SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0662

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

NAME OF INDIVIDUAL **SOCIAL SECURITY NUMBER**

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INSTRUCTIONS:
Please assist us in determining this individual's ability to do work-related activities on a sustained basis. "Sustained basis" means the ability to perform work-related activities eight hours a day for five days a week, or an equivalent work schedule. (SSR 96-8p). 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, respond to the questions about the individual's ability to perform the activity. When doing so, use the following definitions for the rating terms:

- None - Absent or minimal limitations. If limitations are present they are transient and/or expected reactions to psychological stresses.
- Mild - There is a slight limitation in this area, but the individual can generally function well.
- Moderate - There is more than a slight limitation in this area but the individual is still able to function satisfactorily.
- Marked - There is serious limitation in this area. There is a substantial loss in the ability to effectively function.
- Extreme - There is major limitation in this area. There is no useful ability to function in this area.

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 restriction for the following work-related mental activities.

	None	Mild	Moderate	Marked	Extreme
Understand and remember simple instructions.	☐	☐	☐	☐	☐
Carry out simple instructions.	☐	☐	☐	☐	☐
The ability to make judgments on simple work-related decisions.	☐	☐	☐	☐	☐
Understand and remember complex instructions.	☐	☐	☐	☐	☐
Carry out complex instructions.	☐	☐	☐	☐	☐
The ability to make judgments on complex work-related decisions.	☐	☐	☐	☐	☐

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

(2.) Is ability to interact appropriately with supervisors, co-workers, and and the public, as well as respond to changes in a routine 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 restriction for the following work-related mental activities.

	None	Mild	Moderate	Marked	Extreme
Interact appropriately with the public.	☐	☐	☐	☐	☐
Interact appropriately with supervisor(s).	☐	☐	☐	☐	☐
Interact appropriately with co-workers.	☐	☐	☐	☐	☐
Respond appropriately to usual work situations and to changes in a routine work setting.	☐	☐	☐	☐	☐
Respond appropriately to changes in a routine work setting.	☐	☐	☐	☐	☐

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

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

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

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

(4) The limitations above are assumed to be your opinion regarding current limitations only.

However, if you have sufficient information to form an opinion within a reasonable degree of medical or psychological probability as to past limitations, on what date were the limitations you found above first present? _____

(5) If the claimant's impairment(s) include alcohol and/or substance abuse, do these impairments contribute to any of the claimant's limitations as set forth above? If so, please identify and explain what changes you would make to your answers if the claimant was totally abstinent from alcohol and/or substance use/abuse.

(6) Can the individual manage benefits in his/her own best interest? ☐ No ☐ Yes

Signature

Date

Print Name, Title and Medical Specialty (Legibly Please)

PRIVACY ACT STATEMENT: See revised Privacy Act Statement below.

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d), 1614(a)(3)(H)(I) and 1631(d)(1) of the Social Security Act. The information on this form is needed by Social Security to complete processing of the named patient's claim. While giving us the information on this form is voluntary, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim. Although the information you furnish on this form is almost never used for any purpose other than making a determination about disability, such information may be disclosed by Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange information between Social Security and another agency.

Explanations about these and other reasons why information about you 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: See revised Paperwork Reduction Act below.

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 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 15 minutes to read the instructions, gather the facts, and answer the questions. *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.**

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Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a)(3)(H)(I) and 1631(d)(1) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to complete processing of the named patient's claim.

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

We rarely use the information you supply for any purpose other than for determining eligibility for benefits. 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.

Revised Paperwork Reduction Act Statement – OHA Forms

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