Form Approved
OMB No . 0960 - 0500

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

FO 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** 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
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**
13. ☐ **PNEUMOCYSTIS PNEUMONIA OR EXTRAPULMONARY PNEUMOCYSTIS INFECTION**

PROTOZOAN OR HELMINTHIC INFECTIONS

14. ☐ **CRYPTOSPORIDIOSIS, ISOSPORIASIS, OR MICROSPORIDIOSIS,** with diarrhea lasting for 1 month or longer
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**

SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting:

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. We will use the information you provide to make a determination of eligibility for Social Security benefits.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

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

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled, Claims Folders System; and, 60-0103, entitled, Supplemental Security Income Record and Special Veterans Benefits. Additional information about these and other system of records notices and our programs is available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

SSA will insert the following revised PRA Statement 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 (OMB) control number. The OMB control number for this collection is 0960-0500. We estimate that it will take between 10 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

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 ANAL CANAL OR ANAL MARGIN**

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., severe fatigue, fever, malaise, involuntary weight loss, pain, night sweats, nausea, vomiting, headaches, or insomnia).

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 limitation of **ACTIVITIES OF DAILY LIVING;** or

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

☐ Marked limitation 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

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. 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.

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, pancreatitis, hepatitis, peripheral neuropathy, glucose intolerance, muscle weakness, cognitive or other mental limitation).

- Manifestations of HIV must result in significant, documented, symptoms and signs (e.g., severe fatigue, fever, malaise, involuntary weight loss, pain, night sweats, nausea, vomiting, headaches, or insomnia).

Continued on the reverse

WHAT WE MEAN BY "MARKED" LIMITATION 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 limitation in 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 limitation in completing tasks.

~~Privacy Act Statement~~
~~Collection and Use of Personal Information~~

See Revised Privacy Act Statement and PRA

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

~~The information you furnish on this form is voluntary. However, failure to provide us with the requested information 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, including but 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.~~

~~A complete list of routine uses for this information is available in our System of Record Notice entitled, the Master Beneficiary Record (60-0090). Additional information about this and other systems of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local 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 collection is 0960-0500. We estimate that it will take between 10 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.***~~