Addendum to SSA form 4814 (adult) & 4815 (children)

The following opportunistic and indicator diseases that do not appear in section C should be entered on page 3 Section E of SSA form # 4814/15 These diseases are part of HASA's admission criteria but may not necessarily meet SSA's criteria for presumptive SSI/SSD.

1.

- **a.** CD4count <200/mm3 or less than 14% of total lymphocytes
- **b.** Cyclosporiasis
- **c.** Leishmaniasis
- **d.** Oral thrush
- **e.** Oral hairy leukoplakia
- **f.** Extensive, persistent seborrheic dermatitis
- **g.** Necrotizing gingivitis
- **h.** Reiter's syndrome
- **i.** HIV myopathy
- **j.** Chronic persistent fever of unknown etiology
- **k.** Chronic persistent weight loss:>10%baseline weight
- **l.** Cervical dysplasia or neoplasia
- **m.** Chronic vaginal candidiasis
- **n.** Acute retinal necrosis
- **o.** TB Status: ☐ No History ☐PPD+ ☐History Treatment Complete☐Active non-Infectious ☐Directly Observed Therapy

2.

Page 3 section G include physician's license #

Complete:

3. **Household Composition:** ☐Individual (Adults Only in H/H) ☐Family (Children Under Age 18 in H/H)

4. **Social/Case Worker:** _____ _____ _____

name (Print) Phone #

Authorization for Release of Confidential HIV Related Information

Confidential HIV Related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

If you experience discrimination because of release of HIV related information, you may contact the New York State Division on Human Rights at (212) 961-8400 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

Name of person whose HIV related information will be released:
Name and address of person signing this form (if other than above):
Relation to person whose HIV information will be released:
Name and address of person who will be given HIV related information:
Reason for release of HIV related information:
Time during which release is authorized:

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and can change my mind at any time.

Date _____ Signature _____

Notice to Recipient of Confidential HIV Related Information: This information has been disclosed to you from confidential records which are protected by state laws, including Public Health Law §2780 et seq. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized or further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.
{NYS Public Health Law. Article 27-F- §27825,(a)}

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

First *Middle* *Last*

NAME

SSN | Birthday (mm/dd/yy)

SSA USE ONLY NUMBER HOLDER (If other than above)

NAME

SSN

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

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

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

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to:**
   - **Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)**
   - **Drug abuse, alcoholism, or other substance abuse**
   - **Sickle cell anemia**
   - **Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases**
   - **Gene-related impairments (including genetic test results)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after** the date this authorization is signed, as well as past information.

FROM WHOM

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

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called 'disability determination services'), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

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

INDIVIDUAL authorizing disclosure

SIGN ▶

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

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

(Parent/guardian sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

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

SIGN ▶

Phone Number (or Address)

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

SIGN ▶

Phone Number (or Address)

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

Explanation of Form SSA-827,

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

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

You can provide this authorization by signing a Form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

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

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

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

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

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

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

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

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

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

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

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only* ***comments relating to our time estimate to this address, not the completed form.***

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0500

MEDICAL REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

DO/BO CODE:

The individual named below has filed an application for a period of disability and/or disability payments. If you complete this form, your patient may be able to receive early payments. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form SSA-827, "Authorization to Release Medical Information to the Social Security Administration," attached.

☐ I hereby authorize the medical source named below to release or disclose to the Social Security Administration or State agency any medical records or other information regarding my treatment for human immunodeficiency virus (HIV) infection.

CLAIMANT'S SIGNATURE (*Required only if Form SSA-827 is* NOT *attached*)

DATE

A. IDENTIFYING INFORMATION

CLAIMANT'S NAME	CLAIMANT'S SSN	CLAIMANT'S PHONE NUMBER
	– –	( ) –
CLAIMANT's ADDRESS	CLAIMANT'S DATE OF BIRTH	MEDICAL SOURCE'S NAME
	/ /	

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. OPPORTUNISTIC AND INDICATOR DISEASES: *Please check if applicable.*

