AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

MD 21235, within 60 days after receiving our notice refusing to give the donor's address. The request for review must include supporting information or evidence that the requirements of these rules have been met. If we do not furnish address information because an authorized person failed to comply with the confidentiality safeguards of paragraph (g) of this section, the State agency will have an opportunity to submit evidence that the authorized person is now in compliance. If we then determine, based on our review of the request for administrative review and the supporting evidence, that the authorized person meets the requirements of these rules, we will respond to the address request as provided in paragraph (e) of this section. If we determine on administrative review that the requirements have not been met, we will notify the State agency in writing of our decision. We will make our determination within 30 days after receiving the request for administrative review, unless we notify the State agency within this 30-day time period that we will need additional time. Our determination on the request for administrative review will give the findings of fact, the reasons for the decision, and what actions the State agency should take to ensure that it or the blood donation facility is in compliance with these rules.

(g) *Safeguards to ensure confidentiality of blood donor records.* We will require assurance that authorized persons have established and continue to maintain adequate safeguards to protect the confidentiality of both address information received from the Blood Donor Locator Service and related blood donor records. The authorized person must, to the satisfaction of the Secretary—

(1) Establish and maintain a system for standardizing records which includes the reasons for requesting the addresses of blood donors, dates of the requests, and any disclosures of address information;

(2) Store blood donors' addresses received from the Blood Donor Locator Service and all related blood donor records in a secure area or place that is physically safe from access by persons other than those whose duties and responsibilities require access;

(3) Restrict access to these records to authorized employees and officials who need them to perform their official duties related to notifying blood donors who are or may be infected with the human immunodeficiency virus that they may need medical care and treatment;

(4) Advise all personnel who will have access to the records of the confidential nature of the information, the safeguards required to protect the information, and the civil and criminal sanctions for unauthorized use or disclosure of the information;

(5) Destroy the address information received from the Blood Donor Locator Service, as well as any records established in connection with the request which indicate directly or indirectly the identity of the individual, after notifying or attempting to notify the donor at the address obtained from the Blood Donor Locator Service; and

(6) Upon request, report to us the procedures established and utilized to ensure the confidentiality of address information and related blood donor records. We reserve the right to make onsite inspections to ensure that these procedures are adequate and are being followed and to request such information as we may need to ensure that the safeguards required in this section are being met.

(h) *Unauthorized disclosure.* Any official or employee of the Federal Government, a State, or a blood donation facility who discloses blood donor information, except as provided for in this section or under a provision of law, will be subject to the same criminal penalty as provided in section 7213(a) of the Internal Revenue Code of 1986 for the unauthorized disclosure of tax information.

[56 FR 66565, Dec. 24, 1991; 57 FR 956, Jan. 9, 1992]

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950–)

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Subpart A—Introduction, General Provisions and Definitions

AUTHORITY: Secs. 203, 205(a), 216(j), and 702(a)(5) of the Social Security Act (42 U.S.C. 403, 405(a), 416(j), and 902(a)(5)).

§ 404.1 Introduction.

The regulations in this part 404 (Regulations No. 4 of the Social Security Administration) relate to the provisions of title II of the Social Security Act as amended on August 28, 1950, and as further amended thereafter. The regulations in this part are divided into 22 subparts:

(a) Subpart A contains provisions relating to general definitions and use of terms.

(b) Subpart B relates to quarters of coverage and insured status requirements.

(c) Subpart C relates to the computation and recomputation of the primary insurance amount.

(d) Subpart D relates to the requirements for entitlement to monthly benefits and to the lump-sum death payment duration of entitlement and benefit rates.

(e) Subpart E contains provisions relating to the reduction and increase of insurance benefits and to deductions from benefits and lump-sum death payments.

(f) Subpart F relates to overpayments, underpayments, waiver of adjustment or recovery of overpayments and liability of certifying officers.

(g) Subpart G relates to filing of applications and other forms.

(h) Subpart H relates to evidentiary requirements for establishing an initial and continuing right to monthly benefits and for establishing a right to lump-sum death payment. (Evidentiary requirements relating to disability are contained in subpart P.)

(i) Subpart I relates to maintenance and revision of records of wages and self-employment income.

(j) Subpart J relates to initial determinations, the administrative review process, and reopening of determinations and decisions.

(k) Subpart K relates to employment, wages, self-employment and self-employment income.

(l) Subpart L is reserved.

(m) Subpart M relates to coverage of employees of State and local Governments.

(n) Subpart N relates to benefits in cases involving veterans.

(o) Subpart O relates to the interrelationship of the old-age, survivors and disability insurance program with the railroad retirement program.

(p) Subpart P relates to the determination of disability or blindness.

(q) Subpart Q relates to standards, requirements and procedures for States making determinations of disability for the Secretary. It also sets out the Secretary's responsibilities in carrying out the disability determination function.

(r) Subpart R relates to the provisions applicable to attorneys and other individuals who represent applicants in connection with claims for benefits.

(s) Subpart S relates to the payment of benefits to individuals who are entitled to benefits.

(t) Subpart T relates to the negotiation and administration of totalization agreements between the United States and foreign countries.

(u) Subpart U relates to the selection of a representative payee to receive benefits on behalf of a beneficiary and to the duties and responsibilities of a representative payee.

(v) Subpart V relates to payments to State vocational rehabilitative agencies (or alternate participants) for vocational rehabilitation services.

[26 FR 7054, Aug. 5, 1961; 26 FR 7760, Aug. 19, 1961, as amended at 27 FR 4513, May 11, 1962; 28 FR 14492, Dec. 31, 1963; 51 FR 11718, Apr. 7, 1986]

§ 404.2 General definitions and use of terms.

(a) *Terms relating to the Act and regulations.* (1) *The Act* means the Social Security Act, as amended (42 U.S.C. Chapter 7).

(2) *Regulations 2* (20 CFR, 1938 ed., part 402) means the regulations approved July 20, 1937, as amended from time to time, relating to Federal old-age benefits under title II of the Social Security Act and amendments to such title effective prior to January 1, 1940.

(3) *Regulations 3* (20 CFR, 1961 ed., part 403) means the regulations approved May 21, 1940, as amended and supplemented from time to time, relating to Federal old-age and survivors benefits under title II of the Social Security Act and amendments to such title effective prior to January 1, 1951.

(4) *Internal Revenue Code of 1939* means the act approved February 10, 1939 (53 Stat. part 1), as amended.

(5) *Internal Revenue Code of 1954* means the act approved August 16, 1954 (68A Stat. 1), as amended.

(6) *Railroad Retirement Act* means the Railroad Retirement Act of 1937 (50 Stat. 307), as amended.

(7) *Section* means a section of the regulations in part 404 of this chapter unless the context indicates otherwise.

(b) *Secretary; Commissioner; Appeals Council; Administrative Law Judge defined.* (1) *Secretary* means the Secretary of Health and Human Services.

(2) *Commissioner* means the Commissioner of Social Security.

(3) *Appeals Council* means the Appeals Council of the Office of Hearings and Appeals in the Social Security Administration or such member or members thereof as may be designated by the Chairman.

(4) *Administrative Law Judge* means an Administrative Law Judge in the Office of Hearings and Appeals of the Social Security Administration.

(c) *Miscellaneous.* (1) *Certify,* when used in connection with the duty imposed on the Secretary by section 205(i) of the act, means that action taken by the Administration in the form of a written statement addressed to the Managing Trustee, setting forth the name and address of the person to whom payment of a benefit or lump sum, or any part thereof, is to be made, the amount to be paid, and the time at which payment should be made.

(2) *Benefit* means an old-age insurance benefit, disability insurance benefit, wife's insurance benefit, husband's insurance benefit, child's insurance benefit, widow's insurance benefit, widower's insurance benefit, mother's insurance benefit, father's insurance benefit, parent's insurance benefit, or special payment at age 72 under title II of the Act. (Lump sums, which are death payments under title II of the Act, are excluded from the term *benefit* as defined in this part to permit greater clarity in the regulations.)

(3) *Lump sum* means a lump-sum death payment under title II of the act or any person's share of such a payment.

(4) *Attainment of age.* An individual attains a given age on the first moment of the day preceding the anniversary of his birth corresponding to such age.

(5) *State,* unless otherwise indicated, includes (i) the District of Columbia, (ii) the Virgin Islands, (iii) the Commonwealth of Puerto Rico effective January 1, 1951, (iv) Guam and American Samoa, effective September 13, 1960, generally, and for purposes of sections 210(a) and 211 of the act effective after 1960 with respect to service performed after 1960, and effective for taxable years beginning after 1960 with respect to crediting net earnings from self-employment and self-employment income, and (v) the Territories of Alaska and Hawaii prior to January 3, 1959, and August 21, 1959, respectively when those territories acquired statehood.

(6) *United States,* when used in a geographical sense, includes, unless otherwise indicated, (i) the States, (ii) the Territories of Alaska and Hawaii prior to January 3, 1959, and August 21, 1959, respectively, when they acquired statehood, (iii) the District of Columbia, (iv) the Virgin Islands, (v) the Commonwealth of Puerto Rico effective January 1, 1951, and (vi) Guam and American Samoa, effective September 13, 1960, generally, and for purposes of sections 210(a) and 211 of the act, effective after 1960 with respect to service performed after 1960, and effective for taxable years beginning after 1960 with respect to crediting net earnings from

self-employment and self-employment income.

(7) Masculine gender includes the feminine, unless otherwise indicated.

(8) The terms defined in sections 209, 210, and 211 of the act shall have the meanings therein assigned to them.

[26 FR 7055, Aug. 5, 1961; 26 FR 7760, Aug. 19, 1961, as amended at 28 FR 1037, Feb. 2, 1963; 28 FR 14492, Dec. 31, 1963; 29 FR 15509, Nov. 19, 1964; 41 FR 32886, Aug. 6, 1976; 51 FR 11718, Apr. 7, 1986]

§ 404.3 General provisions.

(a) *Extent to which Regulations No. 3 (20 CFR, 1961 ed., part 403) remain in effect.* Regulations No. 3 of the Social Security Administration (20 CFR, 1961 ed., part 403) continue in effect with respect to old-age and survivors insurance benefits under title II of the Act for months prior to September 1950 (except with respect to additional deductions from such benefits under section 203(g) of the Act in effect prior to the Social Security Act Amendments of 1950); with respect to lump-sum death payments under title II of the Act where death occurred after 1939 and before September 1950; and with respect to determinations as to whether, under title II of the Act, services performed before 1951 constitute employment and remuneration paid before 1951 constitutes wages. Except as provided in this paragraph or as specifically incorporated into this part 404 by reference, Regulations No. 3 of the Social Security Administration (20 CFR, 1961 ed., part 403) are superseded by the regulations in this part 404.

(b) *Effect of cross references.* The cross references in the regulations in this part 404 to other portions of the regulations, when the word *see* is used, are made only for convenience and shall be given no legal effect.

(c) *Periods of limitation ending on nonwork days.* Pursuant to the provisions of section 216(j) of the act, effective September 13, 1960, where any provision of title II, or any provision of another law of the United States (other than the Internal Revenue Code of 1954) relating to or changing the effect of title II, or any regulation of the Secretary issued under title II, provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under this title or is necessary to establish or protect any rights under this title, and such period ends on a Saturday, Sunday or Federal legal holiday or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive Order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees either by statute or Executive Order. For purposes of this paragraph, the day on which a period ends shall include the final day of any extended period where such extension is authorized by law or by the Secretary pursuant to law. Such extension of any period of limitation does not apply to periods during which benefits may be paid for months prior to the month an application for such benefits is filed pursuant to § 404.621, or to periods during which an application for benefits may be accepted as such pursuant to § 404.620.

[26 FR 7055, Aug. 5, 1961, as amended at 29 FR 15509, Nov. 19, 1964; 51 FR 11718, Apr. 7, 1986]

Subpart B—Insured Status and Quarters of Coverage

AUTHORITY: Secs. 205(a), 212, 213, 214, 216, 217, 223, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 412, 413, 414, 416, 417, 423, and 902(a)(5)).

SOURCE: 45 FR 25384, Apr. 15, 1980, unless otherwise noted.

GENERAL

§ 404.101 Introduction.

(a) *Insured status.* This subpart explains what we mean when we say that a person has insured status under the social security program. It also describes how a person may become fully insured, currently insured or insured for disability benefits. Your insured status is a basic factor in determining if you are entitled to old-age or disability insurance benefits or to a period of disability. It is also a basic factor in determining if dependents' or survivors' insurance benefits or a lump-sum death payment are payable based on

your earnings record. If you are neither fully nor currently insured, no benefits are payable based on your earnings. (Subpart D of this part describes these benefits and the kind of insured status required for each.) In §§ 404.110 through 404.120 we tell how we determine if you are fully or currently insured. The rules for determining if you are insured for purposes of establishing a period of disability or becoming entitled to disability insurance benefits are in §§ 404.130 through 404.133. Whether you have the required insured status depends on the number of quarters of coverage (QCs) you have acquired.

(b) *QCs.* This subpart also sets out our rules on crediting you with QCs. QCs are used in determining insured status. In general, you are credited with QCs based on the wages you are paid and the self-employment income you derive during certain periods. (See subpart K of this part for a definition of *wages* and *self-employment income.*) Our rules on how and when you acquire a QC are contained in §§ 404.140 through 404.146.

§ 404.102 Definitions.

For the purpose of this subpart—

Act means the Social Security Act, as amended.

Age means how many years old you are. You reach a particular age on the day before your birthday. For example, if your sixty-second birthday is on July 1, 1979, you became age 62 on June 30, 1979.

Quarter or *calendar quarter* means a period of three calendar months ending March 31, June 30, September 30, or December 31 of any year.

We, our, or *us* means the Social Security Administration.

You or *your* means the worker whose insured status is being considered.

FULLY INSURED STATUS

§ 404.110 How we determine fully insured status.

(a) *General.* We describe how we determine the number of quarters of coverage (QCs) you need to be fully insured in paragraphs (b), (c), and (d) of this section. The table in § 404.115 may be used to determine the number of QCs you need to be fully insured under paragraph (b) of this section. We consider certain World War II veterans to have died fully insured (see § 404.111). We also consider certain employees of private nonprofit organizations to be fully insured if they meet special requirements (see § 404.112).

(b) *How many QCs you need to be fully insured.* (1) You need at least 6 QCs but not more than 40 QCs to be fully insured. A person who died before 1951 with at least 6 QCs is fully insured.

(2) You are fully insured for old-age insurance benefits if you have one QC (whenever acquired) for each calendar year elapsing after 1950 or, if later, after the year in which you became age 21, and before the year you reach retirement age, that is, before—

(i) The year you become age 62, if you are a woman;

(ii) The year you become age 62, if you are a man who becomes age 62 after 1974;

(iii) The year 1975, if you are a man who became age 62 in 1973 or 1974; or

(iv) The year you became age 65, if you are a man who became age 62 before 1973.

(3) A person who is otherwise eligible for survivor's benefits and who files an application will be entitled to benefits based on your earnings if you die fully insured. You will be fully insured if you had one QC (whenever acquired) for each calendar year elapsing after 1950 or, if later, after the year you became age 21, and before the earlier of the following years:

(i) The year you die; or

(ii) The year you reach retirement age as shown in paragraph (b)(2) of this section.

(c) *How a period of disability affects the number of QCs you need.* In determining the number of elapsed years under paragraph (b) of this section, we do not count as an elapsed year any year which is wholly or partly in a period of disability we established for you. For example, if we established a period of disability for you from December 5, 1975 through January 31, 1977, the three years, 1975, 1976 and 1977, would not be counted as elapsed years.

(d) *How we credit QCs for fully insured status based on your total wages before 1951*—(1) *General.* For purposes of paragraph (b) of this section, we may use

the following rules in crediting QCs based on your wages before 1951 instead of the rule in § 404.141(b)(1).

(i) We may consider you to have one QC for each $400 of your total wages before 1951, as defined in paragraph (d)(2) of this section, if you have at least 7 elapsed years as determined under paragraph (b)(2) or (b)(3) of this section; and the number of QCs determined under this paragraph plus the number of QCs credited to you for periods after 1950 make you fully insured.

(ii) If you file an application in June 1992 or later and you are not entitled to a benefit under § 404.380 or section 227 of the Act in the month the application is made, we may consider you to have at least one QC before 1951 if you have $400 or more total wages before 1951, as defined in paragraph (d)(2) of this section, provided that the number of QCs credited to you under this paragraph plus the number of QCs credited to you for periods after 1950 make you fully insured.

(2) *What are total wages before 1951.* For purposes of paragraph (d)(1) of this section, your total wages before 1951 include—

(i) Remuneration credited to you before 1951 on the records of the Secretary;

(ii) Wages considered paid to you before 1951 under section 217 of the Act (relating to benefits in case of veterans);

(iii) Compensation under the Railroad Retirement Act of 1937 before 1951 that can be credited to you under title II of the Social Security Act; and

(iv) Wages considered paid to you before 1951 under section 231 of the Act (relating to benefits in case of certain persons interned in the United States during World War II).

(e) *When your fully insured status begins.* You are fully insured as of the first day of the calendar quarter in which you acquire the last needed QC (see § 404.145).

[45 FR 25384, Apr. 15, 1980, as amended at 50 FR 36573, Sept. 9, 1985; 57 FR 23156, June 2, 1992]

§ 404.111 When we consider a person fully insured based on World War II active military or naval service.

We consider that a person, who was not otherwise fully insured, died fully insured if—

(a) The person was in the active military or naval service of the United States during World War II;

(b) The person died within three years after separation from service and before July 27, 1954; and

(c) The conditions in § 404.1350 that permit us to consider the person fully insured are met.

(d) The provisions of this section do not apply to persons filing applications after May 31, 1992, unless a survivor is entitled to benefits under section 202 of the Act based on the primary insurance amount of the fully insured person for the month preceding the month in which the application is made.

[45 FR 25384, Apr. 15, 1980, as amended at 57 FR 23157, June 2, 1992]

§ 404.112 When we consider certain employees of private nonprofit organiations to be fully insured.

If you are age 55 or over on January 1, 1984, and are on that date an employee of an organization described in § 404.1025(a) which does not have in effect a waiver certificate under section 3121(k) of the Code on that date and whose employees are mandatorily covered as a result of section 102 of Pub. L. 98–21, we consider you to be fully insured if you meet the following requirements:

Your age on January 1, 1984 is—	QC's acquired after Dec. 31, 1983
60 or over	6
59 or over but less than age 60	8
58 or over but less than age 59	12
57 or over but less than age 58	16
55 or over but less than age 57	20

[50 FR 36573, Sept. 9, 1985]

§ 404.115 Table for determining the quarters of coverage you need to be fully insured.

(a) *General.* You may use the following table to determine the number of

quarters of coverage (QCs) you need to be fully insured under § 404.110. Paragraphs (b) and (c) of this section tell you how to use this table.

Worker who reaches retirement age as described in § 404.110(b)(2)			Worker who dies before reaching retirement age as described in § 404.110(b)(2)		
Col. I—Date of birth	Col. II [1]				
	Men	Women	Col. III [2]—Year of death	Col. IV [3]	Col. V [4]—Age in year of death
Jan. 1, 1893 or earlier	6	6	[5] 1957	6	[6] 28
Jan. 2, 1893 to Jan. 1, 1894	7	6	1958	7	29
Jan. 2, 1894 to Jan. 1, 1895	8	6	1959	8	30
Jan. 2, 1895 to Jan. 1, 1896	9	6	1960	9	31
Jan. 2, 1896 to Jan. 1, 1897	10	7	1961	10	32
Jan. 2, 1897 to Jan. 1, 1898	11	8	1962	11	33
Jan. 2, 1898 to Jan. 1, 1899	12	9	1963	12	34
Jan. 2, 1899 to Jan. 1, 1900	13	10	1964	13	35
Jan. 2, 1900 to Jan. 1, 1901	14	11	1965	14	36
Jan. 2, 1901 to Jan. 1, 1902	15	12	1966	15	37
Jan. 2, 1902 to Jan. 1, 1903	16	13	1967	16	38
Jan. 2, 1903 to Jan. 1, 1904	17	14	1968	17	39
Jan. 2, 1904 to Jan. 1, 1905	18	15	1969	18	40
Jan. 2, 1905 to Jan. 1, 1906	19	16	1970	19	41
Jan. 2, 1906 to Jan. 1, 1907	20	17	1971	20	42
Jan. 2, 1907 to Jan. 1, 1908	21	18	1972	21	43
Jan. 2, 1908 to Jan. 1, 1909	22	19	1973	22	44
Jan. 2, 1909 to Jan. 1, 1910	23	20	1974	23	45
Jan. 2, 1910 to Jan. 1, 1911	24	21	1975	24	46
Jan. 2, 1911 to Jan. 1, 1912	24	22	1976	25	47
Jan. 2, 1912 to Jan. 1, 1913	24	23	1977	26	48
Jan. 2, 1913 to Jan. 1, 1914	24	24	1978	27	49
Jan. 2, 1914 to Jan. 1, 1915	25	25	1979	28	50
Jan. 2, 1915 to Jan. 1, 1916	26	26	1980	29	51
Jan. 2, 1916 to Jan. 1, 1917	27	27	1981	30	52
Jan. 2, 1917 to Jan. 1, 1918	28	28	1982	31	53
Jan. 2, 1918 to Jan. 1, 1919	29	29	1983	32	54
Jan. 2, 1919 to Jan. 1, 1920	30	30	1984	33	55
Jan. 2, 1920 to Jan. 1, 1921	31	31	1985	34	56
Jan. 2, 1921 to Jan. 1, 1922	32	32	1986	35	57
Jan. 2, 1922 to Jan. 1, 1923	33	33	1987	36	58
Jan. 2, 1923 to Jan. 1, 1924	34	34	1988	37	59
Jan. 2, 1924 to Jan. 1, 1925	35	35	1989	38	60
Jan. 2, 1925 to Jan. 1, 1926	36	36	1990	39	61
Jan. 2, 1926 to Jan. 1, 1927	37	37	[7] 1991	40	62
Jan. 2, 1927 to Jan. 1, 1928	38	38	.....	.....	.....
Jan. 2, 1928 to Jan. 1, 1929	39	39	.....	.....	.....
Jan. 2, 1929 or later	40	.....	.....	.....	

[1] Number of QCs required for fully insured status; living worker or worker who dies after reaching retirement age.
[2] Worker born before Jan. 2, 1930 who dies before reaching retirement age.
[3] Number of QCs required for fully insured status.
[4] Worker born Jan. 2, 1930 or later, who dies before reaching retirement age.
[5] Or earlier.
[6] Or younger.
[7] Or later.

(b) *Number of QCs you need.* The QCs you need for fully insured status are in column II opposite your date of birth in column I. If a worker dies before reaching retirement age as described in § 404.110(b)(2), the QCs needed for fully insured status are shown in column IV opposite—

(1) The year of death in column III, if the worker was born before January 2, 1930; or

(2) The age in the year of death in column V, if the worker was born after January 1, 1930.

(c) *How a period of disability affects the number of QCs you need.* If you had a period of disability established for you, it affects the number of QCs you need to be fully insured (see § 404.110(c)). For each year which is wholly or partly in a period of disability, subtract one QC from the number of QCs shown in the appropriate line and column of the

table as explained in paragraph (b) of this section.

CURRENTLY INSURED STATUS

§ 404.120 How we determine currently insured status.

(a) *What the period is for determining currently insured status.* You are currently insured if you have at least 6 quarters of coverage (QCs) during the 13-quarter period ending with the quarter in which you—

(1) Die;

(2) Most recently became entitled to disability insurance benefits; or

(3) Became entitled to old-age insurance benefits.

(b) *What quarters are not counted as part of the 13-quarter period.* We do not count as part of the 13-quarter period any quarter all or part of which is included in a period of disability established for you, except that the first and last quarters of the period of disability may be counted if they are QCs (see § 404.146(d)).

DISABILITY INSURED STATUS

§ 404.130 How we determine disability insured status.

(a) *General.* We have four different rules for determining if you are insured for purposes of establishing a period of disability or becoming entitled to disability insurance benefits. To have disability insured status, you must meet one of these rules and you must be fully insured (see § 404.132 which tells when the period ends for determining the number of quarters of coverage (QCs) you need to be fully insured).

(b) *Rule I—You must meet the 20/40 requirement.* You are insured in a quarter for purposes of establishing a period of disability or becoming entitled to disability insurance benefits if in that quarter—

(1) You are fully insured; and

(2) You have at least 20 QCs in the 40-quarter period (see paragraph (f) of this section) ending with that quarter.

(c) *Rule II—You become disabled before age 31.* You are insured in a quarter for purposes of establishing a period of disability or becoming entitled to disability insurance benefits if in that quarter—

(1) You have not become (or would not become) age 31;

(2) You are fully insured; and

(3) You have QCs in at least one-half of the quarters during the period ending with that quarter and beginning with the quarter after the quarter you became age 21; however—

(i) If the number of quarters during this period is an odd number, we reduce the number by one; and

(ii) If the period has less than 12 quarters, you must have at least 6 QCs in the 12-quarter period ending with that quarter.

(d) *Rule III—You had a period of disability before age 31.* You are insured in a quarter for purposes of establishing a period of disability or becoming entitled to disability insurance benefits if in that quarter—

(1) You are disabled again at age 31 or later after having had a prior period of disability established which began before age 31 and for which you were only insured under paragraph (c) of this section; and

(2) You are fully insured and have QCs in at least one-half the calendar quarters in the period beginning with the quarter after the quarter you became age 21 and through the quarter in which the later period of disability begins, up to a maximum of 20 QCs out of 40 calendar quarters; however—

(i) If the number of quarters during this period is an odd number, we reduce the number by one;

(ii) If the period has less than 12 quarters, you must have at least 6 QCs in the 12-quarter period ending with that quarter; and

(iii) No monthly benefits may be paid or increased under Rule III before May 1983.

(e) *Rule IV—You are statutorily blind.* You are insured in a quarter for purposes of establishing a period of disability or becoming entitled to disability insurance benefits if in that quarter—

(1) You are disabled by blindness as defined in § 404.1581; and

(2) You are fully insured.

(f) *How we determine the 40-quarter or other period.* In determining the 40-quarter period or other period in paragraph (b), (c), or (d) of this section, we do not count any quarter all or part of

which is in a prior period of disability established for you, unless the quarter is the first or last quarter of this period and the quarter is a QC. However, we will count all the quarters in the prior period of disability established for you if by doing so you would be entitled to benefits or the amount of the benefit would be larger.

[49 FR 28547, July 13, 1984, as amended at 55 FR 7313, Mar. 1, 1990]

§ 404.131 When you must have disability insured status.

(a) *For a period of disability.* To establish a period of disability, you must have disability insured status in the quarter in which you become disabled or in a later quarter in which you are disabled.

(b) *For disability insurance benefits.* (1) To become entitled to disability insurance benefits, you must have disability insured status in the first full month that you are disabled as described in § 404.1501(a), or if later—

(i) The 17th month (if you have to serve a waiting period described in § 404.315(d)) before the month in which you file an application for disability insurance benefits; or

(ii) The 12th month (if you do not have to serve a waiting period) before the month in which you file an application for disability insurance benefits.

(2) If you do not have disability insured status in a month specified in paragraph (b)(1) of this section, you will be insured for disability insurance benefits beginning with the first month after that month in which you do meet the insured status requirement and you also meet all other requirements for disability insurance benefits described in § 404.315.

§ 404.132 How we determine fully insured status for a period of disability or disability insurance benefits.

In determining if you are fully insured for purposes of paragraph (b), (c), (d), or (e) of § 404.130 on disability insured status, we use the fully insured status requirements in § 404.110, but apply the following rules in determining when the period of elasped years ends:

(a) If you are a woman, or a man born after January 1, 1913, the period of elapsed years in § 404.110(b) used in determining the number of quarters of coverage (QCs) you need to be fully insured ends as of the earlier of—

(1) The year you become age 62; or

(2) The year in which—

(i) Your period of disability begins;

(ii) Your waiting period begins (see § 404.315(d)); or

(iii) You become entitled to disability insurance benefits (if you do not have to serve a waiting period).

(b) If you are a man born before January 2, 1913, the period of elapsed years in § 404.110(b) used in determining the number of QCs you need to be fully insured ends as of the earlier of—

(1) The year 1975; or

(2) The year specified in paragraph (a)(2) of this section.

[45 FR 25384, Apr. 15, 1980, as amended at 49 FR 28547, July 13, 1984]

§ 404.133 When we give you quarters of coverage based on military service to establish a period of disability.

For purposes of establishing a period of disability only, we give you quarters of coverage (QCs) for your military service before 1957 (see subpart N of this part). We do this even though we may not use that military service for other purposes of title II of the Act because a periodic benefit is payable from another Federal agency based in whole or in part on the same period of military service.

QUARTERS OF COVERAGE

§ 404.140 What is a quarter of coverage.

(a) *General.* A quarter of coverage (QC) is the basic unit of social security coverage used in determining a worker's insured status. We credit you with QCs based on your earnings covered under social security.

(b) *How we credit QCs based on earnings before 1978 (General).* Before 1978, wages were generally reported on a quarterly basis and self-employment income was reported on an annual basis. For the most part, we credit QCs for calendar years before 1978 based on your quarterly earnings. For these years, as explained in § 404.141, we generally credit you with a QC for each calendar quarter in which you were

paid at least $50 in wages or were credited with at least $100 of self-employment income. Section 404.142 tells how self-employment income derived in a taxable year beginning before 1978 is credited to specific calendar quarters for purposes of § 404.141.

(c) *How we credit QCs based on earnings after 1977 (General).* After 1977, both wages and self-employment income are generally reported on an annual basis. For calendar years after 1977, as explained in § 404.143, we generally credit you with a QC for each part of your total covered earnings in a calendar year that equals the amount required for a QC in that year. Section 404.143 also tells how the amount required for a QC will be increased in the future as average wages increase. Section 404.144 tells how self-employment income derived in a taxable year beginning after 1977 is credited to specific calendar years for purposes of § 404.143.

(d) *When a QC is acquired and when a calendar quarter is not a QC (general).* Section 404.145 tells when a QC is acquired and § 404.146 tells when a calendar quarter cannot be a QC. These rules apply when we credit QCs under § 404.141 or § 404.143.

§ 404.141 How we credit quarters of coverage for calendar years before 1978.

(a) *General.* The rules in this section tell how we credit calendar quarters as quarters of coverage (QCs) for calendar years before 1978. We credit you with a QC for a calendar quarter based on the amount of wages you were paid and self-employment income you derived during certain periods. The rules in paragraphs (b), (c), and (d) of this section are subject to the limitations in § 404.146, which tells when a calendar quarter cannot be a QC.

(b) *How we credit QCs based on wages paid in, or self-employment income credited to, a calendar quarter.* We credit you with a QC for a calendar quarter in which—

(1) You were paid wages of $50 or more (see paragraph (c) of this section for an exception relating to wages paid for agricultural labor); or

(2) You were credited (under § 404.142) with self-employment income of $100 or more.

(c) *How we credit QCs based on wages paid for agricultural labor in a calendar year after 1954.* (1) We credit QCs based on wages for agricultural labor depending on the amount of wages paid during a calendar year for that work. If you were paid wages for agricultural labor in a calendar year after 1954 and before 1978, we credit you with QCs for calendar quarters in that year which are not otherwise QCs according to the following table.

If the wages paid to you in a calendar year for agricultural labor were	We credit you with	And assign: [1]
$400 or more	4 QCs	All.
At least $300 but less than $400.	3 QCs	Last 3.
At least $200 but less than $300.	2 QCs	Last 2.
At least $100 but less than $200.	1 QC	Last.
Less than $100	No QCs.	

[1] One QC to each of the following calendar quarters in that year.

(2) When we assign QCs to calendar quarters in a year as shown in the table in paragraph (c)(1) of this section, you might not meet (or might not meet as early in the year as otherwise possible) the requirements to be fully or currently insured, to be entitled to a computation or recomputation of your primary insurance amount, or to establish a period of disability. If this happens, we assign the QCs to different quarters in that year than those shown in the table if this assignment permits you to meet these requirements (or meet them earlier in the year). We can only reassign QCs for purposes of meeting these requirements.

(d) *How we credit QCs based on wages paid or self-employment income derived in a year.* (1) If you were paid wages in a calendar year after 1950 and before 1978 at least equal to the annual wage limitation in effect for that year as described in § 404.1027(a), we credit you with a QC for each quarter in that calendar year. If you were paid at least $3,000 wages in a calendar year before 1951, we credit you with a QC for each quarter in that calendar year.

(2) If you derived self-employment income (or derived self-employment income and also were paid wages) during a taxable year beginning after 1950 and before 1978 at least equal to the self-employment income and wage

limitation in effect for that year as described in § 404.1068(b), we credit you with a QC for each calendar quarter wholly or partly in that taxable year.

[45 FR 25384, Apr. 15, 1980; 45 FR 41931, June 23, 1980]

§ 404.142 How we credit self-employment income to calendar quarters for taxable years beginning before 1978.

In crediting quarters of coverage under § 404.141(b)(2), we credit any self-employment income you derived during a taxable year that began before 1978 to calendar quarters as follows:

(a) If your taxable year was a calendar year, we credit your self-employment income equally to each quarter of that calendar year.

(b) If your taxable year was not a calendar year (that is, it began on a date other than January 1, or was less than a calendar year), we credit your self-employment income equally—

(1) To the calendar quarter in which your taxable year ended; and

(2) To each of the next three or fewer preceding quarters that were wholly or partly in your taxable year.

§ 404.143 How we credit quarters of coverage for calendar years after 1977.

(a) *Crediting quarters of coverage (QCs).* For calendar years after 1977, we credit you with a QC for each part of the total wages paid and self-employment income credited (under § 404.144) to you in a calendar year that equals the amount required for a QC in that year. For example, if the total of your wages and self-employment income for a calendar year is more than twice, but less than 3 times, the amount required for a QC in that year, we credit you with only 2 QCs for the year. The rules for crediting QCs in this section are subject to the limitations in § 404.146, which tells when a calendar quarter cannot be a QC. In addition, we cannot credit you with more than four QCs for any calendar year. The amount of wages and self-employment income that you must have for each QC is—

(1) $250 for calendar year 1978; and

(2) For each calendar year after 1978, an amount determined by the Secretary for that year (on the basis of a formula in section 213(d)(2) of the Act which reflects national increases in average wages). The amount determined by the Secretary is published in the FEDERAL REGISTER on or before November 1 of the preceding year and included in the appendix to this subpart.

(b) *Assigning QCs.* We assign a QC credited under paragraph (a) of this section to a specific calendar quarter in the calendar year only if the assignment is necessary to—

(1) Give you fully or currently insured status;

(2) Entitle you to a computation or recomputation of your primary insurance amount; or

(3) Permit you to establish a period of disability.

§ 404.144 How we credit self-employment income to calendar years for taxable years beginning after 1977.

In crediting quarters of coverage under § 404.143(a), we credit self-employment income you derived during a taxable year that begins after 1977 to calendar years as follows:

(a) If your taxable year is a calendar year or begins and ends within the same calendar year, we credit your self-employment income to that calendar year.

(b) If your taxable year begins in one calendar year and ends in the following calendar year, we allocate proportionately your self-employment income to the two calendar years on the basis of the number of months in each calendar year which are included completely within your taxable year. We consider the calendar month in which your taxable year ends as included completely within your taxable year.

Example. For the taxable year beginning May 15, 1978, and ending May 14, 1979, your self-employment income is $1200. We credit 7/12 ($700) of your self-employment income to calendar year 1978 and 5/12 ($500) of your self-employment income to calendar year 1979.

§ 404.145 When you acquire a quarter of coverage.

If we credit you with a quarter of coverage (QC) for a calendar quarter under paragraph (b), (c), or (d) of § 404.141 for calendar years before 1978 or assign it to a specific calendar quarter under paragraph (b) of § 404.143 for

calendar years after 1977, you acquire the QC as of the first day of the calendar quarter.

§ 404.146 When a calendar quarter cannot be a quarter of coverage.

This section applies when we credit you with quarters of coverage (QCs) under § 404.141 for calendar years before 1978 and under § 404.143 for calendar years after 1977. We cannot credit you with a QC for—

(a) A calendar quarter that has not begun;

(b) A calendar quarter that begins after the quarter of your death;

(c) A calendar quarter that has already been counted as a QC; or

(d) A calendar quarter that is included in a period of disability established for you, unless—

(1) The quarter is the first or the last quarter of this period; or

(2) The period of disability is not taken into consideration (see § 404.320(a)).

APPENDIX TO SUBPART B OF PART 404—QUARTER OF COVERAGE AMOUNTS FOR CALENDAR YEARS AFTER 1978

This appendix shows the amount determined by the Secretary that is needed for a quarter of coverage for each year after 1978 as explained in § 404.143. We publish the amount as a Notice in the FEDERAL REGISTER on or before November 1 of the preceding year. The amounts determined by the Secretary are as follows:

Calendar year	Amount needed
1979	$260
1980	290
1981	310
1982	340
1983	370
1984	390
1985	410
1986	440
1987	460
1988	470
1989	500
1990	520
1991	540
1992	570

[45 FR 25384, Apr. 15, 1980, as amended at 52 FR 8247, Mar. 17, 1987; 57 FR 44096, Sept 24, 1992]

Subpart C—Computing Primary Insurance Amounts

AUTHORITY: Secs. 202(a), 205(a), 215, and 702(a)(5) of the Social Security Act (42 U.S.C. 402(a), 405(a), 415, and 902(a)(5)).

SOURCE: 47 FR 30734, July 15, 1982, unless otherwise noted.

GENERAL

§ 404.201 Introduction.

In this subpart we describe how we compute your primary insurance amount, which is the first step in finding your monthly social security benefit amount. Your primary insurance amount is the basic figure we use in finding the monthly benefit actually payable to you and to members of your family. For example, if you retire at age 65 or become disabled, your monthly benefit is equal to your primary insurance amount. In other situations, your benefit does not equal your primary insurance amount. For example, if you become entitled to old-age benefits before you reach age 65, your benefit is less than your primary insurance amount, as described in §§ 404.410 through 404.413. Benefits payable to members of your family are a specified percentage of your primary insurance amount. (See subpart D.) We explain how we automatically increase your primary insurance amount to keep it up to date with rises in the cost of living. We also explain how and when we recompute your primary insurance amount and how and when we recalculate your primary insurance amount. We have organized this subpart as follows:

(a) In §§ 404.210 through 404.212, we describe the average-indexed-monthly-earnings method we use for computing primary insurance amounts of workers who after 1978 reach age 62, or become disabled or die before age 62;

(b) In §§ 404.220 through 404.222, we describe the average-monthly-wage method we use for computing primary insurance amounts of workers who reach age 62, become disabled, or die before 1979;

(c) In §§ 404.230 through 404.233, we describe the guaranteed alternative method of computing primary insurance amounts that applies to people

who reach age 62 after 1978 but before 1984;

(d) In §§ 404.240 through 404.242, we describe a method of computing primary insurance amounts (called the old-start method) for people who had all or substantially all their social security earnings before 1951;

(e) In §§ 404.250 through 404.252, we describe special rules we apply in computing primary insurance amounts of people who had a period of disability at some time in their lives;

(f) In §§ 404.260 through 404.261, we describe how we compute the special minimum primary insurance amount for long-term, low-paid workers;

(g) In §§ 404.270 through 404.277, we describe how we automatically adjust primary insurance amounts to take account of rises in the cost of living;

(h) In §§ 404.280 through 404.287, we describe how and when we recompute primary insurance amounts to take into account additional earnings;

(i) In § 404.290, we describe how and when we recalculate primary insurance amounts; and

(j) Appendices I–VI contain material such as figures and formulas that we use in finding a primary insurance amount under various circumstances.

§ 404.202 Other regulations related to this subpart.

This subpart is related to several others. In subpart B of this part, we describe how you become insured for social security benefits as a result of your work in covered employment. In subpart D, we discuss the different kinds of social security benefits available—old-age and disability benefits for you and benefits for your dependents and survivors—the amount of the benefits, and the requirements you and your family must meet to qualify for them; your work status, your age, the size of your family, and other factors may affect the amount of the benefits for you and your family. Rules relating to deductions, reductions, and nonpayment of benefits we describe in subpart E. In subpart F of this part, we describe what we do when a recalculation or recomputation of your primary insurance amount (as described in this subpart) results in our finding that you and your family have been overpaid or underpaid. In subparts G and H of this part, we tell how to apply for benefits and what evidence is needed to establish entitlement to them. In subpart J of this part, we describe how benefits are paid. Then in subparts I, K, N, and O of this part, we discuss your earnings that are taxable and creditable for social security purposes (and how we keep records of them), and deemed military wage credits which may be used in finding your primary insurance amount.

§ 404.203 Definitions.

(a) *General definitions.* As used in this subpart—

Ad hoc increase in primary insurance amounts means an increase in primary insurance amounts enacted by the Congress and signed into law by the President.

Entitled means that a person has applied for benefits and has proven his or her right to them for a given period of time.

We, us, or *our* means the Social Security Administration or the Department of Health and Human Services.

You or *your* means the insured worker who has applied for benefits or a deceased insured worker on whose social security earnings record someone else has applied.

(b) *Other definitions.* To make it easier to find them, we have placed other definitions in the sections of this subpart in which they are used.

§ 404.204 Methods of computing primary insurance amounts—general.

(a) *General.* We compute most workers' primary insurance amounts under one of two major methods. There are, in addition, several special methods of computing primary insurance amounts which we apply to some workers. Your primary insurance amount is the highest of all those computed under the methods for which you are eligible.

(b) *Major methods.* (1) If after 1978 you reach age 62, or become disabled or die before age 62, we compute your primary insurance amount under what we call the *average-indexed-monthly-earnings* method, which is described in §§ 404.210 through 404.212. The earliest of the three dates determines the computation method we use.

(2) If before 1979 you reached age 62, became disabled, or died, we compute your primary insurance amount under what we call the *average-monthly-wage* method, described in §§ 404.220 through 404.222.

(c) *Special methods.* (1) Your primary insurance amount, computed under any of the special methods for which you are eligible as described in this paragraph, may be substituted for your primary insurance amount computed under either major method described in paragraph (b) of this section.

(2) If you reach age 62 during the period 1979–1983, your primary insurance amount is guaranteed to be the highest of—

(i) The primary insurance amount we compute for you under the average-indexed-monthly-earnings method;

(ii) The primary insurance amount we compute for you under the average-monthly-wage method, as modified by the rules described in §§ 404.230 through 404.233; or

(iii) The primary insurance amount computed under what we call the *old-start* method; as described in §§ 404.240 through 404.242.

(3) If you had all or substantially all of your social security earnings before 1951, we will also compute your primary insurance amount under what we call the *old-start* method.

(4) We compute your primary insurance amount under the rules in §§ 404.250 through 404.252, if—

(i) You were disabled and received social security disability insurance benefits sometime in your life;

(ii) Your disability insurance benefits were terminated because of your recovery or because you engaged in substantial gainful activity; and

(iii) You are, after 1978, re-entitled to disability insurance benefits, or entitled to old-age insurance benefits, or have died.

(5) In some situations, we use what we call a *special minimum* computation, described in §§ 404.260 through 404.261, to find your primary insurance amount. Computations under this method reflect long-term, low-wage attachment to covered work.

AVERAGE-INDEXED-MONTHLY EARNINGS METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

§ 404.210 Average-indexed-monthly-earnings method.

(a) *Who is eligible for this method.* If after 1978, you reach age 62, or become disabled or die before age 62, we will compute your primary insurance amount under the average-indexed-monthly-earnings method.

(b) *Steps in computing your primary insurance amount under the average-indexed-monthly-earnings method.* We follow these three major steps in computing your primary insurance amount:

(1) First, we find your *average indexed monthly earnings,* as described in § 404.211;

(2) Second, we find the *benefit formula* in effect for the year you reach age 62, or become disabled or die before age 62, as described in § 404.212; and

(3) Then, we apply that benefit formula to your average indexed monthly earnings to find your primary insurance amount, as described in § 404.212.

(4) Next, we apply any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that became effective in or after the year you reached age 62, unless you are receiving benefits based on the minimum primary insurance amount, in which case not all the increases may be applied, as described in § 404.277.

§ 404.211 Computing your average indexed monthly earnings.

(a) *General.* In this method, your social security earnings after 1950 are *indexed,* as described in paragraph (d) of this section, then averaged over the period of time you can reasonably have been expected to have worked in employment or self-employment covered by social security. (Your earnings before 1951 are not used in finding your average indexed monthly earnings.)

(b) *Which earnings may be used in computing your average indexed monthly earnings*—(1) *Earnings.* In computing your average indexed monthly earnings, we use wages, compensation, self-employment income, and deemed military wage credits (see §§ 404.1340 through 404.1343) that are creditable to

you for social security purposes for years after 1950.

(2) *Computation base years.* We use your earnings in your *computation base years* in finding your average indexed monthly earnings. All years after 1950 up to (but not including) the year you become entitled to old-age or disability insurance benefits, and through the year you die if you had not been entitled to old-age or disability benefits, are computation base years for you. The year you become entitled to benefits and following years may be used as computation base years in a recomputation if their use would result in a higher primary insurance amount. (See §§ 404.280 through 404.287.) However, years after the year you die may not be used as computation base years even if you have earnings credited to you in those years. Computation base years do not include years wholly within a period of disability unless your primary insurance amount would be higher by using the disability years. In such situations, we count all the years during the period of disability, even if you had no earnings in some of them.

(c) *Average of the total wages.* Before we compute your average indexed monthly earnings, we must first know the ''average of the total wages'' of all workers for each year from 1951 until the second year before you become eligible. The average of the total wages for years after 1950 are shown in appendix I. Corresponding figures for more recent years which have not yet been incorporated into this appendix are published in the FEDERAL REGISTER on or before November 1 of the succeeding year. ''Average of the total wages'' (or ''average wage'') means:

(1) For the years 1951 through 1977, four times the amount of average taxable wages that were reported to the Social Security Administration for the first calendar quarter of each year for social security tax purposes. For years prior to 1973, these average wages were determined from a sampling of these reports.

(2) For the years 1978 through 1990, all remuneration reported as wages on Form W–2 to the Internal Revenue Service for all employees for income tax purposes, divided by the number of wage earners. We adjusted those averages to make them comparable to the averages for 1951–1977. For years after 1977, the term includes remuneration for services not covered by social security and remuneration for covered employment in excess of that which is subject to FICA contributions.

(3) For years after 1990, all remuneration reported as wages on Form W–2 to the Internal Revenue Service for all employees for income tax purposes, including remuneration described in paragraph (c)(2) of this section, plus contributions to certain deferred compensation plans described in section 209(k) of the Social Security Act (also reported on Form W–2), divided by the number of wage earners. If both distributions from and contributions to any such deferred compensation plan are reported on Form W–2, we will include only the contributions in the calculation of the average of the total wages. We will adjust those averages to make them comparable to the averages for 1951–1990.

(d) *Indexing your earnings.* (1) The first step in indexing your social security earnings is to find the relationship (under paragraph (d)(2) of this section) between—

(i) The average wage of all workers in your computation base years; and

(ii) The average wage of all workers in your *indexing year.* As a general rule, your indexing year is the second year before the earliest of the year you reach age 62, or become disabled or die before age 62. However, your indexing year is determined under paragraph (d)(4) of this section if you die before age 62, your surviving spouse or surviving divorced spouse is first eligible for benefits after 1984, and the indexing year explained in paragraph (d)(4) results in a higher widow(er)'s benefit than results from determining the indexing year under the general rule.

(2) To find the relationship, we divide the average wages for your indexing year, in turn, by the average wages for each year beginning with 1951 and ending with your indexing year. We use the quotients found in these divisions to index your earnings as described in paragraph (d)(3) of this section.

(3) The second step in indexing your social security earnings is to multiply the actual year-by-year dollar amounts

of your earnings (up to the maximum amounts creditable, as explained in §§ 404.1047 and 404.1096 of this part) by the quotients found in paragraph (d)(2) of this section for each of those years. We round the results to the nearer penny. (The quotient for your indexing year is 1.0; this means that your earnings in that year are used in their actual dollar amount; any earnings after your indexing year that may be used in computing your average indexed monthly earnings are also used in their actual dollar amount.)

Example Ms. A reaches age 62 in July 1979. Her year-by-year social security earnings since 1950 are as follows:

Year	Earnings
1951	$3,200
1952	3,400
1953	3,300
1954	3,600
1955	3,700
1956	3,700
1957	4,000
1958	4,200
1959	4,400
1960	4,500
1961	2,800
1962	2,200
1963	0
1964	0
1965	3,700
1966	4,500
1967	5,400
1968	6,200
1969	6,900
1970	7,300
1971	7,500
1972	7,800
1973	8,200
1974	9,000
1975	9,900
1976	11,100
1977	9,900
1978	11,000

STEP 1

The first step in indexing Ms. A's earnings is to find the relationship between the general wage level in Ms. A's indexing year (1977) and the general wage level in each of the years 1951–1976. We refer to appendix I for average wage figures, and perform the following computations:

Year	I. 1977 general wage level	II. Nationwide average of the total wages	III. Column I divided by column II equals relationship
1951	$9,779.44	$2,799.16	3.4937053
1952	9,779.44	2,973.32	3.2890641
1953	9,779.44	3,139.44	3.1150269
1954	9,779.44	3,155.64	3.0990354
1955	9,779.44	3,301.44	2.9621741
1956	9,779.44	3,532.36	2.7685287
1957	9,779.44	3,641.72	2.6853904
1958	9,779.44	3,673.80	2.6619413
1959	9,779.44	3,855.80	2.5362934
1960	9,779.44	4,007.12	2.4405159
1961	9,779.44	4,086.76	2.3929568
1962	9,779.44	4,291.40	2.2788461
1963	9,779.44	4,396.64	2.2242986
1964	9,779.44	4,576.32	2.1369659
1965	9,779.44	4,658.72	2.0991689
1966	9,779.44	4,938.36	1.9803012
1967	9,779.44	5,213.44	1.8758133
1968	9,779.44	5,571.76	1.7551797
1969	9,779.44	5,893.76	1.6592871
1970	9,779.44	6,186.24	1.5808375
1971	9,779.44	6,497.08	1.5052054
1972	9,779.44	7,133.80	1.3708599
1973	9,779.44	7,580.16	1.2901364
1974	9,779.44	8,030.76	1.2177478
1975	9,779.44	8,630.92	1.1330704
1976	9,779.44	9,226.48	1.0599318
1977	9,779.44	9,779.44	1.0000000

STEP 2

After we have found these indexing quotients, we multiply Ms. A's actual year-by-year earnings by them to find her indexed earnings, as shown below:

Year	I. Actual earnings	II. Indexing quotient	III. Column I multiplied by column II equals indexed earnings
1951	$3,200	3.4937053	$11,179.86
1952	3,400	3.2890641	11,182.82
1953	3,300	3.1150269	10,279.59
1954	3,600	3.0990354	11,156.53
1955	3,700	2.9621741	10,960.04
1956	3,700	2.7685287	10,243.56
1957	4,000	2.6853904	10,741.56
1958	4,200	2.6619413	11,180.15
1959	4,400	2.5362934	11,159.69
1960	4,500	2.4405159	10,982.32
1961	2,800	2.3929568	6,700.28
1962	2,200	2.2788461	5,013.46
1963	0	2.2242986	0
1964	0	2.1369659	0
1965	3,700	2.0991689	7,766.92
1966	4,500	1.9803012	8,911.36
1967	5,400	1.8758133	10,129.39
1968	6,200	1.7551797	10,882.11
1969	6,900	1.6592871	11,449.08
1970	7,300	1.5808375	11,540.11
1971	7,500	1.5052054	11,289.04
1972	7,800	1.3708599	10,692.71
1973	8,200	1.2901364	10,579.12
1974	9,000	1.2177478	10,959.73
1975	9,900	1.1330704	11,217.40
1976	11,100	1.0599318	11,765.24
1977	9,900	1.0000000	9,900.00
1978	11,000	0	11,000.00

(4) We calculate your indexing year under this paragraph if you, the insured worker, die before reaching age

62, your surviving spouse or surviving divorced spouse is first eligible after 1984, and the indexing year calculated under this paragraph results in a higher widow(er)'s benefit than results from the indexing year calculated under the general rule explained in paragraph (d)(1)(ii). For purposes of this paragraph, the indexing year is never earlier than the second year before the year of your death. Except for this limitation, the indexing year is the earlier of—

(i) The year in which you, the insured worker, attained age 60, or would have attained age 60 if you had lived, and

(ii) The second year before the year in which the surviving spouse or the surviving divorced spouse becomes eligible for widow(er)'s benefits, i.e. has attained age 60, or is age 50–59 and disabled.

(e) *Number of years to be considered in finding your average indexed monthly earnings.* To find the number of years to be used in computing your average indexed monthly earnings—

(1) We count the years beginning with 1951, or (if later) the year you reach age 22, and ending with the earliest of the year before you reach age 62, become disabled, or die. Years wholly or partially within a period of disability (as defined in § 404.1501(b) of subpart P of this part) are not counted unless your primary insurance amount would be higher. In that case, we count all the years during the period of disability, even though you had no earnings in some of those years. These are your *elapsed years.* From your elapsed years, we then subtract up to 5 years, the exact number depending on the kind of benefits to which you are entitled. You cannot, under this procedure, have fewer than 2 benefit computation years.

(2) For computing old-age insurance benefits and survivors insurance benefits, we subtract 5 from the number of your elapsed years. See paragraphs (e)(3) and (4) of this section for the dropout as applied to disability benefits. This is the number of your *benefit computation years;* we use the same number of your computation base years (see paragraph (b)(2) of this section) in computing your average indexed monthly earnings. For benefit computation years, we use the years with the highest amounts of earnings after indexing. They may include earnings from years that were not indexed, and must include years of no earnings if you do not have sufficient years with earnings. You cannot have fewer than 2 benefit computation years.

(3) Where the worker is first entitled to disability insurance benefits (DIB) after June 1980, there is an exception to the usual 5 year dropout provision explained in paragraph (e)(2) of this section. (For entitlement before July 1980, we use the usual dropout.) We call this exception the *disability dropout.* We divide the elapsed years by 5 and disregard any fraction. The result, which may not exceed 5, is the number of dropout years. We subtract that number from the number of elapsed years to get the number of benefit computation years, which may not be fewer than 2. After the worker dies, the disability dropout no longer applies and we use the basic 5 dropout years to compute benefits for survivors. We continue to apply the disability dropout when a person becomes entitled to old-age insurance benefits (OAIB), unless his or her entitlement to DIB ended at least 12 months before he or she became eligible for OAIB. For first DIB entitlement before July 1980, we use the rule in paragraph (e)(2) of this section.

(4) For benefits payable after June 1981, the disability dropout might be increased by the *child care dropout.* If the number of disability dropout years is fewer than 3, we will drop out a benefit computation year for each benefit computation year that the worker meets the child care requirement and had no earnings, until the total of all dropout years is 3. The child care requirement for any year is that the worker must have been living with his or her child (or his or her spouse's child) substantially throughout any part of any calendar year that the child was alive and under age 3. In actual practice, no more than 2 child care years may be dropped, because of the combined effect of the number of elapsed years, 1-for-5 dropout years (if any), and the computation years required for the computation.

Example Ms. M., born August 4, 1953, became entitled to disability insurance benefits (DIB) beginning in July 1980 based on a disability which began January 15, 1980. In computing the DIB, we determined that the elapsed years are 1975 through 1979, the number of dropout years is 1 (5 elapsed years divided by 5), and the number of computation years is 4. Since Ms. M. had no earnings in 1975 and 1976, we drop out 1975 and use her earnings for the years 1977 through 1979.

Ms. M. lived with her child, who was born in 1972, in all months of 1973 and 1974 and did not have any earnings in those years. We, therefore, recompute Ms. M.'s DIB beginning with July 1981 to give her the advantage of the child care dropout. To do this, we reduce the 4 computation years by 1 child care year to get 3 computation years. Because the child care dropout cannot be applied to computation years in which the worker had earnings, we can drop only one of Ms. M.'s computation years, i.e., 1976, in addition to the year 1975 which we dropped in the initial computation.

(i) *Living with* means that you and the child ordinarily live in the same home and you exercise, or have the right to exercise, parental control. See § 404.366(c) for a further explanation.

(ii) *Substantially throughout any part of any calendar year* means that any period you were not living with the child during a calendar year did not exceed 3 months. If the child was either born or attained age 3 during the calendar year, the period of absence in the year cannot have exceeded the smaller period of 3 months, or one-half the time after the child's birth or before the child attained age 3.

(iii) *Earnings* means wages for services rendered and net earnings from self-employment minus any net loss for a taxable year. See § 404.429 for a further explanation.

(f) *Your average indexed monthly earnings.* After we have indexed your earnings and found your benefit computation years, we compute your average indexed monthly earnings by—

(1) Totalling your indexed earnings in your benefit computation years;

(2) Dividing the total by the number of months in your benefit computation years; and

(3) Rounding the quotient to the next lower whole dollar. if not already a multiple of $1.

Example. From the example in paragraph (d) of this section, we see that Ms. A reaches age 62 in 1979. Her elapsed years are 1951–1978 (28 years). We subtract 5 from her 28 elapsed years to find that we must use 23 benefit computation years. This means that we will use her 23 highest computation base years to find her average indexed monthly earnings. We exclude the 5 years 1961–1965 and total her indexed earnings for the remaining years, i.e., the benefit computation years (including her unindexed earnings in 1977 and 1978) and get $249,381.41. We then divide that amount by the 276 months in her 23 benefit computation years and find her average indexed monthly earnings to be $903.56, which is rounded down to $903.

[47 FR 30734, July 15, 1982; 47 FR 35479, Aug. 13, 1982, as amended at 48 FR 11695, Mar. 21, 1983; 51 FR 4482, Feb. 5, 1986; 57 FR 1381, Jan. 14, 1992]

§ 404.212 Computing your primary insurance amount from your average indexed monthly earnings.

(a) *General.* We compute your primary insurance amount under the average-indexed-monthly-earnings method by applying a *benefit formula* to your average indexed monthly earnings.

(b) *Benefit formula.* (1) We use the applicable benefit formula in appendix II for the year you reach age 62, become disabled, or die whichever occurs first. If you die before age 62, and your surviving spouse or surviving divorced spouse is first eligible after 1984, we may compute the primary insurance amount, for the purpose of paying benefits to your widow(er), as if you had not died but reached age 62 in the second year after the indexing year that we computed under the provisions of § 404.211(d)(4). We will not use this primary insurance amount for computing benefit amounts for your other survivors or for computing the maximum family benefits payable on your earnings record. Further, we will only use this primary insurance amount if it results in a higher widow(er)'s benefit than would result if we did not use this special computation.

(2) The dollar amounts in the benefit formula are automatically increased each year for persons who attain age 62, or who become disabled or die before age 62 in that year, by the same percentage as the increase in the average of the total wages (see appendix I).

(3) We will publish benefit formulas for years after 1979 in the FEDERAL REGISTER at the same time we publish

the average of the total wage figures. We begin to use a new benefit formula as soon as it is applicable, even before we periodically update appendix II.

(4) We may use a modified formula, as explained in § 404.213, if you are entitled to a pension based on your employment which was not covered by Social Security.

(c) *Computing your primary insurance amount from the benefit formula.* We compute your primary insurance amount by applying the benefit formula to your average indexed monthly earnings and adding the results for each step of the formula. For computations using the benefit formulas in effect for 1979 through 1982, we round the total amount to the next higher multiple of $0.10 if it is not a multiple of $0.10 and for computations using the benefit formulas effective for 1983 and later years, we round to the next lower multiple of $0.10. (See paragraph (e) of this section for a discussion of the minimum primary insurance amount.)

(d) *Adjustment of your primary insurance amount when entitlement to benefits occurs in a year after attainment of age 62, disability or death.* If you (or your survivors) do not become entitled to benefits in the same year you reach age 62, become disabled, or die before age 62, we compute your primary insurance amount by—

(1) Computing your average indexed monthly earnings as described in § 404.211;

(2) Applying to your average indexed monthly earnings the benefit formula for the year in which you reach age 62, or become disabled or die before age 62; and

(3) Applying to the primary insurance amount all automatic cost-of-living and *ad hoc* increases in primary insurance amounts that have gone into effect in or after the year you reached age 62, became disabled, or died before age 62. (See § 404.277 for special rules on minimum benefits, and appendix VI for a table of percentage increases in primary insurance amounts since December 1978. Increases in primary insurance amounts are published in the FEDERAL REGISTER and we periodically update appendix VI.)

(e) *Minimum primary insurance amount.* If you were eligible for benefits, or died without having been eligible, before 1982, your primary insurance amount computed under this method cannot be less than $122. This minimum benefit provision has been repealed effective with January 1982 for most workers and their families where the worker initially becomes eligible for benefits in that or a later month, or dies in January 1982 or a later month without having been eligible before January 1982. For members of a religious order who are required to take a vow of poverty, as explained in 20 CFR 404.1024, and which religious order elected Social Security coverage before December 29, 1981, the repeal is effective with January 1992 based on first eligibility or death in that month or later.

[47 FR 30734, July 15, 1982, as amended at 48 FR 46142, Oct. 11, 1983; 51 FR 4482, Feb. 5, 1986; 52 FR 47916, Dec. 17, 1987]

§ 404.213 Computation where you are eligible for a pension based on your noncovered employment.

(a) *When applicable.* Except as provided in paragraph (d) of this section, we will modify the formula prescribed in § 404.212 and in appendix II of this subpart in the following situations:

(1) You become eligible for old-age insurance benefits after 1985; or

(2) You become eligible for disability insurance benefits after 1985; and

(3) For the same months after 1985 that you are entitled to old-age or disability benefits, you are also entitled to a monthly pension(s) for which you first became eligible after 1985 based in whole or part on your earnings in employment which was not covered under Social Security.We consider you to first become eligible for a monthly pension in the first month for which you met all requirements for the pension except that you were working or had not yet applied. In determining whether you are eligible for a pension before 1986, we consider all applicable service used by the pension-paying agency. (Noncovered employment includes employment outside the United States which is not covered under the United States Social Security system. Pensions from noncovered employment outside the United States include both pensions from social insurance systems

that base benefits on earnings but not on residence or citizenship, and those from private employers. However, for benefits payable for months prior to January 1995, we will not modify the computation of a totalization benefit (see §§ 404.1908 and 404.1918) as a result of your entitlement to another pension based on employment covered by a totalization agreement. Beginning January 1995, we will not modify the computation of a totalization benefit in any case (see § 404.213(e)(8)).

(b) *Amount of your monthly pension that we use.* For purposes of computing your primary insurance amount, we consider the amount of your monthly pension(s) (or the amount prorated on a monthly basis) which is attributable to your noncovered work after 1956 that you are entitled to for the first month in which you are concurrently entitled to Social Security benefits. For applications filed before December 1988, we will use the month of earliest concurrent eligibility. In determining the amount of your monthly pension we will use, we will consider the following:

(1) If your pension is not paid on a monthly basis or is paid in a lump-sum, we will allocate it proportionately as if it were paid monthly. We will allocate this the same way we allocate lump-sum payments for a spouse or surviving spouse whose benefits are reduced because of entitlement to a Government pension. (See § 404.408a.)

(2) If your monthly pension is reduced to provide a survivor's benefit, we will use the unreduced amount.

(3) If the monthly pension amount which we will use in computing your primary insurance amount is not a multiple of $0.10, we will round it to the next lower multiple of $0.10.

(c) *How we compute your primary insurance amount.* When you become entitled to old-age or disability insurance benefits and to a monthly pension, we will compute your primary insurance amount under the average-indexed-monthly-earnings method (§ 404.212) as modified by paragraph (c)(1) and (2) of this section. Where applicable, we will also consider the 1977 simplified old-start method (§ 404.241) as modified by § 404.243 and a special minimum primary insurance amount as explained in §§ 404.260 and 404.261. We will use the highest result from these three methods as your primary insurance amount. We compute under the average-indexed-monthly-earnings method, and use the higher primary insurance amount resulting from the application of paragraphs (c) (1) and (2) of this section, as follows:

(1) The formula in appendix II, except that instead of the first percentage figure (i.e., 90 percent), we use—

(i) 80 percent if you initially become eligible for old-age or disability insurance benefits in 1986;

(ii) 70 percent for initial eligibility in 1987;

(iii) 60 percent for initial eligibility in 1988;

(iv) 50 percent for initial eligibility in 1989;

(v) 40 percent for initial eligibility in 1990 and later years, or

(2) The formula in appendix II minus one-half the portion of your monthly pension which is due to noncovered work after 1956 and for which you were entitled in the first month you were entitled to both Social Security benefits and the monthly pension. If the monthly pension amount is not a multiple of $0.10, we will round to the next lower multiple of $0.10. To determine the portion of your pension which is due to noncovered work after 1956, we consider the total number of years of work used to compute your pension and the percentage of those years which are after 1956, and in which your employment was not covered. We take that percentage of your total pension as the amount which is due to your noncovered work after 1956.

(d) *Alternate computation.* (1) If you have more than 20 but less than 30 years of coverage as defined in the column headed ''Alternate Computation Under § 404.213(d)'' in appendix IV of this subpart, we will compute your primary insurance amount using the applicable percentage given below instead of the first percentage in appendix II of this subpart if the applicable percentage below is larger than the percentage specified in paragraph (c) of this section:

(i) For benefits payable for months before January 1989—

Years of coverage	Percent
29	80
28	70
27	60
26	50

(ii) For benefits payable for months after December 1988—

Years of coverage	Percent
29	85
28	80
27	75
26	70
25	65
24	60
23	55
22	50
21	45

(2) If you later earn additional year(s) of coverage, we will recompute your primary insurance amount, effective with January of the following year.

(e) *Exceptions.* The computations in paragraph (c) of this section do not apply in the following situations:

(1) Payments made under the Railroad Retirement Act are not considered to be a pension from noncovered employment for the purposes of this section. See subpart O of this part for a discussion of railroad retirement benefits.

(2) You were entitled before 1986 to disability insurance benefits in any of the 12 months before you reach age 62 or again become disabled. (See § 404.251 for the appropriate computation.)

(3) You were a Federal employee performing service on January 1, 1984 to which Social Security coverage was extended on that date solely by reason of the amendments made by section 101 of the Social Security Amendments of 1983.

(4) You were an employee of a nonprofit organization who was exempt from Social Security coverage on December 31, 1983 unless you were previously covered under a waiver certificate which was terminated prior to that date..

(5) You have 30 years of coverage as defined in the column headed ''Alternate Computation Under § 404.213(d)'' in appendix IV of this subpart.

(6) Your survivors are entitled to benefits on your record of earnings. (After your death, we will recompute the primary insurance amount to nullify the effect of any monthly pension, based in whole or in part on noncovered employment, to which you had been entitled.)

(7) For benefits payable for months after December 1994, payments by the social security system of a foreign country which are based on a totalization agreement between the United States and that country are not considered to be a pension from noncovered employment for purposes of this section. See subpart T of this part for a discussion of totalization agreements.

(8) For benefits payable for months after December 1994, the computations in paragraph (c) do not apply in the case of an individual whose entitlement to U.S. social security benefits results from a totalization agreement between the United States and a foreign country.

(9) For benefits payable for months after December 1994, you are eligible after 1985 for monthly periodic benefits based wholly on service as a member of a uniformed service, including inactive duty training.

(f) *Entitlement to a totalization benefit and a pension based on noncovered employment.* If, before January 1995, you are entitled to a totalization benefit and to a pension based on noncovered employment that is not covered by a totalization agreement, we count your coverage from a foreign country with which the United States (U.S.) has a totalization agreement and your U.S. coverage to determine if you meet the requirements for the modified computation in paragraph (d) of this section or the exception in paragraph (e)(5) of this section.

(1) Where the amount of your totalization benefit will be determined using a computation method that does not consider foreign earnings (see § 404.1918), we will find your total years of coverage by adding your—

(i) Years of coverage from the agreement country (quarters of coverage credited under § 404.1908 divided by four) and

(ii) Years of U.S. coverage as defined for the purpose of computing the special minimum primary insurance amount under § 404.261.

(2) Where the amount of your totalization benefit will be determined using a computation method that does consider foreign earnings, we will credit your foreign earnings to your U.S. earnings record and then find your total years of coverage using the method described in § 404.261.

[52 FR 47916, Dec. 17, 1987, as amended at 55 FR 21382, May 24, 1990; 57 FR 22429, May 28, 1992; 60 FR 17444, Apr. 6, 1995; 60 FR 56513, Nov. 9, 1995]

AVERAGE-MONTHLY-WAGE METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

§ 404.220 Average-monthly-wage method.

(a) *Who is eligible for this method.* You must before 1979, reach age 62, become disabled or die to be eligible for us to compute your primary insurance amount under the average-monthly-wage method. Also, as explained in § 404.230, if you reach age 62 after 1978 but before 1984, you are eligible to have your primary insurance amount computed under a modified average-monthly-wage method if it is to your advantage. Being eligible for either the average-monthly-wage method or the modified average-monthly-wage method does not preclude your eligibility under the *old-start* method described in §§ 404.240 through 404.242.

(b) *Steps in computing your primary insurance amount under the average-monthly-wage method.* We follow these three major steps in computing your primary insurance amount under the average-monthly-wage method:

(1) First, we find your average monthly wage, as described in § 404.221;

(2) Second, we look at the *benefit table* in appendix III; and

(3) Then we find your primary insurance amount in the benefit table, as described in § 404.222.

(4) Finally, we apply any automatic cost-of-living or *ad hoc* increases that became effective in or after the year you reached age 62, or became disabled, or died before age 62, as explained in §§ 404.270 through 404.277.

§ 404.221 Computing your average monthly wage.

(a) *General.* Under the average-monthly-wage method, your social security earnings are averaged over the length of time you can reasonably have been expected to have worked under social security after 1950 (or after you reached age 21, if later).

(b) *Which of your earnings may be used in computing your average monthly wage.* (1) In computing your average monthly wage, we consider all the wages, compensation, self-employment income, and deemed military wage credits that are creditable to you for social security purposes. (The maximum amounts creditable are explained in §§ 404.1047 and 404.1096 of this part.)

(2) We use your earnings in your *computation base years* in computing your average monthly wage. All years after 1950 up to (but not including) the year you become entitled to old-age or disability insurance benefits, or through the year you die if you had not been entitled to old-age or disability benefits, are computation base years for you. Years after the year you die may not be used as computation base years even if you have earnings credited to you in them. However, years beginning with the year you become entitled to benefits may be used for benefits beginning with the following year if using them would give you a higher primary insurance amount. Years wholly within a period of disability are not computation base years unless your primary insurance amount would be higher if they were. In such situations, we count all the years during the period of disability, even if you had no earnings in some of them.

(c) *Number of years to be considered in computing your average monthly wage.* To find the number of years to be used in computing your average monthly wage—

(1) We count the years beginning with 1951 or (if later) the year you reached age 22 and ending with the year before you reached age 62, or became disabled, or died before age 62. Any part of a year—or years—in which you were disabled, as defined in § 404.1505, is not counted unless doing so

would give you a higher average monthly wage. In that case, we count all the years during the period of disability, even if you had no earnings in some of those years. These are your *elapsed years.* (If you are a male and you reached age 62 before 1975, see paragraph (c)(2) of this section for the rules on finding your elapsed years.)

(2) If you are a male and you reached age 62 in—

(i) 1972 or earlier, we count the years beginning with 1951 and ending with the year before you reached age 65, or became disabled or died before age 65 to find your elapsed years;

(ii) 1973, we count the years beginning with 1951 and ending with the year before you reached age 64, or became disabled or died before age 64 to find your elapsed years; or

(iii) 1974, we count the years beginning with 1951 and ending with the year before you reached age 63, became disabled, or died before age 63 to find your elapsed years.

(3) Then we subtract 5 from the number of your elapsed years. This is the number of your *benefit computation years*; we use the same number of your computation base years in computing your average monthly wage. For benefit computation years, we use the years with the highest amounts of earnings, but they may include years of no earnings. You cannot have fewer than 2 benefit computation years.

(d) *Your average monthly wage.* After we find your benefit computation years, we compute your average monthly wage by—

(1) Totalling your creditable earnings in your benefit computation years;

(2) Dividing the total by the number of months in your benefit computation years; and

(3) Rounding the quotient to the next lower whole dollar if not already a multiple of $1.

Example Mr. B reaches age 62 and becomes entitled to old-age insurance benefits in August 1978. He had no social security earnings before 1951 and his year-by-year social security earnings after 1950 are as follows:

1951	$2,700
1952	2,700
1953	3,400
1954	3,100
1955	4,000
1956	4,100
1957	4,000
1958	4,200
1959	4,800
1960	4,800
1961	4,800
1962	4,800
1963	4,800
1964	1,500
1965	0
1966	0
1967	0
1968	3,100
1969	5,200
1970	7,100
1971	7,800
1972	8,600
1973	8,900
1974	9,700
1975	10,100
1976	10,800
1977	11,900

We first find Mr. B's elapsed years, which are the 27 years 1951–1977. We subtract 5 from his 27 elapsed years to find that we must use 22 benefit computation years in computing his average monthly wage. His computation base years are 1951–1977, which are the years after 1950 and prior to the year he became entitled. This means that we will use his 22 computation base years with the highest earnings to compute his average monthly wage. Thus, we exclude the years 1964–1967 and 1951.

We total his earnings in his benefit computation years and get $132,700. We then divide that amount by the 264 months in his 22 benefit computation years and find his average monthly wage to be $502.65, which is rounded down to $502.

(e) *''Deemed'' average monthly wage for certain deceased veterans of World War II.* Certain deceased veterans of World War II are ''deemed'' to have an average monthly wage of $160 (see §§ 404.1340 through 404.1343 of this part) unless their actual average monthly wage, as found in the method described in paragraphs (a) through (d) of this section is higher.

§ 404.222 Use of benefit table in finding your primary insurance amount from your average monthly wage.

(a) *General.* We find your primary insurance amount under the average-monthly-wage method in the benefit table in appendix III.

(b) *Finding your primary insurance amount from benefit table.* We find your average monthly wage in column III of the table. Your primary insurance amount appears on the same line in column IV (column II if you are entitled to benefits for any of the 12 months preceding the effective month in column IV). As explained in

§ 404.212(e), there is a minimum primary insurance amount of $122 payable for persons who became eligible or died after 1978 and before January 1982. There is also an alternative minimum of $121.80 (before the application of cost-of-living increases) for members of this group whose benefits were computed from the benefit table in effect in December 1978 on the basis of either the old-start computation method in §§ 404.240 through 404.242 or the guaranteed alternative computation method explained in §§ 404.230 through 404.233. However, as can be seen from the extended table in appendix III, the lowest primary insurance amount under this method is now $1.70 for individuals for whom the minimum benefit has been repealed.

Example In the example in § 404.221(d), we computed Mr. B's average monthly wage to be $502. We refer to the December 1978 benefit table in appendix III. Then we find his average monthly wage in column III of the table. Reading across, his primary insurance amount is on the same line in column IV and is $390.50. A 9.9 percent automatic cost-of-living benefit increase was effective for June 1979, increasing Mr. B's primary insurance amount to $429.20, as explained in §§ 404.270 through 404.277. Then, we increase the $429.20 by the 14.3 percent June 1980 cost-of-living benefit increase and get $490.60, and by the 11.2 percent June 1981 increase to get $545.60.

[47 FR 30734, July 15, 1982, as amended at 48 FR 46142, Oct. 11, 1983]

GUARANTEED ALTERNATIVE FOR PEOPLE REACHING AGE 62 AFTER 1978 BUT BEFORE 1984

§ 404.230 Guaranteed alternative.

(a) *General.* If you reach age 62 after 1978 but before 1984, we compute your primary insurance amount under a modified average-monthly-wage method as a *guaranteed alternative* to your primary insurance amount computed under the average-indexed-monthly-earnings method. We also compute your primary insurance amount under the old-start method (§§ 404.240 through 404.242) and under the special rules for a person who had a period of disability (§§ 404.250 through 404.252), if you are eligible. In §§ 404.231 through 404.233, we explain the average-monthly-wage method as the alternative to the average-indexed-monthly-earnings method.

(b) *Restrictions.* (1) To qualify for this guaranteed-alternative computation, you must have some creditable earnings before 1979.

(2) You or your survivors do not qualify for a guaranteed-alternative computation if you were eligible (you attained age 62, became disabled, or died before age 62) for social security benefits based on your own earnings at any time before 1979 unless—

(i) Those benefits were disability insurance benefits which were terminated because you recovered from your disability or you engaged in substantial gainful activity; and

(ii) You spent at least 12 months without being eligible for disability benefits again.

(3) This guaranteed alternative method applies only to old-age insurance benefits and to survivor benefits where the deceased worker reached the month of his or her 62nd birthday after 1978 but before 1984 and died after reaching age 62.

§ 404.231 Steps in computing your primary insurance amount under the guaranteed alternative—general.

If you reach age 62 after 1978 but before 1984, we follow three major steps in finding your guaranteed alternative:

(a) First, we compute your average monthly wage, as described in § 404.232;

(b) Second, we find the primary insurance amount that corresponds to your average monthly wage in the benefit table in appendix III.

(c) Then we apply any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that have become effective in or after the year you reached age 62.

§ 404.232 Computing your average monthly wage under the guaranteed alternative.

(a) *General.* With the exception described in paragraph (b) of this section, we follow the rules in § 404.221 to compute your average monthly wage.

(b) *Exception.* We do not use any year after the year you reach age 61 as a computation base year in computing your average monthly wage for purposes of the guaranteed alternative.

§ 404.233 Adjustment of your guaranteed alternative when you become entitled after age 62.

(a) If you do not become entitled to benefits at the time you reach age 62, we adjust the guaranteed alternative computed for you under § 404.232 as described in paragraph (b) of this section.

(b) To the primary insurance amount computed under the guaranteed alternative, we apply any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that go into effect in the year you reach age 62 and in years up through the year you become entitled to benefits. (See appendix VI for a list of the percentage increases in primary insurance amounts since December 1978.)

EXAMPLE

Mr. C reaches age 62 in January 1981 and becomes entitled to old-age insurance benefits in April 1981. He had no social security earnings before 1951 and his year-by-year social security earnings after 1950 are as follows:

1951	$3,600
1952	3,600
1953	3,600
1954	3,600
1955	4,200
1956	4,200
1957	4,200
1958	4,200
1959	4,800
1960	4,800
1961	4,800
1962	4,800
1963	4,800
1964	4,800
1965	4,800
1966	6,600
1967	6,600
1968	7,800
1969	7,800
1970	7,800
1971	7,800
1972	9,000
1973	10,800
1974	13,200
1975	14,100
1976	15,300
1977	16,500
1978	17,700
1979	22,900
1980	25,900
1981	29,700

Mr. C's elapsed years are the 30 years 1951 through 1980. We subtract 5 from his 30 elapsed years to find that we must use 25 benefit computation years in computing his average monthly wage. His computation base years are 1951 through 1980 which are years after 1950 up to the year he reached age 62. We will use his 25 computation base years with the highest earnings to compute his average monthly wage. Thus, we exclude the years 1951–1955. The year 1981 is not a base year for this computation.

We total his earnings in his benefit computation years and get $236,000. We then divide by the 300 months in his 25 benefit computation years, and find his average monthly wage to be $786.66 which is rounded down to $786.

The primary insurance amount in the benefit table in appendix III that corresponds to Mr. C's average monthly wage is $521.70. The 9.9 percent and 14.3 percent cost of living increase for 1979 and 1980, respectively, are not applicable because Mr. C reached age 62 in 1981.

The average indexed monthly earnings method described in §§ 404.210 through 404.212 considers all of the earnings after 1950, including 1981 earnings which, in Mr. C's case cannot be used in the guaranteed alternative method. Mr. C's primary insurance amount under the average indexed earnings method is $548.40. Therefore, his benefit is based upon the $548.40 primary insurance amount. As in the guaranteed alternative method, Mr. C is not entitled to the cost of living increases for years before the year he reaches age 62.

''OLD-START'' METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

§ 404.240 Old-start method—general.

If you had all or substantially all your social security earnings before 1951, your primary insurance amount computed under the ''1977 simplified old-start'' method may be higher than any other primary insurance amount computed for you under any other method for which you are eligible. As explained in § 404.242, if you reach age 62 after 1978, your primary insurance amount computed under the old-start method is used, for purposes of the guaranteed alternative described in § 404.230, if the old-start primary insurance amount is higher than the one found under the average-monthly-wage method. We may use a modified computation, as explained in § 404.243, if you are entitled to a pension based on your employment which was not covered by Social Security.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47917, Dec. 17, 1987]

§ 404.241 1977 simplified old-start method.

(a) *Who is qualified.*

To qualify for the old-start computation, you must meet the conditions in paragraphs (a) (1), (2), or (3) of this section:

(1) You must—

(i) Have one ''quarter of coverage'' (see §§ 404.101 and 404.110 of this part) before 1951;

(ii) Have attained age 21 after 1936 and before 1950, or attained age 22 after 1950 and earned fewer than 6 quarters of coverage after 1950;

(iii) Have not had a period of disability which began before 1951, unless it can be disregarded, as explained in §404.320 of this part; and,

(iv) Have attained age 62, become disabled, or died, after 1977.

(2)(i) You or your survivor becomes entitled to benefits for June 1992 or later;

(ii) You do not meet the conditions in paragraph (a)(1) of this section, and,

(iii) No person is entitled to benefits on your earnings record in the month before the month you or your survivor becomes entitled to benefits.

(3) A recomputation is first effective for June 1992 or later based on your earnings for 1992 or later.

(b) *Steps in old-start computation.* (1) First, we allocate your earnings during the period 1937–1950 as described in paragraph (c) of this section.

(2) Next, we compute your average monthly wage, as described in paragraph (d) of this section.

(3) Next, we apply the old-start formula to your average monthly wage, as described in paragraph (e)(1) of this section.

(4) Next, we apply certain increments to the amount computed in step (3), as described in paragraph (e)(2) of this section.

(5) Next, we find your primary insurance amount in the benefit table in appendix III, as described in paragraph (f)(1) of this section.

(6) Then, we apply automatic cost-of-living or *ad hoc* increases in primary insurance amounts to the primary insurance amount found in step (5), as described in paragraph (f)(2) of this section.

(c) *Finding your computation base years under the old-start method.* (1) Instead of using your actual year-by-year earnings before 1951, we find your computation base years for 1937–1950 (and the amount of earnings for each of them) by allocating your total 1937–1950 earnings among the years before 1951 under the following procedure:

(i) If you reached age 21 before 1950 and your total 1937–1950 earnings *are not* more than $3,000 times the number of years after the year you reached age 20 and before 1951 (a maximum of 14 years), we allocate your earnings equally among those years, and those years are your computation base years before 1951.

(ii) If you reached age 21 before 1950 and your total 1937–1950 earnings *are* more than $3,000 times the number of years after the year you reached age 20 and before 1951, we allocate your earnings at the rate of $3,000 per year for each year after you reached age 20 and before 1951 up to a maximum of 14 years. We credit any remainder in reverse order to years before age 21 in $3,000 increments and any amount left over of less than $3,000 to the year before the earliest year to which we credited $3,000. No more than $42,000 may be credited in this way and to no more than 14 years. Those years are your computation base years before 1951.

(iii) If you reached age 21 in 1950 or later and your total pre-1951 earnings are $3,000 or less, we credit the total to the year you reached age 20 and that year is your pre-1951 computation base year.

(iv) If you reached age 21 in 1950 or later and your total pre-1951 earnings are more than $3,000, we credit $3,000 to the year you reached age 20 and credit the remainder to earlier years (or year) in blocks of $3,000 in reverse order. We credit any remainder of less than $3,000 to the year before the earliest year to which we had credited $3,000. No more than $42,000 may be credited in this way and to no more than 14 years. Those years are your computation base years before 1951.

(v) If you die before 1951, we allocate your 1937–1950 earnings under paragraphs (c)(1) (i) through (iv), except that in determining the number of years, we will use the year of death instead of 1951. If you die before you attain age 21, the number of years in the period is equal to 1.

(vi) For purposes of paragraphs (c)(1)(i) through (v), if you had a period of disability which began before 1951, we will exclude the years wholly within a period of disability in determining the number of years.

(2)(i) All years after 1950 up to (but not including) the year you become entitled to old-age insurance or disability insurance benefits (or through the year you die if you had not become entitled to old-age or disability benefits) are also computation base years for you.

(ii) Years wholly within a period of disability are not computation base years unless your primary insurance amount would be higher if they were. In such situations, we count all the years during the period of disability, even if you had no earnings in some of them.

Example Ms. D reaches age 62 in June 1979. Her total 1937–1950 social security earnings are $40,000 and she had social security earnings of $7,100 in 1976 and $6,300 in 1977. Since she reaches age 62 after 1978, we first compute her primary insurance amount under the average-indexed-monthly-earnings method (§§ 404.210 through 404.212). As of June 1981, it is $170.50, which is the minimum primary insurance amount applicable, because her average indexed monthly earnings of $50 would yield only $56.50 under the benefit formula. Ms. D reached age 62 after 1978 but before 1984 and her guaranteed alternative under the average-monthly-wage method as of June 1981 is $170.30, which is the minimum primary insurance amount based on average monthly wages of $48. (These amounts include the 9.9, the 14.3, and the 11.2 percent cost-of-living increases effective June 1979, June 1980, and June 1981 respectively.)

Ms. D is also eligible for the old-start method. We first allocate $3,000 of her 1937–1950 earnings to each of her 13 computation base years starting with the year she reached age 21 (1938) and ending with 1950. The remaining $1,000 is credited to the year she reached age 20. Ms. D, then, has 42 computation base years (14 before 1951 and 28 after 1950).

(d) *Computing your average monthly wage under the old-start method.* (1) First, we count your elapsed years, which are the years beginning with 1937 (or the year you reach 22, if later) and ending with the year before you reach age 62, or become disabled or die before age 62. (See § 404.211(e)(1) for the rule on how we treat years wholly or partially within a period of disability.)

(2) Next, we subtract 5 from the number of your elapsed years, and this is the number of computation years we must use. We then choose this number of your computation base years in which you had the highest earnings. These years are your benefit computation years. You must have at least 2 benefit computation years.

(3) Then we compute your average monthly wage by dividing your total creditable earnings in your benefit computation years by the number of months in these years and rounding the quotient to the next lower dollar if not already a multiple of $1.

(e) *Old-start computation formula.* We use the following formula to compute your primary insurance benefit, which we will convert to your primary insurance amount:

(1) We take 40 percent of the first $50 of your average monthly wage, plus 10 percent of the next $200 of your average monthly wage up to a total average monthly wage of $250. (We do not use more than $250 of your average monthly wage.)

(2) We increase the amount found in paragraph (e)(1) of this section by 1 percent for each $1,650 in your pre-1951 earnings, disregarding any remainder less than $1,650. We always increase the amount by at least 4 of these 1 percent increments but may not increase it by more than 14 of them.

(f) *Finding your primary insurance amount under the old-start method.* (1) In column I of the benefit table in appendix III we locate the amount (the primary insurance benefit) computed in paragraph (e) of this section and find the corresponding primary insurance amount on the same line in column IV of the table.

(2) We increase that amount by any automatic cost-of-living or *ad hoc* increases in primary insurance amounts effective since the beginning of the year in which you reached age 62, or became disabled or died before age 62. (See §§ 404.270 through 404.277.)

Example From the example in paragraph (c)(2) of this section, we see that Ms. D's elapsed years total 40 (number of years at ages 22 to 61, both inclusive). Her benefit computation years, therefore, must total 35.

Since she has only 16 years of actual earnings, we must include 19 years of zero earnings in this old-start computation to reach the required 35 benefit computation years.

We next divide her total social security earnings ($53,400) by the 420 months in her benefit computation years and find her average monthly wage to be $127.

We apply the old-start computation formula to Ms. D's average monthly wage as follows: 40 percent of the first $50 of her average monthly wage ($20.00), plus 10 percent of the remaining $77 of her average monthly wage ($7.70), for a total of $27.70.

We then apply 14 1-percent increments to that amount, increasing it by $3.88 to $31.58. We find $31.58 in column I of the December 1978 benefit table in appendix III and find her primary insurance amount of $195.90 on the same line in column IV. We apply the 9.9 percent automatic cost-of-living increase effective for June 1979 to $195.90 and get an old-start primary insurance amount of $215.30 which we then increase to $246.10 to reflect the 14.3 percent cost-of-living increase effective for June 1980, and to $273.70 to reflect the June 1981 increase. Since that primary insurance amount is higher than the $153.10 primary insurance amount computed under the average-monthly-wage method and the $153.30 primary insurance amount computed under the average-indexed-monthly-earnings method, we base Ms. D's benefits (and those of her family) on $215.30 (plus later cost-of-living increases), which is the highest primary insurance amount.

[47 FR 30734, July 15, 1982, as amended at 55 FR 21382, May 24, 1990; 57 FR 23157, June 2, 1992]

§ 404.242 Use of old-start primary insurance amount as guaranteed alternative.

If your primary insurance amount as computed under the old-start method is higher than your primary insurance amount computed under the average-monthly-wage method, your old-start primary insurance amount will serve as the guaranteed alternative to your primary insurance amount computed under the average-indexed-monthly-earnings method, as described in § 404.230. However, earnings that you have in or after the year you reach age 62, or become disabled or die before age 62 are not used in an old-start computation in this situation.

§ 404.243 Computation where you are eligible for a pension based on noncovered employment.

The provisions of § 404.213 are applicable to computations under the old-start method, except for paragraphs (c) (1) and (2) and (d) of that section. Your primary insurance amount will be whichever of the following two amounts is larger:

(a) One-half the primary insurance amount computed according to § 404.241 (before application of the cost of living amount); or

(b) The primary insurance amount computed according to § 404.241 (before application of the cost of living amount), minus one-half the portion of your monthly pension which is due to noncovered work after 1956 and for which you were eligible in the first month you became eligible for Social Security benefits. If the result is not a multiple of $0.10, we will round to the next lower multiple of $0.10. (See § 404.213 (b)(3) if you are not eligible for a monthly pension in the first month you are entitled to Social Security benefits.) To determine the portion of your pension which is due to noncovered work after 1956, we consider the total number of years of work used to compute your pension and the percentage of those years which are after 1956 and in which your employment was not covered. We take that percentage of your total pension as the amount which is due to your noncovered work after 1956.

[52 FR 47918, Dec. 17, 1987]

SPECIAL COMPUTATION RULES FOR PEOPLE WHO HAD A PERIOD OF DISABILITY

§ 404.250 Special computation rules for people who had a period of disability.

If you were disabled at some time in your life, received disability insurance benefits, and those benefits were terminated because you recovered from your disability or because you engaged in substantial gainful activity, special rules apply in computing your primary

insurance amount when you become eligible after 1978 for old-age insurance benefits or if you become re-entitled to disability insurance benefits or die. (For purposes of §§ 404.250 through 404.252, we use the term *second entitlement* to refer to this situation.) There are two sets of rules:

(a) *Second entitlement within 12 months.* If 12 months or fewer pass between the last month for which you received a disability insurance benefit and your second entitlement, see the rules in § 404.251; and

(b) *Second entitlement after more than 12 months.* If more than 12 months pass between the last month for which you received a disability insurance benefit and your second entitlement, see the rules in § 404.252.

§ 404.251 Subsequent entitlement to benefits within 12 months after entitlement to disability benefits ended.

(a) *Disability before 1979; second entitlement after 1978.* In this situation, we compute your second-entitlement primary insurance amount by selecting the highest of the following:

(1) The primary insurance amount to which you were entitled when you last received a benefit, increased by any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that took effect since then;

(2) The primary insurance amount resulting from a recomputation of your primary insurance amount, if one is possible; or

(3) The primary insurance amount computed for you as of the time of your second entitlement under any method for which you are qualified at that time, including the average-indexed-monthly-earnings method if the previous period of disability is disregarded.

(b) *Disability and second entitlement after 1978.* In this situation, we compute your second-entitlement primary insurance amount by selecting the highest of the following:

(1) The primary insurance amount to which you were entitled when you last received a benefit, increased by any automatic cost-of-living or *ad hoc* increases in primary insurance amount that took effect since then;

(2) The primary insurance amount resulting from a recomputation of your primary insurance amount, if one is possible (this recomputation may be under the average-indexed-monthly-earnings method only); or

(3) The primary insurance amount computed for you as of the time of your second entitlement under any method (including an old-start method) for which you are qualifed at that time.

(c) *Disability before 1986; second entitlement after 1985.* When applying the rule in paragraph (b)(3) of this section, we must consider your receipt of a monthly pension based on noncovered employment. (See § 404.213). However, we will disregard your monthly pension if you were previously entitled to disability benefits before 1986 and in any of the 12 months before your second entitlement.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47918, Dec. 17, 1987]

§ 404.252 Subsequent entitlement to benefits more than 12 months after entitlement to disability benefits ended.

In this situation, we compute your second-entitlement primary insurance amount by selecting the higher of the following:

(a) *New primary insurance amount.* The primary insurance amount computed as of the time of your second entitlement under any of the computation methods for which you qualify at the time of your second entitlement; or

(b) *Previous primary insurance amount.* The primary insurance amount to which you were entitled in the last month for which you were entitled to a disability insurance benefit.

SPECIAL MINIMUM PRIMARY INSURANCE AMOUNTS

§ 404.260 Special minimum primary insurance amounts.

Regardless of the method we use to compute your primary insurance amount, if the special minimum primary insurance amount described in § 404.261 is higher, then your benefits

(and those of your dependents or survivors) will be based on the special minimum primary insurance amount. Special minimum primary insurance amounts are not based on a worker's average earnings, as are primary insurance amounts computed under other methods. Rather, the special minimum primary insurance amount is designed to provide higher benefits to people who worked for long periods in low-paid jobs covered by social security.

§ 404.261 Computing your special minimum primary insurance amount.

(a) *Years of coverage.* (1) The first step in computing your special minimum primary insurance amount is to find the number of your years of coverage, which is the sum of—

(i) The quotient found by dividing your total creditable social security earnings during the period 1937–1950 by $900, disregarding any fractional remainder; plus

(ii) The number of your computation base years after 1950 in which your social security earnings were at least the amounts shown in appendix IV. (*Computation base years* mean the same here as in other computation methods discussed in this subpart.)

(2) You must have at least 11 years of coverage to qualify for a special minimum primary insurance amount computation. However, special minimum primary insurance amounts based on little more than 10 years of coverage are usually lower than the regular minimum benefit that was in effect before 1982 (see §§ 404.212(e) and 404.222(b) of this part). In any situation where your primary insurance amount computed under another method is higher, we use that higher amount.

(b) *Computing your special minimum primary insurance amount.* (1) First, we subtract 10 from your years of coverage and multiply the remainder (at least 1 and no more than 20) by $11.50;

(2) Then we increase the amount found in paragraph (b)(1) of this section by any automatic cost-of-living or *ad hoc* increases that have become effective since December 1978 to find your special minimum primary insurance amount. See appendix V for the applicable table, which includes the 9.9 percent cost-of-living increase that became effective June 1979, the 14.3 percent increase that became effective June 1980, and the 11.2 percent increase that became effective June 1981.

Example Ms. F, who attained age 62 in January 1979, had $10,000 in total social security earnings before 1951 and her post-1950 earnings are as follows:

1951	$1,100
1952	950
1953	0
1954	1,000
1955	1,100
1956	1,200
1957	0
1958	1,300
1959	0
1960	1,300
1961	0
1962	1,400
1963	1,300
1964	0
1965	500
1966	700
1967	650
1968	900
1969	1,950
1970	2,100
1971	2,000
1972	1,500
1973	2,700
1974	2,100
1975	2,600
1976	3,850
1977	4,150
1978	0

Her primary insurance amount under the average-indexed-monthly-earnings method as of June 1981 is $240.40 (based on average indexed monthly earnings of $229). Her guaranteed-alternative primary insurance amount under the average-monthly-wage method as of June 1981 is $255.80 (based on average monthly wages of $131).

However, Ms. F has enough earnings before 1951 to allow her 11 years of coverage before 1951 ($10,000÷$900=11, plus a remainder, which we drop). She has sufficient earnings in 1951–52, 1954–56, 1958, 1960, 1962–63, 1969–71, 1973, and 1976–77 to have a year of coverage for each of those years. She thus has 15 years of coverage after 1950 and a total of 26 years of coverage. We subtract 10 from her years of coverage, multiply the remainder (16) by $11.50 and get $184.00. We then apply the June 1979, June 1980, and June 1981 automatic cost-of-living increases (9.9 percent, 14.3 percent, and 11.2 percent, respectively) to that amount to find her special minimum primary insurance amount of $202.30 effective June 1979, $231.30 effective June 1980, and $257.30 effective June 1981. (See appendices V and VI.) Since her special minimum primary insurance amount is higher than the primary insurance amounts computed for her under the other methods described in this subpart for which she is eligible, her benefits (and those of her

family) are based on the special minimum primary insurance amount.

[47 FR 30734, July 15, 1982, as amended at 48 FR 46143, Oct. 11, 1983]

COST-OF-LIVING INCREASES

§ 404.270 Cost-of-living increases.

Your primary insurance amount may be automatically increased each December so it keeps up with rises in the cost of living. These automatic increases also apply to other benefit amounts, as described in § 404.271.

[47 FR 30734, July 15, 1982, as amended at 51 FR 12603, Apr. 14, 1986]

§ 404.271 When automatic cost-of-living increases apply.

Besides increases in the primary insurance amounts of current beneficiaries, automatic cost-of-living increases also apply to—

(a) The benefits of certain uninsured people age 72 and older (see § 404.380);

(b) The special minimum primary insurance amounts (described in §§ 404.260 through 404.261) of current and future beneficiaries;

(c) The primary insurance amounts of people who after 1978 become eligible for benefits or die before becoming eligible (beginning with December of the year they become eligible or die), although certain limitations are placed on the automatic adjustment of the frozen minimum primary insurance amount (as described in § 404.277); and

(d) The *maximum family benefit amounts* in column V of the benefit table in appendix III.

[47 FR 30734, July 15, 1982, as amended at 51 FR 12603, Apr. 14, 1986]

§ 404.272 Indexes we use to measure the rise in the cost-of-living.

(a) *The bases.* To measure increases in the cost-of-living for annual automatic increase purposes, we use either:

(1) The revised Consumer Price Index (CPI) for urban wage earners and clerical workers as published by the Department of Labor, or

(2) The average wage index (AWI), which is the average of the annual total wages that we use to index (i.e., update) a worker's past earnings when we compute his or her primary insurance amount (§ 404.211(c)).

(b) *Effect of the OASDI fund ratio.* Which of these indexes we use to measure increases in the cost-of-living depends on the Old-Age, Survivors, and Disability Insurance (OASDI) fund ratio.

(c) *OASDI fund ratio for years after 1984.* For purposes of cost-of-living increases, the OASDI fund ratio is the ratio of the combined assets in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund (see section 201 of the Social Security Act) on January 1 of a given year, to the estimated expenditures from the Funds in the same year. The January 1 balance consists of the assets (i.e., government bonds and cash) in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, plus Federal Insurance Contributions Act (FICA) and Self-Employment Contributions Act (SECA) taxes transferred to these trust funds on January 1 of the given year, minus the outstanding amounts (principal and interest) owed to the Federal Hospital Insurance Trust Fund as a result of interfund loans. Estimated expenditures are amounts we expect to pay from the Old-Age and Survivors Insurance and the Disability Insurance Trust Funds during the year, including the net amount that we pay into the Railroad Retirement Account, but excluding principal repayments and interest payments to the Hospital Insurance Trust Fund and transfer payments between the Old-Age and Survivors Insurance and the Disability Insurance Trust Funds. The ratio as calculated under this rule is rounded to the nearest 0.1 percent.

(d) *Which index we use.* We use the CPI if the OASDI fund ratio is 15.0 percent or more for any year from 1984 through 1988, and if the ratio is 20.0 percent or more for any year after 1988. We use either the CPI or the AWI, depending on which has the lower percentage increase in the applicable measuring period (see § 404.274), if the OASDI fund ratio is less than 15.0 percent for any year from 1984 through 1988, and if the ratio is less than 20.0

percent for any year after 1988. For example, if the OASDI fund ratio for a year is 17.0 percent, the cost-of-living increase effective December of that year will be based on the CPI.

[51 FR 12603, Apr. 14, 1986]

§ 404.273 When automatic cost-of-living increases are to be made.

We make automatic cost-of-living increases if the applicable index, either the CPI or the AWI, rises by 3.0 percent or more over a specified measuring period (see the rules in § 404.274). If the cost-of-living increase is to be based on an increase of 3.0 percent or more in the CPI, the increase becomes effective in December of the year in which the measuring period ends. If the increase is to be based on an increase of 3.0 percent or more in the AWI, the increase becomes effective in December of the year after the year in which the measuring period ends.

[51 FR 12603, Apr. 14, 1986]

§ 404.274 Measuring the increase in the indexes.

(a) *General.* Depending on the OASDI fund ratio, we measure the rise in one index or in both indexes during the applicable measuring period (described in paragraphs (b) and (c) of this section) to determine whether there will be an automatic cost-of-living increase and if so, its amount.

