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Social Security Disability Readings

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Disability within the Social Security System: An Overview of Law, Procedure, and Advocacy

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(Revised by Hannah Demeritt, August 2015)

A disabled person in the United States may be able to obtain cash benefits from either of two programs: **Social Security Disability** (also known as SSDI, Title II or OASDI) and/or **Supplemental Security Income** (also known as SSI or Title XVI).

SSDI is available to persons who have contributed sufficient sums into the Social Security system through the payment of payroll taxes. Eligibility is not based on financial need. The benefit is a monthly check, the amount of which is determined through the use of a mathematical formula that takes into account the past earnings of the recipient. SSDI also comes with eligibility for **Medicare**, the government health insurance program for the elderly. Eligibility for Medicare begins 29 months after the date the person becomes disabled.

SSI is available to persons of low income and resources. At the current time (2015), a person must have less than $753* per month in "countable" income and less than $2,000 in assets to qualify for the program. The monthly payment in 2015 is $733, but is reduced if the recipient has income from another source or is not responsible for all of her/his living expenses. If both members of a couple apply, the maximum payment for the couple is $1100. The resource limit for a couple is $3000. In North Carolina and many other states, SSI comes with eligibility for **Medicaid** (*not Medicare)*, a joint federal-state health insurance program for low-income people. There is no waiting period for Medicaid.

To obtain either benefit, a person must establish that he/she is disabled. The standard for disability is the same in both programs, as is the process for establishing a disability. The remainder of this paper describes how a person establishes that he/she is disabled.

Administrative Procedures

A person who wishes to obtain disability benefits starts by filing an application with the Social Security Administration. This can be done by phone, online, or in person at the local district office. No representative is needed for this application process. The applicant, or "**claimant**" will be interviewed at the office or by phone by a claims representative, sign releases so Social Security can get medical records, and later, perhaps, will be asked to submit to a medical examination by a doctor chosen by and paid by the Social Security Administration (a "consultative exam" or "CE").

When a person applies, he or she identifies a date when his or her disability began. This is known as the "**alleged onset date**." This date can be any time, even years before the application, but a SSDI claimant cannot receive back benefits for more than 12 months prior to

* The income/payment amount increases annually.

the application date. If the application is for SSI, benefits are not payable until the first of the month following the month of application; there are no back benefits prior to the application date for SSI recipients, even if the evidence supports that the claimant was disabled prior to the application date.

To assess disability, the Social Security Administration contracts with a state agency called **Disability Determination Services (DDS).** DDS "claims examiners" make the initial determination about disability by collecting and reviewing medical records. There is no face-to-face meeting between the DDS examiner and the claimant. The SSA evaluates all other aspects of eligibility (e.g. earnings, financial eligibility, etc.). It usually takes three to four months to get a decision on the initial application, but often it is longer. After the initial disability determination is complete, a letter is mailed to the claimant from Social Security; it reports either an award of benefits or a denial. Advocates tend to see only letters that report denials.

Many people have **concurrent claims**; they have applied for both SSI and SSDI. This happens when SSA's financial calculations indicate that if the person gets SSDI, it will be less than the SSI maximum payment, so he/she will be entitled to both payments. The two payments will total the maximum SSI payment plus $20 ($753 in 2015), assuming there is no other available income.

When there are concurrent claims, there will be two letters of denial. As far as the disability analysis is concerned, though, the substance should be the same. The cases will be consolidated for purposes of the appeal process, so although there will always be two claims, there will not be two separate proceedings.

Medicaid: For persons applying for Medicaid based on their disability, a Social Security disability denial will result in a Medicaid denial. If the Social Security claim is eventually approved, the Medicaid application will be retroactively approved. A person is permitted to appeal the Medicaid denial in a separate hearing system within the Department of Social Services, but does not have to. Our practice is to advise the client to appeal the Medicaid denial through the Department of Social Services. We assist clients with the Medicaid appeal so that they can access Medicaid care more easily during the long wait for a Social Security hearing.

If a disability claim is denied at the initial level, the claimant is entitled to have the application **reconsidered.**

Reconsideration

An applicant has **60 days** from receipt of the notice of the SSA decision to file a **request for reconsideration**. (The date of receipt is presumed to be five days from the date of the letter, so the appeal period is effectively 65 days.) The request must be in writing, but often a claims representative will accept a request by telephone and confirm the request with the written form. A Request for Reconsideration may also be completed online.

Reconsideration means that DDS will review the case and make a new decision. The case is assigned to a new claims examiner. Again, the disability evaluation is done entirely "on paper," meaning the claimant does not get to present testimony to the person making the decision. During reconsideration, however, the claimant can submit additional medical and personal information related to daily activities and the claimant's functional limitations caused by the disability. There is no time limit within which a decision on reconsideration must be issued. It can take as little as two months, or up to six months or more.

The claimant may be represented during this process, though most are not. Before a claimant can be represented, he/she must appoint the representative on a special form, known as a "**1696**," or "**Appointment of Representative**" form. Non-lawyers may represent claimants in the disability process. The Social Security Administration refers to both lawyers and non-lawyers as "**Representatives.**" You should think of yourself at all times as an "**Advocate**."

Hearing

If the individual is denied after Reconsideration, he/she has **60 days** from receipt of the notice of the decision to **request a hearing** before an **Administrative Law Judge** (ALJ). The ALJs who hear disability appeals are employees of SSA and are not part of the Disability Determination Service. They hear only Social Security cases and are generally very knowledgeable about the rules and process. Once a hearing is requested, the case moves from the claimant's local social security office to a regional hearing office, an **Office of Disabiilty Adjudication and Review (ODAR).** In North Carolina, we have ODARs in Raleigh, Fayetteville, Greensboro, and Charlotte.

After a hearing is requested, it will usually take at least a year, often longer, before a hearing is scheduled. Delays are currently running about a year in the Raleigh hearing office and eighteen months in the Fayetteville office. SSA often offers claimant's the opportunity to have a hearing via Video Tele Conference (VTC), where an ALJ from anywhere in the country might hear the case via VTC (like Skype). This is done to expedite the longer waiting periods at some hearing offices. The claimant will receive a notice and form about whether or not he or she is willing to have a VTC hearing. We generally recommend that claimants refuse a VTC and wait for an in-person hearing, even though it usually means waiting several more months. However, we make these decisions with the client on a case-by-case basis. The in-person hearing will be scheduled with at least three weeks notice, but is usually scheduled a few months in advance. The hearing is usually scheduled for a 30-minute to one-hour time slot. It is a non-adversarial hearing, so SSA is not represented by counsel; no one is there trying to prove that the claimant is not disabled. However, depending on the ALJ, a hearing can sometimes feel adversarial.

Prior to the hearing, the appealing party or his/her legal representative may review the documents in the SSA file. All but a very few of Social Security's files are now electronic and can be accessed by registered representatives on SSA's Electronic Records Express (ERE) website. Your supervising attorneys will be able to access ERE, but you will not, but the file can be downloaded in PDF. The agency has a duty to help claimants develop the records, meaning, among other things, that the agency is supposed to collect all relevant medical records.

However, the agency rarely has updated medical records and it is the representative's duty to collect all of the records and submit them to SSA.

Also prior to a scheduled hearing, the claimant (or his representative) may request a **decision "on the record" (OTR).** The representative submits a written brief, along with all of the evidence, and requests that the ALJ enter a favorable ruling based on the evidence in the record, without waiting for a hearing. If the ALJ denies the OTR request, it is not an unfavorable ruling on the claimant's case, it merely means that the ALJ is not willing to make a ruling prior to the hearing. Thus, there is no risk in requesting an OTR. Whether or not to ask for an OTR is also done on a case-by-case basis and depends on several factors.

Once a hearing is scheduled, all written evidence must be submitted at least two weeks prior to the hearing. This is done electronically through ERE. A written brief setting forth the claimant's argument may also be submitted, and we submit a hearing brief in every case. This also needs to be submitted at least two weeks prior to the hearing. The ALJ's decision will be de novo. At the hearing, the ALJ will receive oral testimony from the claimant (and occasionally other witnesses called by the claimant). Some ALJs will ask the representative to make arguments on certain issues, but most do not. More often than not, a **Vocational Expert** (VE), hired by SSA, will also testify at the hearing. The VE's role is to to assist in determining vocational issues, including whether there are jobs the client can do given. The ALJ poses hypothetical questions to the VE, based on a claimant with similar functional limitations, work history, and education of the claimant. The VE will answer whether given the hypothetical there are jobs existing in significant numbers in the national economy which the hypothetical claimant could do and, if so, will give examples of such jobs. Note that the SSA (nor the VE) consider whether such a job exists near where the client lives, if the client could reasonably be expected to be hired for this job, or whether the client has transportation, etc. The determination is solely hypothetical and does not take these matters into consideration, because, as explained later, they are not relevant to the SSA's determination of disability. The claimant's representative has a chance to cross-examine the VE.

The representative has the opportunity to cross-examine the VE. ALJs almost never issue a decision from the bench, but issue a written decision after the hearing and mail it to the claimant and his/her representative. There is no time limit within which the ALJ must decide the case; it generally takes a month or two.

The hearing is recorded and the recording, together with the documents in the file, make up the official record of the case if it is appealed further.

Appeals Council Review

If the hearing decision is again unfavorable, the individual has **60 days to request review by the Appeals Council**. Sometimes the Appeals Council reviews the ALJ's decision without being asked to. There is only one Appeals Council for the entire country, located in Arlington, Virginia. The review at this stage is done based on the record and written legal arguments; there is never an oral presentation.

The Appeals Council will issue a written decision and mail it to the parties involved. There is no time limit within which the Appeals Council must make a decision, and it often takes in excess of a year.

Judicial Review

If the Appeals Council decision is unfavorable, the individual may file an **appeal in Federal District Court within 60 days** of the notice of the Appeals Council decision. The case will be reviewed by a judge or federal magistrate based on the evidence already submitted during the agency appeals process. The court's duty is to determine if the law was properly applied and if the SSA decision was based on "substantial evidence" in the record.

Emergency Situations

Social Security has special procedures for situations in which the claimant is **terminally ill** "TERI" or in a **dire financial need**. Such cases can be given "**critical case**" status and expedited, either through a quick on the record decision or being put at the front of the line for hearings. Any AIDS diagnosis qualifies as terminal illness (known as "**TERI**"). Clients who are homeless or in imminent danger of becoming homeless can be flagged as "Dire Needs" at the hearing level. Because of the long backlog of cases at Social Security, we try to identify cases that are appropriate for Critical Case status. The rules for critical cases are found at HALLEX Section I-02-1-40 (for cases at the hearing level) and POMS Section DI 11005.601 (initial and reconsideration levels). Note that "dire needs" is not considered prior to the hearing level.

Disability Determination

The regulations that control the technical aspects of establishing a disability are found in **20 CFR Part 404 (Social Security Disability, or "Title II" benefits) and Part 416 (SSI, or "Title XVI" benefits).** A number of resources are available in the clinic office to help you to understand the standards. Be sure to look at our library of resource materials on the bookshelf in the pod. You should become familiar with the various books, treatises, and extensive specialized Social Security Practice materials. These are generally much more detailed and thorough than web references, but our web page also contains many useful links.

Definition of Disability: To be considered disabled for Social Security purposes, an individual must have a **severe mental or physical impairment** which:

·can be **verified by a doctor** on the basis of lab tests, physical examination, or other objective medical procedures, *and*

·has lasted, or is expected to last, a minimum of **twelve consecutive months** or result in death, *and*

·prevents the individual from doing his or her previous work or any other **substantial gainful activity** (defined as earning at least $1090 per month in 2015)

The following are some things to notice about the definition:

- There must be an **impairment. An "impairment" is** a diagnosable medical condition. This is to be distinguished from a "**symptom,"** which is a sign of the medical condition. Symptoms include pain, fatigue, nausea, dizziness, etc. Symptoms alone, without a diagnosis of some disease or injury that could cause such symptoms, do not qualify.

- The claimant must have an impairment that is **severe**, meaning that it significantly limits the ability to do work-related activities, such as walk, sit, stand, lift, carry, think, use judgment, etc.

- The impairment must be documented, meaning there must be **objective medical evidence** and not just a self-history.

- The impairment must have lasted 12 months, or be expected to last 12 months, or be expected to result in death. HIV/AIDS is "expected to result in death" so no additional medical documentation of duration is required, but in most of our cases, HIV/AIDS alone is not disabling, so **duration** must be established for the other impairments, e.g. depression, back issues, etc.

- The impairment must **prevent work activities**. Having a particular disease or illness does not alone establish disability. To satisfy the SSA definition of disability, the impairments must interfere with the claimant's ability to engaging in work activities. That is why, for example, a CD-4 (T-Cell) count is not dispositive in a disability application for a person with AIDS.

Five-Step Sequential Evaluation

To make a disability determination, the adjudicator must engage in what is known as the five-step sequential evaluation**.** This is a series of sequential questions, designed to obtain the information needed to determine if the disability meets the definition. The five-step sequential evaluation is as follows:

1) **Is the claimant engaging in substantial gainful activity?** i.e., is he working and earning more than $1090[†] a month? If yes, then not disabled. If no, proceed to second question.

2) **Does the claimant have a severe impairment?** Does the impairment limit in some significant way basic activities: walking, sitting, standing, hearing, seeing, following instructions, concentrating, etc. (If no single impairment is severe, there can still be an affirmative answer to this question if the combination of the claimant's impairments is severe.) If no, then not disabled. If yes, then proceed to next question.

[†] This is the level for 2015. The substantial gainful activity (SGA) figure increases annually. Note that the question whether the claimant is engaging in SGA must be answered not only for the present, but from the time the claimant's disability began. The SGA limit for the year(s) in question must be used, not the current SGA figure.

3) **Does the impairment, or combination of impairments, meet or equal the listing of impairments in Appendix 1 of the CFR?** The "listing of impairments" is a list of conditions that are considered presumptively disabling. For persons with HIV/AIDS, the relevant "listings" are found in the section on the Immune System, at 20 C.F.R. §404, subpart P, Appendix 1, Part A Listing 14.00 et seq. Cancer listings. Mental Health litings ? At Step 3, if the answer to the question is yes, a listing is met or equaled, then the claimant is disabled. If no, then proceed to the next question. (NOTE: Showing that a claimant's impairment "equals" rather than "meets" the listings requires a doctor's opinion that the symptoms experienced by the claimant are "medically equivalent" to those described in the listings. The symptoms experienced by the claimant must be equal in severity and duration to the listed impairments.)

4) **Can the claimant perform "past relevant work"?** Past relevant work is work the client did in the 15 years prior to the date of adjudication. The work must have been done long enough to learn and at the SGA level. If the client can do the work either as actually performed by the client, or as it is generally performed in the national economy, then the claimant is not disabled. If the client can't do past relevant work, then proceed to the next question.

5) Given the claimant's age, educational level, skill level and "residual functional capacity," **are there are still jobs in the national economy that the claimant can perform?** If yes, then not disabled. If no, then disabled.

Residual Functional Capacity

In order to answer the questions at Step 4 or Step 5, the SSA must assess the claimant's "**residual functional capacity,**" or **RFC**. This is essentially a "**step 3.5**." RFC is an assessment of the claimant's remaining capabilities to perform physical and mental activities after considering the full restrictions resulting from the individual's impairment. This is different from whether the claimant is disabled, but is a question used as the basis for determining the particular type of work the claimant may be able to do despite his impairment.

RFC is an assessment of the claimant's physical abilities, mental abilities and certain other abilities. Note that the claimant must be able to perform "**sustained" work-related activities on a "regular and continuing basis"** – essentially a standard work week of 8 hours per day, 5 days per week or the equivalent. In addition to physical and mental abilities, the RFC considers such factors as environmental restrictions, manipulative and postural limitations,

Part of the RFC addresses **exertional limitations**. (20 CFR 404.1567. Exertional limitations are those that affect **strength**. Persons are classified as either being able to do:

- **Sedentary work** – lifting no more than 10 pounds, sitting most of the work day – no more than 2 hours of walking or standing.

- **Light work** – lifting no more than 20 pounds; walking and standing up to six hours a day.

- **Medium work** – lifting no more than 50 pounds; involves frequent carrying of objects weighing up to 25 pounds.

- **Heavy work** – lifting no more than 100 pounds; involves frequent carrying of objects weighing up to 50 pounds.

The second part of the RFC assesses **non-exertional** limitations. These include mental limitations, as well as limitations that are postural, manipulative, or environmental. For Duke Legal Project clients, mental limitations are often important. Some of the **basic mental demands of work** include the ability to:

- understand, carry out, and remember simple instructions;

- make judgments that are commensurate with the functions of unskilled work, i.e., simple work-related decisions.

- respond appropriately to supervision, coworkers and work situations; and

- deal with changes in a routine work setting.

Use of the RFC at Step 5: The "Grids"

At Step 5 – which addresses the ability to do any work for which the claimant is suited based on RFC, age, education, and work experience – the burden of proof shifts to the Social Security Administration. (It has been on the claimant up until now.) To meet that burden, SSA makes use of the **Medical-Vocational Guidelines**, found at 20 C.F.R. §404, subpart P, Appendix II, Part B. These Guidelines are also known as "the grids." The "grids" are a series of charts that direct decisions of "disabled" or "not disabled" for various combinations of RFC and vocational factors.

The younger the claimant, the harder it is to get a finding of disability on the grids. **Only claimants age 50 and over have a reasonable chance on the grids.**

There is a separate grid for persons in each of the exertional categories (sedentary, light, medium, etc.). To be placed on a grid, a person must also be categorized by age, educational level and work experience (looked at in terms of transferability of work skills). When a person is "plotted" on the grids, the grids dictate a result.

If a person has "**non-exertional limitations**," the grids do not mandate a result and can only be used as a "framework" for determination. If the grids do not mandate a result, then the SSA must otherwise show that there are jobs in the national economy that the claimant can perform, given the claimant's residual functional capacity (that is, what the claimant has the ability to do.) At the hearing level, this is done through testimony of a vocational expert.

For younger persons, who lose on the grids, a favorable decision at Step 5 requires evidence of non-exertional limitations that are not accounted for in the grids. Younger clients

often can win when they have serious mental limitations or limitations such as pain or fatigue that make it impossible for them to work on a continuous basis, 8 hours a day, 5 days a week, without attendance problems due to their health.

Pain is considered an "exertional impairment" when it arises when performing an activity, such as walking, lifting, reaching, etc. It is considered a non-exertional impairment when it exists regardless of whether the claimant is exerting himself. If pain is nonexertional, the grids cannot be used to dictate a result of nondisabled.

The Role of the Advocate in Social Security Disability Cases

The job of an effective advocate is to **gather and present evidence** to the Social Security Administration sufficient to prove that the claimant is disabled based on the answers to the questions in the sequential evaluation. The best theory is that the claimant's condition meets one of the listed impairments, which stops the process at question 3. However, many of our clients may not meet a listing, but this does not mean that they aren't disabled pursuant to steps 4 and 5. Even if we hope to win at step 3 (on a "listing" argument), we need to develop a back-up theory that offers a route to success on steps 4 and 5.

