

**OVERVIEW
OF
SOCIAL SECURITY
AND
SUPPLEMENTAL SECURITY INCOME (SSI)**

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TABLE OF CONTENTS

I. OVERVIEW OF SOCIAL SECURITY DISABILITY

- A. How to Establish Disability
- B. Date of Onset and Date of Entitlement
- C. Insured Status Requirement
- D. Application Process
 - 1. Impairments
 - 2. Medical Providers
 - 3. Work History
 - 4. What to Know / Bring
 - 5. When to Apply
- E. Disability Determination Service
 - 1. Function Report
 - 2. Work History
- F. Five Step Evaluation Process
- G. Medical – Vocational Guideline / GRIDS
- H. Auxiliary Benefits
- I. Appeal to ALJ
- J. The Hearing
- K. Appeal from ALJ Decision
- L. Appeal from the AC Denial

II. OVERVIEW OF SSI

- A. Who is Eligible
- B. Date of Entitlement
- C. Financial Considerations.
- D. Benefits

III. APPENDIX

- A. Benefit chart
- B. Medical – Vocational Guideline / GRIDS

- C. Disability Report
 - D. Medical Source Statement of Ability to do Work Related Activities (Physical)
 - E. Medical Source Statement of Ability to do Work Related Activities (Mental)
 - F. Function Report
 - G. Function Report - Example
 - H. Work History (sample page)
 - I. Request for Hearing
 - J. Request for Review of Hearing Decision /Order
-

I. OVERVIEW OF SOCIAL SECURITY DISABILITY

A. HOW TO ESTABLISH DISABILITY

There are two types of disability programs: Disability (DIB), under Title II of the Social Security Act, and Supplemental Security Income (SSI) under Title XVI. These programs share features with Worker's Compensation (WC), APTD, and short and long term disability in that they all provide a substitute income for those who are unable to work due to a disability. The medical test for both DIB and SSI is identical; the nonmedical tests are different.

The regulations define disability as:

...[t]he inability to do any substantial, gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (42 U.S.C. 423, 20 CFR § 404.1505).

It is the claimant's burden to prove an inability to return to any job held within the past 15 years – past relevant work (PRW). The Social Security Administration (SSA) will take into consideration the claimant's age, education, work experience, and the claimant's residual functional capacity (RFC). Once the claimant proves an inability to return to any PRW the burden then shifts to the Commissioner to prove that the claimant can perform other jobs that exist in significant numbers in the national economy.

SSA is supposed to take into consideration all injuries, illnesses or ailments, including pain, and look at how the combination of these problems affects the claimant's

ability to work. For example, Claimant's major disabling condition is a work-related back injury and, in addition, has an allergy to metal that was never a problem at any prior job. This could eliminated a job as a cashier. It is very important that these additional problems be mentioned in the application and in Claimant's doctors' notes. If Claimant is relying upon the combination of problems then all of the problems must be present for a 12 month period.

Be aware that in cases involving drug addiction and alcoholism (DAA) if the addiction is "material" to the finding of disability the claimant will be denied. It is material if the claimant would not meet the definition even if not using drugs or alcohol; then the claimant would be found not disabled. DAA is not material to the determination if the claimant would meet the definition of disability if not using drugs or alcohol. If DAA is not material, then the claimant can be found disabled. See SSR 13-2p.

B. DATE OF ONSET and DATE OF ENTITLEMENT

The date of onset is the date SSA determines that the claimant is disabled and no longer able to work as defined under the Social Security Act. There is a full five month waiting period from the date of onset (D/O) to the date of entitlement (DENT), which is the first month in which disability benefits are paid. A month for SSA begins on the 2nd of one month and ends on the 1st of the next, i.e. June 2 – July 1. For example, if the claimant's date of onset is March 9, 2013 then DENT is September 2013, payable the following month. If the date of application was July 7, 2014 then the first payment is due in October 2013, as benefits are retroactive for up to 1 year prior to the date of application. However, if the date of application was January 2015 then DENT would not be until January 2014. To obtain all the benefits to which a claimant may be entitled the application must be within 18 months of the date of onset.

The claimants are entitled to Medicare Part A at DENT but must wait 2 years from DENT to become eligible for Medicare Parts B and D

Checks are issued according to birthdate:

Birthday Between	Benefits Paid On
1st - 10th	2nd Wednesday
11th - 20th	3rd Wednesday
21st - 31st	4th Wednesday

C. INSURED STATUS REQUIREMENT

The claimant must meet the disability insured status requirement. From age 31 on, you must have 20 quarters of coverage in the last 40 quarters prior to the date of onset. A claimant age 18 to 23 needs 6 of 12 quarters, ending with the date of onset.

From ages 21 to 30 a claimant needs 1 quarter of coverage for every 2 quarters from age 21 until date of onset.

A quarter is merely one quarter of a calendar year or 3 months. In 2015, \$1220 of earnings was required for one quarter of coverage. (See Appendix A). As wages are usually reported annually, to establish the insured status, SSA is only concerned with the amount earned per year, not quarterly. As soon as you earn the amount needed for 4 quarters (\$4880) you are automatically assigned 4 quarters of coverage, even if that occurs in the first month of the year.

To determine the Date Last Insured (DLI) count back 20 earned quarters beginning with the Date of Onset and then count forward 40 quarters. If the date of onset occurs after that date then the claimant is not insured; SSI should then be considered.

D. APPLICATION PROCESS

There are 3 ways to apply: in person at a District (DO) also called a Field Office (FO), on the phone with that office, or online (www.ssa.gov). To find the claimant's FO look online at <https://secure.ssa.gov/ICON/main.jsp>. There are pros and cons to each method. Alert your client that the Claim Representative at the FO will make notes about the claimant's demeanor and demonstrated physical abilities. Applying on the phone or online does not give the Claim Representative the opportunity to observe the claimant. The online process is lengthy and cumbersome.

The claimant will be asked to provide the name of a person that SS can contact about the claim. Unless the claimant is mentally incapable there is no advantage to providing this information. Advise the claimant to be sure to notify SSA of any change of address or phone number.

As all benefits will be paid electronically a bank account number and routing number should be supplied. For purely practical reasons a savings account is preferable to a checking account.

It is a good idea to always get the name, phone number and most importantly the extension of any SS representative with whom you or the claimant speak. This greatly reduces the amount of hold time on the phone and allows you to quickly leave a voice message, as it is rare that a representative will actually answer the phone.

1. IMPAIRMENTS

The claimant must know certain information when applying (Appendix C). The claimant must list all the illnesses, injuries and conditions that affect the ability to work. It is important to list every limiting condition, not just ones that are disabling; include both physical and mental limitations. The claimant should include such non-exertional impairments as fatigue, inability to focus, concentrate and remember, allergies, side effects of medication, poor balance and headaches. Of course, the claimant's treatment provider should have notes that include these complaints. It is vital that the claimant tell

all the medical providers all the conditions, not just the ones that particular provider treats. The claimant also needs to explain how these conditions are limiting. For example, Fibromyalgia pain limits the ability to sit, stand, walk more than "x" minutes at one time, lift more than "y" pounds, concentrate and focus, and requires daytime naps.

2. MEDICAL PROVIDERS

The claimant must know the name and address of the *office* where the medical records of each provider are kept. The claimant will be asked to name each provider but it is better to provide the office name. When the records are requested by each individual provider's name, some records may be omitted. For example, when the claimant calls the doctor's office to say that the medication caused terrible side effects that message, taken by a staff member, may not be included with the records sent to Social Security. Similarly, if all the office records are requested then the relevant test results will be sent as well, and it is not necessary to list every test. It is also not necessary to list every date the claimant saw the provider; giving a date one year prior to the date of onset should be sufficient.

All medical providers are not equal in the eyes of SSA. Nurses, Nurse Practitioners, Physician Assistants, Chiropractors, Physical Therapists, and Social Workers are considered "non-acceptable medical sources" (SSR 06-03p). Acceptable medical sources are licensed Physicians, certified Psychologists, licensed Optometrists for the measurement of visual acuity, licensed Podiatrists for impairments of the foot, and ankle, and qualified Speech-language Pathologists for speech or language impairments. Only acceptable medical sources may diagnose, but non-acceptable sources may give opinions about what the claimant can still do despite the impairment(s). If the treating provider is an acceptable medical source then controlling weight must be given to that source's medical opinion about the nature and severity of the claimant's impairment if the opinion is well supported and not inconsistent with other substantial evidence in the file (SSR 96-2p).

3. WORK HISTORY

In order to establish the date of onset (D/O) it is necessary to know the claimant's work history. If the claimant is still working part time, obtain the pay stubs and calculate on a monthly basis, by pay date, the gross earnings, including bonuses but excluding sick pay, vacation pay and any other amounts that were not paid for work done. If the amount is less than "substantial gainful activity" (SGA) then that month is probably not considered a working month. SGA is now determined primarily by an amount of earnings. In 2015 it is \$1090 gross per month. (See Appendix A). After the 5 month waiting period the claimant can try to work for 3 months if unable to continue due to the impairment the that work may be considered an unsuccessful work attempt (UWA. If the work is found to be UWA then those months are not counted as working months. (SSR 05-02).

