

**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 - Able to function in this area independently, appropriately, effectively, and on a sustained basis.
- Mild - Functioning in this area independently, appropriately, effectively, and on a sustained basis is slightly limited.
- Moderate - Functioning in this area independently, appropriately, effectively, and on a sustained basis is fair.
- Marked - Functioning in this area independently, appropriately, effectively, and on a sustained basis is seriously limited.
- Extreme - Unable to function in this area independently, appropriately, effectively, and on a sustained basis.

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?

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.

☐ No ☐ Yes

	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 the public, as well as respond to changes in a routine work setting, affected by the impairment? 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. ☐ No ☐ Yes

	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.	☐	☐	☐	☐	☐

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 (such as the ability to concentrate, persist, or maintain pace and the ability to adapt or manage oneself) 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

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.

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 15 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.***