The support of the treating physician (or other provider) is the single-most important piece of evidence that a representative can procure and submit. The treating physician's opinion is entitled to great weight. We seek to obtain the treating physician's opinion as to whether the claimant meets a listing, and also as to the claimant's residual functional capacity.

What an Advocate Must Know and Learn to Handle a Social Disability Case Effectively

Like all cases, Social Security Disability cases require the advocate to master both **law** and **facts**. Also, as in all cases, the advocate must master the **technical domain** in which the case resides. In Social Security Disability cases, these domains include **medicine**, **psychiatry,** and **vocational evaluation**.

Law:

The law in disability cases is set forth directly in **federal statutes** (in the Federal code) and **regulations** (in the Code of Federal Regulations). There is naturally **case law** interpreting these sources in each federal circuit, but this is of little use or influence in administrative proceedings. More important are the other governing administrative law sources. When proceeding within the Social Security Administration, these administrative sources are the ones to cite. They include the following:

- **Social Security Rulings (SSR) –** These are the Social Security Administration's interpretations of governing law. They are binding on disability adjudicators. **SSRs** are published electronically on the SSA website (ssa.gov).

- **Program Operations Manual System (POMS) --** This is a huge online manual used by Social Security employees in implementing all of Social Security's programs. This manual is the bible for all local office employees. It is published on the SSA website.

- **Hearings, Appeals, and Litigation Law Manual (HALLEX) –** This much smaller manual is used by Administrative Law Judges and Hearing Office staff. It is found on the SSA website.

You will be assigned readings in some of these sources, but **you must not limit your learning of the law to materials that are assigned for class.** The law in this field is simply too extensive for you to assume that the class readings will be sufficient. You are responsible for researching the governing sources of law and finding the law that will best advance your client's claim.

Facts:

The "**facts**" in Social Security disability cases relate to the client's medical conditions, functional limitations, work experience, and education. Some of these facts are discovered in documents, such as medical, work, or school records. Other facts are contained in the administrative record, which includes the claimant's application and the many pages of questionnaires and forms generated as part of the administrative process. Still other facts must be obtained from witnesses, including the client, their friends, family members, medical providers, social workers, employers, and others with knowledge of relevant facts. It is the advocate's job to identify sources for facts and to obtain them through document requests, witness interviews, and other factual investigation.

Domain Knowledge:

As stated above, disability cases involve several technical domains that must be mastered in order for the advocate to develop and present a legal theory for disability. First, the advocate must gain a thorough understanding of the client's **medical and psychiatric conditions**. This requires extensive medical background reading. While a disability advocate is not expected to go to medical school, he or she must attain a sufficient understanding of the underlying **anatomy, physiology, disease process, diagnostic procedures, and treatment** to intelligently discuss the client's medical issues with the client's doctor. There is simply no substitute. Gaining this domain knowledge may seem a daunting task, but is one that must be undertaken by every lawyer in every case. It can be done, and is done each semester by clinic students.

Most cases will also require that the advocate gain an understanding of the details of the client's **vocational history**. This involves identifying the client's past jobs and understanding the work setting, processes, skills, and requirements of those jobs. This task is generally less technically demanding than the medical knowledge, but it can present challenges.

A Final Word

Most students find the work on disability cases to be some of the most intellectually challenging and time-consuming of the clinic experience. Students are faced with the need to learn law, facts, and domain knowledge, all at the same time. This can feel overwhelming at the beginning. The only way to succeed in handling a disability case is to get past that feeling – and quickly. The semester is too short for you to simply dip your big toe in the ocean that is disability. You have to dive down deep, from the start. Qualities that will help you succeed are: curiosity, attention to detail, organization, good note-taking/outlining, persistence, and ability to fit details into the big picture.

The Clinic provides numerous resources to help you jump-start your advocacy and learning. These include:

- Social Security Disability Protocols and Checklist
- Guidelines for Medical Charting, Drafting Affidavits
- Charts for taking notes on medical records, the Social Security file, and for developing your case theory.
- Online Resources on the course webpage, including the Benefits Page and Sequential Evaluation Page.
- In-house library materials, including Social Security Disability Practice Guides (Bush, Travers, Hall, Morton), and medical texts.
- Your supervising attorneys, who are here for consultation, but expect you to take advantage of these other resources, too.

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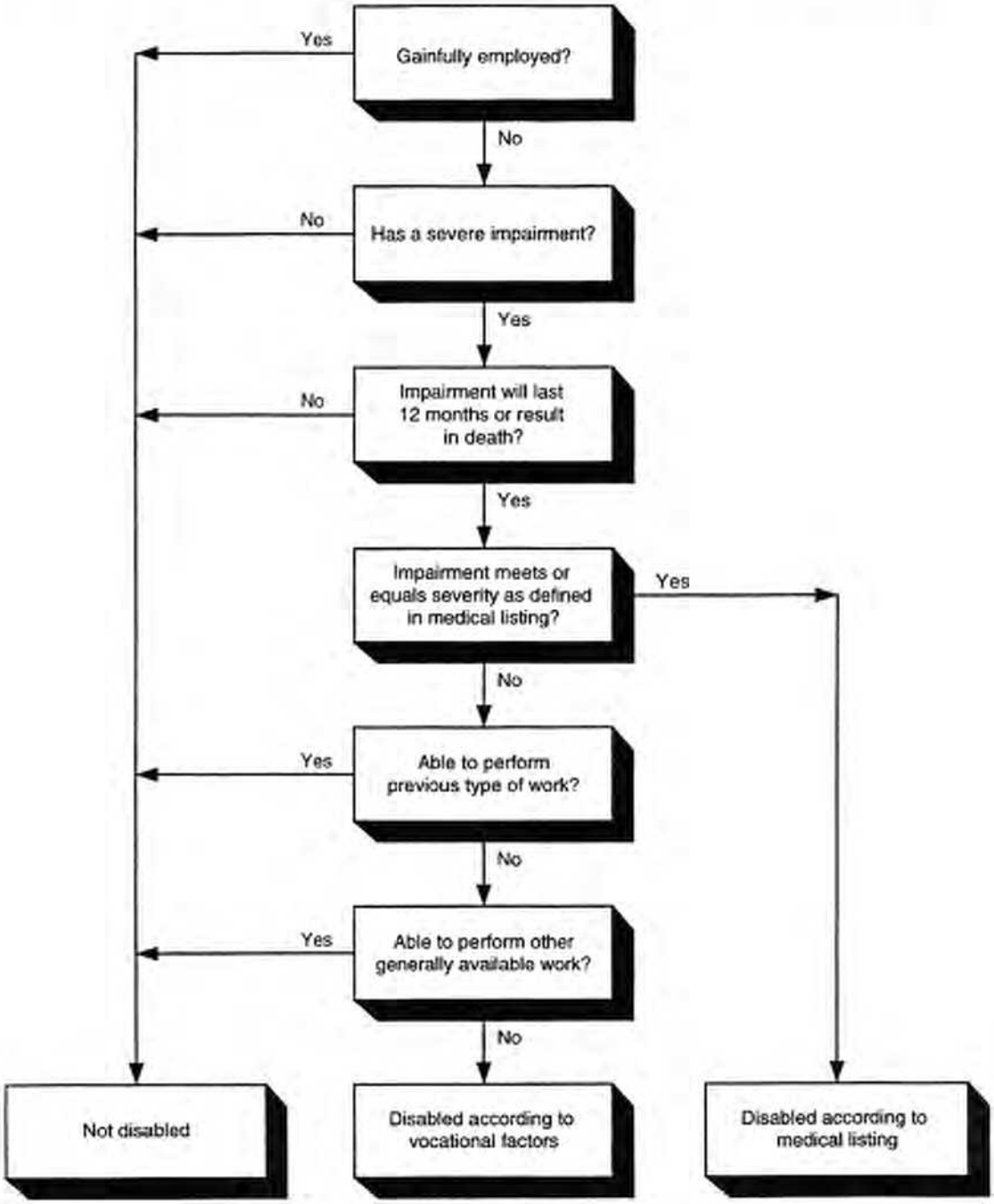
§135 Chart: Social Security Disability and SSI Compared

Issue	SS Disability	SSI
Disability standard:	Same for both programs.	
Source of payment:	Social Security trust fund.	General revenue.
Amount of payment:	Based on worker's earnings record.	Federal amount set by Congress plus state supplement, if any, set by state. State supplement amount may vary according to living arrangement.
Payment to children:	Yes, additional payment based on earnings record to children under age 18 or under age 19 and still in high school.	No increased federal payment for child; but some state SSI supplements add money for children. Otherwise, children may receive welfare, which is not counted as income; i.e., welfare does not reduce SSI benefit amount.
Payment to spouse:	Yes, if child in spouse's care is under age 16 or is disabled. There is an income limit for spouse's payment.	No increased federal payment but some state SSI supplements add money for spouse.
Earnings requirement:	Fully insured (1 QC for each year after age 21); and disability insured status (20/40 rule).	None.
Asset limitation:	None.	$2,000 individual; $3,000 couple.
Unearned income limit:	None.	A small amount is disregarded; the rest is deducted from SSI benefit.
Earned income limit:	Same for both programs for claimants; SGA results in step one denial.	After individual is receiving benefits, SSI has more liberal rules designed to encourage work.
Waiting period:	Five full months from date of onset of disability.	For applications on or after August 22, 1996, payment begins with first of month after all requirements are met. For earlier applications, payment begins with date of application if all requirements are met.
Retroactivity of application:	12 months if all requirements are met.	No retroactivity.

Time limit for reopening for good cause:	4 years.	2 years.
Payment processing office:	Baltimore or regional payment center.	Local office.
Payment applies to:	Previous month.	Current month.
Payment date:	Varies by birthday except concurrent cases paid on 3rd of month.	1st day of month.
Check says:	SOC SEC FOR INS.	SSI.
Attorney's fees:	25 percent of past due benefits withheld for direct payment.	25 percent of back benefits withheld for direct payment.
Medical coverage:	Medicare begins after receipt of 24 months of benefits.	Medicaid coverage in most states begins with entitlement to SSI (sometimes 3 months before).
Eligibility of legal aliens:	Eligible.	Aliens who were lawfully residing in the U.S. on August 22, 1996 are, for the most part, eligible for SSI disability benefits; but those who arrived later are ineligible with limited exceptions.

§111 Diagram: Disability Decision and Sequential Evaluation Process



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The Two Disability Programs

Social Security Disability Insurance	Supplemental Security Income
This program may be called one of many names: RSDHI (Retirement, Survivor, Disability, Health Insurance) SSDI (Social Security Disability Insurance), Title II, DIB (Disability Insurance Benefits)	This program may be called one of two names: SSI (Supplemental Security Income) or Title XVI.
Wage Earner must have accrued sufficient "quarters of coverage".	No work history is required.
Benefits to worker's (wage-earner) family: **Spouses**: If at least age 62, or if caring for either a child under 16 or a disabled child of the worker. **Divorced Spouses**: If the marriage lasted at least 10 years and the person is age 62 years old or older and remains unmarried. **Child:** If under age 18 (or under 19 if a full-time high school or elementary student) and dependent unmarried child of an insured eligible worker. **Disabled Adult Child:** Adult Children (18 or older) of a retired, disabled, or deceased worker, if the disability began before the age of 22.	No family member of the SSI recipient will be eligible for SSI benefits unless he or she independently establishes eligibility for SSI.
From the date one becomes disabled, there is a five-month waiting period prior to receipt of benefits.	No waiting period. An individual may receive benefits as of the first day of the month following month of application.
Provision for payment up to 12 months before the date of application.	Only paid as of first day of month following month of application.
Claimants may receive retroactive benefits up to one year before the date of application.	Retroactive benefits to first day of month following month of application.
Only Worker's Compensation or other Federal or State disability payments may affect payment level.	Any income (earned or unearned) affects benefits.
No resource limits.	Resources must be below $2000 for an individual and $3000 for an eligible couple.
Checks are paid one month behind, i.e., check received in May is recipient's April check.	Checks are paid for the month in which they are received.
Checks are paid on the 3rd of the month for beneficiaries who filed for benefits prior to May 1997; most beneficiaries who apply subsequently will receive checks on either the second, third or fourth Wednesday based on their dates of birth.	Checks are paid on the 1st of the month.
Eligible for Medicare 24 months after establishing eligibility for SSDI. No waiting period for individuals with Lou Gehrig's disease, i.e., ALS.	In two-thirds of states, eligible for Medicaid if receiving even $1.00 of SSI.

Medicaid And Persons With Disabilities

I. Introduction

A. What is Medicaid?

1. Medicaid, also known as Medical Assistance, is a cooperative federal-state program authorized by Title XIX of the Social Security Act. 42 USC 1396 *et seq.*
2. Medicaid is a health insurance program, designed to serve persons with limited income and resources.
3. Administration will occur at the state level, with the state Medicaid agency often delegating decision making to other state agencies, to county or local Medicaid units, or to private health maintenance organizations.
4. Medicaid can pay for a wide range of health-related costs for both children and adults with disabilities.

B. Distinguish from Medicare

1. Medicare is authorized by Title XVIII of the Social Security Act, 42 USC 1395 *et seq.*, and is most frequently associated with the receipt of Social Security benefits.
2. Adults with disabilities can establish Medicare eligibility in three ways:
   a. After 24 months of eligibility for Social Security Disability Insurance (SSDI) benefits;
   b. After 24 months of eligibility for Railroad Retirement disability benefits [*id.* 426(b)]; or
   c. If suffering from kidney disease and not receiving SSDI benefits, upon entering end stage renal disease or developing an impairment that requires regular dialysis or kidney transplantation to maintain life. *Id.* 426-1, 1395c, 1395rr; 42 CFR 406.13(b).
   d. There is also a class of Medicare-Qualified Federal Employees who can qualify for benefits. SSA's Program Operations Manual Systems (POMS) HI 00835.001.
3. Medicare is often an inferior health insurance plan compared to Medicaid. Compared to most state Medicaid programs:
   a. Medicare provides much more limited home health care benefits.
   b. Medicare provides more limited coverage of community-based care.
   c. Typically, Medicare provides more limited coverage for the wide range of durable medical equipment (or assistive technology devices).
   d. Medicare requires payment of premiums, deductibles and co-payments that are typically not required by Medicaid. A state's Medicaid agency

may, subject to income eligibility requirements, pay for the Part B premiums, deductibles and co-payments under the Qualified Medicare Beneficiaries program, or pay for premiums only under the Selected Low-Income Medicare Beneficiaries or QI-1 programs.

C. Why is Medicaid Important to Persons with Disabilities?

1. Medicaid is typically the only or primary health insurance plan for persons with disabilities who have limited income.
2. An increasing number of individuals with disabilities are looking to Medicaid as their primary health insurance plan, notwithstanding higher levels of individual or family income. Medicaid may be available to those individuals through state-specific Medicaid waivers, through optional Medicaid buy-in programs, or through the section 1619(b) provisions, all discussed below.
3. A lack of adequate health insurance is often cited as a primary barrier to both the ability to live in the community and the ability to succeed in employment.

D. What Services Will Medicaid Cover?

1. This varies as states are given great leeway on what optional service categories to cover.
2. Although participation in Medicaid is voluntary, all states participate in the program. Once a state chooses to participate it must comply with federal Medicaid requirements. One such requirement is that a state must offer all "required services."
3. For links to the State Medicaid Agencies, nationwide, see the following link from the Kaiser Family Foundation website: www.statehealthfacts.org.

E. "Required Services" Include:

1. Inpatient Hospital Care
2. Outpatient Hospital Care
3. Physician's Services
4. Laboratories and X-Ray Services
5. Nurse Midwife Services
6. Rural Health Clinic Services
7. Prenatal Care
8. Family Planning Services
9. Skilled Nursing Facility Services For Persons Over Age 21
10. Home Health Care Services to Persons Over 21, Eligible For Skilled Nursing Services (Includes Medical Supplies and Equipment)
11. Pediatric and Family Nurse Practitioner Services
12. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Persons Under Age 21 [See section I.G.3, below.]

13. Vaccines for Children
14. Federally Qualified Health Center

F. The Following "Optional Services" May Be Included in Your State's Medicaid Plan:

1. Podiatrist Services
2. Optometrist Services and Eyeglasses
3. Chiropractor Services
4. Private Duty Nursing
5. Clinic Services
6. Dental Services
7. Physical Therapy
8. Occupational Therapy
9. Speech, Hearing and Language Therapy
10. Prescribed Drugs
11. Dentures
12. Prosthetic Devices
13. Diagnostic Services
14. Screening Services
15. Preventive Services
16. Rehabilitative Services
17. Transportation Services
18. Services for Persons Age 65 or Older in Mental Institutions
19. Intermediate Care Facility Services
20. Intermediate Care Facility Services for Persons with Mental Retardation/Developmental Disabilities and Related Conditions
21. Inpatient Psychiatric Services for Persons under Age 22
22. Christian Science Schools
23. Nursing Facility Services for Persons under Age 21
24. Emergency Hospital Services
25. Personal Care Services
26. Hospice Care
27. Case Management Services
28. Respiratory Care Services
29. Home and Community Bases Services for Individuals with Disabilities and Chronic Medical Conditions [See section VII, below.]

Note: Many of the required and optional services are defined at 42 CFR 440.1-440.185.

HIV as a Chronic Disease

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(Revised for clinic use by Hannah Demeritt, August 2015 (citations omitted))

Take home points:

- **Numbers aren't everything**: CD4 and Viral Load don't predict functioning
- **Most HIV cases won't be listings (at least not HIV listings)**, but 14.08K may be possible
- **Many HIV cases won't be HIV** – HIV may not contribute to disability at all
- **HIV is often accompanied by mental illness** – you may have to develop the record. Key mental issues: Depression, PTSD, Cognitive deficits
- **Understand the underlying psychosocial issues, especially stigma** and how they affect treatment adherence, course of the disease, and drug/alcohol issues
    - Poverty, lack of health insurance, stigma, trauma, depression, PTSD, substance abuse, housing/homelessness issues
- **Be prepared to develop the record,** as many of your HIV+ clients will have skimpy medical records
- **Find a helpful HIV provider** to provide a medical source statement. HIV doctors/nurses/PA's are a rare breed. They will be more helpful than most providers and can help support the claimant's report of subjective symptoms like fatigue, pain, etc.
- **Be prepared to do some medical research** to counter assumptions about favorable course of HIV with antiretroviral medications

* * *

III. Psychosocial Factors

Some of my HIV positive clients are middle class (at least they were before acquiring an expensive life-threatening disease), educated, and endowed with sufficient social capital to navigate their medical care, benefits, housing, and other challenges. They take their medicine faithfully and never miss a doctor's appointment. They are in the minority of my clients.

Although no income, social, or racial group is immune from HIV, there is no escaping the fact that HIV now has its highest impact in communities of color and poverty. People living with HIV have a high incidence of mental illness, substance abuse, and trauma history. Each of those comorbidities is a risk factor for HIV.