It is important to know why the claimant is not working full time. If unemployment

is due to a layoff, lack of available work or any reason unrelated to an impairment then that period of unemployment probably cannot be used as a period of disability.

The claimant must know their work history for the past 15 years. It isn't necessary to know the name of the employer, just the type of job performed and a detailed description of the work performed. It is important to get this right because this will be used to decide if the claimant can return to PRW. Work that lasted less than 6 months or earned less than SGA need not be included. At the time of application only the details of the job done the longest need be described in detail. If the claimant worked as a cashier for several different stores and the job functions were substantially the same then that is just one job no matter how many employers were involved. Conversely, if the claimant worked for only one employer, but over the years performed many different types of jobs (i.e. was promoted from cashier to manager), then each type of work must be described differently.

The claimant will be asked to describe the job in narrative form and by describing the number of hours the various work functions were performed. Claimants usually try to average this so that the total for sit, stand and walk equals 8; but if the job required a variety of positions then this is the wrong way to approach it and could result in a finding that the claimant could return to PRW. Give the number of hours that a worker would need to perform the activity in order to do the job on any given day. If some days the claimant was required to walk half the day, and on other days needed to sit all day, then sit would be 7 – 8 hours (of an 8 hour day) and walk would be 4 hours. Unless the job duties never varied (i.e. sat all day to do data entry) then the total of sit, stand, and walk will always equal more than 8 hours.

The claimants are asked to supply medical records in their possession. That is inadvisable, especially if it is not a complete set of records; let SSA request the necessary records.

4. WHAT TO BRING/KNOW

The claimant does need to supply the following:

- i) The original or a certified copy of the birth certificate.
- ii) The DD-214, if the claimant was in the military.
- iii) If the claimant worked in the calendar year prior to the year of application then that year's W-2 is needed. If taxable earnings appear on the W-2 that were not for work but were severance pay, vacation pay, or any payments other than for work actually performed then this needs to be clarified, preferably by paystubs or a letter from the employer.
- iv) As all payments are now supposed to be made electronically the claimant should bring the routing number and account number of a savings (or checking)

account.

v) The dates of marriage and divorce, especially if a marriage lasted 10 or more years prior to a divorce, and the birthdate of spouse(s),

vi) Birthdates of children who were age 19 or younger and still in high school at DENT, or minors at DENT whether or not in school.

vii) If Worker's Compensation is involved, bring proof of the amount received and Lump Sum Settlement documentation.

5. WHEN TO APPLY

There is no benefit in applying as soon as the disability begins unless the impairment clearly meets a Listing and is unlikely to improve. If the claimant applies too soon the likely result is a denial that states that while disabled now, by the end of the 12 month period the impairment will improve allowing the claimant to return to work, or a flat out denial. The claimant should wait at least 6 months from the expected D/O to apply. This allows the adjudicator to review a more fully developed record. It also allows you to assist the claimant to obtain the doctor's medical opinion of the claimant's remaining abilities (Appendix D and E).

E. DISABILITY DETERMINATION SERVICE

Once the application is completed the electronic file is sent to the Disability Determination Service (DDS) for adjudication. The DDS office for New Hampshire is in Concord (800-266-8096); however sometimes the overflow will be handled by the DDS in Boston. The file is assigned to a Disability Claims Adjudicator who will request the medical records and send the claimant a Function Report (Appendix F), and possibly a Work History (Appendix H). DDS requests that this be returned in 10 days. The Function Report is problematic and time consuming. It is the reason many cases are lost. It is a good idea to give the claimant a copy right after application to do a rough draft which you can then review after the form is sent by DDS.

1. FUNCTION REPORT

A copy of the Function Report is found at Appendix F. (<http://www.socialsecurity.gov/forms/ssa-3373-bk.pdf>). Some of the questions that seem to confuse clients are discussed below.

§ C6. When asked about what the claimant does all day give the times of getting up and going to bed because these activities are compared to an 8 hour work day. Don't list everything the claimant does every day, especially if laundry is done one day, shopping another day and vacuuming the next, because it will look like the claimant does all

these activities every day, straight through without a break. It is better to give a time during which the claimant does chores (i.e. for about 2 hours in the afternoon I try to do some light chores but I need frequent breaks).

§C8 & 9. This question assumes that the claimant is the person responsible for the chore and has a helper. If this is not the case, explain instead of checking the box.

§C12. The claimant may be able to accomplish these tasks but still have problems doing so. Don't check "NO PROBLEM" if the claimant is slower, needs some help or just avoids the task.

§C13. This is a multipart question that is more effectively answered in paragraph form. If the claimant simply reheats frozen dinners or leftovers or pours milk over cold cereal describe that instead of checking "YES". For example: "reheat leftovers, 3x week (5 min), toast or powerbar for breakfast, 4 -5 x week (2 min). I used to cook full meals daily and now I can't due to problems standing and concentrating."

Most clients estimate the time it takes to accomplish tasks incorrectly. They estimate from the time they start until they finish. So if it takes them an hour to make a dinner of frozen vegetables, hamburger and a potato because they require so many rest breaks, but it only takes 5 – 10 minutes of actual preparation time then the answer is 5 – 10 minutes, not 1 hour.

§C14. This should be written in paragraph form and with time estimates of how long it actually takes the claimant and not the machines. Rest breaks are not included in the time it takes to perform an activity but it should be stated that they are required.

§C15. Going outside – this means leaving home, not just sitting on the porch.

§C18. Hobbies and Interests are things claimants actually do and not thing they wish they could still do. If the claimant has the TV on but doesn't follow the program then it should not be listed as an interest, or even as "watching TV", which can be construed as evidence of the ability to concentrate. Claimants list watching TV as a hobby or interest because the form suggests it, but who really thinks of watching TV as a hobby or interest?

2. WORK HISTORY

In the Disability Report, the claimant was asked to describe the type of work that was performed the longest. If there was more than one job then DDS will follow-up with a Work History form (<http://www.socialsecurity.gov/forms/ssa-3369.pdf>). (See Appendix H). The claimant must describe all the work that lasted more than 6 months that was performed within the 15 years prior to the date of onset. It is the type of work and not the employer that is needed

F. FIVE STEP EVALUATION PROCESS

There is a five step sequential evaluation process by which all claims are evaluated (20 CFR 404.1520).

STEP ONE

At Step One SSA considers whether the claimant is working, and if so is that work "substantial gainful activity" (SGA). If the claimant is doing work that is SGA then the finding will be "Not Disabled" regardless of the medical condition, age, education or work experience. Between 1989 and 1997 a gross monthly earning of \$500 or more showed that a claimant had engaged in SGA and was therefore "Not Disabled" (20 C.F.R. 404.1574.) Beginning in 1998 that amount has increased in every year but 2011. In 2015 SGA is \$1090. (Appendix A).

Work the claimant does in 3 months or less and stops due to the impairment the work may be considered an Unsuccessful Work Attempt (UWA), if for 30 days both before and after the UWA there was no work, or work reduced to the non-SGA level, (SSR 05-02). If the work was for 6 months or less there are more requirements for it to be considered UWA. Income from UWA is not considered when calculating the Disability benefit amount.

STEP TWO

Does the claimant has a "severe" impairment. Severe is usually defined as grave, critical or extreme. However, in SSA lingo, an impairment is "severe" if it has a minimal effect on a claimant's physical or mental ability to perform basic work activity (SSR 85-28, 96-3p). A 2008 NH Federal Court case held that this Step-Two requirement is merely a threshold, designed to do no more than screen out groundless claims. Moriarty v. SSA, Civil No. 07-cv-342-SM (D.N.H. 158, 5/28/08). If no severe impairment is found the finding is "Not Disabled".

STEP THREE

If a severe impairment is found, Step Three evaluates whether the impairment meets or equals a listed impairment found at 20 CFR Part 404 Subpart P Appendix 1 Part A. The Listings describe exactly what objective medical finding must exist for various physical and emotional impairments. The following categories are covered: §1.00-Musculoskeletal, §2.00--Special Senses and Speech, §3.00--Respiratory System, §4.00--Cardiovascular, §5.00--Digestive, §6.00--Genitourinary, §7.00--Hematological Disorders, §8.00--Skin Disorders, §9.00--Endocrine System, §10.00--Multiple body Systems, §11.00--Neurological, §12.00--Mental Disorders, §13.00--Malignant Neoplastic, and §14.00--Immune System.

Generally SSA does a good job of matching impairments to a Listing, but many Listings have their own duration requirement. When the denial is issued prior to the end

of the full 12 month durational requirement sufficient time may not have elapsed to see if the Listing is met. For example: a woman who suffers from Cystic Fibrosis stopped work on March 30, 2009, applied 1 month later and received the denial May 31, 2009. Listing § 3.04C requires the occurrence of pulmonary bacterial infections at least once every 6 months with administration of certain prescribed therapy. When the examiner reviewed only 2 months of treatment records it was impossible to see that the claimant met the Listing. The claimant was denied and had to wait an additional 12 months for a hearing to be scheduled. Had the claimant waited at least 6 months to apply she would have been approved much sooner.

