks)?

Sit	Stand/Walk	
☐	☐	less than 2 hours
☐	☐	about 2 hours
☐	☐	about 4 hours
☐	☐	at least 6 hours

D. Does your patient need a job which permits ready access to a bathroom?
☐ Yes ☐ No

E. If your patient's symptom(s) would likely cause the need to take unscheduled **restroom breaks** during an average eight-hour workday,

How many times during an average workday do you expect this to happen?
0 1 2 3 4 5 6 7 8 9 10, more than 10

F. In addition to the above-discussed restroom breaks, if you feel that your patient will also sometimes need to take **additional unscheduled breaks** to lie down, change soiled clothing, rest, etc., during an eight-hour workday, **how many times** during an average workday do you expect this to happen?

0 1 2 3 4 5 6 7 8 9 10, more than 10

G. Due to your patient's symptoms, should your patient elevate leg(s) at least two hours during a typical eight-hour daytime period? ☐ Yes ☐ No

If yes, how high should leg(s) typically be elevated:

☐ at or above heart level ☐ waist level
☐ between heart and waist level ☐ below waist level

H. While engaging in even occasional standing/walking must your patient use a cane or other assistive device for balance? ☐ Yes ☐ No

I. How many pounds can the patient **lift and carry** in a competitive work situation?

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.		☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

J. How often can your patient perform the following waist level activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐

K. If your patient has significant limitations with reaching, handling or fingering, please estimate the percentage of time during an eight-hour workday that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching (inc. Overhead)**
Right	________%	________%	________%
Left	________%	________%	________%

L. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED OR EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Cold			
Heat			
High humidity			
Sunlight			
Ultraviolet light			
Other:			

I. Imagine that your patient was hired to perform competitive full-time work. Please estimate, on average, how often your patient would experience "bad days" so that your patient would be **absent** from work as a result of the impairment(s) or treatment:

☐ never/*less than once* a month
☐ about *once or twice* a month
☐ about *three* days a month
☐ about *four* days a month
☐ *more than four* days a month

Date: ____________________

Signed: ____________________

Print Name: ____________________

Address: ____________________

Name ______________________________ SSN ____________________________

Please assess your patient's mental abilities within the context of the individual's capacity to sustain activities over a normal workday and workweek, on a ongoing basis in a competitive work environment.

THE HIGHER THE NUMBER THE GREATER THE DEGREE OF IMPAIRMENT.

1. **able to perform** designated task or function with no observable limits.
2. able to perform designated function, but has or will have noticeable difficulty (e.g., distracted from job activity) **about 10% or less** of a typical work day (up to about one hour/day).
3. able to perform designated function, but has or will have noticeable difficulty (distracted from job activity) **about 15%** of a typical work day (more than one hour/day).
4. able to perform designated function, but has or will have noticeable difficulty (distracted from job activity) **about 20%** of the work day (more than 1½ hours/day or about one day/week).
5. **not able to perform** designated function on regular, reliable, and sustained schedule basis.

	1	2	3	4	5
Understand, remember and carry out simple, one- or two-step instructions	☐	☐	☐	☐	☐
Understand, remember and carry out detailed instructions	☐	☐	☐	☐	☐
Maintain attention and concentration for at least two straight hours, a few times a day	☐	☐	☐	☐	☐
Perform activities within a schedule and be punctual within customary tolerances	☐	☐	☐	☐	☐
Sustain ordinary routine without special supervision	☐	☐	☐	☐	☐
Complete a normal workday/week without interruptions from symptoms which cause an unreasonable number (more than three/day) and length of rest periods	☐	☐	☐	☐	☐
Perform accurately and at a consistent pace	☐	☐	☐	☐	☐
Accept instructions and respond appropriately to criticism from supervisors	☐	☐	☐	☐	☐
Work in coordination with or proximity to co-workers without being distracted or distracting them or exhibiting behavioral extremes	☐	☐	☐	☐	☐
Deal with stresses of skilled/semiskilled work	☐	☐	☐	☐	☐

Interact appropriately with the general public — Yes ☐ No ☐

Travel alone to workplace incl. use of public transportation — Yes ☐ No ☐

Signature: ____________________________ Date: ______________________

Listing for Scleroderma (14.04)

14.00 Immune System Disorders

A. *What disorders do we evaluate under the immune system disorders listings?*

1. *We evaluate immune system disorders that cause dysfunction in one or more components of your immune system.*

a. The dysfunction may be due to problems in antibody production, impaired cell-mediated immunity, a combined type of antibody/cellular deficiency, impaired phagocytosis, or complement deficiency.

b. Immune system disorders may result in recurrent and unusual infections, or inflammation and dysfunction of the body's own tissues. Immune system disorders can cause a deficit in a single organ or body system that results in extreme (that is, very serious) loss of function. They can also cause lesser degrees of limitations in two or more organs or body systems, and when associated with symptoms or signs, such as severe fatigue, fever, malaise, diffuse musculoskeletal pain, or involuntary weight loss, can also result in extreme limitation.

c. We organize the discussions of immune system disorders in three categories: Autoimmune disorders; Immune deficiency disorders, excluding human immunodeficiency virus (HIV) infection; and HIV infection.

2. *Autoimmune disorders (14.00D).* Autoimmune disorders are caused by dysfunctional immune responses directed against the body's own tissues, resulting in chronic, multisystem impairments that differ in clinical manifestations, course, and outcome. They are sometimes referred to as rheumatic diseases, connective tissue disorders, or collagen vascular disorders. Some of the features of autoimmune disorders in adults differ from the features of the same disorders in children.

3. *Immune deficiency disorders, excluding HIV infection (14.00E).* Immune deficiency disorders are characterized by recurrent or unusual infections that respond poorly to treatment, and are often associated with complications affecting other parts of the body. Immune deficiency disorders are classified as either *primary* (congenital) or *acquired.* Individuals with immune deficiency disorders also have an increased risk of malignancies and of having autoimmune disorders.

4. *Human immunodeficiency virus (HIV) infection (14.00F).* HIV infection may be characterized by increased susceptibility to opportunistic infections, cancers, or other conditions, as described in 14.08.

