“Facilitating applications for disability benefits is perhaps the single most important intervention that clinicians can offer to minimize the health risks associated with poverty and to assure a better quality of life.”

Jim O’Connell, MD, Boston HCH Program

This brochure reviews key criteria for documenting disabilities in claims for Social Security Income (SSI) and Social Security Disability Insurance. We hope that this brochure and the attached packet of sample letters and forms for clinicians documenting medical impairments will help healthcare providers better understand the Social Security Administration’s process for evaluating a claimant’s disability and how clinicians can provide supporting evidence in an efficient and effective manner.
# Documenting Disability:
Strategies & Tips for Medical Providers

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# Strategies Summary

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Documenting Disability: Simple Strategies & Tips for Medical Providers

I. Introduction-- SSI and SSDI


We hope that this brochure and the attached packet of sample letters from clinicians documenting medical impairments and other attached forms will help healthcare providers better understand the Social Security Administration (“SSA”) process for verifying disability and how they may provide supporting evidence in an efficient and effective manner.

Supplemental Security Income (“SSI”) and Social Security Disability Insurance (“SSDI”) are federal programs that provide a safety net (cash aid and either Medicaid or Medicare) for individuals who are aged, blind or disabled. The medical disability criteria are the same for both programs, but the non-medical criteria are different. To qualify for SSDI, individuals must be linked to a worker with specified number quarters of employment before becoming disabled. SSDI is not based on income level or resources. SSDI recipients generally qualify for Medicare after they have received SSDI for 24 months and may also qualify for Medicaid.

SSI is designed for those who have limited income and resources. There is no “quarters” of work rule. The person must be disabled or elderly. States, including California, pay a supplement to the federal SSI grant. Most persons who qualify for SSI are also eligible for Medicaid.

II. The SSI Application Process And Successful Advocacy

A. The Application Process

The first step in the application process for disability benefits is contacting SSA to schedule an appointment to complete the application. SSI benefits can only go back to the date of the application, so it is important to call SSA at 1-800-772-1213 to get a protective filing date. The application can be completed at a later date.

Once filed, SSA forwards applications to California’s Disability Determination Services (DDS), which determines whether applicants meet the federal criteria for disability. DDS sends requests for medical records to all identified treating health care providers and questionnaires to the applicant regarding daily functioning and/or work history.

The SSA defines a disabled adult as “…an individual [age 18 or older who is] unable to engage in 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 a continuous period of not less than 12 months…”

[Children may qualify under different standards.]
Evidence provided by treating clinicians is supposed to weigh more heavily than non-treating medical sources. DDS need not follow up and ensure that all records are sent to them. Based on all available evidence, DDS makes an evaluation of whether the person meets SSA’s criteria for disability. (Described fully in section III below). If the application is denied, SSA sends a letter of denial to the person. An initial denial of benefits may be appealed to SSA for “Reconsideration.” If the claim is still denied, the patient may request a Hearing.

B. A Good Application

Many individuals believe that getting on SSI takes years. Yet, when properly documented and organized, an initial application for benefits may be approved quickly within a few months. However, without upfront advocacy and assistance most applications will be denied. In 1999, only 1/3 of applications filed nationally were approved. This approval rate stands in stark contrast to the successful county and private SSI advocacy programs that achieve success rates of 60 to 90% at application. Keys to a successful application include:

- Gathering and summarizing all medical records; and
- Identifying needed tests, labs or documents to supplement the existing records; and
- Providing clinical based assessments of the person’s functional capacity; and
- Submitting the records/application with a good narrative that summarizes the medical records and functional capacity of the person for DDS.

This training curriculum focuses on providing functional capacity assessments and narrative reports for success at the application stage.

III. SSA’s Five Step Disability Determination Process

A. Steps One and Two

Social Security uses a 5-Step process to determine if someone is disabled. The first two steps examine:

- The severity of the disability – it must have more than a minimal impact on work for the person to qualify for disability
- Whether the person supports them self through work (known as substantial gainful employment);

Most GR recipients who are disabled will pass steps one and two. We therefore focus on steps 3-5 which are most relevant to clinicians.

B. Step 3: Does the Applicant Suffer From an Impairment Which Meets or Equals The Severity of a Listed Impairment?

SSA’s “Listing of Impairments” (the “Listings”) provides specific medical criteria that are presumed to be disabling for a variety of impairments, organized into different body systems. If an applicant is determined to possess an impairment that meets the criteria in the Listings (or is equivalent in severity to) and the impairment has lasted or is expected to last at least 12 months or result in death, then he will be automatically approved. At this step, claims are frequently denied due to the lack of medical evidence that the person’s condition(s) meets the Listings. In many cases, a clinician’s clear and precise evaluation of an individual’s impairment with regard to the Listings is critical to the success of an application.
As part of any program that attempts to obtain benefits at application, and to ensure early approval, clinicians who provide evaluations of their patients for DDS/SSA should (whenever possible) familiarize themselves with the language in the appropriate Listing and use that language in documentation. An effective approach to completing evaluations is for a clinician to compare existing medical records to the criteria of the Listings for the relevant impairments.

As we discuss below, a nurse, social worker, case manager, or physician should draft a narrative summary of the medical evidence with the Listings in mind, comparing the available evidence to the requirements of the Listing(s). But any report or letter to DDS should be signed by a supervising treating M. D. or Ph. D. The attached letters in Appendix A (“App.”) illustrate the use of the Listings as a basis for disability determination.

The forms in Appendix C can also be used to show how an individual meets a specific Listing. If the applicant’s impairment does not meet or equal a Listing, the SSA’s definition of disability may still be met through subsequent steps (4-5) of the administrative process.

1. Listings Example

Listings for mental and physical impairments are somewhat different. Below is an example of a listing for a physical impairment that indicates the required physical symptoms and conditions:

11.04 Central nervous system vascular accident. With one of the following more than 3 month post-vascular accident:

A. sensory or motor aphasia resulting in ineffective speech or communication: or

B. significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station.  

For physical disabilities the Listings primarily contain requirements related to symptoms and clinical findings. On the other hand, most Listings for mental health conditions require not only documentation of symptoms (“Part A”) but also specific limiting effects on life activities and functioning (“Part B and C”).

Social Security evaluates mental limitations with regards to four overall functional areas:

1) Activities of Daily Living
2) Social Functioning
3) Concentration, Persistence or Pace and
4) Episodes of Decompensation.

For the first three areas, a five point scale is used to evaluate degree of limitation: None, Mild, Moderate, Marked, Extreme (See App. B p. 51 for a sample form). Social Security doesn’t say more specifically what each of these degrees of limitations actually means (e.g., in percentages) other than to state that a rating of “none” or “mild” will generally result in a finding that a claimant’s impairment is not severe. Also, in the context of the Listings, a degree of limitation of “Marked” or “Extreme” in two of the functional areas listed above, will often result in a claimant being found disabled, assuming the other requirements of the Listing are met. Letter 2 in Appendix A, (at page 20 (“p.”)) incorporates these concepts into a narrative form.

In regard to the fourth area, Episodes of Decompensation, a four-point scale is used: None, One or Two, Three, Four or More. In the Listing context, Social Security talks about “repeated” episodes of decompensation, “each of extended duration” and this is defined as at least
three episodes within a year, each episode lasting at least 2 weeks. Social Security says that four episodes means there is no ability to do any gainful activity.

If it the medical evidence and the clinician’s findings match the requirements of the Listings the person will be found to be disabled and SSA will not consider steps 4 and 5. If the person doesn’t meet the Listing DDS/SSA proceeds to steps 4 and 5.

C. Step 4: Can the Applicant do Any of Her Past Relevant Work?

If the patient can perform the functional requirements of his/her past work (looking back 15 years), then disability benefits will not be granted. In making this determination, SSA is concerned with the person’s “Residual Functional Capacity” (“RFC”). Put simply, SSA must determine how the disability impacts the person’s ability to work. The completion of evaluations/letters on behalf of individuals who do not meet the criteria of the Listings is critically important to ensuring accurate assessments of the person’s Residual Functional Capacity. The clinician’s job is to connect the diagnoses and impairment to the resulting functional limitations, thus indicating the person’s RFC. The summary section of Letter 4 illustrates this. (App. A @ p. 25; See also SF Narrative App. A @ p. 37)

(Physical Functional Capacity) Please refer to the forms in Appendix B on functional capacity, which can assist clinicians in identifying and documenting the persons’ existing functional limitations. Letters should include information about functional limitations and two key assessments of physical functional capacity, regardless of whether the information is requested by SSA:

1) How many hours during an eight hour work day an individual can sit, stand, or walk, and if they need the option to alternate sitting and standing at will.
2) How many pounds can the individual lift frequently (around 2/3 of the time) and occasionally (about 1/3 of the time).

If you know that the answers to these two questions would preclude the patient from doing their past work, draw that conclusion explicitly in your letter. (See App. A Letter 5 @ p. 27)

(Mental Functional Capacity) The assessment of mental residual functional capacity relies on whether the patient can do even simple, unskilled work on a sustained basis. Questions to consider include whether their condition prevents them from:

1) Interacting appropriately with co workers, the public or supervisors; or
2) Sustaining focused attention sufficiently long to permit the timely completion of tasks usually found in work settings; or
3) Completing a normal workday or workweek without interruption from psychologically based symptoms; or
4) Maintaining adequate attendance.

When writing a letter, document everything you know about the individual’s physical and mental functional capacity. If you know the answers to the above-mentioned questions would preclude the patient from doing their past work, draw that conclusion explicitly in your letter. If you don’t, just clearly describe the limits you know about the person. (See Letter 4, App. A @ p. 25)

At this step, SSA only looks at whether the individual RFC allows them to return to their past work. At Step 5, SSA broadens their inquiry to ask whether the individual has (RFC) to do any work, taking into account their age, education, and work experience.
D. **Step 5: Can the Applicant do Work That Exists in the National Economy, Given his Residual Functional Capacity, Age, Education, and Work Experience?**

This determination is made based on whether an individual has the ability to perform work available in the regional or national economy based on his remaining functional capacity (RFC) and other vocational factors. DDS reviews the person’s medical records, past work history, current conditions, and records of treatment to see what level of work they can perform. It does not matter if an actual job is available for them—the inquiry is about their capacity to work.

SSA divides work into three categories: sedentary, light, and medium. In essence, describing the physical (exertional) demands of a job. The clinicians’ evaluation of a person’s demeanor, physical limitations and ability to think clearly are all key to a determination of what work can be performed and whether the person is disabled or not.

If the applicant is able to perform any work other than their past job, most likely the claim will be denied. If the applicant cannot perform work that is available in the national economy, then the claim is allowed. If the patient cannot perform any sustained work activity without excessive interruptions from psychologically based symptoms, the claim should also be allowed.

In very simplified terms, unskilled individuals with only physical or non-exertional limitations who are unable to perform their past work are likely to be approved at the 5th step of the analysis if they are:

1. 50-54 years old and limited to sedentary work; or
2. 55-59 years old and limited to light work or less; or
3. 60+ years old and limited to medium work or less

The rules are somewhat more lenient for illiterate applicants. People younger than 50, who are illiterate or unable to communicate in English, with past work at the unskilled level (e.g. laborers) have an easier time qualifying than more educated, higher skilled workers. (See chart on next page for an illustration of this). DDS will review the records of such a worker to determine what level of work they can perform. If they are limited to “sedentary” work, they will be found disabled and granted SSI.

Another way people younger than 50 may be able to get benefits is if they can show they are limited to significantly less than the full range of sedentary work due to physical limitations, or more commonly, a combination of physical and mental limitations.

For example, a 48 year old–man with degenerative disc disease who must take a 5-minute break every 15 minutes to alternate sitting with standing or vice-versa, will be able to do well less than the full range of sedentary work, because the number of breaks available in the average sedentary job (morning and afternoon breaks, plus lunch) wouldn’t be enough to accommodate this claimant.

Or, a claimant younger than 50 years old may physically be capable of the full range of sedentary work, but due to her depressive disorder, has a deficit of 20% in the area of concentration, persistence, or pace when
compared to the average worker. Almost all vocational experts will tell you that due to the competitive demands of the workplace, such a claimant would be unemployable.

1. The “Grids”

Social Security uses set criteria, called the Medical Vocational Guidelines, or “the grids,” to determine whether an individual is disabled based on their age, their work history, their educational level, and their level of residual functional capacity. These grids are only applicable for individuals with solely physical impairments and exertional limitations. If an individual has any non-exertional limitations, such as those resulting from mental impairments or mental functional limitations from physical impairments, pain, or any treatments or medications, their disability will be evaluated individually rather than using the grids. The grids can be used to approve a case without vocational expert testimony. On the next page we provide a summary of the grids.
Here is a simplified overview of the criteria in the grids, indicating that a claimant may be found disabled if their work history and education match the level in the relevant square:

<table>
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<th>Claimant's Age</th>
<th>Residual Functional Capacity</th>
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<tbody>
<tr>
<td></td>
<td>Sedentary Work</td>
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</table>
| 60-64          | **Work History**: Skilled but no transferable skills or less  
**Education**: High school graduate, but permits no direct entry into skilled work, or less | **Work History**: Skilled but no transferable skills or less  
**Education**: High school graduate, but permits no direct entry into skilled work, or less | **Work History**: Unskilled or less  
**Education**: Marginal or less  
OR  
**Work History**: None  
**Education**: Limited or less |
| 55-59          | **Work History**: Skilled but no transferable skills or less  
**Education**: High school graduate, but permits no direct entry into skilled work, or less | **Work History**: Skilled but no transferable skills or less  
**Education**: High school graduate, but permits no direct entry into skilled work, or less | **Work History**: None  
**Educational**: Limited or less |
| 50-54          | **Work History**: Skilled but no transferable skills or less  
**Education**: High school graduate, but permits no direct entry into skilled work, or less | **Work History**: Unskilled or none  
**Education**: Illiterate or unable to communicate in English | **Claimant is presumed to be NOT disabled** |
| Less than 49   | **Work History**: Unskilled or none  
**Education**: Illiterate or unable to communicate in English | **Claimant is presumed to be NOT disabled** | **Claimant is presumed to be NOT disabled** |
IV. Putting It All Together – Tips On SSI Advocacy

A. The Clinician’s Role Is Critical.

The role of the clinician is vital to a determination of disability. The medical evidence that clinicians provide through treatment histories, evaluations, tests, reports and narrative letters is what will make or break an application for disability. Quite simply, while vital, the clinician’s role in the SSI application process is to provide objective information and observations of a patient.

We recommend a five-pronged approach for SSI advocacy in county GR/GA, health, and mental health programs:

- gathering all medical records, and summarizing them;
- completing DDS forms and avoiding consultative exams;
- drafting narrative letters and completing forms that include information regarding the person’s functional capacity; and
- when needed, obtaining missing medical evaluations or treatment.

Helping patients with disabilities obtain financial and medical assistance is well within the purview of health care professionals. Time spent providing a current assessment of a patient’s impairments and functional limitations may be reimbursed by DDS and/or billable to Medi-Cal and can help expedite the SSI application process.

1. Gathering and Summarizing Medical Records

The first step in assisting an individual with an application is to find all medical records within or outside of the county health system. Simply gathering and forwarding the records is not the best way to get a person off GR and onto SSI. The clinician or case manager should review the records in light of the appropriate listing(s). Summarizing the key points will help DDS analysts and may well identify a gap—a need for additional testing, evaluation, or, even treatment. DDS analysts may get hundreds of pages of records in a single application and sifting through them (trying to read notes) can be daunting. A summary that highlights key findings is invaluable to DDS’ analysts in making a determination. A good summary may also obviate the need for a consultative examination (discussed below). (See the HCH letters and SF’s narrative letter template in App. A for examples)

When a medical provider who has had a treating history with a patient receives a request for medical records from DDS, the optimal response is to send a letter or evaluation form with the patient’s medical records explaining the patient’s diagnosis and functional limitations. The attached form titled “Medical Source Statement –Mental” is an example of the type of evaluation that could be completed by clinicians when providing documentation for disability benefits claims based on mental conditions. (See App. B @ p. 51; and DDS’ form 1002 @ p. 47). Although describing a patient’s functional limitations can be challenging for medical providers alone, working as part of a clinical team that includes social workers/case managers can facilitate this process. We have included a narrative template that San Francisco uses as part of their SSI advocacy project which includes case workers and clinicians. (See App. A @ p. 37)

Moreover, doctors or analysts who work for DDS routinely rate functional limitations based solely on review of records without ever having met the applicant. Any conflict between the information provided by the treating doctor and the non-examining doctor should generally be resolved in favor of the treating doctor.
2. Filling Out and Supplementing Forms Sent by DDS

*Forms used by DDS*: In addition to the Medical Source Statement—Physical, referenced above, we’ve enclosed other questionnaires that DDS typically sends to treating clinicians in Appendices B and C. These include the 1002—the form used by DDS when evaluating a person’s mental health. (See App. B @ p. 47). It is important for clinicians and other staff involved in SSI advocacy to become familiar with or review these questionnaires so that they become familiar with the limitations that Social Security considers.

In Appendix B, we’ve also included the Residual Functional Capacity (RFC) forms that the DDS uses to establish a claimant’s physical and mental RFC, after they review the medical evidence (including, hopefully, the letters and questionnaires from treating clinicians).

   a. **Tips on Completing Mental Health Forms**

Because many psychologists and psychiatrists are trained in a psycho-social rehabilitative approach they sometimes do their patient a disservice when filling out the mental health forms for DDS (such as the 1002). Clinicians are sometimes hesitant to characterize their patient’s prognosis in a way that will negatively affect the patient’s recovery.

When filling out the 1002 or other forms, especially any prognosis sections, it is important to keep in mind that DDS is looking at whether this person can work---not whether they can live on their own, or be released from an institution. While a prognosis indicating high functioning might be good for the patient in terms of reducing hallucinations or other inappropriate thoughts or behaviors, or becoming compliant with taking medication or returning to society, DDS is simply asking about their ability to work.

Therefore, it is important to remember for mental health questionnaires what is needed is a description of the patient’s prognosis as related to their ability to work and maintain employment.

3. **Narrative Letters Improve Success Rates**

Writing summary letters that detail the person’s condition is essential to making and winning a claim for SSI. DDS will evaluate all of the medical evidence and make the final determination of whether the individual meets the disability standard. Even in a summary letter, a clinician should not make a recommendation or determination of whether the individual patient should or should not be found disabled. The disability determination is solely up to DDS/SSA and the DDS analyst may be annoyed by such conclusions. (See section IV. B below for tips on effective narratives).

