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'S 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** involving the esophagus, trachea, bronchi, or lungs, or at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes
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**
14. ☐ **PNEUMOCYSTIS PNEUMONIA OR EXTRAPULMONARY PNEUMOCYSTIS INFECTION**

PROTOZOAN OR HELMINTHIC INFECTIONS

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

VIRAL INFECTIONS

18. ☐ **CYTOMEGALOVIRUS DISEASE**, at a site other than the liver, spleen, or lymph nodes
19. ☐ **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
20. ☐ **HERPES ZOSTER**, disseminated or with multidermatomal eruptions that are resistant to treatment

21. ☐ PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY

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

MALIGNANT NEOPLASMS

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

24. ☐ **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

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

26. ☐ **SQUAMOUS CELL CARCINOMA OF THE ANAL CANAL OR ANAL MARGIN**

SKIN OR MUCOUS MEMBRANES

27. ☐ **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

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

29. ☐ **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

30. ☐ **THROMBOCYTOPENIA**, with platelet counts of 40,000/mm^3 or less despite prescribed therapy, or recurrent upon withdrawal of treatment; or 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 MANIFESTATIONS OF HIV INFECTION (e.g., HIV ENCEPHALOPATHY, PERIPHERAL NEUROPATHY) RESULTING IN:

31. ☐ **LOSS OF PREVIOUSLY ACQUIRED, OR MARKED DELAY IN ACHIEVING, DEVELOPMENTAL MILESTONES OR INTELLECTUAL ABILITY** (including the sudden onset of a new learning disability)

32. ☐ **IMPAIRED BRAIN GROWTH** (acquired microcephaly or brain atrophy)

33. ☐ **PROGRESSIVE MOTOR DYSFUNCTION** affecting gait and station or fine and gross motor skills

GROWTH DISTURBANCE WITH:

34. ☐ **INVOLUNTARY WEIGHT LOSS (OR FAILURE TO GAIN WEIGHT AT AN APPROPRIATE RATE FOR AGE) RESULTING IN A FALL OF 15 PERCENTILES** from established growth curve (on standard growth charts) that persists for 2 months or longer

35. ☐ **INVOLUNTARY WEIGHT LOSS (OR FAILURE TO GAIN WEIGHT AT AN APPROPRIATE RATE FOR AGE) RESULTING IN A FALL TO BELOW THE THIRD PERCENTILE** from established growth curve (on standard growth charts) that persists for 2 months or longer

36. ☐ **INVOLUNTARY WEIGHT LOSS GREATER THAN 10 PERCENT OF BASELINE** that persists for 2 months or longer

37. ☐ **GROWTH IMPAIRMENT**, with fall of greater than 15 percentiles in height which is sustained; or fall to, or persistence of, height below the third percentile

DIARRHEA

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

CARDIOMYOPATHY

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

PULMONARY CONDITIONS

40. ☐ **LYMPHOID INTERSTITIAL PNEUMONIA/PULMONARY LYMPHOID HYPERPLASIA** (LIP/PLH complex), with respiratory symptoms that significantly interfere with age-appropriate activities, and that cannot be controlled by prescribed treatment

NEPHROPATHY

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

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

42. ☐ **SEPSIS**

43. ☐ **MENINGITIS**

44. ☐ **PNEUMONIA** (non-PCP)

45. ☐ **SEPTIC ARTHRITIS**

46. ☐ **ENDOCARDITIS**

47. ☐ **SINUSITIS**, radiographically documented

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

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

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

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FOR OFFICIAL USE ONLY

☐ **FIELD OFFICE DISPOSITION:**

☐ **DISABILITY DETERMINATION SERVICES DISPOSITION:**

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 compared to children the same age who do not have impairments.

See revised Privacy Act and Paperwork Reduction Act Statements below.

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 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 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, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), and 1633(e)(1) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to make a determination on a claimant's disability claim.

The information you furnish on this form is voluntary. However, failure to provide the requested information could prevent an accurate or timely decision on the named individual's disability claim.

We rarely use the information you supply for any purpose other than for determining eligibility. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an 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 Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state and local level; and

4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.ssa.gov or at your local Social Security office.

The following revised PRA Statement will be inserted into the form at its next scheduled reprinting:

Paperwork Reduction Act Statement - 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 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 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to*: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***