(b) *Measuring period based on CPI.* For the increase effective December 1984 and later years, the measuring period we use for finding the amount of the CPI increase—

(1) Begins with—

(i) Any calendar quarter in which an *ad hoc* benefit increase is effective; or, if later,

(ii) The third calendar quarter of any year in which the last automatic increase became effective; and

(2) Ends with the third calendar quarter of the following year, but only if the CPI has increased by at least 3.0 percent (after rounding to the nearest one-tenth of one percent) since the beginning of the measuring period. (If the CPI increase is less than 3.0 percent, we extend the measuring period to the third quarter of the next year, doing so repeatedly until the 3.0 percent level is reached.) If this measuring period ends in a year after the year in which an *ad hoc* increase was enacted into law or took effect, there can be no cost-of-living increase based on this measuring period, and we will apply the rule in paragraph (d) of this section.

(c) *Measuring period based on AWI.* The measuring period we use for finding the amount of the AWI increase—

(1) Begins with—

(i) The calendar year before the year in which an *ad hoc* benefit increase is effective; or, if later,

(ii) The calendar year before the year in which the last automatic increase became effective; and

(2) Ends with the following year, but only if the AWI has increased by at least 3.0 percent (after rounding to the nearest one-tenth of one percent) in that one-year period. (If the AWI increase is less than 3.0 percent, we extend the measuring period to the next year, doing so repeatedly until the 3.0 percent level is reached.) If this measuring period ends in a year in which an *ad hoc* increase was enacted into law or took effect, there can be no cost-of-living increase based on this measuring period, and we will apply the rule in paragraph (d) of this section.

(d) *When no automatic cost-of-living increase is possible.* No automatic cost-of-living increase is possible for the calendar year that immediately follows a year in which an *ad hoc* increase was enacted into law or took effect. The measuring period for the next automatic cost-of-living increase—

(1) Where the measuring period is based on the CPI,

(i) Begins with the calendar quarter in which the *ad hoc* increase took effect; and

(ii) Ends with the third calendar quarter of the next year in which the CPI has risen by at least 3.0 percent if an *ad hoc* increase was not enacted or effective in the preceding year. (If the CPI increase is less than 3.0 percent, or an *ad hoc* increase was enacted or effective in the prior year, we extend the end of the measuring period to the third quarter of the following year, doing so repeatedly until the 3.0 percent level is reached in a year which does not immediately follow an *ad hoc* increase year.)

(2) Where the measuring period is based on the AWI,

(i) Begins with the calendar year before the year in which the *ad hoc* increase took effect; and

(ii) Ends with the next calendar year in which the AWI has increased by at least 3.0 percent and in which an *ad hoc* increase is not enacted or effective. (If the AWI increase is less than 3.0 percent, we extend the end of the measuring period to the following year, doing so repeatedly until the 3.0 percent level is reached in a year in which an *ad hoc* increase is not enacted or effective.)

[51 FR 12603, Apr. 21, 1986]

§ 404.275 Amount of automatic cost-of-living increases.

(a) *Based on CPI.* When the average of the CPI for the three months of the quarter ending the measuring period is at least 3.0 percent higher than the average of the CPI for the three months of the quarter in which the measuring period began, we compute an automatic cost-of-living increase percentage to be effective beginning with benefits payable for December of the year in which the measuring period ended. To compute the average of the CPI, the three monthly CPI figures (which are published to one decimal place) are added, the total is divided by 3, and the result is rounded to the nearest 0.1. If the CPI is the applicable index (see § 404.272(d)), we apply the increase (rounded to the nearest one-tenth of one percent) to the amounts described in § 404.271. We round the resulting amounts to the next lower multiple of $0.10 if not already a multiple of $0.10.

(b) *Based on AWI.* When the AWI for the year which ends the measuring period is at least 3.0 percent higher than the AWI for the year which begins the measuring period and all the other conditions for an AWI-based increase are met, that percent is the automatic cost-of-living increase which is due beginning with benefits payable for December of the year after the measuring period ended. If the AWI is the applicable index (see § 404.272(d)), we apply that percentage increase (rounded to the nearest one-tenth of one percent) to the amounts described in § 404.271. We round the resulting amounts to the next lower multiple of $0.10 if not already a multiple of $0.10.

(c) *Additional increase.* See § 404.278 for the additional increase which might be possible.

[51 FR 12604, Apr. 21, 1986]

§ 404.276 Publication of notice of increase.

When we determine that an automatic cost-of-living increase is due, we publish in the FEDERAL REGISTER within 45 days of the end of the measuring period used in finding the amount of the increase—

(a) The fact that an increase is due;

(b) The amount of the increase;

(c) The increased special minimum primary insurance amounts; and

(d) The range of increased maximum family benefits that corresponds to the range of increased special minimum primary insurance amounts.

§ 404.277 Automatic increases of "frozen" minimum primary insurance amount.

(a) *General.* There are special rules for automatic cost-of-living increases in the minimum primary insurance amount for people whose primary insurance amount is computed under the average-indexed-monthly-earnings method. The minimum primary insurance amount is *frozen,* for people becoming eligible after 1978, and before 1982, at $122 (the least amount in the benefit table in effect in December 1978, rounded to the next higher $1.00. See appendix III.). The frozen minimum is subject to automatic cost-of-living increases only in years in which you or your dependents or survivors are entitled to benefits.

(b) *Old-age insurance benefit based on frozen minimum primary insurance amount.* We apply automatic cost-of-living increases to your minimum primary insurance amount beginning with the earliest of—

(1) December of the year you become entitled to benefits and get at least a partial benefit; or

(2) December of the year you reach age 65 if you are entitled to benefits at or before age 65, regardless of whether you get at least a partial benefit; or

(3) December of the year you become entitled to benefits if that is not until after you reach age 65.

(c) *Survivor benefits based on minimum primary insurance amount either before or after the worker's entitlement to old-age insurance benefits.* (1) We apply automatic cost-of-living increases to your minimum primary insurance amount for purposes of adjusting the benefits of your survivors—

(i) In June of any year in which your children, your surviving spouse caring for your children, or your parents are entitled to survivors benefits for at least one month; and

(ii) Beginning with June of the earlier of—

(A) The year your aged surviving spouse (as defined in §§ 404.335 and 404.336) becomes entitled to benefits and gets at least a partial benefit; or

(B) The year your surviving spouse is 65 or older and becomes entitled to benefits.

(2) Automatic cost-of-living increases are not applied to your minimum primary insurance amount in any year in which no survivor of yours is entitled to benefits on your social security record.

[47 FR 30734, July 15, 1982, as amended at 48 FR 46143, Oct. 11, 1983; 51 FR 12604, Apr. 14, 1986]

§ 404.278 Additional cost-of-living increase.

(a) *General.* In addition to the cost-of-living increase explained in § 404.275 for a given year, we will further increase the amounts in § 404.271 if—

(1) The OASDI fund ratio is more than 32.0 percent in the given year in which a cost-of-living increase is due; and

(2) In any prior year, the cost-of-living increase was based on the AWI as the lower of the CPI and AWI (or would have been based on the AWI except that it was less than the required 3.0 percent increase).

(b) *Measuring period for the additional increase*—(1) *Beginning.* To compute the additional increase, we begin with—

(i) In the case of certain uninsured beneficiaries age 72 and older (see § 404.380), the first calendar year in which a cost-of-living adjustment was based on the AWI rather than the CPI;

(ii) For all other individuals and for maximum benefits payable to a family, the year in which the insured individual became eligible for old-age or disability benefits to which he or she is currently entitled, or died before becoming eligible.

(2) *Ending.* The end of the measuring period is the year before the first year in which a cost-of-living increase is due based on the CPI and in which the OASDI fund ratio is more than 32.0 percent.

(c) *Compounded percentage benefit increase.* To compute the additional cost-of-living increase, we must first compute the compounded percentage benefit increase (CPBI) for both the cost-of-living increases that were actually paid during the measuring period and for the increases that would have been paid if the CPI had been the basis for all the increases.

(d) *Computing the CPBI.* The computation of the CPBI is as follows—

(1) Obtain the sum of (i) 1.000 and (ii) the actual cost-of-living increase percentage (expressed as a decimal) for each year in the measuring period;

(2) Multiply the resulting amount for the first year by that for the second year, then multiply that product by the amount for the third year, and continue until the last amount has been multiplied by the product of the preceding amounts;

(3) Subtract 1 from the last product;

(4) Multiply the remaining product by 100. The result is what we call the *actual* CPBI.

(5) Substitute the cost-of-living increase percentage(s) that would have been used if the increase(s) had been based on the CPI (for some years, this will be the percentage that was used), and do the same computations as in paragraphs (d)(1) through (4) of this section. The result is what we call the *assumed* CPBI.

(e) *Computing the additional cost-of-living increase.* To compute the precentage increase, we—

(1) Subtract the actual CPBI from the assumed CPBI;

(2) Add 100 to the actual CPBI;

(3) Divide the answer from paragraph (e)(1) of this section by the answer from paragraph (e)(2) of this section, multiply the quotient by 100, and round

to the nearest 0.1. The result is the additional increase percentage, which we apply to the appropriate amount described in § 404.271 after that amount has been increased under § 404.275 for a given year. If that increased amount is not a multiple of $0.10, we will decrease it to the next lower multiple of $0.10.

(f) *Restrictions on paying an additional cost-of-living increase.* We will pay the additional increase to the extent necessary to bring the benefits up to the level they would have been if they had been increased based on the CPI. However, we will pay the additional increase only to the extent payment will not cause the OASDI fund ratio to drop below 32.0 percent for the year after the year in which the increase is effective.

[51 FR 12604, Apr. 21, 1986]

RECOMPUTING YOUR PRIMARY INSURANCE AMOUNT

§ 404.280 Recomputations.

At times after you or your survivors become entitled to benefits, we will recompute your primary insurance amount. Usually we will recompute only if doing so will increase your primary insurance amount. However, we will also recompute your primary insurance amount if you first became eligible for old-age or disability insurance benefits after 1985, and later become entitled to a pension based on your noncovered employment, as explained in § 404.213. There is no limit on the number of times your primary insurance amount may be recomputed, and we do most recomputations automatically. In the following sections, we explain:

(a) Why a recomputation is made (§ 404.281),

(b) When a recomputation takes effect (§ 404.282),

(c) Methods of recomputing (§§ 404.283 and 404.284),

(d) Automatic recomputations (§ 404.285),

(e) Requesting a recomputation (§ 404.286),

(f) Waiving a recomputation (§ 404.287), and

(g) Recomputing when you are entitled to a pension based on noncovered employment (§ 404.288).

[52 FR 47918, Dec. 17, 1987]

§ 404.281 Why your primary insurance amount may be recomputed.

(a) *Earnings not included in earlier computation or recomputation.* The most common reason for recomputing your primary insurance amount is to include earnings of yours that were not used in the first computation or in an earlier recomputation, as described in paragraphs (c) through (e) of this section. These earnings will result in a revised average monthly wage or revised average indexed monthly earnings.

(b) *New computation method enacted.* If a new method of computing or recomputing primary insurance amounts is enacted into law and you are eligible to have your primary insurance amount recomputed under the new method, we will recompute it under the new method if doing so would increase your primary insurance amount.

(c) *Earnings in the year you reach age 62 or become disabled.* In the initial computation of your primary insurance amount, we do not use your earnings in the year you become entitled to old-age insurance benefits or become disabled. However, we can use those earnings (called *lag earnings*) in a recomputation of your primary insurance amount. We recompute and begin paying you the higher benefits in the year after the year you become entitled to old-age benefits or become disabled.

(d) *Earnings not reported to us in time to use them in the computation of your primary insurance amount.* Because of the way reports of earnings are required to be submitted to us for years after 1977, the earnings you have in the year before you become entitled to old-age insurance benefits, or become disabled or in the year you die might not be reported to us in time to use them in computing your primary insurance amount. We recompute your primary insurance amount based on the new earnings information and begin paying you (or your survivors) the higher benefits based on the additional earnings, beginning with the month you became entitled or died.

(e) *Earnings after entitlement that are used in a recomputation.* Earnings that you have after you become entitled to benefits will be used in a recomputation of your primary insurance amount.

(f) *Entitlement to a monthly pension.* We will recompute your primary insurance amount if in a month after you became entitled to old-age or disability insurance benefits, you become entitled to a pension based on noncovered employment, as explained in § 404.213. Further, we will recompute your primary insurance amount after your death to disregard a monthly pension based on noncovered employment which affected your primary insurance amount.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47918, Dec. 17, 1987]

§ 404.282 Effective date of recomputations.

Most recomputations are effective beginning with January of the calendar year after the year in which the additional earnings used in the recomputation were paid. However, a recomputation to include earnings in the year of death (whether or not paid before death) is effective for the month of death. Additionally if you first became eligible for old-age or disability insurance benefits after 1985 and you later also become entitled to a monthly pension based on noncovered employment, we will recompute your primary insurance amount under the rules in § 404.213; this recomputed Social Security benefit amount is effective for the first month you are entitled to the pension. Finally, if your primary insurance amount was affected by your entitlement to a pension, we will recompute the amount to disregard the pension, effective with the month of your death.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47918, Dec. 17, 1987]

§ 404.283 Recomputation under method other than that used to find your primary insurance amount.

In some cases, we may recompute your primary insurance amount under a computation method different from the method used in the computation (or earlier recomputation) of your primary insurance amount, if you are eligible for a computation or recomputation under the different method.

§ 404.284 Recomputations for people who reach age 62, or become disabled or die before age 62 after 1978.

(a) *General.* Years of your earnings after 1978 not used in the computation of your primary insurance amount (or in earlier recomputations) under the average-indexed-monthly-earnings method may be substituted for earlier years of your indexed earnings in a recomputation, but only under the average-indexed-monthly-earnings method. See § 404.288 for the rules on recomputing when you are entitled to a monthly pension based on noncovered employment.

(b) *Substituting actual dollar amounts in earnings for earlier years of indexed earnings.* When we recompute your primary insurance amount under the average-indexed-monthly earnings method, we use actual dollar amounts, i.e., no indexing, for earnings not included in the initial computation or earlier recomputation. These later earnings are substituted for earlier years of indexed or actual earnings that are lower.

(c) *Benefit formula used in recomputation.* The formula that was used in the first computation of your primary insurance amount is also used in recomputations of your primary insurance amount.

(d) *Your recomputed primary insurance amount.* We recompute your primary insurance amount by applying the benefit formula to your average indexed monthly earnings as revised to include additional earnings. See § 404.281. We then increase the recomputed PIA by the amounts of any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that have become effective since you reached age 62, or became disabled or died before age 62.

(e) *Minimum increase in primary insurance amounts.* Your primary insurance amount may not be recomputed unless doing so would increase it by at least $1.

Example 1. Ms. A, whose primary insurance amount we computed to be $432.40 in June 1979 in §§ 404.210 through 404.212 (based on average indexed monthly earnings of $903), had

earnings of $11,000 in 1979 which were not used in the initial computation of her primary insurance amount. We may recompute her primary insurance amount effective for January 1980. In this recomputation, her 1979 earnings may be substituted in their actual dollar amount for the lowest year of her indexed earnings that was used in the initial computation. In Ms. A's case, we substitute the $11,000 for her 1966 indexed earnings of $8,911.36. Her total indexed earnings are now $251,470.05 and her new average indexed monthly earnings are $911. We apply to Ms. A's new average indexed monthly earnings the same benefit formula we used in the initial computation. Doing so produces an amount of $396.00. An automatic cost-of-living increase of 9.9 percent was effective in June 1979. We increase the $396.00 amount by 9.9 percent to find Ms. A's recomputed primary insurance amount of $435.30. Later we increased the primary insurance amount to $497.60 to reflect the 14.3 percent cost-of-living increase beginning June 1980 and to $553.40 to reflect the 11.2 percent cost-of-living increase beginning June 1981.

Example 2. Mr. B, whose primary insurance amount we computed to be $429.20 (based on average monthly wages of $502) in June 1978 in §§ 404.220 through 404.222, had earnings of $12,000 in 1978 which were not used in the initial computation of his primary insurance amount. We may recompute his primary insurance amount effective for January 1979. In this recomputation, his 1978 earnings are substituted for the lowest year of earnings used in the initial computation ($2,700 in 1952). Mr. B's total earnings are now $142,000 and his new average monthly wage is $537.

We next find Mr. B's new average monthly wage in column III of the December 1978 benefit table in appendix III. Reading across, we find his recomputed primary insurance amount on the same line in column IV, which is $407.70. We then apply the 9.9 percent, the 14.3 percent and the 11.2 percent automatic cost-of-living increases for June 1979, June 1980, and June 1981, respectively, to compute Mr. B's primary insurance amount of $569.60.

(f) *Guaranteed alternatives.* We may recompute your primary insurance amount by any of the following methods for which you qualify, if doing so would result in a higher amount than the one computed under the average-indexed-monthly-earnings method. Earnings in or after the year you reach age 62 cannot be used.

(1) If you reached age 62 after 1978 and before 1984, we may recompute to include earnings for years before the year you reached age 62 by using the guaranteed alternative (§ 404.231). We will increase the result by any cost-of-living or *ad hoc* increases in the primary insurance amounts that have become effective in and after the year you reached age 62.

(2) We will also recompute under the old-start guarantee (§ 404.242) and the prior-disability guarantee (§ 404.252) if you meet the requirements of either or both these methods.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47918, Dec. 17, 1987]

§ 404.285 Recomputations performed automatically.

Each year, we examine the earnings record of every retired, disabled, and deceased worker to see if the worker's primary insurance amount may be recomputed under any of the methods we have described. When a recomputation is called for, we perform it automatically and begin paying the higher benefits based on your recomputed primary insurance amount for the earliest possible month that the recomputation can be effective. You do not have to request this service, although you may request a recomputation at an earlier date than one would otherwise be performed (see § 404.286). Doing so, however, does not allow your increased primary insurance amount to be effective any sooner than it would be under an automatic recomputation. You may also waive a recomputation if one would disadvantage you or your family (see § 404.287).

§ 404.286 How to request an immediate recomputation.

You may request that your primary insurance amount be recomputed sooner than it would be recomputed automatically. To do so, you must make the request in writing to us and provide acceptable evidence of your earnings not included in the first computation or earlier recomputation of your primary insurance amount. If doing so will increase your primary insurance amount, we will recompute it. However, we cannot begin paying higher benefits on the recomputed primary insurance amount any sooner than we could under an automatic recomputation, i.e., for January of the year following the year in which the earnings were paid or derived.

§ 404.287 Waiver of recomputation.

If you or your family would be disadvantaged in some way by a recomputation of your primary insurance amount, or you and every member of your family do not want your primary insurance amount to be recomputed for any other reason, you may waive (that is, give up your right to) a recomputation, but you must do so in writing. That you waive one recomputation, however, does not mean that you also waive future recomputations for which you might be eligible.

§ 404.288 Recomputing when you are entitled to a monthly pension based on noncovered employment.

(a) *After entitlement to old-age or disability insurance benefits.* If you first become eligible for old-age or disability insurance benefits after 1985 and you later become entitled to a monthly pension based on noncovered employment, we may recompute your primary insurance amount under the rules in § 404.213. When recomputing, we will use the amount of the pension to which you are entitled or deemed entitled in the first month that you are concurrently eligible for both the pension and old-age or disability insurance benefits. We will disregard the rule in § 404.284(e) that the recomputation must increase your primary insurance amount by at least $1.

(b) *Already entitled to benefits and to a pension based on noncovered employment.* If we have already computed or recomputed your primary insurance amount to take into account your monthly pension, we may later recompute for one of the reasons explained in § 404.281. We will recompute your primary insurance amount under the rules in §§ 404.213 and 404.284. Any increase resulting from the recomputation under the rules of § 404.284 will be added to the most recent primary insurance amount which we had computed to take into account your monthly pension.

(c) *After your death.* If one or more survivors are entitled to benefits after your death, we will recompute the primary insurance amount as though it had never been affected by your entitlement to a monthly pension based in whole or in part on noncovered employment.

[52 FR 47918, Dec. 17, 1987]

RECALCULATIONS OF PRIMARY INSURANCE AMOUNTS

§ 404.290 Recalculations.

(a) Your primary insurance amount may be ''recalculated'' in certain instances. When we recalculate your primary amount, we refigure it under the same method we used in the first computation by taking into account—

(1) Earnings (including compensation for railroad service) incorrectly included or excluded in the first computation;

(2) Special deemed earnings credits including credits for military service (see subpart N of this part) and for individuals interned during World War II (see subpart K of this part), not available at the time of the first computation;

(3) Correction of clerical or mathematical errors; or

(4) Other miscellaneous changes in status.

(b) Unlike recomputations, which may only serve to increase your primary insurance amount, recalculations may serve to either increase or reduce it.

APPENDICES TO SUBPART C

The following appendices contain data that are needed in computing primary insurance amounts. Appendix I contains *average of the total wages* figures, which we use to *index* a worker's earnings for purposes of computing his or her average indexed monthly earnings. Appendix II contains benefit formulas which we apply to a worker's average indexed monthly earnings to find his or her primary insurance amount. Appendix III contains the benefit table we use to find a worker's primary insurance amount from his or her average monthly wage. We use the figures in appendix IV to find your years of coverage for years after 1950 for purposes of your special minimum primary insurance amount. Appendix V contains the table for computing the special minimum primary insurance amount. Appendix VI is a table of the percentage increases in primary insurance amounts since 1978. Appendix VII is a table of the *old-law* contribution and benefit base that would have been effective under the Social Security Act without enactment of the 1977 amendments.

The figures in the appendices are by law automatically adjusted each year. We are required to announce the changes through timely publication in the FEDERAL REGISTER. The only exception to the requirement of publication in the FEDERAL REGISTER is the update of benefit amounts shown in appendix III. We update the benefit amounts for payment purposes but are not required by law to publish this extensive table in the FEDERAL REGISTER. We have not updated the table in appendix III, but the introductory paragraphs at appendix III explain how you can compute the current benefit amount.

When we publish the figures in the FEDERAL REGISTER, we do not change every one of these figures. Instead, we provide new ones for each year that passes. We continue to use the old ones for various computation purposes, as the regulations show. Most of the new figures for these appendices are required by law to be published by November 1 of each year. Notice of automatic cost-of-living increases in primary insurance amounts is required to be published within 45 days of the end of the applicable measuring period for the increase (see §§404.274 and 404.276). In effect, publication is required within 45 days of the end of the third calendar quarter of any year in which there is to be an automatic cost-of-living increase.

We begin to use the new data in computing primary insurance amounts as soon as required by law, even before we periodically update these appendices. If the data you need to find your primary insurance amount have not yet been included in the appendices, you may find the figures in the FEDERAL REGISTER on or about November 1.

[52 FR 8247, Mar. 17, 1987]

APPENDIX I TO SUBPART C OF PART 404—AVERAGE OF THE TOTAL WAGES FOR YEARS AFTER 1950

Explanation: We use these figures to index your social security earnings (as described in §404.211) for purposes of computing your average indexed monthly earnings.

Calendar year	Average of the total wages
1951	$2,799.16
1952	2,973.32
1953	3,139.44
1954	3,155.64
1955	3,301.44
1956	3,532.36
1957	3,641.72
1958	3,673.80
1959	3,855.80
1960	4,007.12
1961	4,086.76
1962	4,291.40
1963	4,396.64
1964	4,576.32
1965	4,658.72
1966	4,938.36
1967	5,213.44
1968	5,571.76
1969	5,893.76
1970	6,186.24
1971	6,497.08
1972	7,133.80
1973	7,580.16
1974	8,030.76
1975	8,630.92
1976	9,226.48
1977	9,779.44
1978	10,556.03
1979	11,479.46
1980	12,513.46
1981	13,773.10
1982	14,531.34
1983	15,239.24
1984	16,135.07
1985	16,822.51
1986	17,321.82
1987	18,426.51
1988	19,334.04
1989	20,099.55
1990	21,027.98

[47 FR 30734, July 15, 1982, as amended at 52 FR 8247, Mar. 17, 1987; 57 FR 44096, Sept. 24, 1992]

APPENDIX II OF SUBPART C OF PART 404—BENEFIT FORMULAS USED WITH AVERAGE INDEXED MONTHLY EARNINGS

As explained in §404.212, we use one of the formulas below to compute your primary insurance amount from your average indexed monthly earnings (AIME). To select the appropriate formula, we find in the left-hand column the year after 1978 in which you reach age 62, or become disabled, or die before age 62. The benefit formula to be used in computing your primary insurance amount is on the same line in the right-hand columns. For example, if you reach age 62 or become disabled or die before age 62 in 1979, then we compute 90 percent of the first $180 of AIME, 32 percent of the next $905 of AIME, and 15 percent of AIME over $1,085. After we figure your amount for each step in the formula, we add the amounts. If the total is not already a multiple of $0.10, we round the total as follows:

(1) For computations using the benefit formulas in effect for 1979 through 1982, we round the total upward to the nearest $0.10, and

(2) For computations using the benefit formulas in effect for 1983 and later, we round the total downward to the nearest $0.10.

BENEFIT FORMULAS

Year you reach age 62 [1]	90 percent of the first—	plus 32 percent of the next—	plus 15 percent of AIME over—
1979	$180	$905	$1,085
1980	194	977	1,171
1981	211	1,063	1,274
1982	230	1,158	1,388
1983	254	1,274	1,528
1984	267	1,345	1,612
1985	280	1,411	1,691
1986	297	1,493	1,790
1987	310	1,556	1,866
1988	319	1,603	1,922
1989	339	1,705	2,044
1990	356	1,789	2,145
1991	370	1,860	2,230
1992	387	1,946	2,333

[1] Or become disabled or die before age 62.

[57 FR 44096, Sept. 24, 1992; 57 FR 45878, Oct. 5, 1992]

APPENDIX III OF SUBPART C OF PART 404—BENEFIT TABLE

This benefit table shows primary insurance amounts and maximum family benefits in effect in December 1978 based on cost-of-living increases which became effective for June 1978. (See §404.403 for information on maximum family benefits.) You will also be able to find primary insurance amounts for an individual whose entitlement began in the period June 1977 through May 1978.

The benefit table in effect in December 1978 had a minimum primary insurance amount of $121.80. As explained in §404.222(b), certain workers eligible, or who died without having been eligible, before 1982 had their benefit computed from this table. However, the minimum benefit provision was repealed for other workers by the 1981 amendments to the Act (the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35 as modified by Pub. L. 97–123). As a result, this benefit table includes a downward extension from the former minimum of $121.80 to the lowest primary insurance amount now possible. The extension is calculated as follows. For each single dollar of average monthly wage in the benefit table, the primary insurance amount shown for December 1978 is $121.80 multiplied by the ratio of that average monthly wage to $76. The upper limit of each primary insurance benefit range in column I of the table is $16.20 multiplied by the ratio of the average monthly wage in column III of the table to $76. The maximum family benefit is 150 percent of the corresponding primary insurance amount.

The repeal of the minimum benefit provision is effective with January 1982 for most workers and their families where the worker initially becomes eligible for benefits after 1981 or dies after 1981 without having been eligible before January 1982. For members of a religious order who are required to take a vow of poverty, as explained in 20 CFR 404.1024, and which religious order elected Social Security coverage before December 29, 1981, the repeal is effective with January 1992 based on first eligibility or death in that month or later.

To use this table, you must first compute the primary insurance benefit (column I) or the average monthly wage (column III), then move across the same line to either column II or column IV as appropriate. To determine increases in primary insurance amounts since December 1978 you should see appendix VI. Appendix VI tells you, by year, the percentage of the increases. In applying each cost-of-living increase to primary insurance amounts, we round the increased primary insurance amount to the next lower multiple of $0.10 if not already a multiple of $0.10. (For cost-of-living increases which are effective before June 1982, we round to the next higher multiple of $0.10.)

EXTENDED DECEMBER 1978 TABLE OF BENEFITS EFFECTIVE JANUARY 1982

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under §404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under §404.221) is—		IV. Primary insurance amount effective January 1982: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
				1	1.70	2.60
	0.42		2	2	3.30	5.00
0.43	.63		3	3	4.90	7.40
.64	.85		4	4	6.50	9.80
.86	1.06		5	5	8.10	12.20
1.07	1.27		6	6	9.70	14.60
1.28	1.49		7	7	11.30	17.00
1.50	1.70		8	8	12.90	19.40
1.71	1.91		9	9	14.50	21.80
1.92	2.13		10	10	16.10	24.20

EXTENDED DECEMBER 1978 TABLE OF BENEFITS EFFECTIVE JANUARY 1982—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective January 1982: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
2.14	2.34		11	11	17.70	26.60
2.35	2.55		12	12	19.30	29.00
2.56	2.77		13	13	20.90	31.40
2.78	2.98		14	14	22.50	33.80
2.99	3.19		15	15	24.10	36.20
3.20	3.41		16	16	25.70	38.60
3.42	3.62		17	17	27.30	41.00
3.63	3.83		18	18	28.90	43.40
3.84	4.05		19	19	30.50	45.80
4.06	4.26		20	20	32.10	48.20
4.27	4.47		21	21	33.70	50.60
4.48	4.68		22	22	35.30	53.00
4.69	4.90		23	23	36.90	55.40
4.91	5.11		24	24	38.50	57.80
5.12	5.32		25	25	40.10	60.20
5.33	5.54		26	26	41.70	62.60
5.55	5.75		27	27	43.30	65.00
5.76	5.96		28	28	44.90	67.40
5.97	6.18		29	29	46.50	69.80
6.19	6.39		30	30	48.10	72.20
6.40	6.60		31	31	49.70	74.60
6.61	6.82		32	32	51.30	77.00
6.83	7.03		33	33	52.90	79.40
7.04	7.24		34	34	54.50	81.80
7.25	7.46		35	35	56.10	84.20
7.47	7.67		36	36	57.70	86.60
7.68	7.88		37	37	59.30	89.00
7.89	8.10		38	38	60.90	91.40
8.11	8.31		39	39	62.60	93.90
8.32	8.52		40	40	64.20	96.30
8.53	8.73		41	41	65.80	98.70
8.74	8.95		42	42	67.40	101.10
8.96	9.16		43	43	69.00	103.50
9.17	9.37		44	44	70.60	105.90
9.38	9.59		45	45	72.20	108.30
9.60	9.80		46	46	73.80	110.70
9.81	10.01		47	47	75.40	113.10
10.02	10.23		48	48	77.00	115.50
10.24	10.44		49	49	78.60	117.90
10.45	10.65		50	50	80.20	120.30
10.66	10.87		51	51	81.80	122.70
10.88	11.08		52	52	83.40	125.10
11.09	11.29		53	53	85.00	127.50
11.30	11.51		54	54	86.60	129.90
11.52	11.72		55	55	88.20	132.30
11.73	11.93		56	56	89.80	134.70
11.94	12.15		57	57	91.40	137.10
12.16	12.36		58	58	93.00	139.50
12.37	12.57		59	59	94.60	141.90
12.58	12.78		60	60	96.20	144.30
12.79	13.00		61	61	97.80	146.70
13.01	13.21		62	62	99.40	149.10
13.22	13.42		63	63	101.00	151.50
13.43	13.64		64	64	102.60	153.90
13.65	13.85		65	65	104.20	156.30
13.86	14.06		66	66	105.80	158.70
14.07	14.28		67	67	107.40	161.10
14.29	14.49		68	68	109.00	163.50
14.50	14.70		69	69	110.60	165.90
14.71	14.92		70	70	112.20	168.30
14.93	15.13		71	71	113.80	170.70
15.14	15.34		72	72	115.40	173.10
15.35	15.56		73	73	117.00	175.50

EXTENDED DECEMBER 1978 TABLE OF BENEFITS EFFECTIVE JANUARY 1982—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective January 1982: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
15.57	15.77		74	74	118.60	177.90
15.78	15.98		75	75	120.20	180.30
15.99	16.20		76	76	121.80	182.70

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
	16.20	114.30		76	121.80	182.70
16.21	16.84	116.10	77	78	123.70	185.60
16.85	17.60	118.80	79	80	126.60	189.90
17.61	18.40	121.00	81	81	128.90	193.50
18.41	19.24	123.00	82	83	131.20	196.80
19.25	20.00	125.80	84	85	134.00	201.00
20.01	20.64	128.10	86	87	136.50	204.80
20.65	21.28	130.10	88	89	138.60	207.90
21.29	21.88	132.70	90	90	141.40	212.10
21.89	22.28	135.00	91	92	143.80	215.70
22.29	22.68	137.20	93	94	146.20	219.20
22.59	23.08	139.40	95	96	148.50	222.80
23.09	23.44	142.00	97	97	151.30	227.00
23.45	23.76	144.30	98	99	153.70	230.60
23.77	24.20	147.10	100	101	156.70	235.10
24.21	24.60	149.20	102	102	158.90	238.50
24.61	25.00	151.70	103	104	161.60	242.40
25.01	25.48	154.50	105	106	164.60	246.90
25.49	25.92	157.00	107	107	167.30	251.00
25.93	26.40	159.40	108	109	169.80	254.80
26.41	26.94	161.90	110	113	172.50	258.80
26.95	27.46	164.20	114	118	174.90	262.40
27.47	28.00	166.70	119	122	177.60	266.50
28.01	28.68	169.30	123	127	180.40	270.60
28.69	29.25	171.80	128	132	183.00	274.60
29.26	29.68	174.10	133	136	185.50	278.30
29.69	30.36	176.50	137	141	188.00	282.10
30.37	30.92	179.10	142	146	190.80	286.20
30.93	31.36	181.70	147	150	193.60	290.40
31.37	32.00	183.90	151	155	195.90	293.90
32.01	32.60	186.50	156	160	198.70	298.10
32.61	33.20	189.00	161	164	201.30	302.00
33.21	33.88	191.40	165	169	203.90	305.90
33.89	34.50	194.00	170	174	206.70	310.10
34.51	35.00	196.30	175	178	209.10	313.70
35.01	35.80	198.90	179	183	211.90	318.00
35.81	36.40	201.30	184	188	214.40	321.70
36.41	37.08	203.90	189	193	217.20	326.00
37.09	37.60	206.40	194	197	219.90	329.90
37.61	38.20	208.80	198	202	222.40	333.60
38.21	39.12	211.50	203	207	225.30	338.00
39.13	39.68	214.00	208	211	228.00	342.00
39.69	40.33	216.00	212	216	230.10	345.20
40.34	41.12	218.70	217	221	233.00	349.50
41.13	41.76	221.20	222	225	235.60	353.40

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
41.77	42.44	223.90	226	230	238.50	357.80
42.45	43.20	226.30	231	235	241.10	361.70
43.21	43.76	229.10	236	239	244.00	366.10
43.77	44.44	231.20	240	244	246.30	371.10
44.45	44.88	233.50	245	249	248.70	378.80
44.89	45.60	236.40	250	253	251.80	384.90
		238.70	254	258	254.30	392.50
		240.80	259	263	256.50	400.00
		243.70	264	267	259.60	206.00
		246.10	268	272	262.10	413.70
		248.70	273	277	264.90	421.20
		251.00	278	281	267.40	427.20
		253.50	282	286	270.00	434.90
		256.20	287	291	272.90	442.60
		258.30	292	295	275.10	448.50
		261.10	296	300	278.10	456.10
		263.50	301	305	280.70	463.80
		265.80	306	309	283.10	469.80
		268.50	310	314	286.00	477.40
		270.70	315	319	288.30	485.10
		273.20	320	323	291.00	491.10
		275.80	324	328	293.80	498.70
		278.10	329	333	296.20	506.20
		281.00	334	337	299.30	512.50
		283.00	338	342	301.40	519.90
		285.60	343	347	304.20	527.50
		288.30	348	351	307.10	533.60
		290.50	352	356	309.40	541.20
		293.30	357	361	312.40	548.80
		295.60	362	365	314.90	554.90
		297.90	366	370	317.30	562.50
		300.60	371	375	320.20	569.90
		303.10	376	379	322.90	576.30
		305.70	380	384	325.60	583.90
		307.90	385	389	328.00	591.30
		310.30	390	393	330.50	597.40
		313.00	394	398	333.40	605.10
		315.40	399	403	336.00	612.70
		318.20	404	407	338.90	618.60
		320.20	408	412	341.10	626.30
		322.50	413	417	343.50	633.80
		324.80	418	421	346.00	639.90
		327.40	422	426	348.70	647.50
		329.60	427	431	351.10	655.10
		331.60	432	436	353.20	662.70
		334.40	437	440	356.20	665.70
		336.50	441	445	358.40	669.70
		338.70	446	450	360.80	673.40
		341.30	451	454	363.50	676.30
		343.50	455	459	365.90	680.10
		345.80	460	464	368.30	683.80
		347.90	465	468	370.60	687.10
		350.70	469	473	373.50	690.80
		352.60	474	478	375.60	694.60
		354.90	479	482	378.00	697.70
		357.40	483	487	380.70	701.60
		359.70	488	492	383.10	705.40
		361.90	493	496	385.50	708.40
		364.50	497	501	388.20	712.10
		366.60	502	506	390.50	715.80
		368.90	507	510	392.90	719.00
		371.10	511	515	395.30	722.80
		373.70	516	520	398.00	726.70

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		375.80	521	524	400.30	729.50
		378.10	525	529	402.70	733.40
		380.80	530	534	405.60	737.10
		382.80	535	538	407.70	740.20
		385.10	539	543	410.20	744.10
		387.60	544	548	412.80	747.80
		389.90	549	553	415.30	751.60
		392.10	554	556	417.60	753.90
		393.90	557	560	419.60	756.90
		396.10	561	563	421.90	759.30
		398.20	564	567	424.10	762.30
		400.40	568	570	426.50	764.50
		402.30	571	574	428.50	767.50
		404.40	575	577	430.70	769.90
		406.20	578	581	432.70	772.80
		408.40	582	584	435.00	775.20
		410.20	585	588	436.90	778.20
		412.60	589	591	439.50	780.50
		414.60	592	595	441.60	783.50
		416.70	596	598	443.80	785.60
		418.70	599	602	446.00	788.90
		420.70	603	605	448.10	791.10
		422.80	606	609	450.30	794.00
		424.90	610	612	452.60	796.50
		426.90	613	616	454.70	799.50
		428.90	617	620	456.80	802.50
		431.00	621	623	459.10	804.80
		433.00	624	627	461.20	807.90
		435.10	628	630	463.40	810.70
		437.10	631	634	465.60	814.70
		439.20	635	637	467.80	818.50
		441.40	638	641	470.10	822.40
		443.20	642	644	472.10	826.10
		445.40	645	648	474.40	830.10
		447.40	649	652	476.50	833.70
		448.60	653	656	477.80	836.10
		449.90	657	660	479.20	838.40
		451.50	661	665	480.90	841.50
		453.10	666	670	482.60	844.50
		454.80	671	675	484.40	847.40
		456.40	676	680	486.10	850.50
		458.00	681	685	487.80	853.50
		459.80	686	690	489.70	856.40
		461.20	691	695	491.20	859.60
		462.80	696	700	492.90	862.60
		464.50	701	705	494.70	865.60
		466.10	706	710	496.40	868.60
		467.70	711	715	498.20	871.50
		469.40	716	720	500.00	874.60
		471.00	721	725	501.70	877.60
		472.60	726	730	503.40	880.70
		474.20	731	735	505.10	883.80
		475.90	736	740	506.90	886.70
		477.40	741	745	508.50	889.90
		478.90	746	750	510.10	892.70
		480.40	751	755	511.70	896.40
		481.80	756	760	513.20	897.80
		483.20	761	765	514.70	900.40
		484.50	766	770	516.00	903.00
		485.80	771	775	517.40	905.40
		487.20	776	780	518.90	907.90
		488.60	781	785	520.40	910.40
		489.80	786	790	521.70	912.90

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		491.10	791	795	523.10	915.40
		492.50	796	800	524.60	918.00
		494.00	801	805	526.20	920.50
		495.30	806	810	527.50	923.00
		496.70	811	815	529.00	925.60
		498.00	816	820	530.40	928.00
		499.40	821	825	531.90	930.60
		500.70	826	830	533.30	933.10
		502.00	831	835	534.70	935.70
		503.30	836	840	536.10	938.10
		504.70	841	845	537.60	940.80
		506.00	846	850	538.90	943.00
		507.50	851	855	540.50	945.70
		508.80	856	860	541.90	948.10
		510.20	861	865	543.40	950.70
		511.50	866	870	544.80	953.20
		512.90	871	875	546.30	955.70
		514.10	876	880	547.60	958.20
		515.50	881	885	549.10	960.80
		516.80	886	890	550.40	963.20
		518.20	891	895	551.90	966.00
		519.60	896	900	553.40	968.30
		521.00	901	905	554.90	970.90
		522.30	906	910	556.30	973.50
		523.70	911	915	557.80	976.00
		525.10	916	920	559.30	978.30
		526.30	921	925	560.60	961.00
		527.60	926	930	561.90	983.40
		529.00	931	935	563.40	985.90
		530.40	936	940	564.90	988.50
		531.70	941	945	566.30	991.00
		533.00	946	950	567.70	993.50
		534.50	951	955	569.30	996.10
		535.90	956	960	570.80	998.60
		537.30	961	965	572.30	1,001.00
		538.40	966	970	573.40	1,003.60
		539.80	971	975	574.90	1,006.20
		541.20	976	980	576.40	1,008.50
		542.60	981	985	577.90	1,011.10
		543.80	986	990	579.20	1,013.60
		545.20	991	995	580.70	1,016.20
		546.60	996	1,000	582.20	1,018.60
		547.80	1,001	1,005	583.50	1,020.70
		548.90	1,006	1,010	584.60	1,023.20
		550.20	1,011	1,015	586.00	1,025.30
		551.50	1,016	1,020	587.40	1,027.80
		552.60	1,021	1,025	588.60	1,029.90
		553.80	1,026	1,030	589.80	1,032.20
		555.10	1,031	1,035	591.20	1,034.50
		556.20	1,036	1,040	592.40	1,036.70
		557.50	1,041	1,045	593.80	1,039.10
		558.80	1,046	1,050	595.20	1,041.30
		559.80	1,051	1,055	596.20	1,043.40
		561.10	1,056	1,060	597.60	1,045.90
		562.40	1,061	1,065	599.00	1,048.00
		563.60	1,066	1,070	600.30	1,050.50
		564.80	1,071	1,075	601.60	1,052.60
		566.00	1,076	1,080	602.80	1,054.90
		567.30	1,081	1,085	604.20	1,057.10
		568.40	1,086	1,090	605.40	1,059.40
		569.70	1,091	1,095	606.80	1,061.70
		571.00	1,096	1,100	608.20	1,064.00
		572.00	1,101	1,105	609.20	1,066.10

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		573.30	1,106	1,110	610.60	1.068.50
		574.60	1,111	1,115	612.00	1,070.70
		575.70	1,116	1,120	613.20	1,073.10
		577.00	1,121	1,125	614.60	1,075.30
		578.20	1,126	1,130	615.80	1,077.60
		579.40	1,131	1,135	617.10	1,079.70
		580.60	1,136	1,140	618.40	1,082.20
		581.90	1,141	1,145	619.80	1,084.40
		583.10	1,146	1,150	621.10	1,086.70
		584.20	1,151	1,555	622.20	1,088.80
		585.50	1,156	1,160	623.60	1,091.10
		586.70	1,161	1,165	624.90	1,093.40
		587.90	1,166	1,170	626.20	1,095.80
		589.20	1,171	1,175	627.50	1,098.00
		590.30	1,176	1,180	628.70	1,100.20
		591.40	1,181	1,185	629.90	1,102.20
		592.60	1,186	1,190	631.20	1,104.30
		593.70	1,191	1,195	632.30	1,106.50
		594.80	1,196	1,200	633.50	1,108.60
		595.90	1,201	1,205	634.70	1,110.60
		597.10	1,206	1,210	636.00	1,112.90
		598.20	1,211	1,215	637.10	1,114.90
		599.30	1,216	1,220	638.30	1,117.00
		600.40	1,221	1,225	639.50	1,119.00
		601.60	1,226	1,230	640.80	1,121.20
		602.70	1,231	1,235	641.90	1,123.30
		603.80	1,236	1,240	643.10	1,125.40
		605.00	1,241	1,245	644.40	1,127.50
		606.10	1,246	1,250	645.50	1,129.60
		607.20	1,251	1,255	646.70	1,131.60
		608.30	1,256	1,260	647.90	1,133.80
		609.50	1,261	1,265	649.20	1,135.90
		610.60	1,266	1,270	650.30	1,138.00
		611.70	1,271	1,275	651.50	1,140.00
		612.80	1,276	1,280	652.70	1,142.20
		613.80	1,281	1,285	653.70	1,144.10
		614.80	1,286	1,290	654.90	1,146.10
		616.00	1,291	1,295	656.10	1,148.00
		617.00	1,296	1,300	657.20	1,150.00
		618.10	1,301	1,305	658.30	1,152.00
		619.10	1,306	1,310	659.40	1,154.00
		620.20	1,311	1,315	660.60	1,155.90
		621.30	1,316	1,320	661.70	1,157.90
		622.30	1,321	1,325	662.80	1,159.80
		623.40	1,326	1,330	664.00	1,161.90
		624.40	1,331	1,335	665.00	1,163.80
		625.50	1,336	1,340	666.20	1,165.80
		626.60	1,341	1,345	667.40	1,167.70
		627.60	1,346	1,350	668.40	1,169.70
		628.70	1,351	1,355	669.60	1,171.70
		629.70	1,356	1,360	670.70	1,173.70
		630.80	1,361	1,365	671.90	1,175.60
		631.80	1,366	1,370	672.90	1,177.70
		632.90	1,371	1,375	674.10	1,179.60
		633.90	1,376	1,380	675.20	1,181.60
		634.90	1,381	1,385	676.20	1,183.40
		635.90	1,386	1,390	677.30	1,185.30
		636.90	1,391	1,395	678.30	1,187.10
		637.90	1,396	1,400	679.40	1,189.00
		638.90	1,401	1,405	680.50	1,190.80
		639.90	1,406	1,410	681.50	1,192.70
		640.90	1,411	1,415	682.60	1,194.60
		641.90	1,416	1,420	683.70	1,196.50

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		642.90	1,421	1,425	685.70	1,198.30
		643.90	1,426	1,430	684.80	1,200.20
		644.90	1,431	1,435	686.90	1,202.00
		645.90	1,436	1,440	687.90	1,203.90
		646.90	1,441	1,445	689.00	1,205.70
		647.90	1,446	1,450	690.10	1,207.70
		648.90	1,451	1,455	691.10	1,209.50
		649.90	1,456	1,460	692.20	1,211.40
		650.90	1,461	1,465	693.30	1,213.20
		651.90	1,466	1,470	694.30	1,215.10
		652.90	1,471	1,475	695.40	1,216.90

[47 FR 30734, July 15, 1982; 47 FR 35479, Aug. 16, 1982, as amended at 48 FR 46143, Oct. 11, 1983; 48 FR 50076, Oct. 31, 1983]

APPENDIX IV OF SUBPART C OF PART 404—EARNINGS NEEDED FOR A YEAR OF COVERAGE AFTER 1950

MINIMUM SOCIAL SECURITY EARNINGS TO QUALIFY FOR A YEAR OF COVERAGE AFTER 1950 FOR PURPOSES OF THE—

Year	Special minimum primary insurance amount	Benefit computations described in section 404.213(d) [2]
1951–1954	$900	$900
1955–1958	1,050	1,050
1959–1965	1,200	1,200
1966–1967	1,650	1,650
1968–1971	1,950	1,950
1972	2,250	2,250
1973	2,700	2,700
1974	3,300	3,300
1975	3,525	3,525
1976	3,825	3,825
1977	4,125	4,125
1978	4,425	4,425
1979	4,725	4,725
1980	5,100	5,100
1981	5,550	5,550
1982	6,075	6,075
1983	6,675	6,675
1984	7,050	7,050
1985	7,425	7,425
1986	7,875	7,875
1987	8,175	8,175
1988	8,400	8,400
1989	8,925	8,925
1990	9,525	9,525
1991	5,940	9,900
1992	6,210	10,350

[2] Applies only to certain individuals with pensions from noncovered employment.

NOTE: For 1951–78, the amounts shown are 25 percent of the contribution and benefit base (the contribution and benefit base is the same as the annual wage limitation as shown in § 404.1047) in effect. For years after 1978, however, the amounts are 25 percent of what the contribution and benefit base would have been if the 1977 Social Security Amendments had not been enacted, except, for special minimum benefit purposes, the applicable percentage is 15 percent for years after 1990.

[57 FR 44096, Sept. 24, 1992]

APPENDIX V OF SUBPART C OF PART 404—COMPUTING THE SPECIAL MINIMUM PRIMARY INSURANCE AMOUNT AND RELATED MAXIMUM FAMILY BENEFITS

These tables are based on section 215(a)(1)(C)(i) of the Social Security Act, as amended. They include the percent cost-of-living increase shown in appendix VI for each effective date.

JUNE 1979

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$12.70	$19.10
12	25.30	38.00
13	38.00	57.00
14	50.60	75.90
15	63.20	94.90
16	75.90	113.90
17	88.50	132.80
18	101.20	151.80
19	113.80	170.70
20	126.40	189.60
21	139.10	208.70
22	151.70	227.60

JUNE 1979—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
23	164.40	246.60
24	177.00	265.50
25	189.60	284.50
26	202.30	303.50
27	214.90	322.40
28	227.50	341.30
29	240.20	360.30
30	252.80	379.20

JUNE 1980

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$14.60	$21.90
12	29.00	43.50
13	43.50	65.30
14	57.90	86.90
15	72.30	108.50
16	86.80	130.20
17	101.20	151.80
18	115.70	173.60
19	130.10	195.20
20	144.50	216.80
21	159.00	238.60
22	173.40	260.20
23	188.00	282.00
24	202.40	303.60
25	216.80	325.20
26	231.30	347.00
27	245.70	368.60
28	260.10	390.20
29	274.60	411.90
30	289.00	433.50

JUNE 1981

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefits
11	$16.30	$24.50
12	32.30	48.50
13	48.40	72.70
14	64.40	96.70
15	80.40	120.70
16	96.60	144.90
17	112.60	168.90
18	128.70	193.10
19	144.70	217.10
20	160.70	241.10
21	176.90	265.40
22	192.90	289.40
23	209.10	313.70
24	225.10	337.70
25	241.10	361.70
26	257.30	386.00
27	273.30	410.00
28	289.30	434.00
29	305.40	458.10
30	321.40	482.10

JUNE 1982

I.—Years of coverage	II.—Primary insurance amount	III.—Maximum family benefit
11	$17.50	$26.30
12	34.60	52.00
13	51.90	78.00
14	69.10	103.80
15	86.30	129.60
16	103.70	155.60
17	120.90	181.30
18	138.20	207.30
19	155.40	233.10
20	172.50	258.90
21	189.90	285.00
22	207.10	310.80
23	224.50	336.90
24	241.70	362.60
25	258.90	388.40
26	276.30	414.50
27	293.50	440.30
28	310.70	466.10
29	327.90	491.90
30	345.10	517.70

DECEMBER 1983

I.—Years of coverage	II.—Primary insurance amount	III.—Maximum family benefit
11	$18.10	$27.20
12	35.80	53.80
13	53.70	80.70
14	71.50	107.40
15	89.30	134.10
16	107.30	161.00
17	125.10	187.60
18	143.00	214.50
19	160.80	241.20
20	178.50	267.90
21	196.50	294.90
22	214.30	321.60
23	232.30	348.60
24	250.10	375.20
25	267.90	401.90
26	285.90	429.00
27	303.70	455.70
28	321.50	482.40
29	339.30	509.10
30	357.10	535.80

DECEMBER 1984

I.—Years of coverage	II.—Primary insurance amount	III.—Maximum family benefit
11	$18.70	$28.10
12	37.00	55.60
13	55.50	83.50
14	74.00	111.10
15	92.40	138.70
16	111.00	166.60
17	129.40	194.10
18	148.00	222.00
19	166.40	249.60
20	184.70	277.20
21	203.30	305.20
22	221.80	332.80
23	240.40	360.80

DECEMBER 1984—Continued

I.—Years of coverage	II.—Primary insurance amount	III.—Maximum family benefit
24	258.80	388.30
25	277.20	415.90
26	295.90	444.00
27	314.30	471.60
28	332.70	499.20
29	351.10	526.90
30	369.50	554.50

DECEMBER 1985

I.—Years of coverage	II.—Primary insurance amount	III.—Maximum family benefit
11	$19.20	$28.90
12	38.10	57.30
13	57.20	86.00
14	76.20	114.50
15	95.20	142.90
16	114.40	171.70
17	133.40	200.10
18	152.50	228.80
19	171.50	257.30
20	190.40	285.70
21	209.60	314.60
22	228.60	343.10
23	247.80	371.90
24	266.80	400.30
25	285.70	428.70
26	305.00	457.70
27	324.00	486.20
28	343.00	514.60
29	361.90	543.20
30	380.90	571.60

DECEMBER 1986

I.—Years of coverage	II.—Primary insurance amount	III.—Maximum family benefit
11	$19.40	$29.20
12	38.50	58.00
13	57.90	87.10
14	77.10	115.90
15	96.40	144.70
16	115.80	173.90
17	135.10	202.70
18	154.40	231.70
19	173.70	260.60
20	192.80	289.40
21	212.30	318.60
22	231.50	347.50
23	251.00	376.70
24	270.20	405.50
25	289.40	434.20
26	308.90	463.60
27	328.20	492.50
28	347.40	521.20
29	366.60	550.20
30	385.80	579.00

DECEMBER 1987

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$20.20	$30.40
12	40.10	60.40
13	60.30	90.70
14	80.30	120.70
15	100.40	150.70
16	120.60	181.20
17	140.70	211.20
18	160.80	241.40
19	180.90	271.50
20	200.80	301.50
21	221.20	331.90
22	241.20	362.00
23	261.50	392.50
24	281.50	422.50
25	301.50	452.40
26	321.80	483.00
27	341.90	513.10
28	361.90	543.00
29	381.90	573.30
30	402.00	603.30

DECEMBER 1988

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$21.00	$31.60
12	41.70	62.80
13	62.70	94.30
14	83.50	125.50
15	104.40	156.70
16	125.40	188.40
17	146.30	219.60
18	167.20	251.00
19	188.10	282.30
20	208.80	313.50
21	230.00	345.10
22	250.80	376.40
23	271.90	408.20
24	292.70	439.40
25	313.50	470.40
26	334.60	502.30
27	355.50	533.60
28	376.30	564.70
29	397.10	596.20
30	418.00	627.40

DECEMBER 1989

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$21.90	$33.00
12	43.60	65.70
13	65.60	98.70
14	87.40	131.30
15	109.30	164.00
16	131.20	197.20
17	153.10	229.90
18	175.00	262.70
19	196.90	295.50
20	218.60	328.20
21	240.80	361.30
22	262.50	394.00
23	284.60	427.30
24	306.40	460.00
25	328.20	492.50

DECEMBER 1989—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
26	350.30	525.90
27	372.20	558.60
28	393.90	591.20
29	415.70	624.20
30	437.60	656.80

DECEMBER 1990

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$23.00	$34.70
12	45.90	69.20
13	69.10	104.00
14	92.10	138.30
15	115.20	172.80
16	138.20	207.80
17	161.30	242.30
18	184.40	276.80
19	207.50	311.40
20	230.40	345.90
21	253.80	380.80
22	276.60	415.20
23	299.90	450.30
24	322.90	484.80
25	345.90	519.00
26	369.20	554.20
27	392.20	588.70
28	415.10	623.10
29	438.10	657.90
30	461.20	692.20

DECEMBER 1991

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$23.80	$35.90
12	47.50	71.70
13	71.60	107.80
14	95.50	143.40
15	119.40	179.10
16	143.30	215.40
17	167.20	251.20
18	191.20	287.00
19	215.10	322.90
20	238.90	358.60
21	263.10	394.80
22	286.80	430.50
23	310.90	466.90
24	334.80	502.70
25	358.60	538.20
26	382.80	574.70
27	406.70	610.40
28	430.40	646.10
29	454.30	682.20
30	478.20	717.80

NOTE: The amounts shown in the above table for years of coverage less than 19 are not payable for June 1981 through December 1981 because the corresponding values shown in column II are less than the $135.70 minimum primary insurance amount payable for that period. For months after December 1981, a special minimum primary insurance amount of $128.70 will be payable.

[47 FR 30734, July 15, 1982, as amended at 52 FR 8248, Mar. 17, 1987; 57 FR 44097, Sept. 24, 1992; 57 FR 45878, Oct. 5, 1992]

APPENDIX VI OF SUBPART C OF PART 404—PERCENTAGE OF AUTOMATIC INCREASES IN PRIMARY INSURANCE AMOUNTS SINCE 1978

Pt. 404, Subpt. C, App. VI

Effective date	Percentage increase
06/79	9.9
06/80	14.3
06/81	11.2
06/82	7.4
12/83	3.5
12/84	3.5
12/85	3.1
12/86	1.3
12/87	4.2
12/88	4.0
12/89	4.7
12/90	5.4
12/91	3.7

[57 FR 44097, Sept. 24, 1992]

APPENDIX VII OF SUBPART C OF PART 404—''OLD-LAW'' CONTRIBUTION AND BENEFIT BASE

Explanation: We use these figures to determine the earnings needed for a year of coverage for years after 1978 (see §404.261 and appendix IV). This is the contribution and benefit base that would have been effective under the Social Security Act without the enactment of the 1977 amendments.

Year	Amount
1979	$18,900
1980	20,400
1981	22,200
1982	24,300
1983	26,700
1984	28,200
1985	29,700
1986	31,500
1987	32,700
1988	33,600
1989	35,700
1990	38,100
1991	39,600
1992	41,400

[52 FR 8248, Mar. 17, 1987, as amended at 57 FR 44097, Sept. 24, 1992; 57 FR 45878, Oct. 5, 1992]

Subpart D—Old-Age, Disability, Dependents' and Survivors' Insurance Benefits; Period of Disability

AUTHORITY: Secs. 202, 203 (a) and (b), 205(a), 216, 223, 225, 228(a)–(e), and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 403 (a) and (b), 405(a), 416, 423, 425, 428(a)–(e), and 902(a)(5)).

SOURCE: 44 FR 34481, June 15, 1979, unless otherwise noted.

GENERAL

§ 404.301 Introduction.

This subpart sets out what requirements you must meet to qualify for social security benefits, how your benefit amounts are figured, when your right to benefits begins and ends, and how family relationships are determined. These benefits are provided by title II of the Social Security Act. They include—

(a) *For workers,* old-age and disability benefits and benefit protection during periods of disability;

(b) *For a worker's dependents,* benefits for a worker's wife, divorced wife, husband, divorced husband, and child;

(c) *For a worker's survivors,* benefits for a worker's widow, widower, divorced wife, child, and parent, and a lump-sum death payment; and

(d) *For uninsured persons age 72 or older,* special payments.

§ 404.302 Other regulations related to this subpart.

This subpart is related to several others. Subpart H sets out what evidence you need to prove you qualify for benefits. Subpart P describes what is needed to prove you are disabled. Subpart E describes when your benefits may be reduced or stopped for a time. Subpart G describes the need for and the effect of an application for benefits. Part 410 describes when you may qualify for black lung benefits. Part 416 describes when you may qualify for supplemental security income. Also 42 CFR part 405 describes when you may qualify for hospital and medical insurance if you are aged, disabled, or have chronic kidney disease.

§ 404.303 Definitions.

As used in this subpart:

Apply means to sign a form or statement that the Social Security Administration accepts as an application for benefits under the rules set out in subpart G.

Eligible means that a person would meet all the requirements for entitlement to benefits for a period of time but has not yet applied.

Entitled means that a person has applied and has proven his or her right to benefits for a period of time.

Insured person or *the insured* means someone who has enough earnings under social security to permit payment of benefits on his or her earnings record. The requirements for becoming insured are described in subpart B.

Permanent home means the true and fixed home (legal domicile) of a person. It is the place to which a person intends to return whenever he or she is absent.

Primary insurance amount means an amount that is determined from the average monthly earnings creditable to the insured person. This term and the manner in which it is computed are explained in subpart C.

We or *Us* means the Social Security Administration.

You means the person who has applied for benefits or the person for whom someone else has applied.

§ 404.304 General rules on benefit amounts.

This subpart describes how the highest monthly benefit amount you ordinarily could qualify for under each type of benefit is determined. However, the highest monthly benefit amount you could qualify for may not be the amount that you actually are paid each month. In a particular month, your benefit amount may be reduced or not paid at all. Under some circumstances, your benefit amount may be increased. The most common reasons for a change in the amount of your benefit payments are listed below:

(a) *Reductions based on age or earnings.* As explained in §§ 404.410 through 404.413, your old-age, wife's, husband's, widow's, or widower's benefits may be reduced if you choose to receive them before age 65. Also, as explained in

§§ 404.415 through 404.417, deductions may be made from your benefits if your earnings or the insured person's earnings go over certain limits.

(b) *Overpayments and underpayments.* Your benefits may be increased or decreased for a time to make up for any previous overpayment or underpayment that was made on the insured person's record. For more information about this, see subpart F.

(c) [Reserved]

(d) *Family maximum.* As explained in § 404.403, there is a maximum amount set for each insured person's earnings record that limits the total benefits payable on that record. If you are entitled to benefits as the insured's dependent or survivor, your benefits may be reduced to keep total benefits payable to the insured's family within these limits.

(e) *Government pension offset.* If you are entitled to wife's, husband's, mother's, father's, widow's or widower's benefits and receive a Government pension for work that was not covered under social security, your benefits may be reduced by the amount of that pension. Special age 72 payments are also reduced by the amount of a Government pension. For more information about this, see § 404.408(a) which covers benefits and § 404.384(c) which covers special age 72 payments.

(f) *Rounding.* After all other deductions or reductions, any monthly benefit which is not a multiple of $1 is reduced to the next lower multiple of $1.

[44 FR 34481, June 15, 1979, as amended at 48 FR 46148, Oct. 11, 1983]

§ 404.305 When you may not be entitled to benefits.

In addition to the situations described in § 404.304 when you may not receive a benefit payment, there are special circumstances when you may not be entitled to benefits. These circumstances are—

(a) *Waiver of benefits.* If you have waived benefits and been granted a tax exemption on religious grounds as described in §§ 404.1039 and 404.1075, no one may become entitled to any benefits or payments on your earnings record and you may not be entitled to benefits on anyone else's earnings record; and

(b) *Person's death caused by an intentional act.* You may not become entitled to or continue to receive any survivor's benefits or payments on the earnings record of any person, or receive any underpayment due a person, if you were convicted of a felony or an act in the nature of a felony of intentionally causing that person's death. If you were subject to the juvenile justice system, you may not become entitled to or continue to receive survivor's benefits or payments on the earnings record of any person, or receive any underpayment due a person, if you were found by a court of competent jurisdiction to have intentionally caused that person's death by committing an act which, if committed by an adult, would have been considered a felony or an act in the nature of a felony.

[44 FR 34481, June 15, 1979, as amended at 47 FR 42098, Sept. 24, 1982; 52 FR 19136, May 21, 1987, 52 FR 21410, June 5, 1987; 58 FR 64888, Dec. 10, 1993]

OLD-AGE AND DISABILITY BENEFITS

§ 404.310 Who is entitled to old-age benefits.

You are entitled to old-age benefits if—

(a) You are at least 62 years old;

(b) You have enough social security earnings to be *fully insured* as defined in §§ 404.110 through 404.115; and

(c) You apply; or you are entitled to disability benefits up to the month you become 65 years old. At age 65, your disability benefits automatically become old-age benefits.

[44 FR 34481, June 15, 1979, as amended at 51 FR 10616, Mar. 28, 1986]

§ 404.311 When entitlement to old-age benefits begins and ends.

(a) You are entitled to old-age benefits at age 65 beginning with the first month covered by your application in which you meet all the requirements for entitlement.

(b) You are entitled to old-age benefits if you have attained age 62, but are under age 65, beginning with the first month covered by your application throughout which you meet all the requirements for entitlement.

(c) Your entitlement to benefits ends with the month before the month of your death.

[48 FR 21926, May 16, 1983]

§ 404.312 Old-age benefit amounts.

(a) If your old-age benefits begin at age 65, your monthly benefit is equal to the primary insurance amount.

(b) If your old-age benefits begin after you become 65 years old, your monthly benefit is your primary insurance amount plus an increase for retiring after age 65. See § 404.313 for a description of these increases.

(c) If your old-age benefits begin before you become 65 years old, your monthly benefit amount is the primary insurance amount minus a reduction for each month you are entitled before you become 65 years old. These reductions are described in §§ 404.410 through 404.413.

[44 FR 34481, June 15, 1979, as amended at 51 FR 12604, Apr. 14, 1986]

§ 404.313 Using delayed retirement credit to increase old-age benefit amount.

(a) *General.* (1) If you do not receive old-age benefits for the month you reach age 65 (retirement age) or for any later month before the month in which you reach age 70 (72 before 1984), you may earn delayed retirement credits which will increase your benefit amount when you retire. You earn delayed retirement credits for each of those months for which you are fully insured and are eligible for but do not receive old-age benefits, either because of your work or earnings, or because you have not applied for benefits. If you were entitled to old-age benefits before age 65 you may still earn delayed retirement credit for months beginning with age 65 in which your benefits were reduced to zero because of your work or earnings.

(2) Retirement age is the age at which entitlement to full benefits may begin and is the age at which you may begin to earn delayed retirement credits. Age 65 is the retirement age for workers who reach that age before the year 2003. For workers who reach age 65 after 2002, retirement age will gradually increase from 65 to 67, depending on each person's date of birth.

(b) *How we determine delayed retirement credits*—(1) *General.* The amount of the delayed retirement credit depends on the year you reach retirement age, and the number of months you are eligible for and do not receive old-age benefits from retirement age to age 70 (72 before 1984). We total these months, which need not be consecutive, multiply the total by the applicable percent as provided in paragraphs (b)(2), (3), and (4) of this section, multiply your benefit amount by this product, and round to the next lowest multiple of $0.10 if the answer is not already a multiple of $0.10. The result is your delayed retirement credit which we add to your benefit amount. The supplementary medical insurance premium, if any, is then deducted and the result is rounded to the next lowest multiple of $1.00 if it is not already a multiple of $1.00.

(2) *Before 1982.* If you reach age 65 before 1982, your delayed retirement credit equals one-twelfth of one percent of your benefit amount times the number of months after 1970 in which you are age 65 or older and for which you are eligible but do not receive old-age benefits.

(3) *After 1981 and before 1990.* If you reach age 65 after 1981 and before 1990, your delayed retirement credit equals one-fourth of one percent of your monthly benefit amount times the number of months in which you are age 65 or older and for which you are eligible but do not receive old-age benefits.

(4) *Beginning with 1990.* If you reach age 65 in 1990 or later, the rate of the delayed retirement credit (i.e., one-fourth of one percent as stated in paragraph (b)(3) of this section) is increased by one-twenty-fourth of one percent in each even year through 2008. Thus, depending on when you reach age 65, your delayed retirement credit percent will be as follows:

Year you reach age 65	Delayed retirement credit percent
1990	7/24 of 1 percent.
1991	7/24 of 1 percent.
1992	1/3 of 1 percent.
1993	1/3 of 1 percent.
1994	3/8 of 1 percent.
1995	3/8 of 1 percent.
1996	5/12 of 1 percent.

Year you reach age 65	Delayed retirement credit percent
1997	5/12 of 1 percent.
1998	11/24 of 1 percent.
1999	11/24 of 1 percent.
2000	1/2 of 1 percent.
2001	1/2 of 1 percent.
2002	13/24 of 1 percent.
2003	13/24 of 1 percent.
2004	7/12 of 1 percent.
2005	7/12 of 1 percent.
2006	5/8 of 1 percent.
2007	5/8 of 1 percent.
2008 and later	2/3 of 1 percent.

Example. Alan was qualified for old-age benefits when he reached age 65 in January 1983, but decided not to apply for old-age benefits immediately because he was still working. When he became age 66 in January 1984, he stopped working and applied for these benefits beginning with that month. Based on his earnings, his primary insurance amount was $226.60, and his monthly old-age benefit after deducting his supplemental medical insurance premium was $211.00 ($226.60 minus $15.50 SMI premium equals $211.10, rounded to $211.00), if no delayed retirement credits were added. However, he did not receive benefits for the 12 months from the month in which he became 65 (January 1983) until the first month in which he stopped working (January 1984). Therefore, his monthly old-age benefit of $226.60 was increased by three percent (one-quarter of one percent times 12 months) to yield a total $233.39, which rounded to the next lower multiple of $0.10 is $233.30. After deducting the SMI premium and rounding to the next lower multiple of $1, the benefit amount is $217.00.

(c) *Effective date of delayed retirement credit.* If you are entitled to benefits, we examine our records after the end of each calendar year to determine whether you have earned the delayed retirement credit (i.e., whether there were months in which you were fully insured and eligible for benefits, but did not receive them). Any increase in your benefit amount due to the delayed retirement credit is effective beginning with January of the year after the year the credit is earned. If you are age 65 or older and eligible for old-age benefits but have not applied, we compute the delayed retirement credit for the year(s) before you applied and pay it to you as part of your first benefit check. The delayed retirement credit for the year you applied and later years is added to your benefits beginning with the following January. However, in either case, in the year in which you attain age 70 (72 before 1984), we compute the credit through the month before the month you reach that age and add it to your benefit amount beginning with that month.

(d) *Delayed retirement credit and special minimum primary insurance amounts.* We do not add any delayed retirement credit to your old-age benefit if your benefit is based on the special minimum primary insurance amount described in § 404.260. We add the delayed retirement credit only to old-age benefits based on your regular primary insurance amount, i.e., as computed under one of the other provisions of subpart C of this part. If your benefit based on the regular primary insurance amount plus your delayed retirement credit is higher than the benefit based on your special minimum primary insurance amount, we pay the higher amount to you. However, if the special minimum primary insurance amount is higher than the regular primary insurance amount without the delayed retirement credit, we use the special minimum primary insurance amount to determine the family maximum and the benefits of others entitled on your earnings record.

(e) *Effect of delayed retirement credit on other benefits*—(1) *Surviving spouse or surviving divorced spouse.* If you earned delayed retirement credits during your lifetime, we compute your surviving spouse's or surviving divorced spouse's benefit based on your regular primary insurance amount plus the amount of the delayed retirement credit. All delayed retirement credits, including credits in the year of death, can be used in computing your surviving spouse's or surviving divorced spouse's benefit beginning with the month of death. We compute the delayed retirement credit up to, but not including, the month of death.

(2) *Other family members.* We do not use your delayed retirement credits to increase the benefits of other family members entitled on your earnings record.

(3) *Family maximum.* The delayed retirement credits are added to your benefit after we compute the family maximum. However, your delayed retirement credits which are used to compute your surviving spouse's or surviving divorced spouse's benefit are added

to the spouse's benefits before we reduce for the family maximum.

[51 FR 12605, Apr. 14, 1986]

§ 404.315 Who is entitled to disability benefits.

(a) *General.* You are entitled to disability benefits while disabled before age 65 if—

(1) You have enough social security earnings to be *insured for disability,* as described in § 404.130;

(2) You apply;

(3) You have a disability, as defined in § 404.1505, or you are not disabled, but you had a disability that ended within the 12-month period before the month you applied; and

(4) You have been disabled for 5 full consecutive months. This 5-month waiting period begins with a month in which you were both insured for disability and disabled. Your waiting period can begin no earlier than the 17th month before the month you apply—no matter how long you were disabled before then. No waiting period is required if you were previously entitled to disability benefits or to a period of disability under § 404.320 any time within 5 years of the month you again became disabled.

(b) *Prohibition against reentitlement to disability benefits if drug addiction or alcoholism is a contributing factor material to the determination of disability.* You cannot be entitled to a period of disability payments if drug addiction or alcoholism is a contributing factor material to the determination of disability and your earlier entitlement to disability benefits on the same basis terminated after you received benefits for 36 months during which treatment was available.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21930, May 16, 1983; 51 FR 10616, Mar. 28, 1986; 51 FR 16166, May 1, 1986; 53 FR 43681, Oct. 28, 1988; 57 FR 30119, July 8, 1992; 60 FR 8145, Feb. 10, 1995]

§ 404.316 When entitlement to disability benefits begins and ends.

(a) You are entitled to disability benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement. If a waiting period is required, your benefits cannot begin earlier than the first month following that period.

(b) Your entitlement to disability benefits ends with the earliest of these months:

(1) The month before the month of your death;

(2) The month before the month you become 65 years old (at age 65 your disability benefits will be automatically changed to old-age benefits);

(3) The second month after the month in which your disability ends as provided in § 404.1594(b)(1), unless continued subject to paragraph (c); or (4) subject to the provisions of paragraph (d) of this section, the month before your termination month (§ 404.325).

(c)(1) Your benefits, and those of your dependents, may be continued after your impairment is no longer disabling if—

(i) Your disability did not end before December 1980, the effective date of this provision of the law;

(ii) You are participating in an appropriate program of vocational rehabilitation, that is, one that has been approved under a State plan approved under title I of the Rehabilitation Act of 1973 and which meets the requirements outlined in 34 CFR part 361 for a rehabilitation program;

(iii) You began the program before your disability ended; and

(iv) We have determined that your completion of the program, or your continuation in the program for a specified period of time, will significantly increase the likelihood that you will not have to return to the disability benefit rolls.

Example: While under a disability from a severe back impairment, ''A'' begins a vocational rehabilitation program under the direction of a State vocational rehabilitation agency with a vocational goal of jewelry repairman. ''A'' is 50 years old, has a high school education, and worked as a route salesman for a bread company for 6 years before becoming disabled. Before ''A'' completes his training, his disability status is reviewed and a determination is made that he is able to do light work. Considering his age, education and work experience, ''A'' is no longer disabled. However, if ''A'' is able to work as a jewelry repairman, he will be considered able to engage in substantial gainful activity even if he can do only sedentary work. Therefore, it is determined that ''A's'' completion of the vocational rehabilitation

program will significantly increase the likelihood that he will be permanently removed from the disability rolls. ''A'' will continue to receive payments until he completes or stops his program, or until it is determined that continued participation will no longer significantly increase the likelihood of permanent removal from the disability rolls.

(2) Your benefits generally will be stopped with the month—

(i) You complete the program;

(ii) You stop participating in the program for any reason; or

(iii) We determine that your continuing participation in the program will no longer significantly increase the likelihood that you will be permanently removed from the disability benefit rolls.

Exception: In no case will your benefits be stopped with a month earlier than the second month after the month your disability ends.

(d) If, after November 1980, you have a disabling impairment (§ 404.1511), you will be paid benefits for all months in which you do not do substantial gainful activity during the reentitlement period (§ 404.1592a) following the end of your trial work period (§ 404.1592). If you are unable to do substantial gainful activity in the first month following the reentitlement period, we will pay you benefits until you are able to do substantial gainful activity. (Earnings during your trial work period do not affect the payment of your benefit.) You will also be paid benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity during those succeeding months. After those three months, you cannot be paid benefits for any months in which you do substantial gainful activity.

(e) If drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 404.1535, you may receive disability benefits on that basis for no more than 36 months regardless of the number of entitlement periods you may have. Not included in these 36 months are months in which treatment for your drug addiction or alcoholism is not available, months before March 1995, and months for which your benefit payments were suspended for any reason. Benefits to your dependents may continue after the 36 months of benefits if, but for the operation of this paragraph, you would otherwise be entitled to benefits based on disability. The 36-month limit is no longer effective for benefits for months beginning after September 2004.

(f) If drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 404.1535 and your disability benefits are suspended for 12 consecutive months because of your failure to comply with treatment requirements, your disability benefits will be terminated effective the first month after such 12-month period. Benefits to your dependents may continue after the 12-month period if, but for the operation of this paragraph, you would otherwise be entitled to benefits based on disability.

[44 FR 34481, June 15, 1979, as amended at 47 FR 31542, July 21, 1982; 47 FR 52693, Nov. 23, 1982; 49 FR 22270, May 29, 1984; 51 FR 17617, May 14, 1986; 60 FR 8145, Feb. 10, 1995]

§ 404.317 Disability benefit amounts.

Your monthly benefit is equal to the primary insurance amount. This amount is computed under the rules in subpart C as if it were an old-age benefit, and as if you were 62 years old at the beginning of the 5-month waiting period mentioned in § 404.315(d). If the 5-month waiting period is not required because of your previous entitlement, your primary insurance amount is figured as if you were 62 years old when you become entitled to benefits this time. Your monthly benefit amount may be reduced if you receive workmen's compensation payments before you become 62 years old as described in § 404.408. Your benefits may also be reduced if you were entitled to other retirement-age benefits before you became 65 years old.

§ 404.320 Who is entitled to a period of disability.

(a) *General.* A period of disability is a continuous period of time during which you are disabled. If you become disabled, you may apply to have our records show how long your disability lasts. You may do this even if you do not qualify for disability benefits. If we

establish a period of disability for you, the months in that period of time will not be counted in figuring your average earnings. If benefits payable on your earnings record would be denied or reduced because of a period of disability, the period of disability will not be taken into consideration.

(b) *Who is entitled.* You are entitled to a period of disability if you meet all the following conditions:

(1) You have or had a disability as defined in § 404.1505.

(2) You are *insured for disability*, as defined in § 404.130 in the calendar quarter in which you became disabled, or in a later calendar quarter in which you were disabled.

(3) You file an application while disabled, or no later than 12 months after the month in which your period of disability ended. If you were unable to apply within the 12-month period after your period of disability ended because of a physical or mental condition as described in § 404.322, you may apply not more than 36 months after the month your disability ended.

(4) At least 5 consecutive months go by from the month in which your period of disability begins and before the month in which it would end.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21930, May 16, 1983; 51 FR 10616, Mar. 28, 1986]

§ 404.321 When a period of disability begins and ends.

(a) *When a period of disability begins.* Your period of disability begins on the day your disability begins if you are insured for disability on that day. If you are not insured for disability on that day, your period of disability will begin on the first day of the first calender quarter after your disability began in which you become insured for disability. Your period of disability may not begin after you become 65 years old.

(b) *When disability ended before December 1, 1980.* Your period of disability ends on the last day of the month before the month in which you become 65 years old or, if earlier, the last day of the second month following the month in which your disability ended.

(c) *When disability ends after November 1980.* Your period of disability ends with the close of whichever of the following is the earliest—

(1) The month before the month in which you become 65 years old;

(2) The month immediately preceding your termination month (§ 404.325); or

(3) If you perform substantial gainful activity during the 15-month period following the end of your trial work period, the last month for which you received benefits.

(d) *When drug addiction or alcoholism is a contributing factor material to the determination of disability.* (1) Your entitlement to receive disability benefit payments ends the month following the month in which, regardless of the number of entitlement periods you may have had based on disability where drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535)—

(i) You have received a total of 36 months of disability benefits. Not included in these 36 months are months in which treatment for your drug addiction or alcoholism is not available, months before March 1995, and months for which your benefits were suspended for any reason; or

(ii) Your benefits have been suspended for 12 consecutive months because of your failure to comply with treatment requirements.

(2) For purposes other than payment of your disability benefits, your period of disability continues until the termination month as explained in § 404.325.

[49 FR 22271, May 29, 1984, as amended at 60 FR 8145, Feb. 10, 1995]

§ 404.322 When you may apply for a period of disability after a delay due to a physical or mental condition.

If because of a physical or mental condition you did not apply for a period of disability within 12 months after your period of disability ended, you may apply not more than 36 months after the month in which your disability ended. Your failure to apply within the 12-month time period will be considered due to a physical or mental condition if during this time—

(a) Your physical condition limited your activities to such an extent that you could not complete and sign an application; or

(b) You were mentally incompetent.

§ 404.325 The termination month.

If you do not have a disabling impairment, your termination month is the third month following the month in which your impairment is not disabling even if it occurs during the trial work period or the reentitlement period. If you continue to have a disabling impairment and complete 9 months of trial work, your termination month will be the third month following the earliest month you perform substantial gainful activity or are determined able to perform substantial gainful activity but in no event earlier than the first month after the 15th month following the end of your trial work period.

Example: You complete your trial work period in December 1980. You are then working at the substantial gainful activity level and continue to do so throughout the 15 months following completion of your trial work period and thereafter. Your termination month will be April 1982, which is the 16th month—that is, the first month in which you performed substantial gainful activity after the 15th month following your trial work period.

Example: You complete your trial work period in December 1980 but you are not able to work at the substantial gainful activity level until December 1982. Your termination month will be March 1983—that is, the third month after the earliest month you perform or are determined able to perform substantial gainful activity.

[49 FR 22271, May 29, 1984]

BENEFITS FOR SPOUSES AND DIVORCED SPOUSES

§ 404.330 Who is entitled to wife's or husband's benefits.

You are entitled to benefits as the wife or husband of an insured person who is entitled to old-age or disability benefits if—

(a) You are the insured's wife or husband based upon a relationship described in §§ 404.345 through 404.346 and one of the following conditions is met:

(1) Your relationship to the insured as a wife or husband has lasted at least 1 year. (You will be considered to meet the 1-year duration requirement throughout the month in which the first anniversary of the marriage occurs.)

(2) You and the insured are the natural parents of a child; or

(3) In the month before you married the insured you were entitled to, or if you had applied and been old enough you could have been entitled to, any of these benefits or payments: Wife's, husband's, widow's, widower's, or parent's benefits; disabled child's benefits; or annuity payments under the Railroad Retirement Act for widows, widowers, parents, or children 18 years old or older;

(b) You apply;

(c) You are age 62 or older throughout a month and you meet all other conditions of entitlement, or you are the insured's wife or husband and have *in your care* (as defined in §§404.348 through 404.349), throughout a month in which all other conditions of entitlement are met, a child who is entitled to child's benefits on the insured's earnings record and the child is either under age 16 or disabled; and

(d) You are not entitled to an old-age or disability benefit based upon a primary insurance amount that is equal to or larger than the full wife's or husband's benefit.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 45 FR 68932, Oct. 17, 1980; 48 FR 21926, May 16, 1983]

§ 404.331 Who is entitled to wife's or husband's benefits as a divorced spouse.

You are entitled to wife's or husband's benefits as the divorced wife or divorced husband of an insured person who is entitled to old-age or disability benefits if you meet the requirements of paragraphs (a) through (e). You are entitled to these benefits even though the insured person is not yet entitled to benefits, if the insured person is at least age 62 and if you meet the requirements of paragraphs (a) through (f). The requirements are that—

(a) You are the insured's divorced wife or divorced husband and—

(1) You were validly married to the insured under State law as described in § 404.345 or you were deemed to be validly married as described in § 404.346; and

(2) You were married to the insured for at least 10 years immediately before your divorce became final;

(b) You apply;

(c) You are not married. (For purposes of meeting this requirement, you will be considered not to be married throughout the month in which the divorce occurred);

(d) You are age 62 or older throughout a month in which all other conditions of entitlement are met; and

(e) You are not entitled to an old-age or disability benefit based upon a primary insurance amount that is equal to or larger than the full wife's or husband's benefit.

(f) You have been divorced from the insured person for at least 2 years.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21926, May 16, 1983; 51 FR 11911, Apr. 8, 1986; 58 FR 64891, Dec. 10, 1993]

§ 404.332 When wife's and husband's benefits begin and end.

(a) You are entitled to wife's or husband's benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement under § 404.330 or § 404.331. However, if you are entitled as a divorced spouse before the insured person becomes entitled, your benefits cannot begin before January 1985 based on an application filed no earlier than that month.

(b) Your entitlement to benefits ends with the month before the month in which one of the following events first occurs:

(1) You become entitled to an old-age or disability benefit based upon a primary insurance amount that is equal to or larger than the full wife's or husband's benefit.

(2) You are the wife or husband and are divorced from the insured person unless you meet the requirements for benefits as a divorced wife or divorced husband as described in § 404.331.

(3) You are the divorced wife or divorced husband and you marry someone, other than the insured who is entitled to old-age benefits, unless that other person is someone entitled to benefits as a wife, husband, widow, widower, father, mother, parent or disabled child. Your benefits will end if you remarry the insured who is not yet entitled to old-age benefits.

(4) If you are under 62 years old, the child who was in your care becomes age 16 (unless disabled) or is otherwise no longer entitled to child's benefits. (See paragraph (c) of this section if you were entitled to wife's or husband's benefits for August 1981 on the basis of having a child in care.)

(5) The insured person dies or is no longer entitled to old age or disability benefits. Exception: Your benefits will continue if the insured person was entitled to disability benefits based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of his or her disability (as described in § 404.1535), the insured person's benefits ended after 36 months of benefits (see § 404.316(e)) or 12 consecutive months of suspension for noncompliance with treatment (see § 404.316(f)), and but for the operation of these provisions, the insured person would remain entitled to benefits based on disability.

(6) If your benefits are based upon a deemed valid marriage and you have not divorced the insured, you marry someone other than the insured.

(7) You die.

(8) You became entitled as the divorced wife or the divorced husband before the insured person became entitled, but he or she is no longer insured.

(c) If you were entitled to wife's or husband's benefits for August 1981 on the basis of having a child in care, your entitlement will continue until September 1983, until the child reaches 18 (unless disabled) or is otherwise no longer entitled to child's benefits, or until one of the events described in paragraph (b)(1), (2), (3), (5), (6) or (7) of this section occurs, whichever is earliest.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21926, May 16, 1983; 49 FR 24115, June 12, 1984; 51 FR 11911, Apr. 8, 1986; 58 FR 64891, Dec. 10, 1993; 60 FR 8145, Feb. 10, 1995]

§ 404.333 Wife's and husband's benefit amounts.

Your wife's or husband's monthly benefit is equal to one-half the insured person's primary insurance amount. If you are entitled as a divorced wife or as a divorced husband before the insured person becomes entitled, we will compute the primary insurance amount as if he or she became entitled to old-age benefits in the first month you are entitled as a divorced wife or

as a divorced husband. The amount of your monthly benefit may change as explained in § 404.304.

[51 FR 11912, Apr. 8, 1986]

§ 404.335 Who is entitled to widow's or widower's benefits.

You may be entitled to benefits as the widow or widower of a person who was fully insured when he or she died. You are entitled to these benefits if—

(a) You are the insured's widow or widower based upon a relationship described in §§ 404.345 through 404.346, and one of the following conditions is met:

(1) Your relationship to the insured as a wife or husband lasted for at least 9 months immediately before the insured died.

(2) Your relationship to the insured as a wife or husband did not last 9 months before the insured died, but at the time of your marriage the insured was reasonably expected to live for 9 months, and—

(i) The death of the insured was accidental. The death is accidental if it was caused by an event that the insured did not expect; it was the result of bodily injuries received from violent and external causes; and as a direct result of these injuries, death occurred not later than 3 months after the day on which the bodily injuries were received. An intentional and voluntary suicide will not be considered an accidental death;

(ii) The death of the insured occurred in the line of duty while he or she was serving on active duty as a member of the uniformed services as defined in § 404.1019; or

(iii) You had been previously married to the insured for at least 9 months.

(3) You and the insured were the natural parents of a child; or you were married to the insured when either of you adopted the other's child or when both of you adopted a child who was then under 18 years old.

(4) In the month before you married the insured, you were entitled to or, if you had applied and had been old enough, could have been entitled to any of these benefits or payments: widow's, widower's, father's (based on the record of a fully insured individual), mother's (based on the record of a fully insured individual), wife's, husband's, parent's, or disabled child's benefits; or annuity payments under the Railroad Retirement Act for widows, widowers, parents, or children age 18 or older;

(b) You apply, except that you need not apply again if—

(1) You are entitled to wife's or husband's benefits for the month before the month in which the insured dies and you are 65 years old or you are not entitled to either old-age or disability benefits;

(2) You are entitled to mother's or father's benefits for the month before the month in which you become 65 years old;

(3) You are entitled to wife's or husband's benefits and to either old-age or disability benefits in the month before the month of the insured's death, you are under age 65 in the month of death, and you have filed a Certificate of Election in which you elect to receive reduced widow's or widower's benefits; or

(4) You applied in 1990 for widow's or widower's benefits based on disability, and:

(i) You were entitled to disability insurance benefits for December 1990, or eligible for supplemental security income or federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, for January 1991; and

(ii) You were found not disabled for any month based on the definition of disability in §§ 404.1577 and 404.1578, as in effect prior to January 1991, but would have been entitled if the standard in § 404.1505(a) had applied. (This exception to the requirement for filing an application is effective only with respect to benefits payable for months after December 1990.);

(c) You are at least 60 years old; or you are at least 50 years old and have a disability as defined in § 404.1505 and—

(1) Your disability started not later than 7 years after the insured died or 7 years after you were last entitled to mother's or father's benefits or to widow's or widower's benefits based upon a disability, whichever occurred last;

(2) Your disability continued during a waiting period of 5 full consecutive months, unless months beginning with

the first month of eligibility for supplemental security income or federally administered State supplementary payments are counted, as explained in paragraph (c)(3) of this section. The waiting period may begin no earlier than the 17th month before you applied; the fifth month before the insured died; or if you were previously entitled to mother's, father's, widow's, or widower's benefits the 5th month before your entitlement to benefits ended. If you were previously entitled to widow's or widower's benefits based upon a disability, the waiting period is not required;

(3) For monthly benefits payable for months after December 1990, if you were or have been eligible for supplemental security income or federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, your disability does not have to have continued through a separate, full 5-month waiting period before you may begin receiving benefits. We will include as months of the 5-month waiting period the months in a period beginning with the first month you received supplemental security income or a federally administered State supplementary payment and continuing through all succeeding months, regardless of whether the months in the period coincide with the months in which your waiting period would have occurred, or whether you continued to be eligible for supplemental security income or a federally administered State supplementary payment after the period began, or whether you met the nondisability requirements for entitlement to widow's or widower's benefits. However, we will not pay you benefits under this provision for any month prior to January 1991; and

(4) You have not previously received 36 months of payments based on disability when drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535), regardless of the number of entitlement periods you may have had, or your current application for widow(er)'s benefits is not based on a disability where drug addiction or alcoholism is a contributing factor material to the determination of disability.

(d) You are not entitled to an old-age benefit that is equal to or larger than the insured person's primary insurance amount; and

(e) You are unmarried, unless—

(1) You remarried after you became 60 years old; or

(2) For benefits for months after 1983—

(i) You are now age 60 or older;

(ii) You remarried after attaining age 50 but before attaining age 60; and

(iii) At the time of the remarriage, you were entitled to widow(er)'s benefits as a disabled widow(er); or

(3) For benefits for months after 1983—

(i) You are now at least age 50 but not yet age 60;

(ii) You remarried after attaining age 50; and

(iii) You met the disability requirements in paragraph (c) of this section at the time of your remarriage (i.e., your disability began within the specified time and before your remarriage).

[44 FR 34481, June 15, 1979, as amended at 47 FR 12162, Mar. 22, 1982; 49 FR 24115, June 12, 1984; 51 FR 4482, Feb. 5, 1986; 51 FR 10616, Mar. 28, 1986; 55 FR 25825, June 25, 1990; 57 FR 30119, July 8, 1992; 59 FR 14747, Mar. 30, 1994; 60 FR 8145, Feb. 10, 1995]

§ 404.336 Who is entitled to widow's or widower's benefits as a surviving divorced spouse.

You may be entitled to widow's or widower's benefits as the surviving divorced wife or the surviving divorced husband of a person who was fully insured when he or she died. You are entitled to these benefits if—

(a) You are the insured's surviving divorced wife or surviving divorced husband and—

(1) You were validly married to the insured under State law as described in § 404.345 or are deemed to be validly married as described in § 404.346; and

(2) You were married to the insured for at least 10 years immediately before your divorce became final;

(b) You apply, except that you need not apply again if—

(1) You are entitled to wife's or husband's benefits for the month before the month in which the insured dies and you are 65 years old or you are not

entitled to old-age or disability benefits;

(2) You are entitled to mother's or father's benefits for the month before the month in which you become 65 years old;

(3) You are entitled to wife's or husband's benefits and to either old-age or disability benefits in the month before the month of the insured's death, you are under age 65 in the month of death, and you have filed a Certificate of Election in which you elect to receive reduced widow's or widower's benefits; or

(4) You applied in 1990 for widow's or widower's benefits based on disability, and:

(i) You were entitled to disability insurance benefits for December 1990, or eligible for supplemental security income or federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, for January 1991; and

(ii) You were found not disabled for any month based on the definition of disability in §§ 404.1577 and 404.1578, as in effect prior to January 1991, but would have been entitled if the standard in § 404.1505(a) had applied. (This exception to the requirement for filing an application is effective only with respect to benefits payable for months after December 1990.);

(c) You are at least 60 years old; or you are at least 50 years old and have a disability as defined in § 404.1505 and—

(1) Your disability started not later than 7 years after the insured died or 7 years after you were last entitled to mother's or father's benefits or to widow's or widower's benefits based upon a disability, whichever occurred last;

(2) Your disability continued during a waiting period of 5 full consecutive months, unless months beginning with the first month of eligibility for supplemental security income or federally administered State supplementary payments are counted, as explained in paragraph (c)(3) of this section. This waiting period may begin no earlier than the 17th month before you applied; the fifth month before the insured died; or if you were previously entitled to mother's, father's, widow's, or widower's benefits, the 5th month before your previous entitlement to benefits ended. If you were previously entitled to widow's or widower's benefits based upon a disability, the waiting period is not required; and

(3) For monthly benefits payable for months after December 1990, if you were or have been eligible for supplemental security income or a federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, your disability does not have to have continued through a separate, full 5-month waiting period before you may begin receiving benefits. We will include as months of the 5-month waiting period the months in a period beginning with the first month you received supplemental security income or a federally administered State supplementary payment and continuing through all succeeding months, regardless of whether the months in the period coincide with the months in which your waiting period would have occurred, or whether you continued to be eligible for supplemental security income or a federally administered State supplementary payment after the period began, or whether you met the nondisability requirements for entitlement to widow's or widower's benefits. However, we will not pay you benefits under this provision for any month prior to January 1991;

(d) You are not entitled to an old-age benefit that is equal to or larger than the insured person's primary insurance amount; and

(e) You are unmarried, unless for benefits for months after 1983—

(1) You remarried after you became 60 years old; or

(2)(i) You are now age 60 or older;

(ii) You remarried after attaining age 50 but before attaining age 60; and

(iii) At the time of the remarriage, you were entitled to widow(er)'s benefits as a disabled widow(er); or

(3)(i) You are now at least age 50 but not yet age 60;

(ii) You remarried after attaining age 50; and

(iii) You met the disability requirements in paragraph (c) of this section at the time of your remarriage (i.e.,

your disability began within the specified time and before your remarriage).

[44 FR 34481, June 15, 1979, as amended at 47 FR 12162, Mar. 22, 1982; 51 FR 4482, Feb. 5, 1986; 55 FR 25300, June 21, 1990; 55 FR 25825, June 25, 1990; 57 FR 30119, July 8, 1992; 58 FR 64891, Dec. 10, 1993]

§ 404.337 When widow's and widower's benefits begin and end.

(a) You are entitled to widow's or widower's benefits under § 404.335 or § 404.336 beginning with the first month covered by your application in which you meet all the other requirements for entitlement.

(b) Your entitlement to benefits ends at the earliest of the following times:

(1) The month before the month in which you become entitled to an old-age benefit that is equal to or larger than the insured's primary insurance amount.

(2) If your widow's or widower's benefit is based upon a disability, the second month after the month your disability ends or, where disability ends on or after December 1, 1980, the month before your termination month (§ 404.325). However payments are subject to the provisions of paragraphs (c) and (d) of this section. You may remain eligible for payment of benefits if you became 65 years old before your termination month and you met the other requirements for widow's or widower's benefits. If your widow's or widower's benefit is based on a finding that drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 404.1535, your entitlement to benefits will terminate the month after the 12th consecutive month of suspension for noncompliance with treatment or after 36 months of benefits on that basis when treatment is available regardless of the number of entitlement periods you may have had, unless you are otherwise disabled without regard to drug addiction or alcoholism.

(3) The month before the month in which you die.

(c)(1) Your benefits may be continued after your impairment is no longer disabling if—

(i) Your disability did not end before December 1980, the effective date of this provision of the law;

(ii) You are participating in an appropriate program of vocational rehabilitation as described in § 404.316(c)(1)(ii);

(iii) You began the program before your disability ended; and

(iv) We have determined that your completion of the program, or your continuation in the program for a specified period of time, will significantly increase the likelihood that you will not have to return to the disability benefit rolls.

(2) Your benefits generally will be stopped with the month—

(i) You complete the program;

(ii) You stop participating in the program for any reason; or

(iii) We determine that your continuing participation in the program will no longer significantly increase the likelihood that you will be permanently removed from the disability benefit rolls.

Exception: In no case will your benefits be stopped with a month earlier than the second month after the month your disability ends.

(d) If, after November 1980, you have a disabling impairment (§ 404.1511), you will be paid benefits for all months in which you do not do substantial gainful activity during the reentitlement period (§ 404.1592a) following the end of your trial work period (§ 404.1592). If you are unable to do substantial gainful activity in the first month following the reentitlement period, we will pay you benefits until you are able to do substantial gainful activity. (Earnings during your trial work period do not affect the payment of your benefits.) You will also be paid benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity during those succeeding months. After those three months, you cannot be paid benefits for any months in which you do substantial gainful activity.

[44 FR 34481, June 15, 1979, as amended at 47 FR 31542, July 21, 1982; 49 FR 22271, May 29, 1984; 51 FR 4482, Feb. 5, 1986; 51 FR 17617, May 14, 1986; 58 FR 64891, Dec. 10, 1993; 60 FR 8146, Feb. 10, 1995]

§ 404.338 Widow's and widower's benefits amounts.

Your widow's or widower's monthly benefit is equal to the insured person's primary insurance amount. If the insured person died before reaching age 62 and you are first eligible after 1984, we may compute a special primary insurance amount for the purpose of determining the amount of your monthly benefit (see § 404.212(b)). We may increase your monthly benefit amount if the insured person earned delayed retirement credit after age 65 by working or by delaying filing for benefits (see § 404.313). The amount of your monthly benefit may change as explained in § 404.304. In addition, your monthly benefit will be reduced if the insured person had been entitled to old-age benefits that were reduced for age because he or she chose to receive them before becoming 65 years old. In this instance, your benefit is reduced, if it would otherwise be higher, to either the amount the insured would have been entitled to if still alive or 82½ percent of his or her primary insurance amount, whichever is larger.

[44 FR 34481, June 15, 1979, as amended at 51 FR 4482, Feb. 5, 1986]

§ 404.339 Who is entitled to mother's or father's benefits.

You may be entitled as the widow or widower to mother's or father's benefits on the earnings record of someone who was fully or currently insured when he or she died. You are entitled to these benefits if—

(a) You are the widow or widower of the insured and meet the conditions described in § 404.335(a)(1);

(b) You apply for these benefits; or you were entitled to wife's benefits for the month before the insured died;

(c) You are unmarried;

(d) You are not entitled to widow's or widower's benefits, or to an old-age benefit that is equal to or larger than the full mother's or father's benefit; and

(e) You have *in your care* the insured's child who is entitled to child's benefits and he or she is under 16 years old or is disabled. Sections 404.348 and 404.349 describe when a child is *in your care.*

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983]

§ 404.340 Who is entitled to mother's or father's benefits as a surviving divorced spouse.

You may be entitled to mother's or father's benefits as the suviving divorced wife or the surviving divorced husband of someone who was fully or currently insured when he or she died. You are entitled to these benefits if—

(a) You were validly married to the insured under State law as described in § 404.345 or you were deemed to be validly married as described in § 404.346 but the marriage ended in a final divorce and—

(1) You are the mother or father of the insured's child; or

(2) You were married to the insured when either of you adopted the other's child or when both of you adopted a child and the child was then under 18 years old;

(b) You apply for these benefits; or you were entitled to wife's or husband's benefits for the month before the insured died;

(c) You are unmarried;

(d) You are not entitled to widow's or widower's benefits, or to an old-age benefit that is equal to or larger than the full mother's or father's benefit; and

(e) You have *in your care* the insured's child who is under age 16 or disabled, is your natural or adopted child, and is entitled to child's benefits on the insured person's record. Sections 404.348 and 404.349 describe when a child is *in your care.*

[44 FR 34481, June 15, 1979, as amended at 45 FR 68932, Oct. 17, 1980; 48 FR 21927, May 16, 1983; 58 FR 64891, Dec. 10, 1993]

§ 404.341 When mother's and father's benefits begin and end.

(a) You are entitled to mother's or father's benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement.

(b) Your entitlement to benefits ends with the month before the month in which one of the following events first occurs:

(1) You become entitled to a widow's or widower's benefit or to an old-age benefit that is equal to or larger than the full mother's or father's benefit.

(2) The child *in your care* becomes age 16 and not disabled or is otherwise no longer entitled to child's benefits. (See paragraph (c) of this section if you were entitled to mother's or father's benefits for August 1981.)

(3) You remarry. Your benefits will not end, however, if you marry someone entitled to old-age, disability, wife's, husband's, widow's, widower's, father's, mother's, parent's or disabled child's benefits.

(4) You die.

(c) If you were entitled to spouse's benefits on the basis of having a child in care, or to mother's or father's benefits for August 1981, your entitlement will continue until September 1983, until the child reaches 18 (unless disabled) or is otherwise no longer entitled to child's benefits, or until one of the events described in paragraph (b)(1), (3), or (4) of this section occurs, whichever is earliest.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 49 FR 24115, June 12, 1984; 58 FR 64891, Dec. 10, 1993]

§ 404.342 Mother's and father's benefit amounts.