**The Problem of Consultative Exams**: Whenever DDS believes that a person’s medical records conflict or aren’t clear enough, they will refer a person to get assessed by an outside medical examiner paid for by SSA called “consultative examiners (“CEs”).” Avoiding the need for CEs should be the goal of all SSI advocacy projects. If a treating medical provider does not send DDS a narrative letter or evaluation form that includes functional information the chances are very good that the person will be referred by DDS to a consultative examination.

Most consultative examiners are paid so little that they cannot afford to spend any real time with the patient. Many spend only 5 or 10 minutes with the person. Rarely do they have access to the person’s medical records. Also, patients often minimize their illnesses and try to be on their best behavior for the appointment. As a result, the CEs often fail to comprehend the full extent of the individual’s impairments. Yet the CE’s report is relied upon heavily by DDS. This often leads to inappropriate denials of benefits.
For this reason it is important that treating physicians provide records and submit their own letters or forms to the best of their ability to avoid the need for a consultative exam.

4 Providing Needed Medical Exams or Treatment

After reviewing the medical records of a patient, the need for further medical evaluations or treatment may be apparent. A successful program addresses these needs by providing or facilitating access to medical services. For instance, with mental health claims, especially those that aren’t accompanied by a physical illness, or don’t evidence repeated institutionalizations or psychotic breaks, DDS often wants to see to a year of mental health treatment. Ensuring such treatment is critical to success. Such treatment and evaluations may be reimbursable by Medi-Cal if timed with a protective filing date or the actual date of filing and after a successful application. Once approved for SSI, Medi-Cal will reimburse for care provided up to three months before the date of application.

Treating medical sources can bill DDS for performing a current evaluation, and may be able to bill Medi-Cal retroactively for services provided while a claim is pending, including assessment.

B. Tips for Writing Effective Medical Summaries

Narrative letters can be valuable in providing a longitudinal picture of a patient’s impairments and treatment that a questionnaire or form might not give. It is always important for the clinicians to include a discussion/assessment of the patient’s limitations in such a letter. To assist providers, App. A contains examples of narrative letters that clinicians have written covering many of the most frequent condition encountered in the GA or homeless population. These materials are taken from Documenting Disability by Health Care for the Homeless (see p. 1, above). We have also included a guide to letter writing used by the San Francisco Human Services Agency in its GA-SSI program. (See App. A @ p. 37). Below is a brief summary of the recommendations regarding medical summary letters found in Appendix A @ p. 15.

Review the Listing for the impairment. Good narrative letters begin with you reviewing the Listings and comparing your clinical findings, notes of symptoms, laboratory results to those in the listings.

Be Specific and Thorough Include your history with the patient (dates, length, and treatment) and the results of any laboratory tests or other diagnostic tools.

Be Candid and describe the severity and duration of the illness(es) include all relevant details such as age, height, weight, work history.

Describe Objective Medical Evidence, hopefully comparing it to the Listings.

Use Appropriate Medical Terminology and Measurements. The Listings will indicate what factors, results, SSA wants to see for an illness.

Always Describe the Person’s Functional Limitations even when you think they may meet the Listings. Include observations of their limits secondary to their condition and any relevant observed behaviors.

Close With A Summary or the Most Pertinent Information and Why the Person Meets a Listing or Can’t Work Due to Their Limitations and Combination of Impairments.

Signed by an Acceptable Medical Source Under SSA’s rules, to establish impairment, evidence must come from certain specific licensed medical
Some clinicians work with a team including social workers or case managers. Case managers may write up a narrative summary, but it is critical that it be signed by a licensed medical provider – not the case manager. (See the template narrative letter from San Francisco’s Human Services Agency, App. A @ p. 36)

C. Ethical Concerns Raised by Clinicians

Some clinicians raise the concern that playing a role in the government’s process for determining a disabled person’s eligibility for benefits will compromise their primary role as health care providers. In resolving this ethical problem, it is important to consider the distinction between the medical provider’s proper role of supplying information of impairments and the SSA’s role of determining whether an individual meets the administrative/legal criteria for a “disability.” As can be seen from the attached packet of sample letters (App. A), the role of the clinician is to accurately and clearly communicate the medical condition of the patient, not to make a determination of whether the patient should be considered “disabled.”

Some clinicians also raise the concern that some patients may be malingering, exaggerating their impairments, or trying to obtain benefits for which they are not qualified. The role of the clinician is not to advocate for the claimant or simply document the patient’s subjectively reported symptoms and impairments, but to report the objective clinical evidence of the patient’s impairments and the functional limitations observed an identified by the clinician.

V. Special Issues Raised by Drug Addiction and Alcoholism

If a claimant is found disabled, and there is medical evidence of drug addiction or alcoholism (“DAA”), Social Security must determine whether the drug and/or alcohol addiction is a significant contributing factor to the determination of disability. If DAA is a material factor then the person will be denied disability.

In reviewing a case where drug addiction and alcoholism may be an issue, Social Security must first determine whether a claimant is disabled under the 5-step sequential evaluation process without attempting to separate out the impact of alcoholism or drug addiction. Then, if the claimant is found disabled, Social Security must consider whether alcoholism or drug addiction is a contributing factor material to the determination of disability. The claimant bears the burden of proving that drug and alcohol addiction is not a contributing factor material to his disability. Social Security explains how they make the determination, by asking:

1. Which of the existing physical or mental limitations would continue if the claimant stopped using drugs or alcohol? Would the claimant be found disabled based on the continuing limitations?

2. If the person’s remaining limitations are not disabling, then drug or alcohol use is “material” to the determination of disability.

3. If the person’s remaining limitations are disabling, then drug or alcohol use is not “material” to the determination of disability.

Clinicians can and should address the issue of a patient’s drug addiction and/or alcoholism in the letters they write.

The form on Interviewing for Alcohol and Drug issues provides a guide on interviewing patients to gather information that can place the alcohol or drug use in context and document the presence or
absence of functional limitations during a claimant’s periods of sobriety. (See App. A @ p. 45)

Letters 3, 6, 7 and 8 in Appendix A provide examples of differentiating the effects of alcohol or drug abuse from the functional impairments caused by medical impairments.

Prepared by Health Consumer Alliance July 20; Updated October 2010

Endnotes

1 In some areas, the reconsideration step no longer exists and a person will go straight to hearings.

2 The Listings area available online at http://www.ssa.gov/disability/professionalsbluebook/.

3 The Listings include 14 body systems, along with criteria for different disabling medical conditions: 1.00 Musculoskeletal System; Special Senses and Speech; 3.00 Respiratory System; 4.00 Cardiovascular System; 5.00 Digestive System; 6.00 Genitourinary Impairment; 7.00 Hematological Disorder; 8.00 Skin disorders; 9.00 Endocrine System; 10.00 Impairments that Affect Multiple Body Systems; 11.00 Neurological; 12.00 Mental Disorders; 13.00 Malignant Neoplastic Diseases; 14.00 Immune System Disorders

4 See Letter 1 in the attached packet of sample letters to see this listing incorporated into a clinician’s letter.

5 A sample of a mental health listing is included in Appendix C at page 61.

6 See Letters 2 and 7 in the attached packet of sample letters to see this listing incorporated into clinicians’ letters.

7 RFC is what an individual can still do despite this or her limitations, or activity that an individual is able to perform consistently during a full work week. SSA considers a work week to be 8 hours a day for 5 days a week.

8 See the packet of clinician letters in Appendix A for examples of functional limitation information.

9 Sedentary Work: Exerting up to 10 lbs of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects. This work involves mostly sitting but may involve brief periods of walking or standing

10 Light Work: Exerting up to 20 lbs of force occasionally and/or up to 10 lbs of force frequently and/or a negligible amount of force to lift, carry, push pull or otherwise move objects. Even if the weight lifted may be a negligible amount a job should be rated as light if it requires walking or standing to a significant degree or when it requires sitting most of the time but requires pushing and pulling of leg controls or if production rate requires constant pushing and pulling materials of negligible amounts.

11 Medium Work: Exerting 20 to 50 lbs of force occasionally, and/or 10 to 25 lbs of force frequently, and/or greater than negligible up to 10 lbs of force constantly to move objects.
12 Social Security Ruling 96-9p gives information on what “less than sedentary” word means. Available online at Http://www.ssa.gov/OP Home/rulings/di/01/S SR 96-09-di-01.html, SSA indicates that, while rare, an individual under age 50 can be found to be capable of less than the full range of sedentary work when any of the individual’s exertional capacities is found to be less than required to perform a full range of sedentary work OR an individual whose exertional capacity would direct a decision of “not disabled,” but the individual has non-exertional limitations (such as pain, mental illness) that narrow the range of potential sedentary work.

13 Grids are available online at http://www.ssa.gov/OP Home/cfr20/4040/404-ap11.htm

14 Payment for purchasing a current exam or testing from a treating source: 20 C.F.R. 416.919h http://www.ssa.gov/OP Home/cfr20/416/416-0919h.htm

15 These include: Licensed Physicians (medical or osteopathic doctors), licensed or certified psychologists, licensed optometrists (for visual disorders only), licensed podiatrists (for foot or foot/ankle disorders only, depending on whether the State in which the podiatrist practices permits practice on the foot only or on the foot and ankle), qualified speech pathologists (speech or language impairments only).

16 The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find the claimant disabled if they stopped using drugs or alcohol.

1) In making this determination, we will evaluate which of the current physical and mental limitations, upon which we based our current disability determination, would remain if the claimant stopped using drugs or alcohol and then determine whether any or all of the remaining limitations would be disabling.

2) If we determine that the claimant’s remaining limitations would not be disabling, we will find that their drug addiction or alcoholism is a contributing factor material to the determination of disability.

3) If we determine that the claimant’s remaining limitations are disabling, they are disabled independent of your drug addiction or alcoholism and we will find that their drug is not a contributing factor material to the determination of disability.
Appendix A

Letter Writing Guidelines &
Interviewing Tips for Clinicians

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LETTER WRITING GUIDELINES

Requests for clinicians to write letters documenting medical impairments may come from patients, attorneys or case workers at the time of initial application, or may come from SSA or the State’s disability determination services as it investigates an applicant’s claim. The following guidelines for such letters are derived from an advocate's guide prepared by Peter H. D. McKee and from a curriculum for medical providers prepared by Paul Quick, M.D, Barry Zevin, MD, and Masa Rambo, FNP.17

1. **Review** the Listing of Impairments for each health problem that your patient has. Note the clinical findings and symptoms of each relevant impairment delineated in the Listing.

2. **Compare** the clinical findings and symptoms specified in the Listing with the findings recorded in your patient's medical record by you or any other medical provider.

3. **Write** a specific letter that

   - Gives your general past history of treatment and dealings with the patient; and specifies the length of your relationship and whether you are the treating physician;

   - Provides a candid observation of the severity and duration of the patient’s impairments, documenting his/her relevant work history, age, height, weight, vital signs, relevant measurements, and physical examination results;

   - Gives objective evidence of the patient’s impairments, one at a time, as defined by the Listing of Impairments, and compares exact findings or symptoms of the relevant listed impairment with the specific findings or symptoms of your patient;

   - Uses the recognized medical terms or measurements described in the age-appropriate Listing of Impairments;

   - If criteria for a listed impairment are not met, specifies the patient’s functional limitations secondary to all specified disorders, how long they have lasted and are expected to last, the patient’s ability to do basic work activities, and any special circumstances (whether the patient fits an adverse profile);

17 An Advocate's In-Depth Guide to Social Security Disability and Medical Letter Guide, prepared by Peter H. D. McKee, JD (Douglas, Drachler & McKee, LLP, 1904 3rd Ave., Ste 1030, Seattle, WA 98101; e-mail: PHDM@Qwest.net); PowerPoint presentation by Paul Quick, MD, Tom Waddell Health Center, San Francisco Department of Public Health (3/13/03). For examples of letters documenting impairments related to serious mental illness, readers are also referred to a publication by the Substance Abuse and Mental Health Services Administration: Stepping Stones to Recovery: A Training Curriculum for Case Managers Assisting People Who Are Homeless to Apply for SSI/SSDI Benefits, prepared by Jeremy Rosen and Yvonne Perret (2005).
• Closes with a summary statement specifying what listing(s) is/are met or how the Listings are equaled, given all functional limitations taken together; and

• Is signed by an acceptable medical source (see page 20) with title and relevant certifications (e.g., board certified, academic credential or other special qualifications). If the letter is written by a nurse practitioner or other provider, it should be co-signed by an acceptable medical source with statement of that person’s involvement.

4. **Attach** all relevant chart notes and progress notes to the letter.
EXAMPLES OF LETTERS SUPPORTING SUCCESSFUL DISABILITY CLAIMS

The following letters were written by medical providers working in Health Care for the Homeless projects in three different regions of the United States. The patients they describe were all awarded disability benefits based on the evidence provided by these clinicians. Each letter represents a slightly different strategy from the others.

- **Letter 1** specifies a medical listing met by the patient’s impairment and work-related functional limitations that resulted from it (p. 44).

- **Letter 2** details evidence to support the conclusion that a medical listing of impairment is met in the “mental disorders” listing. Presenting such evidence is critical; merely stating that the claimant meets a listing is insufficient in many jurisdictions. The evidence documented is fairly easily accessible to Health Care for the Homeless providers, documenting behavior and the results of poor social functioning and judgment. (p. 45)

- **Letter 3** focuses on two medical Listings as the primary basis for disability determination. This letter uses a medical consultation style that is comfortable for many clinicians. It uses several compelling details to eloquently communicate the severity of the patient’s impairment. (p. 48).

- **Letter 4** documents multiple impairments which together are equivalent in severity to a Listing, and describes the patient’s residual functional capacity (p. 50).

- **Letter 5** focuses on functional limitations as the basis for disability determination, since the impairments described neither meet nor equal a medical Listing. This is an example of a letter written by a nurse practitioner in collaboration with a physician. (p. 52).

- **Letter 6** establishes the treating source’s long-term relationship with the claimant, adding credibility to his observations regarding the relationship between the claimant’s substance use and his psychiatric impairments. The physician recommends use of a Representative Payee if disability benefits are awarded. (p. 54)

- **Letter 7** is a good example of the differentiation of effects of the patient’s alcohol use from his other presenting issues. Although the impact of alcohol use on the applicant’s physical and mental conditions is certainly powerful, the physician clearly outlines the other causes of disability; he is also careful to state explicitly that that his patient would be disabled (and has, in fact, remained disabled) during periods of sobriety. (p. 55)

- **Letter 8** addresses the issue of separating the effects of the claimant’s substance dependence from his co-occurring impairments, in the absence of known periods of sobriety. The fact that the author is a certified specialist in Addiction Medicine adds weight to his opinion that the client’s “health seeking behavior...is atypical for patients primarily with stimulant dependence as their diagnosis,” supporting the conclusion that the patient’s Bipolar disorder and personality disorder, in addition to his chronic back pain secondary to an untreated spinal condition of long standing, are primarily responsible for his disability.18 (p. 56)

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18 The disability claims described in letters 6-8 were sent to an administrative law judge known to be very strict in his rulings on claims involving DAA issues. The treating physician provided information at the appeals hearings as an expert in addiction medicine, reiterating information contained in his letters to DDS. Disability benefits were ultimately awarded.
• Letters 9 & 10 have been abbreviated to emphasize the documentation of functional impairment independent of substance use (pp. 59–61). They offer an especially good illustration of documented activities of daily living. Because DDS adjudicators rarely interview or even see applicants, it is important that supporting documentation offer as clear a picture as possible of the impact of the claimant’s impairments on day-to-day functioning.

The physicians who composed and/or signed these letters made the following observations:

• There is a significant amount of regional variation in how disability determination agencies work. Some DDSs rely on treating sources more than others to identify medical Listings that are met or equaled by a claimant’s impairment(s). In Boston, for example, providing evidence that an impairment meets or is equal in severity to a Listing is sufficient for the DDS to determine the claimant disabled; no additional discussion of functional limitations is necessary. In San Francisco, some discussion of functional status is required in addition to presentation of evidence that a Listing has been met, particularly for patients with HIV or mental impairments.

• Many medical providers do not feel competent to describe their patients’ functional impairments. They are more comfortable specifying impairments that meet one or more medical Listings. Although this is the simplest way to document disability, not all patients have disabling conditions that meet or equal a medical Listing, yet many still qualify for SSI/SSDI based on medical-vocational considerations (26.9 percent of allowances in FY 2004).

“Physicians who work at the disability determination agencies or who testify as medical experts at Social Security hearings routinely rate the applicant’s ability to sit, stand, walk, lift, carry, and meet the functional requirements of work — based on a review of treatment records and without the advantage of ever having seen or spoken with the applicant. The law recognizes that any conflict between the functional assessment of a treating physician and the assessment of a non-examining physician should generally be resolved in favor of the treating physician. Therefore, treating physicians should be urged to describe their patients’ functional limitations to the extent possible.”

— David Ettinger, JD, Legal Aid Society of Middle Tennessee and The Cumberlands

Although describing patients’ functional limitations can be challenging for medical providers alone, working as part of a multidisciplinary clinical team that includes social workers-case managers and/or vocational counselors can facilitate this process. It is sometimes easier in the case of homeless applicants who must rely upon charitable organizations for all meals, shelter, and clothing. Some providers ask their clinical staff whether they would want to depend on the claimant for a job they counted on, and if not, why they would not want this person to work for them. This helps to stimulate thinking about what the patient’s functional incapacity is.
LETTER I

November 12, 2004
Re: LJ
SS# xxx-xx-xxxx

To Whom It May Concern:

I am writing this letter on behalf of LJ, a patient of mine at the Austin Cook County Health Center, in support of her claim for disability. She has been a patient at our health center since 5/99 and my patient since 11/00. She has been seen in the clinic an average of 5 times a year during that time period.

Ms. J had a central nervous system cerebro-vascular accident on July 6, 2004 which has left her with significant persistent deficits in right arm and right leg. Her impairments include the following:

Gait and Right lower extremity: She has an unsteady gait that has made her unable to walk safely at a constant rate on a treadmill with the physical therapists. Her therapy goal was to walk on a level treadmill at three miles per hour for 10 minutes. She could not keep herself centered on the treadmill and would have fallen repeatedly had she not been supported by the hand rails. She was unable to walk for more than two minutes at a time. Her right hip flexion strength is 3/5. She steps to the right when trying to walk with her feet in tandem.