B. *What information do we need to show that you have an immune system disorder?* Generally, we need your medical history, a report(s) of a physical examination, a report(s) of laboratory findings, and in some instances, appropriate medically acceptable imaging or tissue biopsy reports to show that you have an immune system disorder. Therefore, we will make every reasonable effort to obtain your medical history, medical findings, and

results of laboratory tests. We explain the information we need in more detail in the sections below.

C. Definitions

1. *Appropriate medically acceptable imaging* includes, but is not limited to, angiography, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. "Appropriate" means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

2. *Constitutional symptoms or signs*, as used in these listings, means severe fatigue, fever, malaise, or involuntary weight loss. *Severe fatigue* means a frequent sense of exhaustion that results in significantly reduced physical activity or mental function. *Malaise* means frequent feelings of illness, bodily discomfort, or lack of well-being that result in significantly reduced physical activity or mental function.

3. *Disseminated* means that a condition is spread over a considerable area. The type and extent of the spread will depend on your specific disease.

4. *Dysfunction* means that one or more of the body regulatory mechanisms are impaired, causing either an excess or deficiency of immunocompetent cells or their products.

5. *Extra-articular* means "other than the joints"; for example, an organ(s) such as the heart, lungs, kidneys, or skin.

6. *Inability to ambulate effectively* has the same meaning as in 1.00B2b.

7. *Inability to perform fine and gross movements effectively* has the same meaning as in 1.00B2c.

8. *Major peripheral joints* has the same meaning as in 1.00F.

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

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

11. *Resistant to treatment* means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate or a course of treatment is appropriate will depend on the specific

disease or condition you have, the body system affected, the usual course of the disorder and its treatment, and the other facts of your particular case.

12. *Severe* means medical severity as used by the medical community. The term does not have the same meaning as it does when we use it in connection with a finding at the second step of the sequential evaluation processes in §§ 404.1520, 416.920, and 416.924.

D. How do we document and evaluate the listed autoimmune disorders?

1. *Systemic lupus erythematosus (14.02).*

a. *General.* Systemic lupus erythematosus (SLE) is a chronic inflammatory disease that can affect any organ or body system. It is frequently, but not always, accompanied by constitutional symptoms or signs (severe fatigue, fever, malaise, involuntary weight loss). Major organ or body system involvement can include: Respiratory (pleuritis, pneumonitis), cardiovascular (endocarditis, myocarditis, pericarditis, vasculitis), renal (glomerulonephritis), hematologic (anemia, leukopenia, thrombocytopenia), skin (photosensitivity), neurologic (seizures), mental (anxiety, fluctuating cognition ("lupus fog"), mood disorders, organic brain syndrome, psychosis), or immune system disorders (inflammatory arthritis). Immunologically, there is an array of circulating serum auto-antibodies and pro- and anti-coagulant proteins that may occur in a highly variable pattern.

b. *Documentation of SLE.* Generally, but not always, the medical evidence will show that your SLE satisfies the criteria in the current "Criteria for the Classification of Systemic Lupus Erythematosus" by the American College of Rheumatology found in the most recent edition of the *Primer on the Rheumatic Diseases* published by the Arthritis Foundation.

2. *Systemic vasculitis (14.03).*

a. *General.*

(i) Vasculitis is an inflammation of blood vessels. It may occur acutely in association with adverse drug reactions, certain chronic infections, and occasionally, malignancies. More often, it is chronic and the cause is unknown. Symptoms vary depending on which blood vessels are involved. Systemic vasculitis may also be associated with other autoimmune disorders; for example, SLE or dermatomyositis.

(ii) There are several clinical patterns, including but not limited to polyarteritis nodosa, Takayasu's arteritis (aortic arch arteritis), giant cell arteritis (temporal arteritis), and Wegener's granulomatosis.

b. *Documentation of systemic vasculitis.* Angiography or tissue biopsy confirms a diagnosis of systemic vasculitis when the disease is suspected clinically. When you have had angiography or tissue biopsy for systemic vasculitis, we will make every reasonable effort to obtain reports of the

results of that procedure. However, we will not purchase angiography or tissue biopsy.

3. *Systemic sclerosis (scleroderma) (14.04).*

a. *General.* Systemic sclerosis (scleroderma) constitutes a spectrum of disease in which thickening of the skin is the clinical hallmark. Raynaud's phenomenon, often medically severe and progressive, is present frequently and may be the peripheral manifestation of a vasospastic abnormality in the heart, lungs, and kidneys. The CREST syndrome (calcinosis, Raynaud's phenomenon, esophageal dysmotility, sclerodactyly, and telangiectasia) is a variant that may slowly progress over years to the generalized process, systemic sclerosis.

b. *Diffuse cutaneous systemic sclerosis.* In diffuse cutaneous systemic sclerosis (also known as diffuse scleroderma), major organ or systemic involvement can include the gastrointestinal tract, lungs, heart, kidneys, and muscle in addition to skin or blood vessels. Although arthritis can occur, joint dysfunction results primarily from soft tissue/cutaneous thickening, fibrosis, and contractures.

c. *Localized scleroderma (linear scleroderma and morphea).*

(i) Localized scleroderma (linear scleroderma and morphea) is more common in children than in adults. However, this type of scleroderma can persist into adulthood. To assess the severity of the impairment, we need a description of the extent of involvement of linear scleroderma and the location of the lesions. For example, linear scleroderma involving the arm but not crossing any joints is not as functionally limiting as sclerodactyly (scleroderma localized to the fingers). Linear scleroderma of a lower extremity involving skin thickening and atrophy of underlying muscle or bone can result in contractures and leg length discrepancy. In such cases, we may evaluate your impairment under the musculoskeletal listings (1.00).

(ii) When there is isolated morphea of the face causing facial disfigurement from unilateral hypoplasia of the mandible, maxilla, zygoma, or orbit, adjudication may be more appropriate under the criteria in the affected body system, such as special senses and speech (2.00) or mental disorders (12.00).