BACTERIAL INFECTIONS

1. ☐ **MYCOBACTERIAL INFECTION** (e.g., caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **PULMONARY TUBERCULOSIS**, resistant to treatment
3. ☐ **NOCARDIOSIS**
4. ☐ **SALMONELLA BACTEREMIA**, recurrent non-typhoid
5. ☐ **SYPHILIS OR NEUROSYPHILIS** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **MULTIPLE OR RECURRENT BACTERIAL INFECTION(S)**, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year

FUNGAL INFECTIONS

7. ☐ **ASPERGILLOSIS**
8. ☐ **CANDIDIASIS**, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs
9. ☐ **COCCIDIOIDOMYCOSIS**, at a site other than the lungs or lymph nodes
10. ☐ **CRYPTOCOCCOSIS**, at a site other than the lungs (e.g., cryptococcal meningitis)
11. ☐ **HISTOPLASMOSIS**, at a site other than the lungs or lymph nodes
12. ☐ **MUCORMYCOSIS**

PROTOZOAN OR HELMINTHIC INFECTIONS

13. ☐ **CRYPTOSPORIDIOSIS, ISOSPORIASIS, OR MICROSPORIDIOSIS**, with diarrhea lasting for 1 month or longer
14. ☐ **PNEUMOCYSTIS CARINII PNEUMONIA OR EXTRAPULMONARY PNEUMOCYSTIS CARINII INFECTION**
15. ☐ **STRONGYLOIDIASIS**, extra-intestinal
16. ☐ **TOXOPLASMOSIS** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS

17. ☐ **CYTOMEGALOVIRUS DISEASE**, at a site other than the liver, spleen, or lymph nodes
18. ☐ **HERPES SIMPLEX VIRUS** causing mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or disseminated infection
19. ☐ **HERPES ZOSTER**, disseminated or with multidermatomal eruptions that are resistant to treatment
20. ☐ **PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY**

21. ☐ **HEPATITIS**, resulting in chronic liver disease manifested by appropriate findings (e.g., persistent ascites, bleeding esophageal varices, hepatic encephalopathy)

MALIGNANT NEOPLASMS

22. ☐ **CARCINOMA OF THE CERVIX**, invasive, FIGO stage II and beyond

23. ☐ **KAPOSI'S SARCOMA**, with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment

24. ☐ **LYMPHOMA** of any type (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkins lymphoma, Hodgkin's disease)

25. ☐ **SQUAMOUS CELL CARCINOMA OF THE ANUS**

SKIN OR MUCOUS MEMBRANES

26. ☐ **CONDITIONS OF THE SKIN OR MUCOUS MEMBRANES**, with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

HEMATOLOGIC ABNORMALITIES

27. ☐ **ANEMIA** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every 2 months

28. ☐ **GRANULOCYTOPENIA**, with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least 3 times in the last 5 months

29. ☐ **THROMBOCYTOPENIA**, with platelet counts repeatedly below 40,000/mm^3 with at least one spontaneous hemorrhage, requiring transfusion in the last 5 months; or intracranial bleeding in the last 12 months

NEUROLOGICAL ABNORMALITIES

30. ☐ **HIV ENCEPHALOPATHY**, characterized by cognitive or motor dysfunction that limits function and progresses

31. ☐ **OTHER NEUROLOGICAL MANIFESTATIONS OF HIV INFECTION** (e.g., peripheral neuropathy), with significant and persistent disorganization of motor function in 2 extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station

HIV WASTING SYNDROME

32. ☐ **HIV WASTING SYNDROME**, characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer; or chronic weakness and documented fever greater than 38° C (100.4°F) for the majority of 1 month or longer

DIARRHEA

33. ☐ **DIARRHEA**, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY

34. ☐ **CARDIOMYOPATHY** (chronic heart failure, or cor pulmonale, or other severe cardiac abnormality not responsive to treatment)

NEPHROPATHY

35. ☐ **NEPHROPATHY**, resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT 3 OR MORE TIMES IN 1 YEAR

36. ☐ **SEPSIS**

37. ☐ **MENINGITIS**

38. ☐ **PNEUMONIA** (non-PCP)

39. ☐ **SEPTIC ARTHRITIS**

40. ☐ **ENDOCARDITIS**

41. ☐ **SINUSITIS**, radiographically documented

NOTE: If you have checked any of the boxes in section C, proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

If you have not checked any of the boxes in section C, please complete section D. See part VI of the instruction sheet for definitions of the terms we use in section D. Proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION

42. a. **REPEATED MANIFESTATIONS OF HIV INFECTION,** including diseases mentioned in section C, items 1-41, but without the specified findings described above, or other diseases, resulting in significant, documented, symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

Please specify:

1. The manifestations your patient has had:
2. The number of episodes occurring in the same 1-year period; and
3. The approximate duration of each episode.