Right upper extremity: Ms. J is right handed. She carries her right arm in a flexed posture when walking. Her right upper extremity strength is 3/5 in flexion and extension at the elbow, and 3/5 in shoulder abduction. She has mildly reduced rapid alternating movements with her right hand and severely reduced ability to write or sign her name. She also has subjective numbness throughout her right arm and moderately reduced ability to identify objects placed in her right hand. She can not carry anything of significant weight (over 2 pounds) in her right hand.

In my opinion, LJ is permanently disabled as a result of her stroke. She meets Social Security listing 11.04 as described in the online Blue Book. She has significant and persistent (over 3 months) disorganization of motor function in 2 extremities (right arm and right leg) resulting in sustained disturbance of gross (inability to carry objects) and dexterous (inability to write) movements or gait and station (her gait is abnormal and unsteady).

LJ also meets the functional requirements for a musculoskeletal listing described at section 1.00 of the listings. She requires a walker for distances as short as a single block and cannot sustain effective ambulation. Her use of the right arm is so restricted that she cannot prepare a simple meal or feed herself without assistance.

During an eight-hour work day, LJ could stand or walk no more than one hour. She can sit without limitation. She is not limited in the ability to lift with her left arm, but she can lift no more than two pounds with her right arm.

LJ has not had a mental evaluation since her stroke, but she has complained of memory loss and an inability to concentrate. If her disability claim cannot be favorably resolved based upon her physical limitations, I would recommend that a neuropsychological evaluation be obtained.

If you have any additional specific questions about her condition, please let me know. I am enclosing copies of my relevant treatment records.

Sincerely,

David Buchanan, MD
Attending Physician
John Stroger Hospital of Cook County
Board Certified in Internal Medicine
Assistant Professor, Rush University

11.04 Central nervous system vascular accident. With one of the following more than 3 months post-vascular accident:
A. Sensory or motor aphasia resulting in ineffective speech or communication; or
B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

Listing of Impairment cited in the preceding letter
Source: 2006 SSA Blue Book
LETTER 2

February 22, 2006
To Whom It May Concern:

I am writing this letter in regards to Mr. J. S., Case # 1111111 and SS# 111-11-1111. This letter is intended to give the Social Security Administration information regarding Mr. S’s current status as it relates to his application for SSI. I am currently Mr. S’s Treating Source. We have had an ongoing treatment relationship since February 2005. I have also consulted on this case with Mr. S’s former therapist George Gilman, LCSW and his Case Manager, Jennifer Alfredson, APSW. Mr. Smith was admitted into the Health Care for the Homeless Case Management Program in August 2005.

Mr. S. is not currently engaging in any Substantial Gainful Activity.

Mr. S. was diagnosed with Bipolar Disorder Type I by myself, Dr. Steven Ortei, in February 2005. Prior to February 2005, Mr. S’s mental impairments were undocumented. Mr. S. had been living in the woods, outdoors, since 2002 and was not seeking any treatment for what he described as problems with his thinking. He was engaged by the Health Care for the Homeless – Street Outreach. He agreed to begin seeing a psychiatrist at Health Care for the Homeless’ Recovery Behavioral Health Clinic. He also agreed to begin working with the Red Cross Outreach Nurse and was referred to a Safe Haven Shelter.

Mr. S’s impairments became clearer once he was staying at Safe Haven, where they have only 8 residents and staff present 24 hours a day. Ms. Alfredson was able to inform this writer about the occurrences at Safe Haven. Mr. S. did not respond appropriately to the supervision at Safe Haven. He did not get along with other residents or the staff and mostly stayed to himself. He had trouble understanding that his situation differed from the other residents. He would become very irritable when comparing his situation to others and would ask why he can’t get a bus pass or other things that residents with income had access to. He expressed paranoia about the other residents and the staff. He demonstrated an irritable and labile mood that inhibited his ability meet the expectations of staff in the area of household chores and/or keeping his room in order. Mr. S demonstrated poor judgment when he had trouble following the rules and was eventually asked to move out due to his chronic non-compliance with the curfew of 10 PM. When Mr. S. left the Safe Haven in September 2005, he went back to living in the woods, outdoors. He was quite upset about the consequence of his poor judgment. I think that Mr. S. does demonstrate a severe impairment.

I think that Mr. S. does meet the criteria listed in the Social Security Blue Book, section 12.04 for Affective Disorders. Mr. S. does have a disturbance of mood, accompanied by partial manic and depressive symptoms. Mr. S. meets the criteria of 12.04 (A) in the following way: Mr. S. has depressive symptoms that were first assessed and documented in February 2005. Mr. S. reported a loss of interest in all activities, a sleep disturbance, feelings of guilt and worthlessness, difficulty concentrating and feeling very paranoid. Mr. S. avoids public transportation due to paranoia and is extremely guarded with Outreach Workers and most other staff that he has come into contact with since being engaged by the Outreach Worker. Mr. S. has also experienced symptoms of mania. Mr. S. has been observed to have pressured speech, flight of ideas, and he is easily distracted. He also gets involved in activities that have negative consequences, such as fighting with people on the streets and has led to both injury and incarceration. Again, Mr. S. reports feeling very paranoid. As a result of the previously described impairments, Mr. S. was diagnosed with Bipolar Disorder and has had periods manifested by the full symptomatic picture and currently is characterized by both depressive and manic symptoms.

And, Mr. S. meets the criteria of 12.04 (B) in the following way: Mr. S. evidences a marked restriction of activities of daily living. Most notably, Mr. S. has been unable to maintain a residence since 2002. Since that time, he has been living outdoors in a wooded area on the East side of Milwaukee. Mr. S. does not appropriately care for his personal grooming and hygiene. His appearance is usually odorless, his clothing dirty, and his hair appears dirty and unruly. Mr. S. has not had the opportunity to demonstrate the ability to pay bills, cook, or shop due to his having no income and living outdoors. When Mr. S. was living at Safe Haven from July until September 2005, his grooming and hygiene did improve somewhat. At the Safe Haven, he still did not have the opportunity to cook or shop. Mr. S. also avoids public transportation due to his paranoia, which then causes anxiety.

Mr. S. has marked difficulties in maintaining social functioning. Mr. S. has demonstrated that he is unable to interact appropriately with other individuals. Mr. S. does not have any relationships with any of his family, which includes his father and six living siblings. Mr. S. has referred to working for temp agencies where he would only work for a short time and he asked to not return. Mr. S. often refers to arguing with others and specifically, he is not welcome to visit his girlfriend because the people she stays with will not allow him to come to their home. When Mr. S. has staying at Safe
Haven, he did not get along with the other residents and complained constantly about their behaviors. It was explained to him that all residents have mental health issues, but Mr. S. continued to not get along with and often argue with the other residents. Mr. S. did attend a Health Care for the Homeless sponsored picnic. He sat by himself and when others went and sat by him, he did not talk with them at all. Mr. S. is often uncooperative with this writer, the Therapist, and the Case Manager. He will attend appointments and then yell at the staff. Mr. S.’s strength is that although he discontinued therapy, he does continue to meet with Case Management staff and the Psychiatrist.

Mr. S. has marked difficulties in maintaining concentration. This writer does not have any observance of Mr. S. in a work setting. Ms. Alfredson was able to report that in the setting of case management, they had great difficulty completing the assessment and initial care plan. Mr. S. cannot concentrate on the task at hand and when asked a question, he begins to answer it, but then gets lost on a long tangent. He is difficult to re-direct. The therapist, Mr. Gilman, noted that he could not assess tasks of short-term memory due to tangents and paranoid thinking that the therapist was actually playing a trick on him. I think that Mr. S’s inability to complete a basic mental status exam is indication that when under the stress of employment, he would not be able to maintain concentration, persistence, or pace.

Mr. S. has also had repeated episodes of decompensation. He was in a decompensated state when first engaged by the Outreach Worker in February 2005. He agreed to treatment by a psychiatrist and after beginning medications, he did demonstrate some improvement. In April 2005, Mr. S. had a Lithium level tested at the lab and the result was slightly below therapeutic level. By May 2005, the Lithium level was within therapeutic level and Mr. S. was reporting to be feeling better. In August 2005, Mr. S. reported to the psychiatrist that he did not take medications for one week and was feeling the effects of mood instability.

In September 2005, Mr. S. again reported to the psychiatrist that he was not taking his medications and his mood was quite irritable. He had also suffered the consequence of getting discharged from the Safe Haven shelter due to non-compliance with rules in September 2005. He continued to report not taking meds and struggling with his moods in October 2005. In November 2005, the consumer reported to be taking his medications again and Case Management was monitoring his medications by only giving him one week at a time. Again, his mood improved, he became more cooperative, and he was granted re-admission to Safe Haven. Also at this time, his psychotropic medication was changed. Mr. S. reported feeling to “up” and agitated from the new medication. By January 2006 he was again asked to leave Safe Haven due to non-compliance with rules. Since that time, he has again been observed to be in a decompensated state. His activities of daily living have diminished, his social functioning markedly impaired, and his concentration again observed to be very low.

In conclusion, it is my opinion that Mr. S. has a severe impairment and meets the criteria listed in section 12.04 of the Social Security Blue Book for Affective Disorder.

Steven Ortei, MD

Date

George Gilman, LCSW

Date

Jennifer G. Alfredson, APSW

Date

Health Care for the Homeless of Milwaukee, Inc.
12.04 Affective disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:
   1. Depressive syndrome characterized by at least four of the following:
      a. Anhedonia or pervasive loss of interest in almost all activities; or
      b. Appetite disturbance with change in weight; or
      c. Sleep disturbance; or
      d. Psychomotor agitation or retardation; or
      e. Decreased energy; or
      f. Feelings of guilt or worthlessness; or
      g. Difficulty concentrating or thinking; or
      h. Thoughts of suicide; or
      i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:
   a. Hyperactivity; or
   b. Pressure of speech; or
   c. Flight of ideas; or
   d. Inflated self-esteem; or
   e. Decreased need for sleep; or
   f. Easy distractibility; or
   g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
   h. Hallucinations, delusions or paranoid thinking; or

3. 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);

AND

B. Resulting in at least two of the following:
   1. Marked restriction of activities of daily living; or
   2. Marked difficulties in maintaining social functioning; or
   3. Marked difficulties in maintaining concentration, persistence, or pace; or
   4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic affective disorder of at least 2 years’ duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
   1. Repeated episodes of decompensation, each of extended duration; or
   2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
   3. Current history of 1 or more years’ inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Listing of Impairment specified in the preceding letter
Source: June 2006 SSA Blue Book
LETTER 3

January 4, 2000

RE: SS# ___/___/____
DOB: ___/___/____

To Whom It May Concern:

I have known Mr. S for the past 15 years, during which time I have cared for this gentleman frequently while working as the Boston Health Care for the Homeless Program’s physician at Boston Medical Center, Massachusetts General Hospital, Pine Street Inn Nurses’ Clinic, and as a member of the outreach teams serving individuals living on the streets of Boston. His medical and psychiatric issues are very complex, and shadowed in a relatively obscure history (most of his medical charts have either been lost or are unavailable to us).

In my professional opinion, this gentleman is totally disabled and unable to partake in substantial gainful activity. He meets the criteria noted in the Listing of Impairments under both Section 11.08 (Neurology, Spinal Cord and Nerve Root Lesions) and Section 12.02 (Mental, Organic Mental Disorders).

Mr. S's life has been decidedly tragic. He apparently left school in the 8th grade, although the circumstances are unclear. On July 19, 1968, at the age of 17, he sustained severe head trauma with facial fractures, loss of the left eye, and brachial plexus injuries with left arm paralysis and muscle contractions when he was struck by a train. Once again, we have few details about the circumstances surrounding this accident. He apparently was in coma for several weeks, and remained hospitalized for approximately six months. The injuries were substantial and devastating. He sustained severe blunt head trauma that left him with a permanent deformity. His left eye required enucleation, and has been a continual source of purulent drainage and intermittent infections since that time. His brachial plexus was severely compromised, and resulted in paralysis of his left biceps and triceps as well as contraction deformities of the left wrist, PIP, and DIP joints. This brachial plexus injury has also caused considerable vascular compromise, and he has well-documented episodes of recurrent frostbite as well as left hand and arm cellulitis. When last evaluated by the vascular surgeons at Boston Medical Center in December, 1998, the plan was to consider either surgical revision of the arm and vasculature or amputation.

Despite these debilitating injuries, Mr. S apparently attempted to work menial jobs from 1970-1974. He was unable to keep these jobs, although we do not know why. At some point during the rehabilitation from his accident, he began to use alcohol heavily. By 1974, at the age of 23, he became literally homeless and has essentially been living in the shelters or on the streets for the past 25 years.

I have thoroughly reviewed Mr. S's most recent chart at Boston Medical Center, which includes the past two years. He has been seen in the emergency department on at least 45 occasions, generally for grand mal seizures, pancreatitis, frostbite, or cellulitis. The ED visits have a tragic monotony, ending virtually always in his refusal to accept hospital or detox admission and an abrupt departure against medical advice. He rarely remains long enough for diagnostic studies, and I was unable to find documentation of a single EEG during this two-year period (although there are references to "abnormal EEGs in the past"). We have also facilitated multiple admissions to detoxification units for Mr. S through our outreach clinic sites, but he has again rarely been able to tolerate more than 2-3 days in any facility.

It is necessary to sort out his substance abuse issues from his underlying medical problems. While alcohol has been a relapsing and debilitating component of his life in the shelters and on the streets for the past 25 years, his head trauma and the brachial plexus injuries preceded his alcoholism and remain the major reason for his disability:

(1) The severe nerve root and brachial plexus injury have left him with paralysis of the left upper arm and contractions of the musculature of his forearm and hands. The vascular compromise from this injury has resulted in repeated episodes of frostbite and cellulitis, even under conditions of mild exposure with ambient temperatures in the 40s. This significant and persistent disorganization of motor function in the left upper extremity in the setting of his brachial plexus injury meets the primary criteria for disability under Section 11.08 of the Listing of Impairments.

(2) His primary disability is an organic mental disorder, and he meets the criteria listed in Section 12.02 of the Listing of Impairments. His massive head trauma resulted in multiple facial fractures (left orbit, zygoma, maxillary sinus), loss of the left eye, and increased intracranial pressure resulting in prolonged coma and requiring decompression with burr holes. This severe damage to the left frontal lobe is undoubtedly the focus of his seizures and most likely explains his disturbances of mood and his emotional lability with well-documented irritability and explosive outbursts. Alcohol clearly
has lowered his seizure threshold, but cannot explain his entire history of seizures, many of which have come (by his report during several prolonged periods of incarceration) while sober and on Dilantin with adequate serum levels.

Most significantly, a head CT scan in September 1998 showed evidence of old burr holes as well as longstanding encephalomalacia in the left frontal lobe, cerebellar atrophy, and ventricular prominence resulting from volume loss. To be specific, Mr. S easily meets the required level of severity for an organic mental disorder. He demonstrates (A) marked affective changes since his head trauma that predate his use of alcohol and have resulted in mood disturbances and emotional lability that have resulted in (B) marked difficulties in maintaining social functioning (as evidenced by 25 years of homelessness and loss of family and social supports) and repeated episodes of deterioration (as evidenced by his inability to remain in hospital or detoxification facilities).

I hope that this letter has been helpful in assessing this most unfortunate gentleman whose life has been devastated by the head trauma and nerve root injuries he sustained at a young age. In my professional opinion, he is totally disabled. Please feel free to call me anytime with further questions.

Respectfully,

James J. O’Connell, M.D.
Boston Health Care for the Homeless Program
Departments of Medicine
Boston Medical Center and Massachusetts General Hospital

11.08 Spinal cord or nerve root lesions, due to any cause with disorganization of motor function as described in 11.04B.

11.04 Central nervous system vascular accident.
With one of the following more than 3 months post-vascular accident:

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.00 Neurological:

C. Persistent disorganization of motor function in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral, cerebellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combinations, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands and arms.

Listing of Impairment specified in the preceding letter
Source: 2006 SSA Blue Book

10.2 Organic mental disorders: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information, intermediate, or long-term (inability to remember information that was known sometime in the past); or
3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or
4. Change in personality; or
5. Disturbance in mood; or
6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., Luria-Nebraska, Halstead-Reitan, etc;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic organic mental disorder of at least 2 years’ duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years’ inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Listing of Impairment specified in the preceding letter
Source: 2006 SSA Blue Book
LETTER 4

May __, 2004
Re: D. A.
SSN: ______
DOB: ___/___/
MRN: ______

To Whom It May Concern:

I am writing as the primary treating physician of D.A. (DOB___/___/___). I have been treating him since 5/3/02 and seeing him at intervals of 1 week due to the complexity of his medical and mental health conditions. His previous medical care has been received in correctional facilities and at San Francisco General Hospital where he is currently under a court mandated restraining order which prevents him from receiving care there. I have reviewed his extensive past medical records (1993-2002). The following are current active medical problems for this patient:

1) Chronic Abdominal Pain: The patient has had multiple abdominal surgeries since childhood. He suffers from chronic pain especially in the left flank and left lower quadrant areas. The pain is constant and unrelenting with periodic increases in intensity several times a day. The pain has been attributed to intra-abdominal adhesions which are not amenable to surgical treatment. The pain is also likely related to recurrent kidney stones and extensive past instrumentation of his urinary tract. The patient has a history of left kidney vascular and ureteral malformations which have led to multiple episodes of nephrolithiasis, hydronephrosis, and required multiple surgeries. He has a history of recurrent uric acid kidney stones. He has required high doses of opiate analgesic medication for at least the last 10 years.

2) Bilateral Inguinal Hernia: The patient has bilateral inguinal hernias which are awaiting repair. These have been present and causing the patient pain for greater than 1 year. At this time surgical consultation is underway. The hernias are a source of pain and limitation in exertion.

3) Degenerative Joint Disease/neuropathic pain: The patient complains of chronic joint pains in his knees and other joints. He has had multiple traumas and accidents and likely has post traumatic arthritis. He also complains of burning/pins and needles type pain in both lower extremities left worse than right. He reports some improvement with gabapentin and indomethacin.

4) Asthma and frequent lower respiratory infections: Patient has had 2 episodes of pneumonia in the past 1 year and several episodes in the past and is frequently dyspneic with exertion. He reports some relief with bronchodilatory inhalers.