Your mother's or father's monthly benefit is equal to 75 percent of the insured person's primary insurance amount. The amount of your monthly benefit may change as explained in § 404.304.

§ 404.344 Your relationship by marriage to the insured.

You may be eligible for benefits if your are related to the insured person as a wife, husband, widow, or widower. To decide your relationship to the insured, we look first to State laws. The State laws that we use are discussed in § 404.345. If your relationship cannot be established under State law, you may still be eligible for benefits if your relationship as the insured's wife, husband, widow, or widower is based upon a *deemed valid marriage* as described in § 404.346.

§ 404.345 Your relationship as wife, husband, widow, or widower under State law.

To decide your relationship as the insured's wife or husband, we look to the laws of the State where the insured had a permanent home when you applied for wife's or husband's benefits. To decide your relationship as the insured's widow or widower, we look to the laws of the State where the insured had a permanent home when he or she died. If the insured's permanent home is not or was not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa, we look to the laws of the District of Columbia. For a definition of permanent home, see § 404.303. If you and the insured were validly married under State law at the time you apply for wife's or husband's benefits or at the time the insured died if you apply for widow's, widower's, mother's, or father's benefits, the relationship requirement will be met. The relationship requirement will also be met if under State law you would be able to inherit a wife's, husband's, widow's, or widower's share of the insured's personal property if he or she were to die without leaving a will.

§ 404.346 Your relationship as wife, husband, widow or widower based upon a deemed valid marriage.

(a) *General.* If your relationship as the insured's wife, husband, widow, or widower cannot be established under State law as explained in § 404.345, you may be eligible for benefits based upon a deemed valid marriage. You will be deemed to be the wife, husband, widow, or widower of the insured if, in good faith, you went through a marriage ceremony with the insured that would have resulted in a valid marriage except for a legal impediment. A legal impediment includes only an impediment which results because a previous marriage had not ended at the time of the ceremony or because there was a defect in the procedure followed in connection with the intended marriage. For example, a defect in the procedure may be found where a marriage was performed through a religious ceremony in a country that requires a civil ceremony for a valid marriage. Good

faith means that at the time of the ceremony you did not know that a legal impediment existed, or if you did know, you thought that it would not prevent a valid marriage.

(b) *Entitlement based upon a deemed valid marriage.* To be entitled to benefits as a wife, husband, widow or widower as the result of a deemed valid marriage, you and the insured must have been living in the same household (see § 404.347) at the time the insured died or, if the insured is living, at the time you apply for benefits. However, a marriage that had been deemed valid, shall continue to be deemed valid if the insured individual and the person entitled to benefits as the wife or husband of the insured individual are no longer living in the same household at the time of death of the insured individual.

[44 FR 34481, June 15, 1979, as amended at 45 FR 65540, Oct. 3, 1980; 48 FR 21927, May 16, 1983; 58 FR 64892, Dec. 10, 1993]

§ 404.347 "Living in the same household" defined.

You may be eligible for benefits as a wife, husband, widow, or widower because your relationship to the insured is based upon a deemed valid marriage, as described in § 404.346, only if you and the insured were living in the same household at the time you apply for wife's or husband's benefits or at the time the insured died if you apply for widow's, widower's, mother's, or father's benefits. Living in the same household means that you and the insured customarily lived together as husband and wife in the same residence. You may be considered to be living in the same household although one of you is temporarily absent from the residence. An absence will be considered temporary if it was due to service in the U.S. Armed Forces. An absence of less than 6 months is also considered temporary if neither you nor the insured were outside of the United States during this time and the absence was due to business or employment; or to confinement in a hospital, nursing home, other medical institution, or a penal institution. Other absences may be considered temporary if it is shown that you and the insured could have reasonably expected to live together in the near future.

§ 404.348 When a child living with you is "in your care".

To become entitled to wife's benefits before you become 62 years old or to mother's or father's benefits, you must have the insured's child *in your care.* A child who has been living with you for at least 30 days is in your care unless—

(a) The child is in active military service;

(b) The child is 16 years old or older and not disabled;

(c) The child is 16 years old or older with a mental disability, but you do not actively supervise his or her activities and you do not make important decisions about his or her needs, either alone or with help from your spouse; or

(d) The child is 16 years old or older with a physical disability, but it is not necessary for you to perform personal services for him or her. Personal services are services such as dressing, feeding, and managing money that the child cannot do alone because of a disability.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983]

§ 404.349 When a child living apart from you is "in your care".

(a) *In your care.* A child living apart from you is in your care if—

(1) The child lived apart from you for not more than 6 months, or the child's current absence from you is not expected to last over 6 months;

(2) The child is under 16 years old, you supervise his or her activities and make important decisions about his or her needs, and one of the following circumstances exist:

(i) The child is living apart because of school but spends at least 30 days vacation with you each year unless some event makes having the vacation unreasonable; and if you and the child's other parent are separated, the school looks to you for decisions about the child's welfare;

(ii) The child is living apart because of your employment but you make regular and substantial contributions to his or her support; see § 404.366(a) for a definition of *contributions for support*;

(iii) The child is living apart because of a physical disability that the child has or that you have; or

(3) The child is 16 years old or older, is mentally disabled, and you supervise his or her activities, make important decisions about his or her needs, and help in his or her upbringing and development.

(b) *Not in your care.* A child living apart from you is not in your care if—

(1) The child is in active military service;

(2) The child is living with his or her other parent;

(3) The child is removed from your custody and control by a court order;

(4) The child is 16 years old or older, is mentally competent, and either has been living apart from you for 6 months or more or begins living apart from you and is expected to be away for more than 6 months;

(5) You gave your right to have custody and control of the child to someone else; or

(6) You are mentally disabled.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983]

CHILD'S BENEFITS

§ 404.350 Who is entitled to child's benefits.

(a) *General.* You are entitled to child's benefits on the earnings record of an insured person who is entitled to old-age or disability benefits or who has died if—

(1) You are the insured person's child, based upon a relationship described in §§ 404.355 through 404.359;

(2) You are dependent on the insured, as defined in §§ 404.360 through 404.365;

(3) You apply;

(4) You are unmarried; and

(5) You are under age 18, you are 18 years old or older and have a disability that began before you became 22 years old, or you are 18 years or older and qualify for benefits as a full-time student as described in § 404.367 or § 404.369.

(b) *Entitlement preclusion for certain disabled children.* If you are a disabled child as referred to in paragraph (a)(5) of this section, and your disability was based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535) and your benefits ended after your receipt of 36 months of benefits, you will not be entitled to benefits based on disability for any month following such 36 months regardless of the number of entitlement periods you have had if, in such following months, drug addiction or alcoholism is a contributing factor material to the later determination of disability (as described in § 404.1535).

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 60 FR 8146, Feb. 10, 1995]

§ 404.351 Who may be reentitled to child's benefits.

If your entitlement to child's benefits has ended, you may be reentitled on the same earnings record if you have not married and if you apply for reentitlement. Your reentitlement may begin with—

(a) The first month in which you qualify as a full-time student. (See §§ 404.367 and 404.369)

(b) The first month in which you are disabled, if your disability began before you became 22 years old; or

(c) The first month you are under a disability that began before the end of the 84th month following the month in which your benefits had ended because an earlier disability had ended.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983]

§ 404.352 When child's benefits begin and end.

(a) *When benefits begin.* (1) If the insured is deceased, you are entitled to child's benefits beginning with the first month covered by your application in which you meet all other requirements for entitlement.

(2) If the insured is living, you are entitled to child's benefits beginning with the first month covered by your application:

(i) *Throughout* which you meet all the other requirements for entitlement if your first month of entitlement is September 1981 or later; or

(ii) *In* which you meet all the other requirements for entitlement if your first month of entitlement is before September 1981.

(b) Your entitlement to benefits ends with the month before the month in which one of the following events first occurs:

(1) You become 18 years old, unless you are disabled or a full-time student. If you become 18 years old and you are disabled, your entitlement to disability benefits ends with the second month following the month in which your disability ends. If your disability ends on or after December 1, 1980, your entitlement to disability benefits continues, subject to the provisions of paragraphs (c) and (d) of this section, until the month before your termination month (§ 404.325). If you become 18 years old and you qualify as a full-time student who is not disabled, your entitlement ends with the last month you are a full-time student or, if earlier, the month before the month you became age 19 (age 22 in certain situations described in § 404.369). If you become age 19 in a month in which you have not completed the requirements for, or received, a diploma or equivalent certificate from an elementary or secondary school, your entitlement will end with the month in which the quarter or semester in which you are enrolled ends if you are required to enroll for each quarter or semester. If the school you are attending does not have a quarter or semester system which requires reenrollment, your benefits will end with the month you complete the course or, if earlier, the first day of the third month following the month in which you become 19 years old.

(2) You marry. Your benefits will not end, however, if you are age 18 or older, disabled, and you marry a person entitled to child's benefits based on disability or person entitled to old-age, divorced wife's, divorced husband's, widow's, widower's, mother's, father's, parent's, or disability benefits.

(3) The insured's entitlement to old-age or disability benefits ends for a reason other than death or the attainment of age 65. Exception: Your benefits will continue if the insured person was entitled to disability benefits based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of his or her disability (as described in § 404.1535), the insured person's benefits ended after 36 months of payment (see § 404.316(e)) or 12 consecutive months of suspension for noncompliance with treatment (see § 404.316(f)), and the insured person remains disabled.

(4) You die.

(c) If you are entitled to benefits as a disabled child age 18 or over and your disability is based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535), your benefits also will terminate under the following conditions:

(1) If your benefits have been suspended for a period of 12 consecutive months for failure to comply with treatment, your benefits will terminate with the month following the 12 months unless you are otherwise disabled without regard to drug addiction or alcoholism (see § 404.470(c)).

(2) If you have received 36 months of benefits on that basis when treatment is available, regardless of the number of entitlement periods you may have had, your benefits will terminate with the month following such 36-month payment period unless you are otherwise disabled without regard to drug addiction or alcoholism.

(d)(1) Your benefits may be continued after your impairment is no longer disabling if—

(i) Your disability did not end before December 1980, the effective date of this provision of the law;

(ii) You are participating in an appropriate program of vocational rehabilitation as described in § 404.316(c)(1)(ii);

(iii) You began the program before your disability ended; and

(iv) We have determined that your completion of the program, or your continuation in the program for a specified period of time, will significantly increase the likelihood that you will not have to return to the disability benefit rolls.

(2) Your benefits generally will be stopped with the month—

(i) You complete the program;

(ii) You stop participating in the program for any reason; or

(iii) We determine that your continuing participation in the program will no longer significantly increase the likelihood that you will be permanently removed from the disability benefit rolls.

Exception: In no case will your benefits be stopped with a month earlier than the second month after the month your disability ends.

(e) If, after November 1980, you have a disabling impairment (§404.1511), you will be paid benefits for all months in which you do not do substantial gainful activity during the reentitlement period (§404.1592a) following the end of your trial work period (§404.1592). If you are unable to do substantial gainful activity in the first month following the reentitlement period, we will pay you benefits until you are able to do substantial gainful activity. (Earnings during your trial work period do not affect the payment of your benefits during that period.) You will also be paid benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity during those succeeding months. After those three months, you cannot be paid benefits for any months in which you do substantial gainful activity.

[44 FR 34481, June 15, 1979, as amended at 47 FR 31543, July 21, 1982; 48 FR 21927, May 16, 1983; 49 FR 22271, May 29, 1984; 49 FR 24115, June 12, 1984; 51 FR 17617, May 14, 1987; 60 FR 8146, Feb. 10, 1995]

§ 404.353 Child's benefit amounts.

(a) *General.* Your child's monthly benefit is equal to one-half of the insured person's primary insurance amount if he or she is alive and three-fourths of the primary insurance amount if he or she has died. The amount of your monthly benefit may change as explained in §§404.304 and 404.369.

(b) *Entitlement to more than one benefit.* If you are entitled to a child's benefit on more than one person's earnings record, you will ordinarily receive only the benefit payable on the record with the highest primary insurance amount. If your benefit before any reduction would be larger on an earnings record with a lower primary insurance amount and no other person entitled to benefits on any earnings record would receive a smaller benefit as a result of your receiving benefits on the record with the lower primary insurance amount, you will receive benefits on that record. See §404.407(d) for a further explanation. If you are entitled to a child's benefit and to other dependent's or survivor's benefits, you can receive only the highest of the benefits.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 48 FR 21928, May 16, 1983; 51 FR 12606, Apr. 14, 1986]

§ 404.354 Your relationship to the insured.

(a) *General.* You may be related to the insured person in one of several ways and be entitled to benefits as his or her child—as a natural child, legally adopted child, stepchild, grandchild, stepgrandchild, or equitably adopted child.

(b) *Use of State laws.* To decide your relationship to the insured, we look to the laws that are in effect in the State where the insured has his or her permanent home when you apply for benefits. If the insured is deceased, we look to the laws that were in effect at the time the insured worker died in the State where the insured had his or her permanent home. If the insured's permanent home is not or was not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa, we will look at the laws of the District of Columbia. For a definition of permanent home, see §404.303. The State laws we use are the ones the courts would use to decide whether you could inherit a child's share of the insured's personal property if he or she were to die without leaving a will. If these laws would not permit you to inherit the insured's personal property as his or her child, you may still be eligible for child's benefits if you are related to the insured in one of the other ways described in §§404.355 through 404.359.

[44 FR 34481, June 15, 1979, as amended at 49 FR 21513, May 22, 1984]

§ 404.355 Who is the insured's natural child.

You may be eligible for benefits as the insured's natural child if one of the following conditions is met:

(a) You could inherit the insured's personal property as his or her natural child under State inheritance laws as described in §404.354.

(b) You are the insured's natural child, and the insured and your mother or father went through a ceremony which would have resulted in a valid marriage between them except for a *legal impediment* described in § 404.346(a).

(c) You are the insured's natural child and your mother or father has not married the insured, but the insured has either acknowledged in writing that you are his or her child, been decreed by a court to be your father or mother, or been ordered by a court to contribute to your support because you are his or her child. In the case where the insured is deceased, the acknowledgement, court decree, or court order must have been made before his or her death. For purposes of determining whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a), the written acknowledgement, court decree, or court order will be considered to have occurred on the first day of the month in which it actually occurred.

(d) Your mother or father has not married the insured but you have evidence other than the evidence described in paragraph (c) of this section to show that the insured is your natural father or mother. Additionally, you must have evidence to show that the insured was either living with you or contributing to your support at the time you applied for benefits. See § 404.366 for an explanation of the terms *living with* and *contributing to your support*. If the insured is not alive at the time of your application you must have evidence to show that the insured was either living with you or contributing to your support when he or she died.

[44 FR 34481, June 15, 1979, as amended at 45 FR 65540, Oct. 3, 1980; 49 FR 24115, June 12, 1984]

§ 404.356 Who is the insured's legally adopted child.

You may be eligible for benefits as the insured's child if you were legally adopted by the insured. If you were legally adopted after the insured's death by his or her surviving spouse you may also be considered the insured's legally adopted child.

§ 404.357 Who is the insured's stepchild.

You may be eligible for benefits as the insured's stepchild if, after your birth, your natural or adopting parent married the insured. The marriage between the insured and your parent must be a valid marriage under State law or a marriage which would be valid except for a *legal impediment* described in § 404.346(a). If the insured is alive when you apply, you must have been his or her stepchild for at least 1 year immediately preceding the day you apply. For purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), you will be considered to meet the one year duration requirement throughout the month in which the anniversary of the marriage occurs. If the insured is not alive when you apply, you must have been his or her stepchild for at least 9 months immediately preceding the day the insured died. This 9-month requirement will not have to be met if the marriage between the insured and your parent lasted less than 9 months under the conditions described in §404.335(a)(2).

[48 FR 21928, May 16, 1983]

§ 404.358 Who is the insured's grandchild or stepgrandchild.

(a) *Grandchild and stepgrandchild defined.* You may be eligible for benefits as the insured's grandchild or stepgrandchild if you are the natural child, adopted child, or stepchild of a person who is the insured's child as defined in §§ 404.355 through 404.357, or § 404.359. Additionally, for you to be eligible as a grandchild or stepgrandchild, your natural or adoptive parents must have been either deceased or under a disability, as defined in § 404.1501(a), at the time your grandparent or stepgrandparent became entitled to old-age or disability benefits or died; or if your grandparent or stepgrandparent had a period of disability that continued until he or she became entitled to benefits or died, at the time the period of disability began. If your parent is deceased, for purposes of determining whether the conditions of entitlement are met *throughout* the

first month as stated in § 404.352(a)(2)(i), your parent will be considered to be deceased as of the first day of the month of death.

(b) *Legally adopted grandchild or stepgrandchild.* If you are the insured's grandchild or stepgrandchild and you are legally adopted by the insured or by the insured's surviving spouse after his or her death, you are considered an adopted child and the dependency requirements of § 404.362 must be met.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21928, May 16, 1983]

§ 404.359 Who is the insured's equitably adopted child.

You may be eligible for benefits as an equitably adopted child if the insured had agreed to adopt you as his or her child but the adoption did not occur. The agreement to adopt you must be one that would be recognized under State law so that you would be able to inherit a child's share of the insured's personal property if he or she were to die without leaving a will. The agreement must be in whatever form, and you must meet whatever requirements for performance under the agreement, that State law directs. If you apply for child's benefits after the insured's death, the law of the State where the insured had his or her permanent home at the time of his or her death will be followed. If you apply for child's benefits during the insured's life, the law of the State where the insured has his or her permanent home at the time or your application will be followed.

§ 404.360 When a child is dependent upon the insured person.

One of the requirements for entitlement to child's benefits is that you be dependent upon the insured. The evidence you need to prove your dependency is determined by how you are related to the insured. To prove your dependency you may be asked to show that at a specific time you lived with the insured, that you received contributions for your support from the insured, or that the insured provided at least one-half of your support. These dependency requirements, and the time at which they must be met, are explained in §§ 404.361 through 404.365. The terms *living with, contributions for support,* and *one-half support* are defined in § 404.366.

§ 404.361 When a natural child is dependent.

If you are the insured's natural child, as defined in § 404.355, you are considered dependent upon him or her. However, if you are legally adopted by someone else during the insured's lifetime and after the adoption you apply for child's benefits on the insured's earnings record, you will be considered dependent upon the insured (your natural parent) only if he or she was either living with you or contributing to your support at one of these times—

(a) When you applied;

(b) When the insured died; or

(c) If the insured had a period of disability that lasted until he or she died or became entitled to disability or old-age benefits, at the beginning of the period of disability or at the time he or she became entitled to benefits.

§ 404.362 When a legally adopted child is dependent.

(a) *General.* If you were legally adopted by the insured before he or she became entitled to old-age or disability benefits, you are considered dependent upon him or her. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits during the life of the insured, you must meet the dependency requirements stated in paragraph (b) of this section. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits after the death of the insured, you are considered dependent upon him or her. If you were adopted after the insured's death by his or her surviving spouse, you may be considered dependent upon the insured only under the conditions described in paragraph (c) of this section.

(b) *Adoption by the insured after he or she became entitled to benefits.* (1) *General.* If you are legally adopted by the insured after he or she became entitled to benefits and you are not the insured's natural child or stepchild, you are considered dependent on the

insured during his or her lifetime only if—

(i) You had not attained age 18 when adoption proceedings were started, and your adoption was issued by a court of competent jurisdiction within the United States; or

(ii) You had attained age 18 before adoption proceedings were started; your adoption was issued by a court of competent jurisdiction within the United States; and you were living with or receiving at least one-half of your support from the insured for the year immediately preceding the month in which your adoption was issued.

(2) *Natural child and stepchild.* If you were legally adopted by the insured after he or she became entitled to benefits and you are the insured's natural child or stepchild, you are considered dependent upon the insured.

(c) *Adoption by the insured's surviving spouse*—(1) *General.* If you are legally adopted by the insured's surviving spouse after the insured's death, you are considered dependent upon the insured as of the date of his or her death if—

(i) You were either living with or receiving at least one-half of your support from the insured at the time of his or her death; and,

(ii) The insured had started adoption proceedings before he or she died; or if the insured had not started the adoption proceedings before he or she died, his or her surviving spouse began and completed the adoption within 2 years of the insured's death.

(2) *Grandchild or stepgrandchild adopted by the insured's surviving spouse.* If you are the grandchild or stepgrandchild of the insured and any time after the death of the insured you are legally adopted by the insured's surviving spouse, you are considered the dependent child of the insured as of the date of his or her death if—

(i) Your adoption took place in the United States;

(ii) At the time of the insured's death, your natural, adopting or stepparent was not living in the insured's household and making regular contributions toward your support; and

(iii) You meet the dependency requirements stated in § 404.364.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 56 FR 24000, May 28, 1991; 57 FR 3938, Feb. 3, 1992]

§ 404.363 When a stepchild is dependent.

If you are the insured's stepchild, as defined in § 404.357, you are considered dependent upon him or her if you were either living with or receiving at least one-half of your support from him or her at one of these times—

(a) When you applied;

(b) When the insured died; or

(c) If the insured had a period of disability that lasted until his or her death or entitlement to disability or old-age benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

§ 404.364 When a grandchild or stepgrandchild is dependent.

If you are the insured's grandchild or stepgrandchild, as defined in § 404.358(a), you are considered dependent upon the insured if—

(a) You began living with the insured before you became 18 years old; and

(b) You were living with the insured in the United States and receiving at least one-half of your support from him for the year before he or she became entitled to old-age or disability benefits or died; or if the insured had a period of disability that lasted until he or she became entitled to benefits or died, for the year immediately before the month in which the period of disability began. If you were born during the 1-year period, the insured must have lived with you and provided at least one-half of your support for *substantially all* of the period that begins on the date of your birth. The term *substantially all* is defined in § 404.362(b)(1)(iii).

§ 404.365 When an equitably adopted child is dependent.

If you are the insured's equitably adopted child, as defined in § 404.359, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at the time of his

or her death. If your equitable adoption is found to have occurred after the insured became entitled to old-age or disability benefits, your dependency cannot be established during the insured's life. If your equitable adoption is found to have occurred before the insured became entitled to old-age or disability benefits, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at one of these times—

(a) When you applied; or

(b) If the insured had a period of disability that lasted until he or she became entitled to old-age or disability benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

§ 404.366 "Contributions for support," "one-half support," and "living with" the insured defined—determining first month of entitlement.

To be eligible for child's or parent's benefits, and in certain Government pension offset cases, you must be dependent upon the insured person at a particular time or be assumed dependent upon him or her. What it means to be a dependent child is explained in §§ 404.360 through 404.365; what it means to be a dependent parent is explained in § 404.370(f); and the Government pension offset is explained in § 404.408a. Your dependency upon the insured person may be based upon whether at a specified time you were receiving *contributions for your support* or *one-half of your support* from the insured person, or whether you were *living with* him or her. These terms are defined in paragraphs (a) through (c) of this section.

(a) *Contributions for support.* The insured makes a contribution for your support if the following conditions are met:

(1) The insured gives some of his or her own cash or goods to help support you. Support includes food, shelter, routine medical care, and other ordinary and customary items needed for your maintenance. The value of any goods the insured contributes is the same as the cost of the goods when he or she gave them for your support. If the insured provides services for you that would otherwise have to be paid for, the cash value of his or her services may be considered a contribution for your support. An example of this would be work the insured does to repair your home. The insured person is making a contribution for your support if you receive an allotment, allowance, or benefit based upon his or her military pay, veterans' pension or compensation, or social security earnings.

(2) Contributions must be made regularly and must be large enough to meet an important part of your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. If the insured person only provides gifts or donations once in a while for special purposes, they will not be considered contributions for your support. Although the insured's contributions must be made on a regular basis, temporary interruptions caused by circumstances beyond the insured person's control, such as illness or unemployment, will be disregarded unless during this interrruption someone else takes over responsibility for supporting you on a permanent basis.

(b) *One-half support.* The insured person provides one-half of your support if he or she makes regular contributions for your ordinary living costs; the amount of these contributions equals or exceeds one-half of your ordinary living costs; and any income (from sources other than the insured person) you have available for support purposes is one-half or less of your ordinary living costs. We will consider any income which is available to you for your support whether or not that income is actually used for your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. A contribution may be in cash, goods, or services. The insured is not providing at least one-half of your support unless he or she has done so for a reasonable period of time. Ordinarily, we consider a reasonable period to be the 12-month period immediately preceding the time when the one-half support requirement must be met under the rules in §§ 404.362 through 404.364 (for child's benefits), in § 404.370(f) (for parent's

benefits) and in § 404.408a(c) (for benefits where the Government pension offset may be applied). A shorter period will be considered reasonable under the following circumstances:

(1) At some point within the 12-month period, the insured either begins or stops providing at least one-half of your support on a permanent basis and this is a change in the way you had been supported up to then. In these circumstances, the time from the change up to the end of the 12-month period will be considered a reasonable period, unless paragraph (b)(2) of this section applies. The change in your source of support must be permanent and not temporary. Changes caused by seasonal employment or customary visits to the insured's home are considered temporary.

(2) The insured provided one-half or more of your support for at least 3 months of the 12-month period, but was forced to stop or reduce contributions because of circumstances beyond his or her control, such as illness or unemployment, and no one else took over the responsibility for providing at least one-half of your support on a permanent basis. Any support you received from a public assistance program is not considered as a taking over of responsibility for your support by someone else. Under these circumstances, a reasonable period is that part of the 12-month period before the insured was forced to reduce or stop providing at least one-half of your support.

(c) *''Living with'' the insured.* You are living with the insured if you ordinarily live in the same home with the insured and he or she is exercising, or has the right to exercise, parental control and authority over your activities. You are living with the insured during temporary separations if you and the insured expect to live together in the same place after the separation. Temporary separations may include the insured's absence because of active military service or imprisonment if he or she still exercises parental control and authority. However, you are not considered to be living with the insured if you are in active military service or in prison. If *living with* is used to establish dependency for your eligibility to child's benefits and the date your application is filed is used for establishing the point for determining dependency, you must have been living with the insured throughout the month your application is filed in order to be entitled to benefits for that month.

(d) *Determining first month of entitlement.* In evaluating whether dependency is established under paragraph (a), (b), or (c) of this section, for purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), we will not use the temporary separation or temporary interruption rules.

[44 FR 34481, June 15, 1979, as amended at 45 FR 65540, Oct. 3, 1980; 48 FR 21928, May 16, 1983; 52 FR 26955, July 17, 1987]

§ 404.367 When you are a "full-time elementary or secondary school student".

Beginning August 1982, you may be eligible for child's benefits if you are a full-time elementary or secondary school student. For the purposes of determining whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a)(2)(i), if you are entitled as a student on the basis of attendance at an elementary or secondary school, you will be considered to be in full-time attendance for a month during any part of which you are in full-time attendance. You are a full-time elementary or secondary school student if you meet all the following conditions:

(a) You attend a school which provides elementary or secondary education, respectively, as determined under the law of the State or other jurisdiction in which it is located;

(b) You are in full-time attendance in a day or evening noncorrespondence course of at least 13 weeks duration and are carrying a subject load which is considered full-time for day students under the institution's standards and practices. Additionally, your scheduled attendance must be at the rate of at least 20 hours per week unless we find that:

(1) The school attended does not schedule at least 20 hours per week and going to that particular school is your only reasonable alternative; or

(2) Your medical condition prevents you from having scheduled attendance of at least 20 hours per week. To prove that your medical condition prevents you from scheduling 20 hours per week, we may request that you provide appropriate medical evidence or a statement from the school.

(c) You are not being paid while attending the school by an employer who has requested or required that you attend the school;

(d) You are in grade 12 or below; and

(e) You are not confined in a jail, prison, or other penal institution or correctional facility for conviction of a felony committed after October 19, 1980. (See § 404.468, paragraphs (b) and (c) for the meaning of *felony* and an explanation of when we consider a person to be confined in a penal or correctional facility.)

[48 FR 21928, May 16, 1983, as amended at 48 FR 55452, Dec. 13, 1983; 56 FR 35999, July 30, 1991]

§ 404.368 When you are considered a full-time student during a period of nonattendance.

If you are a full-time student, your eligibility may continue during a period of nonattendance (including part-time attendance) if all the following conditions are met:

(a) The period of nonattendance is 4 consecutive months or less;

(b) You show us that you intend to resume your studies as a full-time student at the end of the period or at the end of the period you are a full-time student; and

(c) The period of nonattendance is not due to your expulsion or suspension from the school.

[48 FR 21929, May 16, 1983]

§ 404.369 Special rules for entitlement to child's benefits if you are a full-time student for months before August 1982.

(a) *Full-time student for months before August 1982.* You are a full-time student for purposes of benefits for months before August 1982 if:

(1) You are under age 22;

(2) You are attending an educational institution as defined in paragraph (b) of this section;

(3) You are enrolled in noncorrespondence courses and carrying a subject load that is considered full-time for day students under the practices and standards of the educational institution. If you are enrolled in a junior college, college, or university, your course of study must last at least 13 weeks. If you are enrolled in any other educational institution, your course of study must last at least 13 weeks and your scheduled attendance must be at least 20 hours a week. If your full-time attendance either begins or ends in a month, you will be considered a full-time student for that month. You will not be considered a full time student in the month you graduate if you complete your course of study and stop carrying a full-time subject load in a month before the month preceding the month you graduate; and

(4) You are not being paid while attending the educational institution by an employer who has requested or required that you attend the school.

(b) *Educational institution defined.* An educational institution is a school (including a technical, trade, or vocational school), junior college, college, or university that meets any one of the following conditions:

(1) It is operated or directly supported by the United States, by any State or local government, or by a political subdivision of any State or local government;

(2) It is approved by a State agency or subdivision of the State or accredited by a State or nationally recognized accrediting body. A nationally recognized accrediting body is one determined to be such by the U.S. Secretary of Education. A State-recognized accrediting body is one designated or recognized by a State as the proper authority for accrediting schools, colleges, or universities. Approval by a State agency or subdivision includes approval of a school, college, or university as an educational institution or approval of one or more of the courses offered by a school, college or university; or

(3) It is a nonaccredited school, college, or university, but its credits are accepted by at least 3 educational institutions that have been accedited by

a State or nationally recognized accrediting body.

(c) *When benefits can be paid after July 1982 based on attendance at a school other than an elementary or secondary school.* If you meet the conditions for entitlement to student benefits for months before August 1982 as explained in paragraphs (a) and (b) of this section, but do not meet the conditions for entitlement beginning in August 1982 (see § 404.367), your benefits will end with July 1982 unless you meet the following requirements:

(1) You have attained age 18;

(2) You are not under a disability;

(3) You were entitled to child's benefits (as a child, student or disabled child) for August 1981; and

(4) You were in full-time attendance as described in paragraph (a)(3) of this section at a post-secondary school for any month before May 1982. (A post-secondary school is any school which meets the definition of an educational institution as defined in paragraph (b) of this section but is not an elementary or secondary school as defined in § 404.367(a).)

(d) *Limitations on payments for months after July 1982.* If you are entitled to child's benefits based on the requirements of paragraphs (a) and (c) of this section, your benefit amount (prior to any reduction due to the family maximum or deduction on account of work) will be subject to the following limitations:

(1) You will receive no benefits for May through August beginning with calendar year 1982;

(2) Your benefit for September 1982 through April 1983 will be 75 percent of the benefit to which you were entitled for August 1981;

(3) Your benefit for September 1983 through April 1984 will be 50 percent of the benefit to which you were entitled for August 1981;

(4) Your benefit for September 1984 through April 1985 will be 25 percent of the benefit to which you were entitled for August 1981;

(5) You will receive no benefit for months after April 1985; and

(6) If your student benefits continue beyond July 1982 but later end for any reason, you may not become reentitled to student benefits.

[48 FR 21929, May 16, 1983]

PARENT'S BENEFITS

§ 404.370 Who is entitled to parent's benefits.

You may be entitled to parent's benefits on the earnings record of someone who has died and was fully insured. You are entitled to these benefits if all the following conditions are met:

(a) You are related to the insured person as his or her parent in one of the ways described in § 404.374.

(b) You are at least 62 years old.

(c) You have not married since the insured person died.

(d) You apply.

(e) You are not entitled to an old-age benefit equal to or larger than the parent's benefit amount.

(f) You were receiving at least one-half of your support from the insured at the time he or she died, or at the beginning of any period of disability he or she had that continued up to death. See § 404.366(b) for a definition of *one-half support.* If you were receiving one-half of your support from the insured at the time of the insured's death, you must give us proof of this support within 2 years of the insured's death. If you were receiving one-half of your support from the insured at the time his or her period of disability began, you must give us proof of this support within 2 years of the month in which the insured filed his or her application for the period of disability. You must file the evidence of support even though you may not be eligible for parent's benefits until a later time. There are two exceptions to the 2-year filing requirement:

(1) If there is a good cause for failure to provide proof of support within the 2-year period, we will consider the proof you give us as though it were provided within the 2-year period. Good cause does not exist if you were informed of the need to provide the proof within the 2-year period and you neglected to do so or did not intend to do so. Good cause will be found to exist if you did not provide the proof within the time limit due to—

(i) Circumstances beyond your control, such as extended illness, mental or physical incapacity, or a language barrier;

(ii) Incorrect or incomplete information we furnished you;

(iii) Your efforts to get proof of the support without realizing that you could submit the proof after you gave us some other evidence of that support; or

(iv) Unusual or unavoidable circumstances that show you could not reasonably be expected to know of the 2-year time limit.

(2) The Soldiers' and Sailors' Civil Relief Act of 1940 provides for extending the filing time.

§ 404.371 When parent's benefits begin and end.

(a) You are entitled to parent's benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement.

(b) Your entitlement to benefits ends with the month before the month in which one of the following events first occurs:

(1) You become entitled to an old-age benefit equal to or larger than the parent's benefit.

(2) You marry, unless your marriage is to someone entitled to wife's, husband's, widow's, widower's, mother's, father's, parent's or disabled child's benefits. If you marry a person entitled to these benefits, the marriage does not affect your benefits.

(3) You die.

[44 FR 34481, June 15, 1979, as amended at 49 FR 24116, June 12, 1984]

§ 404.373 Parent's benefit amounts.

Your parent's monthly benefit before any reduction that may be made as explained in § 404.304, is figured in one of the following ways:

(a) *One parent entitled.* Your parent's monthly benefit is equal to 82½ percent of the insured person's primary insurance amount if you are the only parent entitled to benefits on his or her earnings record.

(b) *More than one parent entitled.* Your parent's monthly benefit is equal to 75 percent of the insured person's primary insurance amount if there is another parent entitled to benefits on his or her earnings record.

§ 404.374 Parent's relationship to the insured.

You may be eligible for benefits as the insured person's parent if—

(a) You are the mother or father of the insured and would be considered his or her parent under the laws of the State where the insured had a permanent home when he or she died;

(b) You are the adoptive parent of the insured and legally adopted him or her before the insured person became 16 years old; or

(c) You are the stepparent of the insured and you married the insured's parent or adoptive parent before the insured became 16 years old. The marriage must be valid under the laws of the State where the insured had his or her permanent home when he or she died. See § 404.303 for a definition of *permanent home.*

SPECIAL PAYMENT AT AGE 72

§ 404.380 General.

Some older persons had little or no chance to become fully insured for regular social security benefits during their working years. For those who became 72 years old several years ago but are not fully insured, a *special payment* may be payable as described in the following sections.

§ 404.381 Who is entitled to special age 72 payments.

You are entitled to a special age 72 payment if—

(a) You have attained the age of 72; and

(1) You attained such age before 1968; or

(2) You attained such age after 1967—or, for applications filed after November 5, 1990, you attained age 72 after 1967 and before 1972—and have at least 3 quarters of coverage for each calendar year elapsing after 1966 and before the year in which you attained age 72 (see subpart B for a description of quarters of coverage);

(b) You reside in one of the 50 states, the District of Columbia, or the Northern Mariana Islands;

(c) You apply; and

(d) You are a U.S. citizen or a citizen of the Northern Mariana Islands; or you are an alien who was legally admitted for permanent residence in the United States and who has resided here continuously for 5 years. Residence in the United States includes residence in the Northern Mariana Islands, Guam, American Samoa, Puerto Rico, and the Virgin Islands.

[44 FR 34481, June 15, 1979, as amended at 57 FR 21598, May 21, 1992]

§ 404.382 When special age 72 payments begin and end.

(a) Your entitlement to the special age 72 payment begins with the first month covered by your application in which you meet all the other requirements for entitlement.

(b) Your entitlement to this payment ends with the month before the month of your death.

§ 404.383 Special age 72 payment amounts.

(a) *Payment from May 1983 on.* If you are entitled to special age 72 payments from May 1983 on, you will receive a monthly payment of $125.60. If your spouse is also entitled to special age 72 payments, he or she will also receive $125.60. This amount, first payable for June 1982, will be increased when *cost-of-living* adjustments of Social Security benefits occur. This special payment may be reduced, suspended or not paid at all as explained in § 404.384.

(b) *Payment prior to May 1983.* If a husband or a single individual is entitled to special age 72 payments for months prior to May 1983, the amount payable was $125.60 for the months since June 1982. The wife received an amount approximiately one-half the husband's amount (i.e., $63.00 for months in the period June 1982-April 1983).

[49 FR 24116, June 12, 1984]

§ 404.384 Reductions, suspensions, and nonpayments of special age 72 payments.

(a) *General.* Special age 72 payments may not be paid for any month you receive public assistance payments. The payment may be reduced if you or your spouse are eligible for a government pension. In some instances, the special payment may not be paid while you are outside the United States. The rules on when special payments may be suspended, reduced, or not paid are provided in paragraphs (b) through (e) of this section.

(b) *Suspension of special age 72 payments when you receive certain assistance payments.* You cannot receive the special payment if supplemental security income or aid to families with dependent children (AFDC) payments are payable to you, or if your needs are considered in setting the amounts of these assistance payments made to someone else. However, if these assistance payments are stopped, you may receive the special payment beginning with the last month for which the assistance payments were paid.

(c) *Reduction of special age 72 payments when you or your spouse are eligible for a government pension.* Special payments are reduced for any regular government pension (or lump-sum payment given instead of a pension) that you or your spouse are eligible for at retirement. A government pension is any annuity, pension, or retirement pay from the Federal Government, a State government or political subdivision, or any organization wholly owned by the Federal or State government. Also included as a government pension is any social security benefit. The term government pension does not include workmen's compensation payments or Veterans Administration payments for a service-connected disability or death.

(d) *Amount of reduction because of a government pension.* If you are eligible for a government pension, the amount of the pension will be subtracted from your special age 72 payment. If your spouse is eligible for a government pension but is not entitled to the special payment, your special payment is reduced (after any reduction due to your own government pension) by the difference between the pension amount and the full special payment amount. If both you and your spouse are entitled to the special payment, each spouse's payment is first reduced by the amount of his or her own government pension (if any). Then, the wife's special payment is reduced by the amount that the husband's government pension exceeds the full special payment. The

husband's special payment is also reduced by the amount that the wife's government pension exceeds the full special payment.

(e) *Nonpayment of special age 72 payments when you are not residing in the United States.* No special payment is due you for any month you are not a resident of one of the 50 States, the District of Columbia, or the Northern Mariana Islands. Also, payment to you may not be permitted under the rules in § 404.463 if you are an alien living outside the United States.

[44 FR 34481, June 15, 1979, as amended at 49 FR 24116, June 12, 1984]

LUMP-SUM DEATH PAYMENT

§ 404.390 General.

If a person is fully or currently insured when he or she dies, a lump-sum death payment of $255 may be paid to the widow or widower of the deceased if he or she was living in the same household with the deceased at the time of his or her death. If the insured is not survived by a widow or widower who meets this requirement, all or part of the $255 payment may be made to someone else as described in §§ 404.392 and 404.393.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21929, May 16, 1983]

§ 404.391 Who is entitled to the lump-sum death payment as a widow or widower who was living in the same household.

You are entitled to the lump-sum death payment as a widow or widower who was living in the same household if—

(a) You are the widow or widower of the deceased insured individual based upon a relationship described in § 404.345 or § 404.346;

(b) You apply for this payment within two years after the date of the insured's death. You need not apply again if, in the month prior to the death of the insured, you were entitled to wife's or husband's benefits on his or her earnings record; and

(c) You were living in the same household with the insured at the time of his or her death. The term *living in the same household* is defined in § 404.347.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21929, May 16, 1983]

§ 404.392 Who is entitled to the lump-sum death payment when there is no widow or widower who was living in the same household—death occurs after August 1981.

(a) *General.* If the insured individual dies after August 1981 and is not survived by a widow or widower who meets the requirements of § 404.391, the lump-sum death payment shall be paid as follows:

(1) To a person who is entitled (or would have been entitled had a timely application been filed) to widow's or widower's benefits (as described in § 404.335) or mother's or father's benefits (as described in § 404.339) on the work record of the deceased worker for the month of that worker's death; or

(2) If no person described in (1) survives, in equal shares to each person who is entitled (or would have been entitled had a timely application been filed) to child's benefits (as described in § 404.350) on the work record of the deceased worker for the month of that worker's death.

(b) *Application requirement.* A person who meets the requirements of paragraph (a)(1) of this section need not apply to receive the lump-sum death payment if, for the month prior to the death of the insured, that person was entitled to wife's or husband's benefits on the insured's earnings record. Otherwise, an application must be filed within 2 years of the insured's death.

[48 FR 21929, May 16, 1983]

§ 404.393 Who is entitled to the lump-sum death payment when there is no widow or widower who was living in the same household—death occurs before September 1, 1981.

If the insured individual dies before September 1, 1981 and is not survived by a widow or widower who meets the requirements of § 404.391, the lump-sum death payment shall be paid as follows:

(a) If all or part of the burial expenses of the deceased incurred by a funeral home remain unpaid, the funeral home may receive the lump-sum death

payment to the extent of the unpaid expenses if—

(1) A person who has assumed the responsibility for paying these expenses applies for the lump-sum death payment within 2 years of the insured's death, asking that the payment be made to the funeral home; or

(2) At least 90 days have gone by since the death of the insured, no person has assumed responsibility for paying the burial expenses, and the funeral home director or other official of the funeral home applies for the payment.

(b) If all the burial expenses of the insured that were incurred by a funeral home have been paid, and any part of the lump-sum death payment remains, it may be paid to a person who paid these burial expenses and who applies for the payment within 2 years of the insured's death.

(c) If the body of the deceased is not available for burial, but expenses were incurred in connection with a memorial service or any other item for which expenses are customarily incurred in connection with disposing of a deceased's remains, the lump-sum death payment may be paid to a person who paid the expenses and applies for the payment within 2 years of the insured's death.

(d) If any part of the lump-sum death payment remains after payments have been made under paragraphs (a), (b), and (c) of this section, that part of the payment may be made to a person who applies within 2 years of the insured's death and who has paid other expenses of a burial in the following order of priority—

(1) Expenses of opening and closing the grave;

(2) Expenses of providing the burial plot; and

(3) Any remaining expenses in connection with the burial.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979. Redesignated and amended at 48 FR 21929, 21930, May 16, 1983]

§ 404.394 Who is entitled to the lump-sum death payment when burial expenses are paid from the deceased's funds.

If funds of a deceased person were used to pay any of the burial expenses for which payment of the lump-sum can be made under the rules in § 404.393, the deceased person's estate may be entitled to the lump-sum death payment. If you apply for the payment on behalf of a person's estate, you must show you are the legal representative (administrator or executor) of the estate. If there is no legal representative and none will be appointed, you must agree to divide the payment among those who have a right to it under State law, or under foreign law, that applies where the deceased had his or her permanent home at death. We may also require that you get written approval to receive the payment from any of the deceased's closest relatives who are available. A person's closest relatives follow this order: widower or widow; children and the children of any deceased children; parents; brothers and sisters and the children of any deceased brothers and sisters; and other relatives by blood or adoption.

[44 FR 34481, June 15, 1979. Redesignated and amended at 48 FR 21929, 21930, May 16, 1983]

§ 404.395 Who is not entitled to the lump-sum death payment.

The following persons and organizations are not entitled to the lump-sum payment—

(a) The U.S. Government or a foreign government;

(b) Any person who has received or will receive repayment from any other source for the burial expenses he or she paid;

(c) Persons and organizations who are required by a contract to pay the burial expenses except for a tax-exempt, nonprofit home for the sick or aged that paid for burial of a deceased resident or guest or a tax-exempt, nonprofit fraternal organization that paid a member's burial expenses not covered by an express contract;

(d) An employer or organization that paid burial expenses of an employee or member under a plan, system, or general practice other than a home for the sick or aged or a fraternal organization mentioned in paragraph (c) of this section; and

(e) A person or organization that furnished goods or services for the burial unless the goods or services were furnished by—

(1) A State or a political subdivision of a State;

(2) An organization exempt from income tax under section 501(c)(3) or (13) of the Internal Revenue Code; or

(3) A funeral director in connection with burial of a close relative.

[44 FR 34481, June 15, 1979. Redesignated at 48 FR 21929, May 16, 1983]

Subpart E—Deductions; Reductions; and Nonpayments of Benefits

AUTHORITY: Secs. 202, 203, 204 (a) and (e), 205 (a) and (c), 222(b), 223(e), 224, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 403, 404 (a) and (e), 405 (a) and (c), 422(b), 423(e), 424a, 425, and 902(a)(5)).

SOURCE: 32 FR 19159, Dec. 20, 1967, unless otherwise noted.

§ 404.401 Deduction, reduction, and nonpayment of monthly benefits or lump-sum death payments.

Under certain conditions the amount of a monthly insurance benefit (see §§ 404.377 through 404.380 for provisions concerning special payments at age 72) or the lump-sum death payment as calculated under the pertinent provisions of sections 202 and 203 of the Act (including reduction for age under section 202(q) of a monthly benefit) must be increased or decreased to determine the amount to be actually paid to a beneficiary. Increases in the amount of a monthly benefit or lump-sum death payment are based upon recomputation and recalculations of the primary insurance amount (see subpart C of this part). A decrease in the amount of a monthly benefit or lump-sum death payment is required in the following instances:

(a) *Reductions.* A reduction of a person's monthly benefit is required where:

(1) The total amount of the monthly benefits payable on an earnings record exceeds the maximum that may be paid (see § 404.403);

(2) An application for monthly benefits is effective for a month during a retroactive period, and the maximum has already been paid for that month or would be exceeded if such benefit were paid for that month (see § 404.406);

(3) An individual is entitled to old-age or disability insurance benefits in addition to any other monthly benefit (see § 404.407);

(4) An individual under age 65 is concurrently entitled to disability insurance benefits and to certain public disability benefits (see § 404.408);

(5) An individual is entitled in a month to a widow's or widower's insurance benefit that is reduced under section 202 (e)(4) or (f)(5) of the Act and to any other monthly insurance benefit other than an old-age insurance benefit (see § 404.407(b)); or

(6) An individual is entitled in a month to old-age, disability, wife's, husband's, widow's, or widower's insurance benefit and reduction is required under section 202(q) of the Act (see § 404.410).

(b) *Deductions.* A deduction from a monthly benefit or a lump-sum death payment may be required because of:

(1) An individual's earnings or work (see §§ 404.415 and 404.417);

(2) Failure of certain beneficiaries receiving wife's or mother's insurance benefits to have a child in her care (see § 404.421);

(3) The earnings or work of an old-age insurance beneficiary where a wife, husband, or child is also entitled to benefits (see §§ 404.415 and 404.417);

(4) Failure to report within the prescribed period either certain work outside the United States or not having the care of a child (see § 404.451);

(5) Failure to report within the prescribed period earnings from work in employment or self-employment (see § 404.453);

(6) Refusal to accept rehabilitation services in certain cases (see § 404.422); or

(7) Certain taxes which were neither deducted from the wages of maritime employees nor paid to the Federal Government (see § 404.457).

(c) *Adjustments.* Adjustments may be required because an error has been made in payments to an individual (see subpart F of this part).

(d) *Nonpayments.* Nonpayment of monthly benefits may be required because:

(1) The individual is an alien who has been outside the United States for more than 6 months (see § 404.460);

(2) The individual on whose earnings record entitlement is based has been deported (see § 404.464);

(3) The individual is engaged in substantial gainful activity while entitled to disability insurance benefits based on ''statutory blindness'' (see § 404.467); or

(4) The individual has not provided satisfactory proof that he or she has a Social Security number or has not properly applied for a Social Security number (see § 404.469).

(e) *Recalculation.* A reduction by recalculation of a benefit amount may be prescribed because an individual has been convicted of certain offenses (see § 404.465) or because the primary insurance amount is recalculated (see subpart C of this part).

(f) *Suspensions.* Suspension of monthly benefits may be required pursuant to section 203(h)(3) of the Act (the Social Security Administration has information indicating that work deductions may reasonably be expected for the year), or pursuant to section 225 of the Act (the Social Security Administration has information indicating a beneficiary is no longer disabled).

[40 FR 30813, July 23, 1975, as amended at 48 FR 37016, Aug. 16, 1983; 56 FR 41789, Aug. 23, 1991]

§ 404.401a When we do not pay benefits because of a disability beneficiary's work activity.

If you are receiving benefits because you are disabled or blind as defined in title II of the Social Security Act, we will stop your monthly benefits even though you have a disabling impairment (§ 404.1511), if you engage in substantial gainful activity during the reentitlement period (§ 404.1592a) following completion of the trial work period (§ 404.1592). You will, however, be paid benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity in those two months. If anyone else is receiving monthly benefits based on your earnings record, that individual will not be paid benefits for any month for which you cannot be paid benefits during the reentitlement period. Earnings from work activity during a trial work period will not stop your benefits.

[49 FR 22271, May 29, 1984, as amended at 58 FR 64883, Dec. 10, 1993]

§ 404.402 Interrelationship of deductions, reductions, adjustments, and nonpayment of benefits.

(a) *Deductions, reductions, adjustment.* Deductions because of earnings or work (see §§ 404.415 and 404.417); failure to have a child ''in her care'' (see § 404.421); refusal to accept rehabilitation services (see § 404.422); as a penalty for failure to timely report noncovered work outside the United States, failure by a woman to report that she no longer has a child ''in her care,'' or failure to timely report earnings (see §§ 404.451 and 404.453); because of unpaid maritime taxes (see § 404.457); or nonpayments because of drug addiction and alcoholism to individuals other than an insured individual who are entitled to benefits on the insured individual's earnings record are made:

(1) Before making any reductions because of the *maximum* (see § 404.403),

(2) Before applying the benefit *rounding* provisions (see § 404.304(f)), and,

(3) Except for deductions imposed as a penalty (see §§ 404.451 and 404.453), before making any adjustment necessary because an error has been made in the payment of benefits (see subpart F). However, for purposes of charging excess earnings for taxable years beginning after December 1960 or ending after June 1961, see paragraph (b) of this section and § 404.437 for reductions that apply before such charging.

(b) *Reductions, nonpayments.* (1) Reduction because of the *maximum* (see § 404.403) is made:

(i) Before reduction because of simultaneous entitlement to old-age or disability insurance benefits and to other benefits (see § 404.407);

(ii) Before reduction in benefits for age (see §§ 404.410 through 404.413);

(iii) Before adjustment necessary because an error has been made in the payment of benefits (see subpart F of this part);

(iv) Before reduction because of entitlement to certain public disability benefits provided under Federal, State, or local laws or plans (see § 404.408);

(v) Before nonpayment of an individual's benefits because he is an alien living outside the United States for 6 months (see § 404.460), or because of deportation (see § 404.464); and

(vi) Before the redetermination of the amount of benefit payable to an individual who has been convicted of certain offenses (see § 404.465).

(2) Reduction of benefits because of entitlement to certain public disability benefits (see § 404.408) is made before deduction:

(i) Under section 203 of the Act relating to work (see §§ 404.415, 404.417, 404.451, and 404.453) and failure to have care of a child (see §§ 404.421 and 404.451), and

(ii) Under section 222(b) of the Act on account of refusal to accept rehabilitation services (see § 404.422).

(3) Reduction of the benefit of a spouse who is receiving a Government pension (see § 404.408(a)) is made after the withholding of payments as listed in paragraph (d)(1) of this section and after reduction because of receipt of certain public disability benefits (paragraph (b)(2) of this section).

(c) *Alien outside the United States; deportation nonpayment—deduction.* If an individual is subject to nonpayment of a benefit for a month under § 404.460 or § 404.464, no deduction is made from his benefit for that month under § 404.415, § 404.417, or § 404.421, and no deduction is made because of that individual's work from the benefit of any person entitled or deemed entitled to benefits under § 404.420, on his earnings record, for that month.

(d) *Order of priority—deductions and other withholding provisions.* Deductions and other withholding provisions are applied in accordance with the following order of priority:

(1) Current nonpayments under §§ 404.460, 404.464, 404.465, 404.467, and 404.469;

(2) Current reductions under § 404.408;

(3) Current reductions under § 404.408a;

(4) Current deductions under §§ 404.417, 404.421, and 404.422;

(5) Current withholding of benefits under § 404.456;

(6) Unpaid maritime tax deductions (§ 404.457);

(7) Withholdings to recover overpayments (see subpart F of this part);

(8) Penalty deductions under §§ 404.451 and 404.453.

[40 FR 30813, July 23, 1975, as amended at 44 FR 29047, May 18, 1979; 48 FR 37016, Aug. 16, 1983; 48 FR 46148, Oct. 11, 1983; 56 FR 41789, Aug. 23, 1991; 60 FR 8146, Feb. 10, 1995]

§ 404.403 Reduction where total monthly benefits exceed maximum family benefits payable.

(a) *General.* (1) The Social Security Act limits the amount of monthly benefits that can be paid for any month based on the earnings of an insured individual. If the total benefits to which all persons are entitled on one earnings record exceed a maximum amount prescribed by law, then those benefits must be reduced so that they do not exceed that maximum.

(2) The method of determining the total benefits payable (the *family maximum*) depends on when the insured individual died or became eligible, whichever is earlier. For purposes of this section, the year in which the insured individual becomes eligible refers generally to the year in which the individual attains age 62 or becomes disabled. However, where eligibility or death is in 1979 or later, the year of death, attainment of age 62, or beginning of current disability does not control if the insured individual was entitled to a disability benefit within the 12 month period preceding current eligibility or death. Instead the year in which the individual became eligible for the former disability insurance benefit is the year of eligibility.

(3) The benefits of an individual entitled as a divorced spouse or surviving divorced spouse will not be reduced pursuant to this section. The benefits of all other individuals entitled on the same record will be determined under this section as if no such divorced spouse or surviving divorced spouse were entitled to benefits.

(4) In any case where more than one individual is entitled to benefits as the spouse or surviving spouse of a worker for the same month, and at least one of those individuals is entitled based on a marriage not valid under State law (see §§ 404.345 and 404.346), the benefits of the individual whose entitlement is based

on a valid marriage under State law will not be reduced pursuant to this section. The benefits of all other individuals entitled on the same record (unless excluded by paragraph (a)(3) of this section) will be determined under this section as if such validly married individual were not entitled to benefits.

(b) *Eligibility or death before 1979.* Where more than one individual is entitled to monthly benefits for the same month on the same earnings record, a reduction in the total benefits payable for that month may be required (except in cases involving a *saving clause*—see § 404.405) if the maximum family benefit is exceeded. The maximum is exceeded if the total of the monthly benefits exceeds the amount appearing in column V of the applicable table in section 215(a) of the Act on the line on which appears in column IV the primary insurance amount of the insured individual whose earnings record is the basis for the benefits payable. Where the maximum is exceeded, the total benefits for each month after 1964 are reduced to the amount appearing in column V. However, when any of the persons entitled to benefits on the insured individual's earnings would, except for the limitation described in § 404.353(b), be entitled to child's insurance benefits on the basis of the earnings record of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of—

(1) The sum of the maximum amounts of benefits payable on the basis of the earnings records of all such insured individuals, or

(2) The last figure in column V of the applicable table in (or deemed to be in) section 215(a) of the Act. The *applicable* table refers to the table which is effective for the month the benefit is payable.

(c) *Eligible for old-age insurance benefits or dies in 1979.* If an insured individual becomes eligible for old-age insurance benefits or dies in 1979, the monthly maximum is as follows—

(1) 150 percent of the first $230 of the individual's primary insurance amount, plus

(2) 272 percent of the primary insurance amount over $230 but not over $332, plus

(3) 134 percent of the primary insurance amount over $332 but not over $433, plus

(4) 175 percent of the primary insurance amount over $433.

If the total of this computation is not a multiple of $0.10, it will be rounded to the next lower multiple of $0.10.

(d) *Eligible for old-age insurance benefits or dies after 1979.* (1) If an insured individual becomes eligible for old-age insurance benefits or dies after 1979, the monthly maximum is computed as in paragraph (c) of this section. However, the dollar amounts shown there will be updated each year as average earnings rise. This updating is done by first dividing the average of the total wages (see § 404.203(m)) for the second year before the individual dies or becomes eligible, by the average of the total wages for 1977. The result of that computation is then multiplied by each dollar amount in the formula in paragraph (c) of this section. Each updated dollar amount will be rounded to the nearer dollar; if the amount is an exact multiple of $0.50 (but not of $1), it will be rounded to the next higher $1.

(2) Before November 2 of each calendar year after 1978, the Secretary will publish in the FEDERAL REGISTER the formula and updated dollar amounts to be used for determining the monthly maximum for the following year.

(d–1) *Entitled to disability insurance benefits after June 1980.* If you first become eligible for old-age or disability insurance benefits after 1978 and first entitled to disability insurance benefits after June 1980, we compute the monthly family maximum under a formula which is different from that in paragraphs (c) and (d) of this section. The computation under the new formula is as follows:

(1) We take 85 percent of your average indexed monthly earnings (as computed in § 404.212a of this part) and compare that figure with your primary insurance amount (as computed in § 404.212). We work with the larger of these two amounts.

(2) We take 150 percent of your primary insurance amount.

(3) We compare the results of paragraphs (d–1) (1) and (2) of this section. The smaller amount is the monthly family maximum. As a result of this rule, the entitled spouse and children of some workers will not be paid any benefits because the family maximum does not exceed the primary insurance amount.

(e) *Person entitled on more than one record during years after 1978 and before 1984.* (1) If any of the persons entitled to monthly benefits on the earnings record of an insured individual would, except for the limitation described in § 404.353(b), be entitled to child's insurance benefits on the earnings record of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of—(i) the sum of the maximum amounts of benefits payable on the earnings records of all the insured individuals, or (ii) 1.75 times the highest primary insurance amount possible for that month based on the average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year.

(2) If benefits are payable on the earnings of more than one individual and the primary insurance amount of one of the insured individuals was computed under the provisions in effect before 1979 and the primary insurance amount of the others was computed under the provisions in effect after 1978, the maximum monthly benefits cannot be more than the amount computed under paragraph (e)(1) of this section.

(f) *Person entitled on more than one record for years after 1983.* (1) If any person for whom paragraphs (c) and (d) would apply is entitled to monthly benefits on the earnings record of an insured individual would, except for the limitation described in § 404.353(b), be entitled to child's insurance benefits on the earnings record of one or more other insured individuals, the total benefits payable to all persons on the earnings record of any of those insured individuals may not be reduced to less than the smaller of:

(i) The sum of the maximum amounts of benefits payable on the earnings records of all the insured individuals, or

(ii) 1.75 times the highest primary insurance amount possible for January 1983, or if later, January of the year that the person becomes entitled or reentitled on more than one record.

This highest primary insurance amount possible for that year will be based on the average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year. Thereafter, the total monthly benefits payable to persons on the earnings record of those insured individuals will then be increased only when monthly benefits are increased because of cost-of-living adjustments (see § 404.270ff).

(2) If benefits are payable on the earnings of more than one individual and the primary insurance amount of one of the insured individuals was computed under the provisions in effect before 1979 and the primary insurance amount of the other was computed under the provisions in effect after 1978, the maximum monthly benefits cannot be more than the amount computed under paragraph (f)(1) of this section.

[45 FR 1611, Jan. 8, 1980, as amended at 46 FR 25601, May 8, 1981; 48 FR 46148, Oct. 11, 1983; 51 FR 12606, Apr. 14, 1986; 58 FR 64892, Dec. 10, 1993]

§ 404.404 How reduction for maximum affects insured individual and other persons entitled on his earnings record.

If a reduction of monthly benefits is required under the provisions of § 404.403, the monthly benefit amount of each of the persons entitled to a monthly benefits on the same earnings record (with the exception of the individual entitled to old-age or disability insurance benefits) is proportionately reduced so that the total benefits that can be paid in 1 month (including an amount equal to the primary insurance amount of the old-age or disability insurance beneficiary, when applicable) does not exceed the maximum family benefit (except as provided in § 404.405 where various savings clause provisions are described).

§ 404.405 Situations where total benefits can exceed maximum because of "savings clause."

The following provisions are *savings clauses* and describe exceptions to the rules concerning the maximum amount payable on an individual's earnings record in a month as described in § 404.403. The effect of a *savings clause* is to avoid lowering benefit amounts or to guarantee minimum increases to certain persons entitled on the earnings record of the insured individual when a statutory change has been made that would otherwise disadvantage them. The reduction described in § 404.403 does not apply in the following instances:

(a)—(m) [Reserved]

(n) *Months after August 1972.* The reduction described in § 404.403(a) shall not apply to benefits for months after August 1972 where two or more persons were entitled to benefits for August 1972 based upon the filing of an application in August 1972 or earlier and the total of such benefits was subject to reduction for the maximum under § 404.403 (or would have been subject to such reduction except for this paragraph) for January 1971. In such a case, maximum family benefits on the insured individual's earnings record for any month after August 1972 may not be less than the larger of:

(1) The maximum family benefits for such month determined under the applicable table in section 215(a) of the Act (the *applicable* table in section 215(a) is that table which is effective for the month the benefit is payable or in the case of a lump-sum payment, the month the individual died); or

(2) The total obtained by multiplying each benefit for August 1972 after reduction for the maximum but before deduction or reduction for age, by 120 percent and raising each such increased amount, if it is not a multiple of 10 cents, to the next higher multiple of 10 cents.

(o) *Months after December 1972.* The reduction described in § 404.403 shall not apply to benefits for months after December 1972 in the following cases:

(1) In the case of a redetermination of widow's or widower's benefits, the reduction described in § 404.403 shall not apply if:

(i) Two or more persons were entitled to benefits for December 1972 on the earnings records of a deceased individual and at least one such person is entitled to benefits as the deceased individual's widow or widower for December 1972 and for January 1973; and

(ii) The total of benefits to which all persons are entitled for January 1973 is reduced (or would be reduced if deductions were not applicable) for the maximum under § 404.403.

In such case, the benefit of each person referred to in paragraph (o)(1)(i) of this section for months after December 1972 shall be no less than the amount it would have been if the widow's or widower's benefit had not been redetermined under the Social Security Amendments of 1972.

(2) In the case of entitlement to child's benefits based upon disability which began between ages 18 and 22 the reduction described in § 404.403 shall not apply if:

(i) One or more persons were entitled to benefits on the insured individual's earnings record for December 1972 based upon an application filed in that month or earlier; and

(ii) One or more persons not included in paragraph (o)(2)(i) of this section are entitled to child's benefits on that earnings record for January 1973 based upon disability which began in the period from ages 18 to 22; and

(iii) The total benefits to which all persons are entitled on that record for January 1973 is reduced (or would be reduced if deductions were not applicable) for the maximum under § 404.403.

In such case, the benefit of each person referred to in paragraph (o)(2)(i) of this section for months after December 1972 shall be no less than the amount it would have been if the person entitled to child's benefits based upon disability in the period from ages 18 to 22 were not so entitled.

(3) In the case of entitlement of certain surviving divorced mothers, the reduction described in § 404.403 shall not apply if:

(i) One or more persons were entitled to benefits on the insured individual's earnings record for December 1972 based upon an application filed in December 1972 or earlier; and

(ii) One or more persons not included in paragraph (o)(3)(i) of this section are entitled to benefits on that earnings record as a surviving divorced mother for a month after December 1972; and

(iii) The total of benefits to which all persons are entitled on that record for any month after December 1972 is reduced (or would be reduced if deductions were not applicable) for the maximum under § 404.403.

In such case, the benefit of each such person referred to in paragraph (o)(3)(i) of this section for months after December 1972 in which any person referred to in paragraph (o)(3)(ii) of this section is entitled shall be no less than it would have been if the person(s) referred to in paragraph (o)(3)(ii) of this section had not become entitled to benefits.

(p) *Months after December 1973.* The reduction described in § 404.403 shall not apply to benefits for months after December 1973 where two or more persons were entitled to monthly benefits for January 1971 or earlier based upon applications filed in January 1971 or earlier, and the total of such benefits was subject to reduction for the maximum under § 404.403 for January 1971 or earlier. In such a case, maximum family benefits payable on the insured individual's earnings record for any month after January 1971 may not be less than the larger of:

(1) The maximum family benefit for such month shown in the applicable table in section 215(a) of the Act (the *applicable* table in section 215(a) of the Act is that table which is effective for the month the benefit is payable or in the case of a lump-sum payment, the month the individual died); or

(2) The largest amount which has been determined payable for any month for persons entitled to benefits on the insured individual's earnings records; or

(3) In the case of persons entitled to benefits on the insured individual's earnings record for the month immediately preceding the month of a general benefit or cost-of-living increase after September 1972, an amount equal to the sum of the benefit amount for each person (excluding any part of an old-age insurance benefit increased because of delayed retirement under the provisions of § 404.305(a) for the month immediately before the month of increase in the primary insurance amount (after reduction for the family maximum but before deductions or reductions for age) multiplied by the percentage of increase. Any such increased amount, if it is not a multiple of $0.10, will be raised to the next higher multiple of $0.10 for months before June 1982 and reduced to the next lower multiple of $0.10 for months after May 1982.

(q) *Months after May 1978.* The *family maximum* for months after May 1978 is figured for all beneficiaries just as it would have been if none of them had gotten a benefit increase because of the retirement credit if:

(1) One or more persons were entitled (without the reduction required by § 404.406) to monthly benefits for May 1978 on the wages and self-employment income of a deceased wage earner;

(2) The benefit for June 1978 of at least one of those persons is increased by reason of a delayed retirement credit (see § 404.330(b)(4) or § 404.333(b)(4)); and

(3) The total amount of monthly benefits to which all those persons are entitled is reduced because of the maximum or would be so reduced except for certain restrictions (see § 404.403 and § 404.402(a)).

[32 FR 19159, Dec. 20, 1967, as amended at 40 FR 30814, July 23, 1975; 43 FR 8132, Feb. 28, 1978; 43 FR 29277, July 7, 1978; 48 FR 46148, Oct. 11, 1983]

§ 404.406 Reduction for maximum because of retroactive effect of application for monthly benefits.

Under the provisions described in § 404.403, beginning with the month in which a person files an application and becomes entitled to benefits on an insured individual's earnings record, the benefit rate of other persons entitled on the same earnings record (aside from the individual on whose earnings record entitlement is based) are adjusted downward, if necessary, so that the maximum benefits payable on one earnings record will not be exceeded. An application may also be effective (retroactively) for benefits for months before the month of filing (see § 404.607). For any month before the month of filing, however, benefits that have been

previously certified by the Administration for payment to other persons (on the same earnings record) are not changed. Rather, the benefit payment of the person filing the application in the later month is reduced for each month of the retroactive period to the extent that may be necessary, so that no earlier payment to some other person is made erroneous. This means that for each month of the retroactive period the amount payable to the person filing the later application is the difference, if any, between (a) the total amount of benefits actually certified for payment to other persons for that month, and (b) the maximum amount of benefits payable for that month to all persons, including the person filing later.

§ 404.407 Reduction because of entitlement to other benefits.

(a) *Entitlement to old-age or disability insurance benefit and other monthly benefit.* If an individual is entitled to an old-age insurance benefit or disability insurance benefit for any month after August 1958 and to any other monthly benefit payable under the provisions of title II of the Act (see subpart D of this part) for the same month, such other benefit for the month, after any reduction under section 202(q) of the Act because of entitlement to such benefit for months before retirement age and any reduction under section 203(a) of the Act, is reduced (but not below zero) by an amount equal to such old-age insurance benefit (after reduction under section 202(q) of the Act) or such disability insurance benefit, as the case may be.

(b) *Entitlement to widow's or widower's benefit and other monthly benefit.* If an individual is entitled for any month after August 1965 to a widow's or widower's insurance benefit under the provisions of section 202 (e)(4) or (f)(5) of the Act and to any other monthly benefit payable under the provisions of title II of the Act (see subpart D) for the same month, except an old-age insurance benefit, such other insurance benefit for that month, after any reduction under paragraph (a) of this section, any reduction for age under section 202(q) of the Act, and any reduction under the provisions described in section 203(a) of the Act, shall be reduced, but not below zero, by an amount equal to such widow's or widower's insurance benefit after any reduction or reductions under paragraph (a) of this section or section 203(a) of the Act.

(c) *Entitlement to old-age insurance benefit and disability insurance benefit.* Any individual who is entitled for any month after August 1965 to both an old-age insurance benefit and a disability insurance benefit shall be entitled to only the larger of such benefits for such month, except that where the individual so elects, he or she shall instead be entitled to only the smaller of such benefits for such month. Only a person defined in § 404.612 (a), (c), or (d) may make the above described election.

(d) *Child's insurance benefits.* A child may, for any month, be simultaneously entitled to a child's insurance benefit on more than one individual's earnings if all the conditions for entitlement described in § 404.350 are met with respect to each claim. Where a child is simultaneously entitled to child's insurance benefits on more than one earnings record, the general rule is that the child will be paid an amount which is based on the record having the highest primary insurance amount. However, the child will be paid a higher amount which is based on the earnings record having a lower primary insurance amount if no other beneficiary entitled on any record would receive a lower benefit because the child is paid on the record with the lower primary insurance amount. (See § 404.353(b).)

(e) *Entitlement to more than one benefit where not all benefits are child's insurance benefits and no benefit is an old-age or disability insurance benefit.* If an individual (other than an individual to whom section 202 (e)(4) or (f)(5) of the Act applies) is entitled for any month to more than one monthly benefit payable under the provisions of this subpart, none of which is an old-age or disability insurance benefit and all of which are not child's insurance benefits, only the greater of the monthly benefits to which he would (but for the provisions of this paragraph) otherwise be entitled is payable for such month.

For months after August 1965, an individual who is entitled for any month to more than one widow's or widower's insurance benefit to which section 202 (e)(4) or (f)(5) of the Act applies is entitled to only one such benefit for such month, such benefit to be the largest of such benefits.

[32 FR 19159, Dec. 20, 1967, as amended at 51 FR 12606, Apr. 14, 1986; 54 FR 5603, Feb. 6, 1989]

§ 404.408 Reduction of benefits based on disability on account of receipt of certain other disability benefits provided under Federal, State, or local laws or plans.

(a) *When reduction required.* Under section 224 of the Act, a disability insurance benefit to which an individual is entitled under section 223 of the Act for a month (and any monthly benefit for the same month payable to others under section 202 on the basis of the same earnings record) is reduced (except as provided in paragraph (b) of this section) by an amount determined under paragraph (c) of this section if:

(1) The individual first became entitled to disability insurance benefits after 1965 but before September 1981 based on a period of disability that began after June 1, 1965, and before March 1981, and

(i) The individual entitled to the disability insurance benefit is also entitled to periodic benefits under a workers' compensation law or plan of the United States or a State for that month for a total or partial disability (whether or not permanent), and

(ii) The Secretary has, in a month before that month, received a notice of the entitlement, and

(iii) The individual has not attained age 62, or

(2) The individual first became entitled to disability insurance benefits after August 1981 based on a disability that began after February 1981, and

(i) The individual entitled to the disability insurance benefit is also, for that month, concurrently entitled to a periodic benefit (including workers' compensation or any other payments based on a work relationship) on account of a total or partial disability (whether or not permanent) under a law or plan of the United States, a State, a political subdivision, or an instrumentality of two or more of these entities, and

(ii) The individual has not attained age 65.

(b) *When reduction not made.* (1) The reduction of a benefit otherwise required by paragraph (a)(1) of this section is not made if the workers' compensation law or plan under which the periodic benefit is payable provides for the reduction of such periodic benefit when anyone is entitled to a benefit under title II of the Act on the basis of the earnings record of an individual entitled to a disability insurance benefit under section 223 of the Act.

(2) The reduction of a benefit otherwise required by paragraph (a)(2) of this section is not to be made if:

(i) The law or plan under which the periodic public disability benefit is payable provides for the reduction of that benefit when anyone is entitled to a benefit under title II of the Act on the basis of the earnings record of an individual entitled to a disability insurance benefit under section 223 of the Act and that law or plan so provided on February 18, 1981. (The reduction required by paragraph (a)(2) of this section will not be affected by public disability reduction provisions not actually in effect on this date or by changes made after February 18, 1981, to provisions that were in effect on this date providing for the reduction of benefits previously not subject to a reduction); or

(ii) The benefit is a Veterans Administration benefit, a public disability benefit (except workers' compensation) payable to a public employee based on employment covered under Social Security, a public benefit based on need, or a wholly private pension or private insurance benefit.

(c) *Amount of reduction*—(1) *General.* The total of benefits payable for a month under sections 223 and 202 of the Act to which paragraph (a) of this section applies is reduced monthly (but not below zero) by the amount by which the sum of the monthly disability insurance benefits payable on the disabled individual's earnings record and the other public disability benefits payable for that month exceeds the higher of:

(i) Eighty percent of his *average current earnings*, as defined in paragraph (c)(3) of this section, or

(ii) The total of such individual's disability insurance benefit for such month and all other benefits payable for such month based on such individual's earnings record, prior to reduction under this section.

(2) *Limitation on reduction.* In no case may the total of monthly benefits payable for a month to the disabled worker and to the persons entitled to benefits for such month on his earnings record be less than:

(i) The total of the benefits payable (after reduction under paragraph (a) of this section) to such beneficiaries for the first month for which reduction under this section is made, and

(ii) Any increase in such benefits which is made effective for months after the first month for which reduction under this section is made.

(3) *Average current earnings defined.* (i) Beginning January 1, 1979, for purposes of this section, an individual's *average current earnings* is the largest of either paragraph (c)(3)(i) (*a*), (*b*) or (*c*) of this section (after reducing the amount to the next lower multiple of $1 when the amount is not a multiple of $1):

(*a*) The average monthly wage (determined under section 215(b) of the Act as in effect prior to January 1979) used for purposes of computing the individual's disability insurance benefit under section 223 of the Act;

(*b*) One-sixtieth of the total of the individual's wages and earnings from self-employment, without the limitations under sections 209(a) and 211(b)(1) of the Act (see paragraph (c)(3)(ii) of this section), for the 5 consecutive calendar years after 1950 for which the wages and earnings from self-employment were highest; or

(*c*) One-twelfth of the total of the individual's wages and earnings from self-employment, without the limitations under sections 209(a) and 211(b)(1) of the Act (see paragraph (c)(3)(ii) of this section), for the calendar year in which the individual had the highest wages and earnings from self-employment during the period consisting of the calendar year in which the individual became disabled and the 5 years immediately preceding that year. Any amount so computed which is not a multiple of $1 is reduced to the next lower multiple of $1.

(ii) *Method of determining calendar year earnings in excess of the limitations under sections 209(a) and 211(b)(1) of the Act.* For the purposes of paragraph (c)(3)(i) of this section, the extent by which the wages or earnings from self-employment of an individual exceed the maximum amount of earnings creditable under sections 209(a) and 211(b)(1) of the Act in any calendar year after 1950 and before 1978 will ordinarily be estimated on the basis of the earnings information available in the records of Administration. (See subpart I of this part.) If an individual provides satisfactory evidence of his actual earnings in any year, the extent, if any, by which his earnings exceed the limitations under sections 209(a) and 211(b)(1) of the Act shall be determined by the use of such evidence instead of by the use of estimates.

(4) *Reentitlement to disability insurance benefits.* If an individual's entitlement to disability insurance benefits terminates and such individual again becomes entitled to disability insurance benefits, the amount of the reduction is again computed based on the figures specified in this paragraph (c) applicable to the subsequent entitlement.

(5) *Computing disability insurance benefits.* When reduction is required, the total monthly Social Security disability insurance benefits payable after reduction can be more easily computed by subtracting the monthly amount of the other public disability benefit from the higher of paragraph (c)(1) (i) or (ii). This is the method employed in the examples used in this section.

(d) *Items not counted for reduction.* Amounts paid or incurred, or to be incurred, by the individual for medical, legal, or related expenses in connection with the claim for public disability payments (see § 404.408 (a) and (b)) or the injury or occupational disease on which the public disability award or settlement agreement is based, are excluded in computing the reduction under paragraph (a) of this section to the extent they are consonant with the applicable Federal, State, or local law or plan and reflect either the actual amount of expenses already incurred or

a reasonable estimate, given the circumstances in the individual's case, of future expenses. Any expenses not established by evidence required by the Administration or not reflecting a reasonable estimate of the individual's actual future expenses will not be excluded. These medical, legal, or related expenses may be evidenced by the public disability award, compromise agreement, a court order, or by other evidence as the Administration may require. This other evidence may consist of:

(1) A detailed statement by the individual's attorney, physician, or the employer's insurance carrier; or

(2) Bills, receipts, or canceled checks; or

(3) Other clear and convincing evidence indicating the amount of expenses; or

(4) Any combination of the foregoing evidence from which the amount of expenses may be determinable.

(e) *Certification by individual concerning eligibility for public disability benefits.* Where it appears that an individual may be eligible for a public disability benefit which would give rise to a reduction under paragraph (a) of this section, the individual may be required, as a condition of certification for payment of any benefit under section 223 of the Act to any individual for any month, and of any benefit under section 202 of the Act for any month based on such individual's earnings record, to furnish evidence as requested by the Administration and to certify as to:

(1) Whether he or she has filed or intends to file any claim for a public disability benefit, and

(2) If he or she has so filed, whether there has been a decision on the claim. The Secretary may rely, in the absence of evidence to the contrary, upon a certification that he or she has not filed and does not intend to file such a claim, or that he or she has filed and no decision has been made, in certifying any benefit for payment pursuant to section 205(i) of the Act.

(f) *Verification of eligibility or entitlement to a public disability benefit under paragraph (a).* Section 224 of the Act requires the head of any Federal agency to furnish the Secretary information from the Federal agency's records which is needed to determine the reduction amount, if any, or verify other information to carry out the provisions of this section. The Secretary is authorized to enter into agreements with States, political subdivisions, and other organizations that administer a law or plan of public disability benefits in order to obtain information that may be required to carry out the provisions of this section.

(g) *Public disability benefit payable on other than a monthly basis.* Where public disability benefits are paid periodically but not monthly, or in a lump sum as a commutation of or a substitute for periodic benefits, such as a compromise and release settlement, the reduction under this section is made at the time or times and in the amounts that the Administration determines will approximate as nearly as practicable the reduction required under paragraph (a) of this section.

(h) *Priorities.* (1) For an explanation of when a reduction is made under this section where other reductions, deductions, etc., are involved, see § 404.402.

(2) Whenever a reduction in the total of benefits for any month based on an individual's earnings record is made under paragraph (a) of this section, each benefit, except the disability insurance benefit, is first proportionately decreased. Any excess reduction over the sum of all the benefits, other than the disability insurance benefit, is then applied to the disability insurance benefit.

Examples:

Example 1: Effective September 1981, Harold is entitled to a monthly disability primary insurance amount of $507.90 and a monthly public disability benefit of $410.00 from the State. Eighty percent of Harold's average current earnings is $800.00. Because this amount ($800.00) is higher than Harold's disability insurance benefit ($507.90), we subtract Harold's monthly public disability benefit ($410.00) from eighty percent of his average current earnings ($800.00). This leaves Harold a reduced monthly disability benefit of $390.00.

Example 2: In September 1981, Tom is entitled to a monthly disability primary insurance amount of $559.30. His wife and two children are also entitled to monthly benefits of $93.20 each. The total family benefit is $838.90. Tom is also receiving a monthly workers' compensation benefit of $500.00

from the State. Eighty percent of Tom's average current earnings is $820.10. Because the total family benefit ($838.90) is higher than 80 percent of the average current earnings ($820.10), we subtract the monthly workers' compensation benefit ($500.00) from the total family benefit ($838.90), leaving $338.90 payable. This means the monthly benefits to Tom's wife and children are reduced to zero, and Tom's monthly disability benefit is reduced to $338.90.

(i) *Effect of changes in family composition.* The addition or subtraction in the number of beneficiaries in a family may cause the family benefit to become, or cease to be, the applicable limit for reduction purposes under this section. When the family composition changes, the amount of the reduction is recalculated as though the new number of beneficiaries were entitled for the first month the reduction was imposed. If the applicable limit both before and after the change is 80 percent of the average current earnings and the limitation on maximum family benefits is in effect both before and after the change, the amount payable remains the same and is simply redistributed among the beneficiaries entitled on the same earnings record.

Examples:

Example 1: Frank is receiving $500.00 a month under the provisions of a State workers' compensation law. He had a prior period of disability which terminated in June 1978. In September 1981, Frank applies for a second period of disability and is awarded monthly disability insurance benefits with a primary insurance amount of $370.20. His child, Doug, qualifies for benefits of $135.10 a month on Frank's earnings record. The total family benefits is $505.30 monthly.

Frank's average monthly wage (as used to compute the primary insurance amount) is $400.00; eighty percent of his average current earnings (computed by using the 5 consecutive years in which his earnings were highest) is $428.80 (80% of $536.00); eighty percent of Frank's average current earnings (computed by using the 1 calendar year in which his earnings were highest) is $509.60 (80% of $637.00). The highest value for 80 percent of average current earnings is therefore $509.60 (80%). Since this is higher than the total family benefit ($505.30), the $509.60 is the applicable limit in determining the amount of the reduction (or offset). The amount payable after the reduction is—

80% of Frank's average current earnings	$509.60
Frank's monthly workers' compensation benefit	−500.00
Monthly benefit payable to Frank	9.60

No monthly benefits are payable to Doug because the reduction is applied to Doug's benefit first. In December 1981, another child, Mike, becomes entitled on Frank's earnings record. The monthly benefit to each child before reduction is now $109.10, the amount payable when there are two beneficiaries in addition to the wage earner. Thus, the total family benefit becomes $588.40. Because this is now higher than $509.60 (80% of Frank's average current earnings), $588.40 becomes the applicable limit in determining the amount of reduction. The amount payable after the increase in the total family benefit is—

The new total family benefit	$588.40
Frank's monthly workers' compensation rate	−500.00
Monthly benefit payable to Frank	88.40

No monthly benefits are payable to either child because the reduction (or offset) is applied to the family benefits first.

Example 2: Jack became entitled to disability insurance benefits in December 1973 (12/73), with a primary insurance amount (PIA) of $220.40. He was also receiving a workers' compensation benefit. An offset was imposed against the disability insurance benefit. By June 1977 (6/77), Jack's PIA had increased to $298.00 because of several statutory benefit increases. In December 1977 (12/77), his wife, Helen, attained age 65 and filed for unreduced wife's benefits. (She was not entitled to a benefit on her own earnings record.) This benefit was terminated in May 1978 (5/78), at her death. Helen's benefit was computed back to 12/73 as though she were entitled in the first month that offset was imposed against Jack. Since there were no other beneficiaries entitled and Helen's entire monthly benefit amount is subject to offset, the benefit payable to her for 12/77 through April 1978 (4/78), would be $38.80. This gives Helen the protected statutory benefit increases since 12/73. The table below shows how Helen's benefit was computed beginning with the first month offset was imposed.

Month of entitlement/ statutory increase	Jack's PIA	Helen's benefit prior to offset	Helen's statutory increase
December 1973	$220.40	$110.20	.....
March 1974	236.00	118.00	$7.80
June 1974	244.80	122.40	+4.40
June 1975	264.40	132.20	+9.80
June 1976	281.40	140.70	+8.50
June 1977	298.00	149.00	+8.30
December 1977 through April 1978[1]	.....	.....	38.80

[1] Monthly benefit payable to Helen.

(j) *Effect of social security disability insurance benefit increases.* Any increase in benefits due to a recomputation or a statutory increase in benefit rates is

not subject to the reduction for public disability benefits under paragraph (a) and does not change the amount to be deducted from the family benefit. The increase is simply added to what amount, if any, is payable. If a new beneficiary becomes entitled to monthly benefits on the same earnings record after the increase, the amount of the reduction is redistributed among the new beneficiaries entitled under section 202 of the Act and deducted from their current benefit rate.

Example: In March 1981, Chuck became entitled to disability insurance benefits with a primary insurance amount of $362.40 a month. He has a wife and two children who are each entitled to a monthly benefit of $60.40. Chuck is receiving monthly disability compensation from a worker's compensation plan of $410.00. Eighty percent of his average current earnings is $800.00. Because this is higher than the total family benefit ($543.60), $800.00 is the applicable limit in computing the amount of reduction. The amount of monthly benefits payable after the reduction is—

Applicable limit	$800.00
Chuck's monthly disability compensation	−410.00
Total amount payable to Chuck and the family after reduction	$390.00
Amount payable to Chuck	−362.40
Total amount payable to the family	$27.60
$9.20 payable to each family member equals	$27.60
	3

In June 1981, the disability benefit rates were raised to reflect an increase in the cost-of-living. Chuck is now entitled to $403.00 a month and each family member is entitled to $67.20 a month (an increase of $6.80 to each family member). The monthly amounts payable after the cost-of-living increase are now $403.00 to Chuck and $16.00 to each family member ($9.20 plus the $6.80 increase).

In September 1981, another child becomes entitled to benefits based on Chuck's earnings record. The monthly amount payable to the family (excluding Chuck) must now be divided by 4:

$6.90 payable to each family member equals	$27.60
	4

The June 1981 cost-of-living increase is added to determine the amount payable. Chuck continues to receive $403.00 monthly. Each family member receives a cost-of-living increase of $5.10. Thus, the amount payable to each is $12.00 in September 1981 ($6.90 plus the $5.10 increase). (See Example 2 under (i).)

(k) *Effect of changes in the amount of the public disability benefit.* Any change in the amount of the public disability benefit received will result in a recalculation of the reduction under paragraph (a) and, potentially, an adjustment in the amount of such reduction. If the reduction is made under paragraph (a)(1) of this section, any increased reduction will be imposed effective with the month after the month the Secretary received notice of the increase in the public disability benefit (it should be noted that only workers' compensation can cause this reduction). Adjustments due to a decrease in the amount of the public disability benefit will be effective with the actual date the decreased amount was effective. If the reduction is made under paragraph (a)(2) of this section, any increase or decrease in the reduction will be imposed effective with the actual date of entitlement to the new amount of the public disability benefit.

Example: In September 1981, based on a disability which began March 12, 1981, Theresa became entitled to Social Security disability insurance benefits with a primary insurance amount of $445.70 a month. She had previously been entitled to Social Security disability insurance benefits from March 1967 through July 1969. She is receiving a temporary total workers' compensation payment of $227.50 a month. Eighty percent of her average current earnings is $610.50. The amount of monthly disability insurance benefit payable after reduction is—

80 percent of Theresa's average current earnings	$610.50
Theresa's monthly workers' compensation payment	−227.50
Total amount payable to Theresa after reduction	383.00

On November 15, 1981, the Secretary was notified that Theresa's workers' compensation rate was increased to $303.30 a month effective October 1, 1981. This increase reflected a cost-of-living adjustment granted to all workers' compensation recipients in her State. The reduction to her monthly disability insurance benefit is recomputed to take this increase into account—

80 percent of Theresa's average current earnings	$610.50
Theresa's monthly workers' compensation payment beginning October 1, 1981	−303.30
Total new amount payable to Theresa beginning October 1981 after recalculation of the reduction	$307.20

Effective January, 1, 1982, Theresa's workers' compensation payment is decreased to $280.10 a month when she begins to receive a permanent partial payment. The reduction to her monthly disability insurance benefit is again recalculated to reflect her decreased workers' compensation amount—

80 percent of Theresa's average current earnings	$610.50
Theresa's monthly workers' compensation payment beginning January 1, 1982	−280.10
Total new amount payable to Theresa beginning January 1982 after recalculation of the reduction	$330.40

If, in the above example, Theresa had become entitled to disability insurance benefits in August 1981, the increased reduction to her benefit, due to the October 1, 1981 increase in her workers' compensation payment, would have been imposed beginning with December 1981, the month after the month she notified the Social Security Administration of the increase. The later decrease in her workers' compensation payment would still affect her disability insurance benefit beginning with January 1982.

(l) *Redetermination of benefits*—(1) *General.* In the second calendar year after the year in which reduction under this section in the total of an individual's benefits under section 223 of the Act and any benefits under section 202 of the Act based on his or her wages and self-employment income is first required (in a continuous period of months), and in each third year thereafter, the amount of those benefits which are still subject to reduction under this section are redetermined, provided this redetermination does not result in any decrease in the total amount of benefits payable under title II of the Act on the basis of the workers' wages and self-employment income. The redetermined benefit is effective with the January following the year in which the redetermination is made.

(2) *Average current earnings.* In making the redetermination required by paragraph (l)(1) of this section, the individual's average current earnings (as defined in paragraph (c)(3) of this section) is deemed to be the product of his average current earnings as initially determined under paragraph (c)(3) of this section and:

(i) The ratio of the average of the total wages (as defined in § 404.1049) of all persons for whom wages were reported to the Secretary of the Treasury or his delegate for the calendar year before the year in which the redetermination is made, to the average of the total wages of all person reported to the Secretary of the Treasury or his delegate for calendar year 1977 or, if later, the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability); and

(ii) In any case in which the reduction was first computed before 1978, the ratio of the average of the taxable wages reported to the Secretary of Health and Human Services for the first calendar quarter of 1977 to the average of the taxable wages reported to the Secretary of Health and Human Services for the first calendar quarter of the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability). Any amount determined under the preceding two sentences which is not a multiple of $1 is reduced to the next lower multiple of $1.

(3) *Effect of redetermination.* Where the applicable limit on total benefits previously used was 80 percent of the average current earnings, a redetermination under this paragraph may cause an increase in the amount of benefits payable. Also, where the limit previously used was the total family benefit, the redetermination may cause the average current earnings to exceed the total family benefit and thus become the new applicable limit. If for some other reason (such as a statutory increase or recomputation) the benefit has already been increased to a level which equals or exceeds the benefit resulting from a redetermination under this paragraph, no additional increase is made. A redetermination is designed to bring benefits into line with current wage levels when no other change in payments has done so.

Example: In October 1978, Alice became entitled to disability insurance benefits with a primary insurance amount of $505.10. Her two children were also entitled to monthly benefits of $189.40 each. Alice was also entitled to monthly disability compensation benefits of $667.30 from the State. Eighty percent of Alice's average current earnings is $1340.80, and that amount is the applicable limit. The amount of monthly benefits payable after the reduction is—

Applicable limit	$1,340.80
Alice's State disability compensation benefit	−667.30
Total benefits payable to Alice and both children after reduction	$673.50
Alice's disability insurance benefit	−505.10
Payable to the children	$168.40
$84.20 payable to each child after reduction equals	$168.40
	2

In June 1979 and June 1980, cost-of-living increases in Social Security benefits raise Alice's benefit by $50.10 (to $555.20) and $79.40 (to $634.60) respectively. The children's benefits (before reduction) are each raised by $18.80 (to $208.20) and $29.80 (to $238.00). These increases in Social Security benefits are not subject to the reduction (i.e., offset).

In 1980, Alice's average current earnings are redetermined as required by law. The offset is recalculated, and if the amount payable to the family is higher than the current amount payable to the family, that higher amount becomes payable the following January (i.e., January 1981). The current amount payable to the family after the reduction is recalculated—

Alice's 1978 benefit after reduction	$505.10
Alice's cost-of-living increase in June 1979	+50.10
Alice's cost-of-living increase in June 1980	+79.40
One child's 1978 benefit after reduction	+84.20
That child's cost-of-living increase in June 1979	+18.70
That child's cost-of-living increase in June 1980	+29.70
The other child's 1978 benefit after reduction	+84.20
The other child's cost-of-living increase in June 1979	+18.70
The other child's cost-of-living increase in June 1980	+29.70
Total amount payable to the family after reduction in January 1981	899.80

The amount payable to the family after reduction is then recalculated using the redetermined average current earnings—

Average current earnings before redetermination	$1,676.00
Redetermination ratio effective for January 1981	×1.174
Redetermined average current earnings	$1,967.00
	×80%
80% of the redetermined average current earnings	$1,573.60
Alice's State disability compensation benefit	−667.30
Total benefits payable to the family after offset	$906.30

We then compare the total amount currently being paid to the family ($899.80) to the total amount payable after the redetermination ($906.30). In this example, the redetermination yields a higher amount and, therefore, becomes payable the following January (i.e., January 1981). Additional computations are required to determine the amount that will be paid to each family member—

Total benefits payable to the family using the redetermined average current earnings	$906.30
Total cost-of-living increases to both children	−96.80
Balance payable	809.50
Alice's current benefit amount before reduction	−634.60
Payable to the children	174.90
Total cost-of-living increases to both children	+96.80
Total payable to children after reduction	271.70
$135.90 (rounded from $135.85) payable to each child equals	$271.70
	2

[32 FR 19159, Dec. 20, 1967; 33 FR 3060, Feb. 16, 1968, as amended at 37 FR 3425, Feb. 16, 1972; 48 FR 37017, Aug. 16, 1983; 48 FR 38814, Aug. 26, 1983]

§ 404.408a Reduction where spouse is receiving a Government pension.

(a) *When reduction is required.* Unless you meet one of the exceptions in paragraph (b) of this section, your monthly Social Security benefits as a wife, husband, widow, widower, mother, or father will be reduced each month you are receiving a monthly pension from a Federal, State, or local government agency (Government pension) for which you were employed in work not covered by Social Security on the last day of such employment. Your monthly Social Security benefit as a spouse will always be reduced because of your Government pension even if you afterwards return to work for a government agency and that work is covered by Social Security. For purposes of this section, Federal Government employees are not considered to be covered by Social Security if they are covered for Medicare but are not otherwise covered by Social Security. If the government pension is not paid monthly or is paid in a lump-sum, we will determine how much the pension would be if it were paid monthly and then reduce the monthly Social Security benefit accordingly. The number of years covered by a lump-sum payment, and thus the period when the Social Security benefit will be reduced, will generally be clear from the pension plan. If one of the alternatives to a lump-sum payment is a life annuity, and the amount of the monthly benefit for the life annuity can be determined, the reduction will be based on that monthly benefit amount. Where the period or the equivalent monthly pension

benefit is not clear it may be necessary for us to determine the reduction period on an individual basis.

(b) *Exceptions.* The reduction does not apply:

(1) If you are receiving a Government pension based on employment for an interstate instrumentality.

(2) If you received or are eligible to receive a Government pension for one or more months in the period December 1977 through November 1982 and you meet the requirements for Social Security benefits that were applied in January 1977, even though you don't claim benefits, and you don't actually meet the requirements for receiving benefits until a later month. The January 1977 requirements are, for a man, a one-half support test (see paragraph (c) of this section), and, for a woman claiming benefits as a divorced spouse, marriage for at least 20 years to the insured worker. You are considered eligible for a Government pension for any month in which you meet all the requirements for payment except that you are working or have not applied.

(3) If you were receiving or were eligible (as defined in paragraph (b)(2) of this section) to receive a Government pension for one or more months before July 1983, and you meet the dependency test of one-half support that was applied to claimants for husband's and widower's benefits in 1977, even though you don't claim benefits, and you don't actually meet the requirements for receiving benefits until a later month. If you meet the exception in this paragraph but you do not meet the exception in paragraph (b)(2), December 1982 is the earliest month for which the reduction will not affect your benefits.

(4) If you would have been eligible for a pension in a given month except for a requirement which delayed eligibility for such pension until the month following the month in which all other requirements were met, we will consider you to be eligible in that given month for the purpose of meeting one of the exceptions in paragraphs (b) (2) and (3) of this section. If you meet an exception solely because of this provision, your benefits will be unreduced for months after November 1984 only.

(5) If, with respect to monthly benefits payable for months after December 1994, you are receiving a Government pension based wholly upon service as a member of a uniformed service, regardless of whether on active or inactive duty and whether covered by social security. However, if the earnings on the last day of employment as a military reservist were not covered, January 1995 is the earliest month for which the reduction will not affect your benefits.

(c) The *one-half support test.* For a man to meet the January 1977 requirement as provided in the exception in paragraph (b)(2) and for a man or a woman to meet the exception in paragraph (b)(3) of this section, he or she must meet a one-half support test. One-half support is defined in § 404.366 of this part. One-half support must be met at one of the following times:

(1) If the insured person had a period of disability which did not end before he or she became entitled to old-age or disability insurance benefits, or died, you must have been receiving at least one-half support from the insured either—

(i) At the beginning of his or her period of disability;

(ii) At the time he or she became entitled to old-age or disability insurance benefits; or

(iii) If deceased, at the time of his or her death.

(2) If the insured did not have a period of disability at the time of his or her entitlement or death, you must have been receiving at least one-half support from the insured either—

(i) At the time he or she became entitled to old-age insurance benefits; or

(ii) If deceased, at the time of his or her death.

(d) *Amount and priority of reduction.* (1) If you became eligible for a Government pension after June 1983, we will reduce (to zero, if necessary) your monthly Social Security benefits as a spouse by two-thirds the amount of your monthly pension. If the reduction is not a multiple of 10 cents, we will round it to the next higher multiple of 10 cents.

(2) If you became eligible for a Government pension before July 1983 and do not meet one of the exceptions in paragraph (b) of this section, we will reduce (to zero, if necessary) your monthly Social Security benefits as a

spouse by the full amount of your pension for months before December 1984 and by two-thirds the amount of your monthly pension for months after November 1984. If the reduction is not a multiple of 10 cents, we will round it to the next higher multiple of 10 cents.

(3) Your benefit as a spouse will be reduced, if necessary, for age and for simultaneous entitlement to other Social Security benefits before it is reduced because you are receiving a Government pension. In addition, this reduction follows the order of priority as stated in § 404.402(b).

(4) If the monthly benefit payable to you after the required reduction(s) is not a multiple of $1.00, we will reduce it to the next lower multiple of $1.00 as required by § 404.304(f).

(e) *When effective.* This reduction was put into the Social Security Act by the Social Security Amendments of 1977. It only applies to applications for benefits filed in or after December 1977 and only to benefits for December 1977 and later.

[49 FR 41245, Oct. 22, 1984; 50 FR 20902, May 21, 1985, as amended at 51 FR 23052, June 25, 1986; 60 FR 56513, Nov. 9, 1995]

§ 404.408b Reduction of retroactive monthly social security benefits where supplemental security income (SSI) payments were received for the same period.

(a) *When reduction is required.* We will reduce your retroactive social security benefits if—

(1) You are entitled to monthly social security benefits for a month or months before the first month in which those benefits are paid; and

(2) SSI payments (including federally administered State supplementary payments) which were made to you for the same month or months would have been reduced or not made if your social security benefits had been paid when regularly due instead of retroactively.

(b) *Amount of reduction.* Your retroactive monthly social security benefits will be reduced by the amount of the SSI payments (including federally administered State supplementary payments) that would not have been paid to you, if you had received your monthly social security benefits when they were regularly due instead of retroactively.

(c) *Benefits subject to reduction.* The reduction described in this section applies only to monthly social security benefits. Social security benefits which we pay to you for any month after you have begun receiving recurring monthly social security benefits, and for which you did not have to file a new application, are not subject to reduction. The lump-sum death payment, which is not a monthly benefit, is not subject to reduction.

(d) *Refiguring the amount of the reduction.* We will refigure the amount of the reduction if there are subsequent changes affecting your claim which relate to the reduction period described in paragraph (a) of this section. Refiguring is generally required where there is a change in your month of entitlement or the amount of your social security benefits or SSI payments (including federally administered State supplementary payments) for the reduction period.

(e) *Reimbursement of reduced retroactive monthly social security benefits.* The amount of the reduction will be—

(1) First used to reimburse the States for the amount of any federally administered State supplementary payments that would not have been made to you if the monthly social security benefits had been paid when regularly due instead of retroactively; and

(2) The remainder, if any, shall be covered into the general fund of the U.S. Treasury for the amount of SSI benefits that would not have been paid to you if the monthly social security benefits had been paid to you when regularly due instead of retroactively.

[47 FR 4988, Feb. 3, 1982]

§ 404.409 [Reserved]

§ 404.410 Reduction in benefits for age—general.