If the impairment meets or equals a listed impairment, the claimant is found "Disabled". If not, proceed to Step Four.

STEP FOUR

Here the consideration is whether the impairment prevents the claimant from doing past relevant work (PRW). This involves reviewing the claimant's (RFC) and matching it with the physical and mental demands of the claimant's past relevant work (PRW).

RFC is SS's assessment of the extent to which an individual's medically determinable impairment causes restrictions that affect the ability to do work-related activities (SSR 96-4p). SSR 96-8p has clarified that RFC is the maximum remaining ability to do sustained work activities in an ordinary work setting on a regular and continuing basis which means eight hours a day, five days a week or its equivalent.

PRW must have been performed within the last 15 years, lasted long enough for the claimant to learn to do it (usually for 6 months) and was SGA (CFR 404.1565(a), CFR 416.965(a), SSR 82-61). If the claimant can do PRW then the finding is "Not Disabled". The determination of ability to do PRW can include consideration of the job as actually performed and as ordinarily performed by employees throughout the national economy (SSR 82-62). If the claimant proves an inability return to PRW, the burden then shifts to the Commissioner.

STEP FIVE

It becomes the Commissioner's burden to show that there is other work which exists in significant numbers in the national economy which the claimant is capable of performing. The claimant's RFC, age, education and past work experience must be considered. The ALJ may use the testimony of a Vocational Expert (VE) to establish that other work exists, or may use the Medical Vocational Guidelines (GRIDS).

G. MEDICAL-VOCATIONAL GUIDELINE - GRIDS

Medical-Vocational Guidelines are found in Appendix 2 to Subpart P of 20 CFR 404. There are three tables (Appendix B) which mandate a decision of "Disabled" or

"Not Disabled" depending upon the three categories of age, education and PRW. The tables cover an RFC for sedentary, light, and medium work (20 CFR 404.1567, 20 CFR 404.15670. The Adjudicator cannot assume that a medical provider who uses the terms "Sedentary" or "Light" is using SSA's definitions (SSR 96-5p).

Sedentary work is restricted to lifting no more than 10 pounds on an occasional basis and usually involves sitting for at least 6 hours of an 8 hour day; a certain amount of walking and standing (up to 2 hours) may be required. "Occasional" is defined as up to a third of a day; "Frequent" is two thirds of a day and "Constant" is more than two thirds. Most unskilled sedentary jobs require good use of the hands and fingers for repetitive hand / finger actions (SSR 83-10, SSR 96-9p). Light work is restricted to lifting no more than 20 pounds with frequent lifting and carrying of up to 10 pounds.

Light work could require a good deal of walking or standing, or if it requires mostly sitting it may also require pushing and pulling of arm or leg controls. It usually requires the use of arms and hands to grasp, hold and turn objects. Light work is not the same as the Worker's Compensation term "light duty".

Medium work involves lifting no more than 50 pounds with frequent lifting or carrying of up to 25 pounds. If the claimant has the ability to lift 100 pounds or more (heavy /very heavy work), there will usually be no severe physical impairment, without a significant non-exertional impairment.

Age is divided into 5 categories: younger (18-44) and (45-49); closely approaching advanced age (50-54), advanced age (55 or older), and closely approaching retirement age (60-64). For the claimants 55 and older, limited to sedentary work, for skills to be transferrable there must be very little, if any, vocational adjustment (SSR 82-41). The same is true for individuals who are age 60 and older and limited to light work.

There are five educational categories:

- 1) Illiterate (unable to read or write a simple message in English);
- 2) Inability to communicate in English (cannot speak and understand English);
- 3) Marginal (6th grade level or below, with ability in reasoning, arithmetic, and language skills needed to do simple, unskilled types of jobs).
- 4) Limited (7th through 11th grade with ability in reasoning, arithmetic, and language skills, but not enough to allow a person to do most of the more complex job duties needed in semi-skilled or skilled jobs).
- 5) High School Above (GEDs; has ability to do semi-skilled - skilled work).

EXAMPLES USING GRIDS ALONE TO DETERMINE DISABILITY

A) 49 year old worker who cannot speak or understand English and, whose PRW is unskilled and who has impairments that allow for light work: the GRIDS dictate "Not Disabled" (§202.16). If that worker was 50 the GRIDS would dictate "Disabled"

(§202.09).

B) A 55 year old surgical nurse sustained a back injury, had failed back surgery and is limited to sedentary work. If the claimant's skills are transferrable then the finding is "Not Disabled" (§201.06), but if the [EJI] skills are not transferrable or if the vocational adjustment was significant then the GRIDS dictate "Disabled" (§201.07).

If the claimant has non-exertional impairment(s) that significantly erode the occupational base at the identified exertional level, the GRIDS can only be used as a guideline rather than a mandate (SSR 83-14). Non-exertional impairments, such as mental illness, vision, hearing or speech problems, environmental restrictions, or manipulative impairments requires a more thorough evaluation and possibly the use of a Vocational Expert (VE); such an expert may testify once the claimant gets to a Hearing. (SSR 96-9p.)

H. AUXILIARY BENEFITS

Once a claimant has been found disabled auxiliaries may also be entitled to benefits. Auxiliaries can include children or stepchildren, and a spouse or divorced spouse (if the marriage lasted 10 or more years). A child who is in high school can receive benefits until turning 19. If not in high school benefits end at age 18. A disabled child can continue to receive auxiliary benefits indefinitely. The parent of the child who receives auxiliary benefits who stays at home to care for the child can receive auxiliary benefits until the child turns 16. This only makes a difference to the claimant if the other parent and child does not live in the same household as the claimant, as the funds are paid to the custodial parent.

Once approved, a claimant is entitled to Disability Benefits called the Primary Insured Amount (PIA). If the earnings are high enough, the auxiliaries will share either 85% of the insured's average indexed monthly earnings (AIME) or 50% of the insured's PIA, whichever is smaller. If the claimant received Workers Compensation during any period Disability benefits were paid, benefits may be offset. Auxiliary benefits are offset first and PIA second.

I. APPEAL to ALJ

When the claimant's application for disability benefits is denied at the DDS level, an appeal must be filed within 60 days of receipt. It is assumed that it was received within 5 days of the date on the Notice. To file an appeal, complete a Request for Hearing by Administrative Law Judge (ALJ) (Form HA-501). If you did not represent the claimant prior to the receipt of the denial then this can be done by filing a paper Request for Hearing (Appendix I) with the claimant's District or Field Office. However, if you already represent the claimant then you must file the Request for Hearing (<http://www.socialsecurity.gov/forms/ha-501.pdf>) and a Disability Report – Appeal (<http://www.socialsecurity.gov/forms/ssa-3441.pdf>) online.

A hearing will be held in about 1 year at the Office of Disability Adjudication and Appeal (ODAR). You will receive notice of the Hearing at least at least 75 days in advance. Depending on the claimant's address, the ODAR locations are:

Suite 303
1750 Elm St, Manchester, NH 03104,
888-318-7973, or

Suite 301
439 South Union St,
Lawrence, MA 01843
877-405-9189

The Manchester ALJs are: James J D'Alessandro, Lisa Groeneveld-Meijer, Matthew G Levin, Paul G Martin, Thomas Merrill, and Dory Sutker.

The Lawrence ALJs are Jonathan Baird, Timothy Belford, Ellen P Bush, Brian Curley, Eric Eklund, and Tanya Garrian.

You will need to obtain all the updated medical records, and any evidence that DDS should have received but didn't. All evidence must be submitted electronically or by fax 5 days prior to the Hearing.

J. THE HEARING

The Hearing typically takes about 30 minutes. The ALJ may question your client about age, education, work history and why the claimant can't work. Or, the questioning may be turned over to the Attorney. The ALJ may call a Vocational Expert (VE) who can appear in person or by telephone. The ALJ will pose one or more hypothetical questions to the VE which are answered based on the Dictionary of Occupational titles (DOT). The Attorney has the opportunity to cross examine the VE.

The ALJ may also call a Medical Expert (ME) who can be a Psychologist or a medical doctor. The ALJ will ask the ME to describe the objective evidence and will ask if a Listing is met. The ME almost always appears telephonically. The Attorney has the opportunity to cross examine the ME as well.

K. APPEAL FROM THE ALJ DECISION

If, after a Hearing before an ALJ, the claimant is denied, the next step is to file an appeal with the Appeals Council (AC) within 60 days of the date of the receipt of the decision. Again it is assumed that it was received within 5 days. This is done by filing a Request for Review of Hearing Decision (Appendix I), along with a Memo detailing the reasons for the appeal. (<http://www.socialsecurity.gov/forms/ha-520.pdf>).