5) Personality Disorder/History of impulsive, violent, and threatening behavior: The patient has a history of multiple traumatic incidents. He has been incarcerated multiple times. His medical treatment has been compromised by the fact that he violently threatened his previous physician who could no longer treat him and obtained a restraining order keeping the patient away from the entire San Francisco General Hospital. The patient feels he has anxiety from traumas which occurred while he was in prison. Professionals who have interacted with him in the past have noted his anti-social behavior and threats of violence. The patient has poor insight into this and feels his behaviors have been misunderstood but it is clear from his history that he has anti-social personality disorder and poses a potential threat in any work or social environment. The patient also has an impulse control disorder and exhibits very poor judgment.

6) Substance Abuse: The patient reports previous use of stimulants as his primary problem. He reports previous loss of control of his use of opiate medications. At present he reports he is not using amphetamines, cocaine, heroin, or any other non-prescribed medications. He does not drink alcohol and reports that he is subject to random drug testing as a condition of his parole.

7) Hepatitis C Infection: The patient has positive hepatitis C antibody test. Further work up has not been done but his symptoms of fatigue and neuropathy may be attributable to this.

Physical Exam:
Patient appears stated age, somewhat disheveled with poor grooming
HEENT: EOMI, PERRLA, fundi nl. mouth and throat nl, poor dentition with multiple missing teeth and caries
Neck: - adenopathy, - thyromegaly, full ROM

53
Chest: Exp. wheezes and rhonchi, -rales, - dullness
COR: RRR, S1S2, - murmur, pulses nl.
Abd.: multiple healed surgical scars, diffuse tenderness, - rigidity, - point tenderness, + punch tenderness over left flank, bilat. inguinal hernia reducible with some difficulty and pain
Ext.: +crepitate L knee, full ROM at all joints, - edema
Neuro: alert, oriented x3, CNII-XII nl and symmetrical, strength and sensory nl. and symmetrical
Psych: Patient appears anxious and at times impatient, thought content is predominated by his chronic pain, complex medical history, and anger and frustration that he cannot physically perform his previously normal activities. He is homeless and has minimal social supports, no family support network, no social network. He has not appeared intoxicated or impaired in any encounter. -SI, - HI

Current medical plan: refer patient for surgical repair of bilat hernia, refer patient to comprehensive pain management center (requires Medi-Cal or other medical insurance)
Continue current meds - oxycodone with tylenol 5/325 6/d, indomethacin25mg 3 bid, gabapentin 300mg 3tid, albuterol inhaler, hydroxyzine 25mg q8hr prn

In Summary:
This unfortunate 40 year old man is currently homeless and socially isolated. His past records and current exam demonstrate long term chronic severe pain. He also has a personality disorder which has caused him to be involved in many violent situations and extensive conflict. In particular this has caused him to be prevented from receiving medical care at the only public hospital in San Francisco. He has a long history of substance abuse but is currently not using drugs. He appears to have some insight into this problem. His ability to respond appropriately to supervisors or co-workers is highly doubtful due to his personality disorder and the poor prognosis for improvement of these types of conditions. It has been felt that his potential to actually commit violent acts is high. Due to chronic pain his concentration and persistence in tasks are very poor. Mr. A's arthritis and lung disease would prevent him from performing a job which required the ability to stand or walk more than two hour in a work day or to lift more than 15 pounds occasionally. If Mr. A follows through with all medical plans he may achieve some general improvement in his functional level but I do not anticipate that even with the maximum expected improvement and continuing abstinence from drugs that he will ever be able to work again. I have attached copies of my relevant treatment records.

Barry Zevin MD
Internal Medicine
Medical Director, Homeless and Community Services
Tom Waddell Health Center
LETTER 5

May 12, 2004
Re: E. A.
SSN: ________
DOB: ___/___
MRN: ________

Social Security Analyst:
Mr. ______ of the Disability Evaluation Assistance Program referred Mr. E. A. for a medical consultative examination. He was evaluated today in collaboration with Dr. Barry Zevin. Medical records from San Francisco General Hospital and South East Health Center were also used for this report.

Mr. A. was raised in San Francisco. He was a junior high and high school athlete, primarily running track, and playing football and basketball. He left high school in the 12th grade to join the job corps and never finished his GED. He states he is quite illiterate. He can read some words and a few sentences in the newspaper, and has trouble spelling. He does not write very well. After high school he worked in a car wash for approximately 10 years and later became a security guard. He only did security for about 6 months when he was forced to quit due to severe knee pain. He worked off and on, the last job was sweeping the streets for SLUG, which he enjoyed but was only able to do for 6 months, again leaving due to too much missed work from the knee pain and progressive hip pain. His last day of work was 9/11/01.

He now complains of bilateral knee pain, bilateral hip avascular necrosis, benign prostatic hypertrophy and some recurrent "distress", with some depression in the last year. His wife of 23 years passed away 1 year ago and he is having great difficulty adjusting. He has 3 grown children whom he sees only occasionally. He is currently on GA and is living with his grandmother. He states his greatest problem is the constant, throbbing and shooting pain he experiences. He complains of great difficulty using public transportation. He can not get on the “kneeling bus” without using both hands and arms to pull him up the stairs. He states he is unable to carry groceries and cannot sweep or vacuum. He is able to stand for short periods of time to do dishes.

Medical Problems:

Bilateral hip pain
He describes severe aching and shooting pain in his left hip for the last 3-4 years. He was sent to the orthopedic clinic at SFGH. They performed a left hip core decompression for avascular necrosis on 7/25/03. He continues to have constant pain, 8/10 on a pain scale of 1-10, 10 being the worst possible pain. He is being treated with Tylenol with Codiene #3, two every 4-6 hours without relief. He describes the pain as shooting down the side of his leg, sometimes accompanied by a warm sensation of hot oil going down the front. MRI dated 4/22, 2004 shows core decompression of the left hip with granulation and continued avascular necrosis (AVN). The right is without AVN of the trochanteric head but does show inter-trochanteric necrosis. These conditions are consistent with the amount of pain he is experiencing. Due to a GI bleed he is unable to take NSAID’s.

Knees
He complains of recurrent, worsening bilateral knee pain. He remembers being told that he needed “knee cap replacement” with a plastic patella. He was afraid of the surgery and did not pursue it. He was diagnosed with patellofemoral syndrome on the left, after the core decompression of his hip. Plain films from January 8, 2004 show bilateral infarcts of the distal diaphysis of the right and left femur and a bony infarct involving the posteromedial left tibia.

Left arm radiculopathy
He has left arm numbness and a deep ache. The pain is intermittent and often disturbs his sleep. An MRI is scheduled for July 12, 2004 to further evaluate the cause of the radiculopathy.

Low Back Pain
MRI of the lumbar spine dated 4/22/04 showed broad based disk bulges of L3-4, L4-5 and L5-S1. There appears to be mild canal stenosis and the bulges may be touching the L5 and S1 nerve routes.

Substance Use
He describes using drugs and alcohol since the age of 13. He became clean and sober 5 years ago and remains so today. He describes the last year being difficult since his wife’s death but he is proud of himself for not using drugs.

Benign Prostatic Hypertrophy
He has a history of urinary dripping and frequency, which is being followed by a Urologist. He is taking Terazosin 10 mg daily with moderate relief.
Findings:

**General**: Mr. A arrived on time for his appointment. He was clean and well dressed and walked with a cane and a significant broad based limp. He was unable to do the heel to toe walk or walk on his heels and toes without holding on to the walls. He was pleasant and articulate however he had a depressed affect. He seemed somewhat distressed in his speech. He squirmed frequently in his chair and had very frequent spasmodic jerking. He attempted all requested maneuvers with moderate difficulty in carrying them out.

**Height**: 70”, **Weight**: 164 lbs., **B/P sitting (R)**: 140/82, **Pulse**: 72

**HEENT**: Unremarkable

**Spine**: Tender midline at the lumbosacral area. Decreased range of motion with lateral bending bilaterally, limited by pain and loss of flexibility. He did have positive straight leg raises on the right while supine.

**Upper Extremities**: Full ROM and strength equal bilaterally.

**Cor**: Bounding without murmur. Skin is warm and dry.

**Pulm**: Clear to auscultation, all lobes.

**Abd**: Liver tender, not enlarged

**Lower Extremities**: Both knees were painful with flexion. Able to perform a ~30° deep knee bend. Crepitus present bilaterally on passive and active range of motion. He had significant hip pain with flexion limited to ~80°/110° on the left. There was significant loss of internal and external rotation of the left hip. The right hip was painful with all maneuvers, with moderate generalized limited range of motion.

**Neuro**:

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<thead>
<tr>
<th>DTR's</th>
<th>Biceps</th>
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**Summary**

Mr. A is a pleasant 52 year old man. He suffers from significant deep-seated pain in both of his hips and knees as a result of many different disease processes. The progressive nature of the avascular necrosis, intertrochanteric necrosis and bony infarcts in all weight bearing joints, has become almost totally debilitating. Given his long and active athletic and work history, it is evident that he would work if he possibly could. He has made many attempts to maintain work only to have to quit due to the pain and lack of physical endurance. He is still in the process of a workup for his upper extremity radiculopathy.

Observation of him and his physical state during the interview and exam showed him to be in severe discomfort with sitting for even a short period of time. His grimacing and spasmodic jerking from pain were very distracting and obviously debilitating. His broad based gait and limp, assisted by a cane was slow and labored. His depressed / distressed affect could certainly be from the severity of his chronic pain.

I do not believe that Mr. A can sit or stand for more than 15 minutes without the opportunity to alternate position. He cannot walk without the use of a cane. While he holds his cane in his dominant right hand, his use of the left arm/hand is severely restricted by radiculopathy. Although he can use his right hand to lift when in the seated position, he cannot carry even 10 pound weights. He has chronic pain while on a high dose of narcotic medication. His ability to concentrate is severely impaired. His past history of substance use is not material to his case.

If he were to be awarded disability benefits, I believe he would be able to manage his own funds without difficulty. I have enclosed copies of my relevant treatment records.

Sincerely yours,

Masa Rambo, RN, MS, FNP
Barry Zevin, MD
Diplomate, American Board of Internal Medicine

HCH Clinicians' Network
LETTER 6

Medical Summary [10/04] S.L.

I have followed S. L. as his primary care treating physician since 8/15/03. I have seen him approx. every 6 weeks since that time and at times more frequently. Mr. L. is a 54 year old man who initially presented with a history of mental health problems, alcohol abuse, and a history of back problems and hospitalization for “pneumonia and congestive heart failure.” On presentation he was homeless and sleeping on the steps of a church. He was unable to access services due to severe anxiety and shame. He reported a career as a ballet dancer and choreographer both in the United States and Europe. He is currently abstinent from alcohol and seeking psychiatric treatment. His problems and course in summary:

Bipolar disorder: the patient was diagnosed with bipolar disorder in New York City several years ago. He reports greater than 20 years of episodic severe depression, alternating with periods of feeling invincible and starting big projects. Symptoms of his disorder include anxiety with severe panic attacks, many losses including failed relationships, lost friendships, homelessness, and severe interference with his career. He reports bulimia and anorexia as symptoms he has struggled with for many years. He reports episodes of using alcohol to blunt his feelings of irritability, depression, and anxiety. Previous treatment had included Valium and ativan. He reports being told that he might need medications to stabilize his mood but never took these nor believed he needed them. Initial attempts at prescribing Valproate (Depakote) to him were unsuccessful due to his perception of side effects. He was referred to a psychiatrist (Dr. Hammond) and psychotherapist at Mission Mental Health Center. He was prescribed anti-psychotic medication but did not adhere well to this. Most recently he has been restarted on Valproate which he has tolerated since he has been abstaining from alcohol. His poor insight and the presence of a co-occurring narcissistic personality style or disorder have complicated his psychiatric care.

Musculoskeletal complaints: the patient reports a history of problems with his back, extremities, and “diaphragm” which result from his years as a dancer. He has received various therapies in the past for these and reports he can no longer dance professionally due to his pain but otherwise copes with his chronic pain. He has not requested further work up or treatment of his pain.

CHF/pneumonia: these were apparently acute and resolved problems. There are currently no signs of heart or lung problems.

Alcoholism: The patient has a history of drinking in an excessive and uncontrollable manner. He has required several episodes of medically supported detoxification while under my care. He participated in a residential rehab program at Baker Places and was abstinent for 3 months but continued to have severe psychiatric symptoms and relapsed soon after completing the program. He required hospitalization in July 2004 after being assaulted when intoxicated. He had severe alcohol withdrawal at that time and required medical detox. He had a seizure which we have assessed as alcohol related at that time. He has abstained from alcohol since that time and reports he has had 13 years of sobriety between 1989 and 2002 and feels he has the tools to do this again especially if his underlying psychiatric issues are stabilized.

Multiple somatic complaints: The patient has had frequent complaints of respiratory, GI, and GU complaints. These do not seem to be caused by any underlying severe disorder but reflect somatization of his underlying psychiatric disorders.

In Summary: S. L. has a long history of untreated Bipolar disorder and alcoholism. Observation of him during periods of abstinence strongly suggests that his psychiatric disorder is the primary diagnosis. He has been unable to engage in any Substantial Gainful Activity during the period of time I have been treating him. At times he has embarked on volunteer work or started planning for large projects but has been unable to follow through with these commitments. His insight into the nature of his problems is low. With continued treatment he has a guarded chance of recovery and improvement but I would expect this to require several years of adherence with medications, psychotherapy, and abstinence from alcohol. If Mr. L. were to be awarded benefits I would recommend that he have a payee for money management as his illness has a severe effect on his judgment.

Barry Zevin MD
Diplomate American Board of Internal Medicine
Medical Summary Update 2/9/06 S.L.

This is a follow up to a letter written in 10/04. I have continued to follow this patient as his primary care treating physician. I have seen him at intervals of about monthly and at times weekly. Unfortunately the patient’s condition has deteriorated since that time. He has attempted paid or volunteer work a few times in the past year but these have ended quickly due to his inability to maintain psychiatric stability. This will update the patient’s problems as outlined in the previous letter:

**Bipolar disorder / narcissistic personality disorder:** The patient has now been taking Divalproex sodium (Depakote) on a regular basis. He has had good adherence and reports the medication helps avoid what he describes as his manic episodes. He still has episodes of severe depression which have triggered relapses to drinking alcohol several times over the past 4 months. He has had less episodes of panic attacks in the past year but continues with occasional (about once a month) very debilitating panic and daily anxiety effecting his ability to function. He has had several referrals and episodes of treatment in the mental health system since the last report. Each of these has ended with patient dissatisfaction and exacerbations of the patient’s condition. He has also had conflict and increased stress related to his attempts to return to working as a ballet instructor. He was apparently accused of some type of inappropriate behavior toward a young student. These conflicts and difficulties are consistent with his diagnosis of narcissistic personality disorder. Unfortunately no psychotherapy has been effective as of yet in helping the patient cope with this problem. In the past 6 weeks the patient has had at least 6 emergency room visits due to feelings of severe depression, anxiety, and suicidal behavior or ideations. The patient is socially very isolated at this time and is markedly impaired in this area. He is having a very difficult time keeping up with basic self care. He has markedly impaired concentration, persistence, and pace.

**Musculoskeletal complaints:** The patient continues with complaints of back and joint pain. These seem to be degenerative in nature. They limit him from exercising as he would like to and would likely limit his ability to do exertional work. He has not requested treatment or further diagnostic studies for these problems.

**Alcoholism:** The patient maintained sobriety for greater than 1 year during 2004-2005. He reported no or low amounts of craving except during periods of increased anxiety and depression. In the past 3-4 months he has had several drinking episodes (binges). These have resulted in his depression and anxiety getting worse. We treated his alcoholism with extensive counseling and also tried naltrexone. He does not seem to tolerate the medication well and as of yet he does not seem to be having much benefit. He had one episode in residential medically supported detox. He left before completing the full course of treatment (3 weeks) again related to his narcissistic personality disorder. The relationship of his mental illness to his alcoholism continues to be very strong. His mental health symptoms do not abate during periods of sobriety. These symptoms do become more dangerous when he is drinking as he becomes more impulsive and potentially acts on his suicidal ideations.

**In summary:** The patient’s condition has somewhat deteriorated over the past year. The patient meets listings in section 12.04 and 12.08 in the Disability Evaluation Under Social Security. The patient does have a diagnosis of alcoholism and this is of serious concern as outlined above. Observation of the patient during extended periods of sobriety and based on past history indicate that the patient’s impairments exist independent of the patient’s alcoholism and alcoholism is not material to the patients disability. Please feel free to contact me if I can be of any further assistance.

Barry Zevin MD  
Diplomate American Board of Internal Medicine  
Certified in Addiction Medicine  
American Society of Addiction Medicine
I have followed V. H. as his primary care treating physician since 8/6/04. I have seen him at intervals of 1 month or more frequently. The patient presented for care with complaints of back pain, pain from inguinal hernia, history of bipolar disorder, and homelessness. The patient perceived himself as quite ill but also expressed the expectation that he would soon be able to return to work. The patient has been an extremely high user of medical services due to physical illness and mental illness. Since 7/04 the patient has had 166 encounters in our health network alone (San Francisco General Hospital and Tom Waddell Health Center). He has had numerous visits at other hospitals and crisis centers which I do not have records of but have been reported by the patient. He has had conflict with staff and has appeared to be threatening and possibly violent at times. Education and redirection toward more appropriate and healthier uses of the healthcare system have not been effective. This likely reflects the seriousness of his mental health disorders. The patient's medical problems include:

**Chronic Back Pain:** The patient complains of severe and intractable pain in his lower back. He reports onset of this pain after an injury in 2000 in which he reports “disc rupture of L4 and L5.” Medical records from that time are not available to me. Lumbar spine X-Ray shows rotatory levo-scoliosis, osteophytes at the level of L4 through L5, narrowed disc space with vacuum phenomenon seen at the level L5-S1. This is consistent with the patient's history and subjective complaints. He has been treated with NSAIDS which have not been effective. The patient is treated with MS Contin (extended release oral morphine) which has been partially effective for the patient’s pain. He has had constipation and some sedation as a side effect. With use of the morphine he is able to sleep more comfortably and ambulate. He still has severe pain with bending or lifting any weight. He is not interested in considering surgical options and has been too unstable to follow up for physical therapy.

**Inguinal hernia recurrent:** The patient has had R and L inguinal hernias and has had at least 3 surgeries in the past year. His post-operative self care has been poor due to his homeless status and poor judgment. He does have pain in both inguinal areas. His ability to stand long periods or walk for expended periods is effected by this pain.