A. Stigma

Additionally, people living with HIV still face enormous stigma. This is especially true in southern and rural areas, but remains a challenge even in "enlightened" major cities. The stigma comes from several sources. First, there

are still lingering irrational fears of transmission – people with HIV are still our time's lepers. In spite of decades of education, people still worry that they can get HIV from casual contact, mosquitoes, toilet seats, or food. (Think fast – do you know if you could get HIV by drinking out of the same cup as someone who is HIV positive?) Beyond the stigma related to fear of infection, there is "stigma by association." That is, HIV is associated with homosexuality, sexual risk taking, and drug abuse. People assume that someone with HIV got it by doing something bad. Whichever source of stigma predominates, the reality is that stigma is real and is a major barrier to adequate care and prevention. Stigma also contributes to social isolation, as many people with HIV are unwilling to let friends and family members know about their disease.

* * *

2. ***Stigma and medical care*****:** Clients in rural areas that have HIV clinics in the community may be unwilling to be seen going to that clinic. So either they don't get regular medical care or they establish care in another county, often in one of the three major academic medical centers in North Carolina. But they often lack transportation or the organization to make it to their medical appointments which may require a whole day's travel and waiting. Other clients may be afraid for roommates or family members to see their medicines. Here are some common examples encountered in my practice in North Carolina.

- I once had a homeless client who hid his medicines in an abandoned building so no one at the homeless shelter would see them. After a few weeks, he returned to retrieve his pills, and they had been stolen.
- Another semi-homeless client stayed with various friends and relatives for as long as they would keep him. He, too, was unwilling to have his medications with him, so he missed doses frequently, leading to resistance. He died of liver disease the day before he was approved at reconsideration.
- Another client gets medical care in an academic medical center 30 minutes from his home so that he will not be seen going to the local HIV clinic. He even refuses to apply for Medicaid because someone he knew in high school works in the Medicaid office. He has told only one friend about his HIV, keeping his diagnosis from even his immediate family. He frequently misses medical appointments because he lacks transportation. He is unwilling to get a ride from anyone other than the one friend to whom he has disclosed, because he doesn't want to risk exposure of his HIV status.
- Another client feels so worthless because of his HIV that he doesn't take his medications regularly and frequently misses medical appointments.

Indisputably, the stigma of HIV contributes to our clients' difficulty staying healthy.

B. Life Circumstances

In addition to stigma, other factors contribute to the difficulties faced by many people with HIV in managing their disease. Few have health insurance, and they

cannot access Medicaid without establishing disability. Because of their poverty, they often have inadequate or unstable housing. Without stable housing, clients miss medical appointments and medications, and are often lost to follow-up.

C. Trauma

A history of trauma is a huge risk factor for HIV. Traumas include experiencing or witnessing violence, murder, sexual abuse (including rape), and physical abuse; death of a spouse; household dysfunction; being sent to prison or reform school; childhood emotion neglect and physical neglect

A childhood trauma history contributes to many of factors that create risk of HIV: alcohol and substance abuse; risky sexual behavior; higher prevalence of STDs; re-victimization; and mental illness (including depression and PTSD). Trauma is also strongly associated with lack of adherence with HIV treatment, whether directly, or mediated through mental illness. In a study in North Carolina, researchers looked at the association between the number of lifetime traumatic events and non-adherence. Not surprisingly, the rate of non-adherence increased as the number of traumatic events increased. For people with five or more lifetime traumatic events, the non-adherence rate was 34%, three times that of patients who had no trauma experience. So not only do people with a trauma history have a higher likelihood of contracting HIV, they are also more likely than others not to adhere to their treatment regimen. And as discussed above, those who do not adhere get sicker or die.

D. Mental Illness

Mental illness is extremely common in people with HIV. See extended discussion below in connection with HIV comorbidities.

E. Substance Abuse

Many people living with HIV are either active drug users or alcoholics, or have a history of substance abuse. Many suffer from both substance abuse and mental illness. These conditions can lead to poor adherence, disconnection from medical care, risky behavior that leads to development of other conditions, including other STDs, and increased mortality risk.

Many of our disability clients are struggling with substance abuse. In fact, it is difficult to find clients with HIV who do not have substance abuse in their history. In very few cases do we reject a case on this basis. Although a full analysis of issues surrounding Drug Abuse and Alcoholism are beyond the scope of this paper, I can offer a few suggestions that are particularly relevant to cases of substance abusing clients with HIV.

- Don't reject clients with substance abuse issues out of hand. We have only lost one case on this basis, and almost all of our clients have some drug use or history in their records.
- Use disability as a carrot to encourage your client to seek treatment or to stay in treatment. Substance abusers are motivated by reward, not punishment. Find ways to reward positive steps toward sobriety

- Many HIV clinics offer substance abuse and mental health treatment because of its importance to medication adherence. Explore these options.
- When you talk to the HIV provider, discuss the substance abuse and seek an opinion that it does not materially contribute to the client's disability.

F. Hello, client: Challenges for Advocate

These, then, are your clients. Representing them effectively requires unpacking the psychosocial issues that are inextricably linked to their medical conditions and prospects for disability. Also, because of the often inconsistent engagement in medical and mental health care, the client's medical records may be spotty, lacking documentation of subjective symptoms such as fatigue, pain, and depression. Unless the patient is being seen at a major medical facility, the records are likely to be brief and focused exclusively on tracking CD4 and viral load numbers, which can paint a rosier picture of the client's health and functioning than is actually the case. If the "numbers" show that the client has good response to antiretroviral therapy, there will no doubt be numerous statements in the record that the patient is "doing well." The client may not see the same provider for any length of time, so it may be difficult to find a medical source who can provide a statement of the client's functioning. Also, even if there is a consistent medical provider, it may well be a nurse practitioner or physician's assistant rather than an MD.

This presents several challenges for advocates:

- Beefing up the medical record
- Finding a medical provider who can give an opinion about the client's functioning and the significance (or lack thereof) of CD4 and viral load numbers
- Teasing out mental illness that may not be prominent in the record or for which the client may not be getting treatment
- Addressing issues of Drug and Alcohol Abuse
- Addressing issues of noncompliance with treatment

IV. HIV Medical Overview

* * *

A. AIDS

AIDS-defining conditions are rare disorders to which people with normal immune systems are not susceptible. These conditions are seen infrequently in the era of combination drug therapy. AIDS-defining conditions can be found in Listings 14.00 A-K.

Other conditions that are not AIDS defining, but that are identified by the CDC as being HIV-related include:

- Bacillary angiomatosis
- Candidiasis, oropharyngeal (thrush)
- Candidiasis, vulvovaginal; persistent, frequent, or poorly responsive to therapy
- Cervical dysplasia (moderate or severe)/cervical carcinoma in situ

- Constitutional symptoms, such as fever (38.5 C) or diarrhea lasting greater than 1 month
- Hairy leukoplakia, oral
- Herpes zoster (shingles), involving at least two distinct episodes or more than one dermatome
- Idiopathic thrombocytopenic purpura
- Listeriosis
- Pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess
- Peripheral neuropathy

As with the opportunistic infections, most of these conditions are seen very infrequently. The most common HIV complaints in the modern era include:

- Fatigue
- Cognitive deficits (including memory, difficulty concentrating executive function)
- Peripheral Neuropathy
- Diarrhea
- Muscle aches
- Depression
- Weakness
- Painful joints
- Night sweats
- Weight loss
- Shortness of breath with activity
- Abdominal pain
- Gas/bloating
- Weight gain in the stomach area

An excellent resource on medical issues in HIV/AIDS is the recent report of the Institute of Medicine of the National Academy of Sciences, "HIV and Disability: Updating the Social Security Listings," http://www.nap.edu/catalog/1294.html, which was released in late 2010. This publication includes a very current overview of HIV in the context of the disability. It contains a thorough discussion of the key medical concepts. It is available for free online. If you don't get any other resource on HIV, get this one.

B. Key HIV symptoms for disability advocates:

1. Fatigue

Fatigue is probably the most common symptom experienced by people with HIV, and is well studied by researchers. In one study 64% of participants had fatigue. Another study describes fatigue as "the most frequent and debilitating complaint of HIV-infected people, with estimated prevalence rates ranging from 55 to 65%.

Notably, the research has shown that fatigue has no association with physiological markers, including CD4 count or Viral Load. This is true for both

the incidence and severity of fatigue. So good viral suppression and increasing CD4 counts should not undercut a claimant's subjective complaints of debilitating fatigue. Numerous studies have shown that there is no connection. In fact, there has been little success in identifying physiological markers of HIV fatigue. One study states, "our findings suggest that monitoring lab values has little utility in identifying a cause for fatigue." One study reviewed possible physiological associations with fatigue, including antiretroviral drugs, cytokine dysregulation, and basal ganglia dysregulation. It reached no definitive conclusion other than that CD4 and viral load were not predictive of fatigue.

There are some conditions experienced by people with HIV for which fatigue can be a symptom. These include anemia hormonal imbalances (especially low levels of the male hormone testosterone and adrenal hormones), depression and anxiety, poor, and sleep disturbances.

Research has shown that fatigue in people with HIV correlates to various psychosocial factors. These include depressive mood, younger age, more education, being unemployed, not being on antiretroviral therapy, having fewer years since HIV diagnosis, more childhood trauma, more stressful life events, land more psychological distress (PTSD, anxiety, and depression. It makes sense that depression might be associated with HIV fatigue, but fatigue is present in many patients even in the absence of depression.

The many studies on HIV fatigue compellingly describe the functional impacts of this complaint. Barroso et al state that "the consequences of fatigue include having to stop working, limiting one's involvement with family and friends, and needing an entire day to get through the simplest of household chores." These studies have other interesting findings. In one study, the longer a subject had been HIV-infected, the less fatigue they reported. It was speculated that "they have learned adaptive coping strategies that have helped them live with HIV as a chronic, manageable illness; it is also possible that they have modified their lives in incremental steps to accommodate fatigue."

Lessons from fatigue research

These studies provide direction for the advocate representing an HIV positive client in a disability case. First, don't be deterred by CD4 count and viral load. Second, always ask your client about fatigue. Probe beyond simple answers about fatigue to determine the extent to which the client is limiting her activities because of fatigue. Clients may overstate their abilities. They may state that they can clean the house, but it may take all day. They may be able to spend a day going to medical appointments, but it may take a day or two of rest to recover from the energy outlay required. Clients may not volunteer this information; advocates need to probe. A fatigue questionnaire may come in handy. Various practice guides have such questionnaires.

Support from medical sources: Even though abundant research makes clear that CD4 and viral load are not associated with fatigue, you will need to do some work with the judge to overcome a tendency to place great weight on those labs. You may need to submit some of the many studies, or, perhaps even better, get your medical source to explain this medical knowledge. We frequently include a

paragraph such as this one in the medical source statements we draft for supportive providers.

> [responding to DDS comments about exaggerated fatigue]: Specifically troubling are findings in Mr. X' Social Security file that his fatigue could not be expected, given his condition, "to degree alleged." Though Mr. X has had a historically high CD4 count during the time I have treated him, rising as high as 1208, research and clinical practice show that CD4 count numbers provide no reliable correlation with symptoms, and hold no particular weight in terms of threshold for disability. I have cared for persons with low CD4 counts and high HIV viral loads who have no symptoms. In contrast, I have cared for others who have severe symptoms despite a normal CD4 count and a low viral load (such as Mr. X). Mr. X suffers from debilitating fatigue and diarrhea despite his CD4 count. Controlling Mr. X's HIV infection does not solve his complaint of fatigue.

This statement came from an infectious diseases specialist at an academic medical center. In this case, our client had a CD4 count over 1000, but well documented fatigue. We were able to get an OTR.

2. Chronic Diarrhea/GI issues

Diarrhea and other gastrointestinal complaints are still common in the era of antiretroviral medications. We see this symptom in probably a quarter of the HIV positive disability clients that we represent. Diarrhea can range from mild and intermittent to regular and unrelenting. Even with diarrhea that is intermittent, when it is active and requires repeated unscheduled bathroom breaks, it is impossible to accommodate in a job.

Diarrhea can be caused by HIV itself or as a side effect of the HIV or other medications. This is a symptom that can be embarrassing for a client to discuss, so it can be necessary to probe. Needless to say, it is critical to find out how many days in a week the client has diarrhea, how many bowel movements, the degree of urgency, whether he or she has had accidents. Many clients with severe diarrhea carry an extra pair of clothing with them if they will be away from home for any length of time.

3. Peripheral Neuropathy

Many HIV positive clients experience symptoms of peripheral neuropathy such as pain, weakness, burning, or numbness. Studies indicate that more than one-third of HIV patients have symptomatic distal sensory polyneuropathy. One study found 57.2 percent of HIV-infected patients with signs of peripheral neuropathy. In that study, predictors of peripheral neuropathy included older age, lower CD4 nadir, current ARV use, and past exposure to certain ARV medications (the "d" drugs). Not all patients with HIV-associated distal sensory neuropathy experience pain, but in this study 38% of subjects had painful neuropathy. Pain was associated with higher CD4 nadir and major depressive disorder.

Peripheral neuropathy can strike feet, hands or both. It is often severely painful, requiring narcotic pain medications. Researchers have observed that that this condition "has a serious effect on patient quality of life, including on sleep and diverse aspects of physical and emotional functioning. Spontaneous pain is common, and clinicians and patients report that pain often does not respond fully to the usual analgesic medications."

These symptoms can affect basic daily activities such as personal care, walking, gripping, and fingering. Clients with neuropathy will often have difficulties buttoning their clothes, tying their shoes, opening jars, or even holding a pen. The numbness in their feet may affect balance and gait. The pain can interfere with concentration, memory, and attention.

Often these are relatively mild symptoms and have not been evaluated by the medical provider or even mentioned. If the client complains of these symptoms, we obviously urge her/him to report the symptoms to the medical provider. If the client has access to specialty medical care, they should be sent for a nerve conduction study which is diagnostic for neuropathy.

Peripheral neuropathy in HIV positive patients can stem from either the HIV itself, or from the toxic effects of antiretroviral drugs. It is generally not reversible and can require intense pain management. Early in the HAART era, neuropathy was a very common side effect of certain antiretrovirals. Many people with HIV who have been on ARVs since the beginning have severe neuropathy. In cases of severe pain, the clients are placed on strong narcotics, including methadone. These clients have to contend not only with the unremitting pain, but with the sedation of their pain medicines.

4. Cognitive Impairment

Those of us old enough to remember the pre-antiretroviral days can recall the scourge of AIDS dementia, which took hold in advanced cases of AIDS. Prior to the introduction of combination therapy in the US, about 20-30% of people with advanced HIV infection had symptoms of HIV-associated dementia ("HAD"). With the introduction of the powerful drugs, dementia has become a rare occurrence.

However, HIV still causes several neurological disorders, known as HIV-associated neurocognitive disorders ("HAND"). These vary from mild to moderate and include mild cognitive motor disorder and mild neurocognitive disorder. As many as 40% of people with HIV have some form of HAND. The rates are higher – about 50% -- in more advance stages of HIV. They also tend to be more severe in those with the most immune compromise, such as people with a current CD4 less than 50, a nadir CD4 less than 200, and high viral load. Treatment with ARVs may lead to some improvement in HAND symptoms, but this has not been well tested or documented. Even with treatment, "neurocognitive responses to CART have been varied across individuals, and studies of HAND in treated patients have documented high persisting rates of mild-to-moderate neurocognitive impairment."

A variety of causes for the high rates of HAND in the HAART era include irreversible brain injury prior to beginning treatment; incomplete viral suppression in the central nervous system because of poor penetration of some of the common antiretroviral drugs; the possibility that even very low levels of viral replication in the central nervous system could cause neural injury due to prolonged exposure to inflammatory responses and neurotoxic viral proteins; possible neurotoxicity of HIV drugs; and long-term exposure to increased rates of metabolic abnormalities or increased B-amyloid deposition in the brain. Whatever the cause, it is clear that HAND persists in spite of advanced medications that can effectively suppress the virus.

Qualitatively, these disorders are often characterized as mild, but they can have a significant impact on disability. One study notes, "quality of life is greatly affected, with these individuals suffering from disruptions in ability to perform activities of daily living, perhaps most importantly, that of adherence to the HAART regiment." In the pre-HAART era, patients had more impairment in motor skills, cognitive speed, and verbal fluency. In the era of HAART, neurocognitive impairments have tended to involve "memory (learning) and executive function impairment."

As with fatigue, viral suppression does not protect against HAND. What does predict HAND is the client's nadir CD4 count. These disorders can be present in a client who is otherwise "asymptomatic" and whose CD4 count has rebounded. In fact, this is true at a higher rate in the era of ARVs than pre ARV. The strong association of neurocognitive disorders with nadir CD4 count has been one of the factors that has driven recommendations for earlier initiation of ARV treatment.

Because low nadir CD4 predicts HAND, it is especially important for advocates to find out just how low their clients' CD4 count has gone. Particularly with clients who have come into care with advanced disease and very low CD4 count, advocates should inquire carefully about any cognitive difficulties the client may be having. This should include problems with memory, attention, concentration, and processing speed. Many clients with HIV will describe symptoms of "brain fog."

Documenting HAND: In many HIV cases I see, there is some degree of cognitive impairment, but it is rarely documented objectively. Unless the impairment is quite severe and immediately noticeable, neither the treating physician nor Social Security has obtained any psychological or neuropsychological testing. The effects of HAND can be significant, but subtle, and can easily be missed. This is where an advocate can build a record. Ideally, if a client has signs of neurocognitive impairment, neuropsychological testing should be obtained. However, a full battery of neuropsych testing is expensive and will not be ordered by SSA. If a client has insurance, it may be possible to persuade the medical provider to send the client for testing if there are appropriate clinical indicators. Even if the provider is willing to make a referral, though, this will be difficult for patients without insurance. Even when clients are seen at major academic medical centers that have the relevant specialists on staff, a specialty consultation may be unattainable for a client without insurance. In such cases, it may be possible to at least obtain basic IQ and memory testing at

a reasonable cost. While it may not be as good, subtest scores can document impaired functioning in many of the relevant domains.

* * *

5. General Constitutional Symptoms

Clients with HIV may also complain of a vague constellation of constitutional symptoms, including malaise, joint pain, sleep disturbance, night sweats, and fevers. As with fatigue, these symptoms are not always well documented in the client's medical record because visits are short and he or she may not feel that there is anything that can be done about them, or the provider is more focused on the extent to which the virus is suppressed than on the client's quality of life.

In the first full interview with the client, the advocate should identify any of these symptoms and encourage the client to report them to their provider. By the time a hearing comes around, there may be a better record.

6. Drug Side Effects

As stated elsewhere in this paper, the first antiretroviral drugs were highly toxic and produced many debilitating side effects. Many people could not tolerate the drugs. Of those who did, many experienced long term effects, including permanent peripheral neuropathy. Over the last 15 years, more and more HIV drugs have come on line. They are generally less toxic and more easily tolerated, but many people still experience side effects.

There are numerous HIV-specific resources for researching side-effects of ARVs, including the Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents.

C. Comorbidities:

In addition to HIV symptoms, HIV is also complicated by comorbidities such as **Hepatitis C** (and B), **cardiovascular disease**, **endocrine disease, especially diabetes and insulin resistance**, **renal dysfunction**, **tuberculosis**, **mental illness, osteoporosis, and non-HIV cancers**. These comorbidities complicate management of HIV and lead to drug interactions. It can make it much more challenging for the client to keep up with medical appointments and medications. Many of our clients, at a young age, take 10, 20, or more medications daily. For the advocate, it can be challenging teasing apart the symptoms of these many conditions and often the help of the provider is needed.