Remember, your patient need not have the same manifestation each time to meet the definition of repeated manifestations; but, all manifestations used to meet the requirement must have occurred in the same 1-year period. (See attached instructions for the definition of repeated manifestations.)

If you need more space, please use section E.

MANIFESTATIONS:	NO. OF EPISODES IN THE SAME 1 YEAR PERIOD:	DURATION OF EACH EPISODE:
EXAMPLE: Diarrhea	3	1 month each

AND

b. **ANY OF THE FOLLOWING:**

☐ Marked restriction of **ACTIVITIES OF DAILY LIVING;** or

☐ Marked difficulties in maintaining **SOCIAL FUNCTIONING;** or

☐ Marked difficulties in completing tasks in a timely manner due to deficiencies in **CONCENTRATION, PERSISTENCE, OR PACE.**

E. REMARKS: ***(Please use this space if you lack sufficient room in section D or to provide any other comments you wish about your patient.)***

F. MEDICAL SOURCE'S NAME AND ADDRESS ***(Print or type)***

TELEPHONE NUMBER (Area Code)

DATE

KNOWING THAT ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW, I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.

G. SIGNATURE AND TITLE (e.g., physician, R.N.) OF PERSON COMPLETING THIS FORM

▶

FOR OFFICIAL USE ONLY

☐ FIELD OFFICE DISPOSITION:

☐ DISABILITY DETERMINATION SERVICES DISPOSITION:

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0500

MEDICAL REPORT ON CHILD WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

DO/BO CODE:

The individual named below has filed an application for a period of disability and/or disability payments. If you complete this form, your patient may be able to receive early payments. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form SSA-827, "Authorization to Release Medical Information to the Social Security Administration," attached.

☐ I hereby authorize the medical source named below to release or disclose to the Social Security Administration or State agency any medical records or other information regarding the child's treatment for human immunodeficiency virus (HIV) infection.

CLAIMANT'S PARENT OR GUARDIAN'S SIGNATURE *(Required only if Form SSA-827 is NOT attached)*	DATE

A. IDENTIFYING INFORMATION

CLAIMANT'S NAME	CLAIMANT'S SSN	CLAIMANT'S PHONE NUMBER
	– –	( ) —
CLAIMANT'S ADDRESS	**CLAIMANT'S DATE OF BIRTH**	**MEDICAL SOURCE'S NAME**
	/ /	

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. OPPORTUNISTIC AND INDICATOR DISEASES: *Please check if applicable.*

BACTERIAL INFECTIONS

1. ☐ **MYCOBACTERIAL INFECTION** (e.g., caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **PULMONARY TUBERCULOSIS**, resistant to treatment
3. ☐ **NOCARDIOSIS**
4. ☐ **SALMONELLA BACTEREMIA**, recurrent non-typhoid
5. ☐ **SYPHILIS OR NEUROSYPHILIS** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ In a child less than 13 years of age, **MULTIPLE OR RECURRENT PYOGENIC BACTERIAL INFECTION(S)** of the following types: sepsis, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses) occurring 2 or more times in 2 years
7. ☐ **MULTIPLE OR RECURRENT BACTERIAL INFECTION(S)**, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year

FUNGAL INFECTIONS

8. ☐ **ASPERGILLOSIS**
9. ☐ **CANDIDIASIS**, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs
10. ☐ **COCCIDIOIDOMYCOSIS**, at a site other than the lungs or lymph nodes
11. ☐ **CRYPTOCOCCOSIS**, at a site other than the lungs (e.g., cryptococcal meningitis)
12. ☐ **HISTOPLASMOSIS**, at a site other than the lungs or lymph nodes
13. ☐ **MUCORMYCOSIS**