**Asthma/COPD/bronchospasm:** The patient has an extensive smoking history. He is short of breath at times and this is so severe that he must go to the hospital emergency department several times each year. CXR shows increased lung volumes suggestive of COPD. Office spirometry was within predicted range with small improvement after inhaled bronchodilator. The patient uses albuterol and atrovent and steroid inhalers regularly. He may have periodic exacerbations of asthma. His pulmonary symptoms may also be exaggerated by his mental health disorders. Smoking cessation counseling is underway and full PFT’s would be beneficial.

**Bipolar Disorder:** The patient reports bipolar disorder initially diagnosed in 1990. He also reports he was “hyper” as a child but it is unclear if this was ever diagnosed or treated. The patient reports a family history that his mother had manic depression and committed suicide in 1988. The patient reports his symptoms as episodes of severe depression and episodes of acting impulsively and with very poor judgment. He reports he did well when prescribed Lithium between 1990 and 1999. He reports stopping because he thought he was better. He has had many losses and problems since that time including loss of his home and jobs. The patient has received treatment at Westside Crisis Clinic and South of Market Mental Health Clinic. He was initially prescribed several medications and reports adherence to them. He has been non-adherent with appointments and follow up and has not been on medications regularly for approximately the past year. At times he has acted in an impulsive manner here in the clinic and staff have felt threatened and that he was capable of being violent. He has not been physically violent in the clinic but has been asked to leave at times.

At times the patient has appeared quite depressed in the clinic. He is often quite irritable and describes episodes that he can not name as irritability but are quite typical of bipolar disorder. He has exhibited grandiosity at times. He has kept most of his appointments and been late at times. His hygiene and self care has ranged from adequate to poor. He has not been able to obtain or maintain housing and usually uses homeless shelters. He expresses high levels of guilt and shame about his condition at times and minimizes and denies his problems at other times. He appears to have few or no friends and no social support system. The patient has marked impairments in his concentration, persistence and pace. In the time
I have been seeing him his condition has somewhat worsened. We continue to redirect him and move him toward obtaining mental health care. He seems overall hopeless that he will be able to benefit at this point from such care.

**Substance Abuse:** The patient initially reported occasional alcohol use and later noted “recreational” cocaine use. He reported that he felt these were not a problem for him. Further evaluation over time indicates the patient does have a substantial problem with stimulant abuse of crack cocaine. He does not appear to drink alcohol regularly and does not appear to abuse opiates or other sedatives. He has never reported to the clinic in an intoxicated state. He has received very extensive counseling from myself and our staff and been offered assistance. The patient appears to have some insight and acceptance of this as a problem which represents progress from his initial presentation. He has not moved toward obtaining treatment and we continue to use motivational enhancement techniques. The patient’s cocaine use clearly exacerbates his underlying medical and psychiatric conditions.

**Somatization and extensive use of medical system:** The patient has had numerous complaints of pain and numerous other symptoms for which he has presented to emergency rooms and urgent care centers. He does not appear to have severe physical problems causing these symptoms but they appear to represent a high degree of anxiety and somatization. Review of these records demonstrates that the patient has not been making these visits as “drug seeking behavior.” He reports to the medical staff that he is receiving opiate medication from his primary care physician and does not ask for additional medicine. The visits appear to be impulsive behavior and help seeking. Efforts to redirect this help seeking to more productive ends have failed thus far but will continue.

**Summary**
Mr. H. is an unfortunate 48 year old man with physical and mental health problems. He has severe back pain requiring opiate analgesic treatment. It is likely that the extent of this back pain would prevent him from doing any activities that required more than minimal exertion. He has bipolar disorder which manifests as depression at times and irritability and impulsiveness. He has exhibited very poor judgment. He has had multiple losses and been unable to function adequately to obtain his own housing. He uses crack cocaine which exacerbates his condition. I do not believe the patient has had any extended period clean from drugs during my care of him to evaluate the severity of his impairments without drugs. His health seeking behavior is disordered in a way atypical for patients primarily with stimulant dependence as their diagnosis. His symptoms and behavior are more typical of Bipolar disorder and probably a personality disorder than stimulant abuse alone.

As a physician with extensive experience in addiction medicine it is my best judgment that this patient would have severe impairments even if he were abstinent. The patient’s prognosis for improvement is guarded. His back pain is likely to continue or worsen as he ages. His mental health disorders while treatable are not curable. Poor judgment about the need for adherence to medication is particularly common in bipolar disorder. This patient’s impairments taken together meet or equal listings in Disability Evaluation Under Social Security. I believe this is the case independent of the patient’s substance abuse. If this patient were awarded benefits I would recommend that he have a mandated payee due to his poor judgment and likely inability to provide minimal food, clothing, and housing for himself.

Please feel free to contact me if I can provide any further information.

Barry Zevin MD
Diplomate American Board of Internal Medicine
Certified in Addiction Medicine
American Society of Addiction Medicine
LETTER 9

Ms. Jane Jones or Ms. Francine Smith
Disability Determination Services
P. O. Box 6338
Timonium MD 21094-6338

Re: A.P.
DOB: 
SSN: 

Dear Ms. Jones or Ms. Smith:

Ms. A. P. is a 25-year-old, married, Caucasian female who was first hospitalized psychiatrically in August, 1997 and who has had several hospitalizations and day hospital stays since that time. Ms. P. is a soft-spoken, anxious, tall woman of average build. She wears glasses. She is struggling enormously with her illness of schizoaffective disorder and desperately wants, as she states, to be “normal.” She is cooperative with treatment but is easily stressed and, when this happens, she often becomes symptomatic. She needs a great deal of support to maintain herself in the community.

... 

Functional Information

According to Ms. P., a typical day is one in which she gets up at about 8 a.m. and showers. She sometimes eats breakfast. She said that her family assists with cleaning the house. She does clean the cat’s litter boxes and feeds the animals (4 cats and one dog). When she was attending the ADH, her mother-in-law would transport her. She generally watches television during the day. Her husband generally arrives home from work between 4:30-5:00. Her family supplies dinner for Ms. P. and her husband. She goes to bed between 10-10:30 p.m.

Ms. P. experiences significant impairment in her activities of daily living, in her social functioning, and in her ability to complete tasks. She has been unable to work since her release from the Army in 9/97.

Regarding her activities of daily living, in her interview with the SSI Project Director, Ms. P. said that her mother-in-law or her grandmother cooks for her; she said that she doesn’t know how to cook. Earlier in her illness, she had great difficulty talking on the phone and would experience “bad anxiety attacks. I couldn’t sit still enough to use the phone.” She does better with this now. To obtain a phone number, she said that she would call another friend who might have it or would use the yellow pages. Her family, especially her mother-in-law, takes care of her food shopping. She said that she went with her mother-in-law once but became very anxious. At the end of May, Ms. P. still spoke of her struggle with completing housework. She said that her mother-in-law and her husband do most of the household chores. Ms. P.’s grooming and hygiene are usually good except when she is symptomatic. She is able to handle her own finances. She has never been to the post office. Generally, her family or friends provide transportation for her to her appointments or on other outings.

Socially, Ms. P. is much more inhibited than she used to be. She generally stays inside watching television and said she “prefer[s] it.” She said that she becomes “a little uneasy” around “big crowds” and feels as though “people around me can tell I have an illness.” She becomes anxious if there are several people in her house. She said that her heart races and she takes “big gulps of air.” She said that she feels that she handles anger well, by expressing it verbally. Prior to her illness, she said, she was “outgoing.” This is no longer true. She participated in groups at the ADH but prefers individual time with others and in treatment.

Ms. P. often has difficulty persisting and pacing herself in the completion of tasks. She said that she finds it “really hard” to concentrate, but this has improved somewhat since her illness began. She finds that she “lose[s] her train of thought” easily, and this bothers her. She also finds that she has difficulty remembering “things that happened before I got ill.” When giving her history to the SSI Project Director, she had difficulty remembering dates. She said that she used to have a “drawing hobby,” but that she cannot do this anymore. She also enjoyed reading but finds this difficult because of problems with concentration and focus.

Ms. P. has not been employed since she was discharged from the Army in 9/97. Recently, she has been talking about working part-time but has not done so or attempted to do so.
Summary

Ms. P. is a 25-year-old, married woman who was first hospitalized approximately a week after she entered the Army, in August, 1997. Between August and December, 1997, she was hospitalized six times and had three episodes of treatment in a day hospital. Currently, she is involved with an intensive outpatient mental health team that provides treatment and case management services. She meets with her therapist twice a week. With this intensive support, Ms. P. has been able to remain out of the hospital. She is easily stressed, becomes anxious and, less often, experiences a recurrence of psychotic symptoms. She worries a great deal about managing her illness and getting back to “normal.” In addition, she feels stressed in her marital relationship and worries about the finances. Currently, Ms. P. is waiting for placement in a psychiatric rehabilitation day program. This would assist her in providing some structure to her day as, right now, she spends most of the day alone, watching television.

Ms. P.’s illness has been severe and disabling, and she is unable to work.

If you have any questions, please contact Ms. Perret at 410-328-1406 or Dr. Billingsley at 410-555-5555.

Sincerely,

Yvonne M. Perret, LCSW-C
Project Director

John Billingsley, M.D.
Psychiatrist
LETTER 10

May 1, 2001
Ms. Freida Johnson
Disability Determination Services
P.O.Box 7373
Fair Chance, MD 21643-7373

Re: L.W.
DOB:
SSN:

Dear Ms. Johnson:

Mr. L. W. is a 26-year-old, single, African-American male who has a history of psychiatric hospitalization dating back to 1992. Mr. W. is a tall (6'1") man of slim build. He has cognitive limitations; for example, he could not find his way back to the SSI Project office even though he had been there twice before. He has difficulty keeping appointments and needed a great deal of outreach to maintain contact and to stay in treatment. He is a poor historian and is quite vague. He appears to be attempting to provide information, but his recall is poor.

When first interviewed by the SSI Project Director, Mr. W. presented with a strong body odor. He was ill-kempt. His speech was rambling and frequently non-responsive to the question. When asked about his mother, he began to cry. He spoke over and over about "not being able to go on" this way. He could not guarantee that he would be able to keep himself safe. Therefore, the Project Director walked him over to Babylon Psychiatric Crisis Center for evaluation. From there, he was admitted psychiatrically.

... Functional Information

In general, Mr. W. said, most of the time he is up and walking around. He sometimes stays at a mission, sometimes at relatives, and sometimes on the street. For a short period of time, he was living at the Safe Haven, a transitional housing program. Typically, he usually misses breakfast and sometimes eats lunch at the soup kitchens, mostly at Our Daily Bread. He is out most of the day. Mr. W. tends to present his functional ability as more capable than observations note.

Functionally, Mr. W. exhibits significant impairment in most areas. He states that he can cook and names rice and frozen patties as things that he can cook. He is able to use the telephone and could look up a phone number in the yellow pages. He said that he doesn’t eat much and would likely need help shopping for food and other items. He believes that he can keep things clean. However, he has never had his own place to live and his appearance is not clean. Although he states that he makes sure he’s clean, he had a strong body odor on several occasions when seen by the SSI Project staff, and his clothes are often quite dirty. He is unkempt as well. He said that he obtains clothing from the shelters. He describes his psychiatric symptoms in terms of "stress," which affects his ability to take care of his personal needs. He needs a representative payee to handle his presumptive SSI benefits and does not manage money well at all independently. Although he states that he can ride the bus, he does so only on routes that he knows and has difficulty finding new places. As was mentioned, he has been homeless for some time and has never maintained his own independent housing but rather has relied on family and shelters to house him.

Socially, Mr. W. has troubled relationships and has no friends. His relationship with his mother is conflicted as is his relationship with his sister. He notes himself that he has no "long-term" friends. When angered, he claims that he will face the problem and tell others what he didn’t like. However, as recently as last year, he faced an assault charge for hitting his brother in anger. He frequently experiences psychotic symptoms that contribute to very difficult interactions with others. His representation of managing his behavior is not accurate.

Frequently, Mr. W. does not answer the question asked of him, i.e., his response is not appropriate for the question. For example, when asked about his concentration, he said it was "very good" and used as an example the following: "I was up on Pennsylvania Ave. A guy came upon me. I said please don’t do anything to me. I was real scared. I begged him so he left. I believe in honesty." His memory is grossly intact but he has difficulty reporting dates and is vague about his history. He said that he likes "conversating" with others, but his conversation is frequently difficult to follow.

Mr. W. has been unable to sustain any employment for a significant period of time. His primary work history consists of temporary agency placements, and these were generally brief.
Summary
Mr. L. W. is a 26-year-old single male who has a history of psychiatric hospitalization dating back to 1992. Early on in his psychiatric treatment history, he was diagnosed with neuroleptic malignancy syndrome, thus making subsequent treatment difficult. In addition, in the last few years, he has begun abusing marijuana and cocaine, stating that the cocaine helps take the "stress off my mind." Mr. W. has been intermittently homeless for a long period of time. His homelessness, poor interpersonal skills, use of cocaine and marijuana to treat his symptoms, and his dependence on his family have made any semblance of effective independent functioning impossible. He has maintained no steady relationships nor stable living. He has had a lengthy history of psychotic symptoms, violent acting out, lack of compliance with consistent outpatient treatment, and poor management of his life. Mr. W. clearly has schizophrenia. His family has tried to assist him, but they have found him to be very difficult to have in their homes given his assaultive and psychotic behavior. At the present time, Mr. W. is receiving services from the UMMS PACT team, an intensive, mobile outreach team for adults with serious and persistent mental illness. This team is reserved for individuals who have been non-responsive to conventional treatment.

Mr. W. has very limited employment history. He is clearly disabled and unable to work.

If you have any questions, please call Ms. Rothschild at 410-328-1406 or Dr. Brown at 410-328-2564.

Sincerely,

Maria M. Rothschild, LCSW-C
Program Director

Francis Brown, M.D.
Psychiatrist, PACT
### Information is weighted by SSA based on source. Approximate Hierarchy is:

1. Treating MD, Treating Psychologist,
2. Evaluating MD, Evaluating Psychologist
3. Masters level practitioners
4. Medical records
5. Client direct complaint, client descriptions of functioning
6. Family
7. Friends, associates, neighbors

### Clearly identify the source of information.

Distinguishing whether it was
- what the client said or described, or
- what you observed or concluded
- medical records
- other collateral

State Department of Social Services  
Disability and Adult Programs Division  
P.O. Box 24225  
Oakland CA 94623-9917

RE: Psychological Evaluation of Rachael Delbee
SSN: 000-00-0000
DOB: 0/00/52

Dear Analyst:

### Opening Primary goals

Referral information, note who assessed the client - (name(s) and title, skill level), and determined he/she was disabled. Attempt to demonstrate that clients are prescreened prior to meeting you. Only those with disabilities are referred for further evaluation.

I am conducted a psychological evaluation of Ms. Rachael Delbee following her failure in employment activities in which she participated as a client in the DHS County Adult Assistance Program (CAAP) welfare to work program, the Personal Assisted Employment Services (PAES).

Dates of Evaluation:
- 4/14/00  3.0 Hours
- 4/21/00  1.0 Hour

**Total Interview Time:**  4.0 Hours
Sources of Information:
1. Memo composed by Ms. Francine Austin, MSW, of the SF DPH TB Control Division, directed to the South of Market Clinic, intended to refer Ms. Delbee for treatment of depressive symptoms. Dated September 26, 1996.
2. Conversation with Ms. Melissa McChesney, Employment Specialist, providing background information regarding Ms. Delbee behavior.

Tests Administered
1. Semi-structured Clinical Interview
2. Formal Mental Status Evaluation
3. WAIS-3
4. Neurobehavioral Cognitive Screening Examination (Cognistat)

Current Situation:

Quote the client's reason he or she is not working now, Briefly elaborate on how the condition(s) are limiting and recent treatment

When asked that reason that she is unable to work, Ms. Delbee stated, “My back bothers me a lot.” When asked a series of questions to help her elaborate on her condition she reported that her back has bothered her on and off since 1987. She was unable to identify a precipitant to her back problem. She reported that she has trouble sitting or standing for any length of time. She also complained that she has diabetes and she stated, “My sugar is high,” indicating that her condition is not stable. She presented a card on which her prescription for Glyburide and Metformin was written. However there were several different dosages noted and crossed out on the card and the dosage Ms. Delbee said she took differed from those written on the card. The correct medication regimen remained unclear. Ms. Delbee is followed by Janet Diaz, M.D. at San Francisco General Hospital whom she has seen since 1994. Of note, when asked to name her provider, Ms. Delbee spelled the name because she said she was unable to pronounce it. Ms. Delbee complained that she tires easily and has trouble following instructions. She stated, “A lot of times I’m not remembering stuff they tell me.” Ms. Delbee reported that she takes Tylenol for her back pain and no other prescription medications other than those for diabetes.

Ms. Delbee has begun evaluation and treatment of depressive symptoms with Heli Nikulainen, Ph.D. of the PAES Counseling Service.

Activities of Daily Living:

Describe the client's currently living situation, and note any support services he/ she may receive. Describe basic ADL's - how a client feeds and clothes him/ herself and uses free time etc.

Ms. Delbee reported that she lives in a single room occupancy hotel located at 373 Ellis Street, where she has resided for several years. She reported that she is currently participating in a 3-month internship through POWER, a welfare right organization. She reported that she performs some office works that includes answering the phone and typing names into a database. When asked specifically what she had done on one of the mornings prior to the evaluation, she reported that she took a bus to a Muni yard where she spoke to a few workfare participants and handed out some leaflets. She estimated she spent about 15 minutes at the yard and the remainder of the time on a bus ride to and from the location. She was unable to name the Muni site she visited. Ms. Delbee reported that she prepares simple meals. Her description of her daily activities showed that she has no friends and her only social contacts occur in structured settings.
History of Psychological Treatment

- **Symptom history if relevant**
- **Treatment episodes:** precipitant, TX modality, response to treatment, Subjective, e.g. was it helpful, . Objective, e.g. any functional changes in client's life.

As noted above, Ms. Delbee has begun treatment with Heli Nikulainen, Ph.D. of the PAES Counseling Service.

A memo dated September 26, 1996, written by Ms. Francine Austin, MSW, of the SF DPH TB Control Division indicated that Ms. Delbee was under treatment for tuberculosis. The memo provided referral information to the South of Market Mental Health Clinic (SOM) requesting treatment of Ms. Delbee's depressive symptoms. The memo notes that Ms. Delbee experienced depression manifested by changes in weight, social isolation and feeling of low self-esteem. She was described as having developmental delays in childhood and received intervention through special education. The deaths of Ms. Delbee's mother, father, nephew and grandmother in a period from 1993 through 1996 were identified as contributing to and exacerbation of symptoms. Ms. Delbee reported that the SOM Clinic did not accept her for treatment because her symptoms were judged not severe to meet medical necessity.