(iii) Chronic variants of these syndromes include disseminated morphea, Shulman's disease (diffuse fasciitis with eosinophilia), and eosinophilia-myalgia syndrome (often associated with toxins such as toxic oil or contaminated tryptophan), all of which can impose medically severe musculoskeletal dysfunction and may also lead to restrictive pulmonary disease. We evaluate these variants of the disease under the criteria in the musculoskeletal listings (1.00) or respiratory system listings (3.00).

d. *Documentation of systemic sclerosis (scleroderma).* Documentation involves differentiating the clinical features of systemic sclerosis

(scleroderma) from other autoimmune disorders. However, there may be an overlap.

4. *Polymyositis and dermatomyositis (14.05).*

a. *General.* Polymyositis and dermatomyositis are related disorders that are characterized by an inflammatory process in striated muscle, occurring alone or in association with other autoimmune disorders or malignancy. The most common manifestations are symmetric weakness, and less frequently, pain and tenderness of the proximal limb-girdle (shoulder or pelvic) musculature. There may also be involvement of the cervical, cricopharyngeal, esophageal, intercostal, and diaphragmatic muscles.

b. *Documentation of polymyositis and dermatomyositis.* Generally, but not always, polymyositis is associated with elevated serum muscle enzymes (creatine phosphokinase (CPK), aminotransferases, and aldolase), and characteristic abnormalities on electromyography and muscle biopsy. In dermatomyositis there are characteristic skin findings in addition to the findings of polymyositis. When you have had electromyography or muscle biopsy for polymyositis or dermatomyositis, we will make every reasonable effort to obtain reports of the results of that procedure. However, we will not purchase electromyography or muscle biopsy.

c. *Additional information about how we evaluate polymyositis and dermatomyositis under the listings.*

(i) Weakness of your pelvic girdle muscles that results in your inability to rise independently from a squatting or sitting position or to climb stairs may be an indication that you are unable to ambulate effectively. Weakness of your shoulder girdle muscles may result in your inability to perform lifting, carrying, and reaching overhead, and also may seriously affect your ability to perform activities requiring fine movements. We evaluate these limitations under 14.05A.

(ii) We use the malignant neoplastic diseases listings (13.00) to evaluate malignancies associated with polymyositis or dermatomyositis. We evaluate the involvement of other organs/body systems under the criteria for the listings in the affected body system.

5. *Undifferentiated and mixed connective tissue disease (14.06).*

a. *General.* This listing includes syndromes with clinical and immunologic features of several autoimmune disorders, but which do not satisfy the criteria for any of the specific disorders described. For example, you may have clinical features of SLE and systemic vasculitis, and the serologic (blood test) findings of rheumatoid arthritis.

b. *Documentation of undifferentiated and mixed connective tissue disease.* Undifferentiated connective tissue disease is diagnosed when clinical features and serologic (blood test) findings, such as rheumatoid factor or antinuclear antibody (consistent with an autoimmune disorder) are present but do not satisfy the criteria for a specific disease. Mixed connective tissue

disease (MCTD) is diagnosed when clinical features and serologic findings of two or more autoimmune diseases overlap.

6. *Inflammatory arthritis (14.09).*

a. *General.* The spectrum of inflammatory arthritis includes a vast array of disorders that differ in cause, course, and outcome. Clinically, inflammation of major peripheral joints may be the dominant manifestation causing difficulties with ambulation or fine and gross movements; there may be joint pain, swelling, and tenderness. The arthritis may affect other joints, or cause less limitation in ambulation or the performance of fine and gross movements. However, in combination with extra-articular features, including constitutional symptoms or signs (severe fatigue, fever, malaise, involuntary weight loss), inflammatory arthritis may result in an extreme limitation.

b. *Inflammatory arthritis involving the axial spine (spondyloarthropathy).* In adults, inflammatory arthritis involving the axial spine may be associated with disorders such as:

(i) Reiter's syndrome;

(ii) Ankylosing spondylitis;

(iii) Psoriatic arthritis;

(iv) Whipple's disease;

(v) Behçet's disease; and

(vi) Inflammatory bowel disease.

c. *Inflammatory arthritis involving the peripheral joints.* In adults, inflammatory arthritis involving peripheral joints may be associated with disorders such as:

(i) Rheumatoid arthritis;

(ii) Sjögren's syndrome;

(iii) Psoriatic arthritis;

(iv) Crystal deposition disorders (gout and pseudogout);

(v) Lyme disease; and

(vi) Inflammatory bowel disease.

d. *Documentation of inflammatory arthritis.* Generally, but not always, the diagnosis of inflammatory arthritis is based on the clinical features and serologic findings described in the most recent edition of the Primer on the Rheumatic Diseases published by the Arthritis Foundation.

e. *How we evaluate inflammatory arthritis under the listings.*

(i) Listing-level severity in 14.09A and 14.09C1 is shown by an impairment that results in an "extreme" (very serious) limitation. In 14.09A, the criterion is satisfied with persistent inflammation or deformity in one major peripheral weight-bearing joint resulting in the inability to ambulate effectively (as defined in 14.00C6) or one major peripheral joint in each upper extremity resulting in the inability to perform fine and gross movements effectively (as defined in 14.00C7). In 14.09C1, if you have the

required ankylosis (fixation) of your cervical or dorsolumbar spine, we will find that you have an extreme limitation in your ability to see in front of you, above you, and to the side. Therefore, inability to ambulate effectively is implicit in 14.09C1, even though you might not require bilateral upper limb assistance.

(ii) Listing-level severity is shown in 14.09B, 14.09C2, and 14.09D by inflammatory arthritis that involves various combinations of complications of one or more major peripheral joints or other joints, such as inflammation or deformity, extra-articular features, repeated manifestations, and constitutional symptoms or signs. Extra-articular impairments may also meet listings in other body systems.

(iii) Extra-articular features of inflammatory arthritis may involve any body system; for example: Musculoskeletal (heel enthesopathy), ophthalmologic (iridocyclitis, keratoconjunctivitis sicca, uveitis), pulmonary (pleuritis, pulmonary fibrosis or nodules, restrictive lung disease), cardiovascular (aortic valve insufficiency, arrhythmias, coronary arteritis, myocarditis, pericarditis, Raynaud's phenomenon, systemic vasculitis), renal (amyloidosis of the kidney), hematologic (chronic anemia, thrombocytopenia), neurologic (peripheral neuropathy, radiculopathy, spinal cord or cauda equina compression with sensory and motor loss), mental (cognitive dysfunction, poor memory), and immune system (Felty's syndrome (hypersplenism with compromised immune competence)).