PROTOZOAN OR HELMINTHIC INFECTIONS

14. ☐ **CRYPTOSPORIDIOSIS, ISOSPORIASIS, OR MICROSPORIDIOSIS**, with diarrhea lasting for 1 month or longer
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20. ☐ **HERPES ZOSTER**, disseminated or with multidermatomal eruptions that are resistant to treatment

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MALIGNANT NEOPLASMS

22. ☐ **CARCINOMA OF THE CERVIX**, invasive, FIGO stage II and beyond

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HEMATOLOGIC ABNORMALITIES

27. ☐ **ANEMIA** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every 2 months

28. ☐ **GRANULOCYTOPENIA**, with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least 3 times in the last 5 months

29. ☐ **THROMBOCYTOPENIA**, with platelet counts repeatedly below 40,000/mm^3 with at least one spontaneous hemorrhage, requiring transfusion in the last 5 months; or intracranial bleeding in the last 12 months

NEUROLOGICAL ABNORMALITIES

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32. ☐ **HIV WASTING SYNDROME**, characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer; or chronic weakness and documented fever greater than 38° C (100.4°F) for the majority of 1 month or longer

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37. ☐ **MENINGITIS**

38. ☐ **PNEUMONIA** (non-PCP)

39. ☐ **SEPTIC ARTHRITIS**

40. ☐ **ENDOCARDITIS**

41. ☐ **SINUSITIS**, radiographically documented

NOTE: If you have checked any of the boxes in section C, proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

If you have not checked any of the boxes in section C, please complete section D. See part VI of the instruction sheet for definitions of the terms we use in section D. Proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

NOTE: If you have checked any of the boxes in section C, proceed to section E to add any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

If you have not checked any of the boxes in section C, please complete section D. See part VI of the instruction sheet for definitions of the terms we use in section D. Proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION

48. a. **ANY MANIFESTATION(S) OF HIV INFECTION INCLUDING ANY DISEASES LISTED IN SECTION C,** items 1-47, but without the specified findings described above, or any other manifestation(s) of HIV infection; please specify type of manifestation(s):

_____

_____

_____

AND ANY OF THE FOLLOWING FUNCTIONAL LIMITATION(S), COMPLETE ONLY THE ITEMS FOR THE CHILD'S PRESENT AGE GROUP.

b. BIRTH TO ATTAINMENT OF AGE 1 - Any of the following:

1. ☐ **COGNITIVE/COMMUNICATIVE FUNCTIONING** generally acquired by children no more than one-half the child's chronological age (e.g., in infants 0-6 months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing, or chewing); or
2. ☐ **MOTOR DEVELOPMENT** generally acquired by children no more than one-half the child's chronological age; or
3. ☐ **APATHY, OVER-EXCITABILITY, OR FEARFULNESS,** demonstrated by an absent or grossly excessive response to visual stimulation, auditory stimulation, or tactile stimulation; or
4. ☐ **FAILURE TO SUSTAIN SOCIAL INTERACTION** on an ongoing, reciprocal basis as evidenced by inability by 6 months to participate in vocal, visual, and motoric exchanges (including facial expressions); or failure by 9 months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger; or failure to attend to the caregiver's voice or face or to explore an inanimate object for a period of time appropriate to the infant's age; or
5. ☐ **ATTAINMENT OF DEVELOPMENT OR FUNCTION** generally acquired by children no more than two-thirds of the child's chronological age in two or more areas (i.e., cognitive/communicative, motor, and social).

c. AGE 1 TO ATTAINMENT OF AGE 3 - Any of the following:

1. ☐ ***GROSS OR FINE MOTOR DEVELOPMENT*** at a level generally acquired by children no more than one-half the child's chronological age; or
2. ☐ **COGNITIVE/COMMUNICATIVE FUNCTION** at a level generally acquired by children no more than one-half the child's chronological age; or
3. ☐ **SOCIAL FUNCTION** at a level generally acquired by children no more than one-half the child's chronological age; or
4. ☐ **ATTAINMENT OF DEVELOPMENT OR FUNCTION** generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by 1, 2, or 3.

d. AGE 3 TO ATTAINMENT OF AGE 18 - Limitation in at least two of the following areas:

1. ☐ Marked impairment in age-appropriate **COGNITIVE/COMMUNICATIVE FUNCTION** (considering historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available); or
2. ☐ Marked impairment in age-appropriate **SOCIAL FUNCTIONING** (considering information from parents or other individuals who have knowledge of the child, when such information is needed and available); or
3. ☐ Marked impairment in **PERSONAL FUNCTIONING** as evidenced by marked restriction of age-appropriate activities of daily living (considering information from parents or other individuals who have knowledge of the child, when such information is needed and available).
4. ☐ **DEFICIENCIES OF CONCENTRATION, PERSISTENCE, OR PACE** resulting in frequent failure to complete tasks in a timely manner.