Another concern for people with HIV is **premature aging**. As the HIV population ages, it has been observed that even people whose HIV is "controlled" with respect to the key lab values of CD4 and viral load seem to experience typical conditions of aging earlier than the general population. This is particularly true after age 50. Some of the diseases of aging that are striking earlier in people with HIV are cardiovascular disease, osteoporosis, cognitive deficits, depression, high blood pressure, kidney problems, arthritis, diabetes, Alzheimer's disease, and various forms of cancer. For some of these conditions, the increased risk may come from some HIV medications. It is also theorized that HIV may advance the aging process.

1. Mental Illness

Psychiatric disorders are common with HIV, and mental illness is a risk factor for HIV. In many cases, mental illness will be the main event, with the HIV having little or no role in the disability claim. The most common mental disorders seen in people with HIV are major depression, delirium, and anxiety, which are reported in 25 to 50 percent of individuals with HIV. Post Traumatic Stress Disorder is also common in HIV, seen in 13 to 30 percent of people with HIV.

In some cases, clients' psychiatric symptoms stem directly from the HIV diagnosis, either from stigma and social isolation or the stress of living with a life-threatening, chronic illness. Medical or behavioral health records will sometimes report the client's expressions of shame or distress in connection with the diagnosis, or will provide examples of stigmatizing experiences or social isolation. In these instances we argue that the resulting depression or PTSD is a manifestation of the HIV infection under Listing 14.08. (See discussion below.) This is a helpful way to argue mental illness at Step 3 when this illness might not alone satisfy a mental impairment listing.

In other cases, the client has a long history of mental illness, often accompanied by substance abuse. The illness may or may not have been treated. Sometimes the only treatment has been a hospitalization or two in times of crisis. In any case where the client's mental illness is un- or undertreated, it will be important to try to get the client into care.

Many HIV clinics have recognized the need to connect their patients to mental health care in order to improve adherence to treatment as well as prevent secondary HIV infection. Mental illness is tied closely to non-adherence and poorer health outcomes. It is also connected to risky behaviors that lead to further spread of the disease and acquisition of additional STDs. In some major medical centers, the infectious diseases clinic has a dedicated psychiatrist, psychologist or other mental health professional. If you have a client with un or under treated mental illness, this may be a way to connect your client to care. In less resource rich medical clinic settings, getting your client into treatment may be a major challenge.

2. Hepatitis

Hepatitis is a common co-infection with HIV. In our practice, we see more cases of Hepatitis C (HCV) than B (HBV). Both can lead to liver fibrosis (cirrhosis), liver cancer, and death. The incidence of Hepatitis C in the HIV population is estimated at approximately 15-30%. HIV infection has been shown to speed progression of HCV to end-stage liver disease. Co-infected patients may not respond as well to hepatitis treatment. Studies have not shown that Hepatitis C causes more rapid progression of HIV. What is clear, though, is that a patient co-infected with HIV and HCV is much more difficult to manage, given the interactions of the diseases and the liver toxicities of many of the antiretroviral medications. One question is which disease to treat first. Most experts recommend starting ART and getting the HIV under control if the CD4 count is under 200.

Hepatitis C is a disease with a long course. It may take 20 years for the disease to become symptomatic. So for many co-infected clients, the Hepatitis C has little or no effect on the client's functioning. However, even when asymptomatic, fatigue is can be a problem. Skin abnormalities may also be present. As the disease advances, cognitive impairment may occur. Needless to say, many of these symptoms are also present in HIV infection and it can be difficult to tease them apart.

The psychosocial characteristics of many HIV positive patients may adversely affect HCV disease progression. The most obvious concern is the high rate of substance use among people with HIV. Many of our clients are actively drinking or drugging, which contributes to the progress of their disease. Others suffer from depression, which is a contraindication for hepatitis C treatment because a frequent side effect of the treatment is depression. It is common to see a client who is ready for Hepatitis C treatment but who is not placed on treatment because of depression or substance use.

3. Cardiovascular Disease

It is believed that people with HIV are at greater risk of cardiovascular disease than the general population. It is not clear why this is so. One notion is that HIV and the drugs that treat it can lead to increased lipid levels. Another idea is that HIV causes chronic inflammation, which is also a risk for cardiovascular disease. Handling cases of HIV with cardiovascular disease involves no special considerations beyond the increased risk factor.

4. Diabetes

People with HIV have an increased incidence of diabetes. In a study of HIV-infected men, participants were more than four times likely to have diabetes than the general population. Diabetes was particularly associated with several classes of ARVs, the protease inhibitors and nucleoside reverse transcriptase inhibitors (NRTIs). In another study, diabetes was associated with a nadir CD4 count of less than 300.

5. Chronic Kidney Disease

About 30 percent of people with HIV have some form of abnormal kidney function. Chronic kidney disease can put people at increased risk of progression to AIDS-defining illnesses and death. It also complicates treatment of HIV because of the renal toxicity of some antiretroviral drugs.

HIV-associated nephropathy is notable for its quick progression to end-stage renal disease. The prevalence of this condition is uncertain. One study put it at 6.9%. However, results of kidney biopsies from HIV infected people show HIV-associated nephropathy in 40 to 60 percent of specimens.

6. Osteoporosis

Osteoporosis has been found to be more prevalent in people with HIV than the general population, with studies suggesting rates ranging from 3 to 33 percent. As with most HIV associated conditions, there is no clear causation, but possibilities include the virus or antiretroviral medications. Osteoporosis can lead to fractures and frailty.

7. Cancers

Since the introduction of HAART, AIDS-defining cancers have dramatically decreased. The cancers include Kaposi's sarcoma, invasive cervical cancer, and non-Hodgkins lymphoma. While these conditions are less common, they still do occur and generally are aggressive. These cases are likely to be approved at the state agency level.

In the era of HAART, there has been a rise in the rates of non-AIDS- defining cancers. The rate of these cancers is thought to be about twice that of the general population. The most common of these cancers are cancers of the anus, liver, lung, oropharynx, and Hodgkin's lymphoma. Other than Hodgkin's lymphoma, these cancers are not any more severe than in the general population, and do not pose any special challenges for treatment. Hodgkin's lymphoma, however, may be more aggressive in people with HIV.

D. Medication Adherence

In order for antiretroviral drugs to effectively control HIV, it is essential that patients take their medications daily, as prescribed, for the rest of their lives. Adherence to medical regimens is a challenge for all conditions – from hypertension, to lipidemia, to diabetes. Unfortunately, the consequences of non-adherence or inadequate adherence to HIV therapy is more significant than for many other conditions. With poor adherence to HIV medications, the virus can mutate and develop resistance. This can require a change of regimen, which is something providers like to avoid. While the universe of available drugs and combinations has grown in the years since combination drug therapy was first introduced, there are still limits to what is available. Not all drugs can be tolerated by all people, so doctors emphasize the importance of strict adherence so that the arsenal of HIV medications will not be limited.

Because lack of adherence is strongly associated with increased morbidity and mortality, and has serious public health implications there has been a great deal of research on adherence. Some of the predictors of poor adherence include the psychosocial factors discussed above, including mental illness (especially depression, anxiety, PTSD, bipolar disorder) trauma history, poverty, drug abuse, stigma, low education, lack of trust in the health care system, conspiracy theories, complexity of the regimen, memory problems, lack of insurance, and homelessness. Additionally, these are very strong, toxic drugs. Although the newer drugs are generally well tolerated, many do have side effects that are especially problematic in the first weeks or months. Many clients feel better without the medicine that with it. In addition to medication non-adherence, it is often difficult to maintain clients in HIV care, and missed appointments are common. These kinds of problems can be related to the same factors as listed above, as well as lack of transportation.

It is important to be aware of the factors that contribute to poor adherence so that you can be prepared to address this issue. We have never lost a claim noncompliance (yet), but are always vigilant for references to non-adherence in the medical records so that we can address the issue pre-emptively.

* * *

B. The "Repeated Manifestations" Listing: 14.08K

Fortunately, all the conditions that don't quite meet the 14.08 A-J listings can still be stitched together to meet a listing: 14.08K:

> **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.

The 14.08 listing is the one we most frequently consider in our HIV cases. It fits fairly well with the HAART-era experience of HIV. There is often no one condition or symptoms that is disabling, but the combination of all of the conditions severely impacts functioning.

1. Manifestations

Our approach to 14.08K is to start by identifying all possible HIV manifestations, as well as any side effects of HIV drugs, which can be counted as a "manifestation." Manifestations include conditions that are caused by or exacerbated by HIV. This will include conditions that are identified in A-J, but which lack the requisite severity or findings. Examples of A-J items that we often see include diarrhea, weight loss, infections, peripheral neuropathy, and hepatitis. In addition to the A-J items, we include here fatigue, cognitive impairment, sleep disturbances, avascular necrosis, renal insufficiency, diabetes exacerbation, candidiasis (thrush), muscle weakness, pain, night sweats, and any mental distress or impairment that arguably stems from or is exacerbated by the HIV.

Once we identify the possible HIV manifestations, we generally speak with the treating HIV provider and get her/his opinion on which of our proposed manifestations list they can endorse. Sometimes the provider will suggest additional other conditions or symptoms that they believe are related to the HIV. We try to get the provider to give us an opinion that includes an RFC and as much of the following as possible:

- An overview of the medical history and course of treatment.
- A prognosis.
- An explanation of the medical issues in the case, including how various conditions may be related.

- A list of manifestations of HIV (including conditions caused by or exacerbated by HIV)
- Observations of the client during visits, including mood, appearance, reports of subjective complaints, and difficulties functioning.
- An opinion that the client's statements of functional limitations (e.g. need for naps, difficulties with daily activities, limits on walking, standing, etc.) are credible and consistent with the objective medical evidence.
- If the client has a history of substance abuse, an opinion that the substance abuse does not materially contribute to the finding of a disability.
- If the client has a history of non-compliance with medication, an explanation of the reasons for the non-compliance (e.g. medication side effects, difficulties accessing medications, cognitive difficulties, etc.) and/or a statement that compliance would not restore the client's ability to work.
- A brief statement of some medical or scientific point that might be important. For example, if the client has a high CD4 count and/or undetectable viral load, a statement that those lab values to not correlate to fatigue, cognitive impairment or other condition.
-

We find that HIV providers are more open to helping us with medical source statements than providers in other specialties. I think this is because it is not glamorous or lucrative to work with HIV-infected patients. Most of the providers working in this area are doing it because they are dedicated and care about their clients. This level of care will often extend to helping with disability claims. We try to make it easy for them by drafting statements for them based on our telephone conversation.

2. Functional component of the 14.08K listing

In addition to identifying the manifestations, an advocate must also present the claimant's functional limitations that stem from the HIV manifestations. The three categories of functional impairment are identical to those listed in the mental impairments. It should be noted that for 14.08K, it is only necessary to establish one of the categories of functional limitation, although it is rare that only one will apply.

- ***Activities of Daily Living:*** As discussed above in connection with fatigue and cognitive impairment, many people with HIV have adjusted their daily routines so as to cope with their limitations, so they may not perceive themselves to be as limited as they are. It is important to ask how long it takes to do tasks, whether they have to "recover" from undertaking activities such as going to appointments, cleaning, etc., and what kind of help they get from others, including their children.
- ***Social Functioning:*** As discussed earlier, **stigma**, both external and internal, is very common with HIV. Be sure to ask your client who knows about their HIV. They may have contributed to social isolation by keeping their diagnosis secret. They may have withdrawn from activities such as church, or stopped going out with friends. Some clients with visible impairments, such as skin disorders or lypodystrophy (fat

accumulation) may avoid social contact for fear that people will figure out they have HIV.

- ***Difficulties with task completion due to deficiencies in concentration, persistence, or pace.*** Many people living with HIV are able to manage their daily activities, but at a slower pace. Common HIV manifestations such as fatigue, depression, cognitive disorder, weakness, pain, etc., will affect the domains of concentration, persistence or pace. Note that this is an "OR." We often send providers an RFC questionnaire that asks about the percentage of time the client would be off task or unable to keep up the pace. This is useful not only in developing and RFC, but also in establishing this part of the HIV listing.

There is nothing particularly unique to building the functional portion of an HIV case – this is garden variety disability work. Anyone who has developed evidence and testimony concerning fatigue, pain, cognitive impairment or other subjective symptoms knows where to go with this. As in any case, it is important to talk to the client's family, friends, and others who may be aware of their functioning. For people with HIV, that may include infectious disease clinic social workers and HIV or mental health case managers. Most case managers know their clients well and are willing to help. If something helpful can be said, they will say it. Rather than bringing them to the hearing as a witness, we prefer to get written statements. If necessary, though, a case manager can be a helpful witness and a strong ally. Judges generally consider them to be more impartial than family members (though, in fact, they are usually biased in the client's favor). The main concern with case managers/social workers is keeping them from overstating the client's case and giving opinions that are reserved to experts.

SOCIAL SECURITY PROTOCOLS

1. Introduction

Almost all Health Justice Clinic students will handle a disability case. These cases can take a long time from start to finish, often two years or more. So most cases will be handled by a series of students, each of whom will handle different parts of the case. When you receive your disability case, it can be anywhere along the spectrum from beginning to the end.

In these pages, we go through all the steps involved in handling a disability case, but you will probably not do all of them. **It's important that you understand the complete process, though, so you can have an appreciation of what the client and previous students have done, and what will happen after you pass the case along to the next student.**

2. Overview of the Clinic's Social Security case process/procedures

How we get our cases: Our disability clients come to us in a variety ways. Some are referred to us by a social worker, case manager, or medical provider. Sometimes the initial call is from the professional and sometimes from the client. We screen our cases before we agree to represent a client. Most of this part of the process is done by Allison, and Hannah. We gather and review medical records, the social security file, and other pertinent information. We review that information and decide whether the client has a reasonable shot at getting benefits, whether it is logistically feasible to work with the client (e.g., whether we can figure out a way to meet in person with the client), and whether the work will be educational.

Beginning our case work: If we decide to accept the case, we will officially open a file and assign the case to a student. You may be assigned a case that is new to the clinic. As the first student on the case, a the first part of your job will be formalizing our relationship with the client and submitting necessary documents to Social Security, including an "Appointment of Representative form" (Form 1696). Also at the beginning of the case, you will have a lengthy in-person interview and meeting with the client, which you will summarize in great detail in an opening memo. Your interview notes and opening memo will be an important foundation for our work in the case, and each student following you will return to these documents at various stages in the case.

In the early stages of the case and throughout the case, we will be gather medical and other evidence and digest it carefully. We call this "charting" the record. We obtain the Social Security Administration's electronic file and review that carefully. We repeat this set of tasks at each level of the appeal process until the case is finished.

Medical Research: Each student who works on a case must gain a thorough understanding of the client's medical conditions. The importance of this requirement cannot be overstated. It is simply not possible to do an adequate job on a disability case if you don't understand the medicine and science in the case. So, early in your work on the case, you must do whatever medical research is necessary to be sufficiently knowledgeable to understand how the medical facts fit into the disability law, to develop a theory of disability, and to have an intelligent conversation about the case with your client's physician or other medical provider.

We have many medical resources in our office library and there are copious medical resources on the web. The Duke Medical Center Library website is a good resource and is linked from our Clinic website.

Being the second, or third, or fourth student on the case: Because the social security appeals process can take years, we often have cases in our office for years. Some of you will be assigned cases that have been handled by one or more students. You may receive a file that consists of several binders, with hundreds of pages of materials. This can be a bit overwhelming, but don't panic. The advantage of receiving an older case is that you will have a well developed record right at the start. Rather than spending hours charting records, you can pour over the chart and records to gain a detailed understanding of the case early. If you do get a large case file, don't delay in reading it carefully. Start with the transfer memo, case notes, opening memo, and any other memos to the file. Then read the medical chart. Read the medical records themselves. Read the electronic Social Security file, which will be in CLIO. Take notes for yourself as you go along. Pause and do medical research as you go so that you will understand what you are reading.

Developing a theory: One of the most important and intellectually challenging parts of working on a disability case is developing a theory of the case. By "theory" we mean a way of viewing the law and facts together that results in winning the case. Once you have a theory, you will present it to the client's medical provider(s) to try to get their opinion about whether it is valid. Once you have a theory that the provider can endorse, you will draft a statement for the provider to sign. You will also interview other witnesses (the client, people who know them, perhaps an employer) and prepare statements for them to sign.

Presenting/Arguing our Theory. We will present our theory and supporting evidence to Social Security. This will take a different form depending on where the case is in the process. If your case is at the initial or reconsideration level, you will submit your theory and evidence to the Disability Determination Service. At this level, you present your theory/argument informally, in a brief letter. If your case is at the hearing level, you may present your theory in a lengthy memo in support of a Request for a Decision on the Record. This is a kind of "summary judgment" in which you ask the Administrative Law Judge to approve your client's case based on the evidence in the file, without the need of a hearing. The final way in which you may present your theory to Social Security is in a hearing in which you present testimony from your client and possibly other witnesses. Where you present your theory will vary depending where your case is when you are assigned to it. But in most instances, an important part of your work on a disability case will be developing or refining, and presenting your theory.

Maintaining comprehensive medical records and charting. Every student is responsible in a disability case for making sure we have the most recent medical records and "charting" those records. You should always be alert to how up-to-date our records are. If the most recent records are more than three months old, you should request new ones. It is more difficult than you might imagine to make sure that we have all of a client's medial records **It is critical to make sure that we have records from all sources, that the records are regularly updated, that we receive the records we've requested, and that once the records are**

received they are charted and uploaded to SSA by your supervising attorney via ERE.

The rest of this document provides detailed case handling procedures. A shorter version of this material is contained in our Disability Checklist.

PROTOCOLS

I. Initial Steps: Case Screening & Acceptance

Most initial calls from disability applicants are screened by Sandra, Allison, and Hannah. We use the Disability Telephone Screening Sheet to gather information that will help us decide whether to accept a case. You may be asked to do a telephone screening of a disability inquiry. You will do a brief phone interview to complete the Disability Screening Sheet and pass the information on to Hannah or Allison.

In our screening, the most important thing to find out is where the caller is in the application/appeals process and whether there are any approaching deadlines for appeals. Some of the important pieces of information that we record on the Screening Sheet are:

1. What programs has the client applied for? Social Security/SSI or both?

2. At what local Social Security office did the client apply?

3. Was the client turned down after the initial application? If so, when?

4. Did the client appeal the initial denial? (This is called asking for Reconsideration.) If so, when?

5. Was the client's Reconsideration turned down? If so, when?

6. Has the client appealed the Reconsideration decision? (This is called asking for a hearing.) If so, when?

7. Has a hearing been scheduled? If so, when?

Depending on the answers to the above questions, we will take the following steps:

1) **If the client has not yet applied for disability benefits,** we tell the client to go to his/her Social Security Office (most counties have one), and apply for benefits. We do not generally represent clients at the initial application level, but make exceptions from time to time.