(iv) If both inflammation and chronic deformities are present, we evaluate your impairment under the criteria of any appropriate listing.

7. *Sjögren's syndrome (14.10).*

a. *General.*

(i) Sjögren's syndrome is an immune-mediated disorder of the exocrine glands. Involvement of the lacrimal and salivary glands is the hallmark feature, resulting in symptoms of dry eyes and dry mouth, and possible complications, such as corneal damage, blepharitis (eyelid inflammation), dysphagia (difficulty in swallowing), dental caries, and the inability to speak for extended periods of time. Involvement of the exocrine glands of the upper airways may result in persistent dry cough.

(ii) Many other organ systems may be involved, including musculoskeletal (arthritis, myositis), respiratory (interstitial fibrosis), gastrointestinal (dysmotility, dysphagia, involuntary weight loss), genitourinary (interstitial cystitis, renal tubular acidosis), skin (purpura, vasculitis), neurologic (central nervous system disorders, cranial and peripheral neuropathies), mental (cognitive dysfunction, poor memory), and neoplastic (lymphoma). Severe fatigue and malaise are frequently reported. Sjögren's syndrome may be associated with other autoimmune disorders (for example, rheumatoid arthritis or SLE); usually the clinical features of the associated disorder predominate.

b. *Documentation of Sjögren's syndrome.* If you have Sjögren's syndrome, the medical evidence will generally, but not always, show that your disease satisfies the criteria in the current "Criteria for the Classification of Sjögren's Syndrome" by the American College of Rheumatology found in the most recent edition of the *Primer on the Rheumatic Diseases* published by the Arthritis Foundation.

E. How do we document and evaluate immune deficiency disorders, excluding HIV infection?

1. *General.*

a. Immune deficiency disorders can be classified as:

(i) *Primary* (congenital); for example, X-linked agammaglobulinemia, thymic hypoplasia (DiGeorge syndrome), severe combined immunodeficiency (SCID), chronic granulomatous disease (CGD), C1 esterase inhibitor deficiency.

(ii) *Acquired;* for example, medication-related.

b. Primary immune deficiency disorders are seen mainly in children. However, recent advances in the treatment of these disorders have allowed many affected children to survive well into adulthood. Occasionally, these disorders are first diagnosed in adolescence or adulthood.

2. *Documentation of immune deficiency disorders.* The medical evidence must include documentation of the specific type of immune deficiency. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

3. *Immune deficiency disorders treated by stem cell transplantation.*

a. *Evaluation in the first 12 months.* If you undergo stem cell transplantation for your immune deficiency disorder, we will consider you disabled until at least 12 months from the date of the transplant.

b. *Evaluation after the 12-month period has elapsed.* After the 12-month period has elapsed, we will consider any residuals of your immune deficiency disorder as well as any residual impairment(s) resulting from the treatment, such as complications arising from:

(i) Graft-versus-host (GVH) disease.

(ii) Immunosuppressant therapy, such as frequent infections.

(iii) Significant deterioration of other organ systems.

4. *Medication-induced immune suppression.* Medication effects can result in varying degrees of immune suppression, but most resolve when the medication is ceased. However, if you are prescribed medication for long-term immune suppression, such as after an organ transplant, we will evaluate:

a. The frequency and severity of infections.

b. Residuals from the organ transplant itself, after the 12-month period has elapsed.

c. Significant deterioration of other organ systems.

F. How do we document and evaluate human immunodeficiency virus (HIV) infection?

Any individual with HIV infection, including one with a diagnosis of acquired immune deficiency syndrome (AIDS), may be found disabled under 14.08 if his or her impairment meets the criteria in that listing or is medically equivalent to the criteria in that listing.

1. *Documentation of HIV infection.* The medical evidence must include documentation of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice. When you have had laboratory testing for HIV infection, we will make every reasonable effort to obtain reports of the results of that testing. However, we will not purchase laboratory testing to establish whether you have HIV infection.

a. *Definitive documentation of HIV infection.* A definitive diagnosis of HIV infection is documented by one or more of the following laboratory tests:

(i) HIV antibody tests. HIV antibodies are usually first detected by an ELISA screening test performed on serum. Because the ELISA can yield false positive results, confirmation is required using a more definitive test, such as a Western blot or an immunofluorescence assay.

(ii) Positive "viral load" (VL) tests. These tests are normally used to quantitate the amount of the virus present but also document HIV infection. Such tests include the quantitative plasma HIV RNA, quantitative plasma HIV branched DNA, and reverse transcriptase-polymerase chain reaction (RT-PCR).

(iii) HIV DNA detection by polymerase chain reaction (PCR).

(iv) A specimen that contains HIV antigen (for example, serum specimen, lymphocyte culture, or cerebrospinal fluid).

(v) A positive viral culture for HIV from peripheral blood mononuclear cells (PBMC).

(vi) Other tests that are highly specific for detection of HIV and that are consistent with the prevailing state of medical knowledge.

b. *Other acceptable documentation of HIV infection.* We may also document HIV infection without the definitive laboratory evidence described in 14.00F1a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence in your case record. If no definitive laboratory evidence is available, we may document HIV infection by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the

medical evidence. For example, we will accept a diagnosis of HIV infection without definitive laboratory evidence of the HIV infection if you have an opportunistic disease that is predictive of a defect in cell-mediated immunity (for example, toxoplasmosis of the brain, *Pneumocystis* pneumonia (PCP)), and there is no other known cause of diminished resistance to that disease (for example, long-term steroid treatment, lymphoma). In such cases, we will make every reasonable effort to obtain full details of the history, medical findings, and results of testing.