Ms. Delbee reported that her mother suffered from a mental disorder and received psychiatric treatment. She was unable to provide specific information regarding her mother’s condition such as her diagnosis or the type and duration of treatment. She did recall that her mother reported seeing things that were not there and she observed her mother talking to herself. Her mother’s condition resulted in Ms. Delbee’s placement in foster homes in an early age.

History of Substance Abuse and Treatment

If active substance use, provide as much detail about last use and current use pattern as possible.

Ages of Onset, progression of use pattern, impact on functioning.

Treatment episodes: precipitant, TX modality, response to treatment, subjective, e.g. was it helpful, . Objective, e.g. any functional changes in client's life.

Ms. Delbee reported that she drinks alcohol beverages rarely and only during social occasions. She recalled that she last had a drink in December 1999. She denied ever using other psychoactive substances. She demonstrated no behavioral and there is no collateral information that suggests that Ms. Delbee drinks or uses other psychoactive substances habitually.

Family and Social History

**Primary goals**

- Positive and negatives regarding family of origin
- Describe Pre-morbid functioning, highest level of functional abilities in terms of capacity for relationships and education (or put ed in voc).

Ms. Delbee reported that she was born in San Mateo and raised in San Francisco. She is the middle child in the family with two older sisters and a younger brother and sister. At the age of five, Ms. Delbee and her siblings were taken from the parents and placed in different foster homes. She reported that she had little contact with her father during the period she was in the foster care system.
She explained that he did not pay child support and did not visit his children. Ms. Delbee reported that she was in one foster home until about age 14. She explained that the first foster mother neglected her in favor of her genetic offspring. “They (the Department of Social Services) were giving money for me but she’d spend it on her kids.” In the second home, Ms. Delbee felt she was also treated poorly. She stated, “(The foster mother) had handicapped kids. She’d treat me like I was handicapped. She gave me pills to take. I didn’t know what kind.” Ms. Delbee was unable to identify the names or the types of medications she was given except to say that one was a birth control pill. She was also unable to describe possible behavior problems that may have led to a prescription of psychotropic medication. She stated that she learned later that she had been prescribed birth control pills and responded that her first sexual experiences occurred when she was over 30 years old.

Ms. Delbee reported that she attended a special education classed and graduated high school in 1971. After the age of 18 she lived with and became a caretaker to her mother. She reported and the memo from Ms. Austin notes that Ms. Delbee cared for her father and for her mother until their deaths in 1992 and 1993.

Ms. Delbee reported that she has had no long-term relationships. She explained, “I thought it was because I was not good looking. I felt bad about myself.”

**Vocational History**

**Primary goals**

- Describe pre-morbid functioning, highest level of functional abilities in terms of capacity gainful activities and education if not in social.
- SSA is interested in the employment track record for the last 15 years in general and the last 2 years in detail.
- Contrast self report with earnings record.
- Note the reasons that client lost or left jobs

Ms. Delbee reported that after high school, she attended a program she referred to as a “workshop handicapped place” that helped prepare her for work. In 1973 she was placed by the workshop in a job in the mailroom at the U.S. Mint. She described her duties as “putting stuff in envelopes, sorting by zip codes.” She reported that she left this position in 1986 when her position was transferred out of San Francisco. She was then placed in a job in the Navy Shipyard. She reported that, in this job, she rolled up drawing and filed them. She complained that she began to experience physical problems including problems with her hands, pain in her back and legs, and continual thirst. She reported that she left this position in 1989 because of her physical complaints and because she felt unfairly treated. She explained that a co-worker was allowed to work less that she. She has not worked since 1989.

**Medical History**

- Current and past significant medical illness and conditions.
- Current prescriptions and treatment (if not in current situation)
- Effect on functioning (if not in current situation)

Ms. Delbee reported that she underwent a hysterectomy in early adulthood which she blamed on the birth control pills she was given during adolescence without her consent. The memo from Francine Austin notes that Ms. Delbee underwent a hysterectomy also without her consent at age 20 for uncontrolled hemorrhaging.

Ms. Delbee reported that she was diagnosed with diabetes in the late 1980’s.
Mental Status Exam

Recommend that you keep to a consistent outline regardless of disorder. Provide more or less detail as is relevant.

1. General appearance, Motor behavioral, gait, response to interviewer and interview situation, Cognition and Memory

2. Mood and Affect, Vegetative Signs, Suicidality/ Homicidality

3. Thought content and Process, perceptual disturbances.

Ms. Delbee dressed casually for her appointments. She favored dark earth toned clothes. Ms. Delbee’s manner was pleasant and cooperative. She spontaneously answered each question, but her responses provided vague information upon which she frequently was unable to usefully elaborate.

Ms. Delbee’s affect was generally sad and depressed. When asked to describe her mood on she stated, “Okay,” despite obvious signs of depression. She became tearful at times when describing painful memories. She described anhedonia, “I don’t do much for fun.” She complained of feeling tired and not having energy. She reported that she has trouble falling asleep and wakes throughout the night with difficulty falling back asleep. She estimated her current weight to be 194 lbs. with a height of 5’-3”. She reported that her weight was 180 lbs. earlier in the year and she explained that she is eating more because she feels depressed. Her rate of speech was slowed and her voice was soft to inaudible. At times she needed to be requested to repeat her answers and to speak up in order to be heard. This was most apparent during testing when she was failing repeated items. She fidgeted some as she sat through the interview. She appeared to become fatigued in the last hour of the three-hour session. Ms. Delbee’s motor behavior was slowed. Ms. Delbee reported wishing that she were death and thoughts about taking her life. She reported that these thoughts emerge when she thinks about her time spent in foster care and the deaths of her mother and father. She denied that she ever formed a plan to commit suicide. Ms. Delbee denied homicidal thought or a history of assaultive behavior.

Ms. Delbee thought flow was somewhat slowed and her thought production was lower than average. Her thoughts were well organized and associations were relevant. She denied experiencing perceptual disturbances and she demonstrated no behavior that contradicts this assertion. She demonstrated neither magical nor prominent delusional thinking.

Test Results

WAIS IS RARELY REQUIRED. It is not often that our client have mental retardation.

WAIS-3

Full Scale: 67
Verbal: 66 Performance: 76
Vocabulary: 3 Picture Completion: 3
Similarities: 6 Digit Symbol-Coding: 10
Arithmetic: 4 Block Design: 8
Digit Span: 6 Matrix Reasoning: 6
Information: 3 Picture Arrangement: 4
Comprehension: 3 Symbol Search: (10)
Letter-Number Sequencing: (7) Object Assembly: (8)

Neurobehavioral Cognitive Screening Examination (Cognistat)

Level of Consciousness: Alert
Orientation: 12 average
Attention: 3 moderate
Construction: N/A*
Memory: 11 average
Calculations: 3 average
Summary of Test Results

Ms. Delbee's FSIQ as measured on the WAIS-3 is within the range of mild mental retardation. She demonstrated a ten-point variation between Verbal and Performance abilities with her highest performance on the coding and symbol search sub-tests. Her performance is consistent with general observations during the clinical evaluation. Ms. Delbee's general knowledge of facts and her ability to provide descriptions of her situation was limited. As noted previously, her affect became increasingly depressed during the administration of verbal sub-tests. Interestingly, Ms. Delbee's best performance is on coding and symbol search which were skills that she used during her only successful period of employment, in the mailroom at the U.S. Mint.

The Cognistat, which assesses a wide range of cognitive abilities, shows that Ms. Delbee has several areas of impairment. She was fully oriented. Attention, as measured in digit spans was in the moderate ranges of impairment. This is consistent with the performance measured by the WAIS digit span. On the comprehension sub-test, Ms. Delbee performed within the mild range of impairment. She followed simple two-step commands but consistently failed on simple three step operations. She demonstrated mild impairment when asked to repeat sentences. On the memory sub-test, Ms. Delbee required four trials before she was able to correctly repeat the four items. After 5 minutes, she recalled 3 of the 4 objects spontaneously and recalled the fourth when prompted by category. Her performance showed that she requires extra time to learn material. Ms. Delbee's responses to hypothetical situations assessing judgment showed that she was capable of simple problem solving but her solutions involved depending on family members for help. For instance, if she were stranded in the Denver Airport with a dollar in her pocket, she stated that she would, “Get change. Call my sister. Get me money.”

Summary

1. Overall assessment of the reliability of the client's self-report and of other relevant sources.
2. General overview of clients life,
   - Strengths and weaknesses of family of origin and impact on functional ability.
   - Description of highest level of functioning. Academically/Vocationally and Socially, i.e., accomplishments in work and relationships.
   - Onset of symptoms and impact on functioning.
3. Findings of current evaluation.
   - Describe specific symptoms that lead to a DSM diagnosis.
   - Include descriptions that satisfy durational criteria.
Ms. Delbee provided an account of personal history that was limited by vague and impoverished responses that appeared to be attributable to a general lack of cognitive abilities. Ms. Delbee’s behavior was consistent during each of the two interviews and with behavior reported by Ms. McChesney, her Employment Specialist. There is no indication that Ms. Delbee intentionally performed more poorly to secure secondary aims such as to qualify for Social Security benefits.

Ms. Delbee’s account of her history suggests that her mother was significantly impaired and consequently lost custody of her 5 children. Ms. Delbee reported academic difficulties and complained of feeling her two foster mothers showed a lack of concern for her. She described feeling unwanted and treated like she was less important than other children in the household. Her description of her childhood suggests that she experienced the early onset of chronic depression or dysthymia. Ms. Delbee reported that she maintained employment for 13-16 years. She received support from vocational rehabilitation service to secure employment and appears to have lost her job when her mother developed cancer and she experienced the onset of diabetes.

As noted above, Ms. Delbee’s performance on the intelligence testing is within the range of mild mental retardation. Her description of daily activities suggests that she is dependent on others to maintain daily functioning. Her lack of cognitive ability does result in serious complications. For instance, she reported that her diabetes is unstable and she appears to not understand the correct medication regimen.

Ms. Delbee’s current clinical presentation shows signs and symptoms of major depression which include feelings of depression, anergia, anhedonia, insomnia, weight gain, feelings of worthlessness, and suicidal ideation.

**Diagnosis**

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<th>Axis</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>I</td>
<td>296.32</td>
<td>Major Depressive Disorder, moderate</td>
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<tr>
<td></td>
<td>300.4</td>
<td>Dysthymic Disorder, early onset</td>
</tr>
<tr>
<td>II</td>
<td>317</td>
<td>Mild Mental Retardation</td>
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<tr>
<td>III</td>
<td></td>
<td>Diabetes, Self-report of back pain</td>
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<td>IV</td>
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<td>Occupational, economic problems, problems accessing appropriate mental health services.</td>
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<td>V</td>
<td>GAF 40</td>
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**Assessment**

Describe limitations in 3 or 4 of the functional areas in the SSA Listing. Use the Mental Residual Functional Capacity Assessment Form as a guide. Provide descriptions and examples of impairment based on your clinical observation of the client and information from collateral sources. Include a statement about client’s capability to handle his or her funds.

Ms. Delbee demonstrates impairment in daily activities, social functioning and concentration, persistence and pace. While Ms. Delbee has experienced mild chronic depression with an onset in childhood, symptoms have increase in the last decade with the death of her parents and the onset of a chronic medical condition. Ms. Delbee’s ability to manage her medical and mental disorders is limited by her lack of cognitive resources.
Ms. Delbee demonstrates marked impairment in activities of daily living. Her description of her typical day shows a very restricted range of activities. She appears to be dependent on help from others to enable her to attend to daily responsibilities. Ms. Delbee demonstrated confusion regarding many essential tasks such as attending to medical care.

Ms. Delbee is impaired in the area of social relationships. Ms. Delbee’s description of her daily activities shows that she has no social contacts beyond those she comes in contact during her routine activities. She described lack of self-esteem that limits her to interact with peers. Untrained observers would readily recognize that Ms. Delbee appears troubled and depressed.

Ms. Delbee is unable to maintain concentration, persistence and pace. Ms. Delbee demonstrated significant cognitive limitations which impact her ability to understand and follow instructions. Her ability to focus on tasks over the course of a normal workday and workweek is further limited by depressive symptoms that interfere with her ability to sleep and lead to fatigue. The instability of her medical condition, which effects mood and stamina, further limits her ability to attend to gainful activities.

Ms. Delbee is able to handle her funds.

I hope information contained in this report will be useful in your evaluation of Ms. Delbee in her application for benefits under Title II and/or Title XVI of the Social Security Administration. If I can provide additional information, please contact me. I am most easily reached at 415 558-1375.

Sincerely,
Thomas Neill, Ph.D.
Licensed Psychologist
PSY 13004
Interviewing Checklist for Alcohol and/or Illegal Drug (AOD) Use

- Status during periods of sobriety
  - If impairment existed before AOD use started, explore the functional limits caused by the impairment prior to AOD use
  - If the person had periods of sobriety, explore the functional limits caused by the impairments while sober

- If actively using, explore the context of AOD use
  - Why they person started using AOD
  - What effects the AOD has had on their life
  - If treatment has ever helped AOD use
  - How the person sees the relationship between their impairment and their AOD use
  - Relationship of AOD use to past trauma or abuse
Appendix B

Sample Disability Forms on Functional Abilities

<table>
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<th>Form</th>
<th>Page</th>
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<tbody>
<tr>
<td>DDS 1002 - Mental Health Questionnaire</td>
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<td>Medical Source Statement of Ability to Do Work-Related Activities (Mental)</td>
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<td>Physical Assessment Form</td>
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<td>Third Party Questionnaire on Functional Abilities</td>
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<td>Examples of Functional Abilities</td>
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<td>Functional Ability Worksheet</td>
<td>62</td>
</tr>
<tr>
<td>Date Patient First Examined</td>
<td>Date of Most Recent Examination</td>
</tr>
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**EVALUATION FORM FOR MENTAL DISORDERS**

A narrative report, covering the following points, may be substituted instead of this form.

**NOTE:** The evidence needed to evaluate this patient’s claim must be as object and as specific as possible. Specific examples of the patient’s behavior, thinking and functioning are necessary to make a determination. Verbatim quotations of the patient’s speech are frequently useful.

1. **GENERAL OBSERVATIONS.** Does the patient require assistance to keep his/her appointments? in what way and by whom? Please describe posture, gait, mannerisms, and general appearance.

2. **PRESENT ILLNESS.** What are the patient’s complaints and symptoms? How and when did they begin? How does the patient describe complaints (verbatim quotes)?

3. **PAST HISTORY OF MENTAL DISORDER.** If patient has been hospitalized please indicate dates, location, and course of treatment. Also, please describe any treatment received on an outpatient basis.

4. **FAMILY, SOCIAL AND ENVIRONMENTAL HISTORY:** Briefly discuss the following areas, if relevant: family, education, marriage, divorce, work, sickness, alcohol, drug abuse, prison, etc.
5. MENTAL STATUS EXAMINATION: For each of the items listed below, please record enough detailed observations to recreate the patient’s clinical picture.

A. Attitude and Behavior. Please describe the patient’s general attitude, e.g. pleasant, hostile, relaxed, fearful, etc., and any examples of noteworthy behaviors, e.g. fearfulness, motor activity, emotional lability, etc.

B. Intellectual Functioning/Sensorium: Please describe and provide specific examples of orientation, memory, concentration, perceptual or thinking disturbance, judgment, etc. If intellectual functioning or organic involvement have been measured with standardized tests, please include any available results including dates of testing.

C. Affective Status: Please present any evidence of anxiety, depression, phobias, manic syndrome, inappropriate affect, somaform disorder, suicidal/homicidal ideation, etc. Please describe objective signs of any diagnosed affective disorder, e.g. weight change, insomnia, decreased energy, feelings of guilt or worthlessness, anhedonia, etc.

D. Reality Contact: Does the patient present delusions, hallucinations paranoid ideation, confusion, mood swings, emotional lability, emotional withdrawal and or isolation, catatonic or grossly disorganized behavior, loosening of associations, etc. Please describe in detail.
NAME:  
SSN:  
DOB:  
LAC/DMH. MIS. #  

6. CURRENT LEVEL OF FUNCTIONING. Indicate to what extent (if any) the patient’s current mental condition interferes with each of the following with supporting data and examples.

A. Present Daily Activities: Discuss the degree of assistance or direction needed to properly care for personal affairs, do shopping, cook, use public transportation, pay bills, maintain residence, care for grooming and hygiene, etc. In what ways, if any, have the patient’s daily activities changed as a result of the patient’s mental condition?

B. Social Functioning: Describe the patient’s capacity to interact appropriately and communicate effectively with family members, neighbors, friends, landlords, fellow employees, etc. In what ways, if any, have these changed as a result of the patient’s condition?

C. Concentration and Task Completion: Describe the patient’s ability to sustain focused attention, complete everyday household routines, follow and understand simple written or oral instructions, etc. In what ways, if any, have these changed as a result of the patient’s condition?

D. Adaptation to Work or Work-like Situations: Describe the patient’s ability to adapt to stresses common to the work environment including decision-making, attendance, schedules, and interaction with supervisors. In what way, if any, have these changed as a result of the patient’s condition?

E. New Repeated Episodes of Decompensation: (exacerbation or temporary increase in symptoms, accompanied by a loss of adaptive functioning in the above four areas). Examples: increased treatment; change to less stressful situation; alterations in medications; hospitalization or placement in structured living arrangement, like a halfway house or Board & Care. Need dates and duration of episodes.
7. CURRENT MEDICATION (if any): List dosage and response.

8. DIAGNOSIS: (DSM IV)

9. PROGNOSIS: Can the patient’s condition be expected to improve? If so, when do you consider significant changes likely to occur?

10. COMPETENCY: Is the patient competent to manage funds on his/her own behalf?

( ) yes ( ) no

11. ADDITIONAL COMMENTS: Attach additional pages if necessary.
MEDICAL SOURCE STATEMENT OF
ABILITY TO DO WORK-RELATED ACTIVITIES (MENTAL)

NAME OF INDIVIDUAL

SOCIAL SECURITY NUMBER

To assist us in determining this individual’s ability to do work-related activities, please give us your professional opinion of what the individual can still do despite his/her impairment(s). The opinion should be based on your findings with respect to medical history, clinical and laboratory findings, diagnosis, prescribed treatment and response, and prognosis.