2) **If the client has not yet been turned down after the initial application**, we usually tell the client to call us back if s/he is denied. Advise the client that the denial is appealable, and we may be available to assist. **The Durham Social Security Office is located at 3004 Tower Blvd., and their phone number is 541-5443.** The SSA national toll free number is 800-772-1213. We sometimes make exceptions, for instance when a client is especially sick or lacks the ability to adequately pursue the application independently.

3) **If the client has been denied and has not filed for Reconsideration or Appeal,** first find out what the date is on the denial letter. Advise the client that s/he has **60 days** from when the

letter was received to appeal the decision by filing a **Request for Reconsideration** or **Request for Hearing.** (Social Security presumes the date of receipt is 5 days from the date of mailing.) The appeal can be done online or by calling the Social Security to get a form which must be mailed to the client's local (district) Social Security Office. When we do appeals, we do them online to expedite the case.

Fill out an intake form as well as a Disability Screening form, and save them to CLIO. Allison or Hannah will assess the case and determine whether to gather more information or immediately dispose of the case. Be sure that you record when the client's claim was denied. **It is imperative that we make sure that the client understands the appeal deadline, even if we do not accept the case.**

Appeal Forms: Along with the Request for Reconsideration or Request for Hearing form, the client will also need to submit multiple medical releases (SSA form 867) and a form called **Disability Report -- Appeal.** This form asks questions about the client's medical condition since the time of the initial application. If we accept the case, we need to help the client submit the appeal documents within the 60 day deadline. The Disability Report form is available in fillable pdf format on the Clinic web site. However, to expedite the client's case, we submit this form online through SSA.gov. We use the pdf form for taking notes necessary for the online submission process. We will give you details of how to do that. **If you are asking for reconsideration or a hearing online, SSA will not consider the appeal to have been filed until *all forms* have been completed online.**

If you are assigned a new disability case, **make an appointment for a full disability interview**. There are two parts to the disability interview. The first gathers information about the claim, medical history and functional abilities. The second part collects educational and work history. In most instances, you will only be able to complete the first part of the interview in the first meeting. It will take at least an hour and a half. The second part of the disability interview can be done at a second meeting or over the phone. It should take no more than an hour.

Ask the client to bring any letters received from Social Security, his or her medications, the names and addresses of his or her medical providers and any medical reports the client might have. Be prepared to have the client sign multiple general medical releases as well as facility-specific releases. At the interview, get the denial letter from the client and any other information from SSA in the client's possession. You should make a copy of these documents when you return from the interview, and return the original documents to the client. All documents should then be scanned into CLIO and the hard copies put in the client's paper file.

After the first interview, write a detailed opening memo summarizing the disability interview. ***Be as detailed as possible***, as your opening memo will be referred to throughout our work on the case. After the second interview, supplement the opening memo with the education and work information.

The Reconsideration is a "paper review." There is no hearing. Generally, our role at this stage is to ensure that all the relevant medical records are in the Social Security file and sometimes to obtain an affidavit/statement from a medical provider supporting the client's case. After the

appeal has been filed, you can call the Disability Determination Services (DDS) and find out who the claims representative is on the case. If you know that you will have additional medical records to present, let the claims representative know that and ask that s/he not make a decision on the file until you have had a chance to submit the records.

At the Hearing level, our role is to assure that all the medical records get to Social Security, obtain an affidavit/statement from a medical provider, social worker and other third parties supporting the claim and a functional capacity questionnaire from the provider. We submit a legal memorandum in support of the claim, and represent the client at the hearing before the Administrative Law Judge. This will involve the presentation of a direct examination of the client, plus a direct examination of any other witnesses. It could involve the presentation of additional documentary evidence, such as records from Vocational Rehabilitation or a social worker. In some cases, it will involve the cross-examination of either a medical advisor or a vocational expert produced by the Social Security Administration.

5) **If the client has been denied by the Administrative Law Judge**, advise the client that the decision is appealable to the Appeals Council. The Appeals Council sits in northern Virginia and reviews cases from the entire country. Let the client know that favorable decisions from the Appeals Council are very rare and take a long time. The deadline for filing a **request for Appeals Council review** is 60 days from the receipt of the ALJ's denial.

We sometimes represent a client at the Appeals Council. This is a paper review of the case. Normally, we would review the file and the decision from the ALJ, and write a memorandum of law on behalf of the client in an attempt to have the ALJ decision reversed.

6) **If the client has been denied by the Appeals Council**, the case is appealable to the Federal District Court. Discuss with your supervisor to determine what procedures are appropriate.

II. REPRESENTING A CLIENT:

Once we determine to accept a case, the Supervising Attorney will change the case status to "Open" on CLIO and Sandra will prepare a file for you. For Disability cases, we keep our files in looseleaf binders which have a specified set of tabs. You may need to add additional tabs based on the information in your case. Fill out a **Disability Case Status Sheet** in CLIO and fill out as much of it as you can. Print it and place at the front of the binder, before the first tab. **Always keep the Case Status Sheet updated in CLIO**(and print an updated version at the beginning of the semester, mid-term and the end of the semester)**.**

Pertinent information should be entered into the case record in CLIO.

Here is what you will do in handling the case:

A. 1696, Appointment of Representative

If we decide to represent a client, a form 1696, Appointment of Representative must be signed by the client and filed with SSA. Because the Social Security appeal takes so long, all supervising

attorneys should be listed on the form, with Hannah listed as the main representative, unless another attorney will be supervising the case. The client and the supervising attorney must sign the form before it is submitted to SSA.

B. Request and Summarize Medical Records

It is essential that we gather all of the client's medical records. Be sure to get a complete list of all of the client's health care providers from the client – we will need a signed medical release form for each facility. Mistakes on the medical release forms will delay receipt of the records, and thus your ability to make progress on your case, by many weeks. **You must pay *great attention to detail* when requesting medical records.** Some providers will accept our general medical release, but many hospitals and clinics require their own release form, so please check with your supervising attorney or call the provider to find out what they require**.** Many of the facility-specific releases are available on our website. When requesting psychiatric or substance abuse records from Duke, UNC, Lincoln Community Health Center, and some other providers, you must send a separate letter requesting this information**.** Also, many medical release forms have boxes which *must* be checked off or initialed by the client. Before having your client sign any releases, make sure that you understand what the form requires and that you give the client clear and thorough instructions about what and where to sign. **Do NOT have the client fill in the name of the provider on the general release form – have them leave this field blank, and also do NOT have the client fill in ANY DATES – *the dates of records requested should be left blank on the form, as should the date the form was signed*. We only want signatures (and initials and/or boxes checked where applicable)- NO DATES.**

After you have gathered the signed releases, scan them and save them in CLIO. Then fill out the appropriate dates on a clean copy of the form and send each provider a cover letter requesting the records, with the signed release. **Make sure that you do not request records we already have – you must make the dates clear on the form and in your cover letter or often we will receive duplicates. If your client was an inpatient, talk to your supervising attorney about how to request the records.** We have addresses and fax numbers for many providers on our contact list in CLIO. If the provider/facility accepts records requests by fax, send them by fax, as this will save the process. If you fax the request, scan the fax confirmation sheet and save it in CLIO. If you need advice about getting records from specific providers, ask your supervising attorney.

Keep a record on the Disability Case Status Sheet of all of the providers and when the requests were mailed. **Update this form as records are received**. If the records are not received within a few weeks, call to check on the request. Also, when you do receive records, take a look at them to make sure you got everything you were expecting**. It is critical that you follow up on the records to ensure that we have all of them**. Many facilities waive copying fees for us but if a fee is required, simply give the bill to Allison or Hannah.

When you receive records, please scan them and save them to CLIO, using the code "MEDR" (Medical Records). **Medical records files should be saved in the following naming format: facility and dates of records without any commas. (E.g., "UNC 04012014-05152015"**

or "ECU 01072013-02052015). Files need to be named this way because ERE will only accept documents that do not have characters in the file names and it wastes time for your supervising attorney to have to re-name each document so that ERE will accept it. Also, when the files of medical records are named this way, then it is easier for someone after you (or for you) to find records from a certain facility and date. After scanning the records, three-hold punch them and place them in the binder. Additional binders may be necessary. Place the records behind a divider tab that is labeled for the provider. If you need divider tabs/labels, let your supervising attorney know or request them from Sandra.

Once you have started to receive the records, you should create (or update) a chart that lists the records chronologically and summarizes the symptoms, diagnosis and treatment. Get the medical chart template from our website. Charting medical records is a very time-consuming task, so don't wait until all the records have arrived to get started. When you begin charting your records, get some guidance from your supervising attorney. It's usually a good idea to show your supervising attorney the first few entries to make sure they are at an appropriate level of detail. Refer to the "Guidelines for Charting Medical Records" as you chart. Update this chart as you receive all of the records.

In addition to charting the records, you should create a medication list and if the client has HIV, a HIV Labs list. The medication list is a place to track our clients' medications and their purpose. The HIV Labs list will enable us to quickly review the CD4 and viral load levels.

Often, the medical records will be hard to read and difficult to understand. There are several resources to help you decipher the records. In your Clinic notebook you can find (1) explanations of commonly used symbols and abbreviations; (2) definitions of commonly used medical terms. We also have many helpful links on our webpage, including medical references, medical abbreviations and dictionaries and information about particular disorders. Ask your supervising attorney whether any medical students or other sources are available to consult with you about the medical records.

C. Supporting Affidavits:

Develop a list of people who are potential witnesses for the client. These are people who can provide useful information about the client's functional limitations. The list may include social workers, case managers, former employers, family members, friends, and the client.

The first step is to develop questions for the witness after reviewing the client's file. Your supervising attorney will direct you to affidavits prepared in other cases we have handled. After developing your questions, interview the witness. Third, draft the affidavit. (If your witness is a social worker, you may want to have the witness set out and support your theory about the case. See the paragraphs below about formulating a theory and doctor's affidavits.)

Refer to the handout, Guidelines for Drafting Affidavits and Sample Affidavits, in these materials, on the website, and in a binder on the bookshelf in our pod.

After your supervising attorney has approved it, send a draft to the witness with a letter explaining that he/she should review the affidavit. If the witness would like to make any changes, he/she should call you ASAP. If not, you should print the affidavit on bond paper, get it to the witness, and help arrange to have the affidavit signed, notarized, and mailed back to the clinic.

D. Request/Review Social Security File

We need to obtain a copy of Social Security's file. If the client's claim is at the initial or reconsideration phase, you will have to request the file from SSA and they will send it on a CD. Once a hearing has been request, Social Security files are maintained electronically (ERE). Before the file is electronic, we request a copy of the file by sending a letter, with a blank CD and a signed SSA 3328 form, to the client's local SSA office. You may have to follow up with the local SSA office to make sure you get the file on CD. If your client has already requested a hearing and we have submitted a 1696, your supervising attorney will be able to download the SSA file from ERE and save it as a PDF. Please note that we save an OCR'd version of these PDF's, which means that you can search for text in the document. OCR does not pick up every character correctly, but is a very helpful tool in finding things quickly.

When you have a copy of the Social Security file, you must carefully compare the file with the records that we have. **Make a list of medical records that we have that SSA does not**. These records should be submitted to Social Security. This is done via fax or on ERE, depending on whether the case is at the local office or ODAR. Regardless, we need to obtain a special bar code from Social Security to use in submitting documents. Check the file to see whether we already have the bar code. Note that a bar code obtained for initial or reconsideration levels cannot be used for a case that is at the hearing level. You will need to obtain a new bar code from the hearing office (ODAR). Your supervising attorney will upload the records to SSA for you after you inform her that they need to be uploaded. Also please note any medical records that SSA has that we don't and discuss with your supervising attorney whether to request additional records from that provider.

E. Formulate a Theory

After all of the medical records are received, complete the medical records chart. Then develop a theory about how the client meets the listings or otherwise meets the Social Security standards for disability. Your supervising attorney will brainstorm with you about possible theories. Your theory should follow the five steps of the sequential evaluation.

As you work on developing theories, you may realize that additional evidence is needed to support your theory. For instance, the theory you are contemplating may require certain results on a medical test that has not been administered. In such a case, we may be able to ask the client's doctor to refer the client for the necessary test. It may also be possible to ask Social Security to pay for additional evaluations that might establish the client's disability. In some cases, the Clinic will pay to have the client evaluated by a specialist to develop essential evidence. Please discuss any ideas for additional evidence with your supervising attorney.

F. Medical Affidavits/Statements

You also need to obtain affidavits from the client's physicians. In these affidavits your goal is for the physician to describe the client's medical problems and to set out and support your theory about how the client meets the listings. When you are ready to start working on affidavits, ask your supervising attorney to point you to some samples. Then, develop questions for the doctor based on the client's medical records and your theory about the case. If the client has seen several doctors, you may decide to ask one to review the client's records and formulate an opinion about the entire chart. After developing a tentative theory, you should write the doctor, outlining your theory, setting out your questions, and enclosing relevant portions of the Social Security listings. Ask your supervising attorney for a sample letter. You may also want to include a special questionnaire addressing the clients physical or mental functioning. A comprehensive set of such questionnaires is available on the web.

After sending your letter and other materials, interview the doctor (usually by phone). You will need to obtain the doctor's credentials and find out how long the doctor has been treating your client. We have a notebook in the clinic office which contains the Curriculum Vitae of physicians we have used in previous cases. You will also need to explain the relevant Social Security standards to the doctor and ask if your theory is supportable given the client's medical condition. The doctor can sometimes help you formulate a new theory if your current one isn't supportable. Finally, based on your conversation with the doctor, draft the affidavit.

After your supervising attorney has approved the draft affidavit, send or e-mail the affidavit to the doctor asking him/her to review it. If the doctor would like to make any changes, s/he should call you ASAP. You should make the appropriate changes and send it again. As a rule, avoid having the doctor make the changes her/himself; the doctor might inadvertently change some language that is essential to supporting the claim. Once the affidavit is final, the doctor should sign it and have it notarized. Make arrangements for having the affidavit mailed back or picked up, depending on how quickly you need it.

We sometimes ask the doctor to fill out a residual functional capacity questionnaire in addition to the affidavit. Our practice manuals have numerous forms, and several are posted on the website. These questionnaires help us establish the client's residual functional capacity, which is needed to assess Steps 4 and 5 of the sequential evaluation.

G. Evaluation of the Client's past work

Although we try to win our cases at step 3 – based on a listing – if we can, we need to be prepared for steps 4 and 5 as well. In order to do this, we must carefully assess the client's past work and determine why he or she is unable to return to it. We also need to determine whether the past work is "relevant" – that is, it was done recently enough (within 15 years); long enough for the client to have learned it; and that the work was performed at the Substantial Gainful Activity ("SGA") level.

First, we must identify the client's past work. Use the information collected in the disability interview as well as information in the Social Security file to make a list of the jobs the

client held in the last 15 years. Search the Dictionary of Occupational Titles (DOT) to try to find the job or jobs that seem closest to what the client described. The DOT is available in hard copy in our office, and an electronic copy is linked from our website.

When you have identified the likely past jobs, copy the entire DOT entry and review the jobs with your client to determine whether you have the right ones. In most cases, you will need to do this orally. If your client is particularly well educated, you may be able to send the DOT description to your client for review. Once you have come up with what you and the client agree are the past jobs, verify how long the job was done and how much the client earned. Determine if any of the jobs can be excluded as past *relevant* work.

At Step 4, you must establish that your client could not do the job as the client performed is *or* as the job is generally performed in the national economy (i.e., as described in the DOT). Develop your theory as to why the client is no longer able to perform those jobs. You may need to refer to the publication, "Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles" to learn more about specific physical demands of a particular job. Find out from the client specifically which physical and mental demands they can no longer fulfill, and why.

H. Draft Memorandum in Support of Claimant

Prior to the hearing, you will need to draft a legal memorandum to the Administrative Law Judge arguing our theory as to why our client is disabled. The memo will describe the client's educational background, work history, health problems and then our argument as to why the client meets the listings or is otherwise disabled. Your instructor will direct you to sample memos.

Note that in some cases, we will be asking for a decision on the record, well before a hearing is scheduled. This is akin to summary judgment. We ask for such a decision in particularly strong, compelling cases.

I. Prepare Direct Exam for Client for Hearing

At the hearing, you will do a direct examination of your client and any other witnesses. Prior to the hearing, draft questions the questions you will be asking. Basically, you just want to walk the client through the memorandum that we submitted on his/her behalf. Write basic questions that address his/her work history, health, daily activities, etc. You will need to plan to get the client to give a lot of detail. Your supervising attorney can refer you to questions prepared in other cases, to give you some idea of how to proceed. It will also be helpful to refer to some of the Social Security practice guides in the Clinic library.

Record-keeping note: <u>Remember to update the Disability Case Status Sheet form as the case proceeds. It is very important that this form be current at all times.</u> <u>As you will see, case files for disability cases are quite voluminous and include records from numerous sources, which often have to be updated regularly – it is easy for something to get lost in the shuffle if we do not keep the Disability Case Status Sheet current and accurate.</u>

FACTUAL INVESTIGATION:
Essential Information in a Disability Case

Information	Where you find it	How you get it
Medical History & Treatment	• Medical Records (that we collect and that are also in the Social Security File) • Client interview & follow up • Medical providers (MD, PA, NP) • Mental Health providers	• Medical Record Request • Interview client, record in opening memo, follow-up calls • Send questionnaires; letters; phone calls with providers
Background information on claimant's medical conditions	• Medical & Disability resources in clinic library o Morton, Medical Issues in Social Security Disability o Many medical texts • Online clinic resources on links page • Web searching • Other medical resources • Client's providers	• Take advantage of BOOKS in AIDS clinic pod. • Web searches • Duke Medical Library • When interviewing provider, ask questions about medical conditions that you have not been able to answer through your medical research
Work History & Earnings	• Client interview & follow up • Employers – personnel file, pay records • Dib Wiz (full DIB Review Sheet) (obtained from SSA) • SSA file: o Disability Report Adult (SSA Form 3388) o Work History Report (completed by client) • Brief references in medical records and other sources	• Interview client, f/up calls • Make written or phone request to employer, with release • Request from SSA • Request from SSA • Careful review of entire file
Claims information, including • Application date • Protective filing date • Alleged onset date • Date last worked • Dates of denials & appeals • Prior applications	• Client's statements (this may be inaccurate and must be verified) • SSA file: ▪ Disability Report field Office (Form 3387) ▪ Dib Wiz Report	• Interview client • Request from SSA
Names of Third Parties who can describe client's limitations	• Client's statements • SSA file (particularly Form 3387)	• Interview & follow-up calls • Request from SSA

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Guidelines for Charting Medical Records:

The purpose of the medical chart:

The "medical chart" is our way of digesting medical records in a disability case. Using a table format, we write a detailed synopsis of each individual medical record, in chronological order. We frequently quote significant language directly. There are several purposes for charting: It provides a complete, chronological picture of a client's medical history. The very process of charting helps you understand the client's medical conditions at a deep level. In addition, the completed chart is an invaluable tool for preparing documents such as letters to doctors, affidavits, and legal memos. The time invested in charting saves time flipping through medical records and "re-learning" the case when we later draft documents. It can be searched and easily reviewed, unlike the medical records themselves.