Reasons for appeal are: the ALJ abused his or her discretion; there is an error of law; the decision is not supported by substantial evidence; there is a broad policy or

procedural issue that may affect the public interest; or new and material evidence has been submitted showing that the decision is contrary to the weight of all the evidence in the record. It often takes 13 to 18 months to get a response.

L APPEAL FROM THE AC DENIAL

If the AC finds no reason to review the ALJ decision the request for review is denied. To appeal this decision you must file a complaint with the Federal District Court. You have 60 days from receipt of the decision; it is assumed that you received it within 5 days of the date of the decision. The filing fee is \$400.00.

II. OVERVIEW OF SSI

The medical evaluation process is the same as for Disability. The differences are primarily financial.

A. WHO IS ELIGIBLE

Children can be eligible for SSI, however, benefits end at age 18 and the new adult must apply again for SSI. Adults who are not insured and who have limited resources and family income are also eligible. Adults who are insured but who have very low benefits are eligible for their Disability benefit plus a supplement from SSI.

B. DATE OF ENTITLEMENT

There is no 5 month waiting period or retroactive benefits for SSI. After approval, Benefits begin the month after the month of application.

C. FINANCIAL CONSIDERATIONS

There are very strict limits on the amount of family income and resources a claimant can have to be eligible for SSI. For example, consider a claimant who stayed home to care for a young child, who lives with a spouse who works full time, and who returned to work 4 years before being diagnosed with a debilitating disease. This claimant is uninsured but is probably not eligible for SSI because the family income is too high.

A claimant cannot receive cash from any other source or it will be deducted from the benefit amount. If the claimant's friend gives money directly to the claimant to buy dog food (or anything that is not food or shelter), the benefit will be reduced. However, if the friend buys the dog food and gives it to the claimant there is no reduction in benefits.

D. BENEFITS

Benefits are fixed for every recipient. In 2015, the maximum benefit an individual

claimant can receive is \$733 and it is calculated on a monthly basis. (See Appendix A). Unlike Disability, a claimant's auxiliaries are never entitled to benefits. Generally an SSI recipient will receive Medicaid, but in NH, unlike most other states it is not automatic. Income from UWA is considered when the benefit amount is calculated. In addition, all income, including income from work reduced to the non-SGA level is considered when calculating the benefit amount.

APPENDIX A

<u>MONTHLY</u>	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
SGA	\$700	\$740	\$780	\$800	\$810	\$830	\$860	\$900	\$940	\$980
TWP	\$200	\$530	\$560	\$570	\$580	\$590	\$620	\$640	\$670	\$700
BLIND	\$1,117	\$1,240	\$1,300	\$1,330	\$1,350	\$1,380	\$1,450	\$1,500	\$1,570	\$1,640
SSI										
INDIVIDUAL	\$513	\$531	\$545	\$552	\$564	\$579	\$603	\$623	\$637	\$674
COUPLE	\$769	\$796	\$817	\$829	\$846	\$869	\$904	\$934	\$956	\$1,011
WAGES										
PER QUARTER	\$780	\$830	\$870	\$890	\$900	\$920	\$970	\$1,000	\$1,050	\$1,090
PER YEAR	\$3,120	\$3,320	\$3,480	\$3,560	\$3,600	\$3,680	\$3,880	\$4,000	\$4,200	\$4,360
COLA	2.4%	3.5%	2.6%	1.4%	2.1%	2.7%	4.1%	3.3%	2.3%	5.8%
MEDICARE	\$46.00	\$50.00	\$54.50	\$66.60	\$78.20	\$88.50	\$93.50			
MAX BENEFIT								\$2,185	\$2,323	\$2,366

<u>MONTHLY</u>	2010	2011	2012	2013	2014	2015				
SGA	\$1,000	\$1,000	\$1,010	\$1,040	\$1,070	\$1,090				
TWP	\$720	\$720	\$720	\$750	\$770	\$780				
BLIND	1640	\$16,640	\$1,690	\$1,740	\$1,800	\$1,820				
SSI										
INDIVIDUAL	\$674	\$674	\$698	\$710	\$721	\$733				
COUPLE	\$1,011	\$1,011	\$1,010	\$1,066	\$1,082	\$1,100				
WAGES										
PER QUARTER	\$1,120	\$1,120	\$1,130	\$1,160	\$1,200	\$1,220				
PER YEAR	\$4,480	\$4,480	\$4,520	\$4,640	\$4,800	\$4,880				
COLA	0.0%	0.0%	3.6%	1.7%	1.5%	1.7%				
MEDICARE					\$104.00					
MAX BENEFIT	\$2,366	\$2,513	\$2,533	\$2,642	\$2,663					

Table No. 1—Residual Functional Capacity: Maximum Sustained Work Capability Limited to Sedentary Work as a Result of Severe Medically Determinable Impairment(s)

RULE	AGE	EDUCATION	WORK EXPERIENCE	DECISION
201.01	Advanced (55+)	Limited or less	Unskilled or none	Disabled
201.02	" "	" " "	Skilled or semiskilled—skills not transferable	" "
201.03	" "	" " "	Skilled or semiskilled—skills transferable	Not Disabled
201.04	" "	High school graduate or more—does not provide for direct entry into skilled work	Unskilled or none	Disabled
201.05	" "	High school graduate or more—provides for direct entry into skilled work	" " "	Not Disabled
201.06	" "	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	Disabled
201.07	" "	" " " "	Skilled or semiskilled—skills transferable	Not Disabled
201.08	" "	High school graduate or more—provides for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "
201.09	Closely approaching advanced age (50-54)	Limited or less	Unskilled or none	Disabled
201.10	" "	" " "	Skilled or semiskilled—skills not transferable	" "
201.11	" "	" " "	Skilled or semiskilled—skills transferable[1]	" "
201.12	" "	High school graduate or more—does not provide for direct entry into skilled work	Unskilled or none	" "
201.13	" "	High school graduate or more—provides for direct entry into skilled work	" " "	Not Disabled
201.14	" "	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	Disabled
201.15	" "	" " " "	Skilled or semiskilled—skills transferable	Not Disabled
201.16	" "	High school graduate or more—provides for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "

201.17	Younger (45-49)	Illiterate or unable to communicate in English	Unskilled or none	Disabled
201.18	" "	Limited or less—at least literate and able to communicate in English	" " "	Not Disabled
201.19	" "	Limited or less	Skilled or semiskilled—skills not transferable	" "
201.20	" "	" " "	Skilled or semiskilled—skills transferable	" "
201.21	" "	High school graduate or more	Skilled or semiskilled—skills not transferable	" "
201.22	" "	" " "	Skilled or semiskilled—skills transferable	" "
201.23	" "	Illiterate or unable to communicate in English	Unskilled or none	" "
201.24	" "	Limited or less—at least literate and able to communicate in English	" " "	" "
201.25	" "	Limited or less	Skilled or semiskilled—skills not transferable	" "
201.26	" "	" " "	Skilled or semiskilled—skills transferable	" "
201.27	" "	High school graduate or more	Unskilled or none	" "
201.28	" "	" " "	Skilled or semiskilled—skills not transferable	" "
201.29	" "	" " "	Skilled or semiskilled—skills transferable	" "

Table No. 2—Residual Functional Capacity: Maximum Sustained Work Capability Limited to Light Work as a Result of Severe Medically Determinable Impairment(s)

RULE	AGE	EDUCATION	WORK EXPERIENCE	DECISION
202.01	Advanced (55+)	Limited or less	Unskilled or none	Disabled
202.02	" "	" " "	Skilled or semiskilled—skills not transferable	" "
202.03	" "	" " "	Skilled or semiskilled—skills transferable[1]	Not Disabled
202.04	" "	High school graduate or more—does not provide for direct entry into skilled work[2]	Unskilled or none	Disabled
202.05	" "	High school graduate or more—provides for direct entry into skilled work[2]	" " "	Not Disabled
202.06	" "	High school graduate or more—does not provide for direct entry into skilled work[2]	Skilled or semiskilled—skills not transferable	Disabled
202.07	" "	" " " "	Skilled or semiskilled—skills transferable[2]	Not Disabled
202.08	" "	High school graduate or more—provides for direct entry into skilled work[2]	Skilled or semiskilled—skills not transferable	" "
202.09	Closely approaching advanced age (50-54)	Illiterate or unable to communicate in English	Unskilled or none	Disabled
202.10	" "	Limited or less—at least literate and able to communicate in English	" " "	Not Disabled
202.11	" "	Limited or less	Skilled or semiskilled—skills not transferable	" "
202.12	" "	" " "	Skilled or semiskilled—skills transferable	" "
202.13	" "	High school graduate or more	Unskilled or none	" "
202.14	" "	" " "	Skilled or semiskilled—skills not transferable	" "
202.15	" "	" " "	Skilled or semiskilled—skills transferable	" "
202.16	Younger (18-49)	Illiterate or unable to communicate in English	Unskilled or none	" "
202.17	" "	Limited or less—at least literate and able to communicate in English	" " "	" "
202.18	" "	Limited or less	Skilled or semiskilled—skills not transferable	" "
202.19	" "	" " "	Skilled or semiskilled—skills transferable	" "
202.20	" "	" " "	Skilled or semiskilled—skills not transferable	" "
202.20	" "	High school graduate or more	Unskilled or none	" "
202.21	" "	" " "	Skilled or semiskilled—skills not transferable	" "
202.22	" "	" " "	Skilled or semiskilled—skills transferable	" "