E. REMARKS: (Please use this space if you lack sufficient room in section D or to provide any other comments you wish about your patient.)

F. MEDICAL SOURCE'S NAME AND ADDRESS *(Print or type)*	TELEPHONE NUMBER (Area Code)
	DATE

KNOWING THAT ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW, I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.

G. SIGNATURE AND TITLE (e.g., physician, R.N.) OF PERSON COMPLETING THIS FORM

▶

FOR OFFICIAL USE ONLY

☐ FIELD OFFICE DISPOSITION:

☐ DISABILITY DETERMINATION SERVICES DISPOSITION:

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED SSA-4814-F5
(Medical Report On Adult With Allegation Of Human Immunodeficiency Virus (HIV) Infection)

Your patient, identified in section A of the attached form, has filed a claim for Supplemental Security Income disability payments based on HIV infection. **MEDICAL SOURCE:** Please detach this instruction sheet and use it to complete the attached form.

I. PURPOSE OF THIS FORM:
IF YOU COMPLETE AND RETURN THE ATTACHED FORM PROMPTLY, YOUR PATIENT MAY BE ABLE TO RECEIVE PAYMENTS WHILE WE ARE PROCESSING HIS OR HER CLAIM FOR ONGOING DISABILITY PAYMENTS.

This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Determination Services will contact you later to obtain further evidence needed to process your patient's claim.

II. WHO MAY COMPLETE THIS FORM:
A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

III. MEDICAL RELEASE:
An SSA medical release (an SSA-827) signed by your patient should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient.

IV. HOW TO COMPLETE THE FORM:
- If you receive the form from your patient and section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- **ALWAYS COMPLETE SECTION B.**
- **COMPLETE SECTION C, IF APPROPRIATE.** If you check at least one of the items in section C, go right to section E.
- **ONLY COMPLETE SECTION D IF YOU HAVE NOT CHECKED ANY ITEM IN SECTION C.** See the special information below which will help you to complete section D.
- **COMPLETE SECTION E IF YOU WISH TO PROVIDE COMMENTS ON YOUR PATIENT'S CONDITION(S).**
- **ALWAYS COMPLETE SECTIONS F AND G. NOTE: This form is not complete until it is signed.**

V. HOW TO RETURN THE FORM TO US:
- Mail the completed, signed form, as soon as possible, in the return envelope provided.
- If you received the form from your patient without a return envelope, give the completed, signed form back to your patient for return to the SSA field office.

VI. SPECIAL INFORMATION TO HELP YOU COMPLETE SECTION D
HOW WE USE SECTION D:
- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to a "marked" degree in any of the areas listed. See below for an explanation of the term "marked."

SPECIAL TERMS USED IN SECTION D

WHAT WE MEAN BY "REPEATED" MANIFESTATIONS OF HIV INFECTION: *(See Item 42.a)*

"Repeated" means that a condition or combination of conditions:

- Occurs an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; or
- Does not last for 2 weeks, but occurs substantially more frequently than 3 times in a year or once every 4 months; or
- Occurs less often than an average of 3 times a year or once every 4 months but lasts substantially longer than 2 weeks.

WHAT WE MEAN BY "MANIFESTATIONS OF HIV INFECTION": *(See Item 42.a)*

- "Manifestations of HIV infection" may include:

  Any condition listed in section C, but without the findings specified there (e.g., carcinoma of the cervix not meeting the criteria shown in item 22 of the form, diarrhea not meeting the criteria shown in item 33 of the form); or any other condition that is not listed in section C (e.g., oral hairy leukoplakia, myositis).