For each activity shown below:

(1) Respond to the questions about the individual’s ability to perform the activity. When doing check the box indicating the degree of limitation on the following five-point scale

None  Mild  Moderate  Marked  Extreme

If the degree of limitation is “None” or “Mild”, Social Security will generally conclude that the impairment is not severe.

“Extreme” represents a degree of limitation that is incompatible with the ability to do any gainful activity.

(2) Identify the factors (e.g., the particular medical signs, laboratory findings, or other factors described above) that support your assessment.

IT IS VERY IMPORTANT TO DESCRIBE THE FACTORS THAT SUPPORT YOUR ASSESSMENT. WE ARE REQUIRED TO CONSIDER THE EXTENT TO WHICH YOUR ASSESSMENT IS SUPPORTED.

(1) Is ability to understand, remember, and carry out instructions affected by the impairment?  □ No  □ Yes
If “no,” go to question #2. If “yes,” please check the appropriate block to describe the individual’s ability to perform the following work-related mental activities.

- Remember locations and work-like procedures.
- Understand and remember short, simple instructions.
- Carry out short, simple instructions.
- Understand and remember detailed instructions.
- Carry out detailed instructions.
- Maintain attention and concentration for extended periods.
- Perform activities within a schedule, maintain regular attendance, and be punctual.
- Sustain an ordinary routine without special supervision.
- Work with or near others without being distracted by them.
- Make simple work-related decisions.
- Complete a normal workday or workweek.
- Perform at a consistent pace.
What medical/clinical finding(s) support this assessment?

(2) Is ability to respond appropriately to supervision, co-workers, and work pressures affected in a work setting affected by the impairment? □ No □ Yes

If “no,” go to question #3. If “yes,” please check the appropriate block to describe the individual’s ability to perform the following work-related mental activities.

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Marked</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interact appropriately with the public.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ask simple questions or request assistance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept instructions and respond appropriately to criticism from supervisors.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Get along with co-workers and peers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain socially appropriate behavior.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Adhere to basic standards of neatness and cleanliness.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respond appropriately to changes in the work setting.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be aware of normal hazards and take appropriate precautions.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel in unfamiliar places or use public transportation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set realistic goals or make plans independently of others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What supports this assessment?

(3) Are any other capabilities affected by the impairment? □ No □ Yes

If “yes,” please identify the capability and describe how it is affected.

<table>
<thead>
<tr>
<th>Capability</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What medical/clinical findings support this assessment?

(4) Can the individual manage benefits in his/her own best interest? □ No □ Yes
<table>
<thead>
<tr>
<th>Physician's/Psychologist's Signature</th>
<th>Medical Specialty</th>
<th>Date</th>
</tr>
</thead>
</table>

Form HA-1152 (4/99) Page 2
PHYSICAL ASSESSMENT

NAME OF PATIENT ________________________________     SSN_______________

In addition to your examination/treatment records for this patient, please provide a medical assessment of your patient’s physical capacities/limitations as of the earlier of the following two dates:

☐ Date of last visit _______________________________ , or

☐ _________________________________ , end of period being evaluated

A. ☐ The patient has no impairment-related physical limitations; or

B. ☐ In relation to the impairment(s), the patient retains the capacity to:

1. **Occasionally** lift and/or carry (including upward pulling) for up to 1/3rd of an 8-hour workday at a maximum of:

   ☐ less than 10 pounds
   ☐ 10 pounds
   ☐ 20 pounds
   ☐ 50 pounds
   ☐ 100 pounds
   ☐ Cannot assess

2. **Frequently** lift and/or carry from 1/3rd to 2/3rds of an 8-hour workday a maximum of:

   ☐ 10 pounds
   ☐ 25 pounds
   ☐ 50 pounds
   ☐ Cannot assess

3. Stand and/or walk (with normal breaks) for a total of:

   ☐ Less than 2 hours in an 8-hour workday
   ☐ At least 2 hours in an 8-hour workday
   ☐ About 6 hours in an 8-hour workday
   ☐ Cannot assess

What are the medical findings that support this assessment?
4. Sit (with normal breaks) for a total of: 
   - □ Less than about 6 hours in an 8-hour workday
   - □ About 6 hours in an 8-hour workday
   - □ Cannot assess

   What are the medical findings that support this assessment?

5. Postural Limitations

<table>
<thead>
<tr>
<th>Climb</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>- ramps/stairs</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>- ladders/ropes/scaffolds</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Balance</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Stoop</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Kneel</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Crouch</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Crawl</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

   What are the medical findings that support this assessment?

6. Manipulative Limitations

<table>
<thead>
<tr>
<th>Limitation</th>
<th>Limited</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach in all directions (including overhead)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Handling (gross manipulation)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Fingering</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Feeling (skin receptors)</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

   What are the medical findings that support this assessment?
7. **Visual Limitations**  

<table>
<thead>
<tr>
<th>Feature</th>
<th>Limited</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near Acuity</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Far Acuity</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Depth perception</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Accommodation</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Color vision</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Field of vision</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**What are the medical findings that support this assessment?**

8. **Communicative Limitations**  

<table>
<thead>
<tr>
<th>Feature</th>
<th>Limited</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Speaking</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**What are the medical findings that support this assessment?**

9. **Environmental Limitations**  

<table>
<thead>
<tr>
<th>Feature</th>
<th>Limited</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme Cold</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Extreme Heat</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Wetness</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Humidity</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Noise</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Vibration</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
Fumes, odors, dust,  
Gases, poor ventilation, etc. □ □ □

Hazards  
(machinery, heights, etc.) □ □ □

**What are the medical findings that support this assessment?**

SIGNATURE___________________________________________

Address: __________________________________________

Phone: ___________________________________________

DATE____________________________________________
Third Party Questionnaire

RE:
CASE No:
DEA:

1. What is your relationship to this applicant?
   How long have you known him/her?
   How often do you see him/her?

2. Please describe the applicant’s personal appearance. Are there any apparent difficulties with grooming, dress, cleanliness, etc.?

3. Does the applicant exhibit any unusual behavior, mannerisms, fears, posturing, etc.? If so please describe.

4. What indications of memory loss or problems with concentration or focusing have you observed?

5. Does the applicant need assistance in keeping appointments? If yes, from whom?
   Generally, does he/she arrive on time? [ ] Yes [ ] No
   Is he/she cooperative? Please explain.

6. Is the applicant able to understand and carry out simple verbal instructions? [ ] Yes [ ] No
   Written instructions? [ ] Yes [ ] No
   If not, please explain and give examples.

7. What difficulties, if any, does the applicant have interacting and communicating appropriately?
Third Party Questionnaire

8. Have you ever observed the applicant under the influence of drugs or alcohol?
   [  ] Yes        [  ] No
   If yes, how frequently?
   If yes, how recently?

9. Has the applicant filed for SSI/SSA benefits in the past?
   [  ] Yes   [  ] No   [  ] I do not know

10. Please provide us with the names, addresses, and phone numbers of family members or friends
    we may contact, if needed, for assistance.

11. Do you know if the applicant is working with any other agencies?
    Please give name, address, and phone number.

12. Do you have any additional comments or observations?

Your name: ___________________________
Title: ______________________________
Phone Number: ______________________
Date: ______________________________
Examples of Functional Activities and Limitations

Remember to evaluate if the person can do these activities: Independently; Appropriately; Effectively; and Sustained over a period of time

AND

Social Security Wants Degrees of Limitation Expressed In Their Terms, so

Use This Guide In Conjunction With The Physical And Mental “Medical Source Statement” Check-Box Forms

**Work Activities**

**Strength:** Lifting, carrying, sitting, standing, walking, pushing, and pulling

**Postural:** Climbing ramps/stairs/ladder/rope/scaffold, balancing, kneeling, crouching, crawling, stooping

**Manipulative:** Reaching, handling (gross manipulation), fingering (fine manipulation), feeling (skin receptors)

**Visual/Communicative Limitations:** Seeing, hearing, speaking

**Environmental:** Temperature extremes, noise, dust, vibration, fumes, humidity/wetness, hazards (machinery, heights) fumes, odors, chemicals, gases

**Activities of Daily Living**

**Caring for self:** Taking medications, following medical treatment instructions, caring for grooming (hair, nails, facial hair) and hygiene (brushing teeth, showering, clean and appropriate clothing, clean bedding), using the toilet, caring for menstrual periods

**Caring for home:** Shopping for food, clothes, toiletries; meal preparation and cleanup, general cleaning (vacuuming, sweeping, trash removal, tidying), laundry

**Caring for finances:** Paying bills on time, keeping track of money

**Moving through the world:** Using telephone, public transportation, driving
Social Functioning

For Work: Responding appropriately to supervision; interacting appropriately with coworkers and the public, asking simple questions or requesting assistance, work with and near others without being distracted by them, get along with coworkers and peers, maintain socially appropriate behavior, adhere to basic standards of neatness and cleanliness.

In General: Ability to get along with family, friends, neighbors, store clerks, landlords, bus drivers, etc.

Maintaining concentration/persistence/pace

For Work: Remember locations and work-like procedures, understanding, remembering, following and carrying out instructions; maintaining attention and concentration, sustaining an ordinary routine without supervision, performing at a consistent pace, being aware of normal hazards and taking appropriate precautions, responding appropriately to changes in the work setting, complete a normal workday or workweek.

In General: Travel in unfamiliar places, drive, use public transportation.
**Functional Abilities Worksheet**

You may want to use the chart below to record information on the functional abilities and impairments of the patient, before you fill out a Social Security Form.

Remember to evaluate not only whether the patient has a particular functional limitation, but also whether that activity can be sustained throughout an 8-hour work day, 5 days a week. Specifically, Social Security wants to know if a person can do an activity “Frequently” (1/3 to 2/3’s of an 8-hour workday), or “Occasionally” (up to 1/3 of an 8-hour workday), or “Never”

Also evaluate whether the person can do the activity independently, appropriately, and effectively.

<table>
<thead>
<tr>
<th>Work Activities</th>
<th>Manipulative Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities requiring strength</td>
<td></td>
</tr>
<tr>
<td>Sitting</td>
<td>Reaching</td>
</tr>
<tr>
<td>Standing</td>
<td>Handling (gross)</td>
</tr>
<tr>
<td>Walking</td>
<td>Fingering (fine manipulation)</td>
</tr>
<tr>
<td>Lifting/carrying</td>
<td>Feeling (skin receptors)</td>
</tr>
<tr>
<td>Pushing and/or Pulling</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Postural Limitations</th>
<th>Environmental limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Climbing-ramps/stairs/ladder/rope/scaffold</td>
<td>Temperature Extremes</td>
</tr>
<tr>
<td>Balancing</td>
<td>Noise</td>
</tr>
<tr>
<td>Kneeling</td>
<td>Dust</td>
</tr>
<tr>
<td>Crouching</td>
<td>Vibration</td>
</tr>
<tr>
<td>Crawling</td>
<td>Humidity/Wetness</td>
</tr>
<tr>
<td>Stooping</td>
<td>Hazards (machinery, heights ...)</td>
</tr>
<tr>
<td></td>
<td>Fumes, odors, chemicals, gases</td>
</tr>
</tbody>
</table>

**Visual/Communicative**

| Seeing                                        | Hearing                  |
|                                               |                          |
| Speaking                                      |                          |

Prepared by Neighborhood Legal Services Updated by Bay Area Legal Aid (2010)
### Activities of Daily Living

<table>
<thead>
<tr>
<th>Activities</th>
<th>Caring for Self</th>
<th>Caring for Home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caring for Self</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking meds</td>
<td></td>
<td>Shopping for food</td>
</tr>
<tr>
<td>Grooming</td>
<td></td>
<td>Preparing food</td>
</tr>
<tr>
<td>Hygiene</td>
<td></td>
<td>Cleaning</td>
</tr>
<tr>
<td><strong>Caring for Finances</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paying bills</td>
<td></td>
<td>Telephone</td>
</tr>
<tr>
<td>Keeping track of money</td>
<td></td>
<td>Driving or public transport</td>
</tr>
<tr>
<td><strong>Moving in the world</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responding appropriately to supervision</td>
<td></td>
<td>Ability to get along with family, friends, neighbors, store clerks, landlords, bus drivers, etc,</td>
</tr>
<tr>
<td>Interacting appropriately with coworkers and the public</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asking simple questions or requesting assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with or near others without being distracted by them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting along with coworkers and peers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining socially appropriate behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adhere to basic standards of neatness and cleanliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concentration/Persistence/Pace</td>
<td></td>
<td></td>
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<tr>
<td>-------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remember locations and work-like procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding, remembering, following, and carrying out instructions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining attention and concentration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sustaining an ordinary routine without supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performing at a consistent pace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responding appropriately to changes in the work setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being aware of normal hazards and taking appropriate precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete a normal workday or workweek</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel in unfamiliar places, drive, use public transportation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional notes</th>
</tr>
</thead>
</table>

64
Documenting Disability:
Strategies & Tips for Medical Providers

Appendix C

Sample Disability Forms &
Listings for Specific Impairments

<table>
<thead>
<tr>
<th>Condition</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Listings (sample)</td>
<td>66</td>
</tr>
<tr>
<td>Degenerative Joint Disease (Arthritis) Report</td>
<td>68</td>
</tr>
<tr>
<td>Liver Report</td>
<td>70</td>
</tr>
<tr>
<td>Neurological Report</td>
<td>76</td>
</tr>
<tr>
<td>Cardiac Report</td>
<td>80</td>
</tr>
<tr>
<td>Obesity Report</td>
<td>85</td>
</tr>
<tr>
<td>Seizure Description Form</td>
<td>88</td>
</tr>
</tbody>
</table>
12.04 Affective disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:
   a. Anhedonia or pervasive loss of interest in almost all activities; or
   b. Appetite disturbance with change in weight; or
   c. Sleep disturbance; or
   d. Psychomotor agitation or retardation; or
   e. Decreased energy; or
   f. Feelings of guilt or worthlessness; or
   g. Difficulty concentrating or thinking; or
   h. Thoughts of suicide; or
   i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:
   a. Hyperactivity; or
   b. Pressure of speech; or
   c. Flight of ideas; or
   d. Inflated self-esteem; or
   e. Decreased need for sleep; or
SSA’s Sample Mental Disorder Listing ––Affective Disorders

f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions or paranoid thinking; or

3. 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);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.
DEGENERATIVE JOINT DISEASE
(ARTHRITIS) REPORT

Patient’s Name: ________________________________________________________
Social Security #: ______________________________________________________
Date of Birth: _________________________________________________________

TO THE DOCTOR: Please complete the following report attaching copies of lab results for
each condition. Please use the back of the forms if additional space is needed.

1. Does this patient suffer from any arthritic impairment or disease?
   Yes ________ No _________             If yes,

   A. What is the current diagnosis? ____________________________________
   ______________________________________________________________

   B. One what date was the diagnosis first made? _________________________
   C. What is the date of onset, if different?______________________________
   D. How long have you been treating the condition? ______________________
   E. What is the date of the most recent examination?______________________
   F. What was the patient’s height___________ and weight __________ at that
      time?

2. If possible, state the date of onset of disease in each joint (for example: left knee
   8/82): ____________________________________________________________
   ______________________________________________________________
   ______________________________________________________________

3. Please describe any structural changes, i.e., structural deformity, bone destruction or
   bone hypertrophy: ________________________________________________
   ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________

4. Clinical abnormalities:
   A. Atrophy; if present, cite affected joint(s) with appropriate comparative
      measurements: ________________________________________________
      ______________________________________________________________

5. Clinical abnormalities:
   A. Atrophy; if present, cite affected joint(s) with appropriate comparative
      measurements: ________________________________________________
      ______________________________________________________________
B. Describe any local inflammatory or systemic signs: __________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

6. Please list any obtained lab data:

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
<th>Date</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Antinucle</th>
<th>Antibodies</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

7. Functional abnormalities: ________________________________________________

________________________________________________________________________

________________________________________________________________________

Physician Name: __________________________

Signature: __________________________

Address: __________________________

Phone: __________________________
LIVER REPORT

Patient’s Name: ________________________________________________________
Social Security #: ________________________________________________________
Date of Birth: __________________________________________________________

TO THE DOCTOR: Please complete the following report attacking copies of lab results for each condition. Please use the back of the form if additional space is needed.

1. Does this patient suffer from any liver impairment or disease?
   Yes ________  No ________  If yes,
   A. What is the current diagnosis?
      _____________________________________________________________
      ______________________________________________________________
   B. One what date was the diagnosis first made? _________________________
   C. What is the date of onset, if different? ______________________________
   D. How long have you been treating the condition?______________________
   E. What is the date of the most recent examination?______________________
   F. What was the patient’s height___________ and weight __________ at that time?

