Schizophrenia Presumptive Disability Recommendation Form

The claimant named below has filed for a period of disability and/or disability payments due to schizophrenia or schizoaffective disorder. If you complete this form, the claimant 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," is 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 mental health/chemical dependency.**

Claimant Signature (Required only if Form SSA-827 is NOT attached)	**Date**

Claimant Information

Name (Please Print)	**Claimant's SSN**	**Phone Number**
Address	**Date of Birth**	**Medical Source's Name**

For Presumptive Disability, the claimant's condition must meet the criteria noted in Section 1 or Section 2. Please check all applicable boxes.

Section 1 (Must meet criteria in Group A and Group B)

Group A

Medically documented persistence, either continuous or intermittent, of <u>one</u> or more of the following:

☐ Delusions or hallucinations

☐ Catatonic or other grossly disorganized behavior

☐ Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
   a. Blunt affect
   b. Flat affect
   c. Inappropriate affect

☐ Emotional withdrawal and/or isolation

Group B

Resulting in at least <u>two</u> of the following:

☐ Marked restriction of activities of daily living

☐ Marked difficulties in maintaining social functioning

☐ Marked difficulties in maintaining concentration, persistence, or pace

☐ Repeated episodes of decompensation, each of extended duration

Section 2

Medically documented history of a chronic schizophrenic, paranoid, or other psychotic 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 <u>one</u> of the following:

☐ Repeated episodes of decompensation, each of extended duration; or

☐ 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

☐ 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.

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Remarks: (Please use this space if you lack sufficient room in the above sections or to provide additional information that you believe would support a presumptive disability finding.)

Diagnostic Certification (Required)	
☐ **The claimant is *capable* of managing benefits.**	☐ **The claimant is *incapable* of managing benefits.**
☐ **The disturbance is *not* due to the direct physiological effects of substance use or a general medical condition, or due to a psychiatric condition other than *schizophrenia* or *schizoaffective disorder*. Supporting medical evidence will be forwarded to the disability adjudicative component.**	
☐ **I declare under penalty of perjury that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**	
Physician or Licensed Psychologist Name (Please Print)	**License Number**
Address	**Phone Number**
Signature	**Date**

Please provide all evidence necessary (i.e., medical records, psychiatric evaluation reports, list of prescribed psychotropic medication, and so forth) to support a diagnosis of schizophrenia or schizoaffective disorder.

Field Office Use Only	
Meets Presumptive Disability Criteria: ☐ **YES** ☐ **NO**	**Field Office Unit:**

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SPECIAL TERMS USED IN THE FORM

WHAT WE MEAN BY "MARKED"

Where we use "marked" as a standard for measuring the degree of limitation, it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired, or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the individual's ability to function independently, appropriately, effectively, and on a sustained basis.

WHAT WE MEAN BY "ACTIVITIES OF DAILY LIVING"

"Activities of daily living" include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for your grooming and hygiene, using telephones and directories, and using a post office. In the context of an overall situation, we assess the quality of these activities by their independence, appropriateness, effectiveness, and sustainability. We will determine the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

WHAT WE MEAN BY "SOCIAL FUNCTIONING"

"Social functioning" refers to the capacity to interact independently, appropriately, effectively, and on a sustained basis with other individuals. Social functioning includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. The individual may demonstrate impaired social functioning by, for example, a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. The individual may exhibit strength in social functioning by such things as his or her ability to initiate social contacts with others, communicate clearly with others, or interact and actively participate in group activities. We also need to consider cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority (e.g., supervisors), or cooperative behaviors involving coworkers.

WHAT WE MEAN BY "CONCENTRATION, PERSISTENCE OR PACE"

"Concentration, persistence or pace" refers to the ability to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings. Limitations in concentration, persistence, or pace are best observed in work settings, but may also be reflected by limitations in other settings. In addition, major limitations in this area can often be assessed through clinical examination or psychological testing. Wherever possible, however, a mental status examination or psychological test data should be supplemented by other available evidence.

WHAT WE MEAN BY "REPEATED EPISODES OF DECOMPENSATION"

"Episodes of decompensation" are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two). Episodes of

decompensation may be inferred from medical records showing significant alteration in medication; or documentation of the need for a more structured psychological support system (e.g., hospitalizations, placement in a halfway house, or a highly structured and directing household); or other relevant information in the record about the existence, severity, and duration of the episode.

The term "repeated episodes of decompensation, each of extended duration" means three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks. If the individual experiences more frequent episodes of shorter duration or less frequent episodes of longer duration, we use judgment to determine if the duration and functional effects of the episodes are of equal severity. [Comment: Although this reflects what the regulations state in section 12.00C.4 of the Listings, the statement probably isn't particularly helpful to a medical source. You should translate it into something that the source can provide evidence on, such as by adding a sentence that says "You should also let us know if the individual's episodes do not last for 2 weeks, but occur substantially more frequently than 3 times in a year or once every 4 months, or if they occur less often than an average of 3 times a year or once every 4 months, but last substantially longer than 2 weeks." This language reflects what is on the HIV PD form under the definition of "repeated."]

WHAT WE MEAN BY "BASIC WORK ACTIVITIES"

"Basic work activities" are the abilities and aptitudes necessary to do most jobs. Examples include: (1) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (2) capacities for seeing, hearing, and speaking; (3) understanding, carrying out, and remembering simple instructions; (4) use of judgment; (5) responding appropriately to supervision, coworkers, and usual work situations; and (6) dealing with changes in a routine work setting.

WHAT WE MEAN BY "MINIMAL LIMITATION OF ABILITY TO DO BASIC WORK ACTIVITIES"

A limitation is minimal if the impairment (or combination of impairments) has such a minimal effect on the individual that it would not be expected to interfere significantly with the individual's ability to do basic work activities.

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Privacy Act Statement
Collection and Use of Personal Information

Section 1110(b)(1) [42 U.S.C. § 1310(b)(1)] and 1631(a)(4)(B) [42 U.S.C. § 1383(a)(4)(B)] of the Social Security Act and 20 C.F.R. 416.933 authorize us to collect this information.
We will use the information you provide to make a determination on your, 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 your disability claim or on the named individual's disability claim.

We rarely use the information you provide on this consent form for any purpose other than for the reasons explained above. We also may 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 a congressional office in response to an inquiry from that office made at the request of the subject of a record.

2. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

3. To comply with Federal laws requiring the release of information from Social Security records to other agencies (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs); and

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

A complete list of routine uses for this information is available in our System of Records Notice entitled, Disability Insurance and Supplemental Security Income Demonstration Projects and Experiments System, 60-0218. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at any Social Security office.

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 (OMB) control number. The OMB control number for this information collection is 0960-XXXX. We estimate that it will take about 10 minutes to review this form, learn the facts about this new program, and ask any questions you may have. *You may send comments on our time estimate above to*: Social Security Administration, *6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***