An individual's old-age insurance benefit, wife's or husband's benefit or widow's or widower's benefit is reduced if he or she is entitled to the benefit for a month before the month he or she reaches retirement age. For purposes of this section and §§404.411 through 404.413, retirement age is age 65; except that for months prior to January 1973,

retirement age for widows and widowers is age 62. However, in the case of an individual entitled to wife's or husband's benefits, there is no reduction in benefits for any month he or she has in his or her care a child of the insured individual on whose earnings record he or she is entitled if the child is entitled to child's insurance benefits. Similarly, in the case of an individual entitled to widow's or widower's benefits, such benefits will not be reduced below the amount an individual entitled to mother's or father's benefits would receive for any month he or she has in his or her care a child of the insured individual on whose earnings record he or she is entitled if the child is entitled to child's benefits. Reductions in benefits are, subject to §§404.411 through 404.413, made in the amounts described below:

(a) In the case of old-age insurance benefits, the individual's primary insurance amount is reduced by 5/9 of 1 percent multiplied by the number of months preceding the month in which he or she attains retirement age for which he or she is entitled to such benefits;

(b) In the case of wife's or husband's benefits, the individual's benefit amount before any reduction (see §§ 404.304 and 404.333) is reduced first (if necessary) for the family maximum under § 404.403, and then further reduced by 25/36 of 1 percent multiplied by the number of months preceding the month in which he or she attains retirement age for which he or she is entitled to such benefits (but not including any month in which such wife or husband has in his or her care a child of the insured individual on whose earnings record he or she is entitled if the child is entitled to child's benefits);

(c)(1) In the case of widow's or widower's benefits, the individual's benefit amount (for months after December 1972, the amount equal to the insured person's primary insurance amount and for earlier months, the amounts described in §§ 404.304 and 404.338), after any reduction for the family maximum under § 404.403, is reduced or further reduced by 19/40 of 1 percent multiplied by the number of months in the period beginning with the month of attainment of age 60 and ending with the month immediately before the month of attainment of age 65, for which he or she is entitled to such benefits (but not including any month in which such widow or widower has a child of the insured individual in his or her care if the child is entitled to child's benefits). For months prior to January 1973, the widow's or widower's benefit is reduced in the way described in the preceding sentence except that the percentage rate is 5/9 of 1 percent multiplied by the number of months from age 60 to 62 instead of 19/40 of 1 percent multiplied by the number of months from age 60 to 65.

(2) For those widows and widowers receiving benefits based on disability and whose entitlement begins prior to their attaining age 60, their benefits are—

(i) For months after December 1983, not subject to any reduction of their benefits in addition to that under paragraph (c)(1) of this section;

(ii) For the period January 1, 1973–December 31, 1983, subject to a reduction under paragraph (c)(1) of this section and an additional reduction formula of 43/240 of 1 percent multiplied by: (A) The benefit before any reduction for age and (B) the number of months of entitlement to such benefit in the period beginning with month of attainment of age 50 and ending with the month preceding month of attainment of age 60; and

(iii) For months prior to January 1973, subject to the reduction formula described in paragraph (c)(2)(ii) of this section with, however, the percentage rate set at 43/198 of 1 percent.

(d) Benefits reduced under this section may be later adjusted to eliminate reduction for certain months of entitlement prior to retirement age as provided in § 404.412. For special provisions on reducing benefits for months prior to retirement age involving entitlement to two or more benefits and for reducing widow's and widower's benefits on the earnings record of a deceased individual previously entitled to old-age insurance benefits, see §§ 404.411 and 404.338, respectively.

[49 FR 24116, June 12, 1984]

§ 404.411 Special reduction in benefits for age involving entitlement to two or more benefits.

(a) *General.* (1) Except as specifically provided in this section, benefits of an individual entitled to more than one benefit will be reduced for months of entitlement before retirement age according to the provisions of § 404.410. Such age reductions are made before any reduction under the provisions of § 404.407.

(2) If an individual was born after January 1, 1928 and becomes disabled after December 31, 1989, his or her disability insurance benefits are reduced in accordance with paragraph (b)(1) of this section. In other situations involving prior receipt of widow's or widower's insurance benefits, disability insurance benefits are reduced in accordance with paragraph (b)(2) of this section.

(3) If an individual was born after January 1, 1928, his or her old-age insurance benefits are reduced in accordance with § 404.410(a). In other situations involving prior receipt of widow's or widower's insurance benefits, old-age insurance benefits are reduced in accordance with paragraph (c) of this section.

(b) *Reduction in disability insurance benefits after entitlement to old-age insurance benefits, widow's or widower's benefits.* An individual's disability insurance benefits are reduced following entitlement to old-age insurance benefits, widow's or widower's insurance benefits (or following the month in which all conditions for entitlement to widow's or widower's insurance benefits are met except that the individual is entitled to an old-age insurance benefit which equals or exceeds the primary insurance amount on which the widow's or widower's insurance benefit is based) in accordance with the following provisions:

(1) In the case of an individual entitled to disability insurance benefits for a month after the month in which he becomes entitled to an old-age insurance benefit which is reduced for age under § 404.410, the disability insurance benefit is reduced by the amount by which the old-age insurance benefit would be reduced under § 404.410 if he attained age 65 in the first month of his most recent period of entitlement to disability insurance benefits.

(2) In the case of an individual who is first entitled to disability insurance benefits for a month in which or after which he or she attains age 62 and for which he or she is first entitled to a widow's or widower's insurance benefit (or would be so entitled except for entitlement to an equal or higher old-age insurance benefit as explained in the material preceding paragraph (b) of this section) before retirement age, the disability insurance benefits are reduced by the larger of:

(i) The amount the disability insurance benefit would have been reduced under paragraph (b)(1) of this section; or

(ii) The amount equal to the sum of the amount the widow's or widower's benefit would have been reduced under the provisions of § 404.410 if retirement age were 62 (instead of 65) plus the amount by which the disability insurance benefit would have been reduced under paragraph (b)(1) of this section if the benefit were equal to the excess of such benefit over the amount of the widow's or widower's benefit (without consideration of this paragraph (b)(2)) of this section.

(3) In the case of an individual who is first entitled to disability insurance benefits for a month before the month in which he or she attains age 62 and he or she is also entitled to a widow's or widower's insurance benefit (or would be so entitled except for entitlement to an equal or higher old-age insurance benefit as explained in the material preceding paragraph (b) of this section), the disability insurance benefit is reduced as if the widow or widower attained retirement age in the month immediately preceding the first month of his or her most recent period of entitlement to disability insurance benefits;

(c) *Reduction in old-age insurance benefits after entitlement to widow's or widower's insurance benefits.* An individual's old-age insurance benefit is reduced if, in his or her first month of entitlement to that benefit, he or she is also entitled to a widow's or widower's insurance benefit to which he or she was first entitled for a month before

attainment of retirement age or if, before attainment of retirement age, he or she met all conditions for entitlement to widow's or widower's benefits in or before the first month for which he or she was entitled to old-age insurance benefits except that the old-age insurance benefit equals or exceeds the primary insurance amount on which the widow's or widower's insurance benefit would be based. Under these circumstances, the old-age insurance benefit is reduced by the larger of the following:

(1) The amount by which the old-age insurance benefit would be reduced under the regular age reduction provisions of § 404.410; or

(2) An amount equal to the sum of:

(i) The amount by which the widow's or widower's insurance benefit would be reduced under § 404.410 for months prior to age 62; and

(ii) The amount by which the old-age insurance benefit would be reduced under § 404.410 if it were equal to the excess of the individual's primary insurance amount over the widow's or widower's insurance benefit before any reduction for age (but after any reduction for the family maximum under § 404.403).

(d) *Reduction in wife's or husband's insurance benefits when entitled to reduced old-age insurance benefits in the same month.* A wife's or husband's insurance benefit to which a person is first entitled in or after the month of attainment of age 62 is reduced if, in his or her first month of entitlement to that benefit, he or she is also entitled to an old-age insurance benefit (but is not entitled to a disability insurance benefit) to which he or she was first entitled for a month before attainment of age 65. Under these circumstances, the wife's or husband's insurance benefit is reduced by the sum of:

(1) The amount by which the old-age insurance benefit would be reduced under the provisions of § 404.410; and

(2) The amount by which the wife's or husband's insurance benefit would be reduced under the provisions of § 404.410 if it were equal to the excess of such benefit (before any reduction for age but after reduction for the family maximum under § 404.403) over the individual's own primary insurance amount.

(e) *Reduction in wife's, husband's, widow's or widower's insurance benefit because of entitlement to disability insurance benefits in the same month.* A wife's, husband's, widow's, or widower's insurance benefit to which a person is first entitled in or after the month of attainment of age 62 (or in the case of widow's or widower's insurance benefits, age 50) is reduced if, in his or her first month of entitlement to that benefit, he or she is also entitled to a disability insurance benefit. Under these circumstances, the wife's, husband's, widow's, or widower's insurance benefit is reduced by the sum of:

(1) The amount (if any) by which the disability insurance benefit is reduced under paragraph (b)(1) of this section, and

(2) The amount by which the wife's, husband's, widow's, or widower's insurance benefit would be reduced under § 404.410 if it were equal to the excess of such benefit (before any reduction for age but after reduction for the family maximum under § 404.403) over the disability insurance benefit (before any reduction under paragraph (b) of this section).

[40 FR 30816, July 23, 1975, as amended at 55 FR 50551, Dec. 7, 1990]

§ 404.412 Adjustments in benefit reductions for age.

(a) *General.* The following months are not counted for purposes of reducing benefits in accordance with § 404.410;

(1) Months subject to deduction under § 404.415, § 404.417, or § 404.422;

(2) In the case of wife's or husband's insurance benefits, any month in which she or he had a child of the insured individual in her or his care and for which the child was entitled to child's benefits;

(3) In the case of wife's or husband's insurance benefits, any month for which entitlement to such benefits is precluded because the insured person's disability ceased (and, as a result, the insured individual's entitlement to disability insurance benefits ended);

(4) In the case of widow's or widower's insurance benefits, any month in which she or he had in her or his care a child of the deceased insured individual and for which the child was entitled to child's benefits;

(5) In the case of widow's or widower's insurance benefits, any month before attainment of age 62 and any month between age 62 and attainment of age 65 for which he or she was not entitled to such benefits;

(6) In the case of old-age insurance benefits, any month for which the individual was entitled to disability insurance benefits.

(b) *Adjustment by Social Security Administration.* Adjustments in benefits to exclude those months of entitlement which are described in paragraphs (a)(1) through (6) of this section from consideration in determining the amount by which such benefits are reduced are made automatically. Each year the Social Security Administration examines beneficiary records to identify those instances in which an individual has attained age 65 (or age 62 in the case of widow's or widower's insurance benefits) and one or more months described in paragraphs (a)(1) through (6) of this section occurred prior to such age during the period of entitlement to benefits reduced for age. Increases in benefit amounts based upon this adjustment are effective with the month of attainment of age 65, or in the case of widow's and widower's insurance benefits, the month of attainment of age 65 or age 62 (whichever applies).

[40 FR 30817, July 23, 1975, as amended at 49 FR 24117, June 12, 1984]

§ 404.413 Reduction in benefits for age following an increase in primary insurance amounts.

(a) *General.* When an individual's benefits have been reduced for age under the provisions of §§ 404.410 through 404.411, the primary insurance amount on which such benefits are based may be subsequently increased because of recomputation, a general benefit increase pursuant to an amendment of the Act, or increases based upon rises in the cost-of-living under section 215(i) of the Social Security Act. Where the individual's benefits are increased because of an increase in the primary insurance amount, such benefits are reduced separately under §§ 404.410 and 404.411. The benefit amount for months before the effective date of the increase in the primary insurance amount is reduced under § 404.410 (and § 404.411, if applicable) and added to the amount of increase in benefit amount which has been reduced for months of entitlement to the increase prior to the individual's retirement age; the resulting sum will be the total benefit amount to which the individual is entitled for the month of such increase and months thereafter.

(b) *Subsequent reduction of increases in reduced benefit after 1977 applies as or original entitlement.* When an individual's benefits have been reduced for age and the benefit is increased after 1977 due to a rise in the primary insurance amount, the amount of the increase to which the individual is entitled is proportionately reduced as provided in paragraph (c) of this section. When an individual is entitled to more than one benefit which is reduced for age, the rules for reducing the benefit increases apply to each reduced benefit.

(c) *How reduction is computed*—(1) *Entitlement to reduced benefits after 1977.* If an individual becomes entitled after 1977 to a benefit reduced for age, and the primary insurance amount on which the reduced benefit is based is increased, the amount of the increase payable to the individual is reduced by the same percentage as used to reduce the benefit in the month of initial entitlement. Where the reduced benefit of an individual has been adjusted at age 65 (age 62 and 65 for widows) any increase to which the individual becomes entitled thereafter is reduced by the adjusted percentage.

(2) *Entitlement to reduced benefits before 1978.* An individual who became entitled to a benefit reduced for age before 1978, and whose benefit may be increased as a result of an increase in the primary insurance amount after 1977, shall have the amount of the benefit to which he or she is entitled increased by the same percentage as the increase in the primary insurance amount.

[40 FR 30817, July 23, 1975, as amended at 43 FR 33706, Aug. 1, 1978]

§ 404.415 Deductions because of excess earnings; annual earnings test.

(a) *Deductions because of beneficiary's earnings.* Under the annual earnings test, deductions are made from monthly benefits (except disability insurance benefits, child's insurance benefits

based on the child's disability, or widow's or widower's insurance benefits based on the widow's or widower's disability) payable to a beneficiary for each month in a taxable year (whether a calendar year or a fiscal year) beginning after December 1954 in which the beneficiary is under age 72 (age 70 after December 1982) and to which excess earnings are charged under the provisions described in § 404.434.

(b) *Deductions from husband's, wife's, or child's benefits because of excess earnings of the insured individual.* Deductions are made from the wife's, husband's, or child's insurance benefits payable (or deemed payable—see § 404.420) on the insured individual's earnings record because of the excess earnings of the insured individual under the provisions described in § 404.416. However, beginning with January 1985, deductions will not be made from the benefits payable to a divorced wife or a divorced husband who has been divorced from the insured individual for at least 2 years.

[32 FR 19159, Dec. 20, 1967, as amended at 48 FR 4281, Jan. 31, 1983; 51 FR 11912, Apr. 8, 1986]

§ 404.416 Amount of deduction because of excess earnings.

(a) *Deductions because of excess earnings of insured individual.* For taxable years beginning after 1960, or ending after June 1961, if excess earnings (as described in § 404.430) of an insured individual are chargeable under the annual earnings test to a month, a deduction is made from the total of the benefits payable to him and to all other persons entitled (or deemed entitled—see § 404.420) on his earnings record for that month. This deduction is an amount equal to that amount of the excess earnings so charged. (See § 404.434 concerning the manner of charging such excess earnings.) However, beginning with January 1985, deductions will not be made from the benefits payable to a divorced wife or a divorced husband who has been divorced from the insured individual for at least 2 years, and the divorced spouse will be considered as not entitled for purposes of computing the amount of deductions from other beneficiaries.

(b) *Deductions because of excess earnings of other beneficiary.* For taxable years beginning after 1960, or ending after June 1961, if benefits are payable to a person entitled (or deemed entitled—see § 404.420) on the earnings record of the insured individual, and such person has excess earnings (as described in § 404.430) charged to a month, a deduction is made from his benefits only for that month. This deduction is an amount equal to the amount of the excess earnings so charged. (See § 404.434 for charging of excess earnings where both the insured individual and such person have excess earnings.)

[43 FR 8132, Feb. 28, 1978, as amended at 51 FR 11912, Apr. 8, 1986]

§ 404.417 Deductions because of noncovered remunerative activity outside the United States; 45 hour and 7-day work test.

(a) *Deductions because of individual's activity.*—(1) *Prior to May 1983.* For months prior to May 1983, a 7-day work test applies in a month before benefit deductions are made for noncovered remunerative activity outside the United States. A deduction is made from any monthly benefit (except disability insurance benefits, child's insurance benefits based on the child's disability, or widow's or widower's insurance benefits based on the widow's or widower's disability) payable to an individual for each month in a taxable year beginning after December 1954 in which the beneficiary, while under age 72 (age 70 after December 1982), engages in noncovered remunerative activity (see § 404.418) outside the United States on 7 or more different calendar days. The deduction is for an amount equal to the benefit payable to the individual for that month.

(2) *From May 1983 on.* Effective May 1983, a 45-hour work test applies before a benefit deduction is made for the non-covered remunerative activity performed outside the United States in a month by the type of beneficiary described in paragraph (a)(1) of this section.

(b) *Deductions from benefits because of the earnings or work of an insured individual*—(1) *Prior to September 1984.* Where the insured individual entitled to old-age benefits works on 7 or more

days in a month prior to September 1984 while under age 72 (age 70 after December 1982), a deduction is made for that month from any:

(i) Wife's, husband's, or child's insurance benefit payable on the insured individual's earnings record; and

(ii) Mother's, father's, or child's insurance benefit based on child's disability, which under § 404.420 is deemed payable on the insured individual's earnings record because of the beneficiary's marriage to the insured individual.

(2) *From September 1984 on.* Effective September 1984, a benefit deduction is made for a month from the benefits described in paragraph (b)(1) of this section only if the insured individual, while under age 70, has worked in excess of 45 hours in that month.

(3) *Amount of deduction.* The amount of the deduction required by this paragraph (b) is equal to the wife's, husband's or child's benefit.

(4) *From January 1985 on.* Effective January 1985, no deduction will be made from the benefits payable to a divorced wife or a divorced husband who has been divorced from the insured individual for at least 2 years.

[49 FR 24117, June 12, 1984, as amended at 51 FR 11912, Apr. 21, 1986; 52 FR 26145, July 13, 1987]

§ 404.418 "Noncovered remunerative activity outside the United States," defined.

An individual is engaged in noncovered remunerative activity outside the United States for purposes of deductions described in § 404.417 if:

(a) He performs services outside the United States as an employee and the services do not constitute employment as defined in subpart K of this part and, for taxable years ending after 1955, the services are not performed in the active military or naval service of the United States; or

(b) He carries on a trade or business outside the United States (other than the performance of services as an employee) the net income or loss of which is not includable in computing his net earnings from self-employment (as defined in § 404.1050) for a taxable year and would not be excluded from net earnings from self-employment (see § 404.1052) if the trade or business were carried on in the United States. When used in the preceding sentence with respect to a trade or business, the term *United States* does not include the Commonwealth of Puerto Rico, the Virgin Islands and, with respect to taxable years beginning after 1960, Guam or American Samoa, in the case of an alien who is not a resident of the United States (including the Commonwealth of Puerto Rico, the Virgin Islands and, with respect to taxable years beginning after 1960, Guam and American Samoa), and the term *trade or business* shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1954.

§ 404.420 Persons deemed entitled to benefits based on an individual's earnings record.

For purposes of imposing deductions under the annual earnings test (see § 404.415) and the foreign work test (see § 404.417), a person who is married to an old-age insurance beneficiary and who is entitled to a mother's or father's insurance benefit or a child's insurance benefit based on the child's disability (and all these benefits are based on the earnings record of some third person) is deemed entitled to such benefit based on the earnings record of the old-age insurance beneficiary to whom he or she is married. This section is effective for months in any taxable year of the old-age insurance beneficiary that begins after August 1958.

[49 FR 24117, June 12, 1984]

§ 404.421 Deductions because beneficiary failed to have a child in his or her care.

Deductions for failure to have a child in care (as defined in subpart D of this part) are made as follows:

(a) *Wife's or husband's insurance benefits.* A deduction is made from the wife's or husband's insurance benefit to which he or she is entitled for any month if he or she is under age 65 and does not have in his or her care a child of the insured entitled to a child's insurance benefit. However, a deduction is not made for any month in which he or she is age 62 or over, but under age 65, and there is in effect a certificate of election for him or her to receive an

actuarially reduced wife's or husband's insurance benefit for such month (see subpart D of this part).

(b) *Mother's or father's insurance benefits*—(1) *Widow or Widower.* A deduction is made from the mother's or father's insurance benefit to which he or she is entitled as the widow or widower (see subpart D of this part) of the deceased individual upon whose earnings such benefit is based, for any month in which he or she does not have in his or her care a child who is entitled to a child's insurance benefit based on the earnings of the deceased insured individual.

(2) *Surviving divorced mother or father.* A deduction is made from the mother's or father's insurance benefit to which he or she is entitled as the surviving divorced mother or father (see subpart D of this part) of the deceased individual upon whose earnings record such benefit is based, for any month in which she or he does not have in care a child of the deceased individual who is her or his son, daughter, or legally adopted child and who is entitled to a child's insurance benefit based on the earnings of the deceased insured individual.

(c) *Amount to be deducted.* The amount deducted from the benefit, as described in paragraphs (a) and (b) of this section, is equal to the amount of the benefit which is otherwise payable for the month in which she or he does not have a child in his or her care.

(d) *When child is considered not entitled to benefits.* For purposes of paragraphs (a) and (b) of this section a person is considered not entitled to a child's insurance benefit for any month in which he is age 18 or over, and:

(1) Is entitled to a child's insurance benefit based on his own disability and a deduction is made from the child's insurance benefit because of his refusal of rehabilitation services as described in § 404.422(b); or

(2) Is entitled to a child's insurance benefit because he is a full-time student at an educational institution. This paragraph applies to benefits for months after December 1964.

[32 FR 19159, Dec. 20, 1967, as amended at 49 FR 24117, June 12, 1984]

§ 404.422 Deductions because of refusal to accept rehabilitation services.

(a) *Deductions because individual entitled to disability insurance benefits refuses rehabilitation services*—(1) *Disability insurance beneficiary.* A deduction is made from any benefit payable to a disability insurance beneficiary for each month in which he refuses without good cause to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act.

(2) *Other beneficiaries.* For each month in which a deduction is made from an individual's disability insurance benefit because of his refusal to accept rehabilitation services (as described in paragraph (a)(1) of this section), a deduction is also made from:

(i) Any wife's, husband's, or child's insurance benefit payable for that month on the earnings record of the individual entitled to disability insurance benefits;

(ii) Benefits payable for that month to the disability insurance beneficiary's spouse who is entitled (on the earnings record of a third person) to a mother's insurance benefit or to a child's insurance benefit based on disability.

(b) *Deductions because individual entitled to a child's insurance benefit based on disability refuses rehabilitation services.* A deduction is made from any benefit payable to an individual who has attained age 18 and is entitled to a child's insurance benefit based on disability, for each month in which he refuses without good cause to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act unless, in that month, he is a full-time student at an educational institution.

(c) *Deductions because individual entitled to widow's or widower's insurance benefit based on disability refuses rehabilitation services*—(1) *Widow's insurance beneficiary.* A deduction is made from any benefits payable to an individual entitled to a widow's insurance benefit based on disability for each month in which she is under age 60 and refuses without good cause to accept rehabilitation services available to her under a

State plan approved under the Vocational Rehabilitation Act.

(2) *Widower's insurance beneficiary.* A deduction is made from any benefits payable to an individual entitled to a widower's insurance benefit based on disability for each month in which he is under age 60 (age 62 for months prior to January 1973) and refuses without good cause to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act.

(d) *Amount of deduction.* The amount deducted from an individual's benefit for a month under the provisions of paragraph (a), (b), or (c) of this section is an amount equal to the benefit otherwise payable for that month.

(e) *Good cause for refusal of rehabilitation services.* An individual may refuse to accept rehabilitation services (for the purposes of paragraph (a), (b), or (c) of this section) if his refusal is based on good cause. In determining whether an individual has good cause for refusing rehabilitation services, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have which may have caused the individual to refuse such services. We also consider other factors that may have caused an individual to refuse such services. For example, an individual has good cause for refusing rehabilitation services where:

(1) The individual is a member or adherent of any recognized church or religious sect which teaches its members or adherents to rely solely, in the treatment and care of any physical or mental impairment, on prayer or spiritual means through the application and use of the tenets or teachings of such church or sect; and

(2) His refusal to accept rehabilitation services was due solely to his adherence to the teachings or tenets of his church or sect.

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 9429, Apr. 16, 1973; 59 FR 1633, Jan. 12, 1994]

§ 404.423 Manner of making deductions.

Deductions provided for in §§ 404.415, 404.417, 404.421, and 404.422 (as modified in § 404.458) are made by withholding benefits (in whole or in part, depending upon the amount to be withheld) for each month in which an event causing a deduction occurred. If the amount to be deducted is not withheld from the benefits payable in the month in which the event causing the deduction occurred, such amount constitutes a *deduction overpayment* and is subject to adjustment or recovery in accordance with the provisions of subpart F of this part.

§ 404.424 Total amount of deductions where more than one deduction event occurs in a month.

If more than one of the deduction events specified in §§ 404.415, 404.417, and 404.421 occurred in any 1 month, each of which would occasion a deduction equal to the benefit for such month, only an amount equal to such benefit is deducted.

§ 404.425 Total amount of deductions where deduction events occur in more than 1 month.

If a deduction event described in §§ 404.415, 404.417, 404.421, and 404.422 occurs in more than 1 month, the total amount deducted from an individual's benefits is equal to the sum of the deductions for all months in which any such event occurred.

§ 404.428 Earnings in a taxable year.

(a) *General.* (1) In applying the annual earnings test (see § 404.415(a)) under this subpart, all of a beneficiary's earnings (as defined in § 404.429) for all months of the beneficiary's taxable year are used even though the individual may not be entitled to benefits during all months of the taxable year. (See, however, § 404.430 for the rule which applies to earnings of a beneficiary who attains age 72 during the taxable year (age 70 for months after December 1982)).

(2) The taxable year of an employee is presumed to be a calendar year until it is shown to the satisfaction of the Social Security Administration that the individual has a different taxable year. A self-employed individual's taxable year is a calendar year unless the individual has a different taxable year

for the purposes of subtitle A of the Internal Revenue Code of 1954. In either case, the number of months in a taxable year is not affected by—(i) The time a claim for social security benefits is filed, (ii) attainment of any particular age, (iii) marriage or the termination of marriage, or (iv) adoption. For beneficiaries who die on or before November 10, 1988, a taxable year ends with the month of the death of the beneficiary. The month of death is counted as a month of the deceased beneficiary's taxable year in determining whether the beneficiary had excess earnings for the year under § 404.430. For beneficiaries who die after November 10, 1988, the number of months used in determining whether the beneficiary had excess earnings for the year under § 404.430 is 12.

(b) *When derived.* Wages as defined in § 404.429(c) are derived and includable as earnings for the months and year in which the beneficiary rendered the services. Net earnings from self-employment, or net losses therefrom, are derived, or incurred, and are includable as earnings or losses, in the year for which such earnings or losses are reportable for Federal income tax purposes.

[32 FR 19159, Dec. 20, 1967, as amended at 45 FR 48116, July 18, 1980; 48 FR 4282, Jan. 31, 1983; 55 FR 37461, Sept. 12, 1990]

§ 404.429 Earnings; defined.

(a) *General.* When the term *earnings* is used in this subpart other than as a part of the phrase *net earnings from self-employment,* it means an individual's earnings for a taxable year after 1954. It includes the sum of his wages for services rendered in such year, and his net earnings from self-employment for the taxable year, minus any net loss from self-employment for the same taxable year.

(b) *Net earnings from self-employment; net loss from self-employment.* An individual's net earnings from self-employment and his net loss from self-employment are determined under the provisions in subpart K of this part except that:

(1) For the purposes of this section, the provisions in subpart K of this part shall not apply that exclude from the definition of *trade or business* the following occupations:

(i) The performance of the functions of a public office;

(ii) The performance of a service of a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by the order;

(iii) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner;

(iv) For taxable years ending before 1965, the performance by an individual in the exercise of his profession as a doctor of medicine;

(v) For taxable years ending before 1956, the performance of service by an individual in the exercise of his profession as a lawyer, dentist, osteopath, veterinarian, chiropractor, naturopath, or optometrist.

(2) For the sole purpose of the earnings test under this subpart—

(i) An individual who has attained age 65 on or before the last day of his or her taxable year shall have excluded from his or her gross earnings from self-employment, royalties attributable to a copyright or patent obtained before the taxable year in which he or she attained age 65 if the copyright or patent is on property created by his or her own personal efforts; and

(ii) An individual entitled to insurance benefits, under title II of the Act, other than disability insurance benefits or child's insurance benefits payable by reason of being under a disability, shall have excluded from gross earnings for any year after 1977 any self-employment income received in a year after his or her initial year of entitlement that is not attributable to services performed after the first month he or she became entitled to benefits. As used in this paragraph (b)(2)(ii) of this section, *services* means any significant work activity performed by the individual in the operation or management of a trade, profession, or business which can be related to the income received. Such services will be termed *significant services.* Where a portion of the income received in a year is not related to any significant services performed after the

month of initial entitlement, only that portion may be excluded from gross earnings for deduction purposes. The balance of the income counts for deduction purposes. Not counted as *significant services* are—

(A) Actions taken after the initial month of entitlement to sell a crop or product if the crop or product was completely produced or created in or before the month of entitlement. This rule does not apply to income received by an individual from a trade or business of buying and selling products produced or made by others; for example, a grain broker.

(B) Those activities that are related solely to protecting an investment in a currently operating business or that are too irregular, occasional, or minor to be considered as having a bearing on the income received, such as—

(*1*) Hiring an agent, manager, or other employee to operate the business;

(*2*) Signing contracts where the owner's signature is required so long as the major contract negotiations were handled by the owner's agent, manager, or other employees in running the business for the owner;

(*3*) Looking over the company's financial records to assess the effectiveness of those agents, managers, or employees in running the business for the owner;

(*4*) Personally contacting an old and valued customer solely for the purpose of maintaining good will when such contact has a minimal effect on the ongoing operation of the trade or business; or

(*5*) Occasionally filling in for an agent, manager, or other employee or partner in an emergency.

(iii) An individual is presumed to have royalties or other self-employment income countable for purposes of the earnings test until it is shown to the satisfaction of the Social Security Administration that such income may be excluded under § 404.429(b)(2) (i) or (ii).

(3) In figuring an individual's net earnings or net loss from self-employment, all net income or net loss is includable even though (i) the individual did not perform personal services in carrying on the trade or business, (ii) the net profit was less than $400, (iii) the net profit was in excess of the maximum amount creditable to his earnings record, or (iv) the net profit was not reportable for social security tax purposes.

(4) An individual's net earnings from self-employment is the excess of gross income over the allowable business deductions (allowed under the Internal Revenue Code). An individual's net loss from self-employment is the excess of business deductions (that are allowed under the Internal Revenue Code) over gross income. Expenses arising in connection with the production of income excluded from gross income under § 404.429(b)(2)(ii) cannot be deducted from wages or net earnings from self-employment that are not excluded under that section.

(c) *Wages defined.* Wages include the gross amount of an individual's wages rather than the net amount paid after deductions by the employer for items such as taxes and insurance. For purposes of this section, an individual's wages are determined under the provisions of subpart K of this part, except that, notwithstanding the provisions of subpart K, wages also includes:

(1) Remuneration in excess of the amounts in the annual wage limitation table in § 404.1047;

(2) Cash remuneration of less than $50 paid in a calendar quarter to an employee for (i) domestic service in the private home of the employer, or (ii) service not in the course of the employer's trade or business; and

(3) Payments for agricultural labor excluded under § 404.1055.

(4) Remuneration, cash and noncash, for service as a homeworker even though the cash remuneration paid the employee is less than $50 in a calendar quarter; and

(5) For taxable years ending after 1955, services performed outside the United States in the military or naval service of the United States; and

(6) Remuneration for services excepted from employment performed within the United States by an individual as an employee that are for that reason not considered wages under subpart K of this part, if the remuneration for such services is not includable in computing his net earnings from self-

employment or net loss from self-employment, as defined in paragraph (b) of this section.

(d) *Presumptions concerning wages.* For purposes of this section, where reports received by the Administration show wages (as defined in paragraph (c) of this section) were paid to an individual during a taxable year, it is presumed that they were paid to him for services rendered in that year until such time as it is shown to the satisfaction of the Administration that the wages were paid for services rendered in another taxable year. If the reports of wages paid to an individual show his wages for a calendar year, the individual's taxable year is presumed to be a calendar year for purposes of this section until it is shown to the satisfaction of the Administration that his taxable year is not a calendar year.

[32 FR 19159, Dec. 20, 1967, as amended at 41 FR 13912, Apr. 1, 1976; 47 FR 46690, Oct. 20, 1982; 52 FR 8249, Mar. 17, 1987; 57 FR 59913, Dec. 17, 1992]

§ 404.430 Excess earnings defined for taxable years ending after December 1972; monthly exempt amount defined.

(a) *Method of determining excess earnings for years ending after December 1972.* For taxable years ending after 1972, an individual's excess earnings for a taxable year are 50 percent of his or her earnings (as described in § 404.429) for the year which are above the exempt amount. For an individual who has attained retirement age, as defined in section 216(l) of the Act, excess earnings for a taxable year beginning after December 31, 1989, are 33⅓ percent of his or her earnings (as described in § 404.429) for the year which are above the exempt amount. For deaths after November 10, 1988, an individual who dies in the taxable year in which he or she would have attained retirement age shall have his or her excess earnings computed as if he or she had attained retirement age. The exempt amount is obtained by multiplying the number of months in the taxable year (except that the number of months in the taxable year in which the individual dies shall be 12, if death occurs after November 10, 1988) by the following applicable monthly exempt amount.

(1) $175 for taxable years ending after December 1972 and before January 1974;

(2) $200 for taxable years beginning after December 1973 and before January 1975; and

(3) The exempt amount for taxable years ending after December 1974, as determined under paragraphs (c) and (d) of this section. However, earnings in and after the month an individual attains age 72 will not be used to figure excess earnings for retirement test purposes. For the employed individual, wages for months prior to the month of attainment of age 72 are used to figure the excess earnings for retirement test purposes. For the self-employed individual, the pro rata share of the net earnings or net loss for the taxable year for the period prior to the month of attainment of age 72 is used to figure the excess earnings. If the beneficiary was not engaged in self-employment prior to the month of attainment of age 72, any subsequent earnings or losses from self-employment in the taxable year will not be used to figure the excess earnings. Where the excess amount figured under the provisions of this section is not a multiple of $1, it is reduced to the next lower dollar. (All references to age 72 will be age 70 for months after December 1982.)

Example 1. The self-employed beneficiary attained age 72 in July 1979. His net earnings for 1979, his taxable year, were $12,000. The pro rata share of the net earnings for the period prior to July is $6,000. His excess earnings for 1979 for retirement test purposes are $750. This is computed by subtracting $4,500 ($375×12), the exempt amount for 1979, from $6,000 and dividing the result by 2.

Example 2. The beneficiary attained age 72 in July 1979. His taxable year was calendar year 1979. His wages for the period prior to July were $6,000. From August through December 1979, he worked in self-employment and had net earnings in the amount of $2,000. His net earnings from self-employment are not used to figure his excess earnings. Only his wages for the period prior to July 1979 ($6,000) are used to figure his excess earnings. As in example 1, his excess earnings are $750.

Example 3. The facts are the same as in example 2, except that the beneficiary worked in self-employment throughout all of 1979 and had a net loss of $500 from the self-employment activity. The pro rata share of the net loss for the period prior to July is $250. His earnings for the taxable year to be used in figuring excess earnings are $5,750.

This is computed by subtracting the $250 net loss from self-employment from the $6,000 in wages. The excess earnings are $625 (($5,750 − $4,500)÷2).

(b) *Monthly exempt amount defined.* The retirement test monthly exempt amount is the amount of wages which a social security beneficiary may earn in any month without part of his or her monthly benefit being deducted because of excess earnings. For benefits payable for months after 1977, the monthly exempt amount applies only in a beneficiary's grace year or years. (See § 404.435(a) and (c)).

(c) *Method of determining monthly exempt amount for taxable years ending after December 1974.* (1) Except as provided under paragraph (d) of this section, for purposes of paragraph (a)(3) of this section, the applicable monthly exempt amount effective for an individual's taxable year that ends in the calendar year after the calendar year in which an automatic cost-of-living increase in old-age, survivors, and disability insurance benefits is effective is the larger of—

(i) The exempt amount in effect for months in the taxable year in which the exempt amount determination is being made; or

(ii) The amount determined by:

(*a*) Multiplying the monthly exempt amount effective during the taxable year in which the exempt amount determination is being made by the ratio of:

(*1*) The average amount, per employee, of the taxable wages of all employees as reported to the Secretary for the first calendar quarter of the calendar year in which the exempt amount determination is made, to

(*2*) The average amount, per employee, of the taxable wages of all employees as reported to the Secretary for the first calendar quarter of the most recent calendar year in which an increase in the exempt amount was enacted or a determination resulting in such an increase was made, and

(*b*) Rounding the result of such multiplication: (*1*) To the next higher multiple of $10 where such result is a multiple of $5 but not of $10, or (*2*) to the nearest multiple of $10 in any other case.

(2) For purposes of paragraph (c)(1) of this section, *reported for the first calendar quarter* means reported for such first calendar quarter and posted to the earnings records by the Secretary on or before the last day of the Social Security Administration's quarterly updating operations in September of the same year. Earnings items received or posted thereafter are not counted even though they pertain to the first quarter.

(d) *Method of determining monthly exempt amount for taxable years ending after December 1977 for beneficiaries, age 65 or over.* (1) For purposes of paragraph (a)(3) of this section, for all months of taxable years ending after 1977, the applicable monthly exempt amount for an individual who has attained (or, but for the individual's death occurring after November 10, 1988, would have attained) retirement age as defined in section 216(l) of the Act before the close of the taxable year involved is—

(i) $333.33⅓ for each month of any taxable year ending in 1978;

(ii) $375 for each month of any taxable year ending in 1979;

(iii) $416.66⅔ for each month of any taxable year ending in 1980; and

(iv) $458.33⅓ for each month of any taxable year ending in 1981;

(v) $500 for each month of any taxable year ending in 1982;

(vi) $550 for each month of any taxable year ending in 1983;

(vii) $580 for each month of any taxable year ending in 1984;

(viii) $610 for each month of any taxable year ending in 1985;

(ix) $650 for each month of any taxable year ending in 1986;

(x) $680 for each month of any taxable year ending in 1987;

(xi) $700 for each month of any taxable year ending in 1988;

(xii) $740 for each month of any taxable year ending in 1989; and

(xiii) $780 for each month of any taxable year ending in 1990.

(2) Fractional amounts listed in paragraph (d)(1) of this section shall be rounded to the next higher whole dollar amount, unless the individual

shows that doing so results in a different grace year (see § 404.435 (a) and (c)).

[40 FR 42865, Sept. 17, 1975; 40 FR 45805, Oct. 3, 1975, as amended at 45 FR 48117, July 18, 1980; 45 FR 58107, Sept. 2, 1980; 48 FR 4282, Jan. 31, 1983; 55 FR 37461, Sept. 12, 1990]

§ 404.434 Excess earnings; method of charging.

(a) *Months charged.* For purposes of imposing deductions for taxable years after 1960, the excess earnings (as described in § 404.430) of an individual are charged to each month beginning with the first month the individual is entitled in the taxable year in question and continuing, if necessary, to each succeeding month in such taxable year until all of the individual's excess earnings have been charged. Excess earnings, however, are not charged to any month described in §§ 404.435 and 404.436.

(b) *Amount of excess earnings charged*—(1) *Insured individual's excess earnings.* The insured individual's excess earnings are charged on the basis of $1 of excess earnings for each $1 of monthly benefits to which he and all other persons are entitled (or deemed entitled—see § 404.420) for such month on the insured individual's earnings record. (See § 404.439 where the excess earnings for a month are less than the total benefits payable for that month.)

(2) *Excess earnings of beneficiary other than insured individual.* The excess earnings of a person other than the insured individual are charged on the basis of $1 of excess earnings for each $1 of monthly benefits to which he is entitled (see § 404.437) for such month. The excess earnings of such person, however, are charged only against his own benefits.

(3) *Insured individual and person entitled (or deemed entitled) on his earnings record both have excess earnings.* If both the insured individual and a person entitled (or deemed entitled) on his earnings record have excess earnings (as described in § 404.430), the insured individual's excess earnings are charged first against the total family benefits payable (or deemed payable) on his earnings record, as described in paragraph (b)(1) of this section. Next, the excess earnings of a person entitled on the insured individual's earnings record are charged (as described in paragraph (c)(2) of this section) against his own benefits, but only to the extent that his benefits have not already been charged with the excess earnings of the insured individual. See § 404.441 for an example of this process and the manner in which partial monthly benefits are apportioned.

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 17716, July 3, 1973; 43 FR 8133, Feb. 28, 1978]

§ 404.435 Excess earnings; months to which excess earnings cannot be charged.

(a) *Monthly benefits payable for months after 1977.* Beginning with monthly benefits payable for months after 1977, no matter how much a beneficiary earns in a given taxable year, no deduction on account of excess earnings will be made in the benefits payable for any month—

(1) In which he or she was not entitled to a monthly benefit;

(2) In which he or she was considered not entitled to benefits (due to noncovered work outside the United States, no child in care, or refusal of rehabilitation, as described in § 404.436);

(3) In which he or she was age 72 or over (age 70 for months after December 1982);

(4) In which he or she was entitled to payment of disability insurance benefit;

(5) In which he or she was age 18 or over and entitled to a child's insurance benefit based on disability;

(6) In which he or she was entitled to a widow's or widower's insurance benefit based on disability; or

(7) Which was a *nonservice* month (see paragraph (b) of this section) in the beneficiary's *grace year* (see paragraph (c) of this section).

(b) *Nonservice month defined.* A nonservice month is any month in which an individual, while entitled to retirement or survivors benefits—(1) does not work in self-employment (see paragraphs (d) and (e) of this section); (2) does not perform services for wages greater than the monthly exempt amount set for that month (see paragraph (f) of this section and § 404.430 (b), (c), and (d)); and (3) does not work in

noncovered remunerative activity on 7 or more days in a month while outside the United States. A nonservice month occurs even if there are no excess earnings in the year.

(c) *Grace year defined.* (1) A beneficiary's initial grace year is the first taxable year after 1977 in which the beneficiary has a nonservice month (see paragraph (b) of this section) in or after the month in which he or she is entitled to a retirement, auxiliary, or survivor's benefit.

(2) A beneficiary may have another grace year each time his or her entitlement to one type of benefit ends and, after a break in entitlement of at least one month, he or she becomes entitled to a different type of retirement or survivors benefit. The new grace year would then be the taxable year in which occurs the first nonservice month after the break in entitlement.

(3) A month will not be counted as a nonservice month for purposes of determining whether a given year is a beneficiary's grace year if the nonservice month occurred while the beneficiary was entitled to disability benefits under section 223 of the Social Security Act or as a disabled widow, widower, or child under section 202.

(4) A beneficiary entitled to child's benefits, to young wife's or young husband's benefits (entitled only by reason of having a child in his or her care), or to mother's or father's benefits, is entitled to a termination grace year in any year(s) the beneficiary's entitlement to these types of benefits terminates. This provision does not apply if the termination is because of death or if the beneficiary is entitled to a Social Security benefit for the month following the month in which the entitlement ended. The beneficiary is entitled to a termination grace year in addition to any other grace year(s) available to him or her.

Example 1: Don, age 65, will retire from his regular job in April of next year. Although he will have earned $11,000 for January–April of that year and plans to work part time, he will not earn over the monthly exempt amount after April. Don's taxable year is the calendar year. Since next year will be the first year in which he has a nonservice month while entitled to benefits, it will be his grace year and he will be entitled to the monthly earnings test for that year only. He will receive benefits for all months in which he does not earn over the monthly exempt amount (May–December) even though his earnings have substantially exceeded the annual exempt amount. However, in the years that follow, only the annual earnings test will be applied if he has earnings that exceed the annual exempt amount, regardless of his monthly earnings.

Example 2: Marion was entitled to mother's insurance benefits from 1978 because she had a child in her care under age 18. Because she had a nonservice month in 1978, 1978 was her initial grace year. Marion's child married in May 1980 and entitlement to mother's benefits terminated in April 1980. Since Marion's entitlement did not terminate by reason of her death and she was not entitled to another type of Social Security benefit in the month after her entitlement to mother's benefit ended, she is entitled to a termination grace year for 1980, the year in which her entitlement to mother's insurance benefits terminated.

She applied for and became entitled to widow's insurance benefits effective February 1981. Because there was a break in entitlement to benefits of at least one month before entitlement to another type of benefit, 1981 will be a subsequent grace year if Marion has a nonservice month in 1981.

(d) *When an individual works in self-employment.* An individual works in self-employment in any month in which he or she performs substantial services (see § 404.446) in the operation of a trade or business (or in a combination of trades and businesses if there are more than one) as an owner or partner even though there may be no earnings or net earnings caused by the individual's services during the month.

(e) *Presumption regarding work in self-employment.* An individual is presumed to have worked in self-employment in each month of the individual's taxable year until it is shown to the satisfaction of the Social Security Administration that in a particular month the individual did not perform substantial services (see § 404.446(c)) in any trade or business (or in a combination of trades and businesses if there are more than one) from which the net income or loss is included in computing the individual's annual earnings (see § 404.429).

(f) *Presumption regarding services for wages.* An individual is presumed to have performed services in any month for wages (as defined in § 404.429) of more than the applicable monthly exempt amount set for that month until it is shown to the satisfaction of the

Social Security Administration that the individual did not perform services in that month for wages of more than the monthly exempt amount.

[45 FR 48117, July 18, 1980, as amended at 47 FR 46691, Oct. 20, 1982; 48 FR 4282, Jan. 31, 1983]

§ 404.436 Excess earnings; months to which excess earnings cannot be charged because individual is deemed not entitled to benefits.

Under the annual earnings test, excess earnings (as described in § 404.430) are not charged to any month in which an individual is deemed not entitled to a benefit. A beneficiary (i.e., the insured individual or any person entitled or deemed entitled on the individual's earnings record) is deemed not entitled to a benefit for a month if he is subject to a deduction for that month because of:

(a) Engaging in noncovered remunerative activity outside the United States (as described in §§ 404.417 and 404.418); or

(b) Failure to have a child in her care (in the case of a wife under age 65 or a widow or surviving divorced mother under age 62, as described in § 404.421); or

(c) Refusal by a person entitled to a child's insurance benefit based on disability to accept rehabilitation services (as described in § 404.422). (An insured individual's excess earnings are not charged against the benefit of a child entitled (or deemed entitled) on the insured individual's earnings record for any month in which the child is subject to a deduction for refusing rehabilitation services); or

(d) Refusal by an individual entitled to a disability insurance benefit to accept rehabilitation services as described in § 404.422 (e.g., a wife's excess earnings may not be charged against her benefits for months in which the disability insurance beneficiary on whose account she is entitled to wife's benefits incurs a deduction because he refuses rehabilitation services; also, a woman's earnings may not be charged against the mother's insurance benefit or child's insurance benefit she is receiving (on the earnings record of another individual) for months in which her husband refuses rehabilitation services while he is entitled to a disability insurance benefit).

(e) Refusal by a person entitled before age 60 to a widow's/or to a widower's insurance benefit based on disability (before age 62 in the case of a widower's insurance benefit for months before 1973) to accept rehabilitation services (as described in § 404.422).

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 9429, Apr. 16, 1973; 38 FR 17716, July 3, 1973; 43 FR 8133, Feb. 28, 1978]

§ 404.437 Excess earnings; benefit rate subject to deductions because of excess earnings.

For purposes of deductions because of excess earnings (as described in § 404.430), the benefit rate against which excess earnings are charged is the amount of the benefit (other than a disability insurance benefit) to which the person is entitled for the month:

(a) After reduction for the *maximum* (see §§ 404.403 and 404.404). The rate as reduced for the maximum as referred to in this paragraph is the one applicable to remaining entitled beneficiaries after exclusion of beneficiaries deemed not entitled under § 404.436 (due to a deduction for engaging in noncovered remunerative activity outside the United States, failure to have a child in her care, or refusal to accept rehabilitation services);

(b) After any reduction under section 202(q) of the Act because of entitlement to benefits for months before age 65 (this applies only to old-age, wife's, widow's, or husband's benefits);

(c) After any reduction in benefits payable to a person entitled (or deemed entitled; see § 404.420) on the earnings record of the insured individual because of entitlement on his own earnings record to other benefits (see § 404.407); and

(d) After any reduction of benefits payable to a person entitled or deemed entitled on the earnings record of an individual entitled to a disability insurance benefit because of such individual's entitlement to workmen's compensation for months after 1965 (see § 404.408).

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 17716, July 3, 1973; 43 FR 8133, Feb. 28, 1978]

§ 404.439 Partial monthly benefits; excess earnings of the individual charged against his benefits and the benefits of persons entitled (or deemed entitled) to benefits on his earnings record.

Deductions are made against the total family benefits where the excess earnings (as described in § 404.430) of an individual entitled to old-age insurance benefits are charged to a month and require deductions in an amount less than the total family benefits payable on his earnings record for that month (including the amount of a mother's or child's insurance benefit payable to a spouse who is deemed entitled on the individual's earnings record—see § 404.420). The difference between the total benefits payable and the deductions made under the annual earnings test for such month is paid (if otherwise payable under title II of the Act) to each person in the proportion that the benefit to which each is entitled (before the application of the reductions described in § 404.403 for the family maximum, § 404.407 for entitlement to more than one type of benefit, and section 202(q) of the Act for entitlement to benefits before retirement age) and before the application of § 404.304(f) to round to the next lower dollar bears to the total of the benefits to which all of them are entitled, except that the total amount payable to any such person may not exceed the benefits which would have been payable to that person if none of the insured individual's excess earnings had been charged to that month.

Example: A is entitled to an old-age insurance benefit of $165 and his wife is entitled to $82.50 before rounding, making a total of $247.50. After A's excess earnings have been charged to the appropriate months, there remains a partial benefit of $200 payable for October, which is apportioned as follows:

	Original benefit	Fraction of original	Benefit[1]
A	$165	2/3	$133
Wife	82.50	1/3	66
Total	247.50		199

[1] After deductions for excess earnings and after rounding per § 404.304(f).

[38 FR 9429, Apr. 16, 1973, as amended at 38 FR 17717, July 3, 1973; 43 FR 8133, Feb. 28, 1978; 48 FR 46149, Oct. 11, 1983]

§ 404.440 Partial monthly benefits; prorated share of partial payment exceeds the benefit before deduction for excess earnings.

Where, under the apportionment described in § 404.439, a person's prorated share of the partial benefit exceeds the benefit rate to which he was entitled before excess earnings of the insured individual were charged, such person's share of the partial benefit is reduced to the amount he would have been paid had there been no deduction for excess earnings (see example). The remainder of the partial benefit is then paid to other persons eligible to receive benefits in the proportion that the benefit of each such other person bears to the total of the benefits to which all such other persons are entitled (before reduction for the family maximum). Thus, if only two beneficiaries are involved, payment is made to one as if no deduction had been imposed; and the balance of the partial benefit is paid to the other. If three or more beneficiaries are involved, however, reapportionment of the excess of the beneficiary's share of the partial benefit over the amount he would have been paid without the deduction is made in proportion to his original entitlement rate (before reduction for the family maximum). If the excess amount involved at any point totals less than $1, it is not reapportioned; instead, each beneficiary is paid on the basis of the last calculation.

Example: Family maximum is $150. Insured individual's excess earnings charged to the month are $25. The remaining $125 is prorated as partial payment.

	Original benefit	Fraction of original total benefit	Benefit after deductions for excess earnings but before reduction for family maximum	Benefit reduced for maximum but without deductions for excess earnings	Benefit payable after both deductions and reductions (and rounded)
Insured Individual	$100	2/5	50	100.00	75

	Original benefit	Fraction of original total benefit	Benefit after deductions for excess earnings but before reduction for family maximum	Benefit reduced for maximum but without deductions for excess earnings	Benefit payable after both deductions and reductions (and rounded)
Wife	50	1/5	25	16.60	16
Child	50	1/5	25	16.60	16
Child	50	1/5	25	16.60	16

[32 FR 19159, Dec. 20, 1967, as amended at 48 FR 46149, Oct. 11, 1983]

§ 404.441 Partial monthly benefits; insured individual and another person entitled (or deemed entitled) on the same earnings record both have excess earnings.

Where both the insured individual and another person entitled (or deemed entitled) on the same earnings record have excess earnings (as described in § 404.430), their excess earnings are charged, and their partial monthly benefit is apportioned, as follows:

Example: M and his wife are initially entitled to combined total benefits of $264 per month based on M's old-age insurance benefit of $176. For the taxable year in question, M's excess earnings were $1,599 and his wife's excess earnings were $265. Both were under age 65. M had wages of more than $340 in all months of the year except February, while his wife had wages of more than $340 in all months of the year. After M's excess earnings have been charged to the appropriate months (all months through July except February), there remains a partial benefit payment for August of $249, which is allocated to M and his wife in the ratio that the original benefit of each bears to the sum of their original benefits: $166 and $83. His wife's excess earnings are charged against her full benefit for February ($88), her partial benefit for August ($83), her full benefit for September, and from $6 of her October benefit, leaving an $82 benefit payable to her for that month.

[48 FR 46149, Oct. 11, 1983]

§ 404.446 Definition of "substantial services" and "services."

(a) *General.* In general, the substantial services test will be applicable only in a grace year (including a termination grace year) as defined in § 404.435(c)(1). It is a test of whether, in view of all the services rendered by the individual and the surrounding circumstances, the individual reasonably can be considered retired in the month in question. In determining whether an individual has or has not performed substantial services in any month, the following factors are considered:

(1) The amount of time the individual devoted to all trades and businesses;

(2) The nature of the services rendered by the individual;

(3) The extent and nature of the activity performed by the individual before he allegedly retired as compared with that performed thereafter;

(4) The presence or absence of an adequately qualified paid manager, partner, or family member who manages the business;

(5) The type of business establishment involved;

(6) The amount of capital invested in the trade or business; and

(7) The seasonal nature of the trade or business.

(b) *Individual engaged in more than one trade or business.* When an individual, in any month, performs services in more than one trade or business, his services in all trades or businesses are considered together in determining whether he performed substantial services in self-employment in such month.

(c) *Evidentiary requirements.* An individual who alleges that he did not render substantial services in any month, or months, shall submit detailed information about the operation of the trades or businesses, including the individual's activities in connection therewith. When requested to do so by the Administration, the individual shall also submit such additional statements, information, and other evidence as the Administration may consider necessary for a proper determination of whether the individual rendered substantial services in self-employment. Failure of the individual to submit the requested statements, information, and other evidence is a sufficient

basis for a determination that the individual rendered substantial services in self-employment during the period in question.

[32 FR 19159, Dec. 20, 1967, as amended at 47 FR 46691, Oct. 20, 1982]

§ 404.447 Evaluation of factors involved in substantial services test.

In determining whether an individual's services are substantial, consideration is given to the following factors:

(a) *Amount of time devoted to trades or businesses.* Consideration is first given to the amount of time the self-employed individual devotes to all trades or businesses, the net income or loss of which is includable in computing his earnings as defined in § 404.429. For the purposes of this paragraph, the time devoted to a trade or business includes all the time spent by the individual in any activity, whether physical or mental, at the place of business or elsewhere in furtherance of such trade or business. This includes the time spent in advising and planning the operation of the business, making business contacts, attending meetings, and preparing and maintaining the facilities and records of the business. All time spent at the place of business which cannot reasonably be considered unrelated to business activities is considered time devoted to the trade or business. In considering the weight to be given to the time devoted to trades or businesses the following rules are applied:

(1) *Forty-five hours or less in a month devoted to trade or business.* Where the individual establishes that the time devoted to his trades and businesses during a calendar month was not more than 45 hours, the individual's services in that month are not considered substantial unless other factors (see paragraphs (b), (c), and (d) of this section) make such a finding unreasonable. For example, an individual who worked only 15 hours in a month might nevertheless be found to have rendered substantial services if he was managing a sizable business or engaging in a highly skilled occupation. However, the services of less than 15 hours rendered in all trades and businesses during a calendar month are not substantial.

(2) *More than 45 hours in a month devoted to trades and businesses.* Where an individual devotes more than 45 hours to all trades and businesses during a calendar month, it will be found that the individual's services are substantial unless it is established that the individual could reasonably be considered retired in the month and, therefore, that such services were not, in fact, substantial.

(b) *Nature of services rendered.* Consideration is also given to the nature of the services rendered by the individual in any case where a finding that the individual was retired would be unreasonable if based on time alone (see paragraph (a) of this section). The more highly skilled and valuable his services in self-employment are, the more likely the individual rendering such services could not reasonably be considered retired. The performance of services regularly also tends to show that the individual has not retired. Services are considered in relation to the technical and management needs of the business in which they are rendered. Thus, skilled services of a managerial or technical nature may be so important to the conduct of a sizable business that such services would be substantial even though the time required to render the services is considerably less than 45 hours.

(c) *Comparison of services rendered before and after retirement.* Where consideration of the amount of time devoted to a trade or business (see paragraph (a) of this section) and the nature of services rendered (see paragraph (b) of this section) is not sufficient to establish whether an individual's services were substantial, consideration is given to the extent and nature of the services rendered by the individual before his *retirement,* as compared with the services performed during the period in question. A significant reduction in the amount or importance of services rendered in the business tends to show that the individual is retired; absence of such reduction tends to show that the individual is not retired.

(d) *Setting in which services performed.* Where consideration of the factors described in paragraphs (a), (b), and (c) of this section is not sufficient to establish that an individual's services in

self-employment were or were not substantial, all other factors are considered. The presence or absence of a capable manager, the kind and size of the business, the amount of capital invested and whether the business is seasonal, as well as any other pertinent factors, are considered in determining whether the individual's services are such that he can reasonably be considered retired.

§ 404.450 Required reports of work outside the United States or failure to have care of a child.

(a) *Beneficiary engaged in noncovered remunerative activity; report by beneficiary.* Any individual entitled to a benefit which is subject to a deduction in that month because of noncovered remunerative activity outside the United States (see § 404.417) shall report the occurrence of such an event to the Social Security Administration before the receipt and acceptance of a benefit for the second month following the month in which such event occurred.

(b) *Beneficiary receiving wife's, husband's, mother's or father's insurance benefits does not have care of a child; report by beneficiary.* Any person receiving wife's, husband's, mother's, or father's insurance benefits which are subject to a deduction (as described in § 404.421) because he or she did not have a child in his or her care shall report the occurrence of such an event to the Social Security Administration before the receipt and acceptance of a benefit for the second month following the month in which the deduction event occurred.

(c) *Report required by person receiving benefits on behalf of another.* Where a person is receiving benefits on behalf of a beneficiary (see subpart U of this part) it is his duty to make the report to the Administration required by paragraph (a) or (b) of this section, on behalf of the beneficiary.

(d) *Report; content and form.* A report required under the provisions of this section shall be filed with the Social Security Administration. (See § 404.608 for procedures concerning place of filing and date of receipt of such a report.) The report should be made on a form prescribed by the Administration and in accordance with instructions, printed thereon or attached thereto, as prescribed by the Administration. Prescribed forms may be obtained at any office of the Administration. If the prescribed form is not used, the report should be properly identified (e.g., show the name and social security claim number of the beneficiary about whom the report is made), describe the events being reported, tell when the events occurred, furnish any other pertinent data (e.g., who has care of the children), and be properly authenticated (e.g., bear the signature and address of the beneficiary making the report or the person reporting on his behalf). The report should contain all the information needed for a proper determination of whether a deduction applies and, if it does, the period for which such deductions should be made.

[32 FR 19159, Dec. 20, 1967, as amended at 49 FR 24117, June 12, 1984; 51 FR 10616, Mar. 28, 1986]

§ 404.451 Penalty deductions for failure to report within prescribed time limit noncovered remunerative activity outside the United States or not having care of a child.

(a) *Penalty for failure to report.* If an individual (or the person receiving benefits on his behalf) fails to comply with the reporting obligations of § 404.450 within the time specified in § 404.450 and it is found that good cause for such failure does not exist (see § 404.454), a penalty deduction is made from the individual's benefits in addition to the deduction described in § 404.417 (relating to noncovered remunerative activity outside the United States) or § 404.421 (relating to failure to have care of a child).

(b) *Determining amount of penalty deduction.* The amount of the penalty deduction for failure to report noncovered remunerative activity outside the United States or not having care of a child within the prescribed time is determined as follows:

(1) *First failure to make timely report.* The penalty deduction for the first failure to make a timely report is an amount equal to the individual's benefit or benefits for the first month for which the deduction event was not reported timely.

(2) *Second failure to make timely report.* The penalty deduction for the second failure to make a timely report is an amount equal to twice the amount of the individual's benefit or benefits for the first month for which the deduction event in the second failure period was not reported timely.

(3) *Subsequent failures to make timely reports.* The penalty deduction for the third or subsequent failure to file a timely report is an amount equal to three times the amount of the individual's benefit or benefits for the first month for which the deduction event in the third failure period was not reported timely.

(c) *Determining whether a failure to file a timely report is first, second, third, or subsequent failure*—(1) *Failure period.* A failure period runs from the date of one delinquent report (but initially starting with the date of entitlement to monthly benefits) to the date of the next succeeding delinquent report, excluding the date of the earlier report and including the date of the later report. The failure period includes each month for which succeeding delinquent report, excluding a report becomes overdue during a failure period, but it does not include any month for which a report is not yet overdue on the ending date of such period. If *good cause* (see § 404.454) is found for the entire period, the period is not regarded as a failure period.

(2) *First failure.* When no penalty deduction under paragraph (b) of this section has previously been imposed against the beneficiary for failure to report noncovered remunerative activity outside the United States or for failure to report not having care of a child, the earliest month in the first failure period for which a report is delinquent and for which *good cause* (see § 404.454) for failure to make the required report is not found is considered to be the first failure.

(3) *Second failure.* After one penalty deduction under paragraph (b) of this section has been imposed against the beneficiary, the first month for which a report is delinquent in the second failure period is considered to be the second failure.

(4) *Third and subsequent failures.* After a second penalty deduction under paragraph (b) of this section has been imposed against the beneficiary, the first month for which a report is delinquent in the third failure period is considered to be the third failure. Subsequent failures will be determined in the same manner.

Example M became entitled in January 1966 to mother's benefits; these benefits are not payable for any month in which the mother does not have a child in her care. M accepted benefits for each month from January 1966 through June 1967. In July 1967 she reported that she had not had a child in her care in January 1967. As she was not eligible for a benefit for any month in which she did not have a child in her care, M's July 1967 benefit was withheld to recover the overpayment she had received for January 1967, and the next payment she received was for August 1967. No penalty was imposed for her failure to make a timely report of the deduction event that occurred in January 1967 because it was determined that *good cause* existed.

In March 1968 M reported that she had not had a child in her care in September or October 1967; however, she had accepted benefit payments for each month from August 1967 through February 1968. Her benefits for March and April 1968 were withheld to recover the overpayment for September and October 1967. Also, it was determined that *good cause* was not present for M's failure to make a timely report of the deduction event that had occurred in September 1967. A penalty equal to her benefit for September 1967 was deducted from M's May 1968 payment since this was her *first failure* to report not having a child in her care. Payments to her then were continued.

On November 4, 1968, it was learned that M had not had a child in her care in November 1967 or in June, July, or August 1968 although she had accepted benefits for June through October 1968. Consequently, M's benefits for November 1968 through February 1969 were withheld to recover the 4 months' overpayment she received for months in which she did not have a child in her care. In addition, it was determined that *good cause* was not present for M's failure to report the deduction events, and a penalty was imposed equal to twice the amount of M's benefit for the month of June 1968. This was M's *second failure* to report not having a child in her care. No further penalty applied for November 1967 because that month was included in M's *first-failure* period.

(5) *Penalty deductions imposed under § 404.453 not considered.* A failure to make a timely report of earnings as required by § 404.452 for which a penalty deduction is imposed under § 404.453 is

not counted as a failure to report in determining the first or subsequent failure to report noncovered remunerative activity outside the United States or not having care of a child.

(d) *Limitation on amount of penalty deduction.* Notwithstanding the provisions described in paragraph (b) of this section, the amount of the penalty deduction imposed for failure to make a timely report of noncovered remunerative activity outside the United States or for failure to report not having care of a child may not exceed the number of months in that failure period for which the individual received and accepted a benefit and for which a deduction is imposed by reason of his noncovered remunerative activity outside the United States or failure to have care of a child. (See § 404.458 for other limitations on the amount of the penalty deduction.)

[38 FR 3596, Feb. 8, 1973, as amended at 38 FR 9430, Apr. 16, 1973]

§ 404.452 Reports to Social Security Administration of earnings; wages; net earnings from self-employment.

(a) *Conditions under which a report of earnings, wages, and net earnings from self-employment is required.* An individual who, during a taxable year, is entitled to a monthly benefit (except if in each month of his taxable year he was entitled only to a disability insurance benefit) is required to report to the Social Security Administration the total amount of his earnings (as defined in § 404.429) for each such taxable year. A report is required when the individual's total earnings or wages (as defined in § 404.429) for any taxable year ending after 1972 exceed the product of $175 multiplied by the number of months in his taxable year, except that the report is not required for a taxable year if:

(1) The individual attained the age of 72 in or before the first month of his entitlement to benefits in his taxable year, or

(2) The individual's benefit payments were suspended under the provisions described in § 404.456 for all months in a taxable year in which he was entitled to benefits and was under age 72.

(b) *Time within which report must be filed.* The report for any taxable year beginning after 1954 shall be filed with the Social Security Administration on or before the 15th day of the fourth month following the close of the taxable year; for example, April 15 when the beneficiary's taxable year is a calendar year. (See § 404.3(c) where the last day for filing the report falls on a Saturday, Sunday, or legal holiday, or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order.) The filing of an income tax return with the Internal Revenue Service is not such a report as is required to be filed under the provisions of this section even where the income tax return shows the same wages and net earnings from self-employment that must be reported to the Administration under this section.

(c) *Report required by person receiving benefits on behalf of another.* Where a person is receiving benefits on behalf of a beneficiary (see subpart U of this part), it is his duty to make the report to the Administration required by this section.

(d) *Report to be made on forms prescribed by the Social Security Administration.* A report required under the provisions of this section shall be filed with the Social Security Administration. (See § 404.608 for procedures concerning place of filing and date of receipt of such a report.) The report shall be made on a form prescribed by the Social Security Administration and in accordance with the instructions printed on or attached to the form. The prescribed forms may be obtained from any office of the Social Security Administration. If the prescribed form is not used, the report should show the name and social security claim number of the beneficiary about whom the report is made; identify the taxable year for which the report is made; show the total amount of wages for which the beneficiary rendered services during his taxable year, the amount of his net earnings from self-employment for such year, and the amount of his net loss from self-employment for such year; and show the name and address of the individual making the report. To overcome the presumptions that the beneficiary rendered services for wages exceeding the allowable amount and rendered substantial services in self-

employment in each month (see § 404.435), the report should also show the specific months in which the beneficiary did not render services in employment for wages of more than the allowable amount (as described in § 404.435) and did not render substantial services in self-employment (as described in §§ 404.446 and 404.447).

(e) *Requirement to furnish requested information.* A beneficiary, or the person reporting on his behalf, is required to furnish any other information about the beneficiary's earnings and services that the Administration requests for the purpose of determining the correct amount of benefits payable for a taxable year (see § 404.455).

(f) *Extension of time for filing report*—(1) *General.* Notwithstanding the provision described in paragraph (b) of this section, the Administration may grant a reasonable extension of time for making the report of earnings required under this section if it finds that there is valid reason for a delay, but in no case may the period be extended more than 4 months for any taxable year.

(2) *Requirements applicable to requests for extensions.* Before his annual report of earnings is due, a beneficiary may request an extension of time for filing his report. The request must meet all of these requirements:

(i) Be in writing, and

(ii) Be made by the beneficiary, his representative payee, or his authorized agent,

(iii) Be made before the required report is overdue (If an extension of time already has been granted, a request for further extension must be made before the due date as extended previously),

(iv) Be made to an office of the Administration,

(v) Name the beneficiary for whom the annual report must be made and furnish his claim number,

(vi) Identify the year for which an annual report is due and for which an extension of time is requested,

(vii) Explain in the requester's own words the reasons why an extension of time is needed, and how much extended time is needed,

(viii) Show the date the request is made, and

(ix) Be signed by the requester.

(3) *Valid reason defined.* A valid reason is a bona fide need, problem, or situation which makes it impossible or difficult for a beneficiary (or his representative payee) to meet the annual report due date prescribed by law. This may be illness or disability of the one required to make the report, absence or travel so far from home that he does not have and cannot readily obtain the records needed for making his report, inability to obtain evidence required from another source when such evidence is necessary in making the report, inability of his accountant to compile the data needed for the annual report, or any similar situation which has a direct bearing on the individual's ability to comply with his reporting obligation within the specified time limit.

(4) *Evidence that extension of time has been granted.* In the absence of written evidence of a properly approved extension of time for making an annual report of earnings, it will be presumed that no extension of filing time was granted. In such case it will be necessary for the beneficiary to establish whether he otherwise had good cause (§ 404.454) for filing his annual report after the normal due date.

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 9430, Apr. 16, 1973; 43 FR 8133, Feb. 28, 1978; 51 FR 10616, Mar. 28, 1986; 60 FR 56513, Nov. 9, 1995]

§ 404.453 Penalty deductions for failure to report earnings timely.

(a) *Penalty for failure to report earnings; general.* Penalty deductions are imposed against an individual's benefits, in addition to the deductions required because of his excess earnings (see § 404.415), if:

(1) He fails to make a timely report of his earnings as specified in § 404.452 for a taxable year beginning after 1954;

(2) It is found that good cause for failure to report earnings timely (see § 404.454) does not exist;

(3) A deduction is imposed because of his earnings (see § 404.415) for that year; and

(4) He received and accepted any payment of benefits for that year.

(b) *Determining amount of penalty deduction.* The amount of the penalty deduction for failure to report earnings

for a taxable year within the prescribed time is determined as follows:

(1) *First failure to file timely report.* The penalty deduction for the first failure to file a timely report is an amount equal to the individual's benefit or benefits for the last month for which he was entitled to such benefit or benefits during the taxable year, except that with respect to any deductions imposed on or after January 2, 1968, if the amount of the deduction imposed for the taxable year is less than the benefit or benefits for the last month of the taxable year for which he was entitled to a benefit under section 202 of the Act, the penalty deduction is an amount equal to the amount of the deduction imposed but not less than $10.

(2) *Second failure to file timely report.* The penalty deduction for the second failure to file a timely report is an amount equal to twice the amount of the individual's benefit or benefits for the last month for which he was entitled to such benefit or benefits during such taxable year.

(3) *Subsequent failures to file timely reports.* The penalty deduction for the third or subsequent failure to file a timely report is an amount equal to three times the amount of the individual's benefit or benefits for the last month for which he was entitled to such benefit or benefits during such taxable year.

(c) *Determining whether a failure to file a timely report is first, second, or subsequent failure*—(1) *No prior failure.* Where no penalty deduction under this section has previously been imposed against the beneficiary for failure to make a timely report of his earnings, all taxable years (and this may include 2 or more years) for which a report of earnings is overdue as of the date the first delinquent report is made are included in the first failure. The latest of such years for which *good cause* for failure to make the required report (see § 404.454) is not found is considered the first failure to file a timely report.

Example X became entitled to benefits in 1964 and had reportable earnings for 1964, 1965, and 1966. He did not make his annual reports for those years until July 1967. At that time it was found that 1966 was the only year for which he has good cause for not making a timely report of his earnings. Since all taxable years for which a report is overdue as of the date of the first delinquent report are included in the first failure period, it was found that his first failure to make a timely report was for 1965. The penalty is equal to his December 1965 benefit rate. If good cause had also been found for both 1965 and 1964, then X would have *no prior failure* within the meaning of this subsection.

(2) *Second and subsequent failures.* After one penalty deduction under paragraph (b) of this section has been imposed against an individual, each taxable year for which a timely report of earnings is not made (and the count commences with reports of earnings which become delinquent after the date the first delinquent report described in paragraph (c)(1) of this section was made), and for which *good cause* for failure to make the required report is not found, is considered separately in determining whether the failure is the second or subsequent failure to report timely.

Example Y incurred a penalty deduction for not making his 1963 annual report until July 1964. In August 1966 it was found that he had not made a timely report of either his 1964 or 1965 earnings, and good cause was not present with respect to either year. The penalty for 1964 is equal to twice his benefit rate for December 1964. The penalty for 1965 is equal to three times his benefit rate for December 1965.

(3) *Penalty deduction imposed under § 404.451 not considered.* A failure to make a report as required by § 404.450, for which a penalty deduction is imposed under § 404.451, is not counted as a failure to report in determining, under this section, whether a failure to report earnings or wages is the first or subsequent failure to report.

(d) *Limitation on amount of penalty deduction.* Notwithstanding the provisions described in paragraph (b) of this section, the amount of the penalty deduction imposed for failure to file a timely report of earnings for a taxable year may not exceed the number of months in that year for which the individual received and accepted a benefit and for which deductions are imposed by reason of his earnings for such year. (See § 404.458 for other limitations on the amount of the penalty deduction.)

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 3597, Feb. 8, 1973; 38 FR 9431, Apr. 16, 1973]

§ 404.454 Good cause for failure to make required reports.

(a) *General.* The failure of an individual to make a timely report under the provisions described in §§ 404.450 and 404.452 will not result in a penalty deduction if the individual establishes to the satisfaction of the Administration that his failure to file a timely report was due to good cause. Before making any penalty determination as described in §§ 404.451 and 404.453, the individual shall be advised of the penalty and good cause provisions and afforded an opportunity to establish good cause for failure to report timely. The failure of the individual to submit evidence to establish good cause within a specified time may be considered a sufficient basis for a finding that good cause does not exist (see § 404.705). In determining whether good cause for failure to report timely has been established by the individual, consideration is given to whether the failure to report within the proper time limit was the result of untoward circumstances, misleading action of the Social Security Administration, confusion as to the requirements of the Act resulting from amendments to the Act or other legislation, or any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have. For example, *good cause* may be found where failure to file a timely report was caused by:

(1) Serious illness of the individual, or death or serious illness in his immediate family;

(2) Inability of the individual to obtain, within the time required to file the report, earnings information from his employer because of death or serious illness of the employer or one in the employer's immediate family; or unavoidable absence of his employer; or destruction by fire or other damage of the employer's business records;

(3) Destruction by fire, or other damage, of the individual's business records;

(4) Transmittal of the required report within the time required to file the report, in good faith to another Government agency even though the report does not reach the Administration until after the period for reporting has expired;

(5) Unawareness of the statutory provision that an annual report of earnings is required for the taxable year in which the individual attained age 72 provided his earnings for such year exceeded the applicable amount, e.g., $1,680 for a 12-month taxable year ending after December 1967;

(6) Failure on the part of the Administration to furnish forms in sufficient time for an individual to complete and file the report on or before the date it was due, provided the individual made a timely request to the Administration for the forms;

(7) Belief that an extension of time for filing income tax returns granted by the Internal Revenue Service was also applicable to the annual report to be made to the Social Security Administration;

(8) Reliance upon a written report to the Social Security Administration made by, or on behalf of, the beneficiary before the close of the taxable year, if such report contained sufficient information about the beneficiary's earnings or work, to require suspension of his benefits (see § 404.456) and the report was not subsequently refuted or rescinded; or

(9) Failure of the individual to understand reporting responsibilities due to his or her physical, mental, educational, or linguistic limitation(s).

(b) *Notice of determination.* In every case in which it is determined that a penalty deduction should be imposed, the individual shall be advised of the penalty determination and of his reconsideration rights. If it is found that good cause for failure to file a timely report does not exist, the notice will include an explanation of the basis for this finding; the notice will also explain the right to partial adjustment of the overpayment, in accordance with the provisions of § 404.502(c).

(c) *Good cause for subsequent failure.* Where circumstances are similar and an individual fails on more than one occasion to make a timely report, good cause normally will not be found for the second or subsequent violation.

[38 FR 3597, Feb. 8, 1973, as amended at 43 FR 8133, Feb. 28, 1978; 59 FR 1634, Jan. 12, 1994]

§ 404.455 Request by Social Security Administration for reports of earnings and estimated earnings; effect of failure to comply with request.

(a) *Request by Social Security Administration for report during taxable year; effect of failure to comply.* The Social Security Administration may, during the course of a taxable year, request a beneficiary to estimate his or her earnings (as defined in § 404.429) for the current taxable year and for the next taxable year, and to furnish any other information about his or her earnings that the Social Security Administration may specify. If a beneficiary fails to comply with a request for an estimate of earnings for a taxable year, the beneficiary's failure, in itself, constitutes justification under section 203(h) of the Act for a determination that it may reasonably be expected that the beneficiary will have deductions imposed under the provisions described in § 404.415, due to his or her earnings for that taxable year. Furthermore, the failure of the beneficiary to comply with a request for an estimate of earnings for a taxable year will, in itself, constitute justification for the Social Security Administration to use the preceding taxable year's estimate of earnings (or, if available, reported earnings) to suspend payment of benefits for the current or next taxable year.

(b) *Request by Social Security Administration for report after close of taxable year; failure to comply.* After the close of his or her taxable year, the Social Security Administration may request a beneficiary to furnish a report of his or her earnings for the closed taxable year and to furnish any other information about his or her earnings for that year that the Social Security Administration may specify. If he or she fails to comply with this request, this failure shall, in itself, constitute justification under section 203(h) of the Act for a determination that the beneficiary's benefits are subject to deductions as described in § 404.415 for each month in the taxable year (or only for the months thereof specified by the Social Security Administration).

[56 FR 11373, Mar. 18, 1991]

§ 404.456 Current suspension of benefits because an individual works or engages in self-employment.

(a) *Circumstances under which benefit payments may be suspended.* If, on the basis of information obtained by or submitted to the Administration, it is determined that an individual entitled to monthly benefits for any taxable year may reasonably be expected to have deductions imposed against his benefits (as described in § 404.415) by reason of his earnings for such year, the Administration may, before the close of the taxable year, suspend all or part, as the Administration may specify, of the benefits payable to the individual and to all other persons entitled (or deemed entitled—see § 404.420) to benefits on the basis of the individual's earnings record.

(b) *Duration of suspension.* The suspension described in paragraph (a) of this section shall remain in effect with respect to the benefits for each month until the Administration has determined whether or not any deduction under § 404.415 applies for such month.

(c) *When suspension of benefits becomes final.* For taxable years beginning after August 1958, if benefit payments were suspended (as described in paragraph (a) of this section) for all months of entitlement in an individual's taxable year, no benefit payment for any month in that year may be made after the expiration of the period of 3 years, 3 months, and 15 days following the close of the individual's taxable year unless, within that period, the individual, or any person entitled to benefits based on his earnings record, files with the Administration information showing that a benefit for a month is payable to the individual. Subject to the limitations of this paragraph, a determination about deductions may be reopened under the circumstances described in § 404.957.

§ 404.457 Deductions where taxes neither deducted from wages of certain maritime employees nor paid.

(a) *When deduction is required.* A deduction is required where:

(1) An individual performed services after September 1941 and before the termination of Title I of the First War Powers Act, 1941, on or in connection

with any vessel as an officer or crew member; and

(2) The services were performed in the employ of the United States and employment was through the War Shipping Administration or, for services performed before February 11, 1942, through the United States Maritime Commission; and

(3) The services, under the provisions described in § 403.803(d) of this chapter (Regulations No. 3 of the Social Security Administration), constituted employment for purposes of title II of the Social Security Act; and

(4) The taxes imposed (by section 1400 of the Internal Revenue Code of 1939, as amended) with respect to such services were neither deducted from the individual's wages nor paid by the employer.

(b) *Amount of deduction.* The deduction required by paragraph (a) of this section is an amount equal to 1 percent of the wages with respect to which the taxes described in paragraph (a)(4) of this section were neither deducted nor paid by the employer.

(c) *How deduction is made.* The deduction required by paragraph (a) of this section is made by withholding an amount as determined under paragraph (b) of this section from any monthly benefit or lump-sum death payment based on the earnings record of the individual who performed the services described in paragraph (a) of this section.

§ 404.458 Limiting deductions where total family benefits payable would not be affected or would be only partly affected.

Notwithstanding the provisions described in §§ 404.415, 404.417, 404.421, 404.422, 404.451, and 404.453 about the amount of the deduction to be imposed for a month, no such deduction is imposed for a month when the benefits payable for that month to all persons entitled to benefits on the same earnings record and living in the same household remain equal to the maximum benefits payable to them on that earnings record. Where making such deductions and increasing the benefits to others in the household (for the month in which the deduction event occurred) would give members of the household less than the *maximum* (as determined under § 404.404) payable to them, the amount of deduction imposed is reduced to the difference between the maximum amount of benefits payable to them and the total amount which would have been paid if the benefits of members of the household not subject to deductions were increased for that month. The individual subject to the deduction for such month may be paid the difference between the deduction so reduced and his benefit as adjusted under § 404.403 (without application of § 404.402(a)). All other persons in the household are paid, for such month, their benefits as adjusted under § 404.403 without application of § 404.402(a).

[47 FR 43673, Oct. 4, 1982]

§ 404.460 Nonpayment of monthly benefits of aliens outside the United States.

(a) *Nonpayment of monthly benefits to aliens outside the United States more than 6 months.* Except as described in paragraph (b) and subject to the limitations in paragraph (c) of this section after December 1956 no monthly benefit may be paid to any individual who is not a citizen or national of the United States, for any month after the sixth consecutive calendar month during all of which he is outside the United States, and before the first calendar month for all of which he is in the United States after such absence. (See § 404.380 regarding special payments at age 72.)

(1) For nonpayment of benefits under this section, it is necessary that the beneficiary be an alien and while an alien be outside the United States for more than six full consecutive calendar months. In determining whether at the time of a beneficiary's initial entitlement to benefits he has been outside the United States for a period exceeding six full consecutive calendar months, not more than the six calendar months immediately preceding the month of initial entitlement may be considered. For the purposes of this section, *outside the United States* means outside the territorial boundaries of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands of the United States, Guam, and American Samoa.

(2) Effective with 6-month periods beginning after January 2, 1968, after an alien has been outside the United States for any period of 30 consecutive days, he is deemed to be outside the United States continuously until he has returned to the United States and remained in the United States for a period of 30 consecutive days.

(3) Payments which have been discontinued pursuant to the provisions of this section will not be resumed until the alien beneficiary has been in the United States for a full calendar month. A full calendar month includes 24 hours of each day of the calendar month.

(4) Nonpayment of benefits to an individual under this section does not cause nonpayment of benefits to other persons receiving benefits based on the individual's earnings record.

Example R, an alien, leaves the United States on August 15, 1967, and returns on February 1, 1968. He leaves again on February 15, 1968, and does not return until May 15, 1968, when he spends 1 day in the United States. He has been receiving monthly benefits since July 1967.

R's first 6-month period of absence begins September 1, 1967. Since this period begins before January 2, 1968, his visit (Feb. 1, 1968, to Feb. 15, 1968) to the United States for less than 30 consecutive days is sufficient to break this 6-month period.

R's second 6-month period of absence begins March 1, 1968. Since this period begins after January 2, 1968, and he was outside the United States for 30 consecutive days, he must return and spend 30 consecutive days in the United States prior to September 1, 1968, to prevent nonpayment of benefits beginning September 1968. If R fails to return to the United States for 30 consecutive days prior to September 1, 1968, payments will be discontinued and will not be resumed until R spends at least 1 full calendar month in the United States.

(b) *When nonpayment provisions do not apply*. The provisions described in paragraph (a) of this section do not apply, subject to the limitations in paragraph (c) of this section, to a benefit for any month if:

(1) The individual was, or upon application would have been, entitled to a monthly benefit for December 1956, based upon the same earnings record; or

(2)(i) The individual upon whose earnings the benefit is based, before that month, has resided in the United States for a period or periods aggregating 10 years or more or has earned not less than 40 quarters of coverage;

(ii) Except that, effective with the month of July 1968, the provisions of paragraph (b)(2)(i) of this section do not apply if (*a*) the beneficiary is a citizen of a country having a social insurance or pension system which meets the conditions described in paragraphs (b)(7) (i), (ii), and (iii) of this section but does not meet the condition described in paragraph (b)(7)(iv) of this section, or (*b*) the beneficiary is a citizen of a country that has no social insurance or pension system of general application if at any time within 5 years prior to January 1968 (or the first month after December 1967 in which his benefits are subject to suspension pursuant to paragraph (a) of this section) payments to individuals residing in such country were withheld by the Treasury Department under the first section of the Act of October 9, 1940 (31 U.S.C. 123) (see paragraph (c) of this section);

(iii) For purposes of this subparagraph a period of residence begins with the day the insured individual arrives in the United States with the intention of establishing at least a temporary home here; it continues so long as he maintains an attachment to an abode in the United States, accompanied by actual physical presence in the United States for a significant part of the period; and ends with the day of departure from the United States with the intention to reside elsewhere; or

(3) The individual is outside the United States while in the active military or naval service of the United States; or

(4) The individual on whose earnings the benefit is based died before that month and:

(i) Death occurred while the individual was on active duty or inactive duty training as a member of a uniformed service, or

(ii) Death occurred after the individual was discharged or released from a period of active duty or inactive duty training as a member of a uniformed service, and the Administrator of Veterans' Affairs determines, and certifies to the Secretary, that the discharge or release was under conditions other

than dishonorable and that death was as a result of a disease or injury incurred or aggravated in line of duty while on active duty or inactive duty training; or

(5) The individual on whose earnings record the benefit is based worked in service covered by the Railroad Retirement Act, and such work is treated as employment covered by the Social Security Act under the provisions described in subpart O of this part; or

(6) The nonpayment of monthly benefits under the provisions described in paragraph (a) of this section would be contrary to a treaty obligation of the United States in effect on August 1, 1956 (see § 404.463(b)); or

(7) The individual is a citizen of a foreign country that the Secretary determines has in effect a social insurance or pension system (see § 404.463) which meets all of the following conditions:

(i) Such system pays periodic benefits or the actuarial equivalent thereof; and

(ii) The system is of general application; and

(iii) Benefits are paid in this system on account of old age, retirement, or death; and

(iv) Individuals who are citizens of the United States but not citizens of the foreign country and who qualify for such benefits are permitted to receive benefits without restriction or qualification, at their full rate, or the actuarial equivalent thereof, while outside of the foreign country and without regard to the duration of their absence therefrom.

(c) *Nonpayment of monthly benefits to aliens residing in certain countries*—(1) *Benefits for months after June 1968.* Notwithstanding the provisions of paragraphs (a) and (b) of this section, no monthly benefit may be paid for any month after June 1968 to any individual who is not a citizen or national of the United States for any month such individual resides in a country to which payments to individuals in such country are being withheld by the Treasury Department pursuant to the first section of the Act of October 9, 1940 (31 U.S.C. 123).

(2) *Benefits for months before July 1968.* If any benefits which an individual who is not a citizen or national of the United States was entitled to receive under title II of the Social Security Act are, on June 30, 1968, being withheld by the Treasury Department pursuant to the first section of the Act of October 9, 1940 (31 U.S.C. 123), upon removal of the restriction such benefits, payable to such individual for months after the month in which the determination by the Treasury Department that the benefits should be so withheld was made, shall not be paid—

(i) To any person other than such individual, or, if such individual dies before such benefits can be paid, to any person other than an individual who was entitled for the month in which the deceased individual died (with the application of section 202(j)(1) of the Social Security Act) to a monthly benefit under title II of such Act on the basis of the same wages and self-employment income as such deceased individual; or

(ii) In excess of an amount equal to the amount of the last 12 months' benefits that would have been payable to such individual.

(3) *List of countries under Treasury Department alien payment restriction.* Pursuant to the provisions of the first section of the Act of October 9, 1940 (31 U.S.C. 123) the Treasury Department is currently withholding payments to individuals residing in the following countries. Further additions to or deletions from the list of countries will be published in the FEDERAL REGISTER.

Cuba
Democratic Kampuchea (formerly Cambodia)
North Korea
Vietnam

(d) *Nonpayment of monthly benefits to certain aliens entitled to benefits on a worker's earnings record.* An individual who after December 31, 1984 becomes eligible for benefits on the earnings record of a worker for the first time, is an alien, has been outside the United States for more than 6 consecutive months, and is qualified to receive a monthly benefit by reason of the provisions of paragraphs (b)(2), (b)(3), (b)(5), or (b)(7) of this section, must also meet a U.S. residence requirement described in this section to receive benefits:

(1) An alien entitled to benefits as a child of a living or deceased worker—

(i) Must have resided in the U.S. for 5 or more years as the child of the parent on whose earnings record entitlement is based; or

(ii) The parent on whose earnings record the child is entitled and the other parent, if any, must each have either resided in the United States for 5 or more years or died while residing in the U.S.

(2) An alien who meets the requirements for child's benefits based on paragraph (d)(1) of this section above, whose status as a child is based on an adoptive relationship with the living or deceased worker, must also—

(i) Have been adopted within the United States by the worker on whose earnings record the child's entitlement is based; and

(ii) Have lived in the United States with, and received one-half support from, the worker for a period, beginning prior to the child's attainment of age 18, of

(A) At least one year immediately before the month in which the worker became eligible for old-age benefits or disability benefits or died (whichever occurred first), or

(B) If the worker had a period of disability which continued until the worker's entitlement to old-age or disability benefits or death, at least one year immediately before the month in which that period of disability began.

(3) An alien entitled to benefits as a spouse, surviving spouse, divorced spouse, surviving divorced spouse, or surviving divorced mother or father must have resided in the United States for 5 or more years while in a spousal relationship with the person on whose earnings record the entitlement is based. The spousal relationship over the required period can be that of wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, or a combination of two or more of these categories.

(4) An alien who is entitled to parent's benefits must have resided in the United States for 5 or more years as a parent of the person on whose earnings record the entitlement is based.

(5) Individuals eligible for benefits before January 1, 1985 (including those eligible for one category of benefits on a particular worker's earnings record after December 31, 1984, but also eligible for a different category of benefits on the same worker's earnings record before January 1, 1985), will not have to meet the residency requirement.

(6) Definitions applicable to paragraph (d) of this section are as follows:

Eligible for benefits means that an individual satisfies the criteria described in subpart D of this part for benefits at a particular time except that the person need not have applied for those benefits at that time.

Other parent for purposes of paragraph (d)(1)(ii) of this section means any other living parent who is of the opposite sex of the worker and who is the adoptive parent by whom the child was adopted before the child attained age 16 and who is or was the spouse of the person on whose earnings record the child is entitled; or the natural mother or natural father of the child; or the step-parent of the child by a marriage, contracted before the child attained age 16, to the natural or adopting parent on whose earnings record the child is entitled. (Note: Based on this definition, a child may have more than one living *other parent*. However, the child's benefit will be payable for a month if in that month he or she has one *other parent* who had resided in the U.S. for at least 5 years.)

Resided in the United States for satisfying the residency requirement means presence in the United States with the intention of establishing at least a temporary home. A period of residence begins upon arrival in the United States with that intention and continues so long as an attachment to an abode in the United States is maintained, accompanied by actual physical presence in the United States for a significant part of the period, and ending the day of departure from the United States with the intention to reside elsewhere. The period need not have been continuous and the requirement is satisfied if the periods of U.S. residence added together give a total of 5 full years.

(7) The provisions described in paragraph (d) of this section shall not apply

if the beneficiary is a citizen or resident of a country with which the United States has a totalization agreement in force, except to the extent provided by that agreement.

[32 FR 19159, Dec. 20, 1967, as amended at 34 FR 13366, Aug. 19, 1969; 52 FR 8249, Mar. 17, 1987; 52 FR 26145, July 13, 1987; 60 FR 17445, Apr. 6, 1995]

§ 404.461 Nonpayment of lump sum after death of alien outside United States for more than 6 months.

Where an individual dies outside the United States after January 1957 and no monthly benefit was or could have been paid to him for the month preceding the month in which he died because of the provisions described in § 404.460, no lump-sum death payment may be made upon the basis of the individual's earnings record.

§ 404.462 Nonpayment of hospital and medical insurance benefits of alien outside United States for more than 6 months.

No payments may be made under part A (hospital insurance benefits) of title XVIII for items or services furnished to an individual in any month for which the prohibition described in § 404.460 against payment of benefits to an individual outside the United States for more than six full consecutive calendar months is applicable (or would be if he were entitled to any such benefits). Also, no payments may be made under part B (supplementary medical insurance benefits) of title XVIII for expenses incurred by an individual during any month the individual is not paid a monthly benefit by reason of the provisions described in § 404.460 or for which no monthly benefit would be paid if he were otherwise entitled thereto.

§ 404.463 Nonpayment of benefits of aliens outside the United States; "foreign social insurance system," and "treaty obligation" exceptions defined.

(a) *Foreign social insurance system exception.* The following criteria are used to evaluate the social insurance or pension system of a foreign country to determine whether the exception described in § 404.460(b) to the alien nonpayment provisions applies:

(1) *Social insurance or pension system.* A *social insurance system* means a governmental plan which pays benefits as an earned right, on the basis either of contributions or work in employment covered under the plan, without regard to the financial need of the beneficiary. However, a plan of this type may still be regarded as a *social insurance system* though it may provide, in a subordinate fashion, for a supplemental payment based on need. A *pension system* means a governmental plan which pays benefits based on residence or age, or a private employer's plan for which the government has set up uniform standards for coverage, contributions, eligibility, and benefit amounts provided that, in both of these types of plans, the financial need of the beneficiary is not a consideration.

(2) *In effect.* The social insurance or pension system of the foreign country must be *in effect.* This means that the foreign social insurance or pension system is in full operation with regard to taxes (or contributions) and benefits, or is in operation with regard to taxes (or contributions), and provision is made for payments to begin immediately upon the expiration of the period provided in the law for acquiring earliest eligibility. It is not *in effect* if the law leaves the beginning of operation to executive or other administrative action; nor is it in effect if the law has been temporarily suspended.

(3) *General application.* The term *of general application* means that the social insurance or pension system (or combination of systems) covers a substantial portion of the paid labor force in industry and commerce, taking into consideration the industrial classification and size of the paid labor force and the population of the country, as well as occupational, size of employer, and geographical limitations on coverage.

(4) *Periodic benefit or actuarial equivalent.* The term *periodic benefit* means a benefit payable at stated regular intervals of time such as weekly, biweekly, or monthly. *Actuarial equivalent* of a periodic benefit means the commutation of the value of the periodic benefit into a lump-sum payment, taking life expectancy and interest into account.

(5) *Benefits payable on account of old age, retirement, or death.* The requirement that benefits be payable *on account of old age, retirement, or death,* is satisfied if the foreign social insurance plan or system includes provision for payment of benefits to aged or retired persons and to dependents and survivors of covered workers. The requirement is also met where the system pays benefits based only on old age or retirement. The requirement is not met where the only benefits payable are workmen's compensation payments, cash sickness payments, unemployment compensation payments, or maternity insurance benefits.

(6) *System under which U.S. citizens who qualify may receive payment while outside the foreign country.* The foreign social insurance or pension system must permit payments to qualified U.S. citizens while outside such foreign country, regardless of the duration of their absence therefrom and must make the payments without restriction or qualification to these U.S. citizens at full rate, or at the full actuarial value. The foreign system is considered to pay benefits at the full rate if the U.S. citizen receives the full benefit rate in effect for qualified beneficiaries at the time of his award, whether he is then inside or outside the paying country; and he continues to receive the same benefit amount so long as he remains outside that country, even though he may not receive any increases going into effect after his award provided that in those other countries in which such increases are denied to beneficiaries, they are denied to all beneficiaries including nationals of the paying country.

(7) *List of countries which meet the social insurance or pension system exception in section 202(t)(2) of the act.* The following countries have been found to have in effect a social insurance or pension system which meets the requirements of section 202(t)(2) of the Act. Unless otherwise specified, each country meets such requirements effective January 1957. The effect of these findings is that beneficiaries who are citizens of such countries and not citizens of the United States may be paid benefits regardless of the duration of their absence from the United States unless for months beginning after June 1968 they are residing in a country to which payments to individuals are being withheld by the Treasury Department pursuant to the first section of the Act of October 9, 1940 (31 U.S.C. 123). Further additions to or deletions from the list of countries will be published in the FEDERAL REGISTER.

Antigua and Barbuda (effective November 1981)
Argentina (effective July 1968)
Austria (except from January 1958 through June 1961)
Bahamas, Commonwealth of the (effective October 1974)
Barbados (effective July 1968)
Belgium (effective July 1968)
Belize (effective September 1981)
Bolivia
Brazil
Burkina Faso, Republic of (formerly Upper Volta)
Canada (effective January 1966)
Chile
Colombia (effective January 1967)
Costa Rica (effective May 1962)
Cyprus (effective October 1964)
Czechoslovakia (effective July 1968)
Denmark (effective April 1964)
Dominica (effective November 1978)
Dominican Republic (effective November 1984)
Ecuador
El Salvador (effective January 1969)
Finland (effective May 1968)
France (effective June 1968)
Gabon (effective June 1964)
Grenada (effective April 1983)
Guatemala (effective October 1978)
Guyana (effective September 1969)
Iceland (effective December 1980)
Ivory Coast
Jamaica (effective July 1968)
Liechtenstein (effective July 1968)
Luxembourg
Malta (effective September 1964)
Mexico (effective March 1968)
Monaco
Netherlands (effective July 1968)
Nicaragua (effective May 1986)
Norway (effective June 1968)
Panama
Peru (effective February 1969)
Philippines (effective June 1960)
Poland (effective March 1957)
Portugal (effective May 1968)
San Marino (effective January 1965)
Spain (effective May 1966)
St. Christopher and Nevis (effective September 1983)
St. Lucia (effective August 1984)
Sweden (effective July 1966)
Switzerland (effective July 1968)
Trinidad and Tobago (effective July 1975)

Trust Territory of the Pacific Islands (Micronesia) (effective July 1976)
Turkey
United Kingdom
Western Samoa (effective August 1972)
Yugoslavia
Zaire (effective July 1961) (formerly Congo (Kinshasa))

(b) *The ''treaty obligation'' exception.* It is determined that the Treaties of Friendship, Commerce, and Navigation now in force between the United States and the Federal Republic of Germany, Greece, the Republic of Ireland, Israel, Italy, and Japan, respectively, create treaty obligations precluding the application of § 404.460(a) to citizens of such countries; and that the Treaty of Friendship, Commerce, and Navigation now in force between the United States and the Kingdom of the Netherlands creates treaty obligations precluding the application of § 404.460(a) to citizens of that country with respect to monthly survivors benefits only. There is no treaty obligation that would preclude the application of § 404.460(a) to citizens of any country other than those listed above.

[32 FR 19159, Dec. 20, 1967, as amended at 43 FR 2628, Jan. 18, 1978; 52 FR 8249, Mar. 17, 1987]

§ 404.464 Nonpayment of benefits where individual is deported; prohibition against payment of lump sum based on deported individual's earnings records.

(a) *Old-age or disability insurance benefits.* When an individual is deported under the provisions of section 241(a) of the Immigration and Nationality Act (other than under paragraph (1)(C) or (1)(E) thereof), no old-age or disability insurance benefit is payable to the individual for any month occurring after the month in which the Secretary is notified by the Attorney General of the United States that the individual has been deported and before the month in which the individual is thereafter lawfully admitted to the United States for permanent residence. An individual is considered lawfully admitted for permanent residence as of the month he enters the United States with permission to reside here permanently.

(b) *Other monthly benefits.* If, under the provisions described in paragraph (a) of this section, no old-age or disability insurance benefit is payable to an individual for a month, no monthly insurance benefit is payable for that month, based upon the individual's earnings record, to any other person who is not a citizen of the United States and who is outside the United States for any part of that month.

(c) *Lump sum death payment.* No lump-sum death payment is payable on the basis of the earnings of an individual deported under section 241(a) of the Immigration and Nationality Act (other than paragraph (1)(C) or (1)(E) thereof) if the individual dies in or after the month in which the Secretary receives notice that he has been deported and before the month in which the individual is thereafter lawfully admitted to the United States for permanent residence.

[32 FR 19159, Dec. 20, 1967, as amended at 58 FR 64889, Dec. 10, 1993]

§ 404.465 Conviction for subversive activities; effect on monthly benefits and entitlement to hospital insurance benefits.

(a) *Effect of conviction.* Where an individual is convicted of any offense (committed after August 1, 1956) under chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of title 18 U.S.C., or under section 4, 112, or 113 of the Internal Security Act of 1950, as amended, the court, in addition to all other penalties provided by law, may order that, in determining whether any monthly benefit is payable to the individual for the month in which he is convicted or for any month thereafter, and in determining whether the individual is entitled to hospital insurance benefits under part A of title XVIII for any such month, and in determining the amount of the benefit for that month, the following are not to be taken into account:

(1) Any wages paid to such individual, or to any other individual, in the calendar quarter in which such conviction occurred or in any prior calendar quarter, and

(2) Any net earnings from self-employment derived by the individual, or

any other individual, during the taxable year in which the conviction occurred or during any prior taxable year.

(b) *Recalculation of benefit.* When notified by the Attorney General that the additional penalty as described in paragraph (a) of this section has been imposed against any individual entitled to benefits under section 202 or section 223 of the Act (see subpart D), the Administration, for the purposes of determining the individual's entitlement to such benefits as of the month in which convicted and the amount of the benefit, will exclude the applicable wages and net earnings in accordance with the order of the court.

(c) *Effect of pardon.* In the event that an individual, with respect to whom the additional penalty as described in paragraph (a) of this section has been imposed, is granted a pardon of the offense by the President of the United States, such penalty is not applied in determining such individual's entitlement to benefits, and the amount of such benefit, for any month beginning after the date on which the pardon is granted.

§ 404.466 Conviction for subversive activities; effect on enrollment for supplementary medical insurance benefits.

An individual may not enroll under part B (supplementary medical insurance benefits) of title XVIII if he has been convicted of any offense described in § 404.465.