2. *CD4 tests.* Individuals who have HIV infection or other disorders of the immune system may have tests showing a reduction of either the absolute count or the percentage of their T-helper lymphocytes (CD4 cells). The extent of immune suppression correlates with the level or rate of decline of the CD4 count. Generally, when the CD4 count is below 200/mm^3 (or below 14 percent of the total lymphocyte count) the susceptibility to opportunistic infection is greatly increased. Although a reduced CD4 count alone does not establish a definitive diagnosis of HIV infection, a CD4 count below 200 does offer supportive evidence when there are clinical findings, but not a definitive diagnosis of an opportunistic infection(s). However, a reduced CD4 count alone does not document the severity or functional consequences of HIV infection.

3. *Documentation of the manifestations of HIV infection.* The medical evidence must also include documentation of the manifestations of HIV infection. Documentation may be by laboratory evidence or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. *Definitive documentation of the manifestations of HIV infection.* The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection is by culture, serologic test, or microscopic examination of biopsied tissue or other material (for example, bronchial washings). We will make every reasonable effort to obtain specific laboratory evidence of an opportunistic disease or other condition whenever this information is available. If a histologic or other test has been performed, the evidence should include a copy of the appropriate report. If we cannot obtain the report, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including appropriate medically acceptable imaging studies) or microscopic examination of the appropriate tissues or body fluids.

b. *Other acceptable documentation of the manifestations of HIV infection.* We may also document manifestations of HIV infection without the definitive laboratory evidence described in 14.00F3a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence in your case record. For example, many conditions are now commonly diagnosed based on some or all of the following: Medical history, clinical manifestations,

laboratory findings (including appropriate medically acceptable imaging), and treatment responses. In such cases, we will make every reasonable effort to obtain full details of the history, medical findings, and results of testing. The following are examples of how we may document manifestations of HIV infection with other appropriate evidence.

(i) Although a definitive diagnosis of PCP requires identifying the organism in bronchial washings, induced sputum, or lung biopsy, these tests are frequently bypassed if PCP can be diagnosed presumptively. Supportive evidence may include: Fever, dyspnea, hypoxia, CD4 count below 200, and no evidence of bacterial pneumonia. Also supportive are bilateral lung interstitial infiltrates on x-ray, a typical pattern on CAT scan, or a gallium scan positive for pulmonary uptake. Response to anti-PCP therapy usually requires 5-7 days, and such a response can be supportive of the diagnosis.

(ii) Documentation of *Cytomegalovirus* (CMV) disease (14.08D) may present special problems because definitive diagnosis (except for chorioretinitis, which may be diagnosed by an ophthalmologist or optometrist on funduscopic examination) requires identification of viral inclusion bodies or a positive culture from the affected organ and the absence of any other infectious agent likely to be causing the disease. A positive serology test does not establish a definitive diagnosis of CMV disease, but does offer supportive evidence of a presumptive diagnosis of CMV disease. Other clinical findings that support a presumptive diagnosis of CMV may include: Fever, urinary culture positive for CMV, and CD4 count below 200. A clear response to anti-CMV therapy also supports a diagnosis.

(iii) A definitive diagnosis of toxoplasmosis of the brain is based on brain biopsy, but this procedure carries significant risk and is not commonly performed. This condition is usually diagnosed presumptively based on symptoms or signs of fever, headache, focal neurologic deficits, seizures, typical lesions on brain imaging, and a positive serology test.

(iv) Candidiasis of the esophagus (also known as *Candida* esophagitis) may be presumptively diagnosed based on symptoms of retrosternal pain on swallowing (odynophagia) and either oropharyngeal thrush (white patches or plaques) diagnosed on physical examination or by microscopic documentation of *Candida* fungal elements from a noncultured specimen scraped from the oral mucosa. Treatment with oral (systemic) antifungal agents usually produces improvement after 5 or more days of therapy, and such a response can be supportive of the diagnosis.

4. *HIV infection manifestations specific to women.*

a. *General.* Most women with severe immunosuppression secondary to HIV infection exhibit the typical opportunistic infections and other conditions, such as PCP, *Candida* esophagitis, wasting syndrome, cryptococcosis, and toxoplasmosis. However, HIV infection may have different manifestations in women than in men. Adjudicators must carefully scrutinize the medical

evidence and be alert to the variety of medical conditions specific to, or common in, women with HIV infection that may affect their ability to function in the workplace.

b. *Additional considerations for evaluating HIV infection in women.* Many of these manifestations (for example, vulvovaginal candidiasis, pelvic inflammatory disease) occur in women with or without HIV infection, but can be more severe or resistant to treatment, or occur more frequently in a woman whose immune system is suppressed. Therefore, when evaluating the claim of a woman with HIV infection, it is important to consider gynecologic and other problems specific to women, including any associated symptoms (for example, pelvic pain), in assessing the severity of the impairment and resulting functional limitations. We may evaluate manifestations of HIV infection in women under the specific criteria (for example, cervical cancer under 14.08E), under an applicable general category (for example, pelvic inflammatory disease under 14.08A4) or, in appropriate cases, under 14.08K.

5. *Involuntary weight loss.* For purposes of 14.08H, an involuntary weight loss of at least 10 percent of baseline is always considered "significant." Loss of less than 10 percent may or may not be significant, depending on the individual's baseline weight and body habitus. For example, a 7-pound weight loss in a 100-pound woman who is 63 inches tall might be considered significant; but a 14-pound weight loss in a 200-pound woman who is the same height might not be significant. HIV infection that affects the digestive system and results in malnutrition can also be evaluated under 5.08.

G. How do we consider the effects of treatment in evaluating your autoimmune disorder, immune deficiency disorder, or HIV infection?

1. *General.* If your impairment does not otherwise meet the requirements of a listing, we will consider your medical treatment in terms of its effectiveness in improving the signs, symptoms, and laboratory abnormalities of your specific immune system disorder or its manifestations, and in terms of any side effects that limit your functioning. We will make every reasonable effort to obtain a specific description of the treatment you receive (including surgery) for your immune system disorder. We consider:

a. The effects of medications you take.

b. Adverse side effects (acute and chronic).

c. The intrusiveness and complexity of your treatment (for example, the dosing schedule, need for injections).

d. The effect of treatment on your mental functioning (for example, cognitive changes, mood disturbance).

e. Variability of your response to treatment (see 14.00G2).

f. The interactive and cumulative effects of your treatments. For example, many individuals with immune system disorders receive treatment both for their immune system disorders and for the manifestations of the disorders or co-occurring impairments, such as treatment for HIV infection and hepatitis C. The interactive and cumulative effects of these treatments may be greater than the effects of each treatment considered separately.

g. The duration of your treatment.

h. Any other aspects of treatment that may interfere with your ability to function.