Table No. 3—Residual Functional Capacity: Maximum Sustained Work Capability Limited to Medium Work as a Result of Severe Medically Determinable Impairment(s)

RULE	AGE	EDUCATION	WORK EXPERIENCE	DECISION
203.01	Closely Approaching Retirement Age (60-64)	Marginal or one	Unskilled or none	Disabled
203.02	" "	Limited or less	None	" "
203.03	" "	Limited	Unskilled	Not Disabled
203.04	" "	Limited or less	Skilled or semiskilled—skills not transferable	" "
203.05	" "	" " "	Skilled or semiskilled—skills transferable	" "
203.06	" "	High school graduate or more	Unskilled or none	" "
203.07	" "	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "
203.08	" "	" " "	Skilled or semiskilled—skills transferable	" "
203.09	" "	High school graduate or more—provides for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "
203.10	Advanced (55 -59)	Limited or less	None	Disabled
203.11	" "	" " "	Unskilled	Not Disabled
203.12	" "	" " "	Skilled or semiskilled—skills not transferable	" "
203.13	" "	" " "	Skilled or semiskilled—skills transferable	" "
203.14	" "	High school graduate or more	Unskilled or none	" "
203.15	" "	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "
203.16	" "	" " "	Skilled or semiskilled—skills transferable	" "
203.17	" "	High school graduate or more—provides for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "

203.18	Closely Approaching Advanced Age (50-54)	Limited or less	Unskilled or none	" "
203.19	" "	" " "	Skilled or semiskilled—skills not transferable	" "
203.20	" "	" " "	Skilled or semiskilled—skills transferable	" "
203.21	" "	High school graduate or more	Unskilled or none	" "
203.22	" "	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "
203.23	" "	" " "	Skilled or semiskilled—skills transferable	" "
203.24	" "	High school graduate or more—provides for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "
203.25	Younger (18-49)	Limited or less	Unskilled or none	" "
203.26	" "	" " "	Skilled or semiskilled—skills not transferable	" "
203.27	" "	" " "	Skilled or semiskilled—skills transferable	" "
203.28	" "	High school graduate or more	Unskilled or none	" "
203.29	" "	High school graduate or more—does not provide for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "
203.30	" "	" " "	Skilled or semiskilled—skills transferable	" "
203.31	" "	High school graduate or more—provides for direct entry into skilled work	Skilled or semiskilled—skills not transferable	" "

SOCIAL SECURITY ADMINISTRATION

**DISABILITY REPORT
ADULT**

For SSA Use Only
Do not write in this box.

Related SSN _____

Number Holder _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last) _____

B. SOCIAL SECURITY NUMBER _____

C. DAYTIME TELEPHONE NUMBER (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)

Area Code _____ Number _____ Your Number Message Number None

D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries or conditions and can help you with your claim.

NAME _____ RELATIONSHIP _____

ADDRESS _____

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

City _____ State _____ ZIP _____ DAYTIME PHONE _____ Area Code _____ Number _____

E. What is your height without shoes? _____ feet _____ inches

F. What is your weight without shoes? _____ pounds

G. Do you have a medical assistance card? (For Example, Medicaid or Medi-Cal) If "YES," show the number here: YES NO _____

H. Can you speak and understand English? YES NO If "NO," what is your preferred language? _____

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

If you cannot speak and understand English, is there someone we may contact who speaks and understands English and will give you messages? YES NO (If "YES," and that person is the same as in "D" above show "SAME" here. If not, complete the following information.)

NAME _____ RELATIONSHIP _____

ADDRESS _____

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

City _____ State _____ ZIP _____ DAYTIME PHONE _____ Area Code _____ Number _____

I. Can you read and understand English? YES NO J. Can you write more than your name in English? YES NO

Disability Report-Adult-Form SSA-3368-BK

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the illnesses, injuries or conditions that limit your ability to work? _____

B. How do your illnesses, injuries or conditions limit your ability to work? _____

C. Do your illnesses, injuries or conditions cause you **pain** YES NO
or **other symptoms**?

D. When did your illnesses, injuries or conditions **first bother you**?

Month	Day	Year
-------	-----	------

E. When did you become **unable to work** because of your illnesses, injuries or conditions?

Month	Day	Year
-------	-----	------

F. Have you **ever worked**?

YES NO *(If "NO," go to Section 4.)*

G. Did you **work at any time** after the date your illnesses, injuries or conditions first bothered you?

YES NO

H. If "YES," did your illnesses, injuries or conditions cause you to: *(check all that apply)*

- work fewer hours? *(Explain below)*
- change your job duties? *(Explain below)*
- make any job-related changes such as your attendance, help needed, or employers?
(Explain below)

I. Are you **working now**?

YES NO

If "NO," when did you **stop working**?

Month	Day	Year
-------	-----	------

J. Why did you **stop working**? _____

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries or conditions.

JOB TITLE <i>(Example: Cook)</i>	TYPE OF BUSINESS <i>(Example: Restaurant)</i>	DATES WORKED <i>(month & year)</i>		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY <i>(Per hour, day, week, month or year)</i>	
		From	To			\$	
						\$	
						\$	
						\$	
						\$	
						\$	
						\$	
						\$	

B. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

D. In this job, did you:

Use machines, tools or equipment? YES NO

Use technical knowledge or skills? YES NO

Do any writing, complete reports, or perform duties like this? YES NO

E. In this job, how many total hours each day did you:

Walk? _____ Stoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____
 Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____
 Sit? _____ Crouch? *(Bend legs & back down & forward.)* _____ Write, type or handle small objects? _____
 Climb? _____ Crawl? *(Move on hands & knees.)* _____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

G. Check **heaviest** weight lifted:

Less than 10 lbs 10 lbs 20 lbs 50 lbs 100 lbs. or more Other _____

H. Check weight **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

Less than 10 lbs 10 lbs 25 lbs 50 lbs. or more Other _____

I. Did you supervise other people in this job? YES *(Complete items below.)* NO *(If NO, go to J.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

J. Were you a lead worker? YES NO

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? YES NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? YES NO

If you answered "NO" to both of these questions, go to Section 5.

C. List other names you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. List each **DOCTOR/HMO/THERAPIST/OTHER**. Include your next appointment.

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

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

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

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

If you need more space, use Remarks, Section 9.

E. List each HOSPITAL/CLINIC. Include your next appointment.

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

Next appointment _____ Your hospital/clinic number _____

Reasons for visits _____

What treatment did you receive? _____

What doctors do you see at this hospital/clinic on a regular basis? _____

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

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

Next appointment _____ Your hospital/clinic number _____

Reasons for visits _____

What treatment did you receive? _____

What doctors do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does anyone else have medical records or information about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

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

NO

NAME			DATES	
STREET ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN	
PHONE			NEXT APPOINTMENT	
<small>Area Code Phone Number</small>				
CLAIM NUMBER (if any) _____				
REASONS FOR VISITS _____				

If you need more space, use Remarks, Section 9.

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? YES
 If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries or conditions?
 YES NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN DONE OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you have had other tests, list them in Remarks, Section 9.

SECTION 7-EDUCATION/TRAINING INFORMATION

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

Grade school:

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

College:

1 2 3 4 or more

Approximate **date** completed: _____

B. Did you attend **special education** classes? YES NO (If "NO," go to part C)

NAME OF SCHOOL _____

ADDRESS _____

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

City

State

Zip

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school**?

YES NO If "YES," what type? _____

Approximate date completed: _____

**SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT,
or OTHER SUPPORT SERVICES INFORMATION**

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services to help you go to work?

YES (Complete the information below) NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

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

City

State

Zip

DAYTIME PHONE NUMBER _____

Area Code

Number

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

**MEDICAL SOURCE STATEMENT OF
ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)**

NAME OF INDIVIDUAL: _____

SOCIAL SECURITY NO: _____

To determine this individual's ability to do work-related activities on a regular and continuous basis, which means 8 hours a day, for 5 days a week, or an equivalent work schedule. Please give us your opinion for each activity shown below.