§ 404.467 Nonpayment of benefits; individual entitled to disability insurance benefits or childhood disability benefits based on statutory blindness is engaging in substantial gainful activity.

(a) *Disability insurance benefits.* An individual who has attained age 55 and who meets the definition of disability for disability insurance benefits purposes based on *statutory blindness,* as defined in § 404.1581, may be entitled to disability insurance benefits for months in which he is engaged in certain types of substantial gainful activity. No payment, however, may be made to the individual or to beneficiaries entitled to benefits on his earnings record for any month in which such individual engages in any type of substantial gainful activity.

(b) *Childhood disability benefits.* An individual who has attained age 55 and who meets the definition of disability prescribed in § 404.1583 for childhood disability benefits on the basis of statutory blindness may be entitled to childhood disability benefits for months in which he engages in certain types of substantial gainful activity. However, no payment may be made to such individual for any month after December 1972 in which such individual engages in substantial gainful activity.

[39 FR 43715, Dec. 18, 1974, as amended at 51 FR 10616, Mar. 28, 1986]

§ 404.468 Nonpayment of benefits to prisoners.

(a) *General.* No monthly benefits will be paid to any individual for any month any part of which the individual is confined in a jail, prison, or other penal institution or correctional facility for conviction of a felony. This rule applies to disability benefits (§ 404.315) and child's benefits based on disability (§ 404.350) effective with benefits payable for months beginning on or after October 1, 1980. For all other monthly benefits, this rule is effective with benefits payable for months beginning on or after May 1, 1983. However, it applies only to the prisoner; benefit payments to any other person who is entitled on the basis of the prisoner's wages and self-employment income are payable as though the prisoner were receiving benefits.

(b) *Felonious offenses.* An offense will be considered a felony if—

(1) It is a felony under applicable law: or

(2) In a jurisdiction which does not classify any crime as a felony, it is an offense punishable by death or imprisonment for a term exceeding one year.

(c) *Confinement.* In general, a jail, prison, or other penal institution or correctional facility is a facility which is under the control and jurisdiction of the agency in charge of the penal system or in which convicted criminals can be incarcerated. Confinement in such a facility continues as long as the individual is under a sentence of confinement and has not been released due to parole or pardon. An individual is

considered confined even though he or she is temporarily or intermittently outside of that facility (e.g., on work release, attending school, or hospitalized).

(d) *Vocational rehabilitation exception.* The nonpayment provision of paragraph (a) of this section does not apply if a prisoner who is entitled to benefits on the basis of disability is actively and satisfactorily participating in a rehabilitation program which has been specifically approved for the individual by court of law. In addition, the Secretary must determine that the program is expected to result in the individual being able to do substantial gainful activity upon release and within a reasonable time. No benefits will be paid to the prisoner for any month prior to the approval of the program.

[49 FR 48182, Dec. 11, 1984]

§ 404.469 Nonpayment of benefits where individual has not furnished or applied for a Social Security number.

No monthly benefits will be paid to an entitled individual unless he or she either furnishes to the Social Security Administration (SSA) satisfactory proof of his or her Social Security number, or, if the individual has not been assigned a number, he or she makes a proper application for a number (see § 422.103). An individual submits satisfactory proof of his or her Social Security number by furnishing to SSA the number and sufficient additional information that can be used to determine whether that Social Security number or another number has been assigned to the individual. Sufficient additional information may include the entitled individual's date and place of birth, mother's maiden name, and father's name. If the individual does not know his or her Social Security number, SSA will use this additional information to determine the Social Security number, if any, that it assigned to the individual. This rule applies to individuals who become entitled to benefits beginning on or after June 1, 1989.

[56 FR 41789, Aug. 23, 1991]

§ 404.470 Nonpayment of disability benefits due to noncompliance with rules regarding treatment for drug addiction or alcoholism.

(a) *Suspension of monthly benefits.* (1) For an individual entitled to benefits based on a disability (§ 404.1505) and for whom drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535), monthly benefits will be suspended beginning with the first month after we notify the individual in writing that he or she has been determined not to be in compliance with the treatment requirements for such individuals (§ 404.1536).

(2) This rule applies to all individuals entitled to disability benefits (§ 404.315), widow(er)'s benefits (§ 404.335), and child's benefits based on a disability (§ 404.350) effective with benefits paid in months beginning on or after March 1, 1995.

(3) Benefit payments to any other person who is entitled on the basis of a disabled wage earner's entitlement to disability benefits are payable as though the disabled wage earner were receiving benefits.

(b) *Resumption of monthly benefits.* The payment of benefits may be resumed only after an individual demonstrates and maintains compliance with appropriate treatment requirements for:

(1) 2 consecutive months for the first determination of noncompliance;

(2) 3 consecutive months for the second determination of noncompliance; and

(3) 6 consecutive months for the third and all subsequent determinations of noncompliance.

(c) *Termination of benefits.* (1) A suspension of benefit payments due to noncompliance with the treatment requirements for 12 consecutive months will result in termination of benefits effective with the first month following the 12th month of suspension of benefits.

(2) Benefit payments to any other person who is entitled on the basis of a disabled wage earner's entitlement to disability benefits are payable as though the disabled wage earner were receiving benefits.

[60 FR 8146, Feb. 10, 1995]

§ 404.480 Paying benefits in installments: Drug addiction or alcoholism.

(a) *General.* For disabled beneficiaries who receive benefit payments through a representative payee because drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535), certain amounts due the beneficiary for a past period will be paid in installments. The amounts subject to payment in installments include:

(1) Benefits due but unpaid which accrued prior to the month payment was effectuated;

(2) Benefits due but unpaid which accrued during a period of suspension for which the beneficiary was subsequently determined to have been eligible; and

(3) Any adjustment to benefits which results in an accrual of unpaid benefits.

(b) *Installment formula.* Except as provided in paragraph (c) of this section, the amount of the installment payment in any month is limited so that the sum of (1) the amount due for a past period (and payable under paragraph (a) of this section) paid in such month and (2) the amount of any benefit due for the preceding month under such entitlement which is payable in such month, does not exceed two times the amount of the beneficiary's benefit payment for the preceding month. In counting the amount of the beneficiary's benefit payment for the previous month, no reductions or deductions under this title are taken into account.

(c) *Exception to installment limitation.* An exception to the installment payment limitation in paragraph (b) of this section can be granted for the first month in which a beneficiary accrues benefit amounts subject to payment in installments if the beneficiary has unpaid housing expenses which result in a high risk of homelessness for the beneficiary. In that case, the benefit payment may be increased by the amount of the unpaid housing expenses so long as that increase does not exceed the amount of benefits which accrued during the most recent period of nonpayment. We consider a person to be at risk of homelessness if continued nonpayment of the outstanding housing expenses is likely to result in the person losing his or her place to live or if past nonpayment of housing expenses has resulted in the person having no appropriate personal place to live. In determining whether this exception applies, we will ask for evidence of outstanding housing expenses that shows that the person is likely to lose or has already lost his or her place to live. For purposes of this section, homelessness is the state of not being under the control of any public institution and having no appropriate personal place to live. Housing expenses include charges for all items required to maintain shelter (for example, mortgage payments, rent, heating fuel, and electricity).

(d) *Payment through a representative payee.* If the beneficiary does not have a representative payee, payment of amounts subject to installments cannot be made until a representative payee is selected.

(e) *Underpaid beneficiary no longer entitled.* In the case of a beneficiary who is no longer currently entitled to monthly payments, but to whom amounts defined in paragraph (a) of this section are still owing, we will treat such beneficiary's monthly benefit for the last month of entitlement as the beneficiary's benefit for the preceding month and continue to make installment payments of such benefits through a representative payee.

(f) *Beneficiary currently not receiving Social Security benefits because of suspension for noncompliance with treatment.* If a beneficiary is currently not receiving benefits because his or her benefits have been suspended for noncompliance with treatment (as defined in § 404.1536), the payment of amounts under paragraph (a) of this section will stop until the beneficiary has demonstrated compliance with treatment as described in § 404.470 and will again commence with the first month the beneficiary begins to receive benefit payments.

(g) *Underpaid beneficiary deceased.* Upon the death of a beneficiary, any remaining unpaid amounts as defined in paragraph (a) of this section will be treated as underpayments in accordance with § 404.503(b).

[60 FR 8146, Feb. 10, 1995]

Subpart F—Overpayments, Underpayments, Waiver of Adjustment or Recovery of Overpayments, and Liability of a Certifying Officer

AUTHORITY: Secs. 204(a)–(d), 205(a), and 702(a)(5) of the Social Security Act (42 U.S.C. 404(a)–(d), 405(a), and 902(a)(5)); 31 U.S.C. 3720A.

§ 404.501 General applicability of section 204 of the Act.

(a) *In general.* Section 204 of the Act provides for adjustment as set forth in §§ 404.502 and 404.503, in cases where an individual has received more or less than the correct payment due under title II of the Act. As used in this subpart, the term *overpayment* includes a payment in excess of the amount due under title II of the Act, a payment resulting from the failure to impose deductions or to suspend or reduce benefits under sections 203, 222(b), 224, and 228(c), and (d), and (e) of the Act (see subpart E of this part), a payment pursuant to section 205(n) of the Act in an amount in excess of the amount to which the individual is entitled under section 202 or 223 of the Act, a payment resulting from the failure to terminate benefits, and a payment where no amount is payable under title II of the Act. The term *underpayment* as used in this subpart refers only to monthly insurance benefits and includes nonpayment where some amount of such benefits was payable. An underpayment may be in the form of an accrued unpaid benefit amount for which no check has been drawn or in the form of an unnegotiated check payable to a deceased individual. The provisions for adjustment also apply in cases where through error:

(1) A reduction required under section 202(j)(1), 202(k)(3), 203(a), or 205(n) of the Act is not made, or

(2) An increase or decrease required under section 202(d)(2), or 215 (f) or (g) of the Act is not made, or

(3) A deduction required under section 203(b) (as may be modified by the provisions of section 203(h)), 203(c), 203(d), 203(i), 222(b), or 223(a)(1)(D) of the Act or section 907 of the Social Security Amendments of 1939 is not made, or

(4) A suspension required under section 202(n) or 202(t) of the Act is not made, or

(5) A reduction under section 202(q) of the Act is not made, or

(6) A reduction, increase, deduction, or suspension is made which is either more or less than required, or

(7) A payment in excess of the amount due under title XVIII of the Act was made to or on behalf of an individual (see 42 CFR 405.350 through 405.351) entitled to benefits under title II of the Act, or

(8) A payment of past due benefits is made to an individual and such payment had not been reduced by the amount of attorney's fees payable directly to an attorney under section 206 of the Act (see § 404.977).

(9) A reduction under § 404.408b is made which is either more or less than required.

(b) *Payments made on the basis of an erroneous report of death.* Any monthly benefit or lump sum paid under title II of the Act on the basis of an erroneous report by the Department of Defense of the death of an individual in the line of duty while such individual was a member of the uniformed services (as defined in section 210(m) of the Act) on active duty (as defined in section 210(l) of the Act) is deemed a correct payment for any month prior to the month such Department notifies the Administration that such individual is alive.

(c) *Payments made by direct deposit to a financial institution.* When a payment in excess of the amount due under title II of the Act is made by direct deposit to a financial institution to or on behalf of an individual who has died, and the financial institution credits the payment to a joint account of the deceased individual and another person who was entitled to a monthly benefit on the basis of the same earnings record as the deceased individual for the month before the month in which the deceased individual died, the amount of the payment in excess of the correct amount will be an overpayment to the other person.

[34 FR 14887, Sept. 27, 1969, as amended at 44 FR 34942, June 18, 1979; 47 FR 4988, Feb. 3, 1982; 48 FR 46149, Oct. 11, 1983; 55 FR 7313, Mar. 1, 1990]

§ 404.502 Overpayments.

Upon determination that an overpayment has been made, adjustments will be made against monthly benefits and lump sums as follows:

(a) *Individual overpaid is living.* (1) If the individual to whom an overpayment was made is at the time of a determination of such overpayment entitled to a monthly benefit or a lump sum under title II of the Act, or at any time thereafter becomes so entitled, no benefit for any month and no lump sum is payable to such individual, except as provided in paragraphs (c) and (d) of this section, until an amount equal to the amount of the overpayment has been withheld or refunded. Such adjustments will be made against any monthly benefit or lump sum under title II of the Act to which such individual is entitled whether payable on the basis of such individual's earnings or the earnings of another individual.

(2) If any other individual is entitled to benefits for any month on the basis of the same earnings as the overpaid individual, except as adjustment is to be effected pursuant to paragraphs (c) and (d) of this section by withholding a part of the monthly benefit of either the overpaid individual or any other individual entitled to benefits on the basis of the same earnings, no benefit for any month will be paid on such earnings to such other individual until an amount equal to the amount of the overpayment has been withheld or refunded.

(b) *Individual overpaid dies before adjustment.* If an overpaid individual dies before adjustment is completed under the provisions of paragraph (a) of this section, no lump sum and no subsequent monthly benefit will be paid on the basis of earnings which were the basis of the overpayment to such deceased individual until full recovery of the overpayment has been effected, except as provided in paragraphs (c) and (d) of this section or under § 404.515. Such recovery may be effected through:

(1) Payment by the estate of the deceased overpaid individual,

(2) Withholding of amounts due the estate of such individual under title II of the Act,

(3) Withholding a lump sum or monthly benefits due any other individual on the basis of the same earnings which were the basis of the overpayment to the deceased overpaid individual, or

(4) Any combination of the amount above.

(c) *Adjustment by withholding part of a monthly benefit.* (1) Where it is determined that withholding the full amount each month would *defeat the purpose of title II,* i.e., deprive the person of income required for ordinary and necessary living expenses (see § 404.508), adjustment under paragraphs (a) and (b) of this section may be effected by withholding an amount of not less than $10 of the monthly benefit payable to an individual.

(2) Adjustment as provided by this paragraph will not be available if the overpayment was caused by the individual's intentional false statement or representation, or willful concealment of, or deliberate failure to furnish, material information. In such cases, recovery of the overpayment will be accomplished as provided in paragraph (a) of this section.

(d) *Individual overpaid enrolled under supplementary insurance plan.* Notwithstanding the provisions of paragraphs (a), (b), and (c) of this section, if the individual liable for the overpayment is an enrollee under part B of title XVIII of the Act and the overpayment was not caused by such individual's intentional false statement or representation, or willful concealment of, or deliberate failure to furnish, material information, an amount of such individual's monthly benefit which is equal to his obligation for supplementary medical insurance premiums will be applied toward payment of such premiums, and the balance of the monthly benefit will be applied toward recovery of the overpayment. Further adjustment with respect to such balance may be made if the enrollee so requests and meets the conditions of paragraph (c) of this section.

[35 FR 5943, Apr. 10, 1970, as amended at 44 FR 20653, Apr. 6, 1979]

§ 404.502a Notice of right to waiver consideration.

Whenever an initial determination is made that more than the correct amount of payment has been made, notice of the provisions of sections 204(b) and 1870(c) of the Act regarding waiver of adjustment or recovery shall be sent to the overpaid individual and to any other individual against whom adjustment or recovery of the overpayment is to be effected (see § 404.506).

[37 FR 10554, May 25, 1972]

§ 404.503 Underpayments.

Underpayments will be adjusted as follows:

(a) *Individual underpaid is living.* If an individual to whom an underpayment is due is living, the amount of such underpayment will be paid to such individual either in a single payment (if he is not entitled to a monthly benefit or a lump-sum death payment) or by increasing one or more monthly benefits or a lump-sum death payment to which such individual is or becomes entitled.

(b) *Individual dies before adjustment of underpayment.* If an individual to whom an underpayment is due dies before receiving payment or negotiating a check or checks representing such payment, such underpayment will be distributed to the living person (or persons) in the highest order of priority as follows:

(1) The deceased individual's surviving spouse as defined in section 216(c), (g), or (h) of the Act who was either:

(i) Living in the same household (as defined in § 404.347) with the deceased individual at the time of such individual's death, or

(ii) Entitled to a monthly benefit on the basis of the same earnings record as was the deceased individual for the month in which such individual died.

(2) The child or children of the deceased individual (as defined in section 216(e) or (h) of the Act) entitled to a monthly benefit on the basis of the same earnings record as was the deceased individual for the month in which such individual died (if more than one such child, in equal shares to each such child).

(3) The parent or parents of the deceased individual, entitled to a monthly benefit on the basis of the same earnings record as was the deceased individual for the month in which such individual died (if more than one such parent, in equal shares to each such parent). For this purpose, the definition of ''parent'' in § 404.374 includes the parent(s) of any deceased individual who was entitled to benefits under title II of the Act.

(4) The surviving spouse of the deceased individual (as defined in section 216(c), (g), or (h) of the Act) who does not qualify under paragraph (b)(1) of this section.

(5) The child or children of the deceased individual (as defined in section 216(e) or (h) of the Act) who do not qualify under paragraph (b)(2) of this section (if more than one such child, in equal shares to each such child).

(6) The parent or parents of the deceased individual, who do not qualify under paragraph (b)(3) of this section (if more than one such parent, in equal shares to each such parent). For this purpose, the definition of ''parent'' in § 404.374 includes the parent(s) of any deceased individual who was entitled to benefits under title II of the Act.

(7) The legal representative of the estate of the deceased individual as defined in paragraph (d) of this section.

(c) In the event that a person who is otherwise qualified to receive an underpayment under the provisions of paragraph (b) of this section, dies before receiving payment or before negotiating the check or checks representing such payment, his share of the underpayment will be divided among the remaining living person(s) in the same order of priority. In the event that there is (are) no other such person(s), the underpayment will be paid to the living person(s) in the next lower order of priority under paragraph (b) of this section.

(d) *Definition of legal representative.* The term *legal representative,* for the purpose of qualifying to receive an underpayment, generally means the administrator or executor of the estate of the deceased individual. However, it may also include an individual, institution or organization acting on behalf of an unadministered estate, provided

that such person can give the Administration good acquittance (as defined in paragraph (e) of this section). The following persons may qualify as legal representative for the purposes of this subpart, provided they can give the Administration good acquittance:

(1) A person who qualifies under a State's *small estate* statute,

(2) A person resident in a foreign country who, under the laws and customs of that country, has the right to receive assets of the estate,

(3) A public administrator, or

(4) A person who has the authority, under applicable law, to collect the assets of the estate of the deceased individual.

(e) *Definition of ''good acquittance.''* A person is considered to give the Administration *good acquittance* when payment to that person will release the Administration from further liability for such payment.

[34 FR 14487, Sept. 27, 1969, as amended at 35 FR 14129, Sept. 5, 1970; 55 FR 7313, Mar. 1, 1990; 60 FR 17445, Apr. 6, 1995]

§ 404.504 Relation to provisions for reductions and increases.

The amount of an overpayment or underpayment is the difference between the amount paid to the beneficiary and the amount of the payment to which the beneficiary was actually entitled. Such payment, for example, would be equal to the difference between the amount of a benefit in fact paid to the beneficiary and the amount of such benefit as reduced under section 202(j)(1), 202(k)(3), 203(a), or 224(a), or as increased under section 202(d)(2), 202(m), or 215(f) and (g). In effecting an adjustment with respect to an overpayment, no amount can be considered as having been withheld from a particular benefit which is in excess of the amount of such benefit as so decreased.

[34 FR 14888, Sept. 27, 1969]

§ 404.505 Relationship to provisions requiring deductions.

Adjustments required by any of the provisions in this subpart F are made in addition to, but after, any deductions required by section 202(t), 203(b), 203(c), 203(d), and 222(b) of the Act, or section 907 of the Social Security Act Amendments of 1939, and before any deductions required by section 203(g) or 203(h)(2) of the Act.

[34 FR 14888, Sept. 27, 1969]

§ 404.506 When waiver of adjustment or recovery may be applied.

Sections 204(b) and 1870(c) of the Act provide that there shall be no adjustment or recovery in any case where an incorrect payment under title II (old-age, dependent's, survivor's and disability insurance benefits) or under title XVIII (hospital and supplementary medical insurance benefits) has been made (including a payment under section 1814(e) of the Act) with respect to an individual:

(a) Who is without fault, and

(b) Adjustment or recovery would either:

(1) Defeat the purpose of title II of the Act, or

(2) Be against equity and good conscience.

[32 FR 18026, Dec. 16, 1967]

§ 404.507 Fault.

Fault as used in *without fault* (see § 404.506 and 42 CFR 405.355) applies only to the individual. Although the Administration may have been at fault in making the overpayment, that fact does not relieve the overpaid individual or any other individual from whom the Administration seeks to recover the overpayment from liability for repayment if such individual is not without fault. In determining whether an individual is at fault, the Social Security Administration will consider all pertinent circumstances, including the individual's age and intelligence, and any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual has. What constitutes fault (except for *deduction overpayments*—see § 404.510) on the part of the overpaid individual or on the part of any other individual from whom the Administration seeks to recover the overpayment depends upon whether the facts show that the incorrect payment to the individual or to a provider of services or other person, or an incorrect payment made under section 1814(e) of the Act, resulted from:

(a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or

(b) Failure to furnish information which he knew or should have known to be material; or

(c) With respect to the overpaid individual only, acceptance of a payment which he either knew or could have been expected to know was incorrect.

[34 FR 14888, Sept. 27, 1969; 34 FR 15646, Oct. 9, 1969, as amended at 44 FR 34942, June 18, 1979; 59 FR 1634, Jan. 12, 1994]

§ 404.508 Defeat the purpose of Title II.

(a) *General. Defeat the purpose of title II,* for purposes of this subpart, means defeat the purpose of benefits under this title, i.e., to deprive a person of income required for ordinary and necessary living expenses. This depends upon whether the person has an income or financial resources sufficient for more than ordinary and necessary needs, or is dependent upon all of his current benefits for such needs. An individual's ordinary and necessary expenses include:

(1) Fixed living expenses, such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (e.g., life, accident, and health insurance including premiums for supplementary medical insurance benefits under title XVIII), taxes, installment payments, etc.;

(2) Medical, hospitalization, and other similar expenses;

(3) Expenses for the support of others for whom the individual is legally responsible; and

(4) Other miscellaneous expenses which may reasonably be considered as part of the individual's standard of living.

(b) *When adjustment or recovery will defeat the purpose of title II.* Adjustment or recovery will defeat the purposes of title II in (but is not limited to) situations where the person from whom recovery is sought needs substantially all of his current income (including social security monthly benefits) to meet current ordinary and necessary living expenses.

[32 FR 18026, Dec. 16, 1967, as amended at 34 FR 14888, Sept. 27, 1969]

§ 404.509 Against equity and good conscience; defined.

(a) Recovery of an overpayment is *against equity and good conscience* (under title II and title XVIII) if an individual—

(1) Changed his or her position for the worse (Example 1) or relinquished a valuable right (Example 2) because of reliance upon a notice that a payment would be made or because of the overpayment itself; or

(2) Was living in a separate household from the overpaid person at the time of the overpayment and did not receive the overpayment (Examples 3 and 4).

(b) The individual's financial circumstances are not material to a finding of *against equity and good conscience.*

Example 1. A widow, having been awarded benefits for herself and daughter, entered her daughter in private school because the monthly benefits made this possible. After the widow and her daughter received payments for almost a year, the deceased worker was found to be not insured and all payments to the widow and child were incorrect. The widow has no other funds with which to pay the daughter's private school expenses. Having entered the daughter in private school and thus incurred a financial obligation toward which the benefits had been applied, she was in a worse position financially than if she and her daughter had never been entitled to benefits. In this situation, the recovery of the payments would be *against equity and good conscience.*

Example 2. After being awarded old-age insurance benefits, an individual resigned from employment on the assumption he would receive regular monthly benefit payments. It was discovered 3 years later that (due to a Social Security Administration error) his award was erroneous because he did not have the required insured status. Due to his age, the individual was unable to get his job back and could not get any other employment. In this situation, recovery of the overpayments would be *against equity and good conscience* because the individual gave up a valuable right.

Example 3. M divorced K and married L. M died a few years later. When K files for benefits as a surviving divorced wife, she learns that L had been overpaid $3,200 on M's earnings record. Because K and L are both entitled to benefits on M's record of earnings and we could not recover the overpayment from L, we sought recovery from K. K was living in a separate household from L at the time of the overpayment and did not receive the overpayment. K requests waiver of recovery of the $3,200 overpayment from benefits due

her as a surviving divorced wife of M. In this situation, it would be *against equity and good conscience* to recover the overpayment from K.

Example 4. G filed for and was awarded benefits. His daughter, T, also filed for student benefits on G's earnings record. Since T was an independent, full-time student living in another State, she filed for benefits on her own behalf. Later, after T received 12 monthly benefits, the school reported that T had been a full-time student only 2 months and had withdrawn from school. Since T was overpaid 10 monthly benefits, she was requested to return the overpayment to SSA. T did not return the overpayment and further attempts to collect the overpayment were unsuccessful. G was asked to repay the overpayment because he was receiving benefits on the same earnings record. G requested waiver. To support his waiver request G established that he was not at fault in causing the overpayment because he did not know that T was receiving benefits. Since G is without fault and, in addition, meets the requirements of not living in the same household at the time of the overpayment and did not receive the overpayment, it would be *against equity and good conscience* to recover the overpayment from G.

[53 FR 25483, July 7, 1988]

§ 404.510 When an individual is "without fault" in a deduction overpayment.

In determining whether an individual is ''without fault'' with respect to a deduction overpayment, the Social Security Administration will consider all pertinent circumstances, including the individual's age and intelligence, and any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual has. Except as provided in § 404.511 or elsewhere in this subpart F, situations in which an individual will be considered to be ''without fault'' with respect to a deduction overpayment include, but are not limited to, those that are described in this section. An individual will be considered ''without fault'' in accepting a payment which is incorrect because he/she failed to report an event specified in sections 203 (b) and (c) of the Act, or an event specified in section 203(d) of the Act as in effect for monthly benefits for months after December 1960, or because a deduction is required under section 203 (b), (c), (d), or section 222(b) of the Act, or payments were not withheld as required by section 202(t) or section 228 of the Act, if it is shown that such failure to report or acceptance of the overpayment was due to one of the following circumstances:

(a) Reasonable belief that only his net cash earnings (*take-home* pay) are included in determining the annual earnings limitation or the monthly earnings limitation under section 203(f) of the Act.

(b) Reliance upon erroneous information from an official source within the Social Security Administration (or other governmental agency which the individual had reasonable cause to believe was connected with the administration of benefits under title II of the Act) with respect to the interpretation of a pertinent provision of the Social Security Act or regulations pertaining thereto. For example, this circumstance could occur where the individual is misinformed by such source as to the interpretation of a provision in the Act or regulations relating to deductions, or relating to the effect of residence of an alien outside the United States for more than 6 months.

(c) The beneficiary's death caused the earnings limit applicable to his earnings for purposes of deduction and the charging of excess earnings to be reduced below $1,680 for a taxable year ending after 1967.

(d) [Reserved]

(e) Reasonable belief that in determining, for deduction purposes, his earnings from employment and/or net earnings from self-employment in the taxable year in which he became entitled to benefits, earnings in such year prior to such entitlement would be excluded. However, this provision does not apply if his earnings in the taxable year, beginning with the first month of entitlement, exceeded the earnings limitation amount for such year.

(f) Unawareness that his earnings were in excess of the earnings limitation applicable to the imposition of deductions and the charging of excess earnings or that he should have reported such excess where these earnings were greater than anticipated because of:

(1) Retroactive increases in pay, including back-pay awards;

(2) Work at a higher pay rate than realized;

(3) Failure of the employer of an individual unable to keep accurate records to restrict the amount of earnings or the number of hours worked in accordance with a previous agreement with such individual;

(4) The occurrence of five Saturdays (or other work days, e.g., five Mondays) in a month and the earnings for the services on the fifth Saturday or other work day caused the deductions.

(g) The continued issuance of benefit checks to him after he sent notice to the Administration of the event which caused or should have caused the deductions provided that such continued issuance of checks led him to believe in good faith that he was entitled to checks subsequently received.

(h) Lack of knowledge that bonuses, vacation pay, or similar payments, constitute earnings for purposes of the annual earnings limitation.

(i) [Reserved]

(j) Reasonable belief that earnings in excess of the earnings limitation amount for the taxable year would subject him to deductions only for months beginning with the first month in which his earnings exceeded the earnings limitation amount. However, this provision is applicable only if he reported timely to the Administration during the taxable year when his earnings reached the applicable limitation amount for such year.

(k) Lack of knowledge by a wife, husband, or child entitled to wife's, husband's, or child's insurance benefits, as the case may be, that the individual entitled to old-age insurance benefits on the same earnings record has incurred or would incur deductions because of a violation of the annual earnings or 7–day foreign work test, whichever is applicable, provided the wife, husband, or child is not living with such old-age insurance beneficiary and did not know and had no reason to know that such beneficiary's earnings activity or the income derived therefrom has caused or would cause such deductions.

(l) Reasonable belief, with respect to earnings activity for months after December 1982, that net earnings from self-employment after attainment of age 70 (age 72 for months after December 1972 and before January 1983) in the taxable year in which such age was attained would not cause deductions (see § 404.430(a)) with respect to benefits payable for months in that taxable year prior to the attainment of such age.

(m) Reasonable belief by an individual entitled to child's, wife's, husband's, widow's, widower's, mother's, or parent's insurance benefits that earnings from employment and/or net earnings from self-employment after the termination of entitlement (other than termination by reason of entitlement to an old-age insurance benefit) in the taxable year in which the termination event occurred would not cause deductions with respect to benefits payable for months in that taxable year prior to the month in which the termination event occurred.

(n) Failure to understand the deduction provisions of the Act or the occurrence of unusual or unavoidable circumstances the nature of which clearly shows that the individual was unaware of a violation of such deduction provisions.

[27 FR 1162, Feb. 8, 1962, as amended at 28 FR 14492, Dec. 31, 1963; 34 FR 14888, Sept. 27, 1969; 36 FR 23361, Dec. 9, 1971; 43 FR 31318, July 21, 1978; 44 FR 20653, Apr. 6, 1979; 59 FR 1634, Jan. 12, 1994; 60 FR 17445, Apr. 6, 1995]

§ 404.510a When an individual is "without fault" in an entitlement overpayment.

A benefit payment under title II or title XVIII of the Act to or on behalf of an individual who fails to meet one or more requirements for entitlement to such payment or a benefit payment exceeding the amount to which he is entitled, constitutes an entitlement overpayment. Where an individual or other person on behalf of an individual accepts such overpayment because of reliance on erroneous information from an official source within the Social Security Administration (or other governmental agency which the individual had reasonable cause to believe was connected with the administration of benefits under title II or title XVIII of

the Act) with respect to the interpretation of a pertinent provision of the Social Security Act or regulations pertaining thereto, or where an individual or other person on behalf of an individual is overpaid as a result of the adjustment upward (under the family maximum provision in section 203 of the Act) of the benefits of such individual at the time of the proper termination of one or more beneficiaries on the same social security record and the subsequent reduction of the benefits of such individual caused by the reentitlement of the terminated beneficiary(ies) pursuant to a change in a provision of the law, such individual, in accepting such overpayment, will be deemed to be *without fault.* For purposes of this section *governmental agency* includes intermediaries and carriers under contract pursuant to sections 1816 and 1842 of the Act.

[39 FR 43716, Dec. 18, 1974]

§ 404.511 When an individual is at "fault" in a deduction overpayment.

(a) *Degree of care.* An individual will not be *without fault* if the Administration has evidence in its possession which shows either a lack of good faith or failure to exercise a high degree of care in determining whether circumstances which may cause deductions from his benefits should be brought to the attention of the Administration by an immediate report or by return of a benefit check. The high degree of care expected of an individual may vary with the complexity of the circumstances giving rise to the overpayment and the capacity of the particular payee to realize that he is being overpaid. Accordingly, variances in the personal circumstances and situations of individual payees are to be considered in determining whether the necessary degree of care has been exercised by an individual to warrant a finding that he was without fault in accepting a *deduction overpayment.*

(b) *Subsequent deduction overpayments.* The Social Security Administration generally will not find an individual to be without fault where, after having been exonerated for a ''deduction overpayment'' and after having been advised of the correct interpretation of the deduction provision, the individual incurs another ''deduction overpayment'' under the same circumstances as the first overpayment. However, in determining whether the individual is without fault, the Social Security Administration will consider all of the pertinent circumstances surrounding the prior and subsequent ''deduction overpayments,'' including any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which the individual may have.

[16 FR 13054, Dec. 28, 1951, as amended at 59 FR 1634, Jan. 12, 1994]

§ 404.512 When adjustment or recovery of an overpayment will be waived.

(a) *Adjustment or recovery deemed ''against equity and good conscience.''* In the situations described in §§ 404.510(a), (b), and (c), and 404.510a, adjustment or recovery will be waived since it will be deemed such adjustment or recovery is *against equity and good conscience.* Adjustment or recovery will also be deemed *against equity and good conscience* in the situation described in § 404.510(e), but only as to a month in which the individual's earnings from wages do not exceed the total monthly benefits affected for that month.

(b) *Adjustment or recovery considered to defeat the purpose of title II* or be *against equity and good conscience* under certain circumstances. In the situation described in § 404.510(e) (except in the case of an individual whose monthly earnings from wages in employment do not exceed the total monthly benefits affected for a particular month), and in the situations described in § 404.510(f) through (n), adjustment or recovery shall be waived only where the evidence establishes that adjustment or recovery would work a financial hardship (see § 404.508) or would otherwise be inequitable (see § 404.509).

[27 FR 1163, Feb. 8, 1962, as amended at 35 FR 6321, Apr. 18, 1970; 36 FR 23361, Dec. 9, 1971]

§ 404.513 Liability of a certifying officer.

No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any individual.

(a) Where adjustment or recovery of such amount is waived under section 204(b) of the Act; or

(b) Where adjustment under section 204(a) of the Act is not completed prior to the death of all individuals against whose benefits or lump sums deductions are authorized; or

(c) Where a claim for recovery of an overpayment is compromised or collection or adjustment action is suspended or terminated pursuant to the Federal Claims Collection Act of 1966 (31 U.S.C. 951–953) (see § 404.515).

[34 FR 14889, Sept. 27, 1969]

§ 404.515 Collection and compromise of claims for overpayment.

(a) *General effect of the Federal Claims Collection Act of 1966.* Claims by the Administration against an individual for recovery of overpayments under title II or title XVIII (not including title XVIII overpayments for which refund is requested from providers, physicians, or other suppliers of services) of the Act, not exceeding the sum of $20,000, exclusive of interest, may be compromised, or collection suspended or terminated where such individual or his estate does not have the present or prospective ability to pay the full amount of the claim within a reasonable time (see paragraph (c) of this section) or the cost of collection is likely to exceed the amount of recovery (see paragraph (d) of this section) except as provided under paragraph (b) of this section.

(b) *When there will be no compromise, suspension or termination of collection of a claim for overpayment*—(1) *Overpaid individual alive.* In any case where the overpaid individual is alive, a claim for overpayment will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such individual or on the part of any other party having an interest in the claim.

(2) *Overpaid individual deceased.* In any case where the overpaid individual is deceased (i) a claim for overpayment in excess of $5,000 will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication of fraud; the filing of a false claim, or misrepresentation on the part of such deceased individual, and (ii) a claim for overpayment regardless of the amount will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication that any person other than the deceased overpaid individual had a part in the fraudulent action which resulted in the overpayment.

(c) *Inability to pay claim for recovery of overpayment.* In determining whether the overpaid individual is unable to pay a claim for recovery of an overpayment under title II or title XVIII of the Act, the Administration will consider such individual's age, health, present and potential income (including inheritance prospects), assets (e.g., real property, savings account), possible concealment or improper transfer of assets, and assets or income of such individual which may be available in enforced collection proceedings. The Administration will also consider exemptions available to such individual under the pertinent State or Federal law in such proceedings. In the event the overpaid individual is deceased, the Administration will consider the available assets of the estate, taking into account any liens or superior claims against the estate.

(d) *Cost of collection or litigative probabilities.* Where the probable costs of recovering an overpayment under title II or title XVIII of the Act would not justify enforced collection proceedings for the full amount of the claim or there is doubt concerning the Administration's ability to establish its claim as well as the time which it will take to effect such collection, a compromise or settlement for less than the full amount will be considered.

(e) *Amount of compromise.* The amount to be accepted in compromise of a claim for overpayment under title II or title XVIII of the Act shall bear a reasonable relationship to the amount which can be recovered by enforced collection proceedings giving due consideration to the exemptions available to the overpaid individual under State or Federal law and the time which such collection will take.

(f) *Payment.* Payment of the amount which the Administration has agreed to accept as a compromise in full settlement of a claim for recovery of an

overpayment under title II or title XVIII of the Act must be made within the time and in the manner set by the Administration. A claim for such recovery of the overpayment shall not be considered compromised or settled until the full payment of the compromised amount has been made within the time and manner set by the Administration. Failure of the overpaid individual or his estate to make such payment as provided shall result in reinstatement of the full amount of the overpayment less any amounts paid prior to such default.

[34 FR 14889, Sept. 27, 1969; 34 FR 15413, Oct. 3, 1969]

§ 404.520 Referral of overpayments to the Internal Revenue Service for tax refund offset—General.

(a) The standards we will apply and the procedures we will follow before requesting the Internal Revenue Service (IRS) to offset income tax refunds due taxpayers who have an outstanding overpayment are set forth in §§ 404.520 through 404.526. These standards and procedures are authorized by the Deficit Reduction Act of 1984 (31 U.S.C. 3720A), as amended by section 5129 of the Omnibus Budget Reconciliation Act of 1990, and as implemented through Department of the Treasury regulations at 26 CFR 301.6402–6T and Department of Health and Human Services regulations at 45 CFR Part 31.

(b) We will use the IRS tax refund offset procedure to collect overpayments that are certain in amount, past due and legally enforceable, and eligible for tax refund offset under regulations issued by the Secretary of the Treasury. We will use these procedures to collect overpayments only from individuals who are not currently entitled to monthly Social Security benefits under title II of the Act. We will refer an overpayment to the Secretary of the Treasury for offset against tax refunds no sooner than 3 months after our right to collect the overpayment first accrued and no later than 10 years after our right to collect the overpayment first accrued.

[56 FR 52468, Oct. 21, 1991]

§ 404.521 Notice to overpaid individual.

A request for reduction of an IRS tax refund will be made only after we determine that an amount is owed and past due and provide the overpaid individual with 60 calendar days written notice. Our notice of intent to collect an overpayment through IRS tax refund offset will state:

(a) The amount of the overpayment;

(b) That unless, within 60 calendar days from the date of our notice, the overpaid individual repays the overpayment, sends evidence to us at the address given in our notice that the overpayment is not past due or not legally enforceable, or asks us to waive collection of the overpayment under section 204(b) of the Act, we intend to seek collection of the overpayment by requesting that the IRS reduce any amounts payable to the overpaid individual as refunds of Federal income taxes by an amount equal to the amount of the overpayment;

(c) The conditions under which we will waive recovery of an overpayment under section 204(b) of the Act;

(d) That we will review any evidence presented that the overpayment is not past due or not legally enforceable;

(e) That the overpaid individual has the right to inspect and copy our records related to the overpayment as determined by us and will be informed as to where and when the inspection and copying can be done after we receive notice from the overpaid individual that inspection and copying are requested.

[56 FR 52468, Oct. 21, 1991]

§ 404.522 Review within SSA that an overpayment is past due and legally enforceable.

(a) *Notification by overpaid individual.* An overpaid individual who receives a notice as described in § 404.521 has the right to present evidence that all or part of the overpayment is not past due or not legally enforceable. To exercise this right, the individual must notify us and present evidence regarding the overpayment within 60 calendar days from the date of our notice.

(b) *Submission of evidence.* The overpaid individual may submit evidence showing that all or part of the debt is

not past due or not legally enforceable as provided in paragraph (a) of this section. Failure to submit the notification and evidence within 60 calendar days will result in referral of the overpayment to the IRS, unless the overpaid individual, within this 60-day time period, has asked us to waive collection of the overpayment under section 204(b) of the Act and we have not yet determined whether we can grant the waiver request. If the overpaid individual asks us to waive collection of the overpayment, we may ask that evidence to support the request be submitted to us.

(c) *Review of the evidence.* After a timely submission of evidence by the overpaid individual, we will consider all available evidence related to the overpayment. If the overpaid individual has not requested a waiver we will make findings based on a review of the written record, unless we determine that the question of indebtedness cannot be resolved by a review of the documentary evidence. If the overpaid individual has asked us to make a waiver determination and our records do not show that after an oral hearing we had previously determined that he was at ''fault'' in accepting the overpayment, we will not deny the waiver request without first scheduling an oral hearing.

[56 FR 52469, Oct. 21, 1991]

§ 404.523 Findings by SSA.

(a) Following the hearing or a review of the record, we will issue written findings which include supporting rationale for the findings. Issuance of these findings concerning whether the overpayment or part of the overpayment is past due and legally enforceable is the final Agency action with respect to the past-due status and enforceability of the overpayment. If we make a determination that a waiver request cannot be granted, we will issue a written notice of this determination in accordance with the regulations in subpart J of this part. Our referral of the overpayment to the IRS will not be suspended under § 404.525 pending any further administrative review of the waiver request that the individual may seek.

(b) Copies of the findings described in paragraph (a) of this section will be distributed to the overpaid individual and the overpaid individual's attorney or other representative, if any.

(c) If the findings referred to in paragraph (a) of this section affirm that all or part of the overpayment is past due and legally enforceable and, if waiver is requested, we determine that the request cannot be granted, we will refer the overpayment to the IRS. No referral will be made to the IRS if, based on our review of the overpayment, we reverse our prior finding that the overpayment is past due and legally enforceable or, upon consideration of a waiver request, we determine that waiver of our collection of the overpayment is appropriate.

[56 FR 52469, Oct. 21, 1991]

§ 404.524 Review of our records related to the overpayment.

(a) *Notification by the overpaid individual.* An overpaid individual who intends to inspect or copy our records related to the overpayment as determined by us must notify us stating his or her intention to inspect or copy.

(b) *Our response.* In response to a notification by the overpaid individual as described in paragraph (a) of this section, we will notify the overpaid individual of the location and time when the overpaid individual may inspect or copy our records related to the overpayment. We may also, at our discretion, mail copies of the overpayment-related records to the overpaid individual.

[56 FR 52469, Oct. 21, 1991]

§ 404.525 Suspension of offset.

If, within 60 days of the date of the notice described in § 404.521, the overpaid individual notifies us that he or she is exercising a right described in § 404.522(a) and submits evidence pursuant to § 404.522(b) or requests a waiver under § 404.506, we will suspend any notice to the IRS until we have issued written findings that affirm that an overpayment is past due and legally enforceable and, if applicable, make a determination that a waiver request cannot be granted.

[56 FR 52469, Oct. 21, 1991]

§ 404.526 Tax refund insufficient to cover amount of overpayment.

If a tax refund is insufficient to recover an overpayment in a given year, we will recertify the remainder of the overpayment to the IRS in the following year, assuming that all criteria for certification are met at that time.

[56 FR 52469, Oct. 21, 1991]

Subpart G—Filing of Applications and Other Forms

AUTHORITY: Secs. 202 (i), (j), (o), (p), and (r), 205(a), 216(i)(2), 223(b), 228(a), and 702(a)(5) of the Social Security Act (42 U.S.C. 402 (i), (j), (o), (p), and (r), 405(a), 416(i)(2), 423(b), 428(a), and 902(a)(5)).

SOURCE: 44 FR 37209, June 26, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 404.601 Introduction.

This subpart contains the Social Security Administration's rules for filing a claim for old-age, disability, dependents', and survivors' insurance benefits as described in subpart D of part 404. It tells what an application is, who may sign it, where and when it must be signed and filed, the period of time it is in effect and how it may be withdrawn. This subpart also explains when a written statement, request, or notice will be considered filed. Since the application form and procedures for filing a claim under this subpart are the same as those used to establish entitlement to Medicare benefits under 42 CFR part 405, persons who wish to become entitled to Medicare benefits should refer to the provisions of this subpart. Requirements concerning applications for the black lung benefits program are contained in part 410. Requirements concerning applications for the supplemental security income program are contained in part 416. Part 422 contains the requirements for applying for a social security number.

§ 404.602 Definitions.

For the purpose of this subpart—

Applicant means the person who files an application for benefits for himself or herself or for someone else. A person who files for himself or herself is both the *applicant* and the *claimant*.

Application refers only to an application on a form described in § 404.611.

Benefits means any old-age, disability, dependents', and survivors' insurance benefits described in subpart D, including a period of disability.

Claimant means the person who files an application for benefits for himself or herself or the person for whom an application is filed.

We, us, or *our* means the Social Security Administration (SSA).

You or *your* means, as appropriate, the person who applies for benefits, the person for whom an application is filed, or the person who may consider applying for benefits.

§ 404.603 You must file an application to receive benefits.

In addition to meeting other requirements, you must file an application to become entitled to benefits. If you believe you may be entitled to benefits, you should file an application. Filing an application will—

(a) Permit a formal decision to be made on your entitlement to benefits;

(b) Protect your entitlement to any benefits that may be payable for as many as 6 months or 12 months (depending on the type of benefit, as explained in § 404.621) before the application was filed; and

(c) Give you the right to appeal if you are dissatisfied with the decision.

[44 FR 37209, June 26, 1979, as amended at 46 FR 47444, Sept. 28, 1981]

APPLICATIONS

§ 404.610 What makes an application a claim for benefits.

To be considered a claim for benefits, an application must generally meet all of the following conditions:

(a) It must be on an application form as described in § 404.611.

(b) It must be completed and filed with SSA as described in § 404.611.

(c) It must be signed by the claimant or someone described in § 404.612. who may sign an application for the claimant.

(d) The claimant, with the limited exceptions in § 404.615, must be alive at the time it is filed.

§ 404.611 Filing of application with Social Security Administration.

(a) *General rule.* You must apply for benefits on an applications we prescribe. See § 404.614 for places where an application for benefits may be filed.

(b) *Effect of claims filed with the Railroad Retirement Board.* Pursuant to section 5(b) of the Railroad Retirement Act of 1974, as amended, 45 U.S.C. 231d(b), if you file an application with the Railroad Retirement Board on one of its forms for an annuity under section 2 of the Railroad Retirement Act of 1974, as amended, 45 U.S.C. 231a, unless you specify otherwise, this application also will be an application for any benefit to which you may be entitled under title II of the Social Security Act.

(c) *Effect of claims filed with the Veterans Administration.* An application filed with the Veterans Administration on one of its forms for survivors' dependency and indemnity compensation (see section 3005 of title 38 U.S.C.) is also considered an application for social security dependents' and survivors' benefits except the lump-sum death payment.

[44 FR 37209, June 26, 1979, as amended at 51 FR 41951, Nov. 20, 1986; 58 FR 60381, Nov. 16, 1993]

§ 404.612 Who may sign an application.

We will determine who may sign an application according to the following rules:

(a) A claimant who is 18 years old or over, mentally competent, and physically able to do so, must sign his or her own application. If the claim is for child's benefits for a person who is not yet 22 years old, the application may be signed by a parent or a person standing in place of the parent.

(b) A claimant who is between 16 and 18 years old may sign his or her own application if he or she is mentally competent, has no court appointed representative, and is not in the care of any person.

(c) If the claimant is under age 18, or mentally incompetent, or physically unable to sign, the application may be signed by a court appointed representative or a person who is responsible for the care of the claimant, including a relative. If the claimant is in the care of an institution, the manager or principal officer of the institution may sign the application.

(d) If a person who could receive disability benefits or who could have a period of disability established dies before filing, an application for disability benefits or for a period of disability may be signed by a person who would be qualified to receive any benefits due the deceased.

(e) If a person who paid burial expenses for which a lump-sum death payment may be made dies before filing an application for the payment, the application may be signed by a person who could receive the payment for the deceased's estate.

(f) If a written statement showing an intent to claim benefits is filed with us, but the person for whom the benefits are claimed dies before an application is filed, an application may be filed as explained in § 404.630(d).

(g) If a person who could receive benefits on the basis of a ''deemed'' filing date of an application under § 404.633(b)(1)(i) or (b)(2)(i) dies before an application for the benefits is filed, the application may be signed by a person who would be qualified to receive any benefits due the deceased person as explained in § 404.633(b)(1)(ii) and (b)(2)(ii).

(h) If it is necessary to protect a claimant from losing benefits and there is good cause for the claimant not signing the application, we may accept an application signed by some one other than a person described in this section.

Example: Mr. Smith comes to a social security office a few days before the end of a month to file an application for old-age benefits for his neighbor, Mr. Jones. Mr. Jones, a 63 year old widower, just suffered a heart attack and is in the hospital. He asked Mr. Smith to file the application for him. We will accept an application signed by Mr. Smith since it would not be possible to have Mr. Jones sign and file the application until the next calendar month and a loss of one month's benefits would result.

[44 FR 37209, June 26, 1979, as amended at 59 FR 44923, Aug. 31, 1994]

§ 404.613 Evidence of authority to sign an application for another.

(a) A person who signs an application for someone else will be required to

provide evidence of his or her authority to sign the application for the person claiming benefits under the following rules:

(1) If the person who signs is a court appointed representative, he or she must submit a certificate issued by the court showing authority to act for the claimant.

(2) If the person who signs is not a court appointed representative, he or she must submit a statement describing his or her relationship to the claimant. The statement must also describe the extent to which the person is responsible for the care of the claimant. This latter information will not be requested if the application is signed by a parent for a child with whom he or she is living.

(3) If the person who signs is the manager or principal officer of an institution which is responsible for the care of the claimant, he or she must submit a statement indicating the person's position of responsibility at the institution.

(b) We may, at any time, require additional evidence to establish the authority of a person to sign an application for someone else.

§ 404.614 When an application or other form is considered filed.

(a) *General rule.* Except as otherwise provided in paragraph (b) of this section and in §§ 404.630 through 404.633 which relate to the filing date of an application, an application for benefits, or a written statement, request, or notice is filed on the day it is received by an SSA employee at one of our offices or by an SSA employee who is authorized to receive it at a place other than one of our offices.

(b) *Other places and dates of filing.* We will also accept as the date of filing—

(1) The date an application for benefits, or a written statement, request or notice is received by any office of the U.S. Foreign Service or by the Veterans Administration Regional Office in the Philippines;

(2) The date an application for benefits or a written statement, request or notice is mailed to us by the U.S. mail, if using the date we receive it would result in the loss or lessening of rights. The date shown by a U.S. postmark will be used as the date of mailing. If the postmark is unreadable, or there is no postmark, we will consider other evidence of when you mailed it to us; or

(3) The date an application for benefits is filed with the Railroad Retirement Board or the Veterans Administration. See § 404.611 (b) and (c) for an explanation of when an application for benefits filed with the Railroad Retirement Board or the Veterans Administration is considered an application for social security benefits.

[44 FR 37209, June 26, 1979, as amended at 59 FR 44923, Aug. 31, 1994]

§ 404.615 Claimant must be alive when an application is filed.

A claimant must be alive at the time an application is filed. There are the following exceptions to this general rule:

(a) If a disabled person dies before filing an application for disability benefits or a period of disability, a person who would be qualified to receive any benefits due the deceased may file an application. The application must be filed within 3 months after the month in which the disabled person died.

(b) If a person who paid burial expenses for which a lump-sum death payment may be made dies before filing an application for the payment, the application may be signed by a person who could receive the payment for the deceased's estate.

(c) If a written statement showing an intent to claim benefits is filed with us, but the person for whom the benefits are claimed dies before an application is filed, an application may be filed as explained in § 404.630(d).

(d) If a person who could receive benefits on the basis of a ''deemed'' filing date of an application under § 404.633(b)(1)(i) or (b)(2)(i) dies before an application for the benefits is filed, the application may be signed by a person who would be qualified to receive any benefits due the deceased person as explained in § 404.633(b)(1)(ii) and (b)(2)(ii).

[44 FR 37209, June 26, 1979, as amended at 59 FR 44923, Aug. 31, 1994]

EFFECTIVE FILING PERIOD OF APPLICATION

§ 404.620 Filing before the first month you meet the requirements for benefits.

(a) *General rule.* If you file an application for benefits (except special age 72 payments) before the first month you meet all the other requirements for entitlement, the application will remain in effect until we make a final determination on your application unless there is an administrative law judge hearing decision on your application. If there is an administrative law judge hearing decision, your application will remain in effect until the administrative law judge hearing decision is issued.

(1) If you meet all the requirements for entitlement while your application is in effect, we may pay you benefits from the first month that you meet all the requirements.

(2) If you first meet all the requirements for entitlement after the period for which your application was in effect, you must file a new application for benefits. In this case, we may pay you benefits only from the first month that you meet all the requirements based on the new application.

(b) *Filing for special age 72 payments.* The requirements for entitlement to special age 72 payments must be met no later than 3 months after the month an application is filed.

[44 FR 37209, June 26, 1979, as amended at 52 FR 4003, Feb. 9, 1987]

§ 404.621 Filing after the first month you meet the requirements for benefits.

(a) *Filing for disability benefits and for old-age, survivors', or dependents' benefits.* (1)(i) If you file an application for disability benefits, widow's or widower's benefits based on disability, or wife's, husband's, or child's benefits based on the earnings record of a person entitled to disability benefits, after the first month you could have been entitled to them, you may receive benefits for up to 12 months immediately before the month in which your application is filed. Your benefits may begin with the first month in this 12-month period in which you meet all the requirements for entitlement. However, entitlement to wife's or husband's benefits under this rule is limited by paragraph (a)(1)(iii) of this section.

(ii) If you file an application for old-age benefits, widow's or widower's benefits not based on disability, wife's, husband's, or child's benefits based on the earnings record of a person not entitled to disability benefits, or mother's, father's, or parent's benefits, after the first month you could have been entitled to them, you may receive benefits for up to 6 months immediately before the month in which your application is filed. Your benefits may begin with the first month in this 6-month period in which you meet all the requirements for entitlement. However, entitlement to old-age, wife's, husband's, widow's, or widower's benefits under this rule is limited by paragraph (a)(1)(iii) of this section.

(iii) If the effect of the payment of benefits for a month before the month you file would be to reduce your benefits because of your age, you cannot be entitled to old-age, wife's, husband's, widow's, or widower's benefits for any month before the month in which your application is filed, unless you meet one of the conditions in paragraph (a)(2) of this section. (An explanation of the reduction that occurs because of age if you are entitled to these benefits for a month before you reach the retirement age of 65, is in § 404.410.) An example follows that assumes you do not meet any of the conditions in paragraph (a)(2) of this section.

Example: You become 65 years old in April 1981. If you apply for old-age benefits in April, you cannot be entitled to benefits for months in the 6-month period before April because the payment of benefits for any of these months would result in your benefits being reduced for age. If you do not file your application until July 1981, you may be entitled to benefits for the months of April, May, and June 1981 because the payment of benefits for these months would not result in your benefits being reduced for age. You will not, however, receive benefits for the 3 months before April.

(2) The limitation in paragraph (a)(1)(iii) of this section on your entitlement to old-age, wife's, husband's, widow's, or widower's benefits for months before you file an application does not apply if—

(i) You are a widow, widower, surviving divorced wife, or surviving divorced husband who is disabled and could be entitled to retroactive benefits for any month before age 60. If you could not be entitled before age 60, the limitation will prevent payment of benefits to you for past months, but it will not affect the month you become entitled to hospital insurance benefits.

(ii) You are a widow, widower, or surviving divorced spouse of the insured person who died in the month before you applied and you were at least age 60 in the month of death of the insured person on whose earnings record you are claiming benefits. In this case, you can be entitled beginning with the month the insured person died if you choose and if you file your application on or after July 1, 1983.

(b) *Filing for lump-sum death payment.* An application for a lump-sum death payment must be filed within 2 years after the death of the person on whose earnings record the claim is filed. There are two exceptions to the 2-year filing requirement:

(1) If there is a good cause for failure to file within the 2-year period, we will consider your application as though it were filed within the 2-year period. Good cause does not exist if you were informed of the need to file an application within the 2-year period and you neglected to do so or did not desire to make a claim. Good cause will be found to exist if you did not file within the time limit due to—

(i) Circumstances beyond your control, such as extended illness, mental or physical incapacity, or a language barrier;

(ii) Incorrect or incomplete information we furnished you;

(iii) Your efforts to get evidence to support your claim without realizing that you could submit the evidence after filing an application; or

(iv) Unusual or unavoidable circumstances which show that you could not reasonably be expected to know of the time limit.

(2) The Soldiers' and Sailors' Civil Relief Act of 1940 provides for extending the filing time.

(c) *Filing for special age 72 payments.* An application for special age 72 payments is not effective as a claim for benefits for any month before you actually file.

(d) *Filing for a period of disability.* You must file an application for a period of disability while you are disabled or no later than 12 months after the month in which your period of disability ended. If you were unable to apply within the 12-month time period because of a physical or mental condition, you may apply not more than 36 months after your disability ended. The general rule we use to decide whether your failure to file was due to a physical or mental condition is stated in subpart D.

(e) *Filing after death of person eligible for disability benefits or period of disability.* If you file for disability benefits or a period of disability for another person who died before filing an application and you would qualify under § 404.503(b) to receive any benefits due the deceased, you must file an application no later than the end of the third month following the month in which the disabled person died.

[44 FR 37209, June 26, 1979, as amended at 46 FR 47444, Sept. 28, 1981; 51 FR 4482, Feb. 5, 1986; 56 FR 58846, Nov. 22, 1991]

§ 404.622 Limiting an application.

Your application may entitle you to benefits for up to 6 months or 12 months (depending on the type of benefit, as explained in § 404.621) before the month in which it is filed. You may limit the number of months of your entitlement in the 6-month or 12-month period. You may state this choice any time before a decision is made on your claim by indicating, in writing, the month you want your benefits to begin. You may change the first month of entitlement in this 6-month or 12-month period after a decision has been made on your claim under the following conditions:

(a) You file the request in writing.

(b) If you are filing for the claimant, he or she is alive when the request is filed.

(c) If any other person who is entitled to benefits would lose some or all of those benefits because of the change, that person, or the person who filed for him or her, consents in writing.

(d) Any benefit payments that would become improper as a result of the

change in entitlement month are repaid, or we are satisfied that they will be repaid.

[44 FR 37209, June 26, 1979, as amended at 46 FR 47445, Sept. 28, 1981]

§ 404.623 Filing by person eligible for old-age and husband's or wife's benefits.

(a) *Presumed filing for husband's or wife's benefits.* If you file an application for old-age benefits, you are presumed to have filed an application for husband's or wife's benefits in the first month of your entitlement to old-age benefits, if—

(1) Your old-age benefits are reduced for age because you choose to receive them before you become 65 years old; and

(2) You are eligible for either a husband's or a wife's benefit for the first month of your entitlement to old-age benefits.

(b) *Presumed filing for old-age benefits.* (1) If you file an application for a husband's or a wife's benefits, you are presumed to have filed an application for old-age benefits in the first month of your entitlement to husband's or wife's benefits if—

(i) Your husband's or wife's benefits are reduced for age because you choose to receive them before you become 65 years old; and

(ii) You are eligible for old-age benefits for the first month of your entitlement to husband's or wife's benefits.

(2) The rule in paragraph (b)(1) of this section is not used if you are also entitled to disability benefits in the first month of your entitlement to husband's or wife's benefits. In this event, you are presumed to have filed for old-age benefits only if your disability benefits end before you become 65 years old.

FILING DATE BASED ON WRITTEN STATEMENT

§ 404.630 Use of date of written statement as filing date.

If a written statement, such as a letter, indicating your intent to claim benefits either for yourself or for another person is filed with us under the rules stated in § 404.614, we will use the filing date of the written statement as the filing date of the application, if all of the following requirements are met:

(a) The statement indicates an intent to claim benefits.

(b) The statement is signed by the claimant, the claimant's spouse, or a person described in § 404.612. If you telephone us and advise us that you intend to file a claim but cannot file an application before the end of the month, we will prepare and sign a written statement if it is necessary to prevent the loss of benefits.

(c) The claimant files an application with us on an application form as described in § 404.611, or one is filed for the claimant by a person described in § 404.612, within 6 months after the date of a notice we will send advising of the need to file an application. We will send the notice to the claimant. However, if it is clear from the information we receive that the claimant is a minor or is mentally incompetent, we will send the notice to the person who submitted the written statement.

(d) The claimant is alive when the application is filed; or if the claimant has died after the written statement was filed, an application is filed—

(1) By or for a person who would be eligible to receive benefits on the deceased's earnings record;

(2) By a person acting for the deceased's estate; or

(3) If the statement was filed with a hospital under § 404.632, by the hospital if—

(i) No person described in paragraph (d) (1) or (2) of this section can be located; or

(ii) A person described in paragraphs (d) (1) or (2) of this section is located but refuses or fails to file the application unless the refusal or failure to file is because it would be harmful to the deceased person or the deceased's estate.

§ 404.631 Statements filed with the Railroad Retirement Board.

A written statement filed with the Railroad Retirement Board will be considered a written statement filed with us under the rules in § 404.630 if—

(a) The statement indicates an intent to claim any payments under the Railroad Retirement Act;

(b) It bears the signature of the person filing the statement;

(c) No application is filed with the Railroad Retirement Board on one of its forms. If an application has been filed, we will use the date of filing of that application as determined by the Railroad Retirement Board (see § 404.614(b)(3)); and

(d) The statement is sent to us by the Railroad Retirement Board.

§ 404.632 Statements filed with a hospital.

A statement (generally a hospital admission form) filed with a hospital may serve as a written statement under § 404.630 if the requirements of this section are met. The statement will be considered filed with us as of the date it was filed with the hospital and will serve to protect entitlement to benefits. A statement filed with a hospital by you or some other person for you requesting or indicating an intent to claim benefits will be considered a written statement filed with us and § 404.630 will apply to it if—

(a) You are a patient in the hospital;

(b) The hospital provides services covered by hospital insurance under the Medicare program;

(c) An application has not already been filed; and

(d) The statement is sent to us.

DEEMED FILING DATE BASED ON MISINFORMATION

§ 404.633 Deemed filing date in a case of misinformation.

(a) *General.* You may have considered applying for monthly benefits for yourself or for another person, and you may have contacted us in writing, by telephone or in person to inquire about filing an application for these benefits. It is possible that in responding to your inquiry, we may have given you misinformation about your eligibility for such benefits, or the eligibility of the person on whose behalf you were considering applying for benefits, which caused you not to file an application at that time. If this happened, and later an application for such benefits is filed with us, we may establish an earlier filing date under this section.

Example 1: Mrs. Smith, a widow of an insured individual, contacts a Social Security office when she reaches age 60 to inquire about applying for widow's insurance benefits. She is told by an SSA employee that she must be age 62 to be eligible for these benefits. This information, which was incorrect, causes Mrs. Smith not to file an application for benefits. When Mrs. Smith reaches age 62, she again contacts a Social Security office to ask about filing for widow's insurance benefits and learns that she could have received the benefits at age 60. She files an application for these benefits, provides the information required under paragraph (f) of this section to show that an SSA employee provided misinformation, and requests a deemed filing date based on the misinformation which she received from an SSA employee when she was age 60.

Example 2: Ms. Hill, a 22-year-old, is forced to stop work because of illness. When she contacts a Social Security office to inquire about applying for disability insurance benefits, she is told by an SSA employee that she must have 20 quarters of coverage out of the last 40 calendar quarters to be insured for disability insurance benefits. The employee fails to consider the special rules for insured status for persons who become disabled before age 31 and, consequently, tells Ms. Hill that she is not insured because she only has 16 quarters of coverage. The misinformation causes Ms. Hill not to file an application for disability insurance benefits. Because of her illness, she is unable to return to work. A year later, Ms. Hill reads an article that indicates that there are special rules for insured status for young workers who become disabled. She again contacts a Social Security office to inquire about benefits based on disability and learns that she was misinformed earlier about her insured status. She files an application for disability insurance benefits, provides the information required under paragraph (f) of this section to show that an SSA employee provided misinformation, and requests a deemed filing date based on the misinformation provided to her earlier.

(b) *Deemed filing date of an application based on misinformation.* Subject to the requirements and conditions in paragraphs (c) through (g) of this section, we may establish a deemed filing date of an application for monthly benefits under the following provisions.

(1)(i) If we determine that you failed to apply for monthly benefits for yourself because we gave you misinformation about your eligibility for such benefits, we will deem an application for such benefits to have been filed with us on the later of—

(A) The date on which the misinformation was provided to you; or

(B) The date on which you met all of the requirements for entitlement to such benefits, other than the requirement of filing an application.

(ii) Before we may establish a deemed filing date of an application for benefits for you under paragraph (b)(1)(i) of this section, you or a person described in § 404.612 must file an application for such benefits. If you die before an application for the benefits is filed with us, we will consider establishing a deemed filing date of an application for such benefits only if an application for the benefits is filed with us by a person who would be qualified to receive any benefits due you.

(2)(i) If you had authority under § 404.612 to sign an application for benefits for another person, and we determine that you failed to apply for monthly benefits for that person because we gave you misinformation about that person's eligibility for such benefits, we will deem an application for such benefits to have been filed with us on the later of—

(A) The date on which the misinformation was provided to you; or

(B) The date on which the person met all of the requirements for entitlement to such benefits, other than the requirement of filing an application.

(ii) Before we may establish a deemed filing date of an application for benefits for the person under paragraph (b)(2)(i) of this section, you, such person, or another person described in § 404.612 must file an application for such benefits. If the person referred to in paragraph (b)(2)(i) of this section dies before an application for the benefits is filed with us, we will consider establishing a deemed filing date of an application for such benefits only if an application for the benefits is filed with us by a person who would be qualified to receive any benefits due the deceased person.

(c) *Requirements concerning the misinformation.* We apply the following requirements for purposes of paragraph (b) of this section.

(1) The misinformation must have been provided to you by one of our employees while he or she was acting in his or her official capacity as our employee. For purposes of this section, an employee includes an officer of SSA.

(2) Misinformation is information which we consider to be incorrect, misleading, or incomplete in view of the facts which you gave to the employee, or of which the employee was aware or should have been aware, regarding your particular circumstances, or the particular circumstances of the person referred to in paragraph (b)(2)(i) of this section. In addition, for us to find that the information you received was incomplete, the employee must have failed to provide you with the appropriate, additional information which he or she would be required to provide in carrying out his or her official duties.

(3) The misinformation may have been provided to you orally or in writing.

(4) The misinformation must have been provided to you in response to a specific request by you to us for information about your eligibility for benefits or the eligibility for benefits of the person referred to in paragraph (b)(2)(i) of this section for which you were considering filing an application.

(d) *Evidence that misinformation was provided.* We will consider the following evidence in making a determination under paragraph (b) of this section.

(1) *Preferred evidence.* Preferred evidence is written evidence which relates directly to your inquiry about your eligibility for benefits or the eligibility of another person and which shows that we gave you misinformation which caused you not to file an application. Preferred evidence includes, but is not limited to, the following—

(i) A notice, letter or other document which was issued by us and addressed to you; or

(ii) Our record of your telephone call, letter or in-person contact.

(2) *Other evidence.* In the absence of preferred evidence, we will consider other evidence, including your statements about the alleged misinformation, to determine whether we gave you misinformation which caused you not to file an application. We will not find that we gave you misinformation, however, based solely on your statements. Other evidence which you provide or which we obtain must support your statements. Evidence which we will consider includes, but is not limited to, the following—

(i) Your statements about the alleged misinformation, including statements about—

(A) The date and time of the alleged contact(s);

(B) How the contact was made, e.g., by telephone or in person;

(C) The reason(s) the contact was made;

(D) Who gave the misinformation; and

(E) The questions you asked and the facts you gave us, and the questions we asked and the information we gave you, at the time of the contact;

(ii) Statements from others who were present when you were given the alleged misinformation, e.g., a neighbor who accompanied you to our office;

(iii) If you can identify the employee or the employee can recall your inquiry about benefits—

(A) Statements from the employee concerning the alleged contact, including statements about the questions you asked, the facts you gave, the questions the employee asked, and the information provided to you at the time of the alleged contact; and

(B) Our assessment of the likelihood that the employee provided the alleged misinformation;

(iv) An evaluation of the credibility and the validity of your allegations in conjunction with other relevant information; and

(v) Any other information regarding your alleged contact.

(e) *Information which does not constitute satisfactory proof that misinformation was given.* Certain kinds of information will not be considered satisfactory proof that we gave you misinformation which caused you not to file an application. Examples of such information include—

(1) General informational pamphlets that we issue to provide basic program information;

(2) The Personal Earnings and Benefit Estimate Statement that is based on an individual's reported and projected earnings and is an estimate which can be requested at any time;

(3) General information which we review or prepare but which is disseminated by the media, e.g., radio, television, magazines, and newspapers; and

(4) Information provided by other governmental agencies, e.g., the Department of Veterans Affairs, the Department of Defense, State unemployment agencies, and State and local governments.

(f) *Claim for benefits based on misinformation.* You may make a claim for benefits based on misinformation at any time. Your claim must contain information that will enable us to determine if we did provide misinformation to you about your eligibility for benefits, or the eligibility of a person on whose behalf you were considering applying for benefits, which caused you not to file an application for the benefits. Specifically, your claim must be in writing and it must explain what information was provided; how, when and where it was provided and by whom; and why the information caused you not to file an application. If you give us this information, we will make a determination on such a claim for benefits if all of the following conditions are also met.

(1) An application for the benefits described in paragraph (b)(1)(i) or (b)(2)(i) of this section is filed with us by someone described in paragraph (b)(1)(ii) or (b)(2)(ii) of this section, as appropriate. The application must be filed after the alleged misinformation was provided. This application may be—

(i) An application on which we have made a previous final determination or decision awarding the benefits, but only if the claimant continues to be entitled to benefits based on that application;

(ii) An application on which we have made a previous final determination or decision denying the benefits, but only if such determination or decision is reopened under § 404.988; or

(iii) A new application on which we have not made a final determination or decision.

(2) The establishment of a deemed filing date of an application for benefits based on misinformation could result in the claimant becoming entitled to benefits or to additional benefits.

(3) We have not made a previous final determination or decision to which you were a party on a claim for benefits

based on alleged misinformation involving the same facts and issues. This provision does not apply, however, if the final determination or decision may be reopened under § 404.988.

(g) *Effective date.* This section applies only to misinformation which we provided after December 1982. In addition, this section is effective only for benefits payable for months after December 1982.

[59 FR 44924, Aug. 31, 1994]

WITHDRAWAL OF APPLICATION

§ 404.640 Withdrawal of an application.

(a) *Request for withdrawal filed before a determination is made.* An application may be withdrawn before we make a determination on it if—

(1) A written request for withdrawal is filed at a place described in § 404.614 by the claimant or a person who may sign an application for the claimant under § 404.612; and

(2) The claimant is alive at the time the request is filed.

(b) *Request for withdrawal filed after a determination is made.* An application may be withdrawn after we make a determination on it if—

(1) The conditions in paragraph (a) of this section are met;

(2) Any other person whose entitlement would be rendered erroneous because of the withdrawal consents in writing to it. Written consent for the person may be given by someone who could sign an application for him or her under § 404.612; and

(3) All benefits already paid based on the application being withdrawn are repaid or we are satisfied that they will be repaid.

(c) *Request for withdrawal filed after the claimant's death.* An application may be withdrawn after the claimant's death, regardless of whether we have made a determination on it, if—

(1) The claimant's application was for old-age benefits that would be reduced because of his or her age;

(2) The claimant died before we certified his or her benefit entitlement to the Treasury Department for payment;

(3) A written request for withdrawal is filed at a place described in § 404.614 by or for the person eligible for widow's or widower's benefits based on the claimant's earnings; and

(4) The conditions in paragraphs (b)(2) and (3) of this section are met.

(d) *Effect of withdrawal.* If we approve a request to withdraw an application, the application will be considered as though it was never filed. If we disapprove a request for withdrawal, the application is treated as though the request was never filed.

[44 FR 37209, June 26, 1979, as amended at 48 FR 21931, May 16, 1983; 51 FR 37720, Oct. 24, 1986]

§ 404.641 Cancellation of a request to withdraw.

A request to withdraw an application may be cancelled and the application reinstated if—

(a) A written request for cancellation is filed at a place described in § 404.614 by the claimant or someone who may sign an application for the claimant under § 404.612;

(b) The claimant is alive at the time the request for cancellation is filed; and

(c) For a cancellation request received after we have approved the withdrawal, the request is filed no later than 60 days after the date of the notice of approval.

Subpart H—Evidence

AUTHORITY: Secs. 205(a) and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a) and 902(a)(5)).

SOURCE: 43 FR 24795, June 7, 1978, unless otherwise noted.

GENERAL

§ 404.701 Introduction.

This subpart contains the Social Security Administration's basic rules about what evidence is needed when a person claims old-age, disability, dependents' and survivors' insurance benefits as described in subpart D. In addition, there are special evidence requirements for disability benefits. These are contained in subpart P. Evidence of a person's earnings under social security is described in subpart I. Evidence needed to obtain a social security number card is described in part

422. Evidence requirements for the supplemental security income program are contained in part 416.

§ 404.702 Definitions.

As used in this subpart:

Apply means to sign a form or statement that the Social Security Administration accepts as an application for benefits under the rules set out in subpart G.

Benefits means any old-age, disability, dependents' and survivors' insurance benefits described in subpart D, including a period of disability.

Convincing evidence means one or more pieces of evidence that prove you meet a requirement for eligibility. See § 404.708 for the guides we use in deciding whether evidence is convincing.

Eligible means that a person would meet all the requirements for entitlement to benefits for a period of time but has not yet applied.

Entitled means that a person has applied and has proven his or her right to benefits for a period of time.

Evidence means any record, document, or signed statement that helps to show whether you are eligible for benefits or whether you are still entitled to benefits.

Insured person means someone who has enough earnings under social security to permit the payment of benefits on his or her earnings record. He or she is *fully insured, transitionally insured, currently insured,* or *insured for disability* as defined in subpart B.

We or *Us* refers to the Social Security Administration.

You refers to the person who has applied for benefits, or the person for whom someone else has applied.

§ 404.703 When evidence is needed.

When you apply for benefits, we will ask for evidence that you are eligible for them. After you become entitled to benefits, we may ask for evidence showing whether you continue to be entitled to benefits; or evidence showing whether your benefit payments should be reduced or stopped. See § 404.401 for a list showing when benefit payments must be reduced or stopped.

§ 404.704 Your responsibility for giving evidence.

When evidence is needed to prove your eligibility or your right to continue to receive benefit payments, you will be responsible for obtaining and giving the evidence to us. We will be glad to advise you what is needed and how to get it and we will consider any evidence you give us. If your evidence is a foreign-language record or document, we can have it translated for you. Evidence given to us will be kept confidential and not disclosed to anyone but you except under the rules set out in part 401. You should also be aware that Section 208 of the Social Security Act provides criminal penalties for misrepresenting the facts or for making false statements to obtain social security benefits for yourself or someone else.

§ 404.705 Failure to give requested evidence.

Generally, you will be asked to give us by a certain date specific kinds of evidence or information to prove you are eligible for benefits. If we do not receive the evidence or information by that date, we may decide you are not eligible for benefits. If you are already receiving benefits, you may be asked to give us by a certain date information needed to decide whether you continue to be entitled to benefits or whether your benefits should be stopped or reduced. If you do not give us the requested information by the date given, we may decide that you are no longer entitled to benefits or that your benefits should be stopped or reduced. You should let us know if you are unable to give us the requested evidence within the specified time and explain why there will be a delay. If this delay is due to illness, failure to receive timely evidence you have asked for from another source, or a similar circumstance, you will be given additional time to give us the evidence.

§ 404.706 Where to give evidence.

Evidence should be given to the people at a Social Security Administration office. In the Philippines evidence should be given to the people at the Veterans Administration Regional Office. Elsewhere outside the United

States, evidence should be given to the people at a United States Foreign Service Office.

§ 404.707 Original records or copies as evidence.

(a) *General.* To prove your eligibility or continuing entitlement to benefits, you may be asked to show us an original document or record. These original records or documents will be returned to you after we have photocopied them. We will also accept copies of original records that are properly certified and some uncertified birth notifications. These types of records are described below in this section.

(b) *Certified copies of original records.* You may give us copies of original records or extracts from records if they are certified as true and exact copies by—

(1) The official custodian of the record;

(2) A Social Security Administration employee authorized to certify copies;

(3) A Veterans Administration employee if the evidence was given to that agency to obtain veteran's benefits;

(4) A U.S. Consular Officer or employee of the Department of State authorized to certify evidence received outside the United States; or

(5) An employee of a State Agency or State Welfare Office authorized to certify copies of original records in the agency's or office's files.

(c) *Uncertified copies of original records.* You may give us an uncertified photocopy of a birth registration notification as evidence where it is the practice of the local birth registrar to issue them in this way.

§ 404.708 How we decide what is enough evidence.

When you give us evidence, we examine it to see if it is convincing evidence. If it is, no other evidence is needed. In deciding if evidence is convincing, we consider whether—

(a) Information contained in the evidence was given by a person in a position to know the facts;

(b) There was any reason to give false information when the evidence was created;

(c) Information contained in the evidence was given under oath, or with witnesses present, or with the knowledge there was a penalty for giving false information;

(d) The evidence was created at the time the event took place or shortly thereafter;

(e) The evidence has been altered or has any erasures on it; and

(f) Information contained in the evidence agrees with other available evidence, including our records.

§ 404.709 Preferred evidence and other evidence.

If you give us the type of evidence we have shown as *preferred* in the following sections of this subpart, we will generally find it is convincing evidence. This means that unless we have information in our records that raises a doubt about the evidence, other evidence of the same fact will not be needed. If preferred evidence is not available, we will consider any other evidence you give us. If this other evidence is several different records or documents which all show the same information, we may decide it is convincing evidence even though it is not *preferred* evidence. If the other evidence is not convincing by itself, we will ask for additional evidence. If this additional evidence shows the same information, all the evidence considered together may be convincing. When we have convincing evidence of the facts that must be proven or it is clear that the evidence provided does not prove the necessary facts, we will make a formal decision about your benefit rights.

EVIDENCE OF AGE, MARRIAGE, AND DEATH

§ 404.715 When evidence of age is needed.

(a) If you apply for benefits, we will ask for evidence of age which shows your date of birth unless you are applying for—

(1) A lump-sum death payment;

(2) A wife's benefit and you have the insured person's child in your care;

(3) A mother's or father's benefit; or

(4) A disability benefit (or for a period of disability) and neither your eligibility nor benefit amount depends upon your age.

(b) If you apply for wife's benefits while under age 62 or if you apply for a mother's or father's benefit, you will be asked for evidence of the date of birth of the insured person's children in your care.

(c) If you apply for benefits on the earnings record of a deceased person, you may be asked for evidence of his or her age if this is needed to decide whether he or she was insured at the time of death or what benefit amount is payable to you.

§ 404.716 Type of evidence of age to be given.

(a) *Preferred evidence.* The best evidence of your age, if you can obtain it, is either: a birth certificate or hospital birth record recorded before age 5; or a religious record which shows your date of birth and was recorded before age 5.

(b) *Other evidence of age.* If you cannot obtain the preferred evidence of your age, you will be asked for other convincing evidence that shows your date of birth or age at a certain time such as: an original family bible or family record; school records; census records; a statement signed by the physician or midwife who was present at your birth; insurance policies; a marriage record; a passport; an employment record; a delayed birth certificate, your child's birth certificate; or an immigration or naturalization record.

§ 404.720 Evidence of a person's death.

(a) *When evidence of death is required.* If you apply for benefits on the record of a deceased person, we will ask for evidence of the date and place of his or her death. We may also ask for evidence of another person's death if this is needed to prove you are eligible for benefits.

(b) *Preferred evidence of death.* The best evidence of a person's death is—

(1) A certified copy or extract from the public record of death, coroner's report of death, or verdict of a coroner's jury; or a certificate by the custodian of the public record of death;

(2) A statement of the funeral director, attending physician, intern of the institution where death occurred;

(3) A certified copy of, or extract from an official report or finding of death made by an agency or department of the United States; or

(4) If death occurred outside the United States, an official report of death by a United States Consul or other employee of the State Department; or a copy of the public record of death in the foreign country.

(c) *Other evidence of death.* If you cannot obtain the preferred evidence of a person's death, you will be asked to explain why and to give us other convincing evidence such as: the signed statements of two or more people with personal knowledge of the death, giving the place, date, and cause of death.

§ 404.721 Evidence to presume a person is dead.

If you cannot prove the person is dead but evidence of death is needed, we will presume he or she died at a certain time if you give us the following evidence:

(a) A certified copy of, or extract from, an official report or finding by an agency or department of the United States that a missing person is *presumed to be* dead as set out in Federal law (5 U.S.C. 5565). Unless we have other evidence showing an actual date of death, we will use the date he or she was reported missing as the date of death.

(b) Signed statements by those in a position to know and other records which show that the person has been absent from his or her residence and has not been heard from for at least 7 years. If the presumption of death is not rebutted pursuant to § 404.722, we will use as the person's date of death either the date he or she left home, the date ending the 7 year period, or some other date depending upon what the evidence shows is the most likely date of death.

(c) If you are applying for benefits as the insured person's grandchild or stepgrandchild but the evidence does not identify a parent, we will presume the parent died in the first month in which the insured person became entitled to to benefits.

[43 FR 24795, June 7, 1978, as amended at 60 FR 19164, Apr. 17, 1995]

§ 404.722 Rebuttal of a presumption of death.

A presumption of death made based on § 404.721(b) can be rebutted by evidence that establishes that the person is still alive or explains the individual's absence in a manner consistent with continued life rather than death.

Example 1: Evidence in a claim for surviving child's benefits showed that the worker had wages posted to his earnings record in the year following the disappearance. It was established that the wages belonged to the worker and were for work done after his ''disappearance.'' In this situation, the presumption of death is rebutted by evidence (wages belonging to the worker) that the person is still alive after the disappearance.

Example 2: Evidence shows that the worker left the family home shortly after a woman, whom he had been seeing, also disappeared, and that the worker phoned his wife several days after the disappearance to state he intended to begin a new life in California. In this situation the presumption of death is rebutted because the evidence explains the worker's absence in a manner consistent with continued life.

[60 FR 19165, Apr. 17, 1995]

§ 404.723 When evidence of marriage is required.

If you apply for benefits as the insured person's husband or wife, widow or widower, divorced wife or divorced husband, we will ask for evidence of the marriage and where and when it took place. We may also ask for this evidence if you apply for child's benefits or for the lump-sum death payment as the widow or widower. If you are a widow, widower, or divorced wife who remarried after your marriage to the insured person ended, we may also ask for evidence of the remarriage. You may be asked for evidence of someone else's marriage if this is necessary to prove your marriage to the insured person was valid. In deciding whether the marriage to the insured person is valid or not, we will follow the law of the State where the insured person had his or her permanent home when you applied or, if earlier, when he or she died—see § 404.770. What evidence we will ask for depends upon whether the insured person's marriage was a ceremonial marriage, a common-law marriage, or a marriage we will deem to be valid.

[43 FR 24795, June 7, 1978, as amended at 44 FR 34493, June 15, 1979]

§ 404.725 Evidence of a valid ceremonial marriage.

(a) *General.* A valid *ceremonial marriage* is one that follows procedures set by law in the State or foreign country where it takes place. These procedures cover who may perform the marriage ceremony, what licenses or witnesses are needed, and similar rules. A ceremonial marriage can be one that follows certain tribal Indian custom, Chinese custom, or similar traditional procedures. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence of a ceremonial marriage is—

(1) If you are applying for wife's or husband's benefits, signed statements from you and the insured about when and where the marriage took place. If you are applying for the lump-sum death payment as the widow or widower, your signed statement about when and where the marriage took place; or

(2) If you are applying for any other benefits or there is evidence causing some doubt about whether there was a ceremonial marriage: a copy of the public record of marriage or a certified statement as to the marriage; a copy of the religious record of marriage or a certified statement as to what the record shows; or the original marriage certificate.

(c) *Other evidence of a ceremonial marriage.* If preferred evidence of a ceremonial marriage cannot be obtained, we will ask you to explain why and to give us a signed statement of the clergyman or official who held the marriage ceremony, or other convincing evidence of the marriage.

§ 404.726 Evidence of common-law marriage.

(a) *General.* A *common-law marriage* is one considered valid under certain State laws even though there was no formal ceremony. It is a marriage between two persons free to marry, who consider themselves married, live together as man and wife, and, in some

States, meet certain other requirements. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence of a common-law marriage is—

(1) If both the husband and wife are alive, their signed statements and those of two blood relatives;

(2) If either the husband or wife is dead, the signed statements of the one who is alive and those of two blood relatives of the deceased person; or

(3) If both the husband and wife are dead, the signed statements of one blood relative of each;

NOTE: All signed statements should show why the signer believes there was a marriage between the two persons. If a written statement cannot be gotten from a blood relative, one from another person can be used instead.

(c) *Other evidence of common-law marriage.* If you cannot get preferred evidence of a common-law marriage, we will ask you to explain why and to give us other convincing evidence of the marriage. We may not ask you for statements from a blood relative or other person if we believe other evidence presented to us proves the common-law marriage.

§ 404.727 Evidence of a deemed valid marriage.

(a) *General.* A *deemed valid marriage* is a ceremonial marriage we consider valid even though the correct procedures set by State law were not strictly followed or a former marriage had not yet ended. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence of a deemed valid marriage is—

(1) Evidence of the ceremonial marriage as described in § 404.725(b)(2);

(2) If the insured person is alive, his or her signed statement that the other party to the marriage went through the ceremony in good faith and his or her reasons for believing the marriage was valid or believing the other party thought it was valid;

(3) The other party's signed statement that he or she went through the marriage ceremony in good faith and his or her reasons for believing it was valid;

(4) If needed to remove a reasonable doubt, the signed statements of others who might have information about what the other party knew about any previous marriage or other facts showing whether he or she went through the marriage in good faith; and

(5) Evidence the parties to the marriage were living in the same household when you applied for benefits or, if earlier, when the insured person died (see § 404.760).

(c) *Other evidence of a deemed valid marriage.* If you cannot obtain preferred evidence of a deemed valid marriage, we will ask you to explain why and to give us other convincing evidence of the marriage.

§ 404.728 Evidence a marriage has ended.

(a) *When evidence is needed that a marriage has ended.* If you apply for benefits as the insured person's divorced wife or divorced husband, you will be asked for evidence of your divorce. If you are the insured person's widow or divorced wife who had remarried but that husband died, we will ask you for evidence of his death. We may ask for evidence that a previous marriage you or the insured person had was ended before you married each other if this is needed to show the latter marriage was valid. If you apply for benefits as an unmarried person and you had a marriage which was annulled, we will ask for evidence of the annulment. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence a marriage has ended is—

(1) A certified copy of the decree of divorce or annulment; or

(2) Evidence the person you married has died (see § 404.720).

(c) *Other evidence a marriage has ended.* If you cannot obtain preferred evidence the marriage has ended, we will ask you to explain why and to give us other convincing evidence the marriage has ended.

[43 FR 24795, June 7, 1978, as amended at 44 FR 34493, June 15, 1979]

EVIDENCE FOR CHILD'S AND PARENT'S BENEFITS

§ 404.730 When evidence of a parent or child relationship is needed.

If you apply for parent's or child's benefits, we will ask for evidence showing your relationship to the insured person. What evidence we will ask for depends on whether you are the insured person's natural parent or child; or whether you are the stepparent, stepchild, grandchild, stepgrandchild, adopting parent or adopted child.

§ 404.731 Evidence you are a natural parent or child.

If you are the natural parent of the insured person, we will ask for a copy of his or her public or religious birth record made before age 5. If you are the natural child of the insured person, we will ask for a copy of your public or religious birth record made before age 5. In either case, if this record shows the same last name for the insured and the parent or child, we will accept it as convincing evidence of the relationship. However, if other evidence raises some doubt about this record or if the record cannot be gotten, we will ask for other evidence of the relationship. We may also ask for evidence of marriage of the insured person or of his or her parent if this is needed to remove any reasonable doubt about the relationship. To show you are the child of the insured person, you may be asked for evidence you would be able to inherit his or her personal property under State law where he or she had a permanent home (see § 404.770). In addition, we may ask for the insured persons signed statement that you are his or her natural child, or for a copy of any court order showing the insured has been declared to be your natural parent or any court order requiring the insured to contribute to you support because you are his or her son or daughter.

§ 404.732 Evidence you are a stepparent or stepchild.

If you are the stepparent or stepchild of the insured person, we will ask for the evidence described in § 404.731 or § 404.733 that which shows your natural or adoptive relationship to the insured person's husband, wife, widow, or widower. We will also ask for evidence of the husband's, wife's, widow's, or widower's marriage to the insured person—see § 404.725.

§ 404.733 Evidence you are the legally adopting parent or legally adopted child.

If you are the adopting parent or adopted child, we will ask for the following evidence:

(a) A copy of the birth certificate made following the adoption; or if this cannot be gotten, other evidence of the adoption; and, if needed, evidence of the date of adoption;

(b) If the widow or widower adopted the child after the insured person died, the evidence described in paragraph (a) of this section; your written statement whether the insured person was living in the same household with the child when he or she died (see § 404.760); what support the child was getting from any other person or organization; and if the widow or widower had a deemed valid marriage with the insured person, evidence of that marriage—see § 404.727;

(c) If you are the insured's stepchild, grandchild, or stepgrandchild as well as his or her adopted child, we may also ask you for evidence to show how you were related to the insured before the adoption.

§ 404.734 Evidence you are an equitably adopted child.

In many States, the law will treat someone as a child of another if he or she agreed to adopt the child, the natural parents or the person caring for the child were parties to the agreement, he or she and the child then lived together as parent and child, and certain other requirements are met. If you are a child who had this kind or relationship to the insured person (or to the insured persons's wife, widow, or husband), we will ask for evidence of the agreement if it is in writing. If it is not in writing or cannot be gotten, other evidence may be accepted. Also, the following evidence will be asked for: Written statements of your natural parents and the adopting parents and other evidence of the child's relationship to the adopting parents.

§ 404.735 Evidence you are the grandchild or stepgrandchild.

If you are the grandchild or stepgrandchild of the insured person, we will ask you for the kind of evidence described in §§ 404.731 through 404.733 that shows your relationship to your parent and your parent's relationship to the insured.

§ 404.736 Evidence of a child's dependency.

(a) *When evidence of a child's dependency is needed.* If you apply for child's benefit's we may ask for evidence you were the insured person's dependent at a specific time—usually the time you applied or the time the insured died or became disabled. What evidence we ask for depends upon how you are related to the insured person.

(b) *Natural or adopted child.* If you are the insured person's natural or adopted child, we may ask for the following evidence:

(1) A signed statement by someone who knows the facts that confirms this relationship and which shows whether you were legally adopted by someone other than the insured. If you were adopted by someone else while the insured person was alive, but the adoption was annulled, we may ask for a certified copy of the annulment decree or other convincing evidence of the annulment.

(2) A signed statement by someone in a position to know showing when and where you lived with the insured and when and why you may have lived apart; and showing what contributions the insured made to your support and when and how they were made.

(c) *Stepchild.* If you are the insured person's stepchild, we will ask for the following evidence:

(1) A signed statement by someone in a position to know—showing when and where you lived with the insured and when and why you may have lived apart.

(2) A signed statement by someone in a position to know showing you received at least one-half of your support from the insured for the one-year period ending at one of the times mentioned in paragraph (a) of this section; and the income end support you had in this period from any other source.

(d) *Grandchild or Stepgrandchild.* If you are the insured person's grandchild or stepgrandchild, we will ask for evidence described in paragraph (c) of this section showing that you were living together with the insured and receiving one-half of your support from him or her for the year before the insured became entitled to benefits or to a period of disability, or died. We will also ask for evidence of your parent's death or disability.

§ 404.745 Evidence of school attendance for child age 18 or older.

If you apply for child's benefits as a student age 18 or over, we may ask for evidence you are attending school. We may also ask for evidence from the school you attend showing your status at the school. We will ask for the following evidence:

(a) Your signed statement that you are attending school full-time and are not being paid by an employer to attend school.

(b) If you apply before the school year has started and the school is not a high school, a letter of acceptance from the school, receipted bill, or other evidence showing you have enrolled or been accepted at that school.

§ 404.750 Evidence of a parent's support.

If you apply for parent's benefits, we will ask you for evidence to show that you received at least one-half of your support from the insured person in the one-year period before he or she died or became disabled. We may also ask others who know the facts for a signed statement about your sources of support. We will ask you for the following evidence:

(a) The parent's signed statement showing his or her income, any other sources of support, and the amount from each source over the one-year period.

(b) If the statement described in paragraph (a) of this section cannot be obtained, other convincing evidence that the parent received one-half of his or her support from the insured person.

OTHER EVIDENCE REQUIREMENTS

§ 404.760 Evidence of living in the same household with insured person.

If you apply for the lump-sum death payment as the insured person's widow or widower, or for wife's, husband's, widow's, or widower's benefits based upon a deemed valid marriage as described in § 404.727, we will ask for evidence you and the insured were living together in the same household when he or she died; or if the insured is alive, when you applied for benefits. We will ask for the following as evidence of this:

(a) If the insured person is living, his or her signed statement and yours showing whether you were living together when you applied for benefits.

(b) If the insured person is dead, your signed statement showing whether you were living together when he or she died.

(c) If you and the insured person were temporarily living apart, a signed statement explaining where each was living, how long the separation lasted, and why you were separated. If needed to remove any reasonable doubts about this, we may ask for the signed statements of others in a position to know, or for other convincing evidence you and the insured were living together in the same household.

§ 404.762 Evidence of having a child in your care.

If you are under age 65 and apply for wife's benefits based upon caring for a child, or for mother's benefits as a widow or divorced wife, or for father's benefits as a widower, we will ask for evidence that you have the insured person's child in your care. What evidence we will ask for depends upon whether the child is living with you or with someone else. You will be asked to give the following evidence:

(a) If the child is living with you, your signed statement showing that the child is living with you.

(b) If the child is living with someone else—

(1) Your signed statement showing with whom he or she is living and why he or she is living with someone else. We will also ask when he or she last lived with you and how long this separation will last, and what care and contributions you provide for the child;

(2) The signed statement of the one with whom the child is living showing what care you provide and the sources and amounts of support received for the child. If the child is in an institution, an official there should sign the statement. These statements are preferred evidence. If there is a court order or written agreement showing who has custody of the child, you may be asked to give us a copy; and

(3) If you cannot get the preferred evidence described in paragraph (b)(2) of this section, we will ask for other convincing evidence that the child is in your care.

§ 404.765 Evidence of responsibility for or payment of burial expenses.

(a) *When evidence of burial expenses is needed.* If you apply for the lump-sum death payment because you are responsible for paying the funeral home or burial expenses of the insured or because you have paid some or all of these expenses, we will ask for evidence of this.

(b) *What evidence is needed.* We will ask for the following evidence:

(1) Your signed statement showing—

(i) You accepted responsibility for the funeral home expenses or paid some or all of these expenses or other burial expenses; your relationship to the insured person; and, if you are not related by blood or marriage, why you accepted responsibility for, or paid, these expenses;

(ii) Total funeral home expenses and, if necessary, the total of other burial expenses; and if someone else paid part of the expenses, the person's name, address, relationship to the insured person, and amount he or she paid;

(iii) The amount of cash or property you expect to receive as repayment for any burial expenses you paid; and whether anyone has applied for or will apply for any burial allowance from the Veterans Administration or other Federal agency for these expenses; and

(iv) If you are applying as an owner or official of a funeral home, a signed statement from anyone, other than an employee of the home, who helped make the burial arrangements showing

whether he or she accepted responsibility for paying the burial expenses; and

(2) Unless you are applying as an owner or official of a funeral home, a signed statement from the owner or official and, if necessary, from those who supplied other burial goods or services which shows—

(i) The name, address, and relationship to the insured person of everyone who accepted responsibility for, or paid any part of, the burial expenses; and

(ii) Information the owner or official of the funeral home and, if necessary, the supplier has about the expenses and payments mentioned in paragraphs (b)(1)(ii) and (b)(1)(iii) of this section.

§ 404.770 Evidence of where the insured person had a permanent home.

(a) *When evidence of the insured's permanent home is needed.* We may ask for evidence of where the insured person's permanent home was at the time you applied or, if earlier, the time he or she died if—

(1) You apply for benefits as the insured's wife, husband, widow, widower, parent or child; and

(2) Your relationship to the insured depends upon the State law that would be followed in the place where the insured had his or her permanent home when you applied for benefits or when he or she died.

(b) *What evidence is needed.* We will ask for the following evidence of the insured person's permanent home:

(1) Your signed statement showing where the insured considered his permanent home to be.

(2) If the statement in paragraph (b)(1) of this section or other evidence we have raises a reasonable doubt about where the insured's permanent home was, evidence of where he or she paid personal, property, or income taxes, or voted; or other convincing evidence of where his or her permanent home was.

§ 404.780 Evidence of "good cause" for exceeding time limits on accepting proof of support or application for a lump-sum death payment.

(a) *When evidence of good cause* is needed. We may ask for evidence that you had *good cause* (as defined in § 404.370(f)) for not giving us sooner proof of the support you received from the insured as his or her parent. We may also ask for evidence that you had *good cause* (as defined in § 404.621(b)) for not applying sooner for the lump-sum death payment. You may be asked for evidence of *good cause* for these delays if—

(1) You are the insured person's parent giving us proof of support more than 2 years after he or she died, or became disabled; or

(2) You are applying for the lump-sum death payment more than 2 years after the insured died.

(b) *What evidence of good cause* is needed. We will ask for the following evidence of good cause:

(1) Your signed statement explaining why you did not give us the proof of support or the application for lump-sum death payment within the specified 2 year period.

(2) If the statement in paragraph (b)(1) of the section or other evidence raises a reasonable doubt whether there was good cause, other convincing evidence of this.

[43 FR 24795, June 7, 1978, as amended at 44 FR 34493, June 15, 1979]

Subpart I—Records of Earnings

AUTHORITY: Secs. 205(a), (c)(1), (c)(2)(A), (c)(4), (c)(5), (c)(6), and (p), 702(a)(5), and 1143 of the Social Security Act (42 U.S.C. 405(a), (c)(1), (c)(2)(A), (c)(4), (c)(5), (c)(6), and (p), 902(a)(5), and 1320b–13).

SOURCE: 44 FR 38454, July 2, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 404.801 Introduction.

The Social Security Administration (SSA) keeps a record of the earnings of all persons who work in employment or self-employment covered under social security. We use these earnings records to determine entitlement to and the amount of benefits that may be payable based on a person's earnings under the retirement, survivors', disability and health insurance program. This subpart tells what is evidence of earnings, how you can find out what the record of your earnings shows, and how and under what circumstances the

record of your earnings may be changed to correct errors.

§ 404.802 Definitions.

For the purpose of this subpart—

Earnings means wages and self-employment income earned by a person based on work covered by social security. (See subpart K for the rules about what constitutes wages and self-employment income for benefit purposes.)

Period means a taxable year when referring to self-employment income. When referring to wages it means a calendar quarter if the wages were reported or should have been reported quarterly by your employer or a calendar year if the wages were reported or should have been reported annually by your employer.

Record of earnings, earnings record, or *record* means SSA's records of the amounts of wages paid to you and the amounts of self-employment income you received, the periods in which the wages were paid and the self-employment income was received, and the quarters of coverage which you earned based on these earnings.

Survivor means your spouse, divorced wife, child, or parent, who survives you. *Survivor* also includes your surviving divorced wife who may be entitled to benefits as a surviving divorced mother.

Tax return means, as appropriate, a tax return of wages or a tax return of self-employment income (including information returns and other written statements filed with the Commissioner of Internal Revenue under chapter 2 or 21 of the Internal Revenue Code of 1954, as amended).

Time limit means a period of time 3 years, 3 months, and 15 days after any year in which you received earnings. The period may be extended by the Soldiers and Sailors Relief Act of 1940 because of your military service or the military service of certain relatives who survive you (50 U.S.C. App. 501 and following sections). Where the time limit ends on a Federal nonwork day, we will extend it to the next Federal work day.

Wage report means a statement filed by a State under section 218 of the Social Security Act or related regulations. This statement includes wage amounts for which a State is billed and wage amounts for which credits or refunds are made to a State according to an agreement under section 218 of the Act.

We, us, or *our* means the Social Security Administration (SSA).

Year means a calendar year when referring to wages and a taxable year when referring to self-employment income.

You or *your* means any person for whom we maintain a record of earnings.

§ 404.803 Conclusiveness of the record of your earnings.

(a) *Generally.* For social security purposes, SSA records are evidence of the amounts of your earnings and the periods in which they were received.

(b) *Before time limit ends.* Before the time limit ends for a year, SSA records are evidence, but not conclusive evidence, of the amounts and periods of your earnings in that year.

(c) *After time limit ends.* After the time limit ends for a year—

(1) If SSA records show an entry of self-employment income or wages for an employer for a period in that year, our records are conclusive evidence of your self-employment income in that year or the wages paid to you by that employer and the periods in which they were received unless one of the exceptions in § 404.822 applies;

(2) If SSA records show no entry of wages for an employer for a period in that year, our records are conclusive evidence that no wages were paid to you by that employer in that period unless one of the exceptions in § 404.822 applies; and

(3) If SSA records show no entry of self-employment income for that year, our records are conclusive evidence that you did not receive self-employement income in that year unless the exception in § 404.822(b)(2) (i) or (iii) applies.