2. *Variability of your response to treatment.* Your response to treatment and the adverse or beneficial consequences of your treatment may vary widely. The effects of your treatment may be temporary or long term. For example, some individuals may show an initial positive response to a drug or combination of drugs followed by a decrease in effectiveness. When we evaluate your response to treatment and how your treatment may affect you, we consider such factors as disease activity before treatment, requirements for changes in therapeutic regimens, the time required for therapeutic effectiveness of a particular drug or drugs, the limited number of drug combinations that may be available for your impairment(s), and the time-limited efficacy of some drugs. For example, an individual with HIV infection or another immune deficiency disorder who develops pneumonia or tuberculosis may not respond to the same antibiotic regimen used in treating individuals without HIV infection or another immune deficiency disorder, or may not respond to an antibiotic that he or she responded to before. Therefore, we must consider the effects of your treatment on an individual basis, including the effects of your treatment on your ability to function.

3. *How we evaluate the effects of treatment for autoimmune disorders on your ability to function.* Some medications may have acute or long-term side effects. When we consider the effects of corticosteroids or other treatments for autoimmune disorders on your ability to function, we consider the factors in 14.00G1 and 14.00G2. Long-term corticosteroid treatment can cause ischemic necrosis of bone, posterior subcapsular cataract, weight gain, glucose intolerance, increased susceptibility to infection, and osteoporosis that may result in a loss of function. In addition, medications used in the treatment of autoimmune disorders may also have effects on mental functioning, including cognition (for example, memory), concentration, and mood.

4. *How we evaluate the effects of treatment for immune deficiency disorders, excluding HIV infection, on your ability to function.* When we consider the effects of your treatment for your immune deficiency disorder on your ability to function, we consider the factors in 14.00G1 and 14.00G2. A frequent need for treatment such as intravenous immunoglobulin and gamma interferon therapy can be intrusive and interfere with your ability to work. We will also consider whether you have chronic side effects from these

or other medications, including severe fatigue, fever, headaches, high blood pressure, joint swelling, muscle aches, nausea, shortness of breath, or limitations in mental function including cognition (for example, memory), concentration, and mood.

5. *How we evaluate the effects of treatment for HIV infection on your ability to function.*

a. *General.* When we consider the effects of antiretroviral drugs (including the effects of highly active antiretroviral therapy (HAART)) and the effects of treatments for the manifestations of HIV infection on your ability to function, we consider the factors in 14.00G1 and 14.00G2. Side effects of antiretroviral drugs include, but are not limited to: Bone marrow suppression, pancreatitis, gastrointestinal intolerance (nausea, vomiting, diarrhea), neuropathy, rash, hepatotoxicity, lipodystrophy (fat redistribution, such as "buffalo hump"), glucose intolerance, and lactic acidosis. In addition, medications used in the treatment of HIV infection may also have effects on mental functioning, including cognition (for example, memory), concentration, and mood, and may result in malaise, severe fatigue, joint and muscle pain, and insomnia. The symptoms of HIV infection and the side effects of medication may be indistinguishable from each other. We will consider all of your functional limitations, whether they result from your symptoms or signs of HIV infection or the side effects of your treatment.

b. *Structured treatment interruptions.* A structured treatment interruption (STI, also called a "drug holiday") is a treatment practice during which your treating source advises you to stop taking your medications temporarily. An STI in itself does not imply that your medical condition has improved; nor does it imply that you are noncompliant with your treatment because you are following your treating source's advice. Therefore, if you have stopped taking medication because your treating source prescribed or recommended an STI, we will not find that you are failing to follow treatment or draw inferences about the severity of your impairment on this fact alone. We will consider why your treating source has prescribed or recommended an STI and all the other information in your case record when we determine the severity of your impairment.

6. *When there is no record of ongoing treatment.* If you have not received ongoing treatment or have not had an ongoing relationship with the medical community despite the existence of a severe impairment(s), we will evaluate the medical severity and duration of your immune system disorder on the basis of the current objective medical evidence and other evidence in your case record, taking into consideration your medical history, symptoms, clinical and laboratory findings, and medical source opinions. If you have just begun treatment and we cannot determine whether you are disabled based on the evidence we have, we may need to wait to determine the effect of the treatment on your ability to function. The amount of time we need to wait will depend on the facts of your case. If you have not received

treatment, you may not be able to show an impairment that meets the criteria of one of the immune system disorders listings, but your immune system disorder may medically equal a listing or be disabling based on a consideration of your residual functional capacity, age, education, and work experience.

H. How do we consider your symptoms, including your pain, severe fatigue, and malaise?

Your symptoms, including pain, severe fatigue, and malaise, may be important factors in our determination whether your immune system disorder(s) meets or medically equals a listing or in our determination whether you are otherwise able to work. In order for us to consider your symptoms, you must have medical signs or laboratory findings showing the existence of a medically determinable impairment(s) that could reasonably be expected to produce the symptoms. If you have such an impairment(s), we will evaluate the intensity, persistence, and functional effects of your symptoms using the rules throughout 14.00 and in our other regulations. See §§ 404.1528, 404.1529, 416.928, and 416.929. Additionally, when we assess the credibility of your complaints about your symptoms and their functional effects, we will not draw any inferences from the fact that you do not receive treatment or that you are not following treatment without considering all of the relevant evidence in your case record, including any explanations you provide that may explain why you are not receiving or following treatment.