I. LIFTING/CARRYING

A. Maximum ability to lift and carry for 2 hrs, 40 minutes per 8 hour day, every workday.

No limitations 100# 50# 20# 10# less than 10#

B. Maximum ability to lift and carry for 5 hours 20 minutes per 8 hour day, every workday.

No limitations 100# 50# 20# 10# less than 10#

II. SITTING/STANDING/WALKING

A. Does the individual need the opportunity to shift at will from sitting or standing/walking?

Yes No

B. Does the individual need the opportunity to take unscheduled breaks during the work day?

Yes No

C. Please check how long in an 8 hour day the individual can:

AT ONE TIME without interruption

Activity	Minutes								
	0	5	10	15	20	30	45	60	90
Sit	<input type="checkbox"/>								
Stand	<input type="checkbox"/>								
Walk	<input type="checkbox"/>								

TOTAL in an 8-hour day

Activity	Hours								
	<1	1	2	3	4	5	6	7	8
Sit or Stand or Walk	<input type="checkbox"/>								
	<input type="checkbox"/>								
	<input type="checkbox"/>								

D. If the individual could sit, stand or walk as desired, what is the maximum combined ability to sit, stand or walk in an 8 hour day (in hours):

less than 1 1 2 3 4 5 6 7 8

E. Does the individual require the use of a cane to ambulate?

Yes No

If yes, how far or how long can the individual ambulate without the use of a cane? _____

III. REST/BREAKS

A. Will the individual need to take steps to relieve pain or rest, recline, lie down or take breaks at intervals during an 8-hour day? Yes No

If yes, please explain how many breaks and for how long.

If yes, please explain.

B. Will the individual need to elevate the feet or legs during an 8-hour day?

Yes No

If yes, how high and for how long does the individual need to elevate his/her feet or legs?

IV. HANDS/FEET

A. Indicate the total length of time the individual can perform the following activities every 8 hour day:

1.

Activity	Right Hand					Left Hand				
	Less than 2 hours	About 2 hours	About 4 hours	About 6 hours	About 8 hours	Less than 2 hours	About 2 hours	About 4 hours	About 6 hours	About 8 hours
REACHING (overhead)										
REACHING (all other)										
HANDLING										
FINGERING										
FEELING										
PUSH/PULL										

2. Which is the individual's dominant hand? Right Hand Left Hand

B. Indicate the total length of time the individual can perform the following activities every 8 hour day:

Activity	Right Foot					Left Foot				
	Less than 2 hours	About 2 hours	About 4 hours	About 6 hours	About 8 hours	Less than 2 hours	About 2 hours	About 4 hours	About 6 hours	About 8 hours
Operation of Foot Controls										

V. POSTURAL ACTIVITIES

A. Indicate the total length of time in an 8-hour day that the individual can perform the following postural activities:

ACTIVITY	Never	< 2 hours	About 2 hours	About 4 hours	About 6 hours	About 8 hours
CLIMB STAIRS AND RAMPS						
CLIMB LADDERS OR SCAFFOLDS						
BALANCE						
STOOP						
CROUCH						
KNEEL						
CRAWL						

VI. ENVIRONMENTAL LIMITATIONS

A. Indicate the total length of time in an 8-hour day that the individual can tolerate exposure to the following conditions:

CONDITION	Never	<2 hours	About 2 hours	About 4 hours	About 6 hours	About 8 hours
Unprotected heights						
Moving mechanical parts						
Operating a motor vehicle						
Humidity and wetness						
Dust, odors, fumes and pulmonary irritants						
Extreme cold						
Extreme heat						
Vibrations						

B. If the individual has an impairment regarding noise, please describe the limitation:

VII. Describe any other impairments which affect work-related activities, such as speaking, seeing, hearing, fatigue, side effects from medications, difficulty concentrating, focusing, remembering or limitations related to a mental impairment.

VIII. What medical and clinical findings (i.e. physical exam findings, x-ray findings, laboratory test results, history and symptoms including pain, etc) support the limitations described above in questions I-VII?

IX. Assuming your patient was trying to work full time, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

- | | |
|---|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> About three days per month |
| <input type="checkbox"/> About one day per month | <input type="checkbox"/> About four days per month |
| <input type="checkbox"/> About two days per month | <input type="checkbox"/> More than four days per month |

X. These limitations have been present since _____.

XI. Have the limitations you found above lasted or will they last for 12 consecutive months?
 Yes No

What percent of time would the individual be off task due to impairment(s)?

- 5% 10% 15% 20% 25% more than 25%

Date

Signature

Printed/Typed Name: _____

Address: _____

**MEDICAL SOURCE STATEMENT OF
ABILITY TO DO WORK-RELATED ACTIVITIES (MENTAL)**

NAME OF INDIVIDUAL _____

SOCIAL SECURITY NUMBER _____

Please answer the following questions concerning the claimant's impairments

1. Examination date: _____

2. Did you have an opportunity to review the claimant's medical history and to personally interview the claimant?
_____ Yes _____ No

3. DSM-IV Multiaxial Evaluation (presently):

Axis I: _____

Axis IV: _____

Axis II: _____

Axis V: Current GAF: _____

Axis III: _____

Highest GAF Past year: _____

4. DSM-IV Multiaxial Evaluation (at treatment onset date):

Axis I: _____

Axis IV: _____

Axis II: _____

Axis V: Current GAF: _____

Axis III: _____

Highest GAF Past year: _____

5. Describe, if any, side effects from medications that the claimant has listed that may have implications for working. E.g., dizziness, drowsiness, fatigue, lethargy, stomach upset, etc.:

6. List any clinical findings, including results of mental status examinations or any other testing or reports from the claimant that demonstrate the severity of the claimant's mental impairment and symptoms:

7. Identify the claimant's signs and symptoms:

Anhedonia or pervasive loss of interest in almost all activities	Intense and unstable interpersonal relationships and impulsive and damaging behavior
Appetite disturbance with weight change	Disorientation to time and place
Decreased energy	Perceptual or thinking disturbances
Thoughts of suicide	Hallucinations or delusions
Blunt, flat or inappropriate affect	Hyperactivity
Feelings of guilt or worthlessness	Motor tension
Impairment in impulse control	Catatonic or other grossly disorganized behavior
Poverty of content of speech	Emotional lability
Generalized persistent anxiety	Flight of ideas
Somatization unexplained by organic disturbance	Manic syndrome
Mood disturbance	Deeply ingrained, maladaptive patterns of behavior
Difficulty thinking or concentrating	Inflated self-esteem
Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress	Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury.
Psychomotor agitation or retardation	Loosening of associations
Pathological dependence, passivity or aggressivity	Illogical thinking
Persistent disturbances of mood or affect	Vigilance and scanning
Persistent nonorganic disturbance of vision, speech, hearing, use of a limb, movement and its control, or sensation	Pathologically inappropriate suspiciousness or hostility
Change in personality	Pressures of speech
Apprehensive expectation	Easy distractibility
Paranoid thinking or inappropriate suspiciousness	Autonomic hyperactivity
Recurrent obsessions or compulsions which are a source of marked distress	Memory impairment — short, intermediate or long term
Seclusiveness or autistic thinking	Sleep disturbance
Substance dependence	Oddities of thought, perception, speech or behavior
Incoherence	Decreased need for sleep
Emotional withdrawal or isolation	Loss of intellectual ability of 15 IQ points or more
Psychological or behavioral abnormalities associated with a dysfunction of the brain with a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities	Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week
Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes)	A history of multiple physical symptoms (for which there are no organic findings) of several years duration beginning before age 30, that have led the individual to take medicine frequently, see a physician often and alter life patterns significantly
Persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity or situation.	Involvement in activities that have a high probability of painful consequences which are not recognized

8. What is the individual's capacity to sustain each activity over an 8 hour work day and normal work week on an ongoing basis?

None: no limitation on the ability to perform the activity

Mild: an ability to perform the activity satisfactorily most of the time.

Moderate: an ability to perform the activity satisfactorily only some of the time.

Marked: a serious limitation in the area with substantial loss in the ability to function effectively.

Extreme: no useful ability to function in the area.

	None	Mild	Moderate	Marked	Extreme
A. UNDERSTANDING AND MEMORY					
1. The ability to remember locations and work-like procedures.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
2. The ability to understand and remember very short and simple instructions.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
3. The ability to understand and remember detailed instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
B. SUSTAINED CONCENTRATION AND PERSISTENCE					
4. The ability to carry out very short and simple instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
5. The ability to carry out detailed instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
6. The ability to maintain attention and concentration for extended periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
7. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
8. The ability to sustain an ordinary routine without special supervision.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
9. The ability to work in coordination with or proximity to others without being distracted by them.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
10. The ability to make simple work-related decisions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
11. The ability to complete a normal work-day and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

None Mild Moderate Marked Extreme

C. SOCIAL INTERACTION

12. The ability to interact appropriately with the general public. 1. 2. 3. 4. 5.
13. The ability to ask simple questions or request assistance. 1. 2. 3. 4. 5.
14. The ability to accept instructions and respond appropriately to criticism from supervisors. 1. 2. 3. 4. 5.
15. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes. 1. 2. 3. 4. 5.
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness. 1. 2. 3. 4. 5.