OBTAINING EARNINGS INFORMATION

§ 404.810 How to obtain a statement of earnings and a benefit estimate statement.

(a) *Right to a statement of earnings and a benefit estimate.* You or your legal representative or, after your death, your

survivor or the legal representative of your estate may obtain a statement of your earnings as shown on our records at the time of the request. If you have a social security number and have wages or net earnings from self-employment, you may also request and receive an earnings statement that will include an estimate of the monthly old-age, disability, dependents', and survivors' insurance benefits potentially payable on your earnings record, together with a description of the benefits payable under the medicare program. You may request these statements by writing, calling, or visiting a social security office.

(b) *Contents of request.* When you request a statement of your earnings, we will ask you to complete a prescribed form, giving us your name, social security number, date of birth, and sex. You, your authorized representative or, after your death, your survivor or the legal representative of your estate will be asked to sign and date the form. If you are requesting an estimate of the monthly benefits potentially payable on your earnings record, we will also ask you to give us the amount of your earnings for the last year, an estimate of your earnings for the current year, an estimate of your earnings for future years before your planned retirement, and the age at which you plan to retire, so that we can give you a more realistic estimate of the benefits that may be payable on your record. A request for a statement of earnings and a benefit estimate not made on the prescribed form will be accepted if the request is in writing, is signed and dated by the appropriate individual noted above, and contains all the information that is requested on the prescribed form.

[57 FR 54918, Nov. 23, 1992]

§ 404.811 The statement of earnings and benefit estimate.

(a) *General.* After receiving a request for a statement of earnings and the information we need to comply with the request, we will provide you or your authorized representative a statement of the earnings credited to your record at the time of your request. In addition, we will include estimates of the benefits potentially payable on your record with the statement of earnings. If we are unable to provide all this information, we will explain why we are unable to do so.

(b) *Contents of statement of earnings and benefit estimate.* A statement of your earnings that includes an estimate of the monthly benefits potentially payable on your record will contain the following information:

(1) The social security taxed earnings you have received as shown by our records as of the date of your request;

(2) An estimate of the social security and medicare hospital insurance taxes you have paid as shown on our records as of the date of your request;

(3) The number of credits, i.e., quarters of coverage, not exceeding 40, you have for both social security and medicare health insurance purposes;

(4) The total number of credits, i.e., quarters of coverage, you must have for social security benefits;

(5) An estimate of the monthly old-age, disability, dependents', and survivors' insurance benefits potentially payable on your record;

(6) A description of the benefits payable under the medicare program; and

(7) A statement of your right to request a correction of your earnings record.

[57 FR 54919, Nov. 23, 1992]

CORRECTING THE EARNINGS RECORDS

§ 404.820 Filing a request for correction of the record of your earnings.

(a) *When to file a request for correction.* You or your survivor must file a request for correction of the record of your earnings within the time limit for the year being questioned unless one of the exceptions in § 404.822 applies.

(b) *Contents of a request.* (1) A request for correction of an earnings record must be in writing and must state that the record is incorrect.

(2) A request must be signed by you or your survivor or by a person who may sign an application for benefits for you or for your survivor as described in § 404.612.

(3) A request should state the period being questioned.

(4) A request should describe, or have attached to it, any available evidence

which shows that the record of earnings is incorrect.

(c) *Where to file a request.* A request may be filed with an SSA employee at one of our offices or with an SSA employee who is authorized to receive a request at a place other than one of our offices. A request may be filed with the Veterans Administration Regional Office in the Philippines or with any U.S. Foreign Service Office.

(d) *When a request is considered filed.* A request is considered filed on the day it is received by any of our offices, by an authorized SSA employee, by the Veterans Administration Regional Office in the Philippines, or by any U.S. Foreign Service Office. If using the date we receive a mailed request disadvantages the requester, we will use the date the request was mailed to us as shown by a U.S. postmark. If the postmark is unreadable or there is no postmark, we will consider other evidence of the date when the request was mailed.

(e) *Withdrawal of a request for correction.* A request for correction of SSA records of your earnings may be withdrawn as described in § 404.640.

(f) *Cancellation of a request to withdraw.* A request to withdraw a request for correction of SSA records of your earnings may be cancelled as described in § 404.641.

(g) *Determinations on requests.* When we receive a request described in this section, we will make a determination to grant or deny the request. If we deny the request, this determination may be appealed under the provisions of subpart J of this part.

§ 404.821 Correction of the record of your earnings before the time limit ends.

Before the time limit ends for any year, we will correct the record of your earnings for that year for any reason if satisfactory evidence shows SSA records are incorrect. We may correct the record as the result of a request filed under § 404.820 or we may correct it on our own.

§ 404.822 Correction of the record of your earnings after the time limit ends.

(a) *Generally.* After the time limit for any year ends, we may correct the record of your earnings for that year if satisfactory evidence shows SSA records are incorrect and any of the circumstances in paragraphs (b) through (e) of this section applies.

(b) *Correcting SSA records to agree with tax returns.* We will correct SSA records to agree with a tax return of wages or self-employment income to the extent that the amount of earnings shown in the return is correct.

(1) *Tax returns of wages.* We may correct the earnings record to agree with a tax return of wages or with a wage report of a State.

(2) *Tax returns of self-employment income*—(i) *Return filed before the time limit ended.* We may correct the earnings record to agree with a tax return of self-employment income filed before the end of the time limit.

(ii) *Return filed after time limit ended.* We may remove or reduce, but not increase, the amount of self-employment income entered on the earnings record to agree with a tax return of self-employment income filed after the time limit ends.

(iii) *Self-employment income entered in place of erroneously entered wages.* We may enter self-employment income for any year up to an amount erroneously entered in SSA records as wages but which was later removed from the records. However, we may enter self-employment income under this paragraph only if—

(A) An amended tax return is filed before the time limit ends for the year in which the erroneously entered wages were removed; or

(B) Net earnings from self-employment, which are not already entered in the record of your earnings, were included in a tax return filed before the end of the time limit for the year in which the erroneously entered wages were removed.

(c) *Written request for correction or application for benefits filed before the time limit ends*—(1) *Written request for correction.* We may correct an earnings

record if you or your survivor files a request for correction before the time limit for that year ends. The request must state that the earnings record for that year is incorrect. However, we may not correct the record under this paragraph after our determination on the request becomes final.

(2) *Application for benefits.* We may correct an earnings record if an application is filed for monthly benefits or for a lump-sum death payment before the time limit for that year ends. However, we may not correct the record under this paragraph after our determination on the application becomes final.

(3) See subpart J for the rules on the finality of determinations.

(d) *Transfer of wages to or from the Railroad Retirement Board*—(1) *Wages erroneously reported.* We may transfer to or from the records of the Railroad Retirement Board earnings which were erroneously reported to us or to the Railroad Retirement Board.

(2) *Earnings certified by Railroad Retirement Board.* We may enter earnings for railroad work under subpart O if the earnings are certified by the Railroad Retirement Board.

(e) *Other circumstances permitting correction*—(1) *Investigation started before time limit ends.* We may correct an earnings record if the correction is made as the result of an investigation started before, but completed after the time limit ends. An investigation is started when we take an affirmative step leading to a decision on a question about the earnings record, for example, an investigation is started when one SSA unit asks another unit to obtain additional information or evidence. We will remove or reduce earnings on the record under this paragraph only if we carried out the investigation as promptly as circumstances permitted.

(2) *Error apparent on face of records.* We may correct an earnings record to correct errors, such as mechanical or clerical errors, which can be identified and corrected without going beyond any of the pertinent SSA records.

(3) *Fraud.* We may change any entry which was entered on the earnings record as the result of fraud.

(4) *Entries for wrong person or period.* We may correct errors in SSA records resulting from earnings being entered for the wrong person or period.

(5) *Less than correct wages on SSA records.* We may enter wages paid to you by an employer for a period if no part of those wages or less than the correct amount of those wages is entered on SSA records.

(6) *Wage payments under a statute.* We may enter and allocate wages awarded to you for a period as the result of a determination or agreement approved by a court or administrative agency that enforces Federal or State statutes protecting your right to employment or wages.

[44 FR 38454, July 2, 1979, as amended at 57 FR 21600, May 21, 1992]

§ 404.823 Correction of the record of your earnings for work in the employ of the United States.

We may correct the record of your earnings to remove, reduce, or enter earnings for work in the employ of the United States only if—

(a) Correction is permitted under § 404.821 or § 404.822; and

(b) Any necessary determinations concerning the amount of remuneration paid for your work and the periods for which such remuneration was paid have been made as shown by—

(1) A tax return filed under section 3122 of the Internal Revenue Code (26 U.S.C. 3122); or

(2) A certification by the head of the Federal agency or instrumentality of which you have been an employee or his or her agent. A Federal instrumentality for these purposes includes a nonappropriated fund activity of the armed forces or Coast Guard.

[44 FR 38454, July 2, 1979, as amended at 55 FR 24891, June 19, 1990]

NOTICE OF REMOVAL OR REDUCTION OF AN ENTRY OF EARNINGS

§ 404.830 Notice of removal or reduction of your wages.

If we remove or reduce an amount of wages entered on the record of your earnings, we will notify you of this correction if we previously notified you of the amount of your wages for the period involved. We will notify your survivor if we previously notified you or

your survivor of the amount of your earnings for the period involved.

§ 404.831 Notice of removal or reduction of your self-employment income.

If we remove or reduce an amount of self-employment income entered on the record of your earnings, we will notify you of this correction. We will notify your survivor if we previously notified you or your survivor of the amount of your earnings for the period involved.

Subpart J—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

AUTHORITY: Secs. 201(j), 205(a), (b), (d)–(h), and (j), 221, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 401(j), 405(a), (b), (d)–(h), and (j), 421, 425, and 902(a)(5)); 31 U.S.C. 3720A; sec. 5, Pub. L. 97–455, 96 Stat. 2500 (42 U.S.C. 405 note); secs. 5, 6(c)–(e), and 15, Pub. L. 98–460, 98 Stat. 1802 (42 U.S.C. 421 note).

SOURCE: 45 FR 52081, Aug. 5, 1980, unless otherwise noted.

INTRODUCTION, DEFINITIONS, AND INITIAL DETERMINATIONS

§ 404.900 Introduction.

(a) *Explanation of the administrative review process.* This subpart explains the procedures we follow in determining your rights under title II of the Social Security Act. The regulations describe the process of administrative review and explain your right to judicial review after you have taken all the necessary administrative steps. These procedures apply also to persons claiming certain benefits under title XVIII of the Act (Medicare); see 42 CFR 405.701(c). The administrative review process consists of several steps, which usually must be requested within certain time periods and in the following order:

(1) *Initial determination.* This is a determination we make about your entitlement or your continuing entitlement to benefits or about any other matter, as discussed in § 404.902, that gives you a right to further review.

(2) *Reconsideration.* If you are dissatisfied with an initial determination, you may ask us to reconsider it.

(3) *Hearing before an administrative law judge.* If you are dissatisfied with the reconsideration determination, you may request a hearing before an administrative law judge.

(4) *Appeals Council review.* If you are dissatisfied with the decision of the administrative law judge, you may request that the Appeals Council review the decision.

(5) *Federal court review.* When you have completed the steps of the administrative review process listed in paragraphs (a)(1) through (a)(4) of this section, we will have made our final decision. If you are dissatisfied with our final decision, you may request judicial review by filing an action in a Federal district court.

(6) *Expedited appeals process.* At some time after your initial determination has been reviewed, if you have no dispute with our findings of fact and our application and interpretation of the controlling laws, but you believe that a part of the law is unconstitutional, you may use the expedited appeals process. This process permits you to go directly to a Federal district court so that the constitutional issue may be resolved.

(b) *Nature of the administrative review process.* In making a determination or decision in your case, we conduct the administrative review process in an informal, nonadversary manner. In each step of the review process, you may present any information you feel is helpful to your case. Subject to the limitations on Appeals Council consideration of additional evidence (see §§ 404.970(b) and 404.976(b)), we will consider at each step of the review process any information you present as well as all the information in our records. You may present the information yourself or have someone represent you, including an attorney. If you are dissatisfied with our decision in the review process, but do not take the next step within the stated time period, you will lose your right to further administrative review and your right to judicial review, unless you can show us that there was good cause for your failure to make a timely request for review.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 300, Jan 3, 1986; 51 FR 8808, Mar. 14, 1986; 52 FR 4004, Feb. 9, 1987]

§ 404.901 Definitions.

As used in this subpart:

Date you receive notice means 5 days after the date on the notice, unless you show us that you did not receive it within the 5-day period.

Decision means the decision made by an administrative law judge or the Appeals Council.

Determination means the initial determination or the reconsidered determination.

Remand means to return a case for further review.

Vacate means to set aside a previous action.

Waive means to give up a right knowingly and voluntarily.

We, us, or *our* refers to the Social Security Administration.

You or *your* refers to any person claiming a right under the old age, disability, dependents' or survivors' benefits program.

§ 404.902 Administrative actions that are initial determinations.

Initial determinations are the determinations we make that are subject to administrative and judicial review. The initial determination will state the important facts and give the reasons for our conclusions. In the old age, survivors' and disability insurance programs, initial determinations include, but are not limited to, determinations about—

(a) Your entitlement or your continuing entitlement to benefits;

(b) Your reentitlement to benefits;

(c) The amount of your benefit;

(d) A recomputation of your benefit;

(e) A reduction in your disability benefits because you also receive benefits under a workmen's compensation law;

(f) A deduction from your benefits on account of work;

(g) A deduction from your disability benefits because you refuse to accept rehabilitation services;

(h) Termination of your benefits;

(i) Penalty deductions imposed because you failed to report certain events;

(j) Any overpayment or underpayment of your benefits;

(k) Whether an overpayment of benefits must be repaid to us;

(l) How an underpayment of benefits due a deceased person will be paid;

(m) The establishment or termination of a period of disability;

(n) A revision of your earnings record;

(o) Whether the payment of your benefits will be made, on your behalf, to a representative payee, unless you are under age 18, legally incompetent, or you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535);

(p) Your drug addiction or alcoholism;

(q) Who will act as your payee if we determine that representative payment will be made;

(r) An offset of your benefits under § 404.408b because you previously received supplemental security income payments for the same period;

(s) Whether your completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that you will not have to return to the disability benefit rolls and thus, whether your benefits may be continued even though you are not disabled;

(t) Nonpayment of your benefits under § 404.468 because of your confinement in a jail, prison, or other penal institution or correctional facility for conviction of a felony;

(u) Whether or not you have a disabling impairment(s) as defined in § 404.1511;

(v) Nonpayment of your benefits under § 404.469 because you have not furnished us satisfactory proof of your Social Security number, or, if a Social Security number has not been assigned to you, you have not filed a proper application for one; and

(w) A claim for benefits under § 404.633 based on alleged misinformation.

[45 FR 52081, Aug. 5, 1980, as amended at 47 FR 4988, Feb. 3, 1982; 47 FR 31543, July 21, 1982; 49 FR 22272, May 29, 1984; 50 FR 20902, May 21, 1985; 56 FR 41790, Aug. 23, 1991; 59 FR 44925, Aug. 31, 1994; 60 FR 8147, Feb. 10, 1995]

§ 404.903 Administrative actions that are not initial determinations.

Administrative actions that are not initial determinations may be reviewed by us, but they are not subject to the administrative review process provided by this subpart, and they are not subject to judicial review. These actions include, but are not limited to, an action—

(a) Suspending benefits pending an investigation and determination of any factual issue relating to a deduction on account of work;

(b) Suspending benefits pending an investigation to determine if your disability has ceased;

(c) Denying a request to be made a representative payee;

(d) Certifying two or more family members for joint payment of benefits;

(e) Withholding less than the full amount of your monthly benefit to recover an overpayment;

(f) Determining the fee that may be charged or received by a person who has represented you in connection with a proceeding before us;

(g) Disqualifying or suspending a person from acting as your representative in a proceeding before us (See § 404.1745);

(h) Compromising, suspending or terminating collection of an overpayment under the Federal Claims Collection Act;

(i) Extending or not extending the time to file a report of earnings;

(j) Denying your request to extend the time period for requesting review of a determination or a decision;

(k) Denying your request to use the expedited appeals process;

(l) Denying your request to reopen a determination or a decision;

(m) Withholding temporarily benefits based on a wage earner's estimate of earnings to avoid creating an overpayment;

(n) Determining whether (and the amount of) travel expenses incurred are reimbursable in connection with proceedings before us;

(o) Denying your request to readjudicate your claim and apply an Acquiescence Ruling;

(p) Findings on whether we can collect an overpayment by using the Federal income tax refund offset procedure (see § 404.523);

(q) Determining whether an organization may collect a fee from you for expenses it incurred in serving as your representative payee (see § 404.2040a); and

(r) Declining under § 404.633(f) to make a determination on a claim for benefits based on alleged misinformation because one or more of the conditions specified in § 404.633(f) are not met.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 8808, Mar. 14, 1986; 55 FR 1018, Jan. 11, 1990; 56 FR 52469, Oct. 21, 1991; 57 FR 23057, June 1, 1992; 59 FR 44925, Aug. 31, 1994]

§ 404.904 Notice of the initial determination.

We shall mail a written notice of the initial determination to you at your last known address. The reasons for the initial determination and the effect of the initial determination will be stated in the notice. The notice also informs you of the right to a reconsideration. We will not mail a notice if the beneficiary's entitlement to benefits has ended because of his or her death.

[51 FR 300, Jan. 3, 1986]

§ 404.905 Effect of an initial determination.

An initial determination is binding unless you request a reconsideration within the stated time period, or we revise the initial determination.

[51 FR 300, Jan. 3, 1986]

§ 404.906 Testing modifications to the disability determination procedures.

(a) *Applicability and scope.* Notwithstanding any other provision in this part or part 422 of this chapter, we are establishing the procedures set out in this section to test modifications to our disability determination process. These modifications will enable us to test, either individually or in one or more combinations, the effect of: having disability claim managers assume primary responsibility for processing an application for disability benefits; providing persons who have applied for benefits based on disability with the opportunity for an interview with a

decisionmaker when the decisionmaker finds that the evidence in the file is insufficient to make a fully favorable determination or requires an initial determination denying the claim; having a single decisionmaker make the initial determination with assistance from medical consultants, where appropriate; and eliminating the reconsideration step in the administrative review process and having a claimant who is dissatisfied with the initial determination request a hearing before an administrative law judge. The model procedures we test will be designed to provide us with information regarding the effect of these procedural modifications and enable us to decide whether and to what degree the disability determination process would be improved if they were implemented on a national level.

(b) *Procedures for cases included in the tests.* Prior to commencing each test or group of tests in selected site(s), we will publish a notice in the FEDERAL REGISTER. The notice will describe which model or combinations of models we intend to test, where the specific test site(s) will be, and the duration of the test(s). The individuals who participate in the test(s) will be randomly assigned to a test group in each site where the tests are conducted. Paragraphs (b) (1) through (4) of this section lists descriptions of each model.

(1) In the disability claim manager model, when you file an application for benefits based on disability, a disability claim manager will assume primary responsibility for the processing of your claim. The disability claim manager will be the focal point for your contacts with us during the claims intake process and until an initial determination on your claim is made. The disability claim manager will explain the disability programs to you, including the definition of disability and how we determine whether you meet all the requirements for benefits based on disability. The disability claim manager will explain what you will be asked to do throughout the claims process and how you can obtain information or assistance through him or her. The disability claim manager will also provide you with information regarding your right to representation, and he or she will provide you with appropriate referral sources for representation. The disability claim manager may be either a State agency employee or a Federal employee. In some instances, the disability claim manager may be assisted by other individuals.

(2) In the single decisionmaker model, the decisionmaker will make the disability determination and may also determine whether the other conditions for entitlement to benefits based on disability are met. The decisionmaker will make the disability determination after any appropriate consultation with a medical or psychological consultant. The medical or psychological consultant will not be required to sign the disability determination forms we use to have the State agency certify the determination of disability to us (see § 404.1615). However, before an initial determination is made that a claimant is not disabled in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment pursuant to our existing procedures (see § 404.1617). In some instances the decisionmaker may be the disability claim manager described in paragraph (b)(1) of this section. When the decisionmaker is a State agency employee, a team of individuals that includes a Federal employee will determine whether the other conditions for entitlement to benefits are met.

(3) In the predecision interview model, if the decisionmaker(s) finds that the evidence in your file is insufficient to make a fully favorable determination or requires an initial determination denying your claim, a predecision notice will be mailed to you. The notice will tell you that, before the decisionmaker(s) makes an initial determination about whether you are disabled, you may request a predecision interview with the decisionmaker(s). The notice will also tell you that you may submit additional evidence. You must request a predecision interview within 10 days after the date you receive the

predecision notice. You must also submit any additional evidence within 10 days after you receive the predecision notice. If you request a predecision interview, the decisionmaker(s) will conduct the predecision interview in person, by videoconference, or by telephone as the decisionmaker(s) determines is appropriate under the circumstances. If you make a late request for a predecision interview, or submit additional evidence late, but show in writing that you had good cause under the standards in § 404.911 for missing the deadline, the decisionmaker(s) will extend the deadline. If you do not request the predecision interview, or if you do not appear for a scheduled predecision interview and do not submit additional evidence, or if you do not respond to our attempts to communicate with you, the decisionmaker(s) will make an initial determination based upon the evidence in your file. If you identify additional evidence during the predecision interview, which was previously not available, the decisionmaker(s) will advise you to submit the evidence. If you are unable to do so, the decisionmaker(s) may assist you in obtaining it. The decisionmaker(s) also will advise you of the specific timeframes you have for submitting any additional evidence identified during the predecision interview. If you have no treating source(s) (see § 404.1502), or your treating source(s) is unable or unwilling to provide the necessary evidence, or there is a conflict in the evidence that cannot be resolved through evidence from your treating source(s), the decisionmaker(s) may arrange a consultative examination or resolve conflicts according to existing procedures (see § 404.1519a). If you attend the predecision interview, or do not attend the predecision interview but you submit additional evidence, the decisionmaker(s) will make an initial determination based on the evidence in your file, including the additional evidence you submit or the evidence obtained as a result of the predecision notice or interview, or both.

(4) In the reconsideration elimination model, we will modify the disability determination process by eliminating the reconsideration step of the administrative review process. If you receive an initial determination on your claim for benefits based on disability, and you are dissatisfied with the determination, we will notify you that you may request a hearing before an administrative law judge. If you request a hearing before an administrative law judge, we will apply our usual procedures contained in subpart J of this part.

[60 FR 20026, Apr. 24, 1995]

RECONSIDERATION

§ 404.907 Reconsideration—general.

Reconsideration is the first step in the administrative review process that we provide if you are dissatisfied with the initial determination. If you are dissatisfied with our reconsidered determination, you may request a hearing before an administrative law judge.

[51 FR 300, Jan. 3, 1986]

§ 404.908 Parties to a reconsideration.

(a) *Who may request a reconsideration.* If you are dissatisfied with the initial determination, you may request that we reconsider it. In addition, a person who shows in writing that his or her rights may be adversely affected by the initial determination may request a reconsideration.

(b) *Who are parties to a reconsideration.* After a request for the reconsideration, you and any person who shows in writing that his or her rights are adversely affected by the initial determination will be parties to the reconsideration.

§ 404.909 How to request reconsideration.

(a) We shall reconsider an initial determination if you or any other party to the reconsideration files a written request—

(1) Within 60 days after the date you receive notice of the initial determination (or within the extended time period if we extend the time as provided in paragraph (b) of this section);

(2) At one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board if you have 10 or

more years of service in the railroad industry.

(b) *Extension of time to request a reconsideration.* If you want a reconsideration of the initial determination but do not request one in time, you may ask us for more time to request a reconsideration. Your request for an extension of time must be in writing and must give the reasons why the request for reconsideration was not filed within the stated time period. If you show us that you had good cause for missing the deadline, we will extend the time period. To determine whether good cause exists, we use the standards explained in § 404.911.

§ 404.911 Good cause for missing the deadline to request review.

(a) In determining whether you have shown that you had good cause for missing a deadline to request review we consider—

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review.

(b) Examples of circumstances where good cause may exist include, but are not limited to, the following situations:

(1) You were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person.

(2) There was a death or serious illness in your immediate family.

(3) Important records were destroyed or damaged by fire or other accidental cause.

(4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods.

(5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested reconsideration or a hearing, or within 30 days of receiving the explanation you requested Appeal Council review or filed a civil suit.

(6) We gave you incorrect or incomplete information about when and how to request administrative review or to file a civil suit.

(7) You did not receive notice of the determination or decision.

(8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired.

(9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which show that you could not have known of the need to file timely, or which prevented you from filing timely.

[45 FR 52081, Aug. 5, 1980, as amended at 59 FR 1634, Jan. 12, 1994]

§ 404.913 Reconsideration procedures.

(a) *Case review.* With the exception of the type of case described in paragraph (b) of this section, the reconsideration process consists of a case review. Under a case review procedure, we will give you and the other parties to the reconsideration an opportunity to present additional evidence to us. The official who reviews your case will then make a reconsidered determination based on all of this evidence.

(b) *Disability hearing.* If you have been receiving benefits based on disability and you request reconsideration of an initial or revised determination that, based on medical factors, you are not now disabled, we will give you and the other parties to the reconsideration an opportunity for a disability hearing. (See §§ 404.914 through 404.918.)

[51 FR 300, Jan. 3, 1986]

§ 404.914 Disability hearing—general.

(a) *Availability.* We will provide you with an opportunity for a disability hearing if:

(1) You have been receiving benefits based on a medical impairment that renders you disabled;

(2) We have made an initial or revised determination based on medical factors

that you are not now disabled because your impairment:

(i) Has ceased;

(ii) Did not exist; or

(iii) Is no longer disabling; and

(3) You make a timely request for reconsideration of the initial or revised determination.

(b) *Scope.* The disability hearing will address only the initial or revised determination, based on medical factors, that you are not now disabled. Any other issues which arise in connection with your request for reconsideration will be reviewed in accordance with the reconsideration procedures described in § 404.913(a).

(c) *Time and place*—(1) *General.* Either the State agency or the Director of the Office of Disability Hearings or his or her delegate, as appropriate, will set the time and place of your disability hearing. We will send you a notice of the time and place of your disability hearing at least 20 days before the date of the hearing. You may be expected to travel to your disability hearing. (See §§ 404.999a–404.999d regarding reimbursement for travel expenses.)

(2) *Change of time or place.* If you are unable to travel or have some other reason why you cannot attend your disability hearing at the scheduled time or place, you should request at the earliest possible date that the time or place of your hearing be changed. We will change the time or place if there is good cause for doing so under the standards in § 404.936 (c) and (d).

(d) *Combined issues.* If a disability hearing is available to you under paragraph (a) of this section, and you file a new application for benefits while your request for reconsideration is still pending, we may combine the issues on both claims for the purpose of the disability hearing and issue a combined initial/reconsidered determination which is binding with respect to the common issues on both claims.

(e) *Definition.* For purposes of the provisions regarding disability hearings (§§ 404.914 through 404.918) *we, us* or *our* means the Social Security Administration or the State agency.

[51 FR 300, Jan. 3, 1986, as amended at 51 FR 8808, Mar. 14, 1986]

§ 404.915 Disability hearing—disability hearing officers.

(a) *General.* Your disability hearing will be conducted by a disability hearing officer who was not involved in making the determination you are appealing. The disability hearing officer will be an experienced disability examiner, regardless of whether he or she is appointed by a State agency or by the Director of the Office of Disability Hearings or his or her delegate, as described in paragraphs (b) and (c) below.

(b) *State agency hearing officers*—(1) *Appointment of State agency hearing officers.* If a State agency made the initial or revised determination that you are appealing, the disability hearing officer who conducts your disability hearing may be appointed by a State agency. If the disability hearing officer is appointed by a State agency, that individual will be employed by an adjudicatory unit of the State agency other than the adjudicatory unit which made the determination you are appealing.

(2) *State agency* defined. For purposes of this subpart, *State agency* means the adjudicatory component in the State which issues disability determinations.

(c) *Federal hearing officers.* The disability hearing officer who conducts your disability hearing will be appointed by the Director of the Office of Disability Hearings or his or her delegate if:

(1) A component of our office other than a State agency made the determination you are appealing; or

(2) The State agency does not appoint a disability hearing officer to conduct your disability hearing under paragraph (b) of this section.

[51 FR 301, Jan. 3, 1986]

§ 404.916 Disability hearing—procedures.

(a) *General.* The disability hearing will enable you to introduce evidence and present your views to a disability hearing officer if you are dissatisfied with an initial or revised initial determination, based on medical factors, that you are not now disabled as described in § 404.914(a)(2).

(b) *Your procedural rights.* We will advise you that you have the following

procedural rights in connection with the disability hearing process:

(1) You may request that we assist you in obtaining pertinent evidence for your disability hearing and, if necessary, that we issue a subpoena to compel the production of certain evidence or testimony. We will follow subpoena procedures similar to those described in § 404.950(d) for the administrative law judge hearing process;

(2) You may have a representative at the hearing appointed under subpart R of this part, or you may represent yourself;

(3) You or your representative may review the evidence in your case file, either on the date of your hearing or at an earlier time at your request, and present additional evidence;

(4) You may present witnesses and question any witnesses at the hearing;

(5) You may waive your right to appear at the hearing. If you do not appear at the hearing, the disability hearing officer will prepare and issue a written reconsidered determination based on the information in your case file.

(c) *Case preparation.* After you request reconsideration, your case file will be reviewed and prepared for the hearing. This review will be conducted in the component of our office (including a State agency) that made the initial or revised determination, by personnel who were not involved in making the initial or revised determination. Any new evidence you submit in connection with your request for reconsideration will be included in this review. If necessary, further development of the evidence, including arrrangements for medical examinations, will be undertaken by this component. After the case file is prepared for the hearing, it will be forwarded by this component to the disability hearing officer for a hearing. If necessary, the case file may be sent back to this component at any time prior to the issuance of the reconsidered determination for additional development. Under paragraph (d) of this section, this component has the authority to issue a favorable reconsidered determination at any time in its development process.

(d) *Favorable reconsideration determination without a hearing.* If all the evidence in your case file supports a finding that you are now disabled, either the component that prepares your case for hearing under paragraph (c) or the disability hearing officer will issue a written favorable reconsideration determination, even if a disability hearing has not yet been held.

(e) *Opportunity to submit additional evidence after the hearing.* At your request, the disability hearing officer may allow up to 15 days after your disability hearing for receipt of evidence which is not available at the hearing, if:

(1) The disability hearing officer determines that the evidence has a direct bearing on the outcome of the hearing; and

(2) The evidence could not have been obtained before the hearing.

(f) *Opportunity to review and comment on evidence obtained or developed by us after the hearing.* If, for any reason, additional evidence is obtained or developed by us after your disability hearing, and all evidence taken together can be used to support a reconsidered determination that is unfavorable to you with regard to the medical factors of eligibility, we will notify you, in writing, and give you an opportunity to review and comment on the additional evidence. You will be given 10 days from the date you receive our notice to submit your comments (in writing or, in appropriate cases, by telephone), unless there is good cause for granting you additional time, as illustrated by the examples in § 404.911(b). Your comments will be considered before a reconsidered determination is issued. If you believe that it is necessary to have further opportunity for a hearing with respect to the additional evidence, a supplementary hearing may be scheduled at your request. Otherwise, we will ask for your written comments on the additional evidence, or, in appropriate cases, for your telephone comments.

[51 FR 301, Jan. 3, 1986]

§ 404.917 Disability hearing—disability hearing officer's reconsidered determination.

(a) *General.* The disability hearing officer who conducts your disability hearing will prepare and will also issue

a written reconsidered determination, unless:

(1) The disability hearing officer sends the case back for additional development by the component that prepared the case for the hearing, and that component issues a favorable determination, as permitted by § 404.916(c);

(2) It is determined that you are engaging in substantial gainful activity and that you are therefore not disabled; or

(3) The reconsidered determination prepared by the disability hearing officer is reviewed under § 404.918.

(b) *Content.* The disability hearing officer's reconsidered determination will give the findings of fact and the reasons for the reconsidered determination. The reconsidered determination must be based on evidence offered at the disability hearing or otherwise included in the case file.

(c) *Notice.* We will mail you and the other parties a notice of reconsidered determination in accordance with § 404.922.

(d) *Effect.* The disability hearing officer's reconsidered determination, or, if it is changed under § 404.918, the reconsidered determination that is issued by the Director of the Office of Disability Hearings or his or her delegate, is binding in accordance with § 404.921, subject to the exceptions specified in that section.

[51 FR 302, Jan. 3, 1986]

§ 404.918 Disability hearing—review of the disability hearing officer's reconsidered determination before it is issued.

(a) *General.* The Director of the Office of Disability Hearings or his or her delegate may select a sample of disability hearing officers' reconsidered determinations, before they are issued, and review any such case to determine its correctness on any grounds he or she deems appropriate. The Director or his or her delegate shall review any case within the sample if:

(1) There appears to be an abuse of discretion by the hearing officer;

(2) There is an error of law; or

(3) The action, findings or conclusions of the disability hearing officer are not supported by substantial evidence.

If the review indicates that the reconsidered determination prepared by the disability hearing officer is correct, it will be dated and issued immediately upon completion of the review. If the reconsidered determination prepared by the disability hearing officer is found by the Director or his or her delegate to be deficient, it will be changed as described in paragraph (b) of this section.

(b) *Methods of correcting deficiencies in the disability hearing officer's reconsidered determination.* If the reconsidered determination prepared by the disability hearing officer is found by the Director or his or her delegate to be deficient, the Director of the Office of Disability Hearings or his or her delegate will take appropriate action to assure that the deficiency is corrected before a reconsidered determination is issued. The action taken by the Director or his or her delegate will take one of two forms:

(1) The Director or his or her delegate may return the case file either to the component responsible for preparing the case for hearing or to the disability hearing officer, for appropriate further action; or

(2) The Director or his or her delegate may issue a written reconsidered determination which corrects the deficiency.

(c) *Further action on your case if it is sent back by the Director or his or her delegate either to the component that prepared your case for hearing or to the disability hearing officer.* If the Director of the Office of Disability Hearings or his or her delegate sends your case back either to the component responsible for preparing the case for hearing or to the disability hearing officer for appropriate further action, as provided in paragraph (b)(1) of this section, any additional proceedings in your case will be governed by the disability hearing procedures described in § 404.916(f) or if your case is returned to the disability hearing officer and an unfavorable determination is indicated, a supplementary hearing may be scheduled for you before a reconsidered determination is reached in your case.

(d) *Opportunity to comment before the Director or his or her delegate issues a reconsidered determination that is unfavorable to you.* If the Director of the Office of Disability Hearings or his or her delegate proposes to issue a reconsidered determination as described in paragraph (b)(2) of this section, and that reconsidered determination is unfavorable to you, he or she will send you a copy of the proposed reconsidered determination with an explanation of the reasons for it, and will give you an opportunity to submit written comments before it is issued. At your request, you will also be given an opportunity to inspect the pertinent materials in your case file, including the reconsidered determination prepared by the disability hearing officer, before submitting your comments. You will be given 10 days from the date you receive the Director's notice of proposed action to submit your written comments, unless additional time is necessary to provide access to the pertinent file materials or there is good cause for providing more time, as illustrated by the examples in §404.911(b). The Director or his or her delegate will consider your comments before taking any further action on your case.

[51 FR 302, Jan. 3, 1986]

§404.919 Notice of another person's request for reconsideration.

If any other person files a request for reconsideration of the initial determination in your case, we shall notify you at your last known address before we reconsider the initial determination. We shall also give you an opportunity to present any evidence you think helpful to the reconsidered determination.

[45 FR 52081, Aug. 5, 1980. Redesignated at 51 FR 302, Jan. 3, 1986]

§404.920 Reconsidered determination.

After you or another person requests a reconsideration, we shall review the evidence considered in making the initial determination and any other evidence we receive. We shall make our determination based on this evidence.

[45 FR 52081, Aug. 5, 1980. Redesignated at 51 FR 302, Jan. 3, 1986]

§404.921 Effect of a reconsidered determination.

The reconsidered determination is binding unless—

(a) You or any other party to the reconsideration requests a hearing before an administrative law judge within the stated time period and a decision is made;

(b) The expedited appeals process is used; or

(c) The reconsidered determination is revised.

[51 FR 302, Jan. 3, 1986]

§404.922 Notice of a reconsidered determination.

We shall mail a written notice of the reconsidered determination to the parties at their last known address. We shall state the specific reasons for the determination and tell you and any other parties of the right to a hearing. If it is appropriate, we will also tell you and any other parties how to use the expedited appeals process.

[45 FR 52081, Aug. 5, 1980. Redesignated at 51 FR 302, Jan. 3, 1986]

EXPEDITED APPEALS PROCESS

§404.923 Expedited appeals process—general.

By using the expedited appeals process you may go directly to a Federal district court without first completing the administrative review process that is generally required before the court will hear your case.

§404.924 When the expedited appeals process may be used.

You may use the expedited appeals process if all of the following requirements are met:

(a) We have made an initial and a reconsidered determination; an administrative law judge has made a hearing decision; or Appeals Council review has been requested, but a final decision has not been issued.

(b) You are a party to the reconsidered determination or the hearing decision.

(c) You have submitted a written request for the expedited appeals process.

(d) You have claimed, and we agree, that the only factor preventing a favorable determination or decision is a provision in the law that you believe is unconstitutional.

(e) If you are not the only party, all parties to the determination or decision agree to request the expedited appeals process.

§ 404.925 How to request expedited appeals process.

(a) *Time of filing request.* You may request the expedited appeals process—

(1) Within 60 days after the date you receive notice of the reconsidered determination (or within the extended time period if we extend the time as provided in paragraph (c) of this section);

(2) At any time after you have filed a timely request for a hearing but before you receive notice of the administrative law judge's decision;

(3) Within 60 days after the date you receive a notice of the administrative law judge's decision or dismissal (or within the extended time period if we extend the time as provided in paragraph (c) of this section); or

(4) At any time after you have filed a timely request for Appeals Council review, but before you receive notice of the Appeals Council's action.

(b) *Place of filing request.* You may file a written request for the expedited appeals process at one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board if you have 10 or more years of service in the railroad industry.

(c) *Extension of time to request expedited appeals process.* If you want to use the expedited appeals process but do not request it within the stated time period, you may ask for more time to submit your request. Your request for an extension of time must be in writing and must give the reasons why the request for the expedited appeals process was not filed within the stated time period. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

§ 404.926 Agreement in expedited appeals process.

If you meet all the requirements necessary for the use of the expedited appeals process, our authorized representative shall prepare an agreement. The agreement must be signed by you, by every other party to the determination or decision and by our authorized representative. The agreement must provide that—

(a) The facts in your claim are not in dispute;

(b) The sole issue in dispute is whether a provision of the Act that applies to your case is unconstitutional;

(c) Except for your belief that a provision of the Act is unconstitutional, you agree with our interpretation of the law;

(d) If the provision of the Act that you believe is unconstitutional were not applied to your case, your claim would be allowed; and

(e) Our determination or the decision is final for the purpose of seeking judicial review.

§ 404.927 Effect of expedited appeals process agreement.

After an expedited appeals process agreement is signed, you will not need to complete the remaining steps of the administrative review process. Instead, you may file an action in a Federal district court within 60 days after the date you receive notice (a signed copy of the agreement will be mailed to you and will constitute notice) that the agreement has been signed by our authorized representative.

[45 FR 52081, Aug. 5, 1980, as amended at 49 FR 46369, Nov. 26, 1984]

§ 404.928 Expedited appeals process request that does not result in agreement.

If you do not meet all of the requirements necessary to use the expedited appeals process, we shall tell you that your request to use this process is denied and that your request will be considered as a request for a hearing or Appeals Council review, whichever is appropriate.

HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

§ 404.929 Hearing before an administrative law judge—general.

If you are dissatisfied with one of the determinations or decisions listed in § 404.930 you may request a hearing. The Associate Commissioner for Hearings and Appeals, or his or her delegate, shall appoint an administrative law judge to conduct the hearing. If circumstances warrant, the Associate Commissioner, or his or her delegate, may assign your case to another administrative law judge. At the hearing you may appear in person, submit new evidence, examine the evidence used in making the determination or decision under review, and present and question witnesses. The administrative law judge who conducts the hearing may ask you questions. He or she shall issue a decision based on the hearing record. If you waive your right to appear at the hearing, the administrative law judge will make a decision based on the evidence that is in the file and any new evidence that may have been submitted for consideration.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 302, Jan. 3, 1986]

§ 404.930 Availability of a hearing before an administrative law judge.

(a) You or another party may request a hearing before an administrative law judge if we have made—

(1) A reconsidered determination;

(2) A revised determination of an initial determination, unless the revised determination concerns the issue of whether, based on medical factors, you are disabled;

(3) A reconsideration of a revised initial determination concerning the issue of whether, based on medical factors, you are disabled;

(4) A revised reconsidered determination; or

(5) A revised decision based on evidence not included in the record on which the prior decision was based.

(b) We will hold a hearing only if you or another party to the hearing file a written request for a hearing.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.932 Parties to a hearing before an administrative law judge.

(a) *Who may request a hearing.* You may request a hearing if a hearing is available under § 404.930. In addition, a person who shows in writing that his or her rights may be adversely affected by the decision may request a hearing.

(b) *Who are parties to a hearing.* After a request for a hearing is made, you, the other parties to the initial, reconsidered, or revised determination, and any other person who shows in writing that his or her rights may be adversely affected by the hearing, are parties to the hearing. In addition, any other person may be made a party to the hearing if his or her rights may be adversely affected by the decision, and the administrative law judge notifies the person to appear at the hearing or to present evidence supporting his or her interest.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.933 How to request a hearing before an administrative law judge.

(a) *Written request.* You may request a hearing by filing a written request. You should include in your request—

(1) The name and social security number of the wage earner;

(2) The reasons you disagree with the previous determination or decision;

(3) A statement of additional evidence to be submitted and the date you will submit it; and

(4) The name and address of any designated representative.

(b) *When and where to file.* The request must be filed—

(1) Within 60 days after the date you receive notice of the previous determination or decision (or within the extended time period if we extend the time as provided in paragraph (c) of this section);

(2) At one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board for persons having 10 or more years of service in the railroad industry.

(c) *Extension of time to request a hearing.* If you have a right to a hearing but do not request one in time, you may ask for more time to make your request. The request for an extension of

time must be in writing and it must give the reasons why the request for a hearing was not filed within the stated time period. You may file your request for an extension of time at one of our offices. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.935 Submitting evidence prior to a hearing before an administrative law judge.

If possible, the evidence or a summary of evidence you wish to have considered at the hearing should be submitted to the administrative law judge with the request for hearing or within 10 days after filing the request. Each party shall make every effort to be sure that all material evidence is received by the administrative law judge or is available at the time and place set for the hearing.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.936 Time and place for a hearing before an administrative law judge.

(a) The administrative law judge sets the time and place for the hearing. He or she may change the time and place, if it is necessary. After sending the parties reasonable notice of the proposed action, the administrative law judge may adjourn or postpone the hearing or reopen it to receive additional evidence any time before he or she notifies the parties of a hearing decision. Hearings are held in the 50 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, the Commonwealth of Puerto Rico and the Virgin Islands.

(b) If you object to the time or place of the hearing, you must notify the administrative law judge at the earliest possible opportunity before the time set for the hearing. You must state the reason for your objection and state the time and place you want the hearing to be held. If at all possible, the request should be in writing. The administrative law judge will change the time or place of the hearing if you have good cause, as determined under paragraphs (c) and (d) of this section. § 404.938 provides procedures we will follow when you do not respond to a notice of hearing.

(c) The administrative law judge will find good cause for changing the time or place of your scheduled hearing, and will reschedule your hearing if your reason is one of the following circumstances and is supported by the evidence:

(1) You or your representative are unable to attend or to travel to the scheduled hearing because of a serious physical or mental condition, incapacitating injury, or death in the family; or

(2) Severe weather conditions make it impossible to travel to the hearing.

(d) In determining whether good cause exists in circumstances other than those set out in paragraph (c) of this section, the administrative law judge will consider your reason for requesting the change, the facts supporting it, and the impact of the proposed change on the efficient administration of the hearing process. Factors affecting the impact of the change include, but are not limited to, the effect on the processing of other scheduled hearings, delays which might occur in rescheduling your hearing, and whether any prior changes were granted to you. Examples of such other circumstances, which you might give for requesting a change in the time or place of the hearing, include, but are not limited to, the following:

(1) You have attempted to obtain a representative but need additional time;

(2) Your representative was appointed within 30 days of the scheduled hearing and needs additional time to prepare for the hearing;

(3) Your representative has a prior commitment to be in court or at another administrative hearing on the date scheduled for the hearing;

(4) A witness who will testify to facts material to your case would be unavailable to attend the scheduled hearing and the evidence cannot be otherwise obtained;

(5) Transportation is not readily available for you to travel to the hearing;

(6) You live closer to another hearing site; or

(7) You are unrepresented, and you are unable to respond to the notice of hearing because of any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

[45 FR 52081, Aug. 5, 1980, as amended at 50 FR 21438, May 24, 1985; 51 FR 303, Jan. 3, 1986; 59 FR 1634, Jan. 12, 1994]

§ 404.938 Notice of a hearing before an administrative law judge.

After the administrative law judge sets the time and place of the hearing, notice of the hearing will be mailed to the parties at their last known addresses, or given by personal service, unless you have indicated in writing that you do not wish to receive this notice. The notice will be mailed or served at least 20 days before the hearing. The notice of hearing will contain a statement of the specific issues to be decided and tell you that you may designate a person to represent you during the proceedings. The notice will also contain an explanation of the procedures for requesting a change in the time or place of your hearing, a reminder that if you fail to appear at your scheduled hearing without good cause the ALJ may dismiss your hearing request, and other information about the scheduling and conduct of your hearing. If you or your representative do not acknowledge receipt of the notice of hearing, we will attempt to contact you for an explanation. If you tell us that you did not receive the notice of hearing, an amended notice will be sent to you by certified mail. See § 404.936 for the procedures we will follow in deciding whether the time or place of your scheduled hearing will be changed if you do not respond to the notice of hearing.

[50 FR 21438, May 24, 1985, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.939 Objections to the issues.

If you object to the issues to be decided upon at the hearing, you must notify the administrative law judge in writing at the earliest possible opportunity before the time set for the hearing. You must state the reasons for your objections. The administrative law judge shall make a decision on your objections either in writing or at the hearing.

§ 404.940 Disqualification of the administrative law judge.

An administrative law judge shall not conduct a hearing if he or she is prejudiced or partial with respect to any party or has any interest in the matter pending for decision. If you object to the administrative law judge who will conduct the hearing, you must notify the administrative law judge at your earliest opportunity. The administrative law judge shall consider your objections and shall decide whether to proceed with the hearing or withdraw. If he or she withdraws, the Associate Commissioner for Hearings and Appeals, or his or her delegate, will appoint another administrative law judge to conduct the hearing. If the administrative law judge does not withdraw, you may, after the hearing, present your objections to the Appeals Council as reasons why the hearing decision should be revised or a new hearing held before another administrative law judge.

§ 404.941 Prehearing case review.

(a) *General.* After a hearing is requested but before it is held, we may, for the purposes of a prehearing case review, forward the case to the component of our office (including a State agency) that issued the determination being reviewed. That component will decide whether the determination may be revised. A revised determination may be wholly or partially favorable to you. A prehearing case review will not delay the scheduling of a hearing unless you agree to continue the review and delay the hearing. If the prehearing case review is not completed before the date of the hearing, the case will be sent to the administrative law judge unless a favorable revised determination is in process or you and the other parties to the hearing agree in writing to delay the hearing until the review is completed.

(b) *When a prehearing case review may be conducted.* We may conduct a prehearing case review if—

(1) Additional evidence is submitted;

(2) There is an indication that additional evidence is available;

(3) There is a change in the law or regulation; or

(4) There is an error in the file or some other indication that the prior determination may be revised.

(c) *Notice of a prehearing revised determination.* If we revise the determination in a prehearing case review, we shall mail written notice of the revised determination to all parties at their last known address. We shall state the basis for the revised determination and advise all parties of their right to request a hearing on the revised determination within 60 days after the date or receiving this notice.

(d) *Revised determination wholly favorable.* If the revised determination is wholly favorable to you, we shall tell you in the notice that the administrative law judge will dismiss the hearing request unless a party requests that the hearing proceed. A request to continue must be made in writing within 30 days after the date the notice of the revised determination is mailed.

(e) *Revised determination partially favorable.* If the revised determination is partially favorable to you, we shall tell you in the notice what was not favorable. We shall also tell you that the hearing you requested will be held unless you, the parties to the revised determination and the parties to the hearing tell us that all parties agree to dismiss the hearing request.

§ 404.942 Prehearing proceedings and decisions by attorney advisors.

(a) *General.* After a hearing is requested but before it is held, an attorney advisor in our Office of Hearings and Appeals may conduct prehearing proceedings as set out in paragraph (c) of this section. If upon the completion of these proceedings, a decision that is wholly favorable to you and all other parties may be made, an attorney advisor, instead of an administrative law judge, may issue such a decision. The conduct of the prehearing proceedings by the attorney advisor will not delay the scheduling of a hearing. If the prehearing proceedings are not completed before the date of the hearing, the case will be sent to the administrative law judge unless a wholly favorable decision is in process or you and all other parties to the hearing agree in writing to delay the hearing until the proceedings are completed.

(b) *When prehearing proceedings may be conducted by an attorney advisor.* An attorney advisor may conduct prehearing proceedings if you have filed a claim for benefits based on disability and—

(1) New and material evidence is submitted;

(2) There is an indication that additional evidence is available;

(3) There is a change in the law or regulations; or

(4) There is an error in the file or some other indication that a wholly favorable decision may be issued.

(c) *Nature of the prehearing proceedings that may be conducted by an attorney advisor.* As part of the prehearing proceedings, the attorney advisor, in addition to reviewing the existing record, may—

(1) Request additional evidence that may be relevant to the claim, including medical evidence; and

(2) If necessary to clarify the record for the purpose of determining if a wholly favorable decision is warranted, schedule a conference with the parties.

(d) *Notice of a decision by an attorney advisor.* If the attorney advisor issues a wholly favorable decision under this section, we shall mail a written notice of the decision to all parties at their last known address. We shall state the basis for the decision and advise all parties that an administrative law judge will dismiss the hearing request unless a party requests that the hearing proceed. A request to proceed with the hearing must be made in writing within 30 days after the date the notice of the decision of the attorney advisor is mailed.

(e) *Effect of actions under this section.* If under this section, an administrative law judge dismisses a request for a hearing, the dismissal is binding in accordance with § 404.959 unless it is vacated by an administrative law judge or the Appeals Council pursuant to § 404.960. A decision made by an attorney advisor under this section is binding unless—

(1) A party files a request to proceed with the hearing pursuant to paragraph

(d) of this section and an administrative law judge makes a decision;

(2) The Appeals Council reviews the decision on its own motion pursuant to § 404.969 as explained in paragraph (f)(3) of this section; or

(3) The decision of the attorney advisor is revised under the procedures explained in § 404.987.

(f) *Ancillary provisions.* For the purposes of the procedures authorized by this section, the regulations of Part 404 shall apply to—

(1) Authorize an attorney advisor to exercise the functions performed by an administrative law judge under §§ 404.1520a and 404.1546;

(2) Define the term ''decision'' to include a decision made by an attorney advisor, as well as the decisions identified in § 404.901; and

(3) Make the decision of an attorney advisor subject to review by the Appeals Council under § 404.969 if an administrative law judge dismisses the request for a hearing following issuance of the decision, and the Appeals Council decides to review the decision of the attorney advisor anytime within 60 days after the date of the dismissal.

(g) *Sunset provision.* The provisions of this section will no longer be effective on June 30, 1997 unless they are extended by the Commissioner of Social Security by publication of a final rule in the FEDERAL REGISTER.

[60 FR 34131, June 30, 1995]

§ 404.943 Responsibilities of the adjudication officer.

(a)(1) *General.* Under the procedures set out in this section we will test modifications to the procedures we follow when you file a request for a hearing before an administrative law judge in connection with a claim for benefits based on disability where the question of whether you are under a disability as defined in § 404.1505 is at issue. These modifications will enable us to test the effect of having an adjudication officer be your primary point of contact after you file a hearing request and before you have a hearing with an administrative law judge. The tests may be conducted alone, or in combination with the tests of the modifications to the disability determination procedures which we conduct under § 404.906. The adjudication officer, working with you and your representative, if any, will identify issues in dispute, develop evidence, conduct informal conferences, and conduct any other prehearing proceeding as may be necessary. The adjudication officer has the authority to make a decision wholly favorable to you if the evidence so warrants. If the adjudication officer does not make a decision on your claim, your hearing request will be assigned to an administrative law judge for further proceedings.

(2) *Procedures for cases included in the tests.* Prior to commencing tests of the adjudication officer position in selected site(s), we will publish a notice in the FEDERAL REGISTER. The notice will describe where the specific test site(s) will be and the duration of the test(s). We will also state whether the tests of the adjudication officer position in each site will be conducted alone, or in combination with the tests of the modifications to the disability determination procedures which we conduct under § 404.906. The individuals who participate in the test(s) will be assigned randomly to a test group in each site where the tests are conducted.

(b)(1) *Prehearing procedures conducted by an Adjudication Officer.* When you file a request for a hearing before an administrative law judge in connection with a claim for benefits based on disability where the question of whether you are under a disability as defined in § 404.1505 is at issue, the adjudication officer will conduct an interview with you. The interview may take place in person, by telephone, or by videoconference, as the adjudication officer determines is appropriate under the circumstances of your case. If you file a request for an extension of time to request a hearing in accordance with § 404.933(c), the adjudication officer may develop information on, and may decide where the adjudication officer issues a wholly favorable decision to you that you had good cause for missing the deadline for requesting a hearing. To determine whether you had good cause for missing the deadline, the adjudication officer will use the standards contained in § 404.911.

(2) *Representation.* The adjudication officer will provide you with information regarding the hearing process, including your right to representation. As may be appropriate, the adjudication officer will provide you with referral sources for representation, and give you copies of necessary documents to facilitate the appointment of a representative. If you have a representative, the adjudication officer will conduct an informal conference with the representative, in person or by telephone, to identify the issues in dispute and prepare proposed written agreements for the approval of the administrative law judge regarding those issues which are not in dispute and those issues proposed for the hearing. If you decide to proceed without representation, the adjudication officer may hold an informal conference with you. If you obtain representation after the adjudication officer has concluded that your case is ready for a hearing, the administrative law judge will return your case to the adjudication officer who will conduct an informal conference with you and your representative.

(3) *Evidence.* You, or your representative, may submit, or may be asked to obtain and submit, additional evidence to the adjudication officer. As the adjudication officer determines is appropriate under the circumstances of your case, the adjudication officer may refer the claim for further medical or vocational evidence.

(4) *Referral for a hearing.* The adjudication officer will refer the claim to the administrative law judge for further proceedings when the development of evidence is complete, and you or your representative agree that a hearing is ready to be held. If you or your representative are unable to agree with the adjudication officer that the development of evidence is complete, the adjudication officer will note your disagreement and refer the claim to the administrative law judge for further proceedings. At this point, the administrative law judge conducts all further hearing proceedings, including scheduling and holding a hearing (§ 404.936), considering any additional evidence or arguments submitted (§§ 404.935, 404.944, 404.949, 404.950), and issuing a decision or dismissal of your request for a hearing, as may be appropriate (§§ 404.948, 404.953, 404.957). In addition, if the administrative law judge determines on or before the date of your hearing that the development of evidence is not complete, the administrative law judge may return the claim to the adjudication officer to complete the development of the evidence and for such other action as necessary.

(c)(1) *Wholly favorable decisions issued by an adjudication officer.* If, after a hearing is requested but before it is held, the adjudication officer decides that the evidence in your case warrants a decision which is wholly favorable to you, the adjudication officer may issue such a decision. For purposes of the tests authorized under this section, the adjudication officer's decision shall be considered to be a decision as defined in § 404.901. If the adjudication officer issues a decision under this section, it will be in writing and will give the findings of fact and the reasons for the decision. The adjudication officer will evaluate the issues relevant to determining whether or not you are disabled in accordance with the provisions of the Social Security Act, the rules in this part and part 422 of this chapter and applicable Social Security Rulings. For cases in which the adjudication officer issues a decision, he or she may determine your residual functional capacity in the same manner that an administrative law judge is authorized to do so in § 404.1546. The adjudication officer may also evaluate the severity of your mental impairments in the same manner that an administrative law judge is authorized to do so under § 404.1520a. The adjudication officer's decision will be based on the evidence which is included in the record and, subject to paragraph (c)(2) of this section, will complete the actions that will be taken on your request for hearing. A copy of the decision will be mailed to all parties at their last known address. We will tell you in the notice that the administrative law judge will not hold a hearing unless a party to the hearing requests that the hearing proceed. A request to proceed with the hearing must be made in writing within 30 days after the date

the notice of the decision of the adjudication officer is mailed.

(2) *Effect of a decision by an adjudication officer.* A decision by an adjudication officer which is wholly favorable to you under this section, and notification thereof, completes the administrative action on your request for hearing and is binding on all parties to the hearing and not subject to further review, unless—

(i) You or another party requests that the hearing continue, as provided in paragraph (c)(1) of this section;

(ii) The Appeals Council decides to review the decision on its own motion under the authority provided in § 404.969;

(iii) The decision is revised under the procedures explained in §§ 404.987 through 404.989; or

(iv) In a case remanded by a Federal court, the Appeals Council assumes jurisdiction under the procedures in § 404.984.

(3) *Fee for a representative's services.* The adjudication officer may authorize a fee for your representative's services if the adjudication officer makes a decision on your claim that is wholly favorable to you, and you are represented. The actions of, and any fee authorization made by, the adjudication officer with respect to representation will be made in accordance with the provisions of subpart R of this part.

(d) *Who may be an adjudication officer.* The adjudication officer described in this section may be an employee of the Social Security Administration or a State agency that makes disability determinations for us.

[60 FR 47475, Sept. 13, 1995]

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURES

§ 404.944 Administrative law judge hearing procedures—general.

A hearing is open to the parties and to other persons the administrative law judge considers necessary and proper. At the hearing, the administrative law judge looks fully into the issues, questions you and the other witnesses, and accepts as evidence any documents that are material to the issues. The administrative law judge may stop the hearing temporarily and continue it at a later date if he or she believes that there is material evidence missing at the hearing. The administrative law judge may also reopen the hearing at any time before he or she mails a notice of the decision in order to receive new and material evidence. The administrative law judge may decide when the evidence will be presented and when the issues will be discussed.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.946 Issues before an administrative law judge.

(a) *General.* The issues before the administrative law judge include all the issues brought out in the initial, reconsidered or revised determination that were not decided entirely in your favor. However, if evidence presented before or during the hearing causes the administrative law judge to question a fully favorable determination, he or she will notify you and will consider it an issue at the hearing.

(b) *New issues*—(1) *General.* The administrative law judge may consider a new issue at the hearing if he or she notifies you and all the parties about the new issue any time after receiving the hearing request and before mailing notice of the hearing decision. The administrative law judge or any party may raise a new issue; an issue may be raised even though it arose after the request for a hearing and even though it has not been considered in an initial or reconsidered determination. However, it may not be raised if it involves a claim that is within the jurisdiction of a State agency under a Federal-State agreement concerning the determination of disability.

(2) *Notice of a new issue.* The administrative law judge shall notify you and any other party if he or she will consider any new issue. Notice of the time and place of the hearing on any new issues will be given in the manner described in § 404.938, unless you have indicated in writing that you do not wish to receive the notice.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.948 Deciding a case without an oral hearing before an administrative law judge.

(a) *Decision wholly favorable.* If the evidence in the hearing record supports a finding in favor of you and all the parties on every issue, the administrative law judge may issue a hearing decision without holding an oral hearing. However, the notice of the decision will inform you that you have the right to an oral hearing and that you have a right to examine the evidence on which the decision is based.

(b) *Parties do not wish to appear.* (1) The administrative law judge may decide a case on the record and not conduct an oral hearing if—

(i) You and all the parties indicate in writing that you do not wish to appear before the administrative law judge at an oral hearing; or

(ii) You live outside the United States and you do not inform us that you want to appear and there are no other parties who wish to appear.

(2) When an oral hearing is not held, the administrative law judge shall make a record of the material evidence. The record will include the applications, written statements, certificates, reports, affidavits, and other documents that were used in making the determination under review and any additional evidence you or any other party to the hearing present in writing. The decision of the administrative law judge must be based on this record.

(c) *Case remanded for a revised determination.* (1) The administrative law judge may remand a case to the appropriate component of our office for a revised determination if there is reason to believe that the revised determination would be fully favorable to you. This could happen if the administrative law judge receives new and material evidence or if there is a change in the law that permits the favorable determination.

(2) Unless you request the remand, the administrative law judge shall notify you that your case has been remanded and tell you that if you object, you must notify him or her of your objections within 10 days of the date the case is remanded or we will assume that you agree to the remand. If you object to the remand, the administrative law judge will consider the objection and rule on it in writing.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.949 Presenting written statements and oral arguments.

You or a person you designate to act as your representative may appear before the administrative law judge to state your case, to present a written summary of your case, or to enter written statements about the facts and law material to your case in the record. A copy of your written statements should be filed for each party.

§ 404.950 Presenting evidence at a hearing before an administrative law judge.

(a) *The right to appear and present evidence.* Any party to a hearing has the right to appear before the administrative law judge, either personally or by means of a designated representative, to present evidence and to state his or her position.

(b) *Waiver of the right to appear.* You may send the administrative law judge a waiver or a written statement indicating that you do not wish to appear at the hearing. You may withdraw this waiver any time before a notice of the hearing decision is mailed to you. Even if all of the parties waive their right to appear at a hearing, the administrative law judge may notify them of a time and a place for an oral hearing, if he or she believes that a personal appearance and testimony by you or any other party is necessary to decide the case.

(c) *What evidence is admissible at a hearing.* The administrative law judge may receive evidence at the hearing even though the evidence would not be admissible in court under the rules of evidence used by the court.

(d) *Subpoenas.* (1) When it is reasonably necessary for the full presentation of a case, an administrative law judge or a member of the Appeals Council may, on his or her own initiative or at the request of a party, issue subpoenas for the appearance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing.

(2) Parties to a hearing who wish to subpoena documents or witnesses must file a written request for the issuance of a subpoena with the administrative law judge or at one of our offices at least 5 days before the hearing date. The written request must give the names of the witnesses or documents to be produced; describe the address or location of the witnesses or documents with sufficient detail to find them; state the important facts that the witness or document is expected to prove; and indicate why these facts could not be proven without issuing a subpoena.

(3) We will pay the cost of issuing the subpoena.

(4) We will pay subpoenaed witnesses the same fees and mileage they would receive if they had been subpoenaed by a Federal district court.

(e) *Witnesses at a hearing.* Witnesses may appear at a hearing. They shall testify under oath or affirmation, unless the administrative law judge finds an important reason to excuse them from taking an oath or affirmation. The administrative law judge may ask the witnesses any questions material to the issues and shall allow the parties or their designated representatives to do so.

(f) *Collateral estoppel—issues previously decided.* An issue at your hearing may be a fact that has already been decided in one of our previous determinations or decisions in a claim involving the same parties, but arising under a different title of the Act or under the Federal Coal Mine Health and Safety Act. If this happens, the administrative law judge will not consider the issue again, but will accept the factual finding made in the previous determination or decision unless there are reasons to believe that it was wrong.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.951 When a record of a hearing before an administrative law judge is made.

The administrative law judge shall make a complete record of the hearing proceedings. The record will be prepared as a typed copy of the proceedings if—

(a) The case is sent to the Appeals Council without a decision or with a recommended decision by the administrative law judge;

(b) You seek judicial review of your case by filing an action in a Federal district court within the stated time period, unless we request the court to remand the case; or

(c) An administrative law judge or the Appeals Council asks for a written record of the proceedings.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.952 Consolidated hearing before an administrative law judge.

(a) *General.* (1) A consolidated hearing may be held if—

(i) You have requested a hearing to decide your benefit rights under title II of the Act and you have also requested a hearing to decide your rights under another law we administer; and

(ii) One or more of the issues to be considered at the hearing you requested are the same issues that are involved in another claim you have pending before us.

(2) If the administrative law judge decides to hold the hearing on both claims, he or she decides both claims, even if we have not yet made an initial or reconsidered determination on the other claim.

(b) *Record, evidence, and decision.* There will be a single record at a consolidated hearing. This means that the evidence introduced in one case becomes evidence in the other(s). The administrative law judge may make either a separate or consolidated decision.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.953 The decision of an administrative law judge.

(a) *General.* The administrative law judge shall issue a written decision that gives the findings of fact and the reasons for the decision. The decision must be based on evidence offered at the hearing or otherwise included in the record. The administrative law judge shall mail a copy of the decision to all the parties at their last known address. The Appeals Council may also receive a copy of the decision.

(b) *Recommended decision.* Although an administrative law judge will

usually make a decision, he or she may send the case to the Appeals Council with a recommended decision where appropriate. The administrative law judge will mail a copy of the recommended decision to the parties at their last known addresses and send the recommended decision to the Appeals Council.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 54 FR 37792, Sept. 13, 1989]

§ 404.955 The effect of an administrative law judge's decision.

The decision of the administrative law judge is binding on all parties to the hearing unless—

(a) You or another party request a review of the decision by the Appeals Council within the stated time period, and the Appeals Council reviews your case;

(b) You or another party requests a review of the decision by the Appeals Council within the stated time period, the Appeals Council denies your request for review, and you seek judicial review of your case by filing an action in a Federal district court;

(c) The decision is revised by an administrative law judge or the Appeals Council under the procedures explained in § 404.987;

(d) The expedited appeals process is used;

(e) The decision is a recommended decision directed to the Appeals Council; or

(f) In a case remanded by a Federal court, the Appeals Council assumes jurisdiction under the procedures in § 404.984.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 54 FR 37792, Sept. 13, 1989]

§ 404.956 Removal of a hearing request from an administrative law judge to the Appeals Council.

If you have requested a hearing and the request is pending before an administrative law judge, the Appeals Council may assume responsibility for holding a hearing by requesting that the administrative law judge send the hearing request to it. If the Appeals Council holds a hearing, it shall conduct the hearing according to the rules for hearings before an administrative law judge. Notice shall be mailed to all parties at their last known address telling them that the Appeals Council has assumed responsibility for the case.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.957 Dismissal of a request for a hearing before an administrative law judge.

An administrative law judge may dismiss a request for a hearing under any of the following conditions:

(a) At any time before notice of the hearing decision is mailed, you or the party or parties that requested the hearing ask to withdraw the request. This request may be submitted in writing to the administrative law judge or made orally at the hearing.

(b)(1)(i) Neither you nor the person you designate to act as your representative appears at the time and place set for the hearing and you have been notified before the time set for the hearing that your request for hearing may be dismissed without further notice if you did not appear at the time and place of hearing, and good cause has not been found by the administrative law judge for your failure to appear; or

(ii) Neither you nor the person you designate to act as your representative appears at the time and place set for the hearing and within 10 days after the administrative law judge mails you a notice asking why you did not appear, you do not give a good reason for the failure to appear.

(2) In determining good cause or good reason under this paragraph, we will consider any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

(c) The administrative law judge decides that there is cause to dismiss a hearing request entirely or to refuse to consider any one or more of the issues because—

(1) The doctrine of *res judicata* applies in that we have made a previous determination or decision under this subpart about your rights on the same facts and on the same issue or issues, and this previous determination or

decision has become final by either administrative or judicial action;

(2) The person requesting a hearing has no right to it under § 404.930;

(3) You did not request a hearing within the stated time period and we have not extended the time for requesting a hearing under § 404.933(c); or

(4) You die, there are no other parties, and we have no information to show that another person may be adversely affected by the determination that was to be reviewed at the hearing. However, dismissal of the hearing request will be vacated if, within 60 days after the date of the dismissal, another person submits a written request for a hearing on the claim and shows that he or she may be adversely affected by the determination that was to be reviewed at the hearing.

[45 FR 52081, Aug. 5, 1980, as amended at 50 FR 21438, May 24, 1985; 51 FR 303, Jan. 3, 1986; 59 FR 1634, Jan. 12, 1994]

§ 404.958 Notice of dismissal of a request for a hearing before an administrative law judge.

We shall mail a written notice of the dismissal of the hearing request to all parties at their last known address. The notice will state that there is a right to request that the Appeals Council vacate the dismissal action.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.959 Effect of dismissal of a request for a hearing before an administrative law judge.

The dismissal of a request for a hearing is binding, unless it is vacated by an administrative law judge or the Appeals Council.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.960 Vacating a dismissal of a request for a hearing before an administrative law judge.

An administrative law judge or the Appeals Council may vacate any dismissal of a hearing request if, within 60 days after the date you receive the dismissal notice, you request that the dismissal be vacated and show good cause why the hearing request should not have been dismissed. The Appeals Council itself may decide within 60 days after the notice of dismissal is mailed to vacate the dismissal. The Appeals Council shall advise you in writing of any action it takes.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.961 Prehearing and posthearing conferences.

The administrative law judge may decide on his or her own, or at the request of any party to the hearing, to hold a prehearing or posthearing conference to facilitate the hearing or the hearing decision. The administrative law judge shall tell the parties of the time, place and purpose of the conference at least seven days before the conference date, unless the parties have indicated in writing that they do not wish to receive a written notice of the conference. At the conference, the administrative law judge may consider matters in addition to those stated in the notice, if the parties consent in writing. A record of the conference will be made. The administrative law judge shall issue an order stating all agreements and actions resulting from the conference. If the parties do not object, the agreements and actions become part of the hearing record and are binding on all parties.

§ 404.965 [Reserved]

APPEALS COUNCIL REVIEW

§ 404.967 Appeals Council review—general.

If you or any other party is dissatisfied with the hearing decision or with the dismissal of a hearing request, you may request that the Appeals Council review that action. The Appeals Council may deny or dismiss the request for review, or it may grant the request and either issue a decision or remand the case to an administrative law judge. The Appeals Council shall notify the parties at their last known address of the action it takes.

§ 404.968 How to request Appeals Council review.

(a) *Time and place to request Appeals Council review.* You may request Appeals Council review by filing a written request. Any documents or other

evidence you wish to have considered by the Appeals Council should be submitted with your request for review. You may file your request—

(1) Within 60 days after the date you receive notice of the hearing decision or dismissal (or within the extended time period if we extend the time as provided in paragraph (b) of this section);

(2) At one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board if you have 10 or more years of service in the railroad industry.

(b) *Extension of time to request review*. You or any party to a hearing decision may ask that the time for filing a request for the review be extended. The request for an extension of time must be in writing. It must be filed with the Appeals Council, and it must give the reasons why the request for review was not filed within the stated time period. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

§ 404.969 Appeals Council initiates review.

Anytime within 60 days after the date of a hearing decision or dismissal, the Appeals Council itself may decide to review the action that was taken. If the Appeals Council does review the hearing decision or dismissal, notice of the action will be mailed to all parties at their last known address.

§ 404.970 Cases the Appeals Council will review.

(a) The Appeals Council will review a case if—

(1) There appears to be an abuse of discretion by the administrative law judge;

(2) There is an error of law;

(3) The action, findings or conclusions of the administrative law judge are not supported by substantial evidence; or

(4) There is a broad policy or procedural issue that may affect the general public interest.

(b) If new and material evidence is submitted, the Appeals Council shall consider the additional evidence only where it relates to the period on or before the date of the administrative law judge hearing decision. The Appeals Council shall evaluate the entire record including the new and material evidence submitted if it relates to the period on or before the date of the administrative law judge hearing decision. It will then review the case if it finds that the administrative law judge's action, findings, or conclusion is contrary to the weight of the evidence currently of record.

[45 FR 52081, Aug. 5, 1980, as amended at 52 FR 4004, Feb. 9, 1987]

§ 404.971 Dismissal by Appeals Council.

The Appeals Council will dismiss your request for review if you did not file your request within the stated period of time and the time for filing has not been extended. The Appeals Council may also dismiss any proceedings before it if—

(a) You and any other party to the proceedings files a written request for dismissal; or

(b) You or any other party to the proceedings dies and the record clearly shows that dismissal will not adversely affect any other person who wishes to continue the action.

§ 404.972 Effect of dismissal of request for Appeals Council review.

The dismissal of a request for Appeals Council review is binding and not subject to further review.

§ 404.973 Notice of Appeals Council review.

When the Appeals Council decides to review a case, it shall mail a notice to all parties at their last known address stating the reasons for the review and the issues to be considered.

§ 404.974 Obtaining evidence from Appeals Council.

You may request and receive copies or a statement of the documents or other written evidence upon which the hearing decision or dismissal was based and a copy or summary of the transcript of oral evidence. However, you will be asked to pay the costs of

providing these copies unless there is a good reason why you should not pay.

§ 404.975 Filing briefs with the Appeals Council.

Upon request, the Appeals Council shall give you and all other parties a reasonable opportunity to file briefs or other written statements about the facts and law relevant to the case. A copy of each brief or statement should be filed for each party.

§ 404.976 Procedures before Appeals Council on review.

(a) *Limitation of issues.* The Appeals Council may limit the issues it considers if it notifies you and the other parties of the issues it will review.

(b) *Evidence.* (1) The Appeals Council will consider all the evidence in the administrative law judge hearing record as well as any new and material evidence submitted to it which relates to the period on or before the date of the administrative law judge hearing decision. If you submit evidence which does not relate to the period on or before the date of the administrative law judge hearing decision, the Appeals Council will return the additional evidence to you with an explanation as to why it did not accept the additional evidence and will advise you of your right to file a new application. The notice returning the evidence to you will also advise you that if you file a new application within 6 months after the date of the Appeals Council's notice, your request for review will constitute a written statement indicating an intent to claim benefits in accordance with § 404.630. If a new application is filed within 6 months of this notice, the date of the request for review will be used as the filing date for your application.

(2) If additional evidence is needed, the Appeals Council may remand the case to an administrative law judge to receive evidence and issue a new decision. However, if the Appeals Council decides that it can obtain the evidence more quickly, it may do so, unless it will adversely affect your rights.

(c) *Oral argument.* You may request to appear before the Appeals Council to present oral argument. The Appeals Council will grant your request if it decides that your case raises an important question of law or policy or that oral argument would help to reach a proper decision. If your request to appear is granted, the Appeals Council will tell you the time and place of the oral argument at least 10 days before the scheduled date.

[45 FR 52081, Aug. 5, 1980, as amended at 52 FR 4004, Feb. 9, 1987]

§ 404.977 Case remanded by Appeals Council.

(a) *When the Appeals Council may remand a case.* The Appeals Council may remand a case to an administrative law judge so that he or she may hold a hearing and issue a decision or a recommended decision. The Appeals Council may also remand a case in which additional evidence is needed or additional action by the administrative law judge is required.

(b) *Action by administrative law judge on remand.* The administrative law judge shall take any action that is ordered by the Appeals Council and may take any additional action that is not inconsistent with the Appeals Council's remand order.

(c) *Notice when case is returned with a recommended decision.* When the administrative law judge sends a case to the Appeals Council with a recommended decision, a notice is mailed to the parties at their last known address. The notice tells them that the case has been sent to the Appeals Council, explains the rules for filing briefs or other written statements with the Appeals Council, and includes a copy of the recommended decision.

(d) *Filing briefs with and obtaining evidence from the Appeals Council.* (1) You may file briefs or other written statements about the facts and law relevant to your case with the Appeals Council within 20 days of the date that the recommended decision is mailed to you. Any party may ask the Appeals Council for additional time to file briefs or statements. The Appeals Council will extend this period, as appropriate, if you show that you had good cause for missing the deadline.

(2) All other rules for filing briefs with and obtaining evidence from the Appeals Council follow the procedures explained in this subpart.

(e) *Procedures before the Appeals Council.* (1) The Appeals Council, after receiving a recommended decision, will conduct its proceedings and issue its decision according to the procedures explain in this subpart.

(2) If the Appeals Council believes that more evidence is required, it may again remand the case to an administrative law judge for further inquiry into the issues, rehearing, receipt of evidence, and another decision or recommended decision. However, if the Appeals Council decides that it can get the additional evidence more quickly, it will take appropriate action.

§ 404.979 Decision of Appeals Council.

After it has reviewed all the evidence in the administrative law judge hearing record and any additional evidence received, subject to the limitations on Appeals Council consideration of additional evidence in §§ 404.970(b) and 404.976(b), the Appeals Council will make a decision or remand the case to an administrative law judge. The Appeals Council may affirm, modify or reverse the administrative law judge hearing decision or it may adopt, modify or reject a recommended decision. A copy of the Appeals Council's decision will be mailed to the parties at their last known address.

[52 FR 4004, Feb. 9, 1987]

§ 404.981 Effect of Appeals Council's decision or denial of review.

The Appeals Council may deny a party's request for review or it may decide to review a case and make a decision. The Appeals Council's decision, or the decision of the administrative law judge if the request for review is denied, is binding unless you or another party file an action in Federal district court, or the decision is revised. You may file an action in a Federal district court within 60 days after the date you receive notice of the Appeals Council's action.

§ 404.982 Extension of time to file action in Federal district court.

Any party to the Appeals Council's decision or denial of review, or to an expedited appeals process agreement, may request that the time for filing an action in a Federal district court be extended. The request must be in writing and it must give the reasons why the action was not filed within the stated time period. The request must be filed with the Appeals Council, or if it concerns an expedited appeals process agreement, with one of our offices. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

COURT REMAND CASES

§ 404.983 Case remanded by a Federal court.

When a Federal court remands a case to the Secretary for further consideration, the Appeals Council, acting on behalf of the Secretary, may make a decision, or it may remand the case to an administrative law judge with instructions to take action and issue a decision or return the case to the Appeals Council with a recommended decision. If the case is remanded by the Appeals Council, the procedures explained in § 404.977 will be followed. Any issues relating to your claim may be considered by the administrative law judge whether or not they were raised in the administrative proceedings leading to the final decision in your case.

[54 FR 37792, Sept. 13, 1989]

§ 404.984 Appeals Council review of administrative law judge decision in a case remanded by a Federal court.

(a) *General.* In accordance with § 404.983, when a case is remanded by a Federal court for further consideration, the decision of the administrative law judge will become the final decision of the Secretary after remand on your case unless the Appeals Council assumes jurisdiction of the case. The Appeals Council may assume jurisdiction based on written exceptions to the decision of the administrative law judge which you file with the Appeals Council or based on its authority pursuant to paragraph (c) of this section. If the Appeals Council assumes jurisdiction of your case, any issues relating to your claim may be considered by the Appeals Council whether or not they were raised in the administrative

proceedings leading to the final decision in your case or subsequently considered by the administrative law judge in the administrative proceedings following the court's remand order. The Appeals Council will either make a new, independent decision based on the entire record that will be the final decision of the Secretary after remand or remand the case to an administrative law judge for further proceedings.

(b) *You file exceptions disagreeing with the decision of the administrative law judge.* (1) If you disagree with the decision of the administrative law judge, in whole or in part, you may file exceptions to the decision with the Appeals Council. Exceptions may be filed by submitting a written statement to the Appeals Council setting forth your reasons for disagreeing with the decision of the administrative law judge. The exceptions must be filed within 30 days of the date you receive the decision of the administrative law judge or an extension of time in which to submit exceptions must be requested in writing within the 30-day period. A timely request for a 30-day extension will be granted by the Appeals Council. A request for an extension of more than 30 days should include a statement of reasons as to why you need the additional time.

(2) If written exceptions are timely filed, the Appeals Council will consider your reasons for disagreeing with the decision of the administrative law judge and all the issues presented by your case. If the Appeals Council concludes that there is no reason to change the decision of the administrative law judge, it will issue a notice to you addressing your exceptions and explaining why no change in the decision of the administrative law judge is warranted. In this instance, the decision of the administrative law judge is the final decision of the Secretary after remand.

(3) When you file written exceptions to the decision of the administrative law judge, the Appeals Council may assume jurisdiction at any time, even after the 60-day time period which applies when you do not file exceptions. If the Appeals Council assumes jurisdiction, it will make a new, independent decision based on its consideration of the entire record affirming, modifying, or reversing the decision of the administrative law judge or remand the case to an administrative law judge for further proceedings, including a new decision. The new decision of the Appeals Council is the final decision of the Secretary after remand.

(c) *Appeals Council assumes jurisdiction without exceptions being filed.* Any time within 60 days after the date of the decision of the administrative law judge, the Appeals Council may decide to assume jurisdiction of your case even though no written exceptions have been filed. Notice of this action will be mailed to all parties at their last known address. You will be provided with the opportunity to file briefs or other written statements with the Appeals Council about the facts and law relevant to your case. After the briefs or other written statements have been received or the time allowed (usually 30 days) for submitting them has expired, the Appeals Council will either issue a final decision of the Secretary affirming, modifying, or reversing the decision of the administrative law judge, or remand the case to an administrative law judge for further proceedings, including a new decision.

(d) *Exceptions are not filed and the Appeals Council does not otherwise assume jurisdiction.* If no exceptions are filed and the Appeals Council does not assume jurisdiction of your case, the decision of the administrative law judge becomes the final decision of the Secretary after remand.

[54 FR 37792, Sept. 13, 1989; 54 FR 40779, Oct. 3, 1989]

§ 404.985 Application of circuit court law.

The procedures which follow apply to administrative determinations or decisions on claims involving the application of circuit court law.

(a) We will apply a holding in a United States Court of Appeals decision which we determine conflicts with our interpretation of a provision of the Social Security Act or regulations unless the Government seeks further review of that decision or we relitigate the issue presented in the decision in accordance with paragraphs (c) and (d) of this section. We will apply the holding

to claims at all levels of administrative adjudication within the applicable circuit unless the holding, by its nature, applies only at certain levels of adjudication.

(b) When we determine that a United States Court of Appeals holding conflicts with our interpretation of a provision of the Social Security Act or regulations and the Government does not seek further review or is unsuccessful on further review, we will issue a Social Security Acquiescence Ruling that describes the administrative case and the court decision, identifies the issue(s) involved, and explains how we will apply the holding, including, as necessary, how the holding relates to other decisions within the applicable circuit. These rulings will generally be effective on the date of their publication in the FEDERAL REGISTER and will apply to all determinations and decisions made on or after that date. If we make a determination or decision between the date of a circuit court decision and the date we publish an Acquiescence Ruling, the claimant may request application of the published ruling to the prior determination or decision. The claimant must first demonstrate that application of the ruling could change the prior determination or decision. A claimant may so demonstrate by submitting a statement which cites the ruling and indicates what finding or statement in the rationale of the prior determination or decision conflicts with the ruling. If the claimant can so demonstrate, we will readjudicate the claim at the level at which it was last adjudicated in accordance with the ruling. Any readjudication will be limited to consideration of the issue(s) covered by the ruling and any new determination or decision on readjudication will be subject to administrative and judicial review in accordance with this subpart. Our denial of a request for readjudication will not be subject to further administrative or judicial review. If a claimant files a request for readjudication within the sixty day appeal period and we deny that request, we shall extend the time to file an appeal on the merits of the claim to sixty days after the date that we deny the request for readjudication.

(c) After we have published a Social Security Acquiescence Ruling to reflect a holding of a United States Court of Appeals on an issue, we may decide under certain conditions to relitigate that issue within the same circuit. We will relitigate only when the conditions specified in paragraphs (c) (2) and (3) of this section are met, and, in general, one of the events specified in paragraph (c)(1) of this secton occurs.

(1) Activating events: (i) An action by both Houses of Congress indicates that a court case on which an Acquiescence Ruling was based was decided inconsistently with congressional intent, such as may be expressed in a joint resolution, an appropriations restriction, or enactment of legislation which affects a closely analogous body of law;

(ii) A statement in a majority opinion of the same circuit indicates that the court might no longer follow its previous decision if a particular issue were presented again;

(iii) Subsequent circuit court precedent in other circuits supports our interpretation of the Social Security Act or regulations on the issue(s) in question; or

(iv) A subsequent Supreme Court decision presents a reasonable legal basis for questioning a circuit court holding upon which we base a Social Security Acquiescence Ruling.

(2) The General Counsel of the Department of Health and Human Services, after consulting with the Department of Justice, concurs that relitigation of an issue and application of our interpretation of the Social Security Act or regulations at the administrative level within the circuit would be appropriate.

(3) We publish a notice in the FEDERAL REGISTER that we intend to relitigate an Acquiescence Ruling issue and that we will apply our interpretation of the Social Security Act or regulations at the administrative level within the circuit to claims selected for relitigation. The notice will explain why we made this decision.

(d) When we decide to relitigate an issue, we will provide a notice explaining our action to all affected claimants. In adjudicating claims subject to relitigation, decisionmakers throughout the SSA administrative review

process will apply our interpretation of the Social Security Act and regulations, but will also state in written determinations or decisions how the claims would have been decided under the circuit standard. Claims not subject to relitigation will continue to be decided under the Acquiescence Ruling in accordance with the circuit standard. So that affected claimants can be readily identified and any subsequent decision of the circuit court or the Supreme Court can be implemented quickly and efficiently, we will maintain a listing of all claimants who receive this notice and will provide them with the relief ordered by the court.

(e) We will rescind as obsolete a Social Security Acquiescence Ruling and apply our interpretation of the Social Security Act or regulations by publishing a notice in the FEDERAL REGISTER when any of the following events occurs:

(1) The Supreme Court overrules or limits a circuit court holding that was the basis of an Acquiescence Ruling;

(2) A circuit court overrules or limits itself on an issue that was the basis of an Acquiescence Ruling;

(3) A Federal law is enacted that removes the basis for the holding in a decision of a circuit court that was the subject of an Acquiescence Ruling; or

(4) We subsequently clarify, modify or revoke the regulation or ruling that was the subject of circuit court holding that we determined conflicts with our interpretation of the Social Security Act or regulations, or we subsequently publish a new regulation(s) addressing an issue(s) not previously included in our regulations when that issue(s) was the subject of a circuit court holding that conflicted with our interpretation of the Social Security Act or regulations and that holding was not compelled by the statute or Constitution.

[55 FR 1018, Jan. 11, 1990]

REOPENING AND REVISING DETERMINATIONS AND DECISIONS

§ 404.987 Reopening and revising determinations and decisions.

(a) *General.* Generally, if you are dissatisfied with a determination or decision made in the administrative review process, but do not request further review within the stated time period, you lose your right to further review and that determination or decision becomes final. However, a determination or a decision made in your case which is otherwise final and binding may be reopened and revised by us.

(b) *Procedure for reopening and revision.* We may reopen a final determination or decision on our own initiative, or you may ask that a final determination or a decision to which you were a party be reopened. In either instance, if we reopen the determination or decision, we may revise that determination or decision. The conditions under which we may reopen a previous determination or decision, either on our own initiative or at your request, are explained in § 404.988.

[59 FR 8535, Feb. 23, 1994]

§ 404.988 Conditions for reopening.

A determination, revised determination, decision, or revised decision may be reopened—

(a) Within 12 months of the date of the notice of the initial determination, for any reason;

(b) Within four years of the date of the notice of the initial determination if we find good cause, as defined in § 404.989, to reopen the case; or

(c) At any time if—

(1) It was obtained by fraud or similar fault (see § 416.1488(c) of this chapter for factors which we take into account in determining fraud or similar fault);

(2) Another person files a claim on the same earnings record and allowance of the claim adversely affects your claim;

(3) A person previously determined to be dead, and on whose earnings record your entitlement is based, is later found to be alive;

(4) Your claim was denied because you did not prove that a person died, and the death is later established—

(i) By a presumption of death under § 404.721(b); or

(ii) By location or identification of his or her body;

(5) The Railroad Retirement Board has awarded duplicate benefits on the same earnings record;

(6) It either—

(i) Denies the person on whose earnings record your claim is based

gratuitous wage credits for military or naval service because another Federal agency (other than the Veterans Administration) has erroneously certified that it has awarded benefits based on the service; or

(ii) Credits the earnings record of the person on which your claim is based with gratuitous wage credits and another Federal agency (other than the Veterans Administration) certifies that it has awarded a benefit based on the period of service for which the wage credits were granted;

(7) It finds that the claimant did not have insured status, but earnings were later credited to his or her earnings record to correct errors apparent on the face of the earnings record (section 205(c)(5)(C) of the Act), to enter items transferred by the Railroad Retirement Board, which were credited under the Railroad Retirement Act when they should have been credited to the claimant's Social Security earnings record (section 205(c)(5)(D) of the Act), or to correct errors made in the allocation of wages or self-employment income to individuals or periods (section 205(c)(5)(G) of the Act), which would have given him or her insured status at the time of the determination or decision if the earnings had been credited to his or her earnings record at that time, and the evidence of these earnings was in our possession or the possession of the Railroad Retirement Board at the time of the determination or decision;

(8) It is wholly or partially unfavorable to a party, but only to correct clerical error or an error that appears on the face of the evidence that was considered when the determination or decision was made;

(9) It finds that you are entitled to monthly benefits or to a lump sum death payment based on the earnings of a deceased person, and it is later established that:

(i) You were convicted of a felony or an act in the nature of a felony for intentionally causing that person's death; or

(ii) If you were subject to the juvenile justice system, you were found by a court of competent jurisdiction to have intentionally caused that person's death by committing an act which, if committed by an adult, would have been considered a felony or an act in the nature of a felony;

(10) It either—

(i) Denies the person on whose earnings record your claim is based deemed wages for internment during World War II because of an erroneous finding that a benefit based upon the internment has been determined by an agency of the United States to be payable under another Federal law or under a system established by that agency; or

(ii) Awards the person on whose earnings record your claim is based deemed wages for internment during World War II and a benefit based upon the internment is determined by an agency of the United States to be payable under another Federal law or under a system established by that agency; or

(11) It is incorrect because—

(i) You were convicted of a crime that affected your right to receive benefits or your entitlement to a period of disability; or

(ii) Your conviction of a crime that affected your right to receive benefits or your entitlement to a period of disability is overturned.

[45 FR 52081, Aug. 5, 1980, as amended at 49 FR 46369, Nov. 26, 1984; 51 FR 18313, May 19, 1986; 59 FR 1635, Jan. 12, 1994; 60 FR 19165, Apr. 17, 1995]

§ 404.989 Good cause for reopening.

(a) We will find that there is good cause to reopen a determination or decision if—

(1) New and material evidence is furnished;

(2) A clerical error in the computation or recomputation of benefits was made; or

(3) The evidence that was considered in making the determination or decision clearly shows on its face that an error was made.

(b) We will not find good cause to reopen your case if the only reason for reopening is a change of legal interpretation or adminstrative ruling upon which the determination or decision was made.

§ 404.990 Finality of determinations and decisions on revision of an earnings record.

A determination or a decision on a revision of an earnings record may be reopened only within the time period and under the conditions provided in section 205(c) (4) or (5) of the Act, or within 60 days after the date you receive notice of the determination or decision, whichever is later.

§ 404.991 Finality of determinations and decisions to suspend benefit payments for entire taxable year because of earnings.

A determination or decision to suspend benefit payments for an entire taxable year because of earnings may be reopened only within the time period and under the conditions provided in section 203(h)(1)(B) of the Act.

§ 404.991a Late completion of timely investigation.

We may revise a determination or decision after the applicable time period in § 404.988(a) or § 404.988(b) expires if we begin an investigation into whether to revise the determination or decision before the applicable time period expires. We may begin the investigation either based on a request by you or by an action on our part. The investigation is a process of gathering facts after a determination or decision has been reopened to determine if a revision of the determination or decision is applicable.

(a) If we have diligently pursued the investigation to its conclusion, we may revise the determination or decision. The revision may be favorable or unfavorable to you. ''Diligently pursued'' means that in light of the facts and circumstances of a particular case, the necessary action was undertaken and carried out as promptly as the circumstances permitted. Diligent pursuit will be presumed to have been met if we conclude the investigation and if necessary, revise the determination or decision within 6 months from the date we began the investigation.

(b) If we have not diligently pursued the investigation to its conclusion, we will revise the determination or decision if a revision is applicable and if it will be favorable to you. We will not revise the determination or decision if it will be unfavorable to you.

[49 FR 46369, Nov. 26, 1984; 49 FR 48036, Dec. 10, 1984]

§ 404.992 Notice of revised determination or decision.

(a) When a determination or decision is revised, notice of the revision will be mailed to the parties at their last known address. The notice will state the basis for the revised determination or decision and the effect of the revision. The notice will also inform the parties of the right to further review.

(b) If a reconsidered determination that you are disabled, based on medical factors, is reopened for the purpose of being revised, you will be notified, in writing, of the proposed revision and of your right to request that a disability hearing be held before a revised reconsidered determination is issued. If a revised reconsidered determination is issued, you may request a hearing before an administrative law judge.

(c) If an administrative law judge or the Appeals Council proposes to revise a decision, and the revision would be based on evidence not included in the record on which the prior decision was based, you and any other parties to the decision will be notified, in writing, of the proposed action and of your right to request that a hearing be held before any further action is taken. If a revised decision is issued by an administrative law judge, you and any other party may request that it be reviewed by the Appeals Council, or the Appeals Council may review the decision on its own initiative.

(d) If an administrative law judge or the Appeals Council proposes to revise a decision, and the revision would be based only on evidence included in the record on which the prior decision was based, you and any other parties to the decision will be notified, in writing, of the proposed action. If a revised decision is issued by an administrative law judge, you and any other party may request that it be reviewed by the Appeals Council, or the Appeals Council may review the decision on its own initiative.

[51 FR 303, Jan. 3, 1986]

§ 404.993 Effect of revised determination or decision.

A revised determination or decision is binding unless—

(a) You or another party to the revised determination file a written request for reconsideration or a hearing before an administrative law judge, as appropriate;

(b) You or another party to the revised decision file, as appropriate, a request for review by the Appeals Council or a hearing before an administrative law judge;

(c) The Appeals Council reviews the revised decision; or

(d) The revised determination or decision is further revised.

[51 FR 303, Jan. 3, 1986]

§ 404.994 Time and place to request a hearing on revised determination or decision.

You or another party to a revised determination or decision may request, as approporiate, further review or a hearing on the revision by filing a request in writing at one of our offices within 60 days after the date you receive notice of the revision. Further review or a hearing will be held on the revision according to the rules of this subpart.

§ 404.995 Finality of findings when later claim is filed on same earnings record.

If two claims for benefits are filed on the same earnings records, findings of fact made in a determination on the first claim may be revised in determining or deciding the second claim, even though the time limit for revising the findings made in the first claim has passed. However, a finding in connection with a claim that a person was fully or currently insured at the time of filing an application, at the time of death, or any other pertinent time, may be revised only under the conditions stated in § 404.988.

§ 404.996 Increase in future benefits where time period for reopening expires.

If, after the time period for reopening under § 404.988(b) has ended, new evidence is furnished showing a different date of birth or additional earnings for you (or for the person on whose earnings record your claim was based) which would otherwise increase the amount of your benefits, we will make the increase (subject to the limitations provided in section 205(c)(4) and (5) of the Act) but only for benefits payable after the time we received the new evidence. (If the new evidence we receive would lead to a decrease in your benefits, we will take no action if we cannot reopen under § 404.988.)

[49 FR 46369, Nov. 26, 1984]

PAYMENT OF CERTAIN TRAVEL EXPENSES

§ 404.999a Payment of certain travel expenses—general.

When you file a claim for Social Security benefits, you may incur certain travel expenses in pursuing your claim. Sections 404.999b–404.999d explain who may be reimbursed for travel expenses, the types of travel expenses that are reimbursable, and when and how to claim reimbursement. Generally, the agency that requests you to travel will be the agency that reimburses you. No later than when it notifies you of the examination or hearing described in § 404.999b(a), that agency will give you information about the right to travel reimbursement, the right to advance payment and how to request it, the rules on means of travel and unusual travel costs, and the need to submit receipts.

[51 FR 8808, Mar. 14, 1986]

§ 404.999b Who may be reimbursed.

(a) The following individuals may be reimbursed for certain travel expenses—

(1) You, when you attend medical examinations upon request in connection with disability determinations; these are medical examinations requested by the State agency or by us when additional medical evidence is necessary to make a disability determination (also referred to as consultative examinations, see § 404.1517);

(2) You, your representative (see § 404.1705 (a) and (b)), and all unsubpoenaed witnesses we or the State agency determines to be reasonably necessary who attend disability hearings; and

(3) You, your representative, and all unsubpoenaed witnesses we determine to be reasonably necessary who attend hearings on any claim for benefits before an administrative law judge.

(b) Sections 404.999a through 404.999d do not apply to subpoenaed witnesses. They are reimbursed under §§404.950(d) and 404.916(b)(1).

[51 FR 8808, Mar. 14, 1986]

§404.999c What travel expenses are reimbursable.

Reimbursable travel expenses include the ordinary expenses of public or private transportation as well as unusual costs due to special circumstances.

(a) Reimbursement for ordinary travel expenses is limited—

(1) To the cost of travel by the most economical and expeditious means of transportation available and appropriate to the individual's condition of health as determined by the State agency or by us, considering the available means in the following order—

(i) Common carrier (air, rail, or bus);

(ii) Privately owned vehicles;

(iii) Commercially rented vehicles and other special conveyances;

(2) If air travel is necessary, to the coach fare for air travel between the specified travel points involved unless first-class air travel is authorized in advance by the State agency or by the Secretary in instances when—

(i) Space is not available in less-than-first-class accommodations on any scheduled flights in time to accomplish the purpose of the travel;

(ii) First-class accommodations are necessary because you, your representative, or reasonably necessary witness is so handicapped or otherwise impaired that other accommodations are not practical and the impairment is substantiated by competent medical authority;

(iii) Less-than-first-class accommodations on foreign carriers do not provide adequate sanitation or health standards; or

(iv) The use of first-class accommodations would result in an overall savings to the government based on economic considerations, such as the avoidance of additional subsistence costs that would be incurred while awaiting availability of less-than-first-class accommodations.

(b) Unusual travel costs may be reimbursed but must be authorized in advance and in writing by us or the appropriate State official, as applicable, unless they are unexpected or unavoidable; we or the State agency must determine their reasonableness and necessity and must approve them before payment can be made. Unusual expenses that may be covered in connection with travel include, but are not limited to—

(1) Ambulance services;

(2) Attendant services;

(3) Meals;

(4) Lodging; and

(5) Taxicabs.

(c) If we reimburse you for travel, we apply the rules in §§404.999b through 404.999d and the same rates and conditions of payment that govern travel expenses for Federal employees as authorized under 41 CFR chapter 301. If a State agency reimburses you, the reimbursement rates shall be determined by the rules in §§404.999b through 404.999d and that agency's rules and regulations and may differ from one agency to another and also may differ from the Federal reimbursement rates.

(1) When public transportation is used, reimbursement will be made for the actual costs incurred, subject to the restrictions in paragraph (a)(2) of this section on reimbursement for first-class air travel.

(2) When travel is by a privately owned vehicle, reimbursement will be made at the current Federal or State mileage rate specified for that geographic location plus the actual costs of tolls and parking, if travel by a privately owned vehicle is determined appropriate under paragraph (a)(1) of this section. Otherwise, the amount of reimbursement for travel by privately owned vehicle cannot exceed the total cost of the most economical public transportation available for travel between the same two points. *Total cost* includes the cost for all the authorized travelers who travel in the same privately owned vehicle. Advance approval of travel by privately owned vehicle is not required (but could give you assurance of its approval).

(3) Sometimes your health condition dictates a mode of transportation different from the most economical and expeditious. In order for your health to require a mode of transportation other than common carrier or passenger car, you must be so handicapped or otherwise impaired as to require special transportation arrangements and the conditions must be substantiated by competent medical authority.

(d) For travel to a hearing—

(1) Reimbursement is limited to travel within the U.S. For this purpose, the U.S. includes the U.S. as defined in § 404.2(c)(6) and the Northern Mariana Islands.

(2) We or the State agency will reimburse you, your representative, or an unsubpoenaed witness only if the distance from the person's residence or office (whichever he or she travels from) to the hearing site exceeds 75 miles.

(3) For travel expenses incurred on or after April 1, 1991, the amount of reimbursement under this section for travel by your representative to attend a disability hearing or a hearing before an administrative law judge shall not exceed the maximum amount allowable under this section for travel to the hearing site from any point within the geographic area of the office having jurisdiction over the hearing.

(i) The geographic area of the office having jurisdiction over the hearing means, as appropriate—

(A) The designated geographic service area of the State agency adjudicatory unit having responsibility for providing the disability hearing;

(B) If a Federal disability hearing officer holds the disability hearing, the geographic area of the State (which includes a State as defined in § 404.2(c)(5) and also includes the Northern Mariana Islands) in which the claimant resides or, if the claimant is not a resident of a State, in which the hearing officer holds the disability hearing; or

(C) The designated geographic service area of the Office of Hearings and Appeals hearing office having responsibility for providing the hearing before an administrative law judge.