I. How do we use the functional criteria in these listings?

1. The following listings in this body system include standards for evaluating the functional limitations resulting from immune system disorders: 14.02B, for systemic lupus erythematosus; 14.03B, for systemic vasculitis; 14.04D, for systemic sclerosis (scleroderma); 14.05E, for polymyositis and dermatomyositis; 14.06B, for undifferentiated and mixed connective tissue disease; 14.07C, for immune deficiency disorders, excluding HIV infection; 14.08K, for HIV infection; 14.09D, for inflammatory arthritis; and 14.10B, for Sjögren's syndrome.

2. When we use one of the listings cited in 14.00I1, we will consider all relevant information in your case record to determine the full impact of your immune system disorder on your ability to function on a sustained basis. Important factors we will consider when we evaluate your functioning under these listings include, but are not limited to: Your symptoms, the frequency and duration of manifestations of your immune system disorder, periods of exacerbation and remission, and the functional impact of your treatment, including the side effects of your medication.

3. As used in these listings, "repeated" means that the manifestations occur on an average of three times a year, or once every 4 months, each lasting 2 weeks or more; or the manifestations do not last for 2 weeks but occur substantially more frequently than three times in a year or once every 4 months; or they occur less frequently than an average of three times a year or once every 4 months but last substantially longer than 2 weeks. Your impairment will satisfy this criterion regardless of whether you have the same kind of manifestation repeatedly, all different manifestations, or any other combination of manifestations; for example, two of the same kind of manifestation and a different one. You must have the required number of manifestations with the frequency and duration required in this section. Also, the manifestations must occur within the period covered by your claim.

4. To satisfy the functional criterion in a listing, your immune system disorder must result in a "marked" level of limitation in one of three general areas of functioning: Activities of daily living, social functioning, or difficulties in completing tasks due to deficiencies in concentration, persistence, or pace. Functional limitation may result from the impact of the disease process itself on your mental functioning, physical functioning, or both your mental and physical functioning. This could result from persistent or intermittent symptoms, such as depression, severe fatigue, or pain, resulting in a limitation of your ability to do a task, to concentrate, to persevere at a task, or to perform the task at an acceptable rate of speed. You may also have limitations because of your treatment and its side effects (see 14.00G).

5. When "marked" is used as a standard for measuring the degree of functional limitation, it means more than moderate but less than extreme. We do not define "marked" by a specific number of different activities of daily living in which your functioning is impaired, different behaviors in which your social functioning is impaired, or tasks that you are able to complete, but by the nature and overall degree of interference with your functioning. You may have a marked limitation when several activities or functions are impaired, or even when only one is impaired. Also, you need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation seriously interferes with your ability to function independently, appropriately, and effectively. The term "marked" does not imply that you must be confined to bed, hospitalized, or in a nursing home.

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

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

8. *Completing tasks in a timely manner* involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings. We will find that you have a "marked" limitation in completing tasks if you have a serious limitation in your ability to sustain concentration or pace adequate to complete work-related tasks because of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, caused by your immune system disorder (including manifestations of the disorder) or its treatment, even if you are able to do some routine activities of daily living.

J. How do we evaluate your immune system disorder when it does not meet one of these listings?

1. These listings are only examples of immune system disorders that we consider severe enough to prevent you from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. Individuals with immune system disorders, including HIV infection, may manifest signs or symptoms of a mental impairment or of another physical impairment. We may evaluate these impairments under any affected body system. For example, we will evaluate:

a. Musculoskeletal involvement, such as surgical reconstruction of a joint, under 1.00.

b. Ocular involvement, such as dry eye, under 2.00.

c. Respiratory impairments, such as pleuritis, under 3.00.

d. Cardiovascular impairments, such as cardiomyopathy, under 4.00.

e. Digestive impairments, such as hepatitis (including hepatitis C) or weight loss as a result of HIV infection that affects the digestive system, under 5.00.

f. Genitourinary impairments, such as nephropathy, under 6.00.

g. Hematologic abnormalities, such as anemia, granulocytopenia, and thrombocytopenia, under 7.00.

h. Skin impairments, such as persistent fungal and other infectious skin eruptions, and photosensitivity, under 8.00.

i. Neurologic impairments, such as neuropathy or seizures, under 11.00.

j. Mental disorders, such as depression, anxiety, or cognitive deficits, under 12.00.

k. Allergic disorders, such as asthma or atopic dermatitis, under 3.00 or 8.00 or under the criteria in another affected body system.

l. Syphilis or neurosyphilis under the criteria for the affected body system; for example, 2.00 Special senses and speech, 4.00 Cardiovascular system, or 11.00 Neurological.

3. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See §§ 404.1526 and 416.926.) If it does not, you may or may not have the residual functional capacity to engage in substantial gainful activity. Therefore, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. We use the rules in §§ 404.1594, 416.994, and 416.994a as appropriate, when we decide whether you continue to be disabled.

14.01 *Category of Impairments, Immune System Disorders.*

14.02 *Systemic lupus erythematosus.* As described in 14.00D1. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. Repeated manifestations of SLE, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

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

14.03 *Systemic vasculitis.* As described in 14.00D2. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. Repeated manifestations of systemic vasculitis, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.
2. Limitation in maintaining social functioning.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.04 *Systemic sclerosis (scleroderma).* As described in 14.00D3. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and
2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. With one of the following:

1. Toe contractures or fixed deformity of one or both feet, resulting in the inability to ambulate effectively as defined in 14.00C6; or
2. Finger contractures or fixed deformity in both hands, resulting in the inability to perform fine and gross movements effectively as defined in 14.00C7; or
3. Atrophy with irreversible damage in one or both lower extremities, resulting in the inability to ambulate effectively as defined in 14.00C6; or
4. Atrophy with irreversible damage in both upper extremities, resulting in the inability to perform fine and gross movements effectively as defined in 14.00C7.

or

C. Raynaud's phenomenon, characterized by:

1. Gangrene involving at least two extremities; or
2. Ischemia with ulcerations of toes or fingers, resulting in the inability to ambulate effectively or to perform fine and gross movements effectively as defined in 14.00C6 and 14.00C7;

or

D. Repeated manifestations of systemic sclerosis (scleroderma), with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.
2. Limitation in maintaining social functioning.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.05 *Polymyositis and dermatomyositis.* As described in 14.00D4. With:

A. Proximal limb-girdle (pelvic or shoulder) muscle weakness, resulting in inability to ambulate effectively or inability to perform fine and gross movements effectively as defined in 14.00C6 and 14.00C7.

or

B. Impaired swallowing (dysphagia) with aspiration due to muscle weakness.

or

C. Impaired respiration due to intercostal and diaphragmatic muscle weakness.

or

D. Diffuse calcinosis with limitation of joint mobility or intestinal motility.

or

E. Repeated manifestations of polymyositis or dermatomyositis, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.
2. Limitation in maintaining social functioning.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.06 *Undifferentiated and mixed connective tissue disease.* As described in 14.00D5. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and
2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. Repeated manifestations of undifferentiated or mixed connective tissue disease, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.
2. Limitation in maintaining social functioning.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.07 *Immune deficiency disorders, excluding HIV infection.* As described in 14.00E. With:

A. One or more of the following infections. The infection(s) must either be resistant to treatment or require hospitalization or intravenous treatment three or more times in a 12-month period.

1. Sepsis; or

2. Meningitis; or
3. Pneumonia; or
4. Septic arthritis; or
5. Endocarditis; or
6. Sinusitis documented by appropriate medically acceptable imaging.

or

B. Stem cell transplantation as described under 14.00E3. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

or

C. Repeated manifestations of an immune deficiency disorder, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.
2. Limitation in maintaining social function.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.08 *Human immunodeficiency virus (HIV) infection.* With documentation as described in 14.00F and one of the following:

A. Bacterial infections:

1. Mycobacterial infection (for example, caused by *M. avium-intracellulare, M. kansasii,* or *M. tuberculosis*) at a site other than the lungs, skin, or cervical or hilar lymph nodes, or pulmonary tuberculosis resistant to treatment; or
2. Nocardiosis; or
3. *Salmonella* bacteremia, recurrent non-typhoid; or
4. Multiple or recurrent bacterial infections, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in a 12-month period. or

B. Fungal infections:

1. Aspergillosis; or
2. Candidiasis involving the esophagus, trachea, bronchi, or lungs, or at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or
3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or
4. Cryptococcosis, at a site other than the lungs (for example, cryptococcal meningitis); or
5. Histoplasmosis, at a site other than the lungs or lymph nodes; or
6. Mucormycosis; or
7. *Pneumocystis* pneumonia or extrapulmonary *Pneumocystis* infection. or

C. Protozoan or helminthic infections:

1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or

2. Strongyloidiasis, extra-intestinal; or

3. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

or

D. Viral infections:

1. *Cytomegalovirus* disease (documented as described in 14.00F3b(ii)) at a site other than the liver, spleen or lymph nodes; or

2. Herpes simplex virus causing:

a. Mucocutaneous infection (for example, oral, genital, perianal) lasting for 1 month or longer; or

b. Infection at a site other than the skin or mucous membranes (for example, bronchitis, pneumonitis, esophagitis, or encephalitis); or

c. Disseminated infection; or

3. Herpes zoster:

a. Disseminated; or

b. With multidermatomal eruptions that are resistant to treatment; or

4. Progressive multifocal leukoencephalopathy.

or

E. Malignant neoplasms:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or

2. Kaposi's sarcoma with:

a. Extensive oral lesions; or

b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or

3. Lymphoma (for example, primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease); or

4. Squamous cell carcinoma of the anal canal or anal margin.

or

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3, above), with extensive fungating or ulcerating lesions not responding to treatment (for example, dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal *Candida,* condyloma caused by human *Papillomavirus,* genital ulcerative disease).

or

G. HIV encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses.

or

H. HIV wasting syndrome, characterized by involuntary weight loss of 10 percent or more of baseline (computed based on pounds, kilograms, or body mass index (BMI)) or other significant involuntary weight loss as described

in 14.00F5, and in the absence of a concurrent illness that could explain the findings. With either:

1. Chronic diarrhea with two or more loose stools daily lasting for 1 month or longer; or

2. Chronic weakness and documented fever greater than 38 °C (100.4 °F) for the majority of 1 month or longer.

or

I. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

or

J. One or more of the following infections (other than described in A-I, above). The infection(s) must either be resistant to treatment or require hospitalization or intravenous treatment three or more times in a 12-month period.

1. Sepsis; or
2. Meningitis; or
3. Pneumonia; or
4. Septic arthritis; or
5. Endocarditis; or
6. Sinusitis documented by appropriate medically acceptable imaging.

or

K. Repeated (as defined in 14.00I3) manifestations of HIV infection, including those listed in 14.08A-J, but without the requisite findings for those listings (for example, carcinoma of the cervix not meeting the criteria in 14.08E, diarrhea not meeting the criteria in 14.08I), or other manifestations (for example, oral hairy leukoplakia, myositis, pancreatitis, hepatitis, peripheral neuropathy, glucose intolerance, muscle weakness, cognitive or other mental limitation) resulting in significant, documented symptoms or signs (for example, severe fatigue, fever, malaise, involuntary weight loss, pain, night sweats, nausea, vomiting, headaches, or insomnia) and one of the following at the marked level:

1. Limitation of activities of daily living.
2. Limitation in maintaining social functioning.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.09 *Inflammatory arthritis.* As described in 14.00D6. With:

A. Persistent inflammation or persistent deformity of:

1. One or more major peripheral weight-bearing joints resulting in the inability to ambulate effectively (as defined in 14.00C6); or

2. One or more major peripheral joints in each upper extremity resulting in the inability to perform fine and gross movements effectively (as defined in 14.00C7).

or

B. Inflammation or deformity in one or more major peripheral joints with:

1. Involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

C. Ankylosing spondylitis or other spondyloarthropathies, with:

1. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 45° or more of flexion from the vertical position (zero degrees); or

2. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 30° or more of flexion (but less than 45°) measured from the vertical position (zero degrees), and involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity.

or

D. Repeated manifestations of inflammatory arthritis, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

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

14.10 *Sjögren's syndrome.* As described in 14.00D7. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. Repeated manifestations of Sjögren's syndrome, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

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