- Manifestations of HIV must result in significant, documented, symptoms and signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

Continued on the reverse →

WHAT WE MEAN BY "MARKED" LIMITATION OR RESTRICTION IN FUNCTIONING: *(See Item 42.b)*

- When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or in a nursing home.

- A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively.

WHAT WE MEAN BY "ACTIVITIES OF DAILY LIVING": *(See Item 42.b)*

- Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills.

- **EXAMPLE:** An individual with HIV infection who, because of symptoms such as pain, imposed by the illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

WHAT WE MEAN BY "SOCIAL FUNCTIONING": *(See Item 42.b)*

- Social functioning includes the capacity to interact appropriately and communicate effectively with others.

- **EXAMPLE:** An individual with HIV infection who, because of symptoms or a pattern of exacerbation and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to communicate with close friends or relatives) would have marked difficulty maintaining social functioning.

WHAT WE MEAN BY "COMPLETING TASKS IN A TIMELY MANNER": *(See Item 42.b)*

- Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings.

- **EXAMPLE:** An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able to do routine activities of daily living) would have marked difficulty completing tasks.

PRIVACY ACT AND PAPERWORK REDUCTION ACT STATEMENTS:

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1633(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security Programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

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

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

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 10 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED SSA-4815-F6
(Medical Report On Child With Allegation Of Human Immunodeficiency Virus (HIV) Infection)

A claim has been filed for your patient, identified in section A of the attached form, for Supplemental Security Income disability payments based on HIV infection. **MEDICAL SOURCE:** Please detach this instruction sheet and use it to complete the attached form.

I. PURPOSE OF THIS FORM:

IF YOU COMPLETE AND RETURN THE ATTACHED FORM PROMPTLY, YOUR PATIENT MAY BE ABLE TO RECEIVE PAYMENTS WHILE WE ARE PROCESSING HIS OR HER CLAIM FOR ONGOING DISABILITY PAYMENTS.

This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Determination Services will contact you later to obtain further evidence needed to process your patient's claim.

II. WHO MAY COMPLETE THIS FORM:

A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

III. MEDICAL RELEASE:

An SSA medical release (an SSA-827) signed by your patient's parent or guardian should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient's parent or guardian.

IV. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient's parent or guardian and section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- **ALWAYS COMPLETE SECTION B.**
- **COMPLETE SECTION C, IF APPROPRIATE.** If you check at least one of the items in section C, go right to section E.
- **ONLY COMPLETE SECTION D IF YOU HAVE NOT CHECKED ANY ITEM IN SECTION C.** See the special information below which will help you to complete section D.
- **COMPLETE SECTION E IF YOU WISH TO PROVIDE COMMENTS ON YOUR PATIENT'S CONDITION(S).**
- **ALWAYS COMPLETE SECTIONS F AND G. NOTE: This form is not complete until it is signed.**

V. HOW TO RETURN THE FORM TO US:

- Mail the completed, signed form, as soon as possible, in the return envelope provided.
- If you received the form from your patient without a return envelope, give the completed, signed form back to your patient's parent or guardian for return to the SSA field office.

VI. SPECIAL INFORMATION TO HELP YOU COMPLETE SECTION D

HOW WE USE SECTION D:

- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected. Complete only the areas of functioning applicable to the child's age group.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to the extent described.
- For children age 3 to attainment of age 18, the child must have a "marked" restriction of functioning in two areas to be eligible for these payments. See below for an explanation of the term "marked."

SPECIAL TERMS USED IN SECTION D

WHAT WE MEAN BY "MANIFESTATIONS OF HIV INFECTION": *(See item 48.a)*

"Manifestations of HIV infection" may include:

Any condition listed in section C, but without the findings specified there (e.g., oral candidiasis not meeting the criteria show in item 27 of the form, diarrhea not meeting the criteria shown in item 38 of the form); or any other condition that is not listed in section C (e.g., oral hairy leukoplakia, hepatomegaly).

Continued on the reverse →

WHAT WE MEAN BY "MARKED" : *(See Item 48.d - Applies only to Children Age 3 to 18)*

- When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or placed in a residential treatment facility.

- A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively in an age-appropriate manner.

PRIVACY ACT AND PAPERWORK REDUCTION ACT STATEMENTS:

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1633(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security Programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

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

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

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