When you review medical records you will quickly find that they are full of abbreviations and symbols, which you must understand. The following website, which provides a list of symbols and abbreviations is linked on our coursepage: http://him.duhs.duke.edu/modules/HIM_university/index.php?id=8. Of course, you can also just do a web search. If you have a questions or are working with hand-written records, please consult your supervising attorney.

An essential ingredient for useful and efficient charting is some knowledge of your client's illnesses. Without that context, your charting will take longer and you may miss important information. Before you start charting, do some basic medical research. There are numerous resources on our coursepage, the web, and in our clinic library. In particular, we recommend Dr. David Morton, *Medical Issues in Social Security Disability*. This resource is on the bookshelf in our pod.

When you chart medical records, you should always be thinking about what you need to provde your disability case. In a nutshell, those things are:

- The client's **impairments** – that is, **diagnoses**.
- The **medical signs and symptoms** that establish those diagnoses, including **physical exam, laboratory values** (especially CD4 count and viral load), **diagnostic tests** (e.g. x-rays, EKG, liver biopsy), etc.
- The client's **symptoms** that result from those impairments.
- The **frequency, duration**, and **intensity** of those symptom
- How those symptoms affect the client's **functioning**
- The **treatment** and **prognosis** for each impairment

You should chart information that supports our client's case, as well as information that undercuts our client's claim. We need everything relevant, whether it is good or bad. We can't ignore the bad evidence.

Types of documents you will find in the medical file:

1. **Clinic/Office visit notes:** Often typed; sometimes handwritten. These range from very detailed to sketchy. In smaller clinics, they may be handwritten on a pre-printed form. Typically, they will include the patient's complaints, medical history, physical, impressions, current medications, treatment plan. The medical history includes anything in the patient's past medical history. Some of these conditions will have been resolved already, for instance a bout of candidiasis that has been treated. Others will be ongoing, such as HIV, Hepatitis C, depression.

Clinic/Office notes should be charted BEFORE other records. They will give the "big picture," including the impressions and treatment plan of the primary treating physician.

At teaching hospitals, such as Duke or UNC, the note will often be written by a physician in training or nurse practitioner (eg a resident or fellow) and there will be a note that they have been reviewed by the attending physician. In this case, it's generally the resident or fellow who actually saw the patient.

Most physician/provider notes include the same standard components, not necessarily in the following order.

Components of Office Visit Notes:

- **Vital signs**: height, weight, blood pressure, heart rate – *chart this if possibly relevant to your client's case – e.g. there are issues of weight loss, high blood pressure, etc.*

- **List of Medications** (sometimes includes both current and discontinued meds) – *always include medications – if they mostly remain constant, just record changes in medications*

- **History**: Past medical history, reported by the patient or from prior records. *This should be noted once in the chart, unless there is some change*

- **Present Complaint**: what brought the patient in today – this will be patient's explanation of symptoms, what brought them on, etc. *This should always be noted in the chart*

- **Review of Systems**: provider asks patient whether there are any complaints in any of the body systems. This part of the note contains what the patient says, not what the doctor observes. *Note anything that is other than normal. Also note normals if they are germane to any impairment the client is claiming. For example, if the claimant claims to have a back pain, and the musculoskeletal system is marked normal, you would want to note this, as it undercuts the claim.*

- **Physical Examination**: doctor examines patient and records results. *As with the Review of Systems, include abnormals as well as normals in an area of claimed impairment*

- **Assessment**: discussion of possibilities, diagnoses. *Always must be charged*

- **Plan**: actions to be taken, including medications prescribed, consultations or tests ordered. *Always chart this.*

2. **Consult notes:** These are the clinic/office notes of a consulting physician. For example, the family doctor or Infectious Diseases doc may have sent the client to see a specialist in another field, such as a neurologist, liver doc, etc. These notes will be organized in the same manner as the general clinic notes and should be charted in the same manner. The consult notes should be charted along with the clinic/office notes.

3. **Emergency Room visits:** These are generally a pre-printed (or computer generated) form, with record of vital signs, complaints, physical exam, medications given. Because it's pre-printed, often the only indicator will be a symbol of "**+**" or "**-**". The "+" means that the symptom is present. The "–" means it's not.

When charting, be sure to note all symptoms, their duration and intensity. Intensity of pain will be measured on a scale of 1-10, with 10 being high. Be sure to include pain intensity.

ER records will indicate whether the patient was discharged or admitted to the hospital. Be sure to record this information. If the patient was admitted, chart the hospital admission as a separate entry.

4. **Hospital Admissions:** There will often be a huge pile of daily records (nursing notes), consults with specialists, studies, tests, etc. Do NOT chart everything. Start by charting the discharge summary in detail. Then chart the admission note and any consult or test result that was highlighted in the discharge summary. Scan through the rest of the records. Discuss with your supervisor any other records that you think are worth charting. Retain the rest of the records in the file.

5. **Labs:** These are reports of various lab tests, generally from blood or urine. Do not chart these until after you have charted the clinic notes and hospital records. Until you know what's important for your client's case, only chart labs that are not normal. These will usually be noted in the lab report or "H" for "high" or "L" for "low." Often the lab report will include a "reference range," which tells what is considered "normal." Include the reference range when charting (at least on the first entry). You can also find out what's "normal" for a particular lab through various medical research tools (including, often, just googling).

6. **Mental Health/Psychiatric Office Notes:** These are a somewhat special animal. They will often be sketchy and difficult to extract from the provider, for privacy and therapeutic reasons. Record any symptoms noted, their duration and intensity. Any

details about medical or work issues are important too. Often the record will include a diagnosis in a "multiaxis" format. Include the diagnoses for each of the five axes. The final axis is the "GAF" or "Global Assessment of Functioning." Be sure to include the GAF score in your notes. This is a standard (though very subjective) numbering system that will give some idea of the severity of the client's illness and its effect on functioning.

General Principals of Charting:

1. Don't chart blind. The medical records will make a lot more sense if you have a basic understanding of the conditions your client has. Give yourself an overview of the major illnesses through basic medical research. There are many links on our website. You can also get basic information through quick web searches. Continue referring to medical references as you chart.

2. Do your charting in good size chunks. Most students find that they are most productive when they chart in blocks of at least two hours. Charting requires getting organized and focused, which can be difficult to do in the hustle and bustle of daily pod activity. For this reason, you may want to do your charting in the Clinic conference room, or during non-business hours.

3. By the same token, DON'T PROCRASTINATE about charting. It can be overwhelming to face a thick stack of medical records, but if you don't get started, you will never produce anything for your client.

4. Start by charting the clinic notes. This will give you the big picture. DO NOT start by trying to chart labs!

5. Look up all unfamiliar medical terms and abbreviations. It's helpful to insert the definition in brackets in your medical chart. Then, when you, your supervisor, or a future student refers to the chart, it won't be necessary to look up the term/abbreviation again.

6. Always record the CD4 count and viral load. They will often be referenced in the clinic notes as well as lab records.

7. Record all medications the client is taking or has taken. The first time you enter a particular medication, please look it up (easily done through googling) and indicate in brackets what the medication is for. If you want, keep a separate page with more detailed information about the particular medication, or links to references on the drug.

8. When noting symptoms, include the frequency, intensity and duration.

9. Include non-medical information if relevant. Medical records can be an excellent source of information on the client's employment, efforts at employment, living situation, drug/alcohol use, and other aspects of the client's life that may impact the disability case. Always include references to any work the client may be doing or seeking. Also, rsome records which may seem irrelevant– e.g. a broken hand -- may be relevant to claims that the client has a mental impairment that renders her/him unable to get along with others.

DATE	PROVIDER	SUBJECTIVE -- COMPLAINTS HISTORY	OBJECTIVE – EXAM, ASSESSMENT, DIAGNOSIS	DRUGS/TREATMENT
9/25/08	Barbara Jones Community Resource Solutions	Client indicates the need to maintain therapeutic relationship to manage depressive anxiety, panic, anger, guilt feelings, excessive worry, etc. He feels he began to experience difficulties as a teenager due to being a victim of sexual abuse at hands of brother. Other began getting treatment in the past few years. Substance Abuse: He is currently abusing alcohol narcotics monthly. His family has encouraged him to stop. He had a significant period of sobriety that lasted 2 months. His recovery environment includes AA attendances. Symptoms: His depressive symptoms include fatigue, suicidal ideations, decreased concentration. His Manic symptoms include extravagance with money. The client's anxiety symptoms include anxiety, nightmares, and panic. The panic happens mostly after having bad dreams. He has difficult following directions and talks excessively, which are attention symptoms. He has suicidal and homicidal thoughts, but no plan. He has paranoid trends, and his affect is depressed, flat, and confused. His reported mood is calms. His thought form is characterized by loose association, slowness in thought association, and confused. Social History: Raised by his mother, with whom he has a very good relationship and she pays his bills.	Diagnosis: Axis I: 296.34 Bipolar D/O, psychotic features Axis II: V71.01 Antisocial Axis III: HTN, neuropathic pain, HIV Axis IV: unemployed, social isolation Axis V: 52 Summary/Recommendations: The client presents a history that is significant for sexual abuse, suicidal gestures, depression, anxiety, substance abuse, anger, etc. He began experiencing difficulties in his teen years, but it was not until recently , in the past few years that he sought treatment. He does acknowledge a reduction in his depression and anxious feelings as well as his use of substances which he attributes to therapy and psych. medication use. He does recognize he continues to need treatment to learn more effective coping skills to reduce intensity of stress, depression, anger, etc. In addition SA/NA to help with substance abuse issue. Plan: 1) one on one psychotherapy/ depressions/anxiety/panic 2) anger management 3) continued medication management	Atriplea Zypreaxa 25mg QD Trazadone 25mg qhs Lamectol 200 mg qhs Cymbalta 60 mg bid

Using Affidavits in Disability Cases

The Purpose of Affidavits:

An affidavit is a sworn, written statement from a witness. Preparing witness affidavits is an important part of handling a disability case. The witnesses may be doctors, nurses, substance abuse counselors, therapists, social workers, case managers, former employers, friends, relatives, or even the client her/himself.

In civil litigation, affidavits are most commonly used as evidence for motion practice. At trial, evidentiary restrictions permit affidavits only in very limited circumstances. Social Security practice, however, is governed by more lenient evidence requirements. It is common to support a disability claim with written statements from various persons – witnesses – with knowledge of the facts that are relevant to the claim. These statements are not required to be under oath (i.e. an affidavit), but it is our practice to do so because they will carry additional weight.

Affidavits are used in several contexts. At the Reconsideration level, where no testimony is taken, affidavits enable us to provide the claims examiner with statements that will supplement what is in the medical records. At the hearing level, we use Affidavits to support a request for a decision on the record as well as to present testimony without having to bring a busy witness – e.g. a physician – to the hearing. Even when a witness would be willing to attend the hearing, most Administrative Law Judges prefer to avoid having more than one or two witnesses, so we can use an affidavit to supplement the testimony of live witnesses. Most Social Security hearings are limited to one hour.

As part of the process of developing a case, we identify witnesses that would be helpful to support some part of the client's case. We interview those witnesses and if they have helpful information, we offer to draft an affidavit for the witness's signature. If a witness lacks helpful information, we keep notes of what we learned, but don't prepare an affidavit.

Types of Witnesses

The witnesses that we commonly seek in disability cases break down into roughly three categories: 1) Medical providers (physicians, nurse practitioners, physician's assistants, mental health professionals, substance abuse professionals); 2) Social worker/case manager; 3) Friends, relatives, other non-professionals, and the client. Each of these types of witnesses has something different to offer to support our case.

To establish disability under Social Security's rules, we generally must establish medical diagnoses, signs and symptoms; the client's functional capacity; and educational/vocational background. Medical providers help us establish the medical criteria. They can often help us with functional limitations as well. Medical providers generally will qualify as experts, and can thus give expert opinions within their area of expertise. Other witnesses are unlikely to be qualified to give expert opinions, but they

can provide facts and concrete observations to support the client's claim. Social workers/case managers can help us with symptoms and functional limitations. They may also know about the client's education or vocational background. Third parties, such as friends and relatives who have regular contact with the client, can help us prove the client's functional limitations and daily activities. Current or former employers can help us with functional capacity and ability to do work related activities.

Format of an Affidavit

An affidavit consists of numbered paragraphs setting forth the "testimony" of the witness, who is referred to as the "affiant." It generally begins by identifying the affiant and setting forth her/his connection to the client. This establishes the requisite personal knowledge.

Affidavits are written in the first person, from the witness's perspective. As much as possible, we try to use the witness's own words in the affidavit, but most of the affidavit will not be direct quotes from the witness. Your job will be to take good notes and the write out a logically arranged presentation of the witness's statements. Use language and vocabulary appropriate to the witness. An affidavit for an expert can include the terms of art and complex language of the profession. But an affidavit from one of the client's relatives who has a limited education should avoid legalese and complex language the witness would never use.

The affidavit must be signed under oath by the affiant in the presence of a notary public. Sometimes, when the affiant is unable to get to a notary, we will prepare a "statement" rather than an "affidavit." The content is essentially the same, but it will not be under oath or notarized.

Sources of Affidavits:

Medical Providers:

Medical providers can provide affidavit testimony that summarizes the client's medical history and provides a synthesis of the various medical conditions, their severity, prognosis and inter-relationships. Affidavits from medical professionals are usually "expert" affidavits, so we also include information about the provider's training and qualifications. We usually request a CV, a copy of which we attach to the affidavit and incorporate by reference in the document.

Although medical providers usually are "experts," we take care to limit their opinions to their areas of expertise. For instance, an HIV specialist is exceptionally well qualified to give an opinion about the client's HIV. The HIV specialist may also be good source of an opinion on other medical issues, but a specialist in another area may be even better. For instance if a client's HIV is accompanied by liver disease, we would seek an opinion both from the HIV specialist and the liver specialist. On the issue of the liver disease, the latter would carry the most weight.

We do sometimes stretch an HIV specialist's expertise if s/he is the only provider treating a condition other than HIV. This is often the case when a client gets care at a health department and has limited access to specialists. Also, many of our clients suffer from depression or other mental illness. Frequently it is the HIV specialist who is prescribing an anti-depressant or other medication. In such a case we may ask for an opinion from the HIV specialist about the mental illness, but we recognize that it will not carry a lot of weight with Social Security.

Even though we try to limit our medical or mental health provider opinions to the providers area of expertise, there is no problem with asking the provider about their personal observations relating to any other condition. For instance, although a mental health provider is not competent to give an opinion on a client's peripheral neuropathy, the provider may have witnessed the client's difficulties walking, using her fingers, or expressions of pain.

Here are some of the opinions, explanations and other content we seek in medical provider affidavits:

- An opinion that the client meets a particular listed impairment. This is something we hope for in every medical affidavit. As stated above, an opinion will be most helpful when it pertains to the provider's area of expertise.
- An explanation of the medical issues in the case, including how various conditions may be related.
- An overview of the medical history and course of treatment.
- A prognosis.
- Observations of the client during visits, including mood, appearance, reports of subjective complaints.
- An opinion regarding the credibility of the client's subjective complaints, especially pain and fatigue.
- An opinion that the client's statements of functional limitations (e.g. need for naps, difficulties with daily activities, limits on walking, standing, etc.) are consistent with the objective medical evidence.
- If the client has a history of substance abuse, the provider may be able to give us an opinion that the substance abuse does not materially contribute to the finding of a disability.
- If the client has a history of non-compliance with medication, the provider can help explain reasons for the non-compliance (e.g. medication side effects, difficulties accessing medications, cognitive difficulties, etc.)

The process for developing a medical affidavit, in consultation with your supervising attorney, is as follows:

1. Chart all medical records and gain as complete an understanding of the medical evidence as possible. Research the medical conditions as necessary,

using web-based materials and reference materials in the clinic "library."

2. Review Social Security listings and rules to develop a "theory" of the case – i.e., what listings might the client meet? Might the client qualify through the "grids"? What is the client's residual functional capacity?

3. Draft a letter to the provider setting out your suggested case theory and any remaining questions. Send the letter to the provider, with a copy of the relevant Social Security listings.

4. Talk to the provider on the phone and discuss your theory, any insights and observations the doctor can add, including alternate theories, and get answers to your questions.

5. If the medical provider is able to provide information that is useful, offer to draft an affidavit based on the medical records and your conversation for the provider's review. Even if the provider is unwilling to state that the client meets a listing, s/he may be able to provide some other helpful information about the client's condition and functioning.

6. Based on the conversation and the medical records, draft an affidavit for the provider's signature.

7. Send a draft affidavit to the provider, asking the provider to sign or note any changes.

8. Communicate with the provider again to find out whether any changes are needed.

9. Follow-up to get the signed affidavit.

Social Workers/Case Managers/other professionals:

Social Workers and Case Managers can be a good source of information about the client, her/his personal and treatment history, family, symptoms, and functional abilities. Even if they don't turn out to be good affidavit witnesses, they can often lead us to others who can. Social Workers/Case Managers will often have had in-depth, regular contact with the client. Social Workers are often based in a clinic, so they usually haven't been to the client's home. Case Managers, on the other hand, frequently have been to the client's home, met her/his family members, or have helped clients manage basic activities like paying rent, getting bus passes, attempting to work.

Social Workers and Case Managers generally will not qualify as expert witnesses, so their affidavits are useful to flesh out facts, *not conclusions.* They sometimes will offer their opinions about medical or psychological matters, but unless they are providing

mental health services, they are not qualified to give such opinions and we would not include them in an affidavit.

Social Worker/Case Manager affidavits are best when they provide detailed, first person observations of the client's physical and mental capacity, ability to get along with others, handle stress, and take care of daily activities like paying bills, shopping, getting from place to place, taking medications, getting to various appointments, etc. The Social Worker/Case Manager can often identify task with which the client needs assistance from others. Concrete anecdotes are especially helpful. For example, a case manager might be able to say that she has to remind the client of medical appointments, fill her/his pill box, or read and explain her/his mail. A case manager might be able to say that she has observed the client regularly using a cane, that the client dozes off during their meetings, or that she has observed the client when s/he was in pain.

The process for getting a case manager/social worker affidavit is as follows:

1. Become sufficiently familiar with the case so that you understand what is needed to support the client's case.

2. Come up with a list of questions for the witness, in consultation with the supervising attorney.

3. Call the case manager, social worker, or other professional. Ask her/him about the client, including general impressions. Ask the specific questions you developed. Listen for any other insight or information the witness may be able to offer. Ask the witness if s/he would be willing to sign an affidavit you prepare.

4. Evaluate what you heard from the witness and discuss with your supervising attorney. If the witness provided useful information, draft an affidavit summarizing the witness's comments. Give a draft to your supervising attorney.

5. Finalized the draft affidavit with your supervising attorney and send a copy to the witness by mail, fax or e-mail, depending on the preferences of the witness. Include a cover letter or note explaining that the witness should review the draft and let you know of any needed changes. After changes are made, arrange for the witness to sign the affidavit in front of a notary, whether at our office or elsewhere.

Third party Non-professionals – friends, relatives, and the client

The client, her friends and relatives can be important sources of evidence in a disability case. Because the case will often turn on the client's ability to engage in work activities, it's important to develop evidence of what the client can and can't do, as well as what s/he needs assistance with. A key part of the case will be the client's

own account of her/his daily activities, social functioning, symptoms, and functional limitations. Often equally important are the observations of those who are closest to the client -- friends and relatives.