(ii) We or the State agency determine the maximum amount allowable for travel by a representative based on the distance to the hearing site from the farthest point within the appropriate geographic area. In determining the maximum amount allowable for travel between these two points, we or the State agency apply the rules in paragraphs (a) through (c) of this section and the limitations in paragraph (d) (1) and (4) of this section. If the distance between these two points does not exceed 75 miles, we or the State agency will not reimburse any of your representative's travel expenses.

(4) If a change in the location of the hearing is made at your request from the location we or the State agency selected to one farther from your residence or office, neither your additional travel expenses nor the additional travel expenses of your representative and witnesses will be reimbursed.

[51 FR 8808, Mar. 14, 1986, as amended at 59 FR 8532, Feb. 23, 1994]

§ 404.999d When and how to claim reimbursement.

(a)(1) Generally, you will be reimbursed for your expenses after your trip. However, travel advances may be authorized if you request prepayment and show that the requested advance is reasonable and necessary.

(2) You must submit to us or the State agency, as appropriate, an itemized list of what you spent and supporting receipts to be reimbursed.

(3) Arrangements for special means of transportation and related unusual costs may be made only if we or the State agency authorizes the costs in writing in advance of travel, unless the costs are unexpected or unavoidable. If they are unexpected or unavoidable we or the State agency must determine their reasonableness and necessity and must approve them before payment may be made.

(4) If you receive prepayment, you must, within 20 days after your trip, provide to us or the State agency, as appropriate, an itemized list of your actual travel costs and submit supporting receipts. We or the State agency will require you to pay back any balance of the advanced amount that exceeds any approved travel expenses within 20 days after you are notified of the amount of that balance. (State agencies may have their own time

limits in place of the 20-day periods in the preceding two sentences.)

(b) You may claim reimbursable travel expenses incurred by your representative for which you have been billed by your representative, except that if your representative makes a claim for them to us or the State, he or she will be reimbursed directly.

(Approved by the Office of Management and Budget under control number 0960–0434)

[51 FR 8809, Mar. 14, 1986, as amended at 51 FR 44983, Dec. 16, 1986]

Subpart K—Employment, Wages, Self-Employment, and Self-Employment Income

AUTHORITY: Secs. 202(v), 205(a), 209, 210, 211, 229(a), 230, 231, and 702(a)(5) of the Social Security Act (42 U.S.C. 402(v), 405(a), 409, 410, 411, 429(a), 430, 431, and 902(a)(5)).

SOURCE: 45 FR 20075, Mar. 27, 1980, unless otherwise noted.

§ 404.1001 Introduction

(a)(1) In general, your social security benefits are based on your earnings that are on our records. (Subpart I of this part explains how we keep earnings records.) Basically, you receive credit only for earnings that are covered for social security purposes. The earnings are covered only if your work is covered. If you are an employee, your employer files a report of your covered earnings. If you are self-employed, you file a report of your covered earnings. Some work is covered by social security and some work is not. Also, some earnings are covered by social security and some are not. It is important that you are aware of what kinds of work and earnings are covered so that you will know whether your earnings should be on our records.

(2) If you are an employee, your covered work is called *employment*. This subpart explains our rules on the kinds of work that are covered as *employment* and the kinds that are not. We also explain who is an employee.

(3) If your work is *employment*, your covered earnings are called *wages*. This subpart explains our rules on the kinds of earnings that are covered as *wages* and the kinds that are not.

(4) If you work for yourself, you are self-employed. The subpart explains our rules on the kinds of self-employment that are covered and the kinds that are not.

(5) If you are self-employed, your covered earnings are called *self-employment income* which is based on your *net earnings from self-employment* during a taxable year. This subpart explains our rules on the kinds of earnings that are covered as *net earnings from self-employment* and the kinds that are not. We also explain how to figure your *net earnings from self-employment* and determine your *self-employment income* which is the amount that goes on our records.

(b) We include basically only the rules that apply to current work or that the law requires us to publish as regulations. We generally do not include rules that are seldom used or do not apply to current work because of changes in the law.

(c) The Social Security Act and the Internal Revenue Code (Code) have similar provisions on coverage of your earnings because the one law specifies the earnings for which you will receive credit for benefit purposes and the other the earnings on which you must pay social security taxes. Because the Code (title 26 U.S.C.) has some provisions that are not in the Act but which may affect you, you may need to refer to the Code or the Internal Revenue Service regulations (title 26 of the Code of Federal Regulations) to get complete information about your social security coverage.

(d) The rules are organized in the following manner:

(1) Sections 404.1003 through 404.1010 include the rules on employment. We discuss what we mean by employment, what work is covered as employment for social security purposes, and describe the kinds of workers who are considered employees.

(2) In §§ 404.1012 through 404.1037 we discuss various types of work that are not covered as employment for social security purposes.

(3) The rules on wages are found in §§ 404.1041 through 404.1059. We describe what is meant by the term *wages*, discuss the various types of pay that count as wages, and state when the pay counts for Social Security purposes.

We include explanations of agriculture labor, domestic services, service not in the course of the employer's business, and home worker services under *wages* because special standards apply to these services.

(4) Our rules on self-employment and self-employment income are found in §§ 404.1065 through 404.1096. We discuss what we mean by self-employment, what we mean by a trade or business, what types of activities are considered self-employment, how to determine self-employment income, and how net earnings from self-employment are figured.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990]

§ 404.1002 Definitions.

(a) *General definitions.* As used in this subpart—

The *Act* means the Social Security Act, as amended.

The *Code* means the Internal Revenue Code of 1954, as amended.

We, *our*, or *us* means the Social Security Administration.

You or *your* means any person whose earnings from employment or self-employment are included or excluded under social security.

(b) *Other definitions.* For ease of reference, we have placed other definitions in the sections of this subpart in which they are used.

EMPLOYMENT

§ 404.1003 Employment.

Employment means, generally, any service covered by social security performed by an employee for his or her employer. The rules on who is an employee and who is an employer are contained in §§ 404.1005 through 404.1010. Section 404.1004 states the general rule on the kinds of work covered as employment. Exceptions to the general rule are contained in §§ 404.1012 through 404.1037 which explain the kinds of work excluded from employment. All of these rules apply to current work unless otherwise indicated.

§ 404.1004 What work is covered as employment.

(a) *General requirements of employment.* Unless otherwise excluded from coverage under §§ 404.1012 through 404.1037, the work you perform as an employee for your employer is covered as employment under social security if one of the following situations applies:

(1) You perform the work within the United States (whether or not you or your employer are a citizen or resident of the United States).

(2) You perform the work outside the United States and you are a citizen or resident of the United States working for—

(i) An American employer; or

(ii) A foreign affiliate of an American employer that has in effect an agreement covering your work under section 3121(l) of the Code.

(3) You perform the work on or in connection with an American vessel or American aircraft and the conditions in paragraphs (a)(3) (i) and (ii) are met. Your citizenship or residence does not matter. The citizenship or residence of your employer matters only if it affects whether the vessel is an American vessel.

(i) You enter into the contract of employment within the United States or the vessel or aircraft touches at a port or airport within the United States during the performance of your contract of employment on the vessel or aircraft.

(ii) You are employed on and in connection with the vessel or aircraft when outside the United States.

(4) Your work is designated as employment or recognized as equivalent to employment under a totalization agreement. (See § 404.1913. An agreement may exempt work from coverage as well as extend coverage to work.)

(b) *Explanation of terms used in this section.* (1) *American employer* means—

(i) The United States or any of its instrumentalities;

(ii) A State, a political subdivision of a State, or an instrumentality of any one or more States or political subdivisions of a State;

(iii) An individual who is a resident of the United States;

(iv) A partnership, if at least two-thirds of the partners are residents of the United States;

(v) A trust, if all of the trustees are residents of the United States; or

(vi) A corporation organized under the laws of the United States or of any State.

(2) *American aircraft* means an aircraft registered under the laws of the United States.

(3) *American vessel* means a vessel documented or numbered under the laws of the United States. It also includes a vessel neither documented nor numbered under the laws of the United States, nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States, or corporations organized under the laws of the United States or of any State.

(4) *Citizen of the United States* includes a citizen of the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa.

(5) *Foreign affiliate* refers to a foreign affiliate as defined in section 3121(l)(6) of the Code.

(6) *On and in connection with* refers to the performance of work on a vessel or aircraft which concerns the vessel or aircraft. Examples of this kind of work are the services performed on a vessel by employees as officers or crew members, or as employees of concessionaires, of the vessel.

(7) *On or in connection with* refers to work performed on the vessel or aircraft and to work which concerns the vessel or aircraft but not actually performed on it. For example, shore services in connection with repairing, loading, unloading, or provisioning a vessel performed by employees as officers or crew members, or as employees of concessionaires, of the vessel are included, since this work concerns the vessel though not performed on it.

(8) *State* refers to the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

(9) *United States* when used in a geographical sense means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36573, Sept. 9, 1985; 55 FR 51687, Dec. 17, 1990]

§404.1005 Who is an employee.

You must be an employee for your work to be covered as employment for social security purposes. You are an employee if you are—

(a) A corporation officer as described in §404.1006;

(b) A common-law employee as described in §404.1007 (unless you are, after December 31, 1982, a qualified real estate agent or direct seller as described in §404.1069); or

(c) An agent-driver or commission-driver, a full-time life insurance salesman, a home worker, or a traveling or city salesman as described in §404.1008.

[45 FR 20075, Mar. 27, 1980, as amended at 48 FR 40515, Sept. 8, 1983]

§404.1006 Corporation officer.

If you are an officer of a corporation, you are an employee of the corporation if you are paid or you are entitled to be paid for holding office or performing services. However, if you are a director of a corporation, we consider you to be self-employed when you work as a director.

§404.1007 Common-law employee.

(a) *General.* The common-law rules on employer-employee status are the basic test for determining whether you and the person or firm you work for have the relationship of employee and employer. Even though you are considered self-employed under the common-law rules, you may still be an employee for social security purposes under §404.1006 (relating to corporation officers) or §404.1008 (relating to workers in four specific jobs). In general, you are a common-law employee if the person you work for may tell you what to do and how, when, and where to do it. The person or firm you work for does not have to give these orders, but needs only the right to do so. Whether or not you are a common-law employee is not always clear. Several aspects of your job arrangement are considered in determining whether you are an employee or are self-employed under the common-law rules.

(b) *Factors that show employee status.* Some aspects of a job arrangement that may show you are an employee are as follows:

(1) The person you work for may fire you.

(2) The person you work for furnishes you with tools or equipment and a place to work.

(3) You receive training from the person you work for or are required to follow that person's instructions.

(4) You must do the work yourself.

(5) You do not hire, supervise, or pay assistants (unless you are employed as a foreman, manager, or supervisor).

(6) The person you work for sets your hours of work, requires you to work full-time, or restricts you from doing work for others.

(7) The person you work for pays your business or traveling expenses.

(8) You are paid by the hour, week or month.

(c) *Factors that show self-employed status.* Some aspects of a job arrangement or business venture that may show you are self-employed are as follows:

(1) You make a profit or suffer a loss.

(2) You are hired to complete a certain job and if you quit before the job is completed you may be liable for damages.

(3) You work for a number of persons or firms at the same time.

(4) You advertise to the general public that you are available to perform services.

(5) You pay your own expenses and have your own equipment and work place.

(d) *Questions about your status.* If there is a question about whether you are working as an employee or are self-employed, we or the Internal Revenue Service will make a determination after examining all of the facts of your case.

§ 404.1008 Agent-driver or commission-driver, full-time life insurance salesman, home worker, or traveling or city salesman.

(a) *General.* In addition to common-law employees and corporation officers, we consider workers in the four types of jobs described in paragraphs (b) through (e) of this section to be employees if their services are performed under the following conditions:

(1) Under the work arrangement the worker is expected to do substantially all of the work personally.

(2) The worker must not have a substantial investment in the facilities used to do the work. Facilities include such things as a place to work, storage space, equipment, machinery and office furniture. However, facilities do not include tools, equipment or clothing of the kind usually provided by employees nor transportation such as a car or truck.

(3) The work must be performed as part of a continuing work relationship between the worker and the person for whom the work is done. The work performed must not be a single transaction. Part-time and regular seasonal work may be performed as part of a continuing work relationship.

(b) *Agent-driver or commission-driver.* This is a driver hired by another person to distribute meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or dry-cleaning services. We consider you an agent-driver or commission-driver if you are paid a commission based on your sales or the difference between the price you charge your customers and the amount you pay for the goods or services. It makes no difference whether you drive your own truck or the company's truck or whether you solicit the customers you serve.

(c) *Full-time life insurance salesman.* A full-time life insurance salesman's main activity is selling life insurance or annuity contracts, or both, mostly for one life insurance company. If you are a full-time life insurance salesman, you are probably provided office space, stenographic help, telephone, forms, rate books and advertising materials by the company or general agent, without cost to you.

(d) *Home worker.* A home worker is a person who works away from the place of business of the person he or she works for, usually at home. If you are a home worker and you work according to the instructions of the person you work for, on material or goods furnished by that person, and are required to return the finished product to that person (or another person whom he or she designates), you are an employee.

(e) *Traveling or city salesman.* The main activity of a traveling or city salesman is taking orders for

merchandise for another person or firm. The salesman gets orders from wholesalers, retailers, contractors, or operators of hotels, restaurants or other firms whose main business is furnishing food or lodging or both. The salesman sells merchandise to others for resale or for use in their own business. We consider you a traveling or city salesman if most of your work is done for a single person or firm even though you have incidental sideline sales activities. However, you are not an employee under this paragraph as to those sideline sales. If you take orders for a number of persons or firms as a *multiple line* salesman, you are not a traveling or city salesman.

§404.1009 Who is an employer.

A person is an employer if he or she employs at least one employee. Sometimes it is not clear who a worker's employer is, since the employer does not always pay the worker's wages. When there is a question about who the employer is, we use the common-law rules to identify the employer (see §404.1007).

§404.1010 Farm crew leader as employer.

A farm crew leader furnishes workers to do agricultural labor for another person, usually a farm operator. If the crew leader pays the workers (the money can be the crew leader's or the farm operator's), the crew leader is deemed to be the employer of the workers and is self-employed. However, the crew leader is not deemed the employer of the workers if there is a written agreement between the crew leader and the farm operator naming the crew leader as an employee. If the crew leader does not have this agreement and does not pay the workers, we use the common-law rules to determine the crew leader's status.

WORK EXCLUDED FROM EMPLOYMENT

§404.1012 Work excluded from employment.

Certain kinds of work performed by an employee are excluded from employment. They are described in §§404.1014 through 404.1037 and are exceptions to the general rule in §404.1004 on the kinds of work that are covered as employment. In general, if the work performed by an employee is excluded from employment, the work is not covered under social security. However, certain kinds of work performed by an employee, even though excluded from employment, are covered as self-employment for social security purposes. In addition, if part of the work performed by an employee for the same employer is included as employment and part is excluded from employment, all the work may be included or all may be excluded as described in §404.1013.

§404.1013 Included-excluded rule.

(a) If part of your work for an employer during a pay period is covered as employment and part excluded, all of your work during that period is considered covered if at least one-half of your time in the pay period is in covered work. If you spend most of your time in a pay period doing work that is excluded, all of your work in that period is excluded.

(b) A *pay period* is the period for which your employer ordinarily pays you. It cannot be more than 31 consecutive days. If the actual period is not always the same, your usual pay period will be used for applying the included-excluded rule.

(c) The included-excluded rule does not apply and your covered work will be counted if—

(1) Part of your work is covered by the Railroad Retirement Tax Act and part by the Social Security Act; or

(2) You have no usual *pay period* of 31 consecutive days or less, or you have separate pay periods for covered and excluded work.

§404.1014 Domestic service by a student for a local college club, fraternity or sorority.

(a) *General.* If you are a student and do work of a household nature in or about the club rooms or house of a local college club or local chapter of a college fraternity or sorority, and are enrolled and regularly attending classes at a school, college, or university, your work is not covered as employment.

(b) *Explanation of terms.* (1) *Work of a household nature* means the type of work done by cooks, waiters, butlers, maids, janitors, laundresses, furnacemen, handymen, gardeners, housekeepers and housemothers.

(2) A *local college club or local chapter of a college fraternity or sorority* does not include an alumni club or chapter. Also, if the club rooms or house are used mostly for supplying board or lodging to students or nonstudents as a business, the work done is not excluded by this section.

§ 404.1015 Family services.

(a) *General.* If you work as an employee of a relative, the work is excluded from employment if—

(1) You work while under age 18 in the employ of your parent;

(2) You do nonbusiness work (see § 404.1058(a)(3) for an explanation of nonbusiness work) or perform domestic service (as described in § 404.1057(b)) as an employee of your parent while under age 21;

(3) You do nonbusiness work as an employee of your son, daughter, or spouse; or

(4) You perform domestic service in the private home of your son, daughter or spouse as an employee of that son, daughter or spouse unless—

(i) The son or daughter has a child (either natural, adopted or stepchild) living in the home who is under age 18 or, if older, has a mental or physical condition that requires the personal care and supervision of an adult for at least four continuous weeks in the calendar quarter in which the work is done; and

(ii) The son or daughter is a widower or widow, or is divorced and has not remarried, or has a spouse living in the home who, because of a physical or mental condition, is incapable of taking care of the child and the condition is present for at least four continuous weeks in the calendar quarter in which the work is done.

(b) *Family work for other than sole proprietor.* Work for a corporation is not excluded under this section, and work for a partnership is not excluded unless the required family relationship exists between the employee and each of the partners.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59913, Dec. 17, 1992]

§ 404.1016 Foreign agricultural workers.

Farm work done by foreign workers lawfully admitted to the United States on a temporary basis to do farm work is not covered as employment. The excluded work includes any services connected with farm operations.

§ 404.1017 Sharefarmers.

(a) If you are a sharefarmer, your services are not covered as employment, but as self-employment.

(b) You are a sharefarmer if you have an arrangement with the owner or tenant of the land and the arrangement provides for all of the following:

(1) You will produce agricultural or horticultural commodities on the land.

(2) The commodities you produce or the income from their sale will be divided between you and the person with whom you have the agreement.

(3) The amount of your share depends on the amount of commodities you produce.

(c) If under your agreement you are to receive a specific rate of pay, a fixed sum of money or a specific amount of the commodities not based on your production, you are not a sharefarmer for social security purposes.

§ 404.1018 Work by civilians for the United States Government or its instrumentalities—wages paid after 1983.

(a) *General.* If you are a civilian employee of the United States Government or an instrumentality of the United States, your employer will determine the amount of remuneration paid for your work and the periods in or for which such remuneration was paid. We will determine whether your employment is covered under Social Security, the periods of such covered employment, and whether remuneration paid for your work constitutes wages for purposes of Social Security. To make these determinations we will consider the date of your appointment to Federal service, your previous Federal employing agencies and positions

(if any), whether you were covered under Social Security or a Federal civilian retirement system, and whether you made a timely election to join a retirement system established by the Federal Employees' Retirement System Act of 1986 or the Foreign Service Pension System Act of 1986. Using this information and the following rules, we will determine that your service is covered unless—

(1) The service would have been excluded if the rules in effect in January 1983 had remained in effect; and

(i) You have been continuously performing such service since December 31, 1983; or

(ii) You are receiving an annuity from the Civil Service Retirement and Disability Fund or benefits for service as an employee under another retirement system established by a law of the United States and in effect on December 31, 1983, for employees of the Federal Government other than a system for members of the uniformed services.

(2) The service is under the provisions of 28 U.S.C. 294, relating to the assignment of retired Federal justices and judges to active duty.

(b) *Covered services*—(1) *Federal officials.* Any service for which you received remuneration after 1983 is covered if performed—

(i) As the President or the Vice President of the United States;

(ii) In a position placed in the Executive Schedule under 5 U.S.C. 5312 through 5317;

(iii) As a noncareer appointee in the Senior Executive Service or a noncareer member of the Senior Foreign Service;

(iv) In a position to which you are appointed by the President, or his designee, or the Vice President under 3 U.S.C. 105(a)(1), 106(a)(1), or 197(a)(1) or (b)(1) if the maximum rate of basic pay for such position is at or above the rate for level V of the Executive Schedule;

(v) As the Chief Justice of the United States, an Associate Justice of the Supreme Court, a judge of a United States court of appeals, a judge of a United States district court, including the district court of a territory, a judge of the United States Claims Court, a judge of the United States Court of International Trade, a judge of the United States Tax Court, a United States magistrate, or a referee in bankruptcy or United States bankruptcy judge; or

(vi) As a Member, Delegate, or Resident Commissioner of or to the Congress.

(2) *Legislative Branch Employees.* Service you perform for the legislative branch of the Federal Government for which you are paid remuneration after 1983 is generally covered by Social Security if such service is not covered by the Civil Service Retirement System or by another retirement system established by a law of the United States and in effect on December 31, 1983, for employees of the Federal Government other than a system for members of the uniformed services.

(3) *Election to become subject to the Federal Employees' Retirement System or the Foreign Service Pension System.* Your service is covered if:

(i) You timely elect after June 30, 1987, under either the Federal Employees' Retirement System Act or the Central Intelligence Agency Retirement Act, to become subject to the Federal Employees Retirement System provided in 5 U.S.C. 8401 through 8479; or

(ii) You timely elect after June 30, 1987, to become subject to the Foreign Service Pension System provided in 22 U.S.C. 4071 through 4071(k).

(4) *Subsequent Federal civilian service.* If you perform Federal civilian service on or after November 10, 1988, which is described in paragraph (b)(1), (b)(2), or (b)(3) of this section you will continue to be covered for any subsequent Federal Civilian Service not excluded under paragraph (c) of this section.

(c) *Excluded Service.* Notwithstanding § 404.1018a and this section, your service is not covered if performed—

(1) In a penal institution of the United States as an inmate thereof;

(2) As an employee included under 5 U.S.C. 5351(2) relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government, other than as a medical or dental intern or a medical or dental resident in training;

(3) As an employee serving on a temporary basis in case of fire, storm,

earthquake, flood, or other similar emergency; or

(4) Under any other statutory provisions that would require exclusion for reasons other than being in the employ of the Federal Government or an instrumentality of such.

(d) *Work as a Peace Corps Volunteer.* Work performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, 22 U.S.C. 2501 through 2523, is covered as employment.

(e) *Work as Job Corps Enrollee.* Work performed as an enrollee in the Job Corps is considered to be performed in the employ of the United States.

(f) *Work by Volunteer in Service to America.* Work performed and training received as a Volunteer in Service to America is considered to be performed in the employ of the United States if the volunteer is enrolled for a period of service of at least 1 year. If the enrollment is for less than 1 year, we use the common-law rules in § 404.1007 to determine the volunteer's status.

(g) *Meaning of ''continuously performing''*—(1) *Absence of less than 366 days.* You are considered to be continuously performing service described in paragraph (a)(1)(i) of this section if you return to the performance of such service after being separated from such service for a period of less than 366 consecutive days, regardless of whether the period began before, on, or after December 31, 1983.

(2) *Other absences.* You are considered to be continuously performing service described in paragraph (a)(1)(i) of this section regardless of the length of separation or whether the period of separation began before, on, or after December 31, 1983, if you—

(i) Return to the performance of such service after being detailed or transferred from such service to an international organization as described under 5 U.S.C. 3343 or under 5 U.S.C. 3581;

(ii) Are reemployed or reinstated after being separated from such service for the purpose of accepting employment with the American Institute of Taiwan as provided under 22 U.S.C. 3310;

(iii) Return to the performance of such service after performing service as a member of a uniformed service including service in the National Guard and temporary service in the Coast Guard Reserve and after exercising restoration or reemployment rights as provided under 38 U.S.C. chapter 43; or

(iv) Return to the performance of such service after employment by a tribal organization to which section 105(e)(2) of the Indian Self-Determination Act applies.

[53 FR 38944, Oct. 4, 1988; 53 FR 44551, Nov. 3, 1988, as amended at 55 FR 24891, June 19, 1990]

§ 404.1018a Work by civilians for the United States Government or its instrumentalities—remuneration paid prior to 1984.

(a) *General—remuneration paid prior to 1984.* If you worked as a civilian employee of the United States Government or an instrumentality of the United States, your work was excluded from employment if that work was covered by a retirement system established by law. Your work for an instrumentality that was exempt from Social Security tax was also excluded. Certain other work for the United States or an instrumentality of the United States was specifically excluded and is described in this section.

(b) *Work covered by a retirement system—remuneration paid prior to 1984.* Work you did as an employee of the United States or an instrumentality of the United States was excluded from employment if the work was covered by a retirement system established by a law of the United States. If you had a choice as to whether your work was covered by the retirement system, the work was not covered by that system until you chose that coverage. In order for the exclusion to apply, the work you did, rather than the position you held, must have been covered by the retirement system.

(c) *Work that was specifically excluded—remuneration paid prior to 1984.* Work performed by an employee of the United States or an instrumentality of the United States was excluded if it was done—

(1) As the President or Vice President of the United States;

(2) As a Member of the United States Congress, a Delegate to Congress, or a Resident Commissioner;

(3) In the legislative branch of the United States Government;

(4) By a student nurse, student dietitian, student physical therapist or student occupational therapist who was assigned or attached to a Federal hospital, clinic, or medical or dental laboratory;

(5) By a person designated as a student employee with the approval of the Office of Personnel Management who was assigned or attached primarily for training purposes to a Federal hospital, clinic, or medical or dental laboratory, other than a medical or dental intern or resident in training;

(6) By an employee who served on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency;

(7) By a person to whom the Civil Service Retirement Act did not apply because the person's services were subject to another retirement system established by a law of the United States or by the instrumentality of the United States for which the work was done, other than the retirement system established by the Tennessee Valley Authority under the plan approved by the Secretary of Health, Education, and Welfare on December 28, 1956; or

(8) By an inmate of a penal institution of the United States, if the work was done in the penal institution.

(d) *Work for instrumentalities of the United States exempt from employer tax—remuneration paid prior to 1984.*

(1) Work performed by an employee of an instrumentality of the United States was excluded if—

(i) The instrumentality was exempt from the employer tax imposed by section 3111 of the Code or by section 1410 of the Internal Revenue Code of 1939; and

(ii) The exemption was authorized by another law specifically referring to these sections.

(2) Work performed by an employee of an instrumentality of the United States was excluded if the instrumentality was not on December 31, 1950, subject to the employer tax imposed by section 1410 of the Internal Revenue Code of 1939 and the work was covered by a retirement system established by the instrumentality, unless—

(i) The work was for a corporation wholly owned by the United States;

(ii) The work was for a Federal land bank association, a production credit association, a Federal Reserve Bank, a Federal Credit Union, a Federal land bank, a Federal intermediate credit bank, a bank for cooperatives, or a Federal Home Loan Bank;

(iii) The work was for a State, county, or community committee under the Agriculture Marketing Service and the Commodity Stabilization Service, formerly the Production and Marketing Administration; or

(iv) The work was by a civilian, who was not paid from funds appropriated by the Congress, in activities conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense or Secretary of Transportation at installations intended for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Defense Department or the Coast Guard, such as—

(A) Army and Air Force Exchange Service;

(B) Army and Air Force Motion Picture Service;

(C) Coast Guard Exchanges;

(D) Navy Ship's Service Stores; and

(E) Marine Corps Post Exchanges.

(3) For purposes of paragraph (d) (2) of this section, if an employee has a choice as to whether his or her work was covered by a retirement system, the work was not covered by that system until he or she chose that coverage. The work done, rather than the position held, must have been covered by the retirement system.

(e) *Work as a Peace Corps Volunteer—remuneration paid prior to 1984.* Work performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, 22 U.S.C. 2501 through 2523, was covered as employment.

(f) *Work as Job Corps Enrollee—remuneration paid prior to 1984.* Work performed as an enrollee in the Job Corps was considered to be performed in the employ of the United States.

(g) *Work by Volunteer in Service to America—remuneration paid prior to 1984.* Work performed and training received as a Volunteer in Service to America was considered to be performed in the

employ of the United States if the volunteer was enrolled for a period of service of at least one year. If the enrollment was for less than one year, we used the common-law rules in § 404.1007 to determine the volunteer's status.

[53 FR 38945, Oct. 4, 1988]

§ 404.1018b Medicare qualified government employment.

(a) *General.* The work of a Federal, State, or local government employee not otherwise subject to Social Security coverage may constitute Medicare qualified government employment. Medicare qualified government employment means any service which in all ways meets the definition of ''employment'' for title II purposes of the Social Security Act, except for the fact that the service was performed by a Federal, State or local government employee. This employment is used solely in determining eligibility for protection under part A of title XVIII of the Social Security Act (Hospital Insurance) and for coverage under the Medicare program for end-stage renal disease.

(b) *Federal employment.* If, beginning with remuneration paid after 1982, your service as a Federal employee is not otherwise covered employment under the Social Security Act, it is Medicare qualified government employment unless excluded under § 404.1018(c).

(c) *State and local government employment.* If, beginning with service performed after March 31, 1986, your service as an employee of a State or political subdivision (as defined in § 404.1202(b)), Guam, American Samoa, the District of Columbia, or the Northern Mariana Islands is excluded from covered employment solely because of section 210(a)(7) of the Social Security Act which pertains to employees of State and local governments (note §§ 404.1020 through 404.1022), it is Medicare qualified government employment except as provided in paragraphs (c) (1) and (2) of this section.

(1) An individual's service shall not be treated as employment if performed—

(i) By an individual employed by a State or political subdivision for the purpose of relieving that individual from unemployment;

(ii) In a hospital, home, or other institution by a patient or inmate thereof as an employee of a State, political subdivision, or of the District of Columbia;

(iii) By an individual, as an employee of a State, political subdivision or the District of Columbia serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) By an individual as an employee included under 5 U.S.C. 5351(2) (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia government), other than as a medical or dental intern or a medical or dental resident in training; or

(v) By an election official or election worker paid less than $100 in a calendar year for such service.

(2) An individual's service performed for an employer shall not be treated as employment if—

(i) The service would be excluded from coverage under section 210(a)(7) of the Social Security Act which pertains to employees of State and local governments;

(ii) The service is performed by an individual who—

(A) Was performing substantial and regular service for remuneration for that employer before April 1, 1986;

(B) Was a bona fide employee of that employer on March 31, 1986; and

(C) Did not enter into the employment relationship with that employer for purposes of meeting the requirements of paragraphs (c)(2)(ii) (A) and (B) of this section; and

(iii) After March 31, 1986, but prior to the service being performed, the employment relationship with that employer had not been terminated.

[57 FR 59913, Dec. 17, 1992]

§ 404.1019 Work as a member of a uniformed service of the United States.

(a) Your work as a member of a uniformed service of the United States is covered under Social Security (unless creditable under the Railroad Retirement Act), if—

(1) On or after January 1, 1957, the work is service on active duty or active duty for training but not including

service performed while on leave without pay; or

(2) On or after January 1, 1988, the work is service on inactive duty training.

(b) You are a *member of a uniformed service* if—

(1) You are appointed, enlisted, or inducted into (or a retired member of)—

(i) One of the armed services (Army, Navy, Air Force, Marine Corps, or Coast Guard); or

(ii) A component of one of the armed services, including any reserve component as defined in Veterans' Benefits, 38 U.S.C. 101 (except the Coast Guard Reserve as a temporary member);

(2) You are a commissioned officer (including a retired commissioned officer) of the National Oceanic and Atmospheric Administration or the Regular or Reserve Corps of the Public Health Service;

(3) You are a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(4) You are a cadet at the United States Military, Coast Guard, or Air Force Academy, or a midshipman at the United States Naval Academy;

(5) You are a member of the Reserve Officers Training Corps, the Naval Reserve Officers Training Corps, or the Air Force Reserve Officers Training Corps, when ordered to annual training duty for 14 days or more including periods of authorized travel to and from that duty; or

(6) You are selected for active military or naval training under the Military Selective Service Act or are provisionally accepted for active duty in the military or naval service and you are ordered or directed to a place for final acceptance or entry upon active duty and are on the way to or from, or at, that place.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59913, Dec. 17, 1992]

§404.1020 Work for States and their political subdivisions and instrumentalities.

(a) *General.* If you work as an employee of a State, a political subdivision of a State, or any wholly owned instrumentality of one or more of these, your work is excluded from employment unless—

(1) The work is covered under an agreement under section 218 of the Act (see subpart M of this part); or

(2) The work is *covered transportation service* as defined in section 210(k) of the Act (see paragraph (c) of this section).

(3) You perform services after July 1, 1991, as an employee of a State (other than the District of Columbia, Guam, or American Samoa), a political subdivision of a State, or any wholly owned instrumentality of one or more of the foregoing and you are not a member of a retirement system of such State, political subdivision, or instrumentality. Retirement system has the meaning given that term in section 218(b)(4) of the Act, except as provided in regulations prescribed by the Secretary of the Treasury. This paragraph does not apply to services performed—

(i) As an employee employed to relieve you from unemployment;

(ii) In a hospital, home, or other institution where you are a patient or inmate thereof;

(iii) As an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) As an election official or election worker if the remuneration paid in a calendar year for such service is less than $100; or

(v) As an employee in a position compensated solely on a fee basis which is treated, pursuant to section 211(c)(2)(E) of the Act, as a trade or business for purposes of inclusion of the fees in net earnings from self-employment; or

(4) The work is covered under §404.1021 or §404.1022.

(b) *Medicare qualified government employment.* Notwithstanding the provisions of paragraph (a) of this section, your work may be covered as Medicare qualified government employment (see §404.1018b(c) of this subpart).

(c) *Covered transportation service*—(1) *Work for a public transportation system.* If you work for a public transportation system of a State or political subdivision of a State, your work may be covered transportation service if all or part of the system was acquired from private ownership. You must work as an employee of the State or political subdivision in connection with its

operation of a public transportation system for your work to be covered transportation service. This paragraph sets out additional conditions that must be met for your work to be covered transportation service. If you work for a public transportation system but your work is not covered transportation service, your work may be covered for social security purposes under an agreement under section 218 of the Act (see subpart M of this part).

(2) *Transportation system acquired in whole or in part after 1936 and before 1951.* All work after 1950 for a public transportation system is covered transportation service if—

(i) Any part of the transportation system was acquired from private ownership after 1936 and before 1951; and

(ii) No general retirement system covering substantially all work in connection with the operation of the transportation system and guaranteed by the State constitution was in effect on December 31, 1950.

(3) *Transportation system operated on December 31, 1950, no part of which was acquired after 1936 and before 1951.* If no part of a transportation system operated by a State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and before 1951, work for that public transportation system is not covered transportation service unless performed under conditions described in paragraph (b)(4) of this section.

(4) *Addition after 1950 to existing transportation system.* Work for a public transportation system part of which was acquired from private ownership after 1950 as an addition to an existing transportation system is covered transportation service beginning with the first day of the third calendar quarter following the calendar quarter in which the addition was acquired if—

(i) The work is performed by an employee who—

(A) Worked in employment in connection with the operation of the addition before the addition was acquired by the State or political subdivision; and

(B) Became an employee of the State or political subdivision in connection with and at the time of its acquisition of the addition;

(ii) On that first day, work performed by that employee is—

(A) Not covered by a general retirement system; or

(B) Covered by a general retirement system which contains special provisions that apply only to employees described in paragraph (c)(4)(i)(B) of this section;

(iii) The existing transportation system was operated by the State or political subdivision on December 31, 1950; and

(iv) Work for the existing transportation system was not covered transportation service because—

(A) No part of the system was acquired from private ownership after 1936 and before 1951; or

(B) The general retirement system described in paragraph (c)(2)(ii) of this section was in effect on December 31, 1950.

(5) *Transportation system acquired after 1950.* All work for a public transportation system is covered transportation service if—

(i) The transportation system was not operated by the State or political subdivision before 1951;

(ii) All or part of the transportation system was first acquired from private ownership after 1950; and

(iii) At the time the State or political subdivision first acquired any part of its transportation system from private ownership, it did not have a general retirement system covering substantially all work performed in connection with the operation of the transportation system.

(6) *Definitions.* (i) The term *general retirement system* means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision of a State for employees of the State, the political subdivision, or both. The term does not include a fund or system which covers only work performed in positions connected with the operation of the public transportation system.

(ii) A transportation system (or part of a system) is considered to have been acquired from private ownership by a State or political subdivision if—

(A) Before the acquisition, work performed by employees in connection with the operation of the system (or an

acquired part) constituted employment under the Act; and

(B) Some of these employees became employees of the State or political subdivision in connection with and at the time of the acquisition.

(iii) The term *political subdivision* includes an instrumentality of a State, of one or more political subdivisions of a State, or of a State and one or more of its political subdivisions.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59910, 59914, Dec. 17, 1992]

§404.1021 Work for the District of Columbia.

If you work as an employee of the District of Columbia or a wholly owned instrumentality of the District of Columbia, your work is covered as employment unless—

(a) Your work is covered by a retirement system established by a law of the United States; or

(b) You are—

(1) A patient or inmate of a hospital or penal institution and your work is for that hospital or institution;

(2) A student employee (a student nurse, dietitian, or physical or occupational therapist, but not a medical or dental intern or resident in training) of a District of Columbia hospital, clinic, or medical or dental laboratory;

(3) An employee serving temporarily in case of fire, storm, snow, earthquake, flood, or other similar emergency; or

(4) A member of a board, committee, or council of the District of Columbia paid on a per diem, meeting, or other fee basis.

(c) *Medicare qualified government employment.* If your work is not covered under Social Security, it may be covered as Medicare qualified government employment (see §404.1018b(c) of this subpart).

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59914, Dec. 17, 1992]

§404.1022 American Samoa or Guam.

(a) *Work in American Samoa or Guam.* Work in American Samoa or Guam for a private employer is covered as employment the same as in the 50 States. Work done by a resident of the Republic of the Philippines working in Guam on a temporary basis as a nonimmigrant alien admitted to Guam under section 101(a)(15)(H)(ii) of the Immigration and Nationality Act is excluded from coverage regardless of the employer.

(b) *Work for American Samoa or a political subdivision or wholly owned instrumentality of American Samoa.* Work as an officer or employee (including a member of the legislature) of the government of American Samoa, its political subdivisions, or any wholly owned instrumentality of any one or more of these, is covered as employment (unless the work is covered by a retirement system established by a law of the United States). The officer or employee is not considered as an employee of the United States, an agency of the United States, or an instrumentality of the United States, for purposes of title II of the Act. We consider any pay for this work to have been paid by the government of American Samoa, or the political subdivision or the wholly owned instrumentality of American Samoa.

(c) *Work for Guam or a political subdivision or wholly owned instrumentality of Guam.* Work as an officer or employee (including a member of the legislature) of the government of Guam, its political subdivisions, or any wholly owned instrumentality of any one or more of these, is excluded from coverage as employment. However, the exclusion does not apply to employees classified as temporary or intermittent unless the work is—

(1) Covered by a retirement system established by a law of Guam;

(2) Done by an elected official;

(3) Done by a member of the legislature; or

(4) Done in a hospital or penal institution by a patient or inmate of the hospital or penal institution.

(d) *Medicare qualified government employment.* If your work is not covered under Social Security, it may be covered as Medicare qualified government employment (see §404.1018b(c) of this subpart).

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59914, Dec. 17, 1992]

§ 404.1023 Ministers of churches and members of religious orders.

(a) *General.* If you are a duly ordained, commissioned, or licensed minister of a church, the work you do in the exercise of your ministry is excluded from employment. However, it is treated as self-employment for social security purposes. If you are a member of a religious order who has not taken a vow of poverty, the same rule applies to the work you do in the exercise of your duties required by that order. If you are a member of a religious order who has taken a vow of poverty, the work you do in the exercise of duties required by the order (the work may be done for the order or for another employer) is covered as employment only if the order or autonomous subdivision of the order to which you belong has filed an effective election of coverage. The election is made under section 3121(r) of the Code. For the rules on self-employment coverage of ministers and members of religious orders who have not taken vows of poverty, see § 404.1071.

(b) *What is an ordained, commissioned, or licensed minister.* The terms *ordained, commissioned, or licensed* describe the procedures followed by recognized churches or church denominations to vest ministerial status upon qualified individuals. If a church or church denomination has an ordination procedure, the commissioning or licensing of a person as a minister may not make him or her a commissioned or licensed minister for purposes of this subpart. Where there is an ordination procedure, the commissioning or licensing must be recognized as having the same effect as ordination and the person must be fully qualified to exercise all of the ecclesiastical duties of the church or church denomination.

(c) *When is work by a minister in the exercise of the ministry.* (1) A minister is working in the exercise of the ministry when he or she is—

(i) Ministering sacerdotal functions or conducting religious worship (other than as described in paragraph (d)(2) of this section); or

(ii) Working in the control, conduct, and maintenance of a religious organization (including an integral agency of a religious organization) under the authority of a religious body constituting a church or church denomination.

(2) The following rules are used to decide whether a minister's work is in the exercise of the ministry:

(i) Whether the work is the conduct of religious worship or the ministration of sacerdotal functions depends on the tenets and practices of the religious body which is his or her church or church denomination.

(ii) Work in the control, conduct, and maintenance relates to directing, managing, or promoting the activities of the religious organization. Any religious organization is considered to be under the authority of a religious body constituting a church or church denomination if it is organized and dedicated to carrying out the tenets and principles of a faith according to either the requirements or sanctions governing the creation of institutions of the faith.

The term *religious organization* has the same meaning and application as is given to the term for income tax purposes under the Code.

(iii) If a minister is working in the conduct of religious worship or the ministration of sacerdotal functions, the work is in the exercise of the ministry whether or not it is performed for a religious organization. (See paragraph (d)(2) of this section for an exception to this rule.)

Example M, a duly ordained minister, is engaged to work as chaplain at a privately owned university. M spends his entire time working as chaplain. This includes the conduct of religious worship, offering spiritual counsel to the university students, and teaching a class in religion. M is working in the exercise of the ministry.

(iv) If a minister is working for an organization which is operated as an integral agency of a religious organization under the authority of a religious body constituting a church or church denomination, all work by the minister in the conduct of religious worship, in the ministration of sacerdotal functions, or in the control, conduct, and maintenance of the organization is in the exercise of the ministry.

Example M, a duly ordained minister, is engaged by the N Religious Board as director of one of its departments. M performs no other service. The N Religious Board is an integral

agency of O, a religious organization operating under the authority of a religious body constituting a church denomination. M is working in the exercise of the ministry.

(v) If a minister, under an assignment or designation by a religious body constituting a church, works for an organization which is neither a religious organization nor operated as an integral agency of a religious organization, all service performed by him or her, even though the service may not involve the conduct of religious worship or the ministration of sacerdotal functions, is in the exercise of the ministry.

Example. M, a duly ordained minister, is assigned by X, the religious body constituting M's church, to perform advisory service to Y company in connection with the publication of a book dealing with the history of M's church denomination. Y is neither a religious organization nor operated as an integral agency of a religious organization. M performs no other service for X or Y. M is working in the exercise of the ministry.

(vi) If a minister is working for an organization which is neither a religious organization nor operated as an integral agency of a religious organization and the work is not performed under an assignment or designation by ecclesiastical superiors, then only the work done by the minister in the conduct of religious worship or the ministration of sacerdotal functions is in the exercise of the ministry. (See paragraph (d)(2) of this section for an exception to this rule.)

Example. M, a duly ordained minister, is engaged by N University to teach history and mathematics. M does no other work for N although from time to time M performs marriages and conducts funerals for relatives and friends. N University is neither a religious organization nor operated as an integral agency of a religious organization. M is not working for N under an assignment by his ecclesiastical superiors. The work performed by M for N University is not in the exercise of the ministry. However, service performed by M in performing marriages and conducting funerals is in the exercise of the ministry.

(d) *When is work by a minister not in the exercise of the ministry.* (1) Work performed by a duly ordained, commissioned, or licensed minister of a church which is not in the exercise of the ministry is not excluded from employment.

(2) Work performed by a duly ordained, commissioned, or licensed minister of a church as an employee of the United States, or a State, territory, or possession of the United States, or the District of Columbia, or a foreign government, or a political subdivision of any of these, is not in the exercise of the ministry, even though the work may involve the ministration of sacerdotal functions or the conduct of religious worship. For example, we consider service performed as a chaplain in the Armed Forces of the United States to be work performed by a commissioned officer and not by a minister in the exercise of the ministry. Also, service performed by an employee of a State as a chaplain in a State prison is considered to be performed by a civil servant of the State and not by a minister in the exercise of the ministry.

(e) *Work in the exercise of duties required by a religious order.* Work performed by a member of a religious order in the exercise of duties required by the order includes all duties required of the member of the order. The nature or extent of the work is immaterial so long as it is service which the member is directed or required to perform by the member's ecclesiastical superiors.

§404.1024 Election of coverage by religious orders.

A religious order whose members are required to take a vow of poverty, or any autonomous subdivision of that religious order, may elect to have social security coverage extended to the work performed by its members in the exercise of duties required by that order or subdivision. The rules on the election of coverage by these religious orders are described in 26 CFR 31.3121(r). The rules on determining the wages of members of religious orders for which an election of coverage has been made are described in §404.1046.

§404.1025 Work for religious, charitable, educational, or certain other organizations exempt from income tax.

(a) *After 1983.* Work done after 1983 by an employee in the employ of a religious, charitable, educational, or other organization described in section

501(c)(3) of the Code which is exempt from income tax under section 501(a) of the Code is covered as employment unless the work is for a church or church-controlled organization that has elected to have services performed by its employees excluded (see § 404.1026). (See § 404.1059(b) for special wage rule.)

(b) *Before 1984.* Work described in paragraph (a) of this section which was done before 1984 is excluded from employment. However, the exclusion does not apply to work done during the period for which a form SS–15, Certificate Waiving Exemption From Taxes Under the Federal Insurance Contributions Act, was filed (or was deemed to have been filed) with the Internal Revenue Service.

[50 FR 36573, Sept. 9, 1985]

§ 404.1026 Work for a church or qualified church-controlled organization.

(a) *General.* If you work for a church or qualified church-controlled organization, as described in this section, your employer may elect to have your services excluded from employment. You would then be considered to be self-employed and special conditions would apply to you. See § 404.1068(f) for those special conditions. The employer's election of the exclusion must be made with the Internal Revenue Service in accordance with Internal Revenue Service procedures and must state that the church or church-controlled organization is opposed for religious reasons to the payment of Social Security employment taxes. The exclusion applies to current and future employees. If you work in an unrelated trade or business (within the meaning of section 513(a) of the Code) of the church or church-controlled organization, the exclusion does not apply to your services.

(b) *What is a church.* For purposes of this section the term *church* means a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches.

(c) *What is a qualified church-controlled organization.* For purposes of this section the term *qualified church-controlled organization* means any church-controlled organization exempt from income tax under section 501(c)(3) of the Code but does *not* include an organization which:

(1) Offers goods, services, or facilities for sale to the general public, other than on an incidental basis, or for other than a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and

(2) Normally receives more than 25 percent of its support from either governmental sources or receipts from admissions, sales of merchandise, performance of services or furnishing of facilities other than in an unrelated trade or business, or both.

[50 FR 36573, Sept. 9, 1985, as amended at 55 FR 7309, Mar. 1, 1990]

§ 404.1027 Railroad work.

We exclude from employment any work you do as an employee or employee representative as described in the Railroad Retirement Tax Act. However, railroad compensation can be counted for social security purposes under the conditions described in subpart O of this part.

§ 404.1028 Student working for a school, college, or university.

(a) For purposes of this section, a *school, college, or university* has its usual accepted meaning. It does not, however, include any school, college, or university that is an instrumentality or integral part of a State or a political subdivision of a State for which work can only be covered by an agreement under section 218 of the Act. (See subpart M of this part.)

(b) If you are a student, any work you do as an employee of a school, college or university is excluded from employment, if you are enrolled in and regularly attending classes at that school, college, or university. The exclusion also applies to work you do for a private nonprofit auxiliary organization of the school, college, or university if it is organized and operated exclusively for the benefit of, to perform functions of, or to carry out the purposes of the school, college, or university. The organization must be operated, supervised, or controlled by, or in connection with, the school, college, or university.

(c) Whether you are a student for purposes of this section depends on your relationship with your employer. If your main purpose is pursuing a course of study rather than earning a livelihood, we consider you to be a student and your work is not considered employment.

§404.1029 Student nurses.

If you are a student nurse, your work for a hospital or nurses training school is excluded from employment if you are enrolled and regularly attending classes in a nurses training school which is chartered or approved under State law.

§404.1030 Delivery and distribution or sale of newspapers, shopping news, and magazines.

(a) *If you are under age 18.* Work you do before you reach age 18 delivering or distributing newspapers or shopping news is excluded from employment. This does not include delivery or distribution to some point for further delivery or distribution by someone else. If you make house-to-house delivery or sale of newspapers or shopping news (including handbills and similar kinds of advertising material), your work is not covered while you are under age 18. Related work such as assembling newspapers is also excluded.

(b) *If you are any age.* No matter how old you are, work you do in connection with and at the time of the sale of newspapers or magazines to consumers is excluded from employment if there is an arrangement under which—

(1) You are to sell the newspapers or magazines at a fixed price; and

(2) Your pay is the difference between the fixed selling price and the amount you are charged for the newspapers or magazines (whether or not you are guaranteed a minimum amount of compensation or receive credit for unsold newspapers or magazines).

(c) *If you are age 18 or older.* If you have attained age 18, you are self-employed if you work under the arrangement described in paragraph (b) of this section. See §404.1068(b).

§404.1031 Fishing.

(a) If you work on a boat engaged in catching fish or other forms of aquatic animal life, your work is not employment if you have an arrangement with the owner or operator of the boat which provides for all of the following:

(1) You do not receive any cash pay (other than as provided in paragraph (a)(2) of this section).

(2) You receive a share of the catch or a share of the proceeds from the sale of the catch.

(3) The amount of your share depends on the size of the catch.

(4) The operating crew of the boat (or each boat from which you receive a share if the fishing operation involves more than one boat) is normally made up of fewer than 10 individuals.

(b) Work excluded from employment under this section is considered to be self-employment (§404.1068(e)).

§404.1032 Work for a foreign government.

If you work as an employee of a foreign government in any capacity, your work is excluded from employment. If you are a citizen of the United States and work in the United States as an employee of a foreign government, you are considered to be self-employed (§404.1068(d)).

§404.1033 Work for a wholly owned instrumentality of a foreign government.

(a) If you work as an employee of an instrumentality of a foreign government, your work is excluded from employment if—

(1) The instrumentality is wholly owned by the foreign government;

(2) Your work is similar to work performed in foreign countries by employees of the United States Government or its instrumentalities; and

(3) The Secretary of State certifies to the Secretary of the Treasury that the foreign government grants an equivalent exemption for services performed in the foreign country by employees of the United States Government or its instrumentalities.

(b) Your work will not be excluded under this section if any of the conditions in paragraph (a) of this section are not met.

(c) If you are a citizen of the United States and work in the United States as an employee of an instrumentality

of a foreign government and the conditions in paragraph (a) of this section are met, you are considered to be self-employed (§ 404.1068(d)).

§ 404.1034 Work for an international organization.

(a) If you work as an employee of an international organization entitled to enjoy privileges, exemptions, and immunities as an international organization under the International Organizations Immunities Act (59 Stat. 669), your work is excluded from employment. The organization must meet the following conditions:

(1) It must be a public international organization in which the United States participates under a treaty or authority of an act of Congress authorizing, or making an appropriation for, participation.

(2) It must be designated by executive order to be entitled to enjoy the privileges, exemptions, and immunities provided in the International Organizations Immunities Act.

(3) The designation must be in effect, and all conditions and limitations in the designation must be met.

(b) Your work will not be excluded under this section if any of the conditions in paragraph (a) of this section are not met.

(c) If you are a citizen of the United States and work in the United States as an employee of an international organization that meets the conditions in paragraph (a) of this section, you are considered to be self-employed (§ 404.1068(d)).

§ 404.1035 Work for a communist organization.

If you work as an employee of an organization which is registered, or which is required by a final order of the Subversive Activities Control Board to register under the Internal Security Act of 1950 as a communist action, communist-front, or communist-infiltrated organization, your work is excluded from employment. The exclusion is effective with the calendar year in which the organization is registered or the final order is in effect.

§ 404.1036 Certain nonresident aliens.

(a) *Foreign students.* Foreign students (nonimmigrant aliens) may be temporarily in the United States under subparagraph (F) of section 101(a)(15) of the Immigration and Nationality Act to attend a school or other recognized place of study approved by the Attorney General. On-campus work or work under permission granted by the Immigration and Naturalization Service which is done by these students is excluded from employment. Other work done by these foreign students is not excluded from employment under this section.

(b) *Exchange visitors.* Exchange visitors (nonimmigrant aliens) may be temporarily in the United States under subparagraph (J) of section 101(a)(15) of the Immigration and Nationality Act to participate in exchange visitor programs designated by the Secretary of State. Work done by these exchange visitors to carry out the purpose for which they were admitted and for which permission has been granted by the sponsor, is excluded from employment. Other work done by these exchange visitors is not excluded from employment under this section.

(c) *Spouse and children.* Work done by a foreign student's or exchange visitor's alien spouse or minor child who is also temporarily in the United States under subparagraph (F) or (J) of section 101(a)(15) of the Immigration and Nationality Act is not excluded from employment under this section unless that spouse or child and the work that is done meets the conditions of paragraph (a) or (b) of this section.

§ 404.1037 Work on or in connection with a non-American vessel or aircraft.

If you work as an employee within the United States on or in connection with (as explained in § 404.1004(b)(8)) a vessel or aircraft that is not an American vessel (as defined in § 404.1004(b)(3)) or American aircraft (as defined in § 404.1004(b)(2)), your work is excluded from employment if—

(a) You are not a citizen of the United States or your employer is not an American employer (as defined in § 404.1004(b)(1)); and

(b) You are employed on and in connection with (as explained in § 404.1004(b)(7)) the vessel or aircraft when outside the United States.

EXEMPTION FROM SOCIAL SECURITY BY REASON OF RELIGIOUS BELIEF

§ 404.1039 Employers (including partnerships) and employees who are both members of certain religious groups opposed to insurance.

(a) You and your employer (or, if the employer is a partnership, each of its partners) may file applications with the Internal Revenue Service for exemption from your respective shares of the Federal Insurance Contributions Act taxes on your wages paid by that employer if you and your employer (or, if the employer is a partnership, each of its partners)—

(1) Are members of a recognized religious sect or division of the sect; and

(2) Adhere to the tenets or teachings of the sect or division of the sect and for that reason are conscientiously opposed to receiving benefits from any private or public insurance that—

(i) Makes payment in the event of death, disability, old-age, or retirement; or

(ii) Makes payment for the cost of, or provides services for, medical care including the benefits of any insurance system established by the Act.

(b) Both your application and your employer's application (or, if your employer is a partnership, each partner's application) must be filed with and approved by the Internal Revenue Service pursuant to section 3127 of the Internal Revenue Code. An application must contain or be accompanied by the applicant's waiver of all benefits and payments under title II and part A of title XVIII of the Act. See § 404.305 for the effect of the filing of the waiver and the granting of the exemption.

(c) Regardless of whether the applicant meets all these conditions, the application will not be approved unless we find that—

(1) The sect or division of the sect has established tenets or teachings which cause the applicant to be conscientiously opposed to the types of insurance benefits described in paragraph (a)(2) of this section; and

(2) For a substantial period of time it has been the practice for members of the sect or division of the sect to make provision for their dependent members that is reasonable in view of their general level of living; and

(3) The sect or division of the sect has been in existence continuously since December 31, 1950.

(d) An application for exemption will be approved by the Internal Revenue Service only if no benefit or payment under title II or part A of title XVIII of the Act became payable (or, but for section 203 or section 222(b) of the Act, would have become payable) to the applicant at or before the time of the filing of the application for exemption.

(e) The tax exemption ceases to be effective with respect to wages paid beginning with the calendar quarter in which either the employer (or if the employer is a partnership, any of its partners) or the employee involved does not meet the requirements of paragraph (a) of this section or the religious sect or division of the sect is found by us to no longer meet the requirements of paragraph (c) of this section. If the tax exemption ceases to be effective, the waiver of the right to receive Social Security and Medicare Part A benefits will also no longer be effective. Benefits may be payable based upon the wages of the individual, whose exempt status was terminated, for and after the calendar year following the calendar year in which the event occurred upon which the cessation of the exemption is based. Benefits may be payable based upon the self-employment income of the individual whose exempt status was terminated for and after the taxable year in which the event occurred upon which the cessation of the exemption is based.

[58 FR 64889, Dec. 10, 1993]

WAGES

§ 404.1041 Wages.

(a) The term *wages* means remuneration paid to you as an employee for employment unless specifically excluded. Wages are counted in determining your entitlement to retirement, survivors', and disability insurance benefits.

(b) If you are paid wages, it is not important what they are called. Salaries, fees, bonuses and commissions on sales or on insurance premiums are wages if they are remuneration paid for employment.

(c) The way in which you are paid is unimportant. Wages may be paid on the basis of piecework or a percentage of the profits. Wages may be paid on an hourly, daily, weekly, monthly, or yearly basis. (See § 404.1056 for special rules for agricultural labor.)

(d) Your wages can be in any form. You can be paid in cash or something other than cash, for example, in goods or clothing. (See paragraphs (e) and (f) of this section for kinds of employment where cash payments alone are considered wages and § 404.1043(b) concerning the value of meals and lodging as wages.) If your employer pays you cash for your meals and lodging on a regular basis as part of your employment, these payments may be considered wages. Payments other than cash may be counted as wages on the basis of the fair value of the items when paid.

(e) In certain kinds of employment, cash payments alone count as wages. These types of employment are agricultural labor, domestic services, and services not in the course of the employer's trade or business.

(f) To count as wages, payments for services performed by home workers who are employees as described in § 404.1008(d) must be in cash and must amount to $100 or more in a calendar year. Once this cash pay test is met, all remuneration paid, whether in cash or kind, is also wages.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990]

§ 404.1042 Wages when paid and received.

(a) *In general.* Wages are received by an employee at the time they are paid by the employer to the employee. Wages are paid by an employer at the time that they are actually or constructively paid unless they are deemed to be paid later (as described in paragraph (c)(3) of this section).

(b) *Constructive payment.* Wages are constructively paid when they are credited to the account of, or set aside for, an employee so that they may be drawn upon by the employee at any time although not then actually received. To be a payment—

(1) The wages must be credited to or set aside for the employee and must be made available without restriction so that they may be drawn upon at any time; or

(2) The employer must intend to pay or to set aside or credit, and have the ability to pay wages when due to the employee, and failure of the employer to credit or set aside the wages is due to clerical error or mistake in the mechanics of payment, and because of the clerical error or mistake the wages are not actually available at that time.

(c) *Deemed payment.* (1) The first $100 of cash paid, either actually or constructively, by an employer to an employee in a calendar year is considered paid at the time that the amount of the cash payment totals $100 for the year in the case of pay for—

(i) Work not in the course of the employer's trade or business (non-business work);

(ii) Work by certain home workers; and

(iii) Work for an organization exempt from income tax under section 501 of the Code.

(2) We also apply this rule to domestic work in a private home of the employer, except that the test is $50 paid in a calendar quarter.

(3) Cash of less than $150 that an employer pays to an employee in a calendar year, either actually or constructively, for agricultural labor is considered paid at the earliest of—

(i) The time in the calendar year that the employee's pay totals $150; or

(ii) The 20th day of the calendar year on which the employee works for cash pay computed on a time basis.

(4) If an employer pays cash to an employee for two or more of the kinds of work referred to in paragraph (c)(1) of this section, we apply the provisions of this paragraph to the pay for each kind of work.

(d) *Employee tax deductions.* We consider employee tax deductions under section 3101 of the Code to be part of the employee's wages and consider them to be paid at the time of the deduction. We consider other deductions from wages to be wages paid at the

time of the deduction. It is immaterial that the deductions are required or permitted by an act of Congress or the law of any State.

(e) *Tips.* (1) Tips received by an employee in the course of employment, that are considered to be *wages,* are deemed to be paid at the time the employee reports the tips to the employer in a written statement as provided under section 6053(a) of the Code. Tips that are not reported are deemed to be paid to the employee at the time they are received by the employee.

(2) We consider tips to be received in the course of employment whether they are received by the employee from the employer or from another person. Only tips employees receive and keep for themselves are considered to be the employees' pay. If employees split tips, each employee who receives part of the tip receives tips in the course of employment.

(f) *Payments under nonqualified deferred compensation plans.* Amounts that an employee is entitled to receive under nonqualified deferred compensation plans (plans that do not qualify for special tax treatment under the Code) are creditable as wages for Social Security purposes at the later of the following times:

(1) When the services are performed; or

(2) When there is no longer a substantial risk of forfeiture (as defined in section 83 of the Code) of the employee's rights to the deferred compensation.

Any amounts taken into account as wages by this paragraph (and the income attributable thereto) will not thereafter be treated as wages for Social Security purposes.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990]

§ 404.1043 Facilities or privileges—meals and lodging.

(a) *Excluding the value of employer provided facilities or privileges from employee gross income prior to January 1, 1985.* (1) Generally, the facilities or privileges that an employer furnished an employee prior to January 1, 1985 are not wages if the facilities or privileges—

(i) Were of relatively small value; and

(ii) Were offered or furnished by the employer merely as a means of promoting the health, good will, contentment, or efficiency of the employees.

(2) The term *facilities or privileges* for the period prior to January 1, 1985 is intended to include such items as entertainment, medical services, and so-called *courtesy* discounts on purchases.

(b) *Meals and lodging.* The value of the meals and lodging furnished to an employee by an employer for reasons of the employer's convenience is not wages if—

(1) The meals are provided at the employer's place of business; and

(2) The employee, in the case of lodging, is required to accept lodging on the employer's business premises as a condition of employment.

[52 FR 29662, Aug. 11, 1987]

§ 404.1044 Vacation pay.

We consider your salary while on vacation, or a *vacation allowance* paid by your employer, to be wages.

§ 404.1045 Employee expenses.

Amounts that your employer pays you specifically—either as advances or reimbursements—for traveling or for other ordinary and necessary expenses incurred, or reasonably expected to be incurred, in your employer's business are not wages. The employer must identify these travel and other expenses either by making a separate payment or by specifically stating the separate amounts if both wages and expense allowances are combined in a single payment.

§ 404.1046 Pay for work by certain members of religious orders.

(a) If you are a member of a religious order who has taken a vow of poverty (§ 404.1023), and the order has elected Social Security coverage under section 3121(r) of the Code, your wages are figured in a special way. Your wages, for Social Security purposes, are the fair market value of any board, lodging, clothing, and other items of value furnished to you by the order, or furnished to the order on your behalf by another organization or person under an agreement with the order. See paragraph (b) of this section if you perform services for a third party. The order must

report at least $100 a month for each active member. If the fair market value of items furnished to all members of a religious order does not vary significantly, the order may consider all members to have a uniform wage.

(b) If you perform services for a third party, the following rules apply:

(1) If you perform services for another agency of the supervising church or an associated institution, any amounts paid based on such services, whether paid directly to you or to the order, do not count on wages. Only wages figured under (a) above, are counted.

(2) If you perform services in a secular setting as an employee of a third party not affiliated or associated with the supervising church or an associated institution, any amounts paid based on such services, whether paid directly to you or to the order, count as wages paid to you by the third party. These wages are in addition to any wages counted under paragraph (a) of this section.

[55 FR 7309, Mar. 1, 1990; 55 FR 17530, Apr. 25, 1990]

§ 404.1047 Annual wage limitation.

Payments made by an employer to you as an employee in a calendar year that are more than the annual wage limitation are not wages. The annual wage limitation is:

Calendar year	Wage limitation
1951–54	$3,600
1955–58	4,200
1959–65	4,800
1966–67	6,600
1968–71	7,800
1972	9,000
1973	10,800
1974	13,200
1975	14,100
1976	15,300
1977	16,500
1978	17,700
1979	22,900
1980	25,900
1981	29,700
1982	32,400
1983	35,700
1984	37,800
1985	39,600
1986	42,000
1987	43,800
1988	45,000
1989	48,000
1990	51,300
1991	53,400
1992	55,500

[52 FR 8249, Mar. 17, 1987, as amended at 57 FR 44098, Sept 24, 1992]

§ 404.1048 Contribution and benefit base after 1992.

(a) *General.* The contribution and benefit base after 1992 is figured under the formula described in paragraph (b) of this section in any calendar year in which there is an automatic cost-of-living increase in old-age, survivors, and disability insurance benefits. For purposes of this section, the calendar year in which the contribution and benefit base is figured is called the determination year. The base figured in the determination year applies to wages paid after (and taxable years beginning after) the determination year.

(b) *Formula for figuring the contribution and benefit base.* For wages paid after (and taxable years beginning after) the determination year, the contribution and benefit base is the larger of—

(1) The contribution and benefit base in effect for the determination year; or

(2) The amount determined by—

(i) Multiplying the contribution and benefit base in effect for the determination year by the ratio of—

(A) The average of the total wages (as described in paragraph (c) of this section) reported to the Secretary of the Treasury for the calendar year before the determination year to

(B) The average of the total wages reported to the Secretary of the Treasury for the calendar year before the most recent calendar year in which an increase in the contribution and benefit base was enacted or a determination under this section resulting in an increase of the base was made; and

(ii) Rounding the result of the multiplication, if not a multiple of $300, to—

(A) The nearest multiple of $300; or

(B) The next higher multiple of $300 if the result is a multiple of $150.

(c) *Average of the total wages.* The average of the total wages means the amount equal to all remuneration reported as wages on Form W–2 to the Internal Revenue Service for all

employees for income tax purposes plus contributions to certain deferred compensation plans described in section 209(k) of the Social Security Act (also reported on Form W–2), divided by the number of wage earners. If both distributions from and contributions to any such deferred compensation plan are reported on Form W–2, we will include only the contributions in the calculation of the average of the total wages. The reported remuneration and deferred compensation contributions include earnings from work not covered under social security and earnings from work covered under social security that are more than the annual wage limitation described in §404.1047.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990; 57 FR 1382, Jan. 14, 1992]

§404.1049 Payments under an employer plan or system.

(a) Payments to, or on behalf of, you or any of your dependents under your employer's plan or system are excluded from wages if made because of your or your dependents'—

(1) Medical or hospitalization expenses connected with sickness or accident disability; or

(2) Death, except that the exclusion does not apply to payments for group-term life insurance to the extent that the payments are includible in the gross income of the employee under the Internal Revenue Code of 1986, effective with respect to group-term life insurance coverage in effect after 1987 for employees whose employment, for the employer (or successor of that employer) providing the insurance coverage, does not end prior to 1989. Such payments are wages, however, if they are for coverage for an employee who was separated from employment prior to January 1, 1989, if the payments are for any period for which the employee is reemployed by the employer (or successor of that employer) after the date of separation.

(b) Payments to you or your dependents under your employer's plan at or after the termination of your employment relationship because of your death or retirement for disability are excluded from wages.

(c) Payments made after 1983 to you or your dependents under your employer's plan at or after the termination of your employment relationship because of retirement after reaching an age specified in the plan or in a pension plan of the employer are not excluded from wages unless—

(1) The payments are to or from a trust or annuity plan of your employer as described in §404.1052; or

(2) An agreement to retire was in effect on March 24, 1983, between you and your employer and the payments made after 1983 under a nonqualified deferred compensation plan (see §404.1042(f)) are based on services performed for your employer before 1984.

(d) The plan or system established by the employer must provide for the employees generally or for a class or classes of employees. The plan or system may also provide for these employees' dependents. Payments under a plan or system established only for your dependents are not excluded from wages. The plan or system established by the employer can provide for payments on account of one or more of the items in paragraphs (a) and (b) of this section.

(e) For purposes of this section, your dependents include your husband or wife, children, and any other members of your immediate family.

(f) It does not make any difference that the benefit payments are considered in arriving at the amount of your pay or are required by the employment agreement.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 1832, Jan. 14, 1985; 55 FR 7310, Mar. 1, 1990; 55 FR 17530, Apr. 25, 1990]

§404.1050 Retirement payments.

Payments made after 1983 to you (including any amount paid by an employer for insurance or annuities) on account of your retirement for age are not excluded from wages unless—

(a) The payments are to or from a trust or annuity plan of your employer as described in §404.1052; or

(b) The payments satisfy the requirements described in §404.1049(c)(2).

[55 FR 7310, Mar. 1, 1990]

§ 404.1051 Payments on account of sickness or accident disability, or related medical or hospitalization expenses.

(a) We do not include as wages any payment that an employer makes to you, or on your behalf, on account of your sickness or accident disability, or related medical or hospitalization expenses, if the payment is made more than 6 consecutive calendar months following the last calendar month in which you worked for that employer. Payments made during the 6 consecutive months are included as wages.

(b) The exclusion in paragraph (a) of this section also applies to any such payment made by a third party (such as an insurance company). However, if you contributed to your employer's sick pay plan, that portion of the third party payments attributable to your contribution is not wages.

(c) Payments of medical or hospitalization expenses connected with sickness or accident disability are excluded from wages beginning with the first payment only if made under a plan or system of your employer as explained in § 404.1049(a)(1).

(d) Payments under a worker's compensation law are not wages.

[55 FR 7310, Mar. 1, 1990]

§ 404.1052 Payments from or to certain tax exempt trusts or payments under or into certain annuity plans.

(a) We do not include as wages any payment made—

(1) Into a tax-exempt trust or annuity plan by your employer on behalf of you or your beneficiary; or

(2) From a tax-exempt trust or under an annuity plan to, or on behalf of, you or your beneficiary.

(b) The trust must be exempt from tax under sections 401 and 501(a) of the Code, and the annuity plan must be a plan described in section 403(a) of the Code when payment is made.

(c) The exclusion does not apply to payments to an employee of the trust for work done as an employee of the trust.

[55 FR 7310, Mar. 1, 1990]

§ 404.1053 "Qualified benefits" under a cafeteria plan.

We do not include as wages any *qualified benefits* under a cafeteria plan as described in section 125 of the Code if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received. This includes any *qualified benefit* made to you, or on your behalf, pursuant to a salary reduction agreement between you and your employer. The Internal Revenue Service decides whether any plan is a cafeteria plan under section 125 of the Code and whether any benefit under the plan is a *qualified benefit*.

[55 FR 7310, Mar. 1, 1990]

§ 404.1054 Payments by an employer of employee's tax or employee's contribution under State law.

(a) We exclude as wages any payment by an employer (described in paragraph (b) of this section) that is not deducted from the employee's salary (or for which reimbursement is not made by the employee) of either—

(1) The tax imposed by section 3101 of the Code (employee's share of *Social Security tax*); or

(2) Any payment required from an employee under a State unemployment compensation law.

(b) The payments described in paragraph (a) of this section are not included as wages only if they are made by an employer on behalf of an employee employed in—

(1) Domestic service in the private home of the employer; or

(2) Agricultural labor.

[55 FR 7310, Mar. 1, 1990]

§ 404.1055 Payments for agricultural labor.

(a) *The $2,500 expenditures and $150 cash-pay tests.* Your cash payments in a calendar year after 1987 from an employer for agricultural labor (see § 404.1056) are wages if—

(1) Your employer's total expenditures for agricultural labor in that year are $2,500 or more, regardless of how much you were paid, or

(2) Your employer's total expenditures for agricultural labor are less than $2,500 in that year and your employer paid you $150.00 or more in that year.

(b) *Exceptions to the $2,500 expenditures and $150 cash-pay tests.* (1) Noncash payments for agricultural labor are not wages under either the $2,500 expenditures or $150 cash-pay test.

(2) Your cash payments in a calendar year from an employer for agricultural labor are not wages, irrespective of your employer's total annual expenditures for agricultural labor, if you are a hand harvest laborer (i.e., seasonal agricultural labor), and—

(i) Your employer paid you less than $150 in that year;

(ii) You are paid on a piece rate basis in an operation which has been, and is customarily and generally recognized in the region of employment as paying on a piece rate basis;

(iii) You commute daily from your permanent residence to the farm on which you are so employed; and,

(iv) You were employed in agriculture less than 13 weeks during the previous calendar year.

Example: In 1988, A (not a hand harvest laborer) performs agricultural labor for X for cash pay of $144 in the year. X's total agricultural labor expenditures for 1988 are $2,450. Neither the $150 cash-pay test nor the $2,500 expenditures test is met. Therefore, X's payments to A are not wages.

(c) *When cash-pay is creditable as wages.* (1) If you receive cash pay from an employer for services which are agricultural labor and for services which are not agricultural labor, we count only the amounts paid for agricultural labor in determining whether cash payments equal or exceed $150. If the amounts paid are less than $150, we count only those amounts paid for agricultural labor in determining the wages to credit the individual if the $2,500 expenditures test is met (for periods beginning on or after January 1, 1988) or the 20-day work test described in paragraph (c) of this section (for periods of time prior to 1988).

Example: Employer X operates a store and also operates a farm. Employee A, who regularly works in the store, works on X's farm when additional help is required for the farm activities. In calendar year 1988, X pays A $140 cash for agricultural labor performed in that year, and $2,260 for work in connection with the operation of the store. Additionally, X's total expenditures for agricultural labor in 1988 were $2,010. Since the cash payments by X to A in the calendar year 1988 for agricultural labor are less than $150, and total agricultural labor expenditures were under $2,500, the $140 paid by X to A for agricultural labor is not wages. The $2,260 paid for work in the store is wages.

(2) The amount of cash pay for agricultural labor that is creditable to an individual is based on cash paid in a calendar year rather than on amounts earned during a calendar year.

(3) If you receive cash pay for agricultural labor in any one calendar year from more than one employer, we apply the $150 cash-pay test and $2,500 total expenditures test to each employer.

(d) *Application of the $150 cash-pay and 20-day tests prior to 1988.* (1) For the time period prior to 1988, we apply either the $150 a year cash-pay test or the 20-day test. Cash payments are wages if you receive $150 or more from an employer for agricultural labor or under the 20-day test if you perform agricultural labor for which cash pay is computed on a time basis on 20 or more days during a calendar year. For purposes of the 20-day test, the amount of the cash pay is immaterial, and it is immaterial whether you also receive payments other than cash or payments that are not computed on a time basis. If cash paid to you for agricultural labor is computed on a time basis, the payments are not wages unless they are paid in a calendar year in which either the 20-day test or the $150 cash-pay test is met.

[57 FR 59914, Dec. 17, 1992]

§ 404.1056 Explanation of agricultural labor.

(a) *What is agricultural labor.* (1) If you work on a farm as an employee of any person, you are doing agricultural labor if your work has to do with—

(i) Cultivating the soil;

(ii) Raising, shearing, feeding, caring for, training or managing livestock, bees, poultry, fur-bearing animals or wildlife; or

(iii) Raising or harvesting any other agricultural or horticultural commodity.

(2) If you work on a farm as an employee of any person in connection

with the production or harvesting of maple sap, the raising or harvesting of mushrooms, or the hatching of poultry, you are doing agricultural labor. If you work in the processing of maple sap into maple syrup or maple sugar you are not doing agricultural labor even though you work on a farm. Work in a mushroom cave or poultry hatchery is agricultural labor only if the cave or hatchery is operated as part of a farm.

(3) If you work as an employee of the owner, tenant, or other operator of a farm, you are doing agricultural labor if most of your work is done on a farm and is involved with—

(i) The operation, management, conservation, improvement, or maintenance of the farm or its tools or equipment (this may include work by carpenters, painters, mechanics, farm supervisors, irrigation engineers, bookkeepers, and other skilled or semiskilled workers); or

(ii) Salvaging timber or clearing the land of brush and other debris left by a hurricane.

(4) You are doing agricultural labor no matter for whom or where you work, if your work involves—

(i) Cotton ginning;

(ii) Operating or maintaining ditches, canals, reservoirs, or waterways, if they are used only for supplying and storing water for farm purposes and are not owned or operated for profit; or

(iii) Producing or harvesting crude gum (oleoresin) from living trees or processing the crude gum into gum spirits of turpentine and gum resin (if the processing is done by the original producer).

(5) Your work as an employee in the handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage, to a market or to a carrier for transportation to market, of any agricultural or horticultural commodity is agricultural labor if—

(i) You work for a farm operator or a group of farm operators (other than a cooperative organization);

(ii) Your work involves the commodity in its raw or unmanufactured state; and

(iii) The operator produced most of the commodity you work with during the period for which you are paid, or if you work for a group of operators, all of the commodity you work with during the pay period is produced by that group.

(6) If you do nonbusiness work or domestic work in the private home of your employer, it is agricultural labor if you do the work on a farm operated for profit. A farm is not operated for profit if the employer primarily uses it as a residence or for personal or family recreation or pleasure. (See § 404.1058 for an explanation of domestic work and § 404.1059(a) for an explanation of nonbusiness work.)

(7) The term *farm operator* means an owner, tenant, or other person, in possession of and operating a farm.

(8) Work is not *agricultural labor* if it is done in the employ of a cooperative organization, which includes corporations, joint-stock companies, and associations treated as corporations under the Code. Any unincorporated group of operators is considered to be a cooperative organization if more than 20 operators are in the group at any time during the calendar year in which the work is done.

(9) Processing work which changes the commodity from its raw or natural state is not agricultural labor. An example of this is the extraction of juices from fruits or vegetables. However, work in the cutting and drying of fruits or vegetables does not change the commodity from its raw or natural state and can be agricultural labor.

(10) The term *commodity* means a single agricultural or horticultural product. For example, all apples are a commodity, while apples and oranges are two commodities.

(11) Work connected with the commerical canning or freezing of a commodity is not agricultural labor nor is work done after the delivery of the commodity to a terminal market for distribution for consumption.

(b) *What is a farm.* For purposes of social security coverage, *farm* includes a stock, dairy, poultry, fruit, fur-bearing animal, or truck farm, plantation, ranch, nursery, range or orchard. A farm also includes a greenhouse or other similar structure used mostly for raising agricultural or horticultural products. A greenhouse or other similar structure used mostly for other

purposes such as display, storage, making wreaths and bouquets is not a farm.

[45 FR 20075, Mar. 27, 1980. Redesignated at 55 FR 7310, Mar. 1, 1990]

§ 404.1057 Domestic service in the employer's home.

(a) *Payments for domestic service*—(1) *The $50 standard.* We do not include as wages cash payments that an employer makes to you in any calendar quarter for domestic service in the employer's private home, unless the cash pay in that calendar quarter is $50 or more. Non-cash payments for domestic service are not counted as wages.

(2) *How evaluation is made.* We apply the $50 standard for a calendar quarter based on when the payments are made to you rather than when the pay is earned. To count toward the $50 amount, payment must be made to you in cash (including checks or other forms of money). We apply the $50 standard only to services performed as a domestic. If an employer pays you for performing other work, the cash pay for the nondomestic work does not count toward the $50 domestic service pay required for the remuneration to count as wages.

(3) *More than one domestic employer.* The $50 standard applies to each employer when you perform domestic services for more than one employer in a calendar quarter. The wages paid by more than one employer for domestic services may not be combined to decide whether you have been paid $50 or more in a calendar quarter. The standard applies to each employee when an employer has two or more domestic employees during a calendar quarter.

(4) *Rounding dollar amounts for reporting.* For social security purposes, an employer has an option in the way he or she reports cash wages paid for domestic service in his or her private home. The employer may report the actual wages paid or may round the wages to the nearest dollar. For purposes of rounding to the nearest dollar the cents are disregarded unless it amounts to one-half dollar or more, in which case it will be raised to $1. If an employer uses this method to report a cash payment to you for domestic service in his or her private home in a calendar quarter, he or she must use the same method to report payments to other employees in that quarter for similar services.

(b) *What is domestic service.* Domestic service is work of a household nature done by you in or about a private home of the employer. A private home is a fixed place of residence of a person or family. A separate dwelling unit maintained by a person in an apartment house, hotel, or other similar establishment may be a private home. If a house is used primarily for supplying board or lodging to the public as a business enterprise, it is not a private home. In general, services of a household nature in or about a private home include services performed by cooks, waiters, butlers, housekeepers, governessess, maids, valets, baby sitters, janitors, laundresses, furnacemen, caretakers, handymen, gardeners, footmen, grooms, and chauffeurs of automobiles for family use. Pay for these services does not come under this provision unless the services are performed in or about a private home of the employer. Pay for services not of a household nature, such as services performed as a private secretary, tutor, or librarian, even though performed in the employer's home, does not come under this provision.

[45 FR 20075, Mar. 27, 1980; 45 FR 25060, Apr. 14, 1980. Redesignated at 55 FR 7310, Mar. 1, 1990]

§ 404.1058 Special situations.

(a) *Payments for service not in course of employer's trade or business (nonbusiness work) and payments to certain home workers*—(1) The $100 standard. We do not include as wages cash pay of less than $100 paid to you in a calendar year by an employer for services not in the course of the employer's trade or business (nonbusiness work) and for services as a home worker as described in § 404.1008(d).

(2) *How evaluation is made.* (i) We apply the $100 standard for a calendar year based on when the payments are made to you rather than when the pay is earned. To count toward the $100 amount, payment must be in cash (including checks or other forms of money). The $100 standard applies to each employer when you perform services not in the course of the employer's

trade or business or as a homeworker for two or more employers.

(ii) If the employer has two or more employees, the standard applies to each employee. In applying the $100 standard, we disregard cash payments for any other type of services you perform for the employer.

(iii) The noncash payments an employer pays you for services not in the course of the employer's trade or business are not wages even if the employer has paid you cash wages of $100 or more in the calendar year for services of that type.

(iv) Amounts paid to you as a home worker as described in § 404.1008(d) are not wages unless you are paid $100 or more in cash in a calendar year. If you meet this test, any noncash payments you receive for your services also count as wages.

(v) Amounts paid to you as a home worker in a common-law employment relationship (see § 404.1007) count as wages regardless of amount or whether paid in cash or kind.

(3) *Definitions.* The term *services not in the course of the employer's trade or business* (also called nonbusiness work) means services that do not promote or advance the trade or business of the employer. Services performed for a corporation do not come within this definition. A homeworker is described in § 404.1008(c).

(b) *Nonprofit, income-tax exempt organizations*—(1) *The $100 standard.* We do not include as wages payments of less than $100 in a calendar year made by an employer that is an organization exempt from income tax under section 501 of the Code.

(2) *How evaluation is made.* We apply the $100 standard for a calendar year based on when the payments are made to you rather than when the pay is earned. To figure the $100 amount, both cash and noncash payments are counted. The $100 standard applies to each employer where you render services for two or more nonprofit, income-tax exempt organizations during a calendar year. The $100 standard also applies to each of you where a nonprofit, income-tax exempt organization has two or more employees. In applying the standard, the tax-exempt status of the employer and not the nature or place of your services is controlling.

(c) *Payments to members of the uniformed services*—(1) *The standard.* We include as the wages of a member of the uniformed services—

(i) Basic pay, as explained in paragraph (c)(3) of this section, for performing the services described in paragraph (a)(1) of § 404.1019 of this subpart; or

(ii) Compensation, as explained in paragraph (c)(4) of this section, for performing the services described in paragraph (a)(2) of § 404.1019 of this subpart.

(2) *Wages deemed paid.* These following provisions apply to members of the uniformed services who perform services as described in paragraph (a)(1) of § 404.1019 of this subpart.

(i) After 1977, a member of the uniformed services is considered to have been paid additional wages of $100 for each $300 of basic pay paid to the individual in a calendar year. The amount of additional wages deemed paid cannot be more than $1,200 for any calendar year. No wages may be deemed paid for units of basic pay which are less than $300.

(ii) Before 1978, a member of the uniformed services is considered to have been paid additional wages of $300 for each calendar quarter after 1956 in which the individual is paid any amount of basic pay.

(3) *Basic pay. Basic pay* means the monthly pay prescribed by 37 U.S.C. 203 (Pay and Allowances for the Uniformed Services) for a member of the uniformed services on active duty or on active duty for training.

(4) *Compensation.* ''Compensation'' refers to the remuneration received for services as a member of a uniformed service, based on regulations issued by the Secretary concerned (as defined in 37 U.S.C. 101(5) under 37 U.S.C. 206(a), where such member is not entitled to the basic pay (as defined by paragraph (3) of this section).

(d) *Payments to volunteers and volunteer leaders in the Peace Corps.* If you are a *volunteer* or *volunteer leader* under the provisions of the Peace Corps Act (*22 U.S.C. 2501ff*), payments for your services are wages with the exception of amounts in excess of the amounts certified as payable under section 5(*c*) or 6(*1*) of the Peace Corps Act.

Amounts certified under those sections are considered to have been paid to the individual at the time the service is performed. See §404.1018(*e*) on coverage of these services.

(e) *Moving expenses.* We do not include as wages amounts paid to, or on behalf of, an employee for moving expenses if it is reasonable to believe that a similar deduction is allowable under section 217 of the Code.

(f) *Payments by employer to survivor or estate of former employee.* We do not include as wages any payment by an employer to a survivor or the estate of a former employee after the calendar year in which the employee died.

(g) *Payments to an employee who is entitled to disability insurance benefits.* We do not include as wages any payments made by an employer to an employee if at the time such payment is made—

(1) The employee is entitled to disability insurance benefits under the Act;

(2) The employee's entitlement to such benefits began before the calendar year in which the employer's payment is made; and

(3) The employee performed no work for the employer in the period in which the payments were paid by such employer (regardless of whether the employee worked in the period the payments were earned).

(h) *Tips.* (1) We include as wages tips received by an employee if—

(i) The tips are paid in cash; and

(ii) The tips amount to $20 or more and are received in the course of employment by an employee in a calendar month.

(2) Cash tips include checks and other forms of money. Tips received in a form other than cash, such as passes, tickets, or other goods are not wages. If an employee works for more than one employer in a calendar month, we apply the $20 tip test to work done for each employer.

(i) *Payments by employer under group legal services plan.* We do not include as wages any contribution, payment, or service, provided by an employer under a qualified group legal services plan which is excludable from the gross income of an employee, or the employee's spouse or dependents, under section 120 of the Code.

[45 FR 20075, Mar. 27, 1980, as amended at 52 FR 29662, Aug. 11, 1987. Redesignated and amended at 55 FR 7310, Mar. 1, 1990; 57 FR 59914, Dec. 17, 1992]

§404.1059 Deemed wages for certain individuals interned during World War II.

(a) *In general.* Persons who were interned during any period of time from December 7, 1941, through December 31, 1946, by the United States Government at a place operated by the Government within the United States for the internment of United States citizens of Japanese ancestry are deemed to have been paid wages (in addition to wages actually paid) as provided in paragraph (c) of this section during any period after attaining age 18 while interned. This provision is effective for determining entitlement to, and the amount of, any monthly benefit for months after December 1972, for determining entitlement to, and the amount of, any lump-sum death payment in the case of a death after December 1972, and for establishing a period of disability.

(b) *Information needed to process deemed wages.* Unless we have already made a determination on deemed wages for a period of internment of an individual, any person applying for a monthly benefit, a recalculation of benefits by reason of this section, or a lump-sum death payment, must submit certain information before the benefit or payment may be computed on the basis of deemed wages. This information is—

(1) The place where the individual worked before internment;

(2) The highest hourly wage before internment;

(3) The place and date of internment;

(4) Date of birth (if not previously furnished);

(5) Whether or not another Federal benefit is being received based wholly or in part upon the period of internment; and

(6) In the case of a woman, her maiden name.

(c) *Amount of deemed wages.* The amount of wages which may be deemed is determined as follows:

(1) *Employed prior to internment.* If the individual was employed before being interned, the deemed wages are the greater of—

(i) The highest actual hourly rate of pay received for any employment before internment, multiplied by 40 for each full week during the period of internment; or

(ii) The Federal minimum hourly rate in effect for the period of internment, multiplied by 40 for each full week during that period.

(2) *Self-employed or not employed prior to internment.* If the individual was self-employed or was not employed before the period of internment, the deemed wages are the Federal minimum hourly rate in effect for that period, multiplied by 40 for each full week during the period.

(d) *When wages are not deemed.* Wages are not deemed under this section—

(1) For any period before the quarter in which the individual attained age 18; or

(2) If a larger benefit is payable without the deemed wages; or

(3) If a benefit based in whole or in part upon internment is determined by any agency of the United States to be payable under any other law of the United States or under a system set up by that agency. However, this exception does not apply in cases where the failure to receive deemed wages reduces the primary insurance amount by 50 cents or less.

(e) *Certification of internment.* The certification concerning the internment is made by the Archivist of the United States or his or her representative. After the internment has been verified, wages are deemed to have been paid to the internee.

[45 FR 20075, Mar. 27, 1980, as amended at 52 FR 29662, Aug. 11, 1987. Redesignated at 55 FR 7310, Mar. 1, 1990]

§ 404.1060 [Reserved]

SELF-EMPLOYMENT

§ 404.1065 Self-employment coverage.

For an individual to have self-employment coverage under social security, the individual must be engaged in a trade or business and have net earnings from self-employment that can be counted as self-employment income for social security purposes. The rules explaining whether you are engaged in a trade or business are in §§ 404.1066 through 404.1077. What are net earnings from self-employment is discussed in §§ 404.1080 through 404.1095. Section 404.1096 describes the net earnings from self-employment that are counted as self-employment income for social security purposes. See § 404.1913 for the effect of a totalization agreement on self-employment coverage. An agreement may exempt an activity from coverage as well as extend coverage to an activity.

[50 FR 36574, Sept. 9, 1985]

§ 404.1066 Trade or business in general.

For you to be covered as a self-employed person for social security purposes, you must be engaged in a trade or business. You can carry on a trade or business as an individual or as a member of a partnership. With some exceptions, the term *trade or business* has the same meaning as it does when used in section 162 of the Code.

§ 404.1068 Employees who are considered self-employed.

(a) *General.* Although we generally exclude services performed by employees from the definition of trade or business, certain types of services are considered a trade or business even though performed by employees. If you perform any of the services described in paragraphs (b) through (f) of this section, you are self-employed for social security purposes. Certain other services described in § 404.1071 (relating to ministers and members of religious orders) and § 404.1073 (relating to certain public officers) may be considered a trade or business even though performed by employees.

(b) *Newspaper vendors.* If you have attained age 18 and perform services as a newspaper vendor that are described in § 404.1030(b), you are engaged in a trade or business.

(c) *Sharefarmers.* If you perform services as a sharefarmer that are described in § 404.1017, you are engaged in a trade or business.

(d) *Employees of a foreign government, an instrumentality wholly owned by a*

foreign government, or an international organization. If you are a United States citizen and perform the services that are described in §404.1032, §404.1033(a), or §404.1034(a), you are engaged in a trade or business if the services are performed in the United States.

(e) *Certain fishermen.* If you perform services as a fisherman that are described in §404.1031, you are engaged in a trade or business.

(f) *Employees of a church or church-controlled organization that has elected to exclude employees from coverage as employment.* If you perform services that are excluded from employment as described in §404.1026, you are engaged in a trade or business. Special rules apply to your earnings from those services which are known as church employee income. If you are paid $100 or more in a taxable year by an employer who has elected to have its employees excluded, those earnings are self-employment income (see §404.1096(c)(1)). In figuring your church employee income you may not reduce that income by any deductions attributable to your work. Your church employee income and deductions may not be taken into account in determining the amount of other net earnings from self-employment. Effective for taxable years beginning on or after January 1, 1990, your church employee income is exempt from self-employment tax under the conditions set forth for members of certain religious groups (see §404.1075).

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985; 58 FR 64889, Dec. 10, 1993]

§404.1069 Real estate agents and direct sellers.

(a) *Trade or business.* If you perform services after 1982 as a qualified real estate agent or as a direct seller, as defined in section 3508 of the Code, you are considered to be engaging in a trade or business.

(b) *Who is a qualified real estate agent.* You are a qualified real estate agent as defined in section 3508 of the Code if you are a salesperson and—

(1) You are a licensed real estate agent;

(2) Substantially all of the earnings (whether or not paid in cash) for the services you perform as a real estate agent are directly related to sales or other output (including the performance of services) rather than to the number of hours worked; and

(3) Your services are performed under a written contract between yourself and the person for whom the services are performed which provides you will not be treated as an employee with respect to these services for Federal tax purposes.

(c) *Who is a direct seller.* You are a direct seller as defined in section 3508 of the Code if—

(1) You are engaged in the trade or business of selling (or soliciting the sale of) consumer products—

(i) To any buyer on a buy-sell basis, a deposit-commission basis, or any similar basis which the Secretary of the Treasury prescribes by regulations, for resale (by the buyer or any other person) in the home or in other than a permanent retail establishment; or

(ii) In the home or in other than a permanent retail establishment; and

(2) Substantially all of your earnings (whether or not paid in cash) for the performance of these services are directly related to sales or other output (including the performance of services) rather than to the number of hours worked; and

(3) Your services are performed under a written contract between yourself and the person for whom the services are performed which provides you will not be treated as an employee with respect to these services for Federal tax purposes.

[48 FR 40515, Sept. 8, 1983]

§404.1070 Christian Science practitioners.

If you are a Christian Science practitioner, the services you perform in the exercise of your profession are a trade or business unless you were granted an exemption from coverage under section 1402(e) of the Code, and you did not revoke such exemption in accordance with section 1704(b) of the Tax Reform Act of 1986. An exemption cannot be granted if you filed a valid waiver certificate under the provisions that apply to taxable years ending before 1968.

[55 FR 7311, Mar. 1, 1990]

§ 404.1071 Ministers and members of religious orders.

(a) If you are a duly ordained, commissioned, or licensed minister of a church, or a member of a religious order who has not taken a vow of poverty, the services you perform in the exercise of your ministry or in the exercise of duties required by the order (§ 404.1023(c) and (e)) are a trade or business unless you filed for and were granted an exemption from coverage under section 1402(e) of the Code, and you did not revoke such exemption in accordance with section 1704(b) of the Tax Reform Act of 1986. An exemption cannot be granted if you filed a valid waiver certificate under the provisions that apply to taxable years ending before 1968.

(b) If you are a member of a religious order and have taken a vow of poverty, the services you perform in the exercise of your duties required by the order may be covered as employment. (See § 404.1023 (a) and (e)).

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7311, Mar. 1, 1990]

§ 404.1073 Public office.

(a) *General.* The performance of the functions of a public office is not a trade or business except under the circumstances explained in paragraph (b) of this section. If you are an officer of a State or political subdivision, you are considered as employee of the State or political subdivision.

(b) *State and local governmental employees paid by fees.* (1) *Voluntary coverage under section 218 of the Act.* The services of employees of States and political subdivisions, including those in positions paid solely on a fee-basis, may be covered as employment by a Federal-State agreement under section 218 of the Act (see subpart M of this part). States, when entering into these agreements, have the option of excluding under the agreement coverage of services in positions paid solely by fees. If you occupy a position paid solely on a fee-basis and the State has not covered your services under section 218 of the Act, you are considered to be engaged in a trade or business.

(2) *Mandatory old-age, survivors, disability, and hospital insurance coverage.* Beginning with services performed after July 1, 1991, Social Security coverage (old-age, survivors, disability, and hospital insurance) is mandatory, with certain exceptions, for services performed by employees of a State, a political subdivision of a State, or of a wholly owned instrumentality of one or more of the foregoing, if the employees are not members of a retirement system of the State, political subdivision, or instrumentality. Among the exclusions from such mandatory coverage is service performed by an employee in a position compensated solely on a fee-basis which is treated pursuant to section 211(c)(2)(E) of the Act as a trade or business for purposes of inclusion of such fees in the net earnings from self-employment.

(3) If you are a notary public, you are not a public officer even though you perform a public function. Your services as a notary public are not covered for social security purposes.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59910, Dec. 17, 1992]

§ 404.1074 Farm crew leader who is self-employed.

If you are a farm crew leader and are deemed the employer of the workers as described in § 404.1010, we consider you to be engaged in a trade or business. This includes services performed in furnishing workers to perform agricultural labor for others, as well as services performed as a member of the crew.

§ 404.1075 Members of certain religious groups opposed to insurance.

(a) You may file an application with the Internal Revenue Service for exemption from social security self-employment tax if—

(1) You are a member of a recognized religious sect or division of the sect; and

(2) You adhere to the tenets or teachings of the sect or division of the sect and for this reason are conscientiously opposed to receiving benefits from any private or public insurance that—

(i) Makes payments in the event of death, disability, old age, or retirement; or

(ii) Makes payments toward the cost of, or provides services for, medical

care (including the benefits of any insurance system established by the Act).

(b) Your application must be filed under the rules described in 26 CFR 1.1402(h). An application must contain or be accompanied by the applicant's waiver of all benefits and payments under title II and part A of title XVIII of the Act. See § 404.305 for the effect of the filing of the waiver and the granting of the exemption.

(c) Regardless of whether you meet all these conditions, your application for exemption will not be approved unless we find that—

(1) The sect or division of the sect has established tenets or teachings which cause you to be conscientiously opposed to the types of insurance benefits described in paragraph (a)(2) of this section;

(2) For a substantial period of time it has been the practice for members of the sect or division of the sect to make provision for their dependent members which is reasonable in view of their general level of living; and

(3) The sect or division of the sect has been in existence continuously since December 31, 1950.

(d) Your application for exemption will be approved by the Internal Revenue Service only if no benefit or other payment under title II or part A of title XVIII of the Act became payable or, but for section 203 or section 222(b) of the Act, would have become payable, to you or on your behalf at or before the time of the filing of your application for exemption.

(e) The tax exemption ceases to be effective for any taxable year ending after the time you do not meet the requirements of paragraph (a) of this section or after the time we find the religious sect or division of the sect of which you are a member no longer meets the requirements of paragraph (c) of this section. If your tax exemption ceases to be effective, your waiver of the right to receive Social Security and Medicare part A benefits will also no longer be effective. Benefits may be payable based upon your wages for and after the calendar year following the calendar year in which the event occurred upon which the cessation of the exemption is based. Benefits may be payable based upon your self-employment income for and after the taxable year in which the event occurred upon which the cessation of the exemption is based.

[45 FR 20075, Mar. 27, 1980, as amended at 58 FR 64890, Dec. 10, 1993]

§ 404.1077 Individuals under railroad retirement system.

If you are an employee or employee representative as defined in section 3231(b) and (c) of the Code, your work is not a trade or business. Your services are covered under the railroad retirement system.

SELF-EMPLOYMENT INCOME

§ 404.1080 Net earnings from self-employment.

(a) *Definition of net earnings from self-employment.* If you are self-employed, you must first determine the amount of your net earnings from self-employment before figuring the amount of your earnings that count for social security purposes. Some of your earnings may not be included as net earnings from self-employment even though they are taxable for income tax purposes. If you are an employee but we consider you to be self-employed for social security purposes, you must figure your earnings as though you were actually self-employed unless you work for a church or church-controlled organization that has exempted its employees (see § 404.1068(f)). Subject to the special rules in §§ 404.1081 through 404.1095, the term *net earnings from self-employment* means—

(1) Your gross income, as figured under subtitle A of the Code, from any trade or business you carried on, less deductions attributed to your trade or business that are allowed by that subtitle; plus

(2) Your distributive share of income (or loss) from a trade or business carried on by a partnership of which you are a member, as described in paragraph (b) of this section.

(b) *Income or loss from a partnership.* (1) Your distributive share (whether or not actually distributed) of the income or loss from any trade or business carried on by a partnership of which you are a member, other than as a limited

partner, is determined under section 704 of the Code.

(2) If you are a limited partner, your distributive share is included in your net earnings from self-employment if—

(i) The amount is payable to you for services you render to or on behalf of the partnerships; and

(ii) It is a guaranteed payment described in section 707(c) of the Code.

(3) You are a *limited partner* if your financial liability for the obligations of the partnership is limited to the amount of your financial investment in the partnership. Generally, you will not have to perform services in the operation of, or participate in the control of, the business carried on by the partnership for the taxable year involved.

(c) *Reporting methods.* Your gross income from a trade or business includes the gross income you received (under the cash method) or that accrued to you (under the accrual method) from the trade or business in the taxable year. It is immaterial that the income may be attributable in whole or in part to services you rendered or other acts you performed in a prior taxable year.

(d) *What is a taxable year.* (1) The term *taxable year* means—

(i) Your annual accounting period on which you regularly figure your income in keeping your books; or

(ii) A short period resulting from your death before the end of your annual accounting period or from a change of your annual accounting period.

(2) The term *annual accounting period* means—

(i) A calendar year, consisting of 12 months ending on December 31; or

(ii) A fiscal year, consisting of—

(A) 12 months ending on the last day of any month other than December; or

(B) A period, if elected under section 441 of the Code, that varies from 52 to 53 weeks and always ends on the same day of the week that occurs last in a calendar month or nearest to the last day of the calendar month.

(3) Your taxable year for figuring self-employment income is the same as your taxable year for the purposes of subtitle A of the Code. Your taxable year is a calendar year if—

(i) You keep no books;

(ii) You have no annual accounting period; or

(iii) You have an annual accounting period that differs from the definition of fiscal year as described in paragraph (d)(2)(ii) of this section.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985]

§ 404.1081 General rules for figuring net earnings from self-employment.

(a) *Determining net earnings.* (1) In determining your gross income and the deductions attributable to your trade or business for the purpose of determining your net earnings from self-employment, the provisions that apply to the taxes imposed by sections 1 and 3 of the Code are used.

(2) If you use the accrual method of accounting to figure your taxable income from a trade or business, you must use the same method in determining your net earnings from self-employment.

(3) If you are engaged in a trade or business of selling property on the installment plan and elect, under the provisions of section 453 of the Code, to use the installment method of accounting in figuring your income, you must use the installment method in determining your net earnings from self-employment.