2. If there is evidence of chronic alcoholism, would the liver impairment persist at the same level of severity if there were no alcoholism?
   ____________________________________________________________________
   ____________________________________________________________________

3. Is the liver condition acute? Yes_____  No___ or chronic? Yes____  No____

4. Is it due to:
   A. Primary hepatic disorder? Yes______  No______
   B. A systematic disorder involving the liver? Yes______  No______
      If so, which disorder? ____________________________________________
   C. Abuse of or dependence on alcohol or other drugs?
      Yes______  No______

5. Is there cholecystitis of intrahepatic origin? Yes______  No______
   extrahepatic origin? Yes______  No______

6. Are there complications? If yes, please describe:___________________________
   ____________________________________________________________________
   ____________________________________________________________________

7. Have you palpated the liver? Yes______  No______
   If so, describe the results ____________________________________________
   ____________________________________________________________________
Is there:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enlargement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid shrinking</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Unusual firmness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Abnormality</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Describe: ______________________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. What are the lab values for:
   | Value | Date(s) |
---|-------|---------|
Serum bilirubin | | |
Alkaline phosphatase | | |
Serum aminotransferase | | |
(ALT formerly SGPT) | | |
Alanintransferase | | |
(ALT formerly SGPT) | | |
Other | | |

9. What is the prothrombin time? | Value | Date |
---|------|------|

10. Are there enzyme abnormalities? Yes_____ No_________
   If so, what (include dates):

11. Is there hypoalbuminemia of 3.0 gm. or less?
   Yes______ No______

12. What diagnostic procedures have been performed?
   | Date | Results |
---|------|---------|
Biopsy | | |
Paracentesis | | |
Peritoneoscopy | | |
Needle biopsy | | |
Endoscopy | | |
X-Ray | | |
Other | | |

13. Has surgery been recommended? Yes______ No______
   If so, what procedure? ____________________________________

14. Has surgery been performed? Yes______ No______ If so:
   When_____________________________________________________
   Where___________________________________________________
Procedure__________________________________________________________

Results____________________________________________________________

15. Does the patient suffer esophageal varices? Yes_____ No_____  
If so, when was it first diagnosed? ____________________________________  
Have there been hemorrhages attributable to the varices?  
Yes_____ No_______  Date(s) ________________________________  
__________________________________________________________________  
__________________________________________________________________  
__________________________________________________________________  
__________________________________________________________________  
Duration: _________________________________________________________  

16. Does the patient have ascites not attributable to other causes?  
Yes_____ No_______  If so, when was it first observed?  
__________________________________________________________________  
__________________________________________________________________  
__________________________________________________________________  

17. Is there hepatic cell necrosis or inflammation? Yes_____ No_____  
If so, how long has it persisted? _____________________________________  

18. Is there portal hypertension? Yes_____ No_____  
How diagnosed? ____________________________________________________  
What were the test results? ____________________________________________  

19. Is the patient jaundiced? Yes_____ No_____  If so, is it due to:  
Hemolysis _______ ________  
Hepatocellular dysfunction _______ ________  
Biliary obstruction _______ ________  
Other _______ ________  

20. Has EEG been performed? Yes_____ No_____  
Date(s)____________________________________________________________  
Results____________________________________________________________  

21. Is there hepatic or portal-system encephalopathy?  
Yes _____ No_____  
If so, what is the cause or precipitating event ____________________________  
__________________________________________________________________  
__________________________________________________________________
Is there:

A. Asterixis                                                Yes ______   No______    Date_______
B. Cerebral edema                                     Yes ______   No______    Date_______
C. Impaired consciousness                             Yes ______   No______    Date_______
D. Loss of cognitive abilities                      Yes ______   No______    Date_______
E. Affective changes                                  Yes ______   No______    Date_______
F. Persistence of disorientation to time/place        Yes _____  No______    Date_______
G. Memory impairment                                      Yes ______   No______    Date_______
H. Perceptual or thinking disturbances               Yes _____  No______    Date_______
I. Change in personality                                    Yes ______   No______    Date_______
J. Disturbance in mood                                     Yes ______   No______    Date_______
K. Emotional liability                                    Yes _____  No______    Date_______
L. Loss of measured intelligence of at least 15 I.Q. points      Yes _____  No______    Date_______
M. Marked restriction of activities of daily living        Yes _____  No______    Date_______
N. Marked difficulty in maintaining social functioning     Yes _____  No______    Date_______
O. Deficiencies of concentration                           Yes _____  No______    Date_______
P. Deficiencies of persistence in pace                    Yes _____  No______    Date_______
Q. Repeated episodes of deterioration or decompression at work of work like setting.        Yes _____  No______    Date_______

22. Does the patient suffer from cirrhosis?           Yes______                    No_________
If so, what is the etiology? ___________________________________________
__________________________________________________________________
What was it first diagnosed? _______________________________________________________________________
__________________________________________________________________

23. What clinical signs in addition to the above, have you observed?

Anorexia                                                Yes _____  No_____    Date_______
Wasted extremities                                     Yes _____  No_____    Date_______
Peripheral edema                                         Yes _____  No_____    Date_______
Protuberant belly                                         Yes _____  No_____    Date_______
Glossitis                                                Yes _____  No_____    Date_______
Vascular spiders                                         Yes _____  No_____    Date_______
Splenomegaly                                             Yes _____  No_____    Date_______
Gynecomastia                                             Yes _____  No_____    Date_______
Parotid gland enlargement                                Yes _____  No_____    Date_______
Hair loss                                                Yes _____  No_____    Date_______
Testicular atrophy                                       Yes _____  No_____    Date_______
Peripheral neuropathy                                    Yes _____  No_____    Date_______
Clotting disturbances                                    Yes _____  No_____    Date_______
Renal abnormalities                               Yes ______   No______    Date_______
Clubbing of fingers                               Yes ______   No______    Date_______
Weight loss                                       Yes ______   No______    Date_______

24. What symptoms has the patient mentioned which are consistent with the diagnosis?
Pruritus                                             Yes ______   No______    Date_______
Pain                                                  Yes ______   No______    Date_______
Fatigue                                               Yes ______   No______    Date_______
Weakness                                              Yes ______   No______    Date_______
Nausea                                                Yes ______   No______    Date_______
Malaise                                               Yes ______   No______    Date_______
Vomiting                                              Yes ______   No______    Date_______
Loss of libido                                        Yes ______   No______    Date_______
Loss of appetite                                      Yes ______   No______    Date_______
Abnormal sensation                                  Yes ______   No______    Date_______

25. What is the present therapy for the condition? __________________________________________

26. What has been the response to treatment? ____________________________________________

27. What medication has been prescribed? ________________________________________________

28. Are there any reported or observed side effects from the medication?
   Yes ______   No______            If so, what are they? ________________________

29. What modifications to lifestyle or daily living have been recommended?
   ______________________________________________
   ______________________________________________

30. What other medical or psychological conditions does the patient suffer in addition to
    those described above? ________________________________________
   ______________________________________________
   ______________________________________________
31. Are you treating these conditions?  Yes ______  No______

_________________________________________  ___________________
Signature of Physician            Date Report Completed

Please print  

Physician Name _________________________

Address _______________________________

Phone ________________________________

Specialty _______________________________
NEUROLOGICAL REPORT

Patient’s Name: ________________________________________________________
Social Security #: ________________________________________________________
Date of Birth: ___________________________________________________________

1. Does this patient suffer from any neurological impairment or disease?
   Yes ________  No ________  If yes,
   A. What is the current diagnosis? ____________________________________
   B. One what date was the diagnosis first made? _________________________
   C. What is the date of onset, if different? ______________________________
   D. What is the date of the most recent examination?______________________
   E. What was the patient’s height___________ and weight __________ at that
time?

2. Is paralysis or paresis present?  Yes______  No______
   If yes, please describe location and severity ______________________________
   ____________________________________________________________________
   ____________________________________________________________________

3. Please describe residual functioning capacity in the patient’s extremities:
   A. Upper extremities (check all that apply indicating % of function left)
      |
      | Pushing/pulling | Left % | Right % |
      | Gross manipulation | | |
      | Fine manipulation | | |
      |
      | Lifting | Left | Right |
      | Less than 5 lbs? yes ____ no____ yes ____ no____ |
      | 5 to 10 lbs? yes ____ no____ yes ____ no____ |
      | 10 to 20 lbs? yes ____ no____ yes ____ no____ |
      |
a. Are there allegations of pain?  Yes______  No______
   If yes, please describe _______________________________________________
   b. If no, is there a medical or psychological explanation for the pain complained
      of?
   ________________________________________________________________
   c. Is there any loss of grip in hands?  Yes_____  No___
B. Lower extremities:
   a. Have there been any Conduction Studies performed?
      Yes______  No______  If yes, please give results
      ___________________________________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
   b. Straight leg raising results: __________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
   c. Describe gait: ______________________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
   d. Ambulation:  Normal______  Cane______  Crutches______
                   Wheelchair______  Bedfast______
   c. Coordination of extremities:  Poor______  Fair______
                   Good______  No impairment______
C. Is assistance in weight bearing needed?  Yes______  No______
   If yes, please describe _____________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
4. Does the patient have sensory or motor aphasia? Yes______  No______
   If yes, please describe ability to communicate _________________________
   ___________________________________________________________________
   ___________________________________________________________________
5. Indicate and describe presence and severity of any of the following:
   Sensory changes _____________________________________________
   Atrophy ________________________________________________
   Tremor ________________________________________________
   Fibrillation _____________________________________________
   Festination _____________________________________________
Nystagmus

6. Results of pertinent laboratory test with dates (such as EEG, CT scan, x-ray, etc...)

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

7. Has the patient’s mental status been affected by impairment(s)? Yes____ No____
   Is yes, please describe ________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

8. The patient’s condition is Improving _____ Stable_____ Deteriorating _________
   Remarks: ____________________________
   ___________________________________________________________________

9. What is the present therapy for the condition? _____________________________
   ___________________________________________________________________

10. What has been the response to the therapy? _______________________________
   ___________________________________________________________________

11. What medication is the patient currently taking for the condition? __________
   ___________________________________________________________________

12. Are there any side effects from the medication observed or reported?
    Yes_____ No______ If so, what are they?
    ___________________________________________________________________

13. Please note any other medical impairment that would restrict the patient’s ability to
    function: ____________________________
    ___________________________________________________________________
14. Are you treating these other impairments?  Yes______  No_____  

_________________________________________  ___________________
Signature of Physician                  Date Report Completed

Please print  
Physician Name ____________________________
Address _________________________________
Phone _________________________________
Specialty _______________________________
CARDIAC
RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

To: __________________________________________

Re: ________________________________________ (Name of Patient)

___________________________________________ (Social Security No.)

Please answer the following questions concerning your patient's impairments. Attach all relevant treatment notes, laboratory and test results that have not been provided previously to the Social Security Administration.

1. Frequency and length of contact: ____________________________________________

2. Diagnosis (with New York Heart Association functional classification):

_________________________________________________________________________

3. Prognosis: ________________________________________________________________

4. Identify the clinical findings, laboratory and test results that show your patient's medical impairments: __________________________________________________________

_________________________________________________________________________

5. Identify all of your patient's symptoms:

   __ chest pain  __ edema
   __ anginal equivalent pain  __ nausea
   __ shortness of breath  __ palpitations
   __ fatigue  __ dizziness
   __ weakness  __ sweatiness

Other: ________________________________________________________________

6. If your patient has anginal pain, describe the frequency, nature, location, radiation, precipitating factors, and severity of this pain:

_________________________________________________________________________

_________________________________________________________________________

7. Is your patient a malingeringer?  __ Yes  __ No

8. Does your patient have marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though your patient is comfortable at rest?  __ Yes  __ No
9. a. What is the role of stress in bringing on your patient's symptoms?

________________________________________________________________________

b. To what degree can your patient tolerate work stress?

__ Incapable of even “low stress” jobs  __ Capable of low stress jobs

__ Moderate stress is okay  __ Capable of high stress work

c. Please explain the reasons for your conclusion: ______________________________

________________________________________________________________________

10. Do your patient's physical symptoms and limitations cause emotional difficulties such as depression or chronic anxiety?  __ Yes  __ No

Please explain: _____________________________________________________________________________

11. Do emotional factors contribute to the severity of your patient's subjective symptoms and functional limitations?  __ Yes  __ No

12. How often during a typical workday is your patient’s experience of cardiac symptoms (including psychological preoccupation with his/her cardiac condition, if any) severe enough to interfere with attention and concentration needed to perform even simple work tasks?

__ Never  __ Rarely  __ Occasionally  __ Frequently  __ Constantly

For this and other questions on this form, “rarely” means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

13. Are your patient's impairments (physical impairments plus any emotional impairments) reasonably consistent with the symptoms and functional limitations described in this evaluation?  __ Yes  __ No

If no, please explain: __________________________________________________________________________

14. a. List of prescribed medications: ________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
b. Describe any side effects of your patient's medication and identify any implications for working: ________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

15. Have your patient's impairments lasted or can they be expected to last at least twelve months?  __Yes  __No

16. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a competitive work situation:
   a. How many city blocks can your patient walk without rest or severe pain? _______
   
   b. Please indicate how long your patient can sit and stand/walk total in an 8 hour working day (with normal breaks).

<table>
<thead>
<tr>
<th>Sit</th>
<th>Stand/Walk</th>
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<tbody>
<tr>
<td></td>
<td>less than 2 hours</td>
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<tr>
<td></td>
<td>about 2 hours</td>
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<tr>
<td></td>
<td>about 4 hours</td>
</tr>
<tr>
<td></td>
<td>at least 6 hours</td>
</tr>
</tbody>
</table>

   c. Does your patient need a job that permits shifting positions at will from sitting, standing or walking?  __Yes  __No

   d. Will your patient sometimes need to take unscheduled breaks during an 8 hour working day?  __Yes  __No
      If yes,  1) how often do you think this will happen?  ____________________________
      2) how long (on average) will your patient have to rest before returning to work?  ____________________________
      3) on such a break, will your patient need to __ lie down or __ sit quietly?

   e. With prolonged sitting, should your patient's leg(s) be elevated?  __Yes  __No
      If yes,  1) how high should the leg(s) be elevated?  ____________________________
      2) if your patient had a sedentary job, what percentage of time during an 8 hour working day should the leg(s) be elevated?  ____________________________
f. How many pounds can your patient lift and carry in a competitive work situation?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
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<tbody>
<tr>
<td>Less than 10 lbs.</td>
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<tr>
<td>10 lbs.</td>
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<tr>
<td>20 lbs.</td>
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<tr>
<td>50 lbs.</td>
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</tbody>
</table>

f. How often can your patient perform the following activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stoop (bend)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crouch/ squat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb ladders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb stairs</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ENVIRONMENTAL RESTRICTIONS</th>
<th>NO RESTRICTIONS</th>
<th>AVOID CONCENTRATED EXPOSURE</th>
<th>AVOID EVEN MODERATE EXPOSURE</th>
<th>AVOID ALL EXPOSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme cold</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extreme heat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High humidity</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Wetness</td>
<td></td>
<td></td>
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<tr>
<td>Cigarette smoke</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Perfumes</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Soldering fluxes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Solvents/cleaners</td>
<td></td>
<td></td>
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<tr>
<td>Fumes, odors, gases</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Dust</td>
<td></td>
<td></td>
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<tr>
<td>Chemicals</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>List other irritants:</td>
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<td></td>
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</tbody>
</table>
i. Are your patient’s impairments likely to produce “good days” and “bad days”?  
__ Yes       __ No

If yes, 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:

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

17. What is the earliest date that the description of symptoms and limitations in this questionnaire applies?

18. Please describe any other limitations (such as limitations using arms, hands, fingers, psychological limitations, limited vision, difficulty hearing, etc.) that would affect your patient’s ability to work at a regular job on a sustained basis:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Date:  
Signature:  

Printed/Typed Name:  
Address:  

7-45a  
3/02  
§234.3
OBESITY REPORT

Patient’s Name: ________________________________________________________
Social Security #: ______________________________________________________
Date of Birth: ________________________________________________________

TO THE DOCTOR: Please complete the following report attaching copies of lab results for each condition. Please use the back of the form if additional space is needed.

1. Does this patient suffer from any obesity?

   Yes ________   No ________   If yes,

   A. What is the current diagnosis? ____________________________________

   B. One what date was the diagnosis first made? _______________________

   C. What is the date of onset, if different? ____________________________

   D. Is there a known medical etiology? ________________________________

   E. How long have you been treating the condition?_____________________

   F. What is the date of the most recent examination?____________________

   G. What was the patient’s height___________ and weight __________ at that time?

   H. What weights have been recorded in the last 12 months? Please provide at least three weights.

      DATE          WEIGHT
      __________    __________
      __________    __________
      __________    __________

2. What lab tests have been performed?

   A. Blood sugar
       fasting               Yes No Date(s) Results
       post-prandial        Yes No Date(s) Results
   B. Serum cholesterol
   C. Triglycerides
   D. Lipids
   E. Other

   Yes No Date(s) Results
3. Does the patient exhibit any complications */ caused by the obesity? (check all applicable).
   ______ Hypertension; if so, please report date and last blood pressure readings:
   1. __________________________________________________________
   2. _________________________________________________________
   3. _________________________________________________________

   ______ Artherialsclerotic heart disease
   ______ Diabetes
   ______ Musculoskeletal disorder
   ______ Other, please explain ________________________________________

* NOTE - if any exist - fill out other forms.

4. What therapy, if any, has been prescribed, not simply recommended? __________
   ____________________________________________________________________

5. Does patient comply with therapy? Yes ________    No _______

6. What medications, if any, is the patient currently taking for the condition and/or other complications?  ________________________________________________
   ____________________________________________________________________

7. Are there any side effects from the medication observed or reported?
   Yes ________ No _________ If so, what? ________________
   ____________________________________________________________________
   ____________________________________________________________________

8. Does the patient have a history of congestive heart failure? Yes _____       No _____
   If yes, is there a manifestation of past evidence of vascular congestion?
   ___________ hepatomegaly
   ___________ Peripheral or
   ___________ Pulmonary edema
   (Please attach any supporting documentation of recorded observations, findings, or lab results)

9. Is there chronic venous insufficiency? Yes _____       No _____
   If yes, are there superficial varicosities in a lower extremity with pain on weight bearing and persistent edema?   Yes _____       No _____

10. Is there a history of respiratory disease? Yes _____       No _____
    A. Is the total forced vital capacity equal to or less than 2.0 liters? __________
B. What is the level of hypoxemia at rest? ________________________________

11. From what other medical or psychological condition does the patient suffer from in addition to those described above.
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

12. Are you treating these conditions? Yes ______ No_____

______________________________  ________________________________
Signature of Physician           Date Report Completed

Please print

Physician Name ___________________________

Address _______________________________

Phone _______________________________

Specialty ______________________________
SEIZURE DESCRIPTION FORM

Applicant ________________________________
SSN ______________________________________

Note: Please answer the following questions based on your actual observations.

1. Dates of seizures witness: _____________________________________________
   ____________________________________________________________________

2. Does the claimant have the seizures during the day, during the night, or both? _____
   ____________________________________________________________________

3. How often does the claimant have seizures? _______________________________
   ____________________________________________________________________

4. How many seizures have you witnessed? _________________________________
   ____________________________________________________________________

5. When was the last time the claimant had a seizure of which you are aware? _____
   ____________________________________________________________________

6. Please describe a typical seizure by answering the following questions:
   a. Does the claimant loose consciousness?  
      Yes _________  No _________
      If Yes, for how long? _____________________________________________
   b. Does the claimant bite his/her tongue?  
      Yes _________  No _________
   c. Does he/she lose bladder or bowel control?  
      Yes _________  No _________
   d. Has he/she been injured during a seizure?  
      Yes _________  No _________
   e. Please try to describe his/her behavior immediately following a seizure: _____
      ____________________________________________________________________
      ____________________________________________________________________
      ____________________________________________________________________
7. Please give a phone number where you can be reached: _____________________

8. What is your relationship to the above person? __________________________

____________________________________________________________________
____________________________________________________________________

____________________________________________                     _____________
                                  Signature                                                                            Date

____________________________________________

____________________________________________

____________________________________________

Address

Phone: _____________________________________