D. ADAPTATION

17. The ability to respond appropriately to changes in the work setting. 1. 2. 3. 4. 5.
18. The ability to be aware of normal hazards and take appropriate precautions. 1. 2. 3. 4. 5.
19. The ability to travel in unfamiliar places or use public transportation. 1. 2. 3. 4. 5.
20. The ability to set realistic goals or make plans independently of others. 1. 2. 3. 4. 5.

If limitations fall in the 3 most limited categories, please explain your assessment:

9. What percent of the time would the individual be off task due to the impairment(s):

- 5% 10% 15% 20% 25% more than 25%

10. Does the claimant have a low IQ or reduced intellectual functioning? Yes No
If yes, please explain (with reference to specific test results):

11. Does the psychiatric condition exacerbate the claimant's experience of pain or any other physical symptom? Yes No

If yes, please explain:

12. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

- Never About one day per month About two days per month About three days per month About four days per month More than four days per month

13. Has the claimant's impairment lasted or can it be expected to last at least twelve months? Yes No

14. Has the claimant's impairment lasted or can it be expected to last at least forty-eight months? Yes No

15. Is the claimant a malingerer? Yes No

16. Are the claimant's impairments reasonably consistent with the symptoms and functional limitations described in this evaluation? Yes No

If no, please explain:

17. Please describe any additional reasons not covered above why the claimant would have difficulty working at a regular job on a sustained basis:

18. Can the claimant manage benefits in his or her own best interest? Yes No

19. What is the *earliest date* that the above description of limitations applies? _____

20. Would these impairments, taken as a whole prevent the claimant from working 50 weeks a year, 40 hours a week, 5 days a week and 8 hours a day? Yes No

Date

Signature

Printed/Typed Name: _____

Address: _____

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only
Do not write in this box.

Related SSN _____

Number Holder _____

SECTION A - GENERAL INFORMATION

1. NAME OF DISABLED PERSON *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER

3. YOUR DAYTIME TELEPHONE NUMBER *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

Area Code Phone Number

Your Number Message Number None

4. a. Where do you live? *(Check one.)*

House Apartment Boarding House Nursing Home
 Shelter Group Home Other *(What?)* _____

b. With whom do you live? *(Check one.)*

Alone With Family With Friends
 Other *(Describe relationship.)* _____

SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

5. How do your illnesses, injuries, or conditions limit your ability to work?

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? Yes No

If "YES," for whom do you care, and what do you do for them? _____

8. Do you take care of pets or other animals? Yes No

If "YES," what do you do for them? _____

9. Does anyone help you care for other people or animals? Yes No

If "YES," who helps, and what do they do to help? _____

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

11. Do the illnesses, injuries, or conditions affect your sleep? Yes No

If "YES," how? _____

12. **PERSONAL CARE** (Check here if **NO PROBLEM** with personal care.)

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress _____

Bathe _____

Care for hair _____

Shave _____

Feed self _____

Use the toilet _____

Other _____

b. Do you need any special reminders to take care of personal needs and grooming? Yes No

If "YES," what type of help or reminders are needed? _____

c. Do you need help or reminders taking medicine? Yes No

If "YES," what kind of help do you need? _____

13. MEALS

a. Do you prepare your own meals? Yes No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.) _____

How often do you prepare food or meals? (For example, daily, weekly, monthly.) _____

How long does it take you? _____

Any changes in cooking habits since the illness, injuries, or conditions began? _____

b. If "No," explain why you cannot or do not prepare meals. _____

14. HOUSE AND YARD WORK

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.) _____

b. How much time does it take you, and how often do you do each of these things? _____

c. Do you need help or encouragement doing these things? Yes No

If "YES," what help is needed? _____

d. If you don't do house or yard work, explain why not. _____

15. GETTING AROUND

a. How often do you go outside? _____
If you don't go out at all, explain why not. _____

b. When going out, how do you travel? (Check all that apply.)

- Walk Drive a car Ride in a car Ride a bicycle
 Use public transportation Other (Explain) _____

c. When going out, can you go out alone? Yes No
If "NO," explain why you can't go out alone. _____

d. Do you drive? Yes No
If you don't drive, explain why not. _____

16. SHOPPING

a. If you do any shopping, do you shop: (Check all that apply.)

- In stores By phone By mail By computer

b. Describe what you shop for. _____

c. How often do you shop and how long does it take? _____

17. MONEY

a. Are you able to:

- Pay bills Yes No Handle a savings account Yes No
Count change Yes No Use a checkbook/money orders Yes No

Explain all "NO" answers. _____

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? Yes No

If "YES," explain how the ability to handle money has changed. _____

18. HOBBIES AND INTERESTS

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

b. How often and how well do you do these things? _____

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

19. SOCIAL ACTIVITIES

a. Do you spend time with others? (*In person, on the phone, on the computer, etc.*) Yes No

If "YES," describe the kinds of things you do with others. _____

How often do you do these things? _____

b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.) _____

Do you need to be reminded to go places? Yes No

How often do you go and how much do you take part? _____

Do you need someone to accompany you? Yes No

c. Do you have any problems getting along with family, friends, neighbors, or others? Yes No

If "YES," explain. _____

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

SECTION D - INFORMATION ABOUT ABILITIES

20. a. Check any of the following items that your illnesses, injuries, or conditions affect:

- Lifting Walking Stair Climbing Understanding
- Squatting Sitting Seeing Following Instructions
- Bending Kneeling Memory Using Hands
- Standing Talking Completing Tasks Getting Along With Others
- Reaching Hearing Concentration

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far])

b. Are you: Right Handed? Left Handed?

c. How far can you walk before needing to stop and rest? _____
If you have to rest, how long before you can resume walking? _____

d. For how long can you pay attention? _____

e. Do you finish what you start? (For example, a conversation, chores, reading, watching a movie.) Yes No

f. How well do you follow written instructions? (For example, a recipe.) _____

g. How well do you follow spoken instructions? _____

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.) _____

i. Have you ever been fired or laid off from a job because of problems getting along with other people? Yes No

If "YES," please explain. _____

If "YES," please give name of employer. _____

j. How well do you handle stress? _____

k. How well do you handle changes in routine? _____

l. Have you noticed any unusual behavior or fears? Yes No

If "YES," please explain. _____

21. Do you use any of the following? (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Brace/Splint | <input type="checkbox"/> Glasses/Contact Lenses |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Artificial Limb | <input type="checkbox"/> Artificial Voice Box |
| <input type="checkbox"/> Other (Explain) _____ | | |

Which of these were prescribed by a doctor? _____

When was it prescribed? _____

When do you need to use these aids? _____

Claimant, who lived with his sister, wrote in his Function Report:

SECTION B - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

which ALOT of IV, Etc

12. **PERSONAL CARE** (Check here if **NO PROBLEM** with personal care.)

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress Hard To Bend

Bathe ok

Care for Hair ok

Shave ok

Feed Self ok

Use the Toilet ok

Other? Leg problems

13. **MEALS**

a. Do you prepare your own meals?

Yes No

If YES, what kind of food do you prepare? (for example, sandwiches, frozen dinners, or complete meals with several courses) Beef Chicken pork
Junk food frozen

How often do you prepare food or meals? (for example, daily, weekly, monthly)

How long does it take you? 4 min to 1 hour

Any changes in cooking habits since the illness, injuries, or conditions began?
frozen food

b. If you do not prepare your own meals, please explain why you cannot or do not prepare meals:
frozen

18. HOBBIES AND INTERESTS

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing TV sports, etc.) _____

b. How often and how well do you do these things? not often
what I do I do slowly

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.
legs very weak must sit alone

20.

h. How well do you get along with authority figures? (For Example: police, bosses, landlords or teachers)? not well been in and out of jail my life

i. Have you ever been fired or laid off from a job because of problems getting along with other people? Yes No
If "YES," please explain. always quit

His sister wrote in a 3rd party Function Report:

**SECTION B
INFORMATION ABOUT DAILY ACTIVITIES**

8. Describe what the disabled person does from the time he/she wakes up until going to bed.

When having a good day will go out, Reads, When not having good day
Sits around, watches T.V. Sleeps

15. MEALS

a. Does the disabled person prepare his/her own meals?

Yes No

If YES, what kind of food is prepared (for example, sandwiches, frozen dinners, or complete meals with several courses?) prepared meals only

How often does he/she prepare food or meals? (for example, daily, weekly, monthly)

daily

How long does it take him/her? about half hour

16. HOUSE AND YARD WORK

a List household chores, both indoors and outdoors, that the disabled person is able to do (for example, cleaning, laundry, household repairs, ironing, mowing, etc.)

laundry Sometimes ~~swipe~~ wipe the floor, Pick up his room

b. How much time do chores take, and how often does he/she do each of these things?

It varies

c Does he/she need help or encouragement doing these things?