Third party affidavits should come from people who know the client and have regular contact with her/him. The best witnesses are those who see the client frequently, usually at least weekly. Family members often have the best vantage point. Although they may seem biased, their account of concrete facts concerning the client's limitations, daily activities, needs for assistance, etc. can be very persuasive. The key is to stick to facts and concrete examples. Anecdotes are especially strong. Look for a story about a particular event that illustrates the client's limitations, such as an incident where the witness drove the client to the emergency because he was in such extreme pain.

Remember, third parties are not experts. We don't seek opinions from them. Nonetheless, third parties will often offer an opinion, even when they are not qualified to do so. Although a third party may tell you that the client "can't work," such an opinion will be of limited value. Include it in the affidavit, but be sure it's supported by facts and stories. It's those raw facts that are persuasive, not the opinion.

The protocol for obtaining third party affidavits is as follows:

1. Ask the client to identify people who know her/him well and see her/him on a regular basis. Ask the client to let you contact these people. You might ask the client to call ahead and let the witness know you will be calling. Be sure to clarify what the witness knows about your client's medical condition and make sure you understand any off limits areas. Believe it or not, some clients will identify relatives or friends who can talk about their limitations even though the witness is unaware of the client's HIV diagnosis. This can be challenging to navigate, but it can be done.

2. Draft questions for the witnesses and review them with your supervising attorney. Take into account the listings you are targeting so you craft your inquiries to the proof you are seeking.

3. Call the witness and find out what s/he can say. Ask your questions but also listen to what the witness has to say. The witness may have additional insights.

4. If the witness offers helpful information, draft an affidavit. After reviewing it with your supervising attorney, send it to the witness for review. Once you've worked out any changes, give the witness instructions for getting it signed and notarized. As with other affidavits, if getting it notarized is too logistically complicated, convert the affidavit to a "statement" that will not require signature under oath.

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§120 Medical-Vocational Guidelines

In determining whether a claimant is capable of performing other work that exists in significant numbers, SSA decision makers are faced with the difficult task of weighing the relative importance of the factors for consideration identified by the Social Security Act: the claimant's remaining work capacity, known as residual functional capacity or RFC; age; education; and work experience, including whether or not the claimant has developed work skills transferable to other work within his or her RFC. Before 1979 SSA relied on vocational expert (VE) testimony to analyze these factors and determine how many jobs existed in the economy for a particular claimant. It was then up to the ALJ to determine whether the number of jobs identified by the vocational expert was "significant." As one might imagine, this procedure yielded disparate results, varying from VE to VE and ALJ to ALJ.

To achieve more consistency in decision-making, SSA promulgated regulations, effective in 1979, known as the Medical-Vocational Guidelines. These appear as Appendix 2 to the Social Security disability regulations cited as 20 C.F.R. Part 404, Subpart P, Appendix 2. The Medical-Vocational Guidelines contain three charts, called grids, which answer the question whether a claimant is or is not disabled for different combinations of maximum physical residual functional capacity, age, education and work experience. If a claimant's profile matches one of the rules in the Medical-Vocational Guidelines, the rules, which are binding on decision-makers, direct the outcome of the case. *See* §121.1 for a chart that shows the maximum residual functional capacity a claimant can have and still be found disabled. You may use this chart to determine to what degree your client must be exertionally limited if he or she is to be found disabled. But do not neglect a careful analysis of age, education and work experience. Your analysis might make a different rule applicable.

If a claimant's profile differs from that described in the grids, the rules do not directly answer the question of whether the claimant is or is not disabled—but they must be used as a "framework" for decision-making. This happens where a claimant's exertional limitations fall between those described by the three grids for sedentary, light and medium work; where a claimant cannot do a full range of sedentary work; and where there are nonexertional limitations such as in cases involving mental, sensory or skin impairments, postural or manipulative limitations or environmental limitations. As a rule, ALJs call vocational experts to testify when the Medical-Vocational Guidelines must be used as a framework.

§121 Maximum Residual Functional Capacity

The following chart is a composite of information from the three grids in the Medical-Vocational Guidelines. The chart focuses on those rules that result in a claimant being found disabled. It shows different combinations of age, education and work experience with the maximum exertional residual functional capacity that a claimant may have and still be found disabled. Thus, the chart shows what you have to prove when, for example, a 55-year-old high school graduate with an unskilled work background comes to your office to discuss a heart impairment: the claimant must have an RFC for light work or less in order to win the case.

(Text continued on page 1-22.)

§121.1 Chart: Maximum RFC Possible for Disability Finding

Age	Education	Previous work experience	Max. RFC	Rule
60-64	6th grade or less	Unskilled	Medium	203.01
	7th to 11th grade	Unskilled	Light	202.01
	11th grade or less	None	Medium	203.02
	11th grade or less	Skilled or semiskilled—skills not transferable	Light	202.02
	High school graduate or more—does not provide for direct entry into skilled work	Unskilled or none	Light	202.04
	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	Light	202.06
55-59	11th grade or less	None	Medium	203.10
	11th grade or less	Unskilled	Light	202.01
	11th grade or less	Skilled or semiskilled—skills not transferable	Light	202.02
	High school graduate or more—does not provide for direct entry into skilled work	Unskilled or none	Light	202.04
	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	Light	202.06
50-54	Illiterate or unable to communicate in English	Unskilled or none	Light	202.09
	11th grade or less—at least literate and able to communicate in English	Unskilled or none	Sedentary	201.09
	High school graduate or more—does not provide for direct entry into skilled work	Unskilled or none	Sedentary	201.12
	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	Sedentary	201.14
45-49	Illiterate or unable to communicate in English	Unskilled or none	Sedentary	201.17
	All educational levels—at least literate and able to communicate in English	Unskilled, none, or skilled or semiskilled—skills not transferable	Sedentary occupational base must be significantly compromised	201.00(h)
18-44	All educational levels including illiterate or unable to communicate in English	Unskilled, none, or skilled or semiskilled—skills not transferable	Sedentary occupational base must be significantly compromised	201.00(h)

§122 Age

Age is second only to residual functional capacity as a determinant of whether or not someone is found disabled by the Medical-Vocational Guidelines. The regulations provide that in determining whether a claimant is disabled, SSA will consider the claimant's chronological age in combination with the claimant's residual functional capacity, education, and work experience. SSA will not consider a claimant's ability to adjust to other work on the basis of the claimant's age alone. "In determining the extent to which age affects a person's ability to adjust to other work, we consider advancing age to be an increasingly limiting factor in the person's ability to make such an adjustment." 20 C.F.R. § 404.1563(a).

SSA groups claimants who are under age 45, those ages 45 through 49, 50 through 54, 55 through 59, and 60 through 64. Those within each age category are treated alike. Thus, a 50-year-old claimant will be treated the same as a 54-year-old claimant. However, according to the regulations, these age categories will not be applied "mechanically in a borderline situation." 20 C.F.R. § 404.1563(b) and SSR 86-8. Therefore, a claimant who is within a few months of a birthday that puts him or her into a disabled category in the Medical-Vocational Guidelines is supposed to get the benefit of the doubt.

Normally where a rule directs a conclusion that a claimant is disabled because of reaching a specified age, SSA will find the claimant disabled as of the day before his or her birthday. POMS DI 25015.005 A.1. and GN 00302.400. But where the alleged onset date is a few months prior to an age at which a rule directs a finding of disabled, the Appeals Council has stated that it will take a "sliding scale" approach by looking at whether a claimant has additional vocational adversities that support use of the higher age category. HALLEX II-5-3-2.

For example, where poor education or limited work experience operates against a claimant, one may argue that the age category ought to be stretched. According to POMS DI 25015.005A.1, the borderline age rule applies only when a claimant is within "a few days or a few months" of the next higher age category. "Determining how much time can separate an individual's actual age from the next higher age category is a matter for adjudicative judgment. Such judgments must be supported by the evidence in file and be carefully explained. However, finding a borderline situation as much as one year before the next higher age is difficult to justify and, therefore, will be rare." POMS DI 25015.005A.

According to POMS DI 25015.005B.1:

> Once it has been decided that a borderline age situation exists ..., the adjudicator then considers whether the specific facts of the individual case support the use of the next higher age category. If they do not, the individual's chronological age is used in adjudication—even when he or she is only a few days from attaining a critical age.
>
> - The medical-vocational rules fully consider the relative adversities of a claimant's exertional capabilities, age, education and work experience (including skill level).
> - Therefore, additional vocational adversities in residual functional capacity (RFC), education, or work experience (beyond those already considered in the rules) are needed to support a determination to use the next higher age.
> - Additional vocational adversity is found when some adjudicative factor(s) is relatively more adverse when considered in terms of that factor's stated criteria, or when there is an additional element(s) which has adverse vocational implications.
> - The longer the period of time between an individual's actual age and attainment of the next higher age category, the progressively greater the additional adversity that must be present to support the use of the next higher age.
> - Conversely, the shorter the period between an individual's actual age and the next higher age category, the less adversity and justification that are needed.
> - If there are no additional vocational adversities justifying use of the higher age category, the adjudicator will use the claimant's chronological age.

The examples given in POMS DI 25015.005B.2 of additional vocational adversities are quite generous:

- "The presence of an additional impairment(s) which infringes upon—without substantially narrowing—a claimant's remaining occupational base (*e.g.*, a nonse-

vere allergy to printing ink or other unique substance used in an isolated industry)";

- "A limitation that does not significantly erode an individual's remaining unskilled occupational base (*e.g.*, a limitation to no overhead reaching or to no frequent stooping for an individual with a sedentary exertional level, or any mental limitation that at least permits the performance of unskilled work)";
- "A claimant who may be barely literate in English or have only a marginal ability to communicate in English";
- "A history of work experience in an unskilled job(s) in one isolated industry or work setting (*e.g.*, a family business or oyster bed worker or forest worker)."

Thus, it appears that virtually any vocational adversity may justify use of a higher age category in a borderline age situation.

How age affects a claimant's ability to work is not explained anywhere in the regulations. Instead, it appears in the commentary that was published when the Medical-Vocational Guidelines were first promulgated. "[W]here age is critical to a decision, recognition is taken of increasing physiological deterioration in the senses, joints, eye-hand coordination, reflexes, thinking processes, *etc.*, which diminish a severely impaired person's aptitude for new learning and adaptation to new jobs." 43 Fed. Reg. 55,359 (1978). At another point this commentary refers to age "in terms of how the progressive deteriorative changes which occur as individuals get older affect their vocational capacities to perform jobs." 43 Fed. Reg. 55,353 (1978).

§123 Education

As a rule, SSA uses the highest grade completed in school in evaluating educational level. However, the regulation itself recognizes that a person's actual educational abilities may be higher or lower. SSA will accept evidence that a claimant's actual educational level is lower than the numerical grade completed in school. 20 C.F.R. § 404.1564(b). Achievement testing, such as with the Wide Range Achievement Test (WRAT), may show a low educational level.

§124 Work Experience

SSA classifies work as unskilled, semiskilled and skilled. Unskilled work is work that may be learned in 30 days or less. 20 C.F.R. § 404.1568(a). Everything else is either semiskilled or skilled. For the purposes of the Medical-Vocational Guidelines, semiskilled and skilled work is treated as one category. This treatment has spawned the issue of transferability of work skills. *See*, §349 *et seq.*

§125 Full or Wide Range of Work

Under certain circumstances, a claimant can somewhat exceed the maximum residual functional capacity stated in the Medical-Vocational Guidelines (see chart at §121.1) and still be found disabled under the rule for the lower RFC. To give an example: a claimant's doctor says the claimant may not lift more than 50 pounds but fails to explain that the claimant may not engage in repetitive lifting of weights of more than about 10 pounds and may not bend or stoop frequently. Based on the 50-pound lifting limitation, SSA may leap to the conclusion that the grid for medium work should be applied and issue a denial decision.

However, to apply a rule from one of the grids in the Medical-Vocational Guidelines to the facts of a particular claimant's case, that claimant must be capable of doing a "full or wide range" of work at the exertional level applicable to that grid. That is, the claimant must be capable of substantially all of the activities at that exertional level. SSRs 83-10 and 83-11.

Medium work requires frequent lifting of 25 pounds and frequent bending or stooping, both of which are beyond the capacity of our hypothetical claimant. Thus, our claimant has the RFC for only slightly more than light work. Therefore, the light grid may be applied, which may require a decision that this claimant is disabled. For more information about how to evaluate an RFC that falls between ranges of work, *see* Social Security Ruling 83-12.

As you can see, understanding the definitions of the exertional levels that appear in 20 C.F.R. § 404.1567 is extremely important to application of the proper grid to your client's case. Social Security Ruling 83-10 provides the most detailed explanation of medium, light and sedentary work. These explanations are set forth below.

§125.1 Definition of Medium Work From SSR 83-10

"The regulations define medium work as lifting no more than 50 pounds at a time with frequent lift-

ing or carrying of objects weighing up to 25 pounds. A full range of medium work requires standing or walking, off and on, for a total of approximately 6 hours in an 8-hour workday in order to meet the requirements of frequent lifting or carrying objects weighing up to 25 pounds. As in light work, sitting may occur intermittently during the remaining time. Use of the arms and hands is necessary to grasp, hold, and turn objects, as opposed to the finer activities in much sedentary work, which require precision use of the fingers as well as use of the hands and arms.

"The considerable lifting required for the full range of medium work usually requires frequent bending-stooping. (Stooping is a type of bending in which a person bends his body downward and forward by bending the spine at the waist.) Flexibility of the knees as well as the torso is important for this activity. (Crouching is bending both the legs and spine in order to bend the body downward and forward.) However, there are relatively few occupations in the national economy which require exertion in terms of weights that must be lifted at times (or involve equivalent exertion in pushing or pulling), but are performed primarily in a sitting position, *e.g.*, taxi driver, bus driver, and tank-truck driver (semiskilled jobs). In most medium jobs, being on one's feet for most of the workday is critical. Being able to do frequent lifting or carrying of objects weighing up to 25 pounds is often more critical than being able to lift up to 50 pounds at a time."

§125.2 Definition of Light Work From SSR 83-10

"The regulations define light work as lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted in a particular light job may be very little, a job is in this category when it requires a good deal of walking or standing—the primary difference between sedentary and most light jobs. A job also is in this category when it involves sitting most of the time but with some pushing and pulling of arm-hand or leg-foot controls, which require greater exertion than in sedentary work; *e.g.*, mattress sewing machine operator, motor-grader operator, and road-roller operator (skilled and semiskilled jobs in these particular instances). Relatively few unskilled light jobs are performed in a seated position.

"'Frequent' means occurring from one-third to two-thirds of the time. Since frequent lifting or carrying requires being on one's feet up to two-thirds of a workday, the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday. Sitting may occur intermittently during the remaining time. The lifting requirement for the majority of light jobs can be accomplished with occasional, rather than frequent, stooping. Many unskilled light jobs are performed primarily in one location, with the ability to stand being more critical than the ability to walk. They require use of arms and hands to grasp and to hold and turn objects, and they generally do not require use of the fingers for fine activities to the extent required in much sedentary work."

§125.3 Definition of Sedentary Work From SSR 83-10

"The regulations define sedentary work as involving lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers and small tools. Although sitting is involved, a certain amount of walking and standing often is necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. By its very nature, work performed primarily in a seated position entails no significant stooping. Most unskilled sedentary jobs require good use of the hands and fingers for repetitive hand-finger actions.

"'Occasionally' means occurring from very little up to one-third of the time. Since being on one's feet is required 'occasionally' at the sedentary level of exertion, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday, and sitting should generally total approximately 6 hours of an 8-hour workday. Work processes in specific jobs will dictate how often and how long a person will need to be on his or her feet to obtain or return small articles."

§126 RFC for Less Than Full Range of Sedentary Work

Go back and look at the chart, §121.1, for the age categories under 50. At first glance, proof of disability for almost everyone under age 50 looks like an impossible task. Disability for such individuals

requires proof that they can do much less than a full or wide range of sedentary work, described by SSR 83-12 as a "significance compromise" of the sedentary occupational base. This means, according to SSR 96-9p, that jobs for them do not exist in significant numbers. Although this is frequently difficult, it is not impossible.

For example, our hypothetical machine operator in §100 has an RFC for much less than a wide range of sedentary work. He may be found disabled despite his young age and high school education because of a limitation to sedentary work *plus* an impairment that affects bimanual dexterity. This result is based on SSRs 83-10 and 96-9p, which point out that "most sedentary jobs require good use of both hands." However, a note of caution is appropriate here. SSA's position, in effect, is that although a person limited to sedentary work with limited bimanual dexterity will *usually* be found disabled, this conclusion can be rebutted by vocational expert testimony in an individual case.

For most claimants under age 50, as a preliminary matter, it is necessary to show that they can do neither a wide range of sedentary work nor a wide range of light work. It is essential, then, to have a thorough understanding of SSA's definitions of sedentary and light work. *See* §§125.2 and 125.3, from Social Security Ruling 83-10.

In order to prove that the sedentary occupational base is significantly compromised, you will usually look for a combination of exertional and nonexertional impairments. Each additional impairment whittles away the range of sedentary work that a claimant is capable of doing to arrive at the point where jobs do not exist in significant numbers. *See* §§260 *et seq.*, on designing a case for a claimant under age 50. *See* §348.8, on dealing with vocational experts regarding whether significant numbers of jobs exist within the claimant's RFC.

Often, you will find individuals who, for one reason or another, cannot sit for the six hours out of an eight-hour day required to do sedentary work, nor can they stand for six hours out of an eight-hour day required to do light work. A common residual functional capacity describes claimants who must alternate between sitting and standing. Although Social Security Ruling 83-12 analyzes this RFC, this RFC does present several challenges to lawyers representing claimants, a subject dealt with in detail at §§348.4 and 348.9. The SSR 83-12 statement on the subject is reproduced below.

§126.1 Alternate Sitting and Standing From SSRs 83-12 and 96-9p

SSR 83-12 provides:

> In some disability claims, the medical facts lead to an assessment of RFC which is compatible with the performance of either sedentary or light work except that the person must alternate periods of sitting and standing. The individual may be able to sit for a time, but must then get up and stand or walk for a while before returning to sitting. Such an individual is not functionally capable of doing either the prolonged sitting contemplated in the definition of sedentary work (and for the relatively few light jobs which are performed primarily in a seated position) or the prolonged standing or walking contemplated for most light work. (Persons who can adjust sitting and standing by doing so at breaks, lunch periods, etc., would still be able to perform a defined range of work.)
>
> There are some jobs in the national economy—typically professional and managerial ones—in which a person can sit or stand with a degree of choice. If an individual had such a job and is still capable of performing it, or is capable of transferring work skills to such jobs, he or she would not be found disabled. However, most jobs have ongoing work processes which demand that a worker be in a certain place or posture for at least a certain length of time to accomplish a certain task. Unskilled types of jobs are particularly structured so that a person cannot ordinarily sit or stand at will. In cases of unusual limitation of ability to sit or stand, a V[ocational] S[pecialist] should be consulted to clarify the implications for the occupational base.