Yes No

If YES, what help is needed? Motivation

- d For how long can the disabled person pay attention? a few minuets
- e Does the disabled person finish what he/she starts? (For Example: a conversation, chores, reading, watching a movie)
- Yes No Don't always
- f. How well does the disabled person follow written instructions such as a recipe?
- Don't well
- g. How well does the disabled person follow spoken instructions? Don't well

The ALJ wrote:

Not only do treatment notes fail to document a presentation consistent with the claimant's complaints of pain, I note that the claimant's function report shows that he engages in activities that are inconsistent with the full extent of his allegations. The claimant indicated that *he spends much of his day sitting and watching television; this is consistent with the limit to no more than 2 hours of standing and walking per day*. He noted difficulty bending, but he has *no problem standing to bathe, reaching to care for his hair, transitioning between sitting and standing to use the toilet, or using his hands and upper extremities for shaving and feeding*.

He spends up to an hour preparing meals. The claimant is able to drive a car and operate the foot and hand controls. He shops twice a month in the grocery store. He attends appointments and visits with friends at home and in public (Exhibit B4E). The claimant's sister stated that he cannot lift heavy objects, but he *can do laundry, sweep the floor, and pick up his belongings* (Exhibit B3E). These activities are consistent with the range of work described above, as he avoids heavy lifting, but otherwise *has little difficulty remaining seated for extended periods and can walk for short distances*. (emphasis added)

The RFC was:

light work except he could sit up to 6 hours and stand/walk up to 2 hours in an 8-hour workday; occasional postural activities; limited to simple, repetitive tasks; could maintain concentration, persistence, and pace, for one hour at a time before having a 2-3 minute break before continuing on for another hour. He could interact with coworkers and supervisors on routine matters, but should avoid more than superficial interactions with the public.

WORK HISTORY REPORT

For SSA Use Only
Do not write in this box.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last)

B. SOCIAL SECURITY NUMBER

C. DAYTIME TELEPHONE NUMBER *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

() -
Area Code Phone Number

Your Number

Message Number

None

SECTION 2 - INFORMATION ABOUT YOUR WORK

List all the jobs that you have had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

	Job Title	Type of Business	Dates Worked	
			From	To
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Work History Report - Form SSA-3369-BK

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1

Rate of Pay \$ _____	Per (Check One) <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Hours per day	Days Per Week
-------------------------	--	---------------	---------------

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

In this job, did you:

- Use machines, tools, or equipment? YES NO
- Use technical knowledge or skills? YES NO
- Do any writing, complete reports, or perform duties like this? YES NO

In this job, how many total hours each day did you:

- Walk? _____
- Stand? _____
- Sit? _____
- Climb? _____
- Stoop? (Bend down and forward at waist) _____
- Kneel? (Bend legs to rest on knees) _____
- Crouch? (Bend legs & back down & forward) _____
- Crawl? (Move on hands & knees) _____
- Handle, grab, or grasp big objects? _____
- Reach? _____
- Write, type, or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

Check the **heaviest** weight lifted:

- Less than 10 lbs 10 lbs 20 lbs 50 lbs 100 lbs. or more Other _____

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

- Less than 10 lbs 10 lbs 25 lbs 50 lbs or more Other _____

Did you supervise other people in this job? YES (Complete the next 3 items.) NO (Skip to the last question on this page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

Were you a lead worker? YES NO

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

(Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)

See Privacy Act Notice

1. Claimant Name	2. Claimant SSN	3. Claim Number, if different
------------------	-----------------	-------------------------------

4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

5. I have additional evidence to submit. <input type="checkbox"/> Yes <input type="checkbox"/> No Name and source of additional evidence, if not included. Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.	6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks <input type="checkbox"/> I wish to appear at a hearing. <input type="checkbox"/> I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)
---	---

Representation: You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

7. CLAIMANT SIGNATURE (OPTIONAL)	DATE	8. NAME OF REPRESENTATIVE (if any)	DATE
RESIDENCE ADDRESS		ADDRESS	
CITY	STATE	ZIP CODE	CITY
			STATE
			ZIP CODE
TELEPHONE NUMBER	FAX NUMBER	TELEPHONE NUMBER	FAX NUMBER

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING

9. Request received on _____ by: _____
(Date) (Print Name) (Title)
(Address) (Servicing FO Code) (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination? Yes No
If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Check all claim types that apply:
12. Interpreter needed <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Retirement and Survivors Insurance Only (RSI)
Language (including sign language):	<input type="checkbox"/> Title II Disability - Worker or child only (DIWC)
13. Check one: <input type="checkbox"/> Initial Entitlement Case	<input type="checkbox"/> Title II Disability - Widow(er) only (DIWW)
<input type="checkbox"/> Disability Cessation Case or <input type="checkbox"/> Other Postentitlement Case	<input type="checkbox"/> Title XVI (SSI) Aged only (SSIA)
14. HO COPY SENT TO: _____ HO on _____	<input type="checkbox"/> Title XVI Blind only (SSIB)
<input type="checkbox"/> Claims Folder (CF) Attached: <input type="checkbox"/> Title (T) II; <input type="checkbox"/> T XVI;	<input type="checkbox"/> Title XVI Disability only (SSID)
<input type="checkbox"/> T VIII; <input type="checkbox"/> T XVIII; <input type="checkbox"/> T II CF held in FO <input type="checkbox"/> Electronic Folder	<input type="checkbox"/> Title XVI/Title II Concurrent Aged Claim (SSAC)
<input type="checkbox"/> CF requested <input type="checkbox"/> T II; <input type="checkbox"/> T XVI; <input type="checkbox"/> T VIII; <input type="checkbox"/> T XVIII	<input type="checkbox"/> Title XVI/Title II Concurrent Blind (SSBC)
(Copy of email or phone report attached)	<input type="checkbox"/> Title XVI/Title II Concurrent Disability (SSDC)
16. CF COPY SENT TO: _____ HO on _____	<input type="checkbox"/> Title XVIII Hospital/Supplementary Insurance (HI/SMI)
<input type="checkbox"/> CF Attached: <input type="checkbox"/> Title (T) II; <input type="checkbox"/> T XVI; <input type="checkbox"/> T XVIII	<input type="checkbox"/> Title VIII Only Special Veterans Benefits (SVB)
<input type="checkbox"/> Other Attached: _____	<input type="checkbox"/> Title VIII/Title XVI (SVB/SSI)
	<input type="checkbox"/> Other - Specify: _____

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended ALJ decision.)

(Either mail the signed original form to the Appeals Council at the address shown below, or take or mail the signed original to your local Social Security office, the Department of Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service Post and keep a copy for your records.)

See Privacy Act Notice

1. CLAIMANT NAME	CLAIMANT SSN - -
2. WAGE EARNER NAME, IF DIFFERENT	3. CLAIMANT CLAIM NUMBER, IF DIFFERENT - -

4. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

ADDITIONAL EVIDENCE

If you have additional evidence submit it with this request for review. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. This will ensure that the Appeals Council has the opportunity to consider the additional evidence before taking its action. If you request an extension of time, you should explain the reason(s) you are unable to submit the evidence or legal argument now. If you neither submit evidence or legal argument now nor within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence of record.

IMPORTANT: WRITE YOUR SOCIAL SECURITY NUMBER ON ANY LETTER OR MATERIAL YOU SEND US. IF YOU RECEIVED A BARCODE FROM US, THE BARCODE SHOULD ACCOMPANY THIS DOCUMENT AND ANY OTHER MATERIAL YOU SUBMIT TO US.

SIGNATURE BLOCKS: You should complete No. 5 and your representative (if any) should complete No. 6. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 6.

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

5. CLAIMANT'S SIGNATURE	6. REPRESENTATIVE'S SIGNATURE
DATE	DATE
PRINT NAME	PRINT NAME <input type="checkbox"/> ATTORNEY <input type="checkbox"/> NON-ATTORNEY
ADDRESS	ADDRESS
(CITY, STATE, ZIP CODE)	(CITY, STATE, ZIP CODE)
TELEPHONE NUMBER () -	TELEPHONE NUMBER () -
FAX NUMBER () -	FAX NUMBER () -

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

7. Request received for the Social Security Administration on _____ by: _____
(Date) (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

8. Is the request for review received within 65 days of the ALJ's Decision/Dismissal? Yes No

9. If "No" checked: (1) attach claimant's explanation for delay; and
 (2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

10. Check one: <input type="checkbox"/> Initial Entitlement <input type="checkbox"/> Termination or other	11. Check all claim types that apply : <input type="checkbox"/> Retirement or survivors (RSI) <input type="checkbox"/> Disability-Worker (DIWC) <input type="checkbox"/> Disability-Widow(er) (DIWW) <input type="checkbox"/> Disability-Child (DIWC) <input type="checkbox"/> SSI Aged (SSIA) <input type="checkbox"/> SSI Blind (SSIB) <input type="checkbox"/> SSI Disability (SSID) <input type="checkbox"/> Title VIII Only (SVB) <input type="checkbox"/> Title VIII/Title XVI (SVB/SSI) <input type="checkbox"/> Other - Specify: _____
APPEALS COUNCIL OFFICE OF DISABILITY ADJUDICATION AND REVIEW, SSA 5107 Leesburg Pike FALLS CHURCH, VA 22041 - 3255	