SSR 96-9p added the following to the discussion of alternate sitting and standing jobs:

"**Alternate sitting and standing**: An individual may need to alternate the required sitting of sedentary work by standing (and, possibly, walking) periodically. Where this need cannot be accommodated by scheduled breaks and a lunch period, the occupational base for a full range of unskilled sedentary work will be eroded. The extent of the erosion will

depend on the facts in the case record, such as the frequency of the need to alternate sitting and standing and the length of time needed to stand. The RFC assessment must be specific as to the frequency of the individual's need to alternate sitting and standing. It may be especially useful in these situations to consult a vocational resource in order to determine whether the individual is able to make an adjustment to other work."

§127 Nonexertional Limitations

Exertional abilities involve sitting, standing, walking, lifting, carrying, pushing and pulling. 20 C.F.R. § 404.1569a. A limitation of any other work-related ability is a nonexertional limitation. A list of categories and examples follows:

Category	Example
Postural:	**Need to alternate sitting and standing; Need to elevate leg; Difficulty turning head; Balance problems; Difficulty bending, stooping or squatting.**
Manipulative:	**Difficulties with reaching, grasping, handling, fingering.**
Environmental:	**Difficulties working around fumes, dust, etc.; Difficulties tolerating noise, heights, humidity or temperature extremes; Inability to be around dangerous machinery.**
Mental:	**Difficulties relating with others; Difficulty understanding, remembering or carrying out simple instructions; Inability to maintain attention or concentration; Poor stress tolerance.**
Sensory:	**Difficulties speaking, hearing, feeling or seeing.**

This list is by no means exhaustive. Note that a nonexertional *impairment* may impose more than one type of nonexertional *limitation*. For example, a skin impairment may impose both environmental and manipulative limitations and may affect work in other ways, also. Some impairments, such as certain gastro-intestinal impairments, impose nonexertional limitations by forcing a worker to be absent from the work area to lie down or go to the restroom, *etc.*

Many impairments have both exertional and nonexertional implications. For example, amputation of an arm will limit the weight a claimant can lift, an exertional impairment, and will limit bimanual dexterity, a nonexertional manipulative impairment.

Nonexertional impairments need to be carefully examined. They are discussed in Social Security Rulings 83-12, 83-14, 85-15, 96-4p, 96-8p and 96-9p. You may need to consult your own vocational expert for help evaluating the impact of such limitations on your client's ability to work.

§128 Transferable Work Skills

You also may need a vocational expert to help you manage the complex problem of transferability of work skills. If you examine the three grids from the Medical-Vocational Guidelines, you will discover that a claimant is never disabled if the claimant has skills transferable to jobs within his or her RFC that exist in significant numbers. On the other hand a finding of no transferable work skills may lead to a finding of disability in certain cases. But note that in only two age categories does the issue of transferability of skills determine the outcome of the case. If a claimant is age 50 or older and is limited to sedentary work, the claimant wins or loses the case based upon whether or not the claimant has skills transferable to sedentary work. If a claimant is age 55 or older, this rule extends to light work—a claimant wins or loses based on whether or not the claimant has skills transferable to a significant range of semiskilled or skilled light work.

Since an unskilled work background produces no transferable skills, the rules about transferability apply only to claimants with histories of semiskilled or skilled work.

The standards for determining transferability differ for age categories beginning with ages 50, 55 and 60, making it easier as a claimant gets older to

show that skills are not transferable to a significant range of work within the claimant's RFC. At age 50, garden-variety transferability of skills to sedentary work is all that is required to turn down a case based on the presence of transferable skills. To find that skills of a 55-year-old claimant are transferable to sedentary work, SSA must meet a higher burden. It must show that there is "very little, if any, vocational adjustment required in terms of tools, work settings, or the industry." Rule 201.00(f) of the Medical-Vocational Guidelines. A 55-year-old claimant limited to light work needs only garden-variety transferable work skills in order to be turned down. But at age 60 for claimants limited to light work, SSA must meet a higher burden—the same higher burden that applies to 55-year-olds limited to sedentary work. *See* Rules 202.00(c) and (e) of the Medical-Vocational Guidelines. *See* §349.6 for a chart showing the transferability standards for different ages; *and see* §349 for an extensive discussion of the transferability issue.

In that rare situation where recently completed education provides for direct entry into skilled work, the Guidelines always require a finding of not disabled. *See* Rules 201.05, 201.08, 201.13, 201.16, 202.05, 202.08, 203.09, 203.17 and 203.24.

§129 Medical-Vocational Guidelines as Framework for Decision-Making

The grids govern the outcome of cases where they exactly describe a claimant. But the characteristics of many claimants do not fall squarely within the Guidelines. For example, a claimant's residual functional capacity may fall between ranges of work, a claimant may have only nonexertional impairments, or a claimant may have a combination of exertional and nonexertional impairments. In these cases, the Medical-Vocational Guidelines, by their own terms, are to be used as "an overall structure for evaluation" and a "framework for consideration" of disability. *See* Rules 200.00(d) and (e).

The most important principle of the Medical-Vocational Guidelines may be stated as follows: the more adverse a claimant's vocational factors (age, education and work experience), the more remaining residual functional capacity the claimant may have and still be found disabled. Consider our hypothetical housewife in §100. She is age 55, has a limited education and no relevant work experience. The grids find her disabled despite her residual functional capacity for medium work, a capacity which means that she is physically capable of performing about 2,500 out of the approximately 3,100 unskilled occupations identified in the *Dictionary of Occupational Titles*.

This fundamental principle of the Guidelines is based on the concept of vocational adaptability. Younger, better-educated people with work experience are more adaptable to job changes despite a decline in RFC caused by a medical impairment. Such younger claimants must demonstrate a more restricted RFC in order to be found disabled. Indeed, according to the Medical-Vocational Guidelines, English-speaking claimants with exertional impairments who are under age 50 must have such restricted RFCs that they are limited to much less than a wide range of sedentary work—to the point that jobs do not exist in significant numbers, according to SSR 96-9p. Using the Guidelines as a framework, an English-speaking claimant under age 50 with nonexertional impairments must have a similarly restricted occupational base.

Using the Medical-Vocational Guidelines as a framework for analysis is a slippery concept that is not well understood by claimants' attorneys or even by ALJs. It is the subject of three Social Security Rulings, SSRs 83-12, 83-14 and 85-15. SSR 96-9p, with its emphasis on whether jobs exist in significant numbers, departs somewhat from the earlier rulings. *See* §348, for a detailed discussion.

VOCATIONAL TERMS
QUICK REFERENCE

STRENGTH

Level	Lift	Carry	Walk/Stand	Sit
Sedentary	Occasionally up to 10 #	Occasionally – small objects	No more than 2 hours	6 hours
Light	Occasionally up to 20 #	Frequently up to 10 #	6 hours	
Medium	20-50 # occasionally 10-25 # frequently	Frequently carry up to 25 #	6 hours	
Heavy	50-100 # occasionally	Frequently lift/carry 50 #	6-8 hours	

Occasionally = up to 2 hours in a work day
Frequently = up to 6 hours in a work day
Constantly = 6+ hours

Age Factors

Age group	Ages
Younger Individual	Under age 50
Approaching advanced age	50-54
Advanced age	55 and over
Closely approaching retirement age	60-64

Education

Education Level	Description
Illiterate	-inability to read or write in English -able to sign name, but can't read/write a simple communication in English -generally, little or no formal schooling in English
Marginal	-6th grade or less -ability to do reasoning, math, language required for simple, unskilled job
Limited	-7^{th} – 11^{th} grade -reasoning, math, language skills beyond unskilled work, but not enough for most semiskilled or skilled jobs
High School and Above	-12^{th} grade or above -generally qualify worker for semiskilled through skilled work

See: POMS DI 25001.001 Medical-Vocational Terms

Academic Development & Training Time

Specific Vocational Preparation (SVP)

SVP is the amount of time needed to learn the techniques, acquire the information, and develop the facility for average performance in a specific job-worker situation. **SVP** comes from vocational education, civilian, military, and institutional work experience, apprenticeship, and from in-plant and on-the-job training

Skill level	SVP	Number of jobs	Training Time	Sedentary #	Total Sedentary at SVP level
Unskilled	1	191	Short demo only	6	
	2	2936	Up to 30 days	131	>137
Semi-skilled	3	2200	30 days-3 months	144	
	4	1637	3-6 months	136	>280
Skilled	5	1207	6 months-1 year	140	
	6	1333	1-2 years (Cert/AA)	161	>603
	7	2060	2-4 years (AA/BA/BS)	302	
Highly Skilled	8	1151	4-10 years (MS/PhD)	357	
	9	46	Over 10 years	28	>385

General Educational Development (GED)

GED depicts formal and informal education that develops basic reasoning/direction following skills and language/math skills. Experience or self study can develop GED. Levels below are only guidelines

GED		Reasoning	Math	Language
High	6	Intellectual	Advanced, Calculus	Graduate
	5	Scientific	Statistics	College
Avg	4	High School	Algebra	High School
	3	Grade 7-8	7-8	7-8
Low	2	Grade 4-6	4-6	4-6
	1	Grade 1-3	1-3	1-3

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The DOT has been replaced by the O*Net

Contents

The DOT was created by the Employment and Training Administration, and was last updated in 1991. It is included on the Office of Administrative Law Judges (OALJ) web site because it is a standard reference in several types of cases adjudicated by the OALJ, especially in older labor-related immigration cases.

The DOT, however, has been replaced by the O*NET. For information on O*Net, see

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Printed copies of the DOT may be purchased from the Government Printing Office/Superintendent of Documents' Online Bookstore (select the Sales Product Catalog, and search for &quotDictionary of Occupational Titles").

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- Witnesses

311.137-022 WAITER/WAITRESS, HEAD (hotel & rest.)

Supervises and coordinates activities of dining-room employees engaged in providing courteous and rapid service to diners: Greets guests and escorts them to tables. Schedules dining reservations. Arranges parties for patrons. Adjusts complaints regarding food or service. Hires and trains dining-room employees. Notifies payroll department regarding work schedules and time records. May assist in preparing menus. May plan and execute details for banquets [STEWARD/STEWARDESS, BANQUET (hotel & rest.); MANAGER, CATERING (hotel & rest.)]. May supervise WAITERS/WAITRESSES, ROOM SERVICE (hotel & rest.) and be designated Captain, Room Service (hotel & rest.).
GOE: 09.01.03 STRENGTH: L GED: R4 M3 L4 SVP: 6 DLU: 77

311.472-010 FAST-FOODS WORKER (hotel & rest.) alternate titles: cashier, fast foods restaurant

Serves customer of fast food restaurant: Requests customer order and depresses keys of multicounting machine to simultaneously record order and compute bill. Selects requested food items from serving or storage areas and assembles items on serving tray or in takeout bag. Notifies kitchen personnel of shortages or special orders. Serves cold drinks, using drink-dispensing machine, or frozen milk drinks or desserts, using milkshake or frozen custard machine. Makes and serves hot beverages, using automatic water heater or coffeemaker. Presses lids onto beverages and places beverages on serving tray or in takeout container. Receives payment. May cook or apportion french fries or perform other minor duties to prepare food, serve customers, or maintain orderly eating or serving areas.
GOE: 09.04.01 STRENGTH: L GED: R2 M2 L2 SVP: 2 DLU: 86

311.477-010 CAR HOP (hotel & rest.) alternate titles: drive-in waiter/waitress

Serves food and refreshments to patrons in cars: Takes order and relays order to kitchen or serving counter to be filled. Places filled order on tray and fastens tray to car door. Totals and presents check to customer and accepts payment for service. Removes tray and stacks dishes for return to kitchen. Sweeps service area with broom. May prepare fountain drinks, such as sodas, milkshakes, and malted milks. May restock service counter with items, such as ice, napkins, and straws.
GOE: 09.04.01 STRENGTH: L GED: R2 M2 L2 SVP: 2 DLU: 80

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COMPONENTS OF THE DEFINITION TRAILER

The following descriptions of the components of the Definition Trailer are in inverse order to their placement in the trailer.

I. DATE OF LAST UPDATE (DLU)

Listed as the final element in the trailer following the definition, the Date of Last Update indicates the last year in which material was gathered for that occupation. A DLU of "77" would indicate that the occupation has not been studied by an analyst since publication of the fourth edition DOT in 1977.

II. SPECIFIC VOCATIONAL PREPARATION (SVP)

Specific Vocational Preparation is defined as the amount of lapsed time required by a typical worker to learn the techniques, acquire the information, and develop the facility needed for average performance in a specific job-worker situation.

This training may be acquired in a school, work, military, institutional, or vocational environment. It does not include the orientation time required of a fully qualified worker to become accustomed to the special conditions of any new job. Specific vocational training includes: vocational education, apprenticeship training, in-plant training, on-the-job training, and essential experience in other jobs.

Specific vocational training includes training given in any of the following circumstances:

a. Vocational education (high school; commercial or shop training; technical school; art school; and that part of college training which is organized around a specific vocational objective);
b. Apprenticeship training (for apprenticeable jobs only);
c. In-plant training (organized classroom study provided by an employer);
d. On-the-job training (serving as learner or trainee on the job under the instruction of a qualified worker);
e. Essential experience in other jobs (serving in less responsible jobs which lead to the higher grade job or serving in other jobs which qualify).

The following is an explanation of the various levels of specific vocational preparation:

Level	Time
1	Short demonstration only
2	Anything beyond short demonstration up to and including 1 month
3	Over 1 month up to and including 3 months
4	Over 3 months up to and including 6 months
5	Over 6 months up to and including 1 year
6	Over 1 year up to and including 2 years
7	Over 2 years up to and including 4 years
8	Over 4 years up to and including 10 years
9	Over 10 years

Note: The levels of this scale are mutually exclusive and do not overlap.

III. GENERAL EDUCATIONAL DEVELOPMENT (GED)

General Educational Development embraces those aspects of education (formal and informal) which are required of the worker for satisfactory job performance. This is edu-

Scale of General Education Development (GED)

LEVEL	REASONING DEVELOPMENT	MATHEMATICAL DEVELOPMENT	LANGUAGE DEVELOPMENT
6	Apply principles of logical or scientific thinking to a wide range of intellectual and practical problems. Deal with nonverbal symbolism (formulas, scientific equations, graphs, musical notes, etc.) in its most difficult phases. Deal with a variety of abstract and concrete variables. Apprehend the most abstruse classes of concepts.	Advanced calculus: Work with limits, continuity, real number systems, mean value theorems, and implicit functions theorems. Modern Algebra: Apply fundamental concepts of theories of groups, rings, and fields. Work with differential equations, linear algebra, infinite series, advanced operations methods, and functions of real and complex variables. Statistics: Work with mathematical statistics, mathematical probability and applications, experimental design, statistical inference, and econometrics.	Reading: Read literature, book and play reviews, scientific and technical journals, abstracts, financial reports, and legal documents. Writing: Write novels, plays, editorials, journals, speeches, manuals, critiques, poetry, and songs. Speaking: Coversant in the theory, principles, and methods of effective and persuasive speaking, voice and diction, phonetics, and discussion and debate.
5	Apply principles of logical or scientific thinking to define problems, collect data, establish facts, and draw valid conclusions. Interpret an extensive variety of technical instructions in mathematical or diagrammatic form. Deal with several abstract and concrete variables.	Algebra: Work with exponents and logarithms, linear equations, quadratic equations, mathematical induction and binomial theorem, and permutations. Calculus: Apply concepts of analytic geometry, differentiations and integration of algebraic functions with applications. Statistics: Apply mathematical operations to frequency distributions, reliability and validity of tests, normal curve, analysis of variance, correlation techniques, chi-square application and sampling theory, and factor analysis.	Same as Level 6.
4	Apply principles of rational systems to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists. Interpret a variety of instructions furnished in written, oral diagrammatic, or schedule form.	Algebra: Deal with system of real numbers; linear, quadratic, rational, exponential, logarithmic, angle and circular functions, and inverse functions; related algebraic solution of equations and inequalities; limits and continuity, and probability and statistical inference. Geometry: Deductive axiomatic geometry, plane and solid; and rectangular coordinates. Shop Math: Practical application of fractions, percentages, ratio and proportion, mensuration, logarithms, slide rule, practical algebra, geometric construction, and essentials of trigonometry.	Reading: Read novels, poems, newspapers, periodicals, journals, manuals, dictionaries, thesauruses, and encyclopedias. Writing: Prepare business letters, expositions, summaries, and reports, using prescribed format and conforming to all rules of punctuation, grammar, diction, and style. Speaking: Participate in panel discussions, dramatizations, and debates. Speak extemporaneously on a variety of subjects.

LEVEL	REASONING DEVELOPMENT	MATHEMATICAL DEVELOPMENT	LANGUAGE DEVELOPMENT
3	Apply commonsense understanding to carry out instructions furnished in written, oral, or diagrammatic form. Deal with problems involving several concrete variables in or from standardized situations.	Compute discount, interest, profit and loss; commission, markup, and selling price; ratio and proportion, and percentage. Calculate surfaces, volumes, weights, and measures. Algebra: Calculate variables and formulas; monomials and polynomials; ratio and proportion variables; and square roots and radicals. Geometry: Calculate plane and solid figures; circumference, area, and volume. Understand kinds of angles, and properties of pairs of angles.	Reading: Read a variety of novels, magazines, atlases, and encyclopedias. Read safety rules, instructions in the use and maintenance of shop tools and equipment, and methods and procedures in mechanical drawing and layout work. Writing: Write reports and essays with proper format, punctuation, spelling, and grammar, using all parts of speech. Speaking: Speak before an audience with poise, voice control, and confidence, using correct English and well-modulated voice.
2	Apply commonsense understanding to carry out detailed but uninvolved written or oral instructions. Deal with problems involving a few concrete variables in or from standardized situations.	Add, subtract, multiply, and divide all units of measure. Perform the four operations with like common and decimal fractions. Compute ratio, rate, and percent. Draw and interpret bar graphs. Perform arithmetic operations involving all American monetary units.	Reading: Passtive vocabulary of 5,000–6,000 words. Read at rate of 190–215 words per minute. Read adventure stories and comic books, looking up unfamiliar words in dictionary for meaning, spelling, and pronunciation. Read instructions for assembling model cars and airplanes. Writing: Write compound and complex sentences, using cursive style, proper end punctuation, and employing adjectives and adverbs. Speaking: Speak clearly and distinctly with appropiate pauses and emphasis, correct pronunciation, variations in word order, using present, perfect, and future tenses.
1	Apply commonsense understanding to carry out simple one- or two-step instructions. Deal with standardized situations with occasional or no variables in or from these situations encountered on the job.	Add and subtract two digit numbers. Multiply and divide 10's and 100's by 2, 3, 4, 5. Perform the four basic arithmetic operations with coins as part of a dollar. Perform operations with units such as cup, pint, and quart; inch, foot, and yard; and ounce and pound.	Reading: Recognize meaning of 2,500 (two- or three-syllable) words. Read at rate of 95–120 words per minute. Compare similarities and differences between words and between series of numbers. Writing: Print simple sentences containing subject, verb, and object, and series of numbers, names, and addresses. Speaking: Speak simple sentences, using normal word order, and present and past tenses.