(4) Any income which can be excluded from gross income under any provision of subtitle A of the Code cannot be counted in determining your net earnings from self-employment, unless—

(i) You are a resident of Puerto Rico (see § 404.1089);

(ii) You are a minister or member of a religious order (see § 404.1091);

(iii) You are a United States citizen or resident engaged in a trade or business outside the United States (see § 404.1092); or

(iv) You are a citizen of, or have income from sources within, certain possessions of the United States (see § 404.1093).

(b) *Trade or business carried on.* You must carry on the trade or business either personally or through agents or employees. Income from a trade or business carried on by an estate or trust is not included in determining the net earnings from self-employment

of the individual beneficiaries of the estate or trust.

(c) *Aggregate net earnings.* If you are engaged in more than one trade or business, your net earnings from self-employment consist of the total of the net income and losses of all the trades or businesses you carry on. A loss in one trade or business you carry on offsets the income from another trade or business.

(d) *Partnerships.* When you have net earnings from self-employment from a partnership as described in § 404.1080 (a) and (b), those net earnings are combined with your other net earnings from self-employment in determining your total net earnings from self-employment for the taxable year.

(e) *Different taxable years.* If you are a partner and your taxable year is different from that of the partnership, you must include, in figuring your net earnings from self-employment, your distributive share of the income or loss of the partnership for its taxable year ending with or within your taxable year. For the special rule in case of the termination of a partner's taxable year as a result of death, see § 404.1087.

(f) *Meaning of partnerships.* A partnership for social security purposes is one that is recognized as a partnership for income tax purposes. For income tax purposes, the term *partnership* includes not only a partnership as known under common law, but also a syndicate, group, pool, joint venture, or other unincorporated organization that carries on any trade or business, financial operation, or venture, and which is not a trust, estate, or a corporation.

(g) *Proprietorship taxed as domestic corporation.* If you are a proprietor of an unincorporated business enterprise and have elected to be taxed as a domestic corporation, you must figure your net earnings from self-employment without regard to the election you have made.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985]

§ 404.1082 Rentals from real estate; material participation.

(a) *In general.* Your rentals from real estate and from personal property leased with the real estate (including rentals paid in crop shares) and the deductions attributable to the rentals are excluded in figuring your net earnings from self-employment, unless you receive the rentals in the course of a trade or business as a real estate dealer. If you are an owner or lessee of land, rentals paid in crop shares include income you get under an agreement with another person if the arrangement provides for the following:

(1) The other person will produce agricultural or horticultural commodities on the land.

(2) The commodities produced, or the income from their sale, will be divided between you and the other person.

(3) The amount of your share depends on the amount of the commodities produced.

(b) *Real estate dealers.* (1) You are a real estate dealer if you are engaged in the business of selling real estate to customers for profit.

(2) If you merely hold real estate for investment or speculation and receive rental income from it, you are not considered a real estate dealer.

(3) If you are a real estate dealer, but also hold real estate for investment or speculation in addition to real estate you hold for sale to customers, only the rental income from the real estate held for sale to customers and the deductions attributable to it are included in determining your net earnings from self-employment. The rental income from real estate you hold for investment or speculation and the deductions attributable to it are not counted in figuring your net earnings from self-employment.

(c) *Special rule for farm rental income*—(1) *In general.* If you own or lease land, any income you derive from it is included in figuring your net earnings from self-employment if—

(i) The income results from an arrangement between you and another person which provides for the other person to produce agricultural or horticultural commodities on the land that you own or lease and for you to materially participate in the production or the management of the production of the agricultural or horticultural commodities; and

(ii) You actually do materially participate.

(2) *Nature of arrangement.* (i) The arrangement between you and the other person may be either oral or written. It must provide that the other person will produce one or more agricultural or horticultural commodities and that you will materially participate in the production or the management of the production of the commodities.

(ii) The term *production,* refers to the physical work performed and the expenses incurred in producing a commodity. It includes activities like the actual work of planting, cultivating, and harvesting crops, and the furnishing of machinery, implements, seed, and livestock.

(iii) The term *management of the production,* refers to services performed in making managerial decisions about the production of the crop, such as when to plant, cultivate, dust, spray, or harvest, and includes advising and consulting, making inspections, and making decisions on matters, such as rotation of crops, the type of crops to be grown, the type of livestock to be raised, and the type of machinery and implements to be furnished.

(3) *Material participation.* (i) If you show that you periodically advise or consult with the other person, who under the rental arrangement produces the agricultural or horticultural commodities, and also show that you periodically inspect the production activities on the land, you will have presented strong evidence that you are materially participating.

(ii) If you also show that you furnish a large portion of the machinery, tools, and livestock used in the production of the commodities, or that you furnish or advance monies, or assume financial responsibility, for a substantial part of the expense involved in the production of the commodities, you will have established that you are materially participating.

(4) *Employees or agents.* We consider any farm rental arrangement entered into by your employee or agent and another person to be an arrangement entered into by you. However, we do not consider the services of an employee or agent as your services in determining the extent to which you have participated in the production or management of production of a commodity.

(5) *Examples.*

Example 1. After the death of her husband, Ms. A rents her farm, together with its machinery and equipment, to B for one-half of the proceeds from the commodities produced on the farm by B. It is agreed that B will live in the tenant house on the farm and be responsible for the overall operation of the farm, such as planting, cultivating, and harvesting the field crops, caring for the orchard and harvesting the fruit and caring for the livestock and poultry. It also is agreed that Ms. A will continue to live in the farm residence and help B operate the farm. Under the agreement it is expected that Ms. A will regularly operate and clean the cream separator and feed the poultry flock and collect the eggs. When possible she will assist B in such work as spraying the fruit trees, penning livestock, culling the poultry, and controlling weeds. She will also assist in preparing the meals when B engages seasonal workers. The agreement between Ms. A and B clearly provides that she will materially participate in the overall production operations to be conducted on her farm by B. In actual practice, Ms. A regularly performs those services. The regularly performed services are material to the production of an agricultural commodity, and the services performed are material to the production operations to which they relate. The furnishing of a substantial portion of the farm machinery and equipment also supports the conclusion that Ms. A has materially participated. Accordingly, the rental income Ms. A receives from her farm should be included in her net earnings from self-employment.

Example 2. G owns a fully-equipped farm which he rents to H under an arrangement which provides that G will materially participate in the management of the production of crops raised on the farm under the arrangement. G lives in town about 5 miles from the farm. About twice a month he visits the farm and looks over the buildings and equipment. G may occasionally, in an emergency, discuss with H some phase of a crop production activity. In effect, H has complete charge of the management of farming operations regardless of the understanding between him and G. Although G pays one-half of the cost of the seed and fertilizer and is charged for the cost of materials purchased by H to make all necessary repairs, G's activities are not material in the crop production activities. Accordingly, G's income from the crops is not included in net earnings from self-employment.

(d) *Rental income from living quarters*—(1) *No services provided for occupants.* Payments you receive for renting living quarters in a private residence, duplex, or multiple-housing unit are generally rental income from real estate.

Except in the case of real estate dealers, these payments are excluded in determining net earnings from self-employment, even if the payments are in part attributable to personal property furnished under the lease.

(2) *Services provided for occupants.* (i) Payments you receive for renting living quarters where services are also provided to the occupant, as in hotels, boarding houses, or apartment houses furnishing hotel services, or in tourist camps or tourist homes, are included in determining your net earnings from self-employment. Any payments you receive for the use of space in parking lots, warehouses, or storage garages are also included in determining your net earnings from self-employment.

(ii) Generally, we consider services to be provided to the occupant if they are primarily for the occupant's convenience and are other than those usually provided in connection with the rental of rooms or other space for occupancy only. We consider the supplying of maid service to be a service provided to the occupant. However, we do not consider the furnishing of heat and light, the cleaning of public entrances, exits, stairways, and lobbies and the collection of trash, as services provided to the occupant.

Example A owns a building containing four apartments. During the taxable year, A received $1,400 from apartments numbered 1 and 2, which are rented without services provided to the occupants, and $3,600 from apartments numbered 3 and 4, which are rented with services provided. A's fixed expenses for the four apartments are $1,200 during the taxable year. In addition, A has $500 of expenses attributable to the services provided to the occupants of apartments 3 and 4. In determining his net earnings from self-employment, A includes the $3,600 received from apartments 3 and 4, and the expenses of $1,100 ($500 plus one-half of $1,200) attributable to them. The rentals and expenses attributable to apartments 1 and 2 are excluded. Therefore, A has $2,500 of net earnings from self-employment from the building for the taxable year.

(e) *Treatment of business income which includes rentals from real estate.* If an individual or a partnership is engaged in a trade or business other than real estate, and part of the income is rentals from real estate, only that part of the income which is not rentals and the expenses attributable to that portion are included in determining net earnings from self-employment.

§ 404.1083 Dividends and interest.

(a) The dividends you receive on shares of stock are excluded in determining your net earnings from self-employment, unless you are a dealer in stocks and securities and receive the dividends in the course of your trade or business.

(b) The interest you receive on a bond, debenture, note, certificate, or other evidence of indebtedness issued with interest coupons or in registered form by any corporation (including one issued by a government or political subdivision) is excluded in determining your net earnings from self-employment, unless you are a dealer in stocks and securities and receive the interest in the course of your trade or business.

(c) If you hold stocks or securities for investment or speculation purposes, any dividends and interest you receive that are excludable under paragraphs (a) and (b) of this section are excluded in determining your net earnings from self-employment, whether or not you are a dealer in stocks and securities.

(d) A dealer in stocks or securities is a merchant with an established place of business who is regularly engaged in the business of purchasing stocks or securities and reselling them to customers. The dealer, as a merchant, buys stocks or securities and sells them to customers with a view to making a profit. Persons who buy and sell or hold stocks or securities for investment or speculation, regardless of whether the buying or selling constitutes a trade or business, are not dealers in stocks or securities.

[45 FR 20075, Mar. 25, 1980; 45 FR 25060, Apr. 14, 1980]

§ 404.1084 Gain or loss from disposition of property; capital assets; timber, coal, and iron ore; involuntary conversion.

(a) If you are engaged in a trade or business, you must, in determining your net earnings from self-employment, exclude any gain or loss—

(1) That is considered a gain or loss from the sale or exchange of a capital asset;

(2) From the cutting of timber or from the disposal of timber or coal, even if held primarily for sale to customers, if section 631 of the Code applies to the gain or loss;

(3) From the disposal of iron ore mined in the United States, even if held primarily for sale to customers, if section 631 of the Code applies to the gain or loss; and

(4) From the sale, exchange, involuntary conversion, or other disposition of property that is not—

(i) Stock in trade or other property of a kind which would properly be included in inventory if on hand at the close of the taxable year; or

(ii) Property held primarily for sale to customers in the ordinary course of a trade or business;

(b) For purposes of paragraph (a)(4) of this section, it is immaterial whether a gain or loss is treated as a capital gain or as an ordinary gain or loss for purposes other than determining earnings from self-employment.

(c) For purposes of paragraph (a)(4) of this section—

(1) The term *involuntary conversion* means a compulsory or unintended change of property into other property or money as a result of such things as destruction, theft or seizure; and

(2) The term *other disposition* includes destruction or loss by fire, theft, storm, shipwreck, or other casualty, even though there is no change of the property into other property or money.

Example During the taxable year 1976, A, who owns a grocery store, had a net profit of $1,500 from the sale of groceries and a gain of $350 from the sale of a refrigerator case. During the same year, he had a loss of $2,000 as a result of damage by fire to the store building. In figuring taxable income for income tax purposes, all of these items are considered. In determining net earnings from self-employment, however, only the $1,500 of profit derived from the sale of groceries is included. The $350 gain and the $2,000 loss are excluded.

§ 404.1085 Net operating loss deduction.

When determining your net earnings from self-employment, you disregard the deduction provided by section 172 of the Code that relates to net operating losses sustained in years other than the taxable year.

§ 404.1086 Community income.

(a) *In case of an individual.* (1) If community property laws apply to income that an individual derives from a trade or business (other than a trade or business carried on by a partnership), all of the gross income and the deductions attributable to the income are generally treated as the gross income and deductions of the husband. However, if the wife exercises substantially all of the management and control of that trade or business, all of the gross income and deductions are treated as the gross income and deductions of the wife.

(2) The term *management and control* means management and control in fact, not the management and control given to the husband under the community property laws. For example, a wife who operates a beauty parlor without any significant help from her husband will be considered as having substantially all of the management and control of the business, despite the provision of any community property law giving the husband the right of management and control of community property. The income and deductions from the operations of the beauty parlor are considered the income and deductions of the wife.

(b) *In case of a partnership.* Even though only a portion of a partner's distributive share of the income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to the share, all of the distributive share is included in figuring the net earnings from self-employment of that partner. No part of the share is taken into account in figuring the net earnings from self-employment of the spouse of the partner. In any case in which both spouses are members of the same partnership, the distributive share of the income or loss of each spouse is included in figuring the net earnings from self-employment of that spouse.

§ 404.1087 Figuring partner's net earnings from self-employment for taxable year which ends as a result of death.

(a) *General.* In the case of a deceased partner whose taxable year ends

because of death, the deceased partner's net earnings from self-employment includes the amount of his or her distributive share of partnership ordinary income or loss for the partnership's taxable year that is attributable to an interest in the partnership through the month of death.

(b) *Computation.* (1) The deceased partner's distributive share of partnership ordinary income or loss for the partnership taxable year in which death occurred is determined by applying the rules contained in paragraphs (d) and (f) of §404.1081.

(2) The portion of the distributive share to be included in the deceased partner's net earnings from self-employment for his or her last taxable year is determined by treating the ordinary income or loss constituting the distributive share as having been realized or sustained ratably over the partnership taxable year during which the deceased partner had an interest in the partnership and during which the deceased partner's estate, or any other person succeeding by reason of the death to rights to his partnership interest, held an interest in the partnership.

(c) *Deceased partner's distributive share.* A deceased partner's distributive share includes the distributive share of the estate or of any other person succeeding to the interest of a deceased partner. It does not include any share attributable to a partnership interest that was not held by the deceased partner at the time of death. If a deceased partner's estate should acquire an interest in a partnership in addition to the interest to which it succeeded upon the death of the deceased partner, the amount of the distributive share attributable to the additional interest acquired by the estate is not included in computing the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year.

(d) *Options available to farmers.* In determining the applicability of the optional method of figuring net earnings from self-employment to a member of a farm partnership it is necessary to determine the partner's distributive share of partnership gross income or distributive share of income described in section 702(a)(8) of the Code.

§404.1088 Retirement payment to retired partners.

(a) *In general.* If you are a retired partner, in figuring your net earnings from self-employment you must exclude payments made to you on a periodic basis by a partnershp on account of your retirement and which are to continue until your death. This exclusion applies only if the payments are made under a written plan which meets the requirements set out in 26 CFR 1.1402(a)–(17) and the conditions in paragraph (b) of this section are met. The necessary requirements and conditions must be met throughout the entire partnership's taxable year for the payments to be excluded so that either all or none of the payments are excluded.

(b) *Other conditions.* You must have been paid your full share of the partnership's capital before the close of the partnership's taxable year in which retirement payments are made. Also, no member of the partnership can have any financial obligations to you (in his or her capacity as a partner) except to make the retirement payments. Lastly, you cannot perform any services for the partnership in the partnership's taxable year which falls wholly or partially in your taxable year in which you receive the retirement payments.

Example. D, a partner in the DEF partnership, retired from the partnership as of December 31, 1976. The taxable year of both D and the partnership is the calendar year. During the partnership's taxable year ending December 31, 1977, D rendered no service to any trade or business carried on by the partnership. On or before December 31, 1977, all obligations (other than retirement payments under the plan) from the other partners to D were liquidated, and D's share of the capital of the partnership was paid to him. Retirement payments received by D under the partnership's plan in his taxable year ending December 31, 1977, are excluded in determining net earnings from self-employment (if any) for that taxable year.

§404.1089 Figuring net earnings for residents and nonresidents of Puerto Rico.

(a) *Residents.* If you are a resident of Puerto Rico, whether or not you are an

alien, a citizen of the United States, or a citizen of Puerto Rico, you must figure your net earnings from self-employment in the same manner as would a citizen of the United States residing in the United States. In figuring your net earnings from self-employment you must include your income from sources in Puerto Rico even though you are a resident of Puerto Rico during the entire taxable year.

(b) *Nonresidents.* A citizen of Puerto Rico, who is also a citizen of the United States and who is not a resident of Puerto Rico must figure net earnings from self-employment in the same manner as other citizens of the United States.

§ 404.1090 Personal exemption deduction.

The deduction provided by section 151 of the Code, relating to personal exemptions, is excluded in determining net earnings from self-employment.

§ 404.1091 Figuring net earnings for ministers and members of religious orders.

(a) *General.* If you are a duly ordained, commissioned, or licensed minister of a church or a member of a religious order who has not taken a vow of poverty, we consider you to be engaged in a trade or business under the conditions described in § 404.1071 with regard to services described in § 404.1023 (c) and (e). In figuring your net earnings from self-employment from performing these services, you must include certain income (described in paragraphs (b) and (c) of this section) that may be excluded from your gross income for income tax purposes.

(b) *Housing and meals.* You must include in figuring your net earnings from self-employment the rental value of a home furnished to you and any rental allowance paid to you as payment for services performed in the exercise of your ministry or in the exercise of duties required by your order even though the rental value or rental allowance may be excluded from gross income by section 107 of the Code. Also, the value of any meals or lodging furnished to you in connection with the performance of these services is included in figuring your net earnings from self-employment even though their value is excluded from gross income by section 119 of the Code.

(c) *Services outside the United States.* If you one are a citizen or resident of the United States performing services outside the United States which are in the exercise of your ministry or in the exercise of duties required by your order, your net earnings from self-employment from the performance of these services are figured as described in paragraph (b) of this section. However, they are figured without regard to the exclusions from gross income provided in sections 911 and 931 of the Code relating to earned income from services performed outside the United States and from sources within possessions of the United States.

[45 FR.20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985]

§ 404.1092 Figuring net earnings for U.S. citizens or residents living outside the United States.

(a) *Taxable years beginning after December 31, 1983.* If you are a citizen or resident of the United States and are engaged in a trade or business outside the United States, your net earnings from self-employment are figured without regard to the exclusion from gross income provided by section 911 (a)(1) of the Code.

(b) *Taxable years beginning after December 31, 1981, and before January 1, 1984.* If you are a citizen of the United States and were engaged in a trade or business outside the United States, your net earnings from self-employment are figured without regard to the exclusion from gross income provided by section 911(a)(1) of the Code unless you are a resident of a foreign country or countries for an uninterrupted period which includes an entire taxable year.

[50 FR 36574, Sept. 9, 1985]

§ 404.1093 Possession of the United States.

In using the exclusions from gross income provided under section 931 of the Code (relating to income from sources within possessions of the United States) and section 932 of the Code (relating to citizens of possessions of the United States) for purposes of figuring

your net earnings from self-employment, the term *possession of the United States* shall be deemed not to include the Virgin Islands, Guam, or American Samoa.

§ 404.1094 Options available for figuring net earnings from self-employment.

(a) *General.* If you have income from a trade or business in certain situations, you have options for figuring your net earnings from self-employment. The options available to you depend on whether you have income from an agricultural trade or business or a non-agricultural trade or business. For a definition of agricultural trade or business see § 404.1095.

(b) *Agricultural trade or business.* The net earnings from self-employment you derive from an agricultural trade or business may, at your option, be figured as follows:

(1) *Gross income of $2,400 or less.* If your gross income is $2,400 or less you may, at your option, report 66⅔ percent of the gross income as net earnings from self-employment instead of your actual net earnings from your business.

(2) *Gross income of more than $2,400.* If your gross income is more than $2,400 and your actual net earnings from your business are less than $1,600 you may, at your option, report $1,600 as net earnings from self-employment instead of your actual net earnings. If your actual net earnings are $1,600 or more you cannot use the optional method.

(3) *Two or more agricultural trades or businesses.* If you carry on more than one agricultural trade or business as a sole proprietor or as a partner, you must combine your gross income and net income from each trade or business to find out whether you may use the optional method of figuring net earnings.

(c) *Non-agricultural trade or business.* (1) The net earnings from self-employment you derive from a non-agricultural trade or business may be reported under an optional method if you are self-employed on a regular basis (as defined in paragraph (c)(4) of this section). You cannot use the optional method of reporting for more than 5 taxable years, and you cannot report less than your actual net earnings from self-employment.

(2) *Computation.* If your actual net earnings from self-employment are less than $1,600 and less than 66⅔ percent of your gross income, you may, at your option, report 66⅔ percent of your gross income (but not more than $1,600) as your net earnings from self-employment.

Example. A operates a grocery store and files income tax returns on a calendar year basis. A meets the *self-employed on a regular basis* requirement because actual net earnings from self-employment were $400 or more in 1976 and in 1977. Gross income and net profit from operating the grocery store in 1978 through 1980 are as follows:

	1978	1979	1980
Gross income	$2,800	$1,200	$1,000
Net profit	300	400	800

For the year 1978, A may report as annual net earnings from self-employment either—

(i) None. (Actual net earnings from self-employment are less than $400); or

(ii) $1,600. (Non-agricultural option, 66⅔ percent of $2,800, but not to exceed the $1,600 maximum.)

For the year 1979, A may report as annual net earnings from self-employment either—

(i) $400. (Actual net earnings from self-employment); or

(ii) $800. (Non-agricultural option, 66⅔ percent of $1,200.)

For the year 1980, A must report $800, the actual net earnings from self-employment. The non-agricultural option is not available because A's actual net earnings are not less than 66⅔ percent of the gross income.

(3) *Figuring net earnings from both non-agricultural and agricultural self-employment.* If you are self-employed on a regular basis, you may use the non-agricultural optional method of reporting when you have both non-agricultural and agricultural trades or businesses. However, in order to use this method, your actual net earnings from non-agricultural self-employment combined with your actual net earnings from agricultural self-employment, or your optional net earnings from agricultural self-employment, must be less than $1,600, and the net non-agricultural earnings must be less than 66⅔ percent of your gross non-agricultural income. If you qualify for using both the non-agricultural and agricultural option, you may report less than your actual

total net earnings, but not less than your actual net earnings from non-agricultural self-employment alone. If you elect to use both options in a given taxable year, the combined maximum reportable net earnings from self-employment may not exceed $1,600.

Example C was regularly self-employed. She derived actual net earnings from self-employment of $400 or more in 1975 and in 1976. Her gross income and net profit from operating both a grocery store and a farm in 1978 are:

GROCERY STORE	
Gross income	$1,000
Net profit	800
FARM	
Gross income	$2,600
Net profit	400

For the year 1978, C may report $1,200 (actual net earnings from self-employment from both businesses), or $2,400 ($1,600 agricultural option (66⅔ percent of $2,600 farm gross income not to exceed $1,600) and $800 grocery store profit). C cannot use the non-agricultural option for 1978 because her actual grocery store net exceeds 66⅔ percent of her grocery store gross income.

(4) *Self-employed on a regular basis.* For any taxable year beginning after 1972, we consider you to be self-employed on a regular basis, or to be a member of a partnership on a regular basis, if, in at least 2 of the 3 taxable years immediately before that taxable year, you had actual net earnings from self-employment of not less than $400 from agricultural and non-agricultural trades or businesses (including your distributive share of the net income or loss from any partnership of which you are a member).

(d) *Members of partnerships.* If you are a member of a partnership you may use the optional method of reporting. Your gross income is your distributive share of the partnership's gross income (after all guaranteed payments to which section 707(c) of the Code applies have been deducted), plus your own guaranteed payment.

(e) *Computing gross income.* For purposes of this section gross income means—

(1) Under the cash method of computing, the gross receipts from the trade or business reduced by the cost or other basis of property that was purchased and sold, minus any income that is excluded in computing net earnings from self-employment; or

(2) Under the accrual method of computing, the gross income minus any income that is excluded in figuring net earnings from self-employment.

(f) *Exercise of option.* For each taxable year for which you are eligible to use the optional method and elect to use that method, you must figure your net earnings from self-employment in that manner on your tax return for that year. If you wish to change your method of reporting after your tax return is filed, you may change it by filing an amended tax return with the Internal Revenue Service or by filing with us Form 2190, Change in Method of Computing Net Earnings from Self-Employment.

§ 404.1095 Agricultural trade or business.

(a) An agricultural trade or business is one in which, if the trade or business were carried on entirely by employees, the major portion of the services would be agricultural labor (§ 404.1057).

(b)(1) If the services are partly agricultural and partly non-agricultural, the time devoted to the performance of each type of service is the test used to determine whether the major portion of the services is agricultural labor.

(2) If more than half of the time spent in performing all the services is spent in performing services that are agricultural labor, the trade or business is agricultural.

(3) If half or less of the time spent in performing all the services is spent in performing services that are agricultural labor, the trade or business is not agricultural. The time spent in performing the services is figured by adding the time spent in the trade or business during the taxable year by every individual (including the individual carrying on the trade or business and the members of that individual's family).

(c) We do not apply the rules in this section if the non-agricultural services are performed in connection with a trade or business separate and distinct from the agricultural trade or business. A roadside automobile service station on a farm is a trade or business

separate and distinct from the agricultural trade or business, and the gross income from the service station, less the deductions attributable to it, is to be considered in determining net earnings from self-employment.

(d) We consider a sharefarmer (see § 404.1068(c)) or a materially participating owner or tenant (see § 404.1082(c)) to be engaged in an agricultural trade or business. We use the rules in this section to determine whether a farm crew leader who is self-employed (see § 404.1074) is engaged in an agricultural trade or business.

§ 404.1096 Self-employment income.

(a) *General.* Self-employment income is the amount of your net earnings from self-employment that is subject to social security tax and counted for social security benefit purposes. The term *self-employment income* means the net earnings from self-employment you derive in a taxable year, except as described in paragraphs (b), (c) and (d) of this section.

(b) *Maximum self-employment income.* (1) The term *self-employment income* does not include that part of your net earnings from self-employment that exceeds (or that part of your net earnings from self-employment which, when added to the wages you received in that taxable year, exceeds)—

Taxable year	Amount
Ending before 1955	$3,600
Ending in 1955 through 1958	4,200
Ending in 1959 through 1965	4,800
Ending in 1966 and 1967	6,600
Ending after 1967 and beginning before 1972	7,800
Beginning in 1972	9,000
Beginning in 1973	10,800
Beginning in 1974	13,200
Beginning in 1975	14,100
Beginning in 1976	15,300
Beginning in 1977	16,500
Beginning in 1978	17,700
Beginning in 1979	22,900
Beginning in 1980	25,900
Beginning in 1981	29,700
Beginning in 1982	32,400
Beginning in 1983	35,700
Beginning in 1984	37,800
Beginning in 1985	39,600
Beginning in 1986	42,000
Beginning in 1987	43,800
Beginning in 1988	45,000
Beginning in 1989	48,000
Beginning in 1990	51,300
Beginning in 1991	53,400
Beginning in 1992	55,500

(2) For the purpose of this paragraph the term *wages* includes remuneration paid to an employee for services covered by an agreement entered into under section 218 of the Act, or an agreement entered into under section 3121(l) of the Code, which would be wages under section 209 of Act if the services were considered employment under section 210(a) of the Act.

(c) *Minimum net earnings from self employment.* (1) Self-employment income does not include your net earnings from self-employment when the amount of those earnings for the taxable year is less than $400. If you have only $300 of net earnings from self-employment for the taxable year you would not have any self-employment income. (Special rules apply if you are paid $100 or more and work for a church or church-controlled organization that has exempted its employees (see § 404.1068(f)).)

(2) If you have net earnings from self–employment of $400 or more for the taxable year you may have less than $400 of creditable self–employment income. This occurs where your net earnings from self–employment is $400 or more for a taxable year and the amount of your net earnings from self–employment plus the amount of the wages paid to you during that taxable year exceed the maximum creditable earnings for a year. For example, if you had net earnings from self–employment of $1,000 for 1978, and were also paid wages of $17,500 during 1978, your creditable self–employment income for 1978 would be $200.

(d) *Nonresident aliens.* A nonresident alien has self-employment income only if coverage is provided under a totalization agreement [see § 404.1913]. We do not consider an individual who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa to be a nonresident alien.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36575, Sept. 9, 1985; 52 FR 8250, Mar. 17, 1987; 57 FR 44098, Sept. 24, 1992]

Subpart L—[Reserved]

Subpart M—Coverage of Employees of State and Local Governments

AUTHORITY: Secs. 205, 210, 218, and 702(a)(5) of the Social Security Act (42 U.S.C. 405, 410, 418, and 902(a)(5)); sec. 12110, Pub. L. 99–272, 100 Stat. 287 (42 U.S.C. 418 note); sec. 9002, Pub. L. 99–509, 100 Stat. 1970.

SOURCE: 53 FR 32976, Aug. 29, 1988, unless otherwise noted.

GENERAL

§ 404.1200 General.

(a) *Coverage under section 218 of the Act.* Under section 218 of the Social Security Act (the Act) a State may ask the Secretary of Health and Human Services to enter into an agreement to extend Federal old-age, survivors, disability and hospital insurance coverage to groups of employees of the State and its political subdivisions. The Secretary shall enter into such an agreement. State and local government employees, after being covered under an agreement, have the same benefit rights and responsibilities as other employees who are mandatorily covered under the programs. For payments due on wages paid before 1987, the State assumes full financial and reporting responsibility for all groups covered under its agreement. The agreement may not be terminated in its entirety or with respect to any coverage group under that agreement. For payments due on wages paid in the year 1987 and years later, section 9002 of Pub. L. 99–509 amends section 218 of the Act by transferring responsibility for collecting contributions due and receiving wage reports from the Social Security Administration (SSA) to the Internal Revenue Service (IRS). Sections of the regulations wholly or partly affected by this amendment to the Act are appended with the phrase ''—for wages paid prior to 1987.''

(b) *Mandatory old-age, survivors, disability, and hospital insurance coverage.* Under section 210(a)(7)(F) of the Act, mandatory old-age, survivors, disability, and hospital insurance coverage is extended to certain services performed after July 1, 1991, by individuals who are employees of a State (other than the District of Columbia, Guam, or American Samoa), a political subdivision of the State, or any wholly owned instrumentality of one or more of the foregoing, and who are not members of the employer's retirement system. Certain services are excluded from such mandatory coverage (see § 404.1020(a)(3).

[53 FR 32976, Aug. 29, 1988, as amended at 57 FR 59911, Dec. 17, 1992]

§ 404.1201 Scope of this subpart regarding coverage and wage reports and adjustments.

This subpart contains the rules of SSA about:

(a) Coverage under section 218 of the Act—

(b) Contributions, wage reports, and adjustments—for wages paid prior to 1987—

(1) How a State must identify covered employees and what records it must keep on those employees;

(2) Periodic reviews of the source records kept on covered employees;

(3) How and when a State must report wages and pay contributions;

(4) What the State's liability for contributions is and how SSA figures the amount of those contributions;

(5) What happens if a State fails to pay its contributions timely;

(6) How errors in reports and contribution payments are corrected;

(7) How overpayments of contributions are credited or refunded;

(8) How assessments are made if contributions are underpaid; and

(9) How a State can obtain administrative or judicial review of a decision on a credit, refund, or assessment.

[53 FR 32976, Aug. 29, 1988, as amended at 57 FR 59911, Dec. 17, 1992]

§ 404.1202 Definitions.

(a) Terms which have special meaning in this subpart are described in this section. Where necessary, further explanation is included in the section where the term is used.

(b) Coverage terms:

Agreement— The agreement between the Secretary of Health and Human Services and the State containing the conditions under which retirement, survivors, disability and hospital

insurance coverage is provided for State and local government employees.

Coverage— The extension of Social Security protection (retirement, survivors, disability, and hospital insurance) by agreement between the Secretary of Health and Human Services and a State to employees of the State and its political subdivisions or by agreement between the Secretary of Health and Human Services and an interstate instrumentality to employees of the interstate instrumentality.

Coverage group— The grouping by which employees are covered under an agreement.

Employee— An employee as defined in section 210(j) of the Act. Usually, the common-law control test is used in determining whether an employer-employee relationship exists. The term also includes an officer of a State or political subdivision.

Governmental function— The traditional functions of government: legislative, executive, and judicial.

Interstate instrumentality— An independent legal entity organized by two or more States to carry out one or more functions. For Social Security coverage purposes under section 218 of the Act, an interstate instrumentality is treated, to the extent practicable, as a ''State.''

Modification— A change to the agreement between the Secretary of Health and Human Services and a State which provides coverage of the services of employees not previously covered or which alters the agreement in some other respect.

Political subdivision— A separate legal entity of a State which usually has specific governmental functions. The term ordinarily includes a county, city, town, village, or school district, and in many States, a sanitation, utility, reclamation, drainage, flood control, or similar district. A political subdivision includes an instrumentality of a State, one or more politicial subdivisions of a State, or a State and one or more of its political subdivisions.

Proprietary function— A business engaged in by a State or political subdivision such as a public amusement park or public parking lot.

Retirement system— A pension, annuity, retirement, or similar fund or system established by a State or political subdivision.

Secretary— The Secretary of Health and Human Services or authorized delegate.

SSA— The Social Security Administration.

State— Includes the fifty States, Puerto Rico, and the Virgin Islands. It does not include the District of Columbia, Guam or American Samoa. ''State'' also refers to an interstate instrumentality where applicable.

We— The Social Security Administration.

(c) Contributions, wage reporting, and adjustment terms—for wages paid prior to 1987:

Allowance of a credit or refund— The written notice to a State of the determination by SSA of the amount owed to the State by SSA, the period involved, and the basis for the determination.

Assessment— The written notice to a State of the determination by SSA of the amount (contributions or accrued interest) owed to SSA by the State, the period involved, and the basis for the determination.

Contributions— Payments made under an agreement which the State deposits in a Federal Reserve bank. The amounts are based on the wages paid to employees whose services are covered under an agreement. These amounts are equal to the taxes imposed under the Internal Revenue Code on emp1oyers and employees in private employment.

Contribution return— Form used to identify and account for all contributions actions.

Disallowance of a State's claim for credit or refund— The written notice to a State of the determination by SSA that the State's claim for credit or refund is denied, the period involved, and the basis for the determination.

Overpayment— A payment of more than the correct amount of contributions or interest.

Underpayment— A payment of less than the correct amount of contributions or interest.

Wage Reports— Forms used to identify employees who were paid wages for

covered employment and the amounts of those wages paid. This includes corrective reports.

§ 404.1203 Evidence—for wages paid prior to 1987.

(a) *State's responsibility for submitting evidence.* The State, under the provisions of the agreement, is responsible for accurately reporting the wages paid employees for services covered by the agreement and for paying the correct amount of contributions due on those wages. This responsibility includes submitting evidence to verify the accuracy of the reports and payments.

(b) *Failure to submit requested evidence.* The State is required to submit information timely to SSA. If we request additional evidence to verify the accuracy of reports and payments, we specify when that evidence must be submitted. If we do not receive the evidence timely, and the State provides no satisfactory explanation for its failure to submit the evidence timely, we may proceed, if appropriate, on the basis of the information we have. Proceeding on the basis of the information we have permits us to credit the wage records of employees properly, where possible, while continuing to work with the State to resolve remaining discrepancies.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1203 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§ 404.1204 Designating officials to act on behalf of the State.

(a) Each State which enters into an agreement shall designate the official or officials authorized to act on the State's behalf in administering the agreement. Each State shall inform SSA of the name, title, and address of the designated official(s) and the extent of each official's authority. For example, a State may indicate that the State official is authorized:

(1) To enter into an agreement and execute modifications to the agreement; and

(2) To carry out the ministerial duties necessary to administer the agreement.

For wages paid prior to 1987:

(3) To enter into agreements to extend or re-extend the time limit for assessment or credit;

(4) To make arrangements in connection with onsite reviews; and

(5) To request administrative review of an assessment, an allowance of a credit or refund, or a disallowance of a credit or refund.

(b) Each State shall inform SSA timely of changes in designated officials or changes in their authority.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1204 was revised, effective Aug. 29, 1988 with the exception of paragraphs (a)(5) and (b). Section 404.1204(a)(5) and (b) contain reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

WHAT GROUPS OF EMPLOYEES MAY BE COVERED

§ 404.1205 Absolute coverage groups.

(a) *General.* An absolute coverage group is a permanent grouping of employees, e.g., all the employees of a city or town. It is a coverage group for coverage and reporting purposes. When used for coverage purposes, the term refers to groups of employees whose positions are not under a retirement system. An absolute coverage group may include positions which were formerly under a retirement system and, at the State's option, employees who are in positions under a retirement system but who are ineligible (see § 404.1208) to become members of that system.

(b) *What an absolute coverage group consists of.* An absolute coverage group consists of one of the following employee groups:

(1) State employees performing services in connection with the State's governmental functions;

(2) State employees performing services in connection with a single proprietary function of the State;

(3) Employees of a State's political subdivision performing services in connection with that subdivision's governmental functions;

(4) Employees of a State's political subdivision performing services in connection with a single proprietary function of the subdivision;

(5) Civilian employees of a State's National Guard units; and

(6) Individuals employed under an agreement between a State and the U.S. Department of Agriculture as agricultural products inspectors.

(c) *Designated coverage groups.* A State may provide coverage for designated (i.e., selected) absolute coverage groups of the State or a political subdivision. When coverage is extended to these designated groups, the State must specifically identify each group as a designated absolute coverage group and furnish the effective date of coverage and any optional exclusion(s) for each group. Where a State has provided coverage to designated absolute coverage groups, the State may, by modifying its agreement, extend that coverage to any absolute coverage group in the State.

§404.1206 Retirement system coverage groups.

(a) *General.* Section 218(d) of the Act authorizes coverage of services of employees in positions under a retirement system. For purposes of obtaining coverage, a system may be considered a separate retirement system authorized by section 218(d)(6) (A) or (B) of the Act. Under this section of the Act a State may designate the positions of any one of the following groupings of employees as a separate retirement system:

(1) The entire system;

(2) The employees of the State under the system;

(3) The employees of each political subdivision in the State under the system;

(4) The employees of the State and the employees of any one or more of the State's political subdivisions;

(5) The employees of any combination of the State's political subdivisions;

(6) The employees of each institution of higher learning, including junior colleges and teachers colleges; or

(7) The employees of a hospital which is an integral part of a political subdivision.

If State law requires a State or political subdivision to have a retirement system, it is considered established even though no action has been taken to establish the system.

(b) *Retirement system coverage groups.* A retirement system coverage group is a grouping of employees in positions under a retirement system. Employees in positions under the system have voted for coverage for the system by referendum and a State has provided coverage by agreement or modification of its agreement. It is not a permanent grouping. It exists only for referendum and coverage purposes and is not a separate group for reporting purposes. Once coverage has been obtained, the retirememt system coverage group becomes part of one of the absolute coverage groups described in §404.1205(b).

(c) *What a retirement system coverage group consists of.* A retirement system coverage group consists of:

(1) Current employees—all employees whose services are not already covered by the agreement, who are in positions covered by the same retirement system on the date an agreement or modification of the agreement is made applicable to the system;

(2) Future employees—all employees in positions brought under the system after an agreement or modification of the agreement is signed; and

(3) Other employees—all employees in positions which had been under the retirement system but which were not under the retirement system when the group was covered (including ineligibles who had been optionally excluded from coverage under section 218(c)(3)(B) of the Act).

(d) *Referendum procedures.* Prior to signing the agreement or modification, the governor or an official of the State named by the governor (for an interstate instrumentality, its chief executive officer) must certify to the Secretary that:

(1) All eligible employees were given at least 90 days' notice of the referendum;

(2) All eligible employees were given an opportunity to vote in the referendum;

(3) Only eligible employees were permitted to vote in the referendum;

(4) Voting was by secret written ballot on the question of whether service in positions covered by the retirement system should be included under an agreement;

(5) The referendum was conducted under the supervision of the governor or agency or individual named by him; and

(6) A majority of the retirement system's eligible employees voted for coverage under an agreement.

The State has two years from the date of a favorable referendum to enter into an agreement or modification extending coverage to the retirement system coverage group. If the referendum is unfavorable, another referendum cannot be held until at least one year after that unfavorable referendum.

(e) *Who is covered.* If a majority of the eligible employees in a retirement system vote for coverage, all employees in positions in that retirement system become covered.

(f) *Coverage of employees in positions under more than one retirement system.* (1) If an employee occupies two or more positions each of which is under a different retirement system, the employee's coverage in each position depends upon the coverage extended to each position under each system.

(2) If an employee is in a single position which is under more than one retirement system (because the employee's occupancy of that position permits her or him to become a member of more than one retirement system), the employee is covered when the retirement system coverage group including her or his position is covered under an agreement unless (A) he or she is not a member of the retirement system being covered and (B) he or she is a member of a retirement system which has not been covered. This rule also applies to the coverage of services in policemen's and firemen's positions in interstate instrumentalities and in those States named in § 404.1212(c)(1).

§ 404.1207 Divided retirement system coverage groups.

(a) *General.* Under section 218(d)(6)(C) of the Act certain States and under section 218(g)(2) of the Act all interstate instrumentalities may divide a retirement system based on whether the employees in positions under that system want coverage. The States having this authority are Alaska, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin.

(b) *Divided retirement system coverage group.* A divided retirement system coverage group is a grouping under a retirement system of positions of members of the system who voted for coverage and positions of individuals who become members of the system (the ''yes'' group), and positions of members of the system who did not elect coverage (the ''no'' group) and ineligible employees (see § 404.1208). For purposes of this section for groups covered after 1959, the term ''member'' also includes individuals who have an option to become members of the retirement system but have not done so. The position of a member in the ''no'' group can be covered if, within two years after the agreement or modification extending coverage to the ''yes'' group is executed, the State provides an opportunity to transfer the position to the covered ''yes'' group and the individual occupying the position makes a written request for the transfer. The members of the ''no'' group can also be covered if, by referendum, a majority of them vote for coverage. If the majority votes for coverage, all positions of the members of the ''no'' group become covered. There is no further subdivision of the ''no'' group into those who voted for and those who voted against coverage. If the State requests, the ineligibles in the ''no'' group may become part of the ''yes'' group and have their services covered.

(c) *Referendum procedures.* To divide a retirement system, the State must conduct a referendum among the system's employees. If the system is to be divided, the governor or an individual named by him must certify to the Secretary that:

(1) The referendum was held by written ballot on the question of whether members of a retirement system wish coverage under an agreement;

(2) All members of the retirement system at the time the vote was held had the opportunity to vote;

(3) All members of the system on the date the notice of the referendum was issued were given at least 90 days' notice regarding the referendum;

(4) The referendum was conducted under the supervision of the governor or agency or person designated by him; and

(5) The retirement system was divided into two parts, one composed of positions of members of the system who voted for coverage and the other composed of the remaining positions under the retirement system.

After the referendum the State may include those members who chose coverage under its agreement as a retirement system coverage group. The State has two years from the date of the referendum to enter into an agreement or modification extending coverage to that group.

§404.1208 Ineligible employees.

(a) *Definition.* An ineligible is an employee who, on first occupying a position under a retirement system, is not eligible for membership in that system because of a personal disqualification like age, physical condition, or length of service.

(b) *Coverage of ineligible employees.* A State may, in its agreement or any modification to the agreement, provide coverage for the services of ineligible employees in one of three ways:

(1) As part of or as an addition to an absolute coverage group;

(2) As part of a retirement system coverage group covering all positions under the retirement system; or

(3) As part of or as an addition to a retirement system coverage group composed of those members in positions in a retirement system who chose coverage.

§404.1209 Mandatorily excluded services.

Some services are mandatorily excluded from coverage under a State's agreement. They are:

(a) Services of employees who are hired to relieve them from unemployment;

(b) Services performed in an institution by a patient or inmate of the institution;

(c) Transportation service subject to the Federal Insurance Contributions Act;

(d) Certain emergency services in case of fire, storm, snow, volcano, earthquake, flood or other similar emergency; and

(e) Services other than agricultural labor or student services which would be excluded from coverage if performed for a private employer.

(f) Services covered under section 210(a)(7)(F) of the Act. (See §404.1200(b).)

[53 FR 32976, Aug. 29, 1988, as amended at 57 FR 59911, Dec. 17, 1992]

§404.1210 Optionally excluded services.

Certain services and positions may, if the State requests it, be excluded from coverage. These exclusions may be applied on a statewide basis or selectively by coverage groups. They are:

(a) Services in any class or classes of elective positions;

(b) Services in any class or classes of part-time positions;

(c) Services in any class or classes of positions where the pay is on a fee basis;

(d) Any agricultural labor or student services which would also be excluded if performed for a private employer; and

(e) Services performed by election officials or election workers if the payments for those services:

(1) In a calendar quarter are less than $50; or

(2) For modifications executed after 1977, in a calendar year are less than $100.

§404.1211 Interstate instrumentalities.

For Social Security coverage purposes under section 218 of the Act, interstate instrumentalities are treated, to the extent practicable, as States, that is:

(a) They must be legally authorized to enter into an agreement with the Secretary;

(b) They are subject to the same rules that are applied to the States;

(c) They may divide retirement systems and cover only the positions of members who want coverage; and

(d) They may provide coverage for firemen and policemen in positions under a retirement system.

§ 404.1212 Policemen and firemen.

(a) *General.* For Social Security coverage purposes under section 218 of the Act, a policeman's or fireman's position is any position so classified under State statutes or court decisions. Generally, these positions are in the organized police and fire departments of incorporated cities, towns, and villages. In most States, a policeman is a member of the ''police'' which is an organized civil force for maintaining order, preventing and detecting crimes, and enforcing laws. The terms ''policeman'' and ''fireman'' do not include services in positions which, although connected with police and firefighting functions, are not policeman or fireman positions.

(b) *Providing coverage.* A State may provide coverage of:

(1) Policemen's and firemen's positions not under a retirement system as part of an absolute coverage group;

(2) Policemen's or firemen's positions, or both, as part of a retirement system coverage group for the States specified in paragraph (c)(1) of this section; or

(3) Firemen's positions only as a separate retirement system as set forth in paragraph (c)(2) of this section.

(c) *Policemen and firemen in positions under a retirement system.* (1) Some States and all interstate instrumentalities may provide coverage for employees in policemen's or firemen's positions, or both, which are under a retirement system by following the majority vote referendum procedures in § 404.1206(d). The States are Alabama, California, Florida, Georgia, Hawaii, Idaho, Kansas, Maine, Maryland, Mississippi, Montana, New York, North Carolina, North Dakota, Oregon, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington. Some States and all interstate instrumentalities may use the desire for coverage procedures in § 404.1207. The States are California, Florida, Georgia, Hawaii, New York, North Dakota, Tennessee, Texas, Vermont, and Washington.

(2) All States not listed in paragraph (c)(1) of this section may provide coverage for employees in firemen's positions which are under a retirement system by:

(i) Following the referendum procedures in § 404.1206(d); and

(ii) Submitting a certification by the governor, or an individual named by her or him, to the Secretary that extending coverage to this group of employees will improve their overall benefit protection.

HOW COVERAGE UNDER AGREEMENTS IS OBTAINED AND CONTINUES

§ 404.1214 Agreement for coverage.

(a) *General.* A State may enter into a written agreement with the Secretary to provide for Social Security coverage for its employees or the employees of one or more of its political subdivisions. An interstate instrumentality may enter into a similar agreement for its employees. These agreements cover employees in groups of positions or by types of services rather than the individual employees.

(b) *Procedures.* A State or interstate instrumentality may request coverage by submitting to SSA a proposed written agreement for the desired coverage.

(c) *Authority to enter into an agreement for coverage*—(1) *Federal law.* Section 218(a) of the Act requires the Secretary to enter into an agreement, at the request of the State, to extend Social Security coverage to the State's employees or those of its political subdivisions. Section 218(g) authorizes the Secretary to enter into an agreement, at the request of an interstate instrumentality, to extend Social Security coverage to the employees of the interstate instrumentality.

(2) *State law.* State law must authorize a State or an interstate instrumentality to enter into an agreement with the Secretary for Social Security coverage.

(d) *Provisions of the agreement.* The agreement must include:

(1) A description of the specific services to be covered and excluded;

(2) The State's promise to pay, to the Secretary of the Treasury,

contributions equal to the sum of the taxes which would be required under the Federal Insurance Contributions Act from employers and employees if the employment were in the private sector;

(3) The State's promise to comply with the regulations the Secretary prescribes for carrying out the provisions of section 218 of the Act; and

(4) Identification of the political subdivisions, coverage groups, or services being covered and the services that are excluded.

The agreement must be signed by the authorized State or interstate instrumentality official and the Secretary or his or her designee.

(e) *Effective date.* The agreement must specify an effective date of coverage. However, the effective date cannot be earlier than the last day of the sixth calendar year preceding the year in which the agreement is mailed or delivered by other means to the Secretary. The agreement is effective after the effective date.

(f) *Applicability of agreement.* The agreement establishes the continuing relationship between the Secretary and the State or interstate instrumentality except as it is modified (see §§ 404.1215–404.1217).

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1214 was revised, effective Aug. 29, 1988 with the exception of paragraph (d). Section 404.1214(d) contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§ 404.1215 Modification of agreement.

(a) *General.* A State or interstate instrumentality may modify in writing its agreement, for example, to:

(1) Exclude, in limited situations, employee services or positions previously covered;

(2) Include additional coverage groups; or

(3) Include as covered services:

(i) Services of covered employees for additional retroactive periods of time; and

(ii) Services previously excluded from coverage.

(b) *Controlling date for retroactive coverage.* A State may specify in the modification a date to make all individuals in the coverage group who were in an employment relationship on that date eligible for retroactive coverage. This date is known as the controlling date for retroactive coverage. It can be no earlier than the date the modification is mailed or otherwise delivered to the Secretary nor can it be later than the date the modification is signed by the Secretary. If the State does not designate a controlling date, the date the modification is signed by the Secretary is the controlling date.

(c) *Conditions for modification.* The provisions of section 218 of the Act which apply to the original agreement also apply to a modification to the agreement.

(d) *Effective date.* Generally, a modification must specify an effective date of coverage. However, the effective date cannot be earlier than the last day of the sixth calendar year preceding the year in which the modification is mailed or delivered by other means to the Secretary. The modification is effective after the effective date.

§ 404.1216 Modification of agreement to correct an error.

(a) *General.* If an agreement or modification contains an error, the State may correct the error by a subsequent modification to the agreement. For example, the agreement or modification incorrectly lists a covered service as an optionally excluded service or shows an improper effective date of coverage. In correcting this type of error, which affects the extent of coverage, the State must submit a modification along with evidence to establish that the error occurred. However, a modification is not needed to correct minor typographical or clerical errors. For example, an agreement or modification incorrectly lists School District No. 12 as School District No. 13. This type of error can be corrected based on a written request from the appropriate official of the State or interstate instrumentality.

(b) *Correction of errors involving erroneous reporting to the IRS—for wages paid prior to 1987.* Where a State or political subdivision makes reports and payments to the Internal Revenue

Service under the provisions of the Federal Insurance Contributions Act which apply to employees in private employment in the mistaken belief that this action would provide coverage for its employees, the State may provide the desired coverage for those same periods of time by a subsequent modification to its agreement. If State law permits, the State may make that coverage effective with the first day of the first period for which the erroneous reports and payments were made. (In this instance, the limitation on retroactive coverage described in § 404.1215(d) is not applicable.) Where the State does not want to provide such retroactive coverage or is not permitted to do so by State law, the State may provide the coverage for the affected coverage group as of a specified date (§ 404.1215(b)). The coverage would then apply to the services performed by individuals as members of the coverage group

(1) Who were employees on that date, and

(2) Whose wages were erroneously reported to IRS, and

(3) For whom a refund of FICA taxes has not been obtained at the time the Secretary executes the modification.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1216 was revised, effective August 29, 1988 with the exception of paragraph (a). Section 404.1216(a) contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§ 404.1217 Continuation of coverage.

The coverage of State and local government employees continues as follows:

(a) *Absolute coverage group.* Generally, the services of an employee covered as a part of an absolute coverage group (see § 404.1205) continue to be covered indefinitely. A position covered as a part of an absolute coverage group continues to be covered even if the position later comes under a retirement system. This includes policemen's and firemen's positions which are covered with an absolute coverage group.

(b) *Retirement system coverage group.* Generally, the services of employees in positions covered as a part of a retirement system coverage group continue to be covered indefinitely. For a retirement system coverage group made up of members who chose coverage, a position continues to be covered until it is removed from the retirement system and is no longer occupied by a member who chose coverage or by a new member of the system. Coverage is not terminated because the positions are later covered under additional retirement systems or removed from coverage under a retirement system, or because the retirement system is abolished with respect to the positions. However, if the retirement system has been abolished, newly created or reclassified positions or positions in a newly created political subdivision cannot be covered as a part of the retirement system coverage group. If the retirement system is not abolished, a newly created or reclassified position is a part of the coverage group if the position would have been a part of the group had it existed earlier. If the retirement system coverage group is made up of members who chose coverage, the newly created or reclassified position is a part of the coverage group if it is occupied by a member who chose coverage or by a new member.

§ 404.1218 Resumption of coverage.

Before April 20, 1983, an agreement could be terminated in its entirety or with respect to one or more coverage groups designated by the State. Coverage of any coverage group which has been previously terminated may be resumed by a modification to the agreement.

§ 404.1219 Dissolution of political subdivision.

If a political subdivision whose employees are covered under the agreement is legally dissolved, the State shall give us satisfactory evidence of its dissolution or nonexistence. The evidence must establish that the entity is not merely inactive or dormant, but that it no longer legally exists. We will notify the State whether the evidence is satisfactory.

HOW TO IDENTIFY COVERED EMPLOYEES

§404.1220 Identification numbers.

(a) *State and local government.* When a State submits a modification to its agreement under section 218 of the Act, SSA will assign a special identification number to each political subdivision included in that modification. SSA will inform the State of the special identification number(s) by sending a Form SSA–214–CD, ''Notice of Identifying Number,'' to the State. These numbers are assigned only for State bookkeeping purposes unless coverage is extended to periods prior to 1987. Then, the special number will be assigned and used for reporting the pre-1987 wages to SSA. The special number will also be assigned to an interstate instrumentality if pre-1987 coverage is obtained and SSA will send a Form SSA–214–CD to the interstate instrumentality to notify it of the number assigned.

(b) *Coverage group number for coverage groups.* If a State's agreement provides coverage for a State or a political subdivision based on designated proprietary or governmental functions, the State shall furnish a list of those groups. The list shall identify each designated function and the title and business address of the official responsible for filing each designated group's wage report. SSA assigns a coverage group number to each designated group based on the information furnished in the list.

(c) *Unit numbers for payroll record units.* SSA assigns, at a State's request, unit numbers to payroll record units within a State or political subdivision. When a State requests separate payroll record unit numbers, it must furnish the following:

(1) The name of each payroll record unit for the coverage group; and

(2) The title and business address of the official responsible for each payroll unit.

(d) *Unit numbers where contribution amounts are limited—for wages paid prior to 1987.* An agreement, or modification of an agreement, may provide for the computation of contributions as prescribed in §404.1256 for some employees of a political subdivision. In this situation, SSA assigns special unit numbers to the political subdivision to identify those employees. SSA does not assign a special unit number to a political subdivision in which the contributions for all employees are computed as prescribed in §404.1256.

(e) *Use.* For wages paid prior to 1987, the employer shall show the appropriate SSA-issued identifying number, including any coverage group or payroll record unit number, on records, reports, returns, and claims to report wages, adjustments, and contributions.

[53 FR 32976, Aug. 29, 1988, as amended at 60 FR 42433, Aug. 16, 1995]

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1220 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

WHAT RECORDS OF COVERAGE MUST BE KEPT

§404.1225 Records—for wages paid prior to 1987.

(a) *Who keeps the records.* Every State which enters into an agreement shall keep, or require the political subdivisions whose employees are included under its agreement to keep, accurate records of all remuneration (whether in cash or in a medium other than cash) paid to employees performing services covered by that agreement. These records shall show for each employee:

(1) The employee's name, address, and Social Security number;

(2) The total amount of remuneration (including any amount withheld as contributions or for any other reason) and the date the remuneration was paid and the period of services covered by the payment;

(3) The amount of remuneration which constitutes wages (see §404.1041 for wages and §§404.1047–404.1059 for exclusions from wages); and

(4) The amount of the employee's contribution, if any, withheld or collected, and if collected at a time other than the time such payment was made, the date collected. If the total remuneration (paragraph (a)(2) of this section) and the amount which is subject to contribution (paragraph (a)(3) of this section) are not equal, the reason shall be stated.

The State shall keep copies of all returns, reports, schedules, and statements required by this subpart, copies of claims for refund or credit, and copies of documents about each adjustment made under § 404.1265 or § 404.1271 as part of its records. These records may be maintained by the State or, for employees of a political subdivision, by the political subdivision. Each State shall use forms and systems of accounting as will enable the Secretary to determine whether the contributions for which the State is liable are correctly figured and paid.

(b) *Place and period of time for keeping records.* All records required by this section shall:

(1) Be kept at one or more convenient and safe locations accessible to reviewing personnel (see § 404.1232(a));

(2) Be available for inspection by reviewing personnel at any time; and

(3) Be maintained for at least four years from the date of the event recorded. (This four-year requirement applies regardless of whether, in the meantime, the employing entity has been legally dissolved or, before April 20, 1983, the agreement was terminated in its entirety or in part.)

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1225 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

REVIEW OF COMPLIANCE BY STATE WITH ITS AGREEMENT

§ 404.1230 Onsite review program.

To ensure that the services of employees covered by a State's agreement are reported and that those employees receive Social Security credit for their covered earnings, we periodically review the source records upon which a State's contribution returns and wage reports are based. These reviews are designed:

(a) To measure the effectiveness of the State's systems for ensuring that all wages for those employees covered by its agreement are reported and Social Security contributions on those wages are paid;

(b) To detect any misunderstanding of coverage or reporting errors and to advise the State of the corrective action it must take; and

(c) To find ways to improve a State's recordkeeping and reporting operations for the mutual benefit of the State and SSA.

§ 404.1231 Scope of review.

The onsite review focuses on four areas:

(a) State's controls and recordkeeping—to assess a State's systems for assuring timely receipt, correctness, and completeness of wage reports and contribution returns;

(b) Instruction, education, and guidance a State provides local reporting officials—to assess a State's systems for assuring on a continuing basis that all reporting officials and their staffs have the necessary instructions, guidelines, and training to meet the State's coverage, reporting and recordkeeping requirements;

(c) Compliance by reporting officials—to assess a State's systems for assuring that the reporting officials in the State have adequate recordkeeping procedures, are properly applying the appropriate provisions of the State's agreement, and are complying with reporting requirements; and

(d) Quality control with prompt corrective action—to assess a State's systems for assuring that its reports and those of its political subdivisions are correct, for identifying the causes and extent of any deficiencies, and for promptly correcting these deficiencies.

§ 404.1232 Conduct of review.

(a) Generally, SSA staff personnel conduct the onsite review. Occasionally, members of the Office of the Inspector General, Department of Health and Human Services (HHS), may conduct or participate in the review.

(b) The review is done when considered necessary by SSA or HHS or, if practicable, in response to a State's specific request for a review.

(c) All pertinent source records prepared by the State or its political subdivisions are reviewed, on site, to verify the wage reports and contribution returns. We may review with the appropriate employees in a subdivision

those source records and how the information is gathered, processed, and maintained. We notify the State's Social Security Administrator when we plan to make the review and request her or him to make the necessary arrangements.

(d) The review is a cooperative effort between SSA and the States to improve the methods for reporting and maintaining wage data to carry out the provisions of the agreement.

§404.1234 Reports of review's findings.

We provide the State Social Security Administrator with reports of the review's findings. These reports may contain coverage questions which need development and resolution and reporting errors or omissions for the State to correct promptly. These reports may also recommend actions the State can take to improve its information gathering, recordkeeping, and wage reporting systems, and those of its political subdivisions.

HOW TO REPORT WAGES AND CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

§404.1237 Wage reports and contribution returns—general—for wages paid prior to 1987.

(a) *Wage reports.* Each State shall report each year the wages paid each covered employee during that year. With the wage report the State shall also identify, as prescribed by SSA, each political subdivision by its assigned identification number and, where appropriate, any coverage group or payroll record unit number assigned.

(b) *Wage reports of remuneration for agricultural labor.* A State may exclude from its agreement any services of employees the remuneration for which is not wages under section 209(h)(2) of the Act. Section 209(h)(2) excludes as wages the cash remuneration an employer pays employees for agricultural labor which is less than $150 in a calendar year, or, if the employee performs the agricultural labor for the employer on less than 20 days during a calendar year, the cash remuneration computed on a time basis. If a State does exclude the services and the individual meets the cash-pay or 20-day test described in §404.1056, the State shall identify on the wage report and on any adjustment report each individual performing agricultural labor and the amount paid to her or him.

(c) *Contribution returns.* The State shall forward the contribution return as set out in §404.1249(b). It shall make contribution payments under §404.1262.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1237 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§404.1239 Wage reports for employees performing services in more than one coverage group—for wages paid prior to 1987.

(a) *Employee of State in more than one coverage group.* If a State employee is in more than one coverage group, the State shall report the employee's total wages, up to the annual wage limitations in §404.1047, as though the wages were paid by only one of the coverage groups.

(b) *Employee of political subdivision in more than one coverage group.* If an employee of a political subdivision is in more than one coverage group, the State shall report the employee's total wages, up to the annual wage limitations in §404.1047, as though the wages were paid by only one of the coverage groups.

(c) *Employee of State and one or more political subdivisions.* If an individual performs covered services as an employee of the State and an employee of one or more political subdivisions and the State agreement does not provide for limiting contributions under section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509, the State and each political subdivision shall report the amount of covered wages it paid the employee up to the annual wage limitations in §404.1047.

(d) *Employee of more than one political subdivision.* If an individual performs covered services as an employee of more than one political subdivision and the State agreement does not provide for limiting contributions under section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509, each political subdivision shall report

the covered wages it paid the employee up to the annual wage limitations in § 404.1047.

(e) *Employee performing covered services for more than one political entity where section 218(e)(2) of the Act is applicable.* If an agreement provides for limiting contributions under section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509, the reporting officials compute the total amount of wages paid the employee by two or more political subdivisions of a State, or a State and one or more of its political subdivisions, which were subject to section 218(e)(2) of the Act. The State reports the amount of wages paid up to the annual wage limitations in § 404.1047. The employee is treated as having only one employer. If the employee also had wages not subject to section 218(e)(2) of the Act, the State shall report those wages separately.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1239 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§ 404.1242 Back pay.

(a) *Back pay defined.* Back pay is pay received in one period of time which would have been paid in a prior period of time except for a wrongful or improper action taken by an employer. It includes pay made under Federal or State laws intended to create an employment relationship (including situations where there is unlawful refusal to hire) or to protect an employee's right to wages.

(b) *Back pay under a statute.* Back pay under a statute is a payment by an employer following an award, determination or agreement approved or sanctioned by a court or administrative agency responsible for enforcing a Federal or State statute protecting an employee's right to employment or wages. Examples of these statutes are:

(1) National Labor Relations Act or a State labor relations act;

(2) Federal or State laws providing reemployment rights to veterans;

(3) State minimum wage laws; and

(4) Civil Rights Act of 1964.

Payments based on legislation comparable to and having a similar effect as those listed in this paragraph may also qualify as having been made under a statute. Back pay under a statute, excluding penalties, is wages if paid for covered employment. It is allocated to the periods of time in which it should have been paid if the employer had not violated the statute. For backpay awards affecting periods prior to 1987, a State must fill a wage report and pay the contributions due for all periods involved in the back pay award under the rules applicable to those periods.

(c) *Back pay not under a statute.* Where the employer and the employee agree on the amount payable without any award, determination or agreement approved or sanctioned by a court or administrative agency, the payment is not made under a statute. This back pay cannot be allocated to prior periods of time but must be reported by the employer for the period in which it is paid.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1242 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§ 404.1243 Use of reporting forms—for wages paid prior to 1987.

(a) *Submitting wage reports.* In the form and manner required by SSA, a State shall submit an annual report of the covered wages the State and its political subdivisions paid their employees. Any supplemental, adjustment, or correctional wage report filed is considered a part of the State's wage report.

(b) *Correction of errors.* If a State fails to report or incorrectly reports an employee's wages on its wage report, the State shall submit a corrective report as required by SSA.

(c) *Reporting on magnetic tape or other media.* After approval by SSA, a State may substitute magnetic tape or other media for any form required for submitting a report or reporting information.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1243 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§404.1247 When to report wages—for wages paid prior to 1987.

A State shall report wages for the calendar year in which they were actually paid. If the wages were constructively paid in a prior calendar year, the wages shall be reported for the prior year (see §404.1042(b) regarding constructive payment of wages).

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1247 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§404.1249 When and where to make deposits of contributions and to file contribution returns and wage reports—for wages paid prior to 1987.

(a) *Deposits of contributions.* The State shall pay contributions in the manner required in §404.1262. (For failure to make deposits when due see §404.1265.) The contribution payment is considered made when received by the appropriate Federal Reserve bank or branch (see §404.1262). Except as provided in paragraphs (b) (2) and (3) and paragraph (c) of this section, contributions are due and payable as follows:

(1) *For wages paid before July 1, 1980.* Contribution payments for wages paid in a calendar quarter are due on the 15th day of the second month following the end of the calendar quarter during which the wages were paid.

(2) *For wages paid beginning July 1, 1980, and before January 1984.* Contribution payments for wages paid in a calendar month are due within the thirty day period following the last day of that month.

(3) *For wages paid after December 1983 and prior to 1987.* Contribution payments for wages paid in the first half of a calendar month are due on the last day of that month. Contribution payments for wages paid in the second half of that calendar month are due on the fifteenth day of the next month. (For purposes of this section, the first half of a calendar month is the first 15 days of that month and the second half is the remainder of that month.)

(b) *Contribution returns and wage reports*—(1) *Where to be filed.* The State shall file the original copies of all contribution returns, wage reports, and adjustment reports with the SSA.

(2) *When to be filed*—(i) *For years prior to execution of agreement or modification.* If an agreement or modification provides for the coverage of employees for periods prior to 1987, the State shall pay contributions due and shall file wage reports with SSA for these periods within 90 days after the date of the notice that the Secretary has signed the agreement or modification.

(ii) *For year of execution of agreement or modification.* If the agreement or modification provides for the coverage of employees for the year of execution of the agreement or modification, the State may, within 90 days after the date of the notice that the Secretary has signed the agreement or modification, submit a single contribution return and pay all contributions due for the following periods:

(A) The month in which the agreement or modification was signed;

(B) Any prior months in that year; and

(C) Any subsequent months before January 1984 (half-months after December 1983) whose contribution return and payment due date is within this 90 day period. The State shall file wage reports for that year by February 28 of the year following the date of execution or within 90 days of the date of the notice, whichever is later.

(iii) *For years after execution of agreement or modification.* Except as described in paragraph (b)(2)(ii) of this section, when the State pays its contributions under paragraph (a) of this section, it shall also file a contribution return. The State shall file the wage report for any calendar year after the year of execution of the agreement or modification by February 28 of the following calendar year.

(iv) For good cause shown, and upon written request by a State, the Secretary may allow additional time for

filing the reports and paying the related contributions described in paragraphs (b)(2)(i) and (b)(2)(ii) of this section.

(3) *Due date is on a weekend, legal holiday or Federal nonworkday.* If the last day for filing the wage report falls on a weekend, legal holiday or Federal nonworkday, the State may file the wage report on the next Federal workday. If the due date for paying contributions for the wages paid in a period (as specified in paragraph (a) of this section) falls on a weekend, legal holiday or Federal nonworkday, the State shall pay the contributions and shall file the contribution return no later than—

(i) The preceding Federal workday for wages paid in July 1980 through December 1983;

(ii) The next Federal workday for wages paid before July 1980 or after December 1983.

(4) *Submitting reports and payments.* When submitting the contribution returns or wage reports the State shall release them in time to reach SSA by the due date. When submitting contribution payments as described in § 404.1262, the State shall release the payments in time to reach the appropriate Federal Reserve bank or branch by the due date. In determining when to release any returns, reports, or payments the State shall provide sufficient time for them to timely reach their destination under the method of submission used, e.g., mail or electronic transfer of funds.

(c) *Payments by third party on account of sickness or accident disability.* Where a third party makes a payment to an employee on account of sickness or accident disability which constitutes wages for services covered under a State agreement, the wages will be considered, for purposes of the deposits required under this section, to have been paid to the employee on the date on which the employer receives notice from the third party of the amount of the payment. No interest will be assessed for failure to make a timely deposit of contributions due on such wages for which a deposit was made after December 1981 and before July 1982, to the extent that the failure to make the deposit timely is due to reasonable cause and not willful neglect.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1249 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§ 404.1251 Final reports—for wages paid prior to 1987.

If a political subdivision is legally dissolved, the State shall file a final report on that entity. The report shall include each coverage group whose existence ceases with that of the entity. It shall:

(a) Be marked ''final report'';

(b) Cover the period during which final payment of wages subject to the agreement is made; and

(c) Indicate the last date wages were paid.

With the final report, the State shall submit a statement showing the title and business address of the State official responsible for keeping the State's records and of each State and local official responsible for keeping the records for each coverage group whose existence is ended. The State shall also identify, as prescribed by SSA, each political subdivision by its assigned number and, where applicable, any coverage group or payroll record unit number assigned.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1251 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

WHAT IS A STATE'S LIABILITY FOR CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

§ 404.1255 State's liability for contributions—for wages paid prior to 1987.

A State's liability for contributions equals the sum of the taxes which would be imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954, if the services of the employees covered by the State's agreement were employment as defined in section 3121 of the Code. The State's liability begins when those covered services are

performed, for which wages are actually or constructively paid to those individuals, including wages paid in a form other than cash (see § 404.1041(d)). If an agreement is effective retroactively, the State's liability for contributions on wages paid during the retroactive period begins with the date of execution of the agreement or applicable modification. Where coverage of a coverage group has been terminated, the State is liable for contributions on wages paid for covered services even if the wages are paid after the effective date of termination of coverage.

§ 404.1256 Limitation on State's liability for contributions for multiple employment situations—for wages paid prior to 1987.

(a) *Limitation due to multiple employment.* Where an individual in any calendar year performs covered services as an employee of a State and as an employee of one or more political subdivisions of the State, or as an employee of more than one political subdivision; and the State provides all the funds for payment of the amounts which are equivalent to the taxes imposed on the employer under FICA on that individual's remuneration for those services; and no political subdivision reimburses the State for paying those amounts; the State's agreement or modification of an agreement may provide that the State's liability for the contributions on that individual's remuneration shall be computed as though the individual had performed services in employment for only one political subdivision. The State may then total the individual's covered wages from all these governmental employers and compute the contributions based on that total subject to the wage limitations in § 404.1047.

(b) *Identification of employees in multiple employment.* An agreement or modification of an agreement providing for the computation of contributions as described in paragraph (a) of this section shall identify the class or classes of employees to whose wages this method of computing contributions applies. For example, the State may provide that such computation shall apply to the wages paid to all individuals for services performed in positions covered by a particular retirement system, or to the wages paid to all individuals who are members of any two or more coverage groups designated in an agreement or modification. The State shall promptly notify SSA if the conditions in paragraph (a) of this section are no longer met by any class or classes of employees identified in an agreement or modification. In its notification, the State shall identify each class of employees and the date on which the conditions ceased to be met.

(c) *Effective date.* In the agreement or modification, the State shall provide that the computation of contributions shall apply to wages paid after the effective date stated in the agreement or modification. That date may be the last day of any calendar year; however, it may be no earlier than January 1 of the year in which the agreement or modification is submitted to SSA.

FIGURING THE AMOUNT OF THE STATE'S CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

§ 404.1260 Amount of contributions—for wages paid prior to 1987.

The State's contributions are equal to the product of the applicable contribution rate (which is equivalent to both the tax rates imposed under sections 3101 and 3111 of the Internal Revenue Code) times the amount of wages actually or constructively paid for covered services each year (subject to the wage limitations in § 404.1047) to the employee.

§ 404.1262 Manner of payment of contributions by State—for wages paid prior to 1987.

When paying its contributions, the State shall deposit its payment at the specific Federal Reserve bank or branch designated by SSA.

§ 404.1263 When fractional part of a cent may be disregarded—for wages paid prior to 1987.

In paying contributions to a Federal Reserve bank or branch, a State may disregard a fractional part of a cent unless it amounts to one-half cent or more, in which case it shall be increased to one cent. Fractional parts of

a cent shall be used in computing the total of contributions.

IF A STATE FAILS TO MAKE TIMELY PAYMENTS—FOR WAGES PAID PRIOR TO 1987

§ 404.1265 Addition of interest to contributions—for wages paid prior to 1987.

(a) *Contributions not paid timely.* If a State fails to pay its contributions to the appropriate Federal Reserve bank or branch (see § 404.1262), when due under § 404.1249(a), we add interest on the unpaid amount of the contributions beginning with the date the payment was due, except as described in paragraphs (b) and (c) of this section. Interest, if charged, begins with the due date even if it is a weekend, legal holiday or Federal nonwork day. Interest is added at the rate prescribed in section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509.

(b) *Method of making adjustment.* (1) If a State shall file a contribution return and shall accompany such return with payment of contributions due and payable as reported on such return in accordance with § 404.1249 but the amount of the contributions reported and paid is less than the correct amount of contributions due and payable and the underpayment of contributions is attributable to an error in computing the contributions (other than an error in applying the rate of contributions in effect at the time the wages were paid), the State shall adjust the underpayment by reporting the additional amount due by reason of such underpayment either as an adjustment of total contributions due with the first wage report filed after notification of the underpayment by the Social Security Administration, or as a single adjustment of total contributions due with any contribution return filed prior to the filing of such wage report.

(2) If an underpayment of contributions is due to an underreporting of or a failure to report one or more employees:

(i) Where the underreporting or failure to report has been ascertained by the State, the State may cause an adjustment by filing a report within 30 days after ascertainment of the error by the State;

(ii) Where the underreporting or failure to report has been ascertained by the Social Security Administration, a notification of underpayment shall be forwarded to the State, and the State may cause an adjustment of the underpayment by returning to the Social Security Administration, within 30 days from the date of the notification, a copy of the notification of underpayment and the State's corrected report. The report shall show the amount of wages, if any, erroneously reported for the reporting period and the correct amount of wages that should have been reported and the identification number of the State or the political subdivision for each employee who was omitted or erroneously reported. The filing to correct an underreporting of or a failure to report one or more employees' wages shall not constitute an adjustment under this section unless the wages were erroneously omitted or erroneously reported.

(c) *Payment.* The amount of each underpayment adjusted in accordance with this section shall be paid to the Federal Reserve Bank, or branch thereof, serving the district in which the State is located, without interest, at the time of reporting the adjustment; except that where any amounts due with respect to such an adjustment had been paid in error to IRS and a refund thereof timely requested from, or instituted by, IRS, the amount of underpayment adjusted in accordance with this section, plus any interest paid by IRS on the amount of such underpayment, shall be paid to the Federal Reserve Bank, or branch thereof, serving the district in which the State is located, at the time of reporting the adjustment or within 30 days after the date of issuance by IRS of the refund of the erroneous payments, whichever is later. Except as provided in the preceding sentence of this paragraph, if an adjustment is reported pursuant to paragraph (b) of this section, but the amount thereof is not paid when due, interest thereafter accrues.

(d) *Verifying contributions paid against reported wages.* We check the computation of contributions to verify that a State has paid the correct amount of contributions on the wages it reports for a calendar year (see § 404.1249(b)(2)).

If we determine that a State paid less than the amount of contributions due for that year, we add interest to the amount of the underpayment. We would add interest beginning with the date the unpaid contributions were initially due to the date those contributions are paid. However, if the total amount of the underpayment is 5 percent or less than 5 percent of the contributions due for a calendar year based upon the State's wage report and the State deposits the underpaid amount within 30 days after the date of our notification to the State of the amount due, the State may request that the interest on the underpaid amount be waived for good cause. This request must be made within 30 days of our notification to the State of the amount due. Such requests will be evaluated on an individual basis. The evaluation will include, but not be limited to, consideration of such factors as the circumstances causing the late payment, the State's past record of late payments and the amount involved.

Examples

(1) The records of a political subdivision for the month of June are destroyed by fire. The State makes an estimated deposit of contributions for the month of June for that political subdivision and deposits contributions for the month of June for all other political subdivisions based on actual records. At the time SSA verifies contributions paid against reported wages, we discover that the State has paid only 97 percent of its total liability for the year. Within 30 days after we notify it of the amount due, the State asks that we waive the interest on the unpaid amount and the State deposits the unpaid amount. In this situation, we would waive the interest on the unpaid contributions.

(2) We would waive interest if:

(i) Some of the political subdivisions made small arithmetical errors in preparing their reports of wages,

(ii) After verification of the contributions paid against reported wages, SSA discovers that minimal additional contributions are due,

(iii) Within 30 days of our notice to the State regarding this underpayment the State, which usually makes its deposits timely, pays the amount due, and

(iv) Within that same 30 day period the State requests that we waive the interest due.

(3) We would not waive interest where a State frequently has problems depositing its contributions timely. Reasons given for the delays are, e.g., the computer was down, the 5 p.m. mail pickup was missed, one of the school district reports was misplaced. If requested we would not waive interest on this State's late payment of contributions based upon its past record of late payments and because of the circumstances cited.

(e) *Due date is on a weekend, legal holiday or Federal nonworkday.* If the last day of the 30-day periods specified in paragraphs (b) and (d) of this section is on a weekend, legal holiday or Federal nonworkday, the State shall make the required deposit or request for waiver of payment of interest on the next Federal workday.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1265 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§404.1267 Failure to make timely payments—for wages paid prior to 1987.

If a State does not pay its contributions when due, the Secretary has the authority under section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509 to deduct the amounts of the unpaid contributions plus interest at the rate prescribed from any amounts certified by her or him to the Secretary of the Treasury for payments to the State under any other provision of the Social Security Act. The Secretary notifies the Secretary of the Treasury of the amounts deducted and requests that the amount be credited to the Trust Funds. Amounts deducted are considered paid to the State under the other provision of the Social Security Act.

HOW ERRORS IN REPORTS AND CONTRIBUTIONS ARE ADJUSTED—FOR WAGES PAID PRIOR TO 1987

§404.1270 Adjustments in general—for wages paid prior to 1987.

States have the opportunity to adjust errors in the payment of contributions. A State but not its political subdivisions is authorized to adjust errors in the underpayment of contributions.

Similarly, the State shall file all claims for credits or refunds and SSA makes the credits and refunds only to the State. Generally, we do not refund contributions in cash to a State unless the State is not expected to have future liability for contributions under section 218 of the Act.

§ 404.1271 Adjustment of overpayment of contributions—for wages paid prior to 1987.

(a) *General.* If a State pays more than the correct amount of contributions, the State shall adjust the overpayment with the next contribution return filed on which the amount owed equals or exceeds the amount of the overpayment.

(b) *Overpayment due to overreporting of wages*—(1) *Report to file.* If the overpayment is due to the State's reporting more than the correct amount of wages paid to one or more employees during a reporting period and the overpayment is not adjusted under paragraph (a) of this section, the State shall file a report on the appropriate form showing:

(i) The corrected wage data as prescribed by SSA; and

(ii) The reason why the original reporting was incorrect.

(2) *Refund or credit of overpayment where section 218(e)(2) of the Act not applicable.* If:

(i) The State collected contributions from employees in excess of the amount of taxes that would have been required under section 3101 of the Internal Revenue Code; and

(ii) The State paid to the Secretary of the Treasury those contributions plus a matching amount in excess of the taxes which would have been required from an employer under section 3111 of the Code; and

(iii) The services of the employees in question would have constituted employment under section 3121(b) of the Code; and

(iv) Section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509 does not apply (see § 404.1256(a)), then the State shall adjust the overpaid contributions under paragraph (b)(1) of this section. With its adjustment the State, where appropriate, shall include on the prescribed form a statement that the employees from whom the excess contributions were collected have not received nor expect to receive a refund of excess contributions under section 6413(c) of the Internal Revenue Code of 1954 (see § 404.1275(b)). Generally, if the State does not include this statement with its adjustment request, we only refund or credit the State for up to one-half of the overpaid amount.

(c) *Refund or credit of overpayment where section 218(e)(2) of the Act applicable.* (1) *General.* If—

(i) The overreporting of the amount of wages paid to one or more employees during a reporting period(s) is due to a computation of contributions under § 404.1256 for a year or years prior to the year in which the agreement or modification providing for the computation is entered into, or

(ii) The overreporting is due to a failure to compute § 404.1256,

the State shall adjust the overpayment under paragraph (b)(1) of this section. An overpayment due to overreported wages which does not result from the computation of contributions or a failure to compute contributions under § 404.1256 shall also be adjusted by the State under paragraph (b)(1) of this section. If the adjustment of the overpayment results in an underreporting of wages for any employee by the State or any political subdivision, the State shall include with the report adjusting the overpayment a report adjusting each underreporting. If the adjustment of the overpayment does not result in an underreporting of wages for any employee by the State or any political subdivision, the State shall include with the report adjusting the overpayment a statement that the adjustment of the overpayment does not result in any underreporting.

(2) *Amount of refund or credit.* If the State collects excess contributions from employees, the State's claim for refund or credit is limited to the overpaid amounts. (See § 404.1275 relating to adjustment of employee contributions.) If—

(i) The State collected the correct amount of contributions from employees based on the amount of wages reported and the Forms W–2 issued to the employees show only the amount of contributions actually collected, but

the amount of wages reported is being adjusted downward, or

(ii) The State collects excess contributions from employees but Forms W–2 have not been issued for an amount of wages which is being adjusted downward, the State may claim a refund or credit for the overpaid amounts. Where the State's claim for refund or credit is for the total overpaid amount, the adjustment report shall include a statement that excess contributions have not been collected from employees, or, where excess contributions have been collected, that Forms W–2 have not been issued and that, when issued, they will show the correct amount of employee contributions.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1271 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§ 404.1272 Refund or recomputation of overpayments which are not adjustable—for wages paid prior to 1987.

(a) *General.* If a State pays more than the correct amount of contributions or interest to the appropriate Federal Reserve bank or branch (see § 404.1262), and no adjustment in the amount of reported wages is necessary, that State may file a claim for refund or recomputation of the overpayment.

(b) *Form of claim.* No special form is required to make a claim for a refund or recomputation. If a credit is taken under § 404.1271, a claim is not required.

(c) *Proof of representative capacity.* If a report or return is made by an authorized official of the State who ceases to act in an official capacity and a claim for a refund is made by a successor official, the successor official must submit with the claim written evidence showing that he or she has the authority to make a claim for and receive a refund of any contributions paid by the former official. The written evidence is not necessary if the successor official has previously filed one or more reports or returns which contain her or his signature and official title.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1272 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget. A notice announcing the effective date will be published in the FEDERAL REGISTER.

§ 404.1275 Adjustment of employee contributions—for wages paid prior to 1987.

The amount of contributions a State deducts from an employee's remuneration for covered services, or any correction of that amount, is a matter between the employee and the State or political subdivision. The State shall show any correction of an employee's contribution on statements it furnishes the employee under § 404.1226. Where the State issues an employee a Form W–2 and then submits an overpayment adjustment but claims less than the total overpaid amount as a refund or credit, the State shall not correct the previously issued Form W–2 to reflect that adjustment.

§ 404.1276 Reports and payments erroneously made to Internal Revenue Service-transfer of funds—for wages paid prior to 1987.

(a) *General.* In some instances, State or local governmental entities not covered under an agreement make reports and pay contributions to IRS under the Federal Insurance Contributions Act (FICA) procedures applicable to private employers in the mistaken belief that this provides Social Security coverage under section 218 of the Act for their employees. In other instances, entities which are covered under an agreement erroneously report to IRS, or a State or local government employee reports other employees to IRS or reports to IRS as a self-employed individual. Where these reports and payments are erroneously made to IRS, the State may correct the error and obtain coverage under its agreement as described in paragraphs (b) through (f) of this section.

(b) *Political subdivision not included in the State agreement.* We notify the State that if it desires coverage, it may be provided by either a regular modification or an error modification, depending on the circumstances (§§ 404.1215

and 404.1216). In most cases, the State may obtain coverage by a regular modification. If a regular modification cannot be used (e.g., State law does not permit the retroactive effective date which would be desired), the State may use an error modification. The effective date of either modification depends on the facts of the situation being corrected.

(c) *Political subdivision included in the agreement.* If a political subdivision included in the agreement erroneously makes reports and payments under FICA procedures, the State must correct the reportings for periods not barred by the statute of limitations. If the covered entity reported both under the agreement and under FICA procedures, we notify IRS and make necessary corrections in the earnings records. We also advise the State that the entity which reported under FICA procedures should request a refund of payments erroneously made to IRS.

(d) *State and local government employees erroneously reported as employees of individual or as self-employed—(1) Covered entity.* If employees of a covered entity are erroneously reported as employees of an individual or as self-employed, we advise the State that the individual who made the reports should request a refund from IRS for periods not barred by the statute of limitations. We require the State to file correctional reports and returns for any periods open under the State and local statute of limitations.

(2) *Noncovered entity.* We advise the State that the individual who made the reports should request a refund from IRS for the periods not barred by the statute of limitations. If the State wishes to provide coverage, it must submit a modification as discussed in paragraph (b) of this section. If the State does not wish to provide coverage, we void the reports. Amounts reported for periods barred by the statute of limitations remain on the earnings records.

(e) *Filing wage reports and paying contributions.* Generally, the entity or individual that makes the erroneous reports and payments requests the refund from IRS for periods not barred by the statute of limitations. The State files the necessary reports with SSA and pays any contributions due. The reports shall conform to the coverage provided by the agreement to the extent permitted by the statute of limitations. The due date for these reports depends on whether original reports or adjustment reports are involved. Reports and contribution returns for the entire retroactive period of coverage provided by a regular or error modification are due 90 days after the date of execution of the modification. The time limitations for issuing assessments and credits or refunds extend from this due date. Thus, SSA may issue assessments or credits or refunds for periods barred to refund by IRS. The State may request that reports and payments for the IRS barred periods be considered made under the agreement as described in paragraph (f) of this section.

(f) *Use of transfer procedure.* In limited situations, the State may request that reports and payments the State or a political subdivision (but not an individual) erroneously made under FICA procedures and which have been posted to the employee's earnings record be considered made under the State's agreement. We use a transfer procedure to do this. The transfer procedure may be used only where

(1) The periods are open to assessment under the State and local statute of limitations;

(2) The erroneous reports to be transferred are posted to SSA's records;

(3) The periods are barred to refund under the IRS statute of limitations; and

(4) A refund is not obtained from IRS by the reporting entity.

HOW OVERPAYMENTS OF CONTRIBUTIONS ARE CREDITED OR REFUNDED—FOR WAGES PAID PRIOR TO 1987

§ 404.1280 Allowance of credits or refunds—for wages paid prior to 1987.

If a State pays more than the amount of contributions due under an agreement, SSA may allow the State, subject to the time limitations in § 404.1282 and the exceptions to the time limitations in § 404.1283, a credit or refund of the overpayment.

§404.1281 Credits or refunds for periods of time during which no liability exists—for wages paid prior to 1987.

If a State pays contributions for any period of time for which contributions are not due, but the State is liable for contributions for another period, we credit the amount paid against the amount of contributions for which the State is liable. We refund any balance to the State.

§404.1282 Time limitations on credits or refunds—for wages paid prior to 1987.

(a) *General.* To get a credit or refund, a State must file a claim for a credit or refund of the overpaid amount with the Secretary before the applicable time limitation expires. The State's claim for credit or refund is considered filed with the Secretary when it is delivered or mailed to the Secretary. Where the time limitation ends on a weekend, legal holiday or Federal nonworkday, we consider a claim timely filed if it is filed on the next Federal workday.

(b) *Time limitation.* Subject to the exceptions in §404.1283, a State must file a claim for credit or refund of an overpayment before the end of the latest of the following time periods:

(1) 3 years, 3 months, and 15 days after the year in which the wages in question were paid or alleged to have been paid; or

(2) 3 years after the due date of the payment which included the overpayment; or

(3) 2 years after the overpayment was made to the Secretary of the Treasury.

§404.1283 Exceptions to the time limitations on credits or refunds for wages paid prior to 1987.

(a) (1) *Extension by agreement.* The applicable time period described in §404.1282 for filing a claim for credit for, or refund of, an overpayment may, before the expiration of such period, be extended for no more than 6 months by written agreement between the State and the Secretary. The agreement must involve and identify a known issue or reporting error. It must also identify the periods involved, the time limitation which is being extended and the date to which it is being extended, and the coverage group(s) and position(s) or individual(s) to which the agreement applies. The extension of the period of limitation shall not become effective until the agreement is signed by the appropriate State official and the Secretary. (See §404.3(c) for the applicable rule where periods of limitation expire on nonwork days.) A claim for credit or refund filed by the State before the extended time limit ends shall be considered to have been filed within the time period limitation specified in section 218(r)(1) of the Act as it read prior to the enactment of Pub. L. 99–509. (See §404.1282.)

(2) *Reextension.* An extension agreement provided for in paragraph (a)(1) of this section may be reextended by written agreement between the State and the Secretary for no more than 6 months at a time beyond the expiration of the prior extension or reextension agreement, and only if one of the following conditions is met:

(i) Litigation (including intrastate litigation) or a review under §§404.1290 or 404.1297 involving wage reports or corrections on the same issue is pending; or

(ii) The State is actively pursuing corrections of a known error which require additional time to complete; or

(iii) The Social Security Administration is developing a coverage or wage issue which was being considered before the statute of limitations expired and additional time is needed to make a determination; or

(iv) The Social Security Administration has not issued to the State a final audit statement on the State's wage or correction reports; or

(v) There is pending Federal legislation which may substantially affect the issue in question, or the issue has national implications.

(b) *Deletion of wage entry on employee's earnings record.* If the Secretary, under section 205(c)(5) (A), (B), or (E) of the Act, deletes a wage entry on an individual's earnings record, a claim for credit or refund of the overpayment resulting from the deletion is considered filed within the applicable time limitations in §404.1282 if

(1) The State files the claim before the Secretary's decision regarding the

deletion of the wage entry from the individual's earnings record becomes final or

(2) The State files a claim regarding the deletion of the wage entry from the individual's earnings record which entry is erroneous because of fraud.

§ 404.1284 Offsetting underpayments against overpayments—for wages paid prior to 1987.

(a) *State fails to make adjustment for allowance of credit.* If SSA notifies a State that a credit is due the State, and the State does not make the adjustment for the allowance of the credit, SSA offsets the credit against any contributions or interest due. Before making the offset, SSA will give the State an opportunity to make the adjustment.

(b) *State fails to make adjustment for underpayment of contributions or interest due.* If SSA notifies a State that contributions or interest are due, and the State does not pay the contributions or interest, SSA offsets the contributions or interest due against any credit due the State. Before making the offset, SSA will give the State an opportunity to pay the underpayment or interest due.

HOW ASSESSMENTS FOR UNDERPAYMENTS OF CONTRIBUTIONS ARE MADE—FOR WAGES PAID PRIOR TO 1987

§ 404.1285 Assessments of amounts due—for wages paid prior to 1987.

(a) A State is liable for any amount due (which includes contributions or interest) under an agreement until the Secretary is satisfied that the amount has been paid to the Secretary of the Treasury. If the Secretary is not satisfied that a State has paid the amount due, the Secretary issues an assessment for the amount due subject to the time limitations in § 404.1286 and the exceptions to the time limitations in §§ 404.1287 and 404.1289. If detailed wage information is not available, the assessment is issued based on the following:

(1) The largest number of individuals whose services are known to be covered under the agreement is used for computation purposes;

(2) The individuals are assumed to have maximum creditable earnings each year;

(3) The earnings are considered wages for covered services; and

(4) The amount computed is increased by twenty percent to insure that all covered wages are included in the assessment.

(b) If the State pays the amount assessed and the assessed amount is later determined to be more than the amount actually due, we issue a refund or credit to that State for the excess amount. When the assessment is issued within the applicable time limitation, there is no time limit on collecting the amount due. An assessment is issued on the date that it is mailed or otherwise delivered to the State.

§ 404.1286 Time limitations on assessments—for wages paid prior to 1987.

(a) Subject to the exceptions to the time limitations in §§ 404.1287 and 404.1289, a State is not liable for an amount due under an agreement unless the Secretary makes an assessment for that amount before the later of the following periods ends:

(1) Three years, 3 months, and 15 days after the year in which the wages, upon which the amount is due, were paid; or

(2) Three years after the date the amount became due.

(b) Where the time limitation ends on a weekend, legal holiday or Federal nonworkday, an assessment is considered timely if the Secretary makes the assessment on the next Federal workday.

§ 404.1287 Exceptions to the time limitations on assessments—for wages paid prior to 1987.

(a)(1) *Extension by agreement.* The applicable time period described in § 404.1286 for assessment of an amount due may, before the expiration of such period, be extended for no more than 6 months by written agreement between the State and the Secretary. The agreement must involve and identify a known issue or reporting error. It must also identify the periods involved, the time limitation which is being extended and the date to which it is being extended, and the coverage group(s)

and position(s) or individual(s) to which the agreement applies. The extension of the period of limitation shall not become effective until the agreement is signed by the appropriate State official and the Secretary. (See § 404.3(c) for the applicable rule where periods of limitation expire on nonwork days.) An assessment made by the Secretary before the extended time limit ends shall be considered to have been made within the time period limitation specified in section 218(q)(2) of the Act as it read prior to the enactment of Pub. L. 99–509. (See § 404.1286.)

(2) *Reextension.* An extension agreement provided for in paragraph (a)(1) of this section may be reextended by written agreement between the State and the Secretary for no more than 6 months at a time beyond the expiration of the prior extension or reextension agreement, and only if one of the following conditions is met:

(i) Litigation (including intrastate litigation) or a review under § 404.1290 or § 404.1297 involving wage reports or corrections on the same issue is pending; or

(ii) The State is actively pursuing corrections of a known error which require additional time to complete; or

(iii) The Social Security Administration is developing a coverage or wage issue which was being considered before the statute of limitations expired and additional time is needed to make a determination; or

(iv) The Social Security Administration has not issued to the State a final audit statement on the State's wage or correction reports; or

(v) There is pending Federal legislation which may substantially affect the issue in question, or the issue has national implications.

(b) *The 365-day period.* If a State files a report before the applicable time limitation in § 404.1286 (or any extension under paragraph (a) of this section) ends and makes no payment or pays less than the correct amount due, the Secretary may assess the State for the amount due after the applicable time limitation has ended. However, the Secretary must make the assessment no later than the 365th day after the day the State makes payment to the Secretary of the Treasury. The Secretary can only make this assessment on the wages paid to the reported individuals for the reported periods. The Secretary, in making this assessment, credits the amount paid by the State on these individuals' wages for those reported periods.

(c) *Revision of employee's earnings record.* If, under section 205(c)(5) (A) or (B) of the Act, the Secretary credits wages to an individual's earnings record, the Secretary may make an assessment for any amount due on those wages before the Secretary's decision on revising the individual's earnings record becomes final. (Sections 404.822(c) (1) and (2) describe the time limits for revising an earnings record where an individual has applied for monthly benefits or a lump-sum death payment or requested that we correct his earnings record.)

(d) *Overpayment of contributions on wages of employee having other wages in a period barred to assessment.* If the Secretary allows a State a credit or refund of an overpayment for wages paid or alleged to have been paid an individual in a calendar year but the facts upon which the allowance is based establish that contributions are due on other wages paid that individual in that year which are barred to assessment, we may make an assessment notwithstanding the periods of limitation in § 404.1286. The assessment, however, must be made before or at the time we notify the State of the allowance of the credit or refund. In this situation, the Secretary reduces the amount of the State's credit or refund by the assessed amount and notifies the State accordingly. For purposes of this paragraph, the assessment shall only include contributions and not interest as provided for in section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509.

Example: The State files an adjustment report timely to correct an error in the amount reported as wages for an employee. The correction reduces the employee's wages for the year to less than the maximum amount creditable. The employee has other earnings in the same year which were not reported because of the previously reported maximum amounts. The applicable time limitation for assessing contributions on wages for the year has expired before the credit was allowed. The Secretary may assess for the underpaid contributions but no later than

thd date of the notice to the State that its claim for a credit had been allowed.

(e) *Evasion of payment.* The Secretary may make an assessment of an amount due at any time where the State's failure to pay the amount due results from the fraudulent attempt of an officer or employee of the State or political subdivision to defeat or evade payment of that amount.

§ 404.1289 Payment after expiration of time limitation for assessment—for wages paid prior to 1987.

The Secretary accepts wage reports filed by a State even though the applicable time limitation described in § 404.1286 (or as the time limitation is extended under § 404.1287) has expired, provided:

(a) The State pays to the Secretary of the Treasury the amount due on the wages paid to employees performing services in the coverage group in the calendar years for which the wage reports are being made; and

(b) The State agrees in writing with the Secretary to extend the time limitation for all employees in the coverage group in the calendar years for which the wage reports are being made.

In this situation, the time period for assessment is extended until the Secretary notifies the State that the wage reports are accepted. Where the State pays the amount due within the time period as extended under this section, the amount shall not include interest as provided for in section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509.

SECRETARY'S REVIEW OF DECISIONS ON CREDITS, REFUNDS, OR ASSESSMENTS—FOR WAGES PAID PRIOR TO 1987

§ 404.1290 Review of decisions by the Secretary—for wages paid prior to 1987.

(a) *Delegation of authority.* The Secretary, who has the authority under section 218(s) of the Act as it read prior to the enactment of Pub. L. 99–509 to review decisions on credits, refunds or assessments, has delegated this authority to the Commissioner of Social Security.

(b) *What decisions will be reviewed.* A State, under section 218(s) of the Act as it read prior to the enactment of Pub. L. 99–509, may request review of an assessment of an amount due from the State, an allowance to the State of a credit or refund of an overpayment, or a disallowance of the State's claim for credit or refund of an overpayment. The Commissioner may review regardless of whether the amount assessed has been paid or whether the credit or refund has been accepted by the State. Prior to the Commissioner's review, however, an assessment, allowance or disallowance may be reconsidered under §§ 404.1291 through 404.1293.

§ 404.1291 Reconsideration—for wages paid prior to 1987.

After the State requests review of the assessment or allowance or disallowance of a credit or refund, and prior to the Commissioner's review, that decision may be reconsidered, and affirmed, modified, or reversed. We notify the State of the reconsidered determination and the basis for it. The State may request the Commissioner to review this reconsidered determination under § 404.1294(b). In limited situations, SSA and the State may agree that the reconsideration process should be waived, e.g., where major policy is at issue.

§ 404.1292 How to request review—for wages paid prior to 1987.

(a) *Form of request.* No particular form of request is required. However, a written request for review must:

(1) Identify the assessment, allowance or disallowance being questioned;

(2) Describe the specific issue on which the review is requested;

(3) Contain any additional information or argument relevant to that issue; and

(4) Be signed by an official authorized to request the review on behalf of the State.

(b) *Submitting additional material.* A State has 90 days from the date it requests review to submit additional evidence it wishes considered during the review process. The time limit for submitting additional evidence may be extended upon written request of the State and for good cause shown.

§404.1293 Time for filing request for review—for wages paid prior to 1987.

(a) *Time for filing.* The State must file its request for review within 90 days after the date of the notice of assessment, allowance, or disallowance. Usually, the date of the request for review is considered the filing date. Where the 90-day period ends on a weekend, legal holiday or Federal nonworkday, a request filed on the next Federal workday is considered as timely filed.

(b) *Extension of time.* For good cause shown, and upon written application by a State filed prior to the expiration of the time for filing a request for review, additional time for filing the request may be allowed.

§404.1294 Notification to State after reconsideration—for wages paid prior to 1987.

(a) The State will be notified in writing of the reconsidered determination on the assessment, allowance, or disallowance, and the basis for the determination.

(b) If the State does not agree with the reconsidered determination, it has 90 days from the date of notice of the reconsidered determination to request the Commissioner to review that determination. The rules on what the request should contain and the time for filing the request are the same as in §§404.1292 and 404.1293.

§404.1295 Commissioner's review—for wages paid prior to 1987.

Upon request by the State, the Commissioner will review the reconsidered determination (or the assessment, allowance or disallowance as initially issued if reconsideration is waived under §404.1291). If necessary, the Commissioner may request the State to furnish additional evidence. Based upon the evidence considered in connection with the assessment, allowance or disallowance and any additional evidence submitted by the State or otherwise obtained by the Commissioner, the Commissioner affirms, modifies, or reverses the assessment, allowance or disallowance.

§404.1296 Commissioner's notification to the State—for wages paid prior to 1987.

The Commissioner notifies the State in writing of the decision on the assessment, allowance, or disallowance, and the basis for the decision.

HOW A STATE MAY SEEK COURT REVIEW OF SECRETARY'S DECISION—FOR WAGES PAID PRIOR TO 1987

§404.1297 Review by court—for wages paid prior to 1987.

(a) *Who can file civil action in court.* A State may file a civil action under section 218(t) of the Act as it read prior to the enactment of Pub. L. 99–509 requesting a district court of the United States to review any decision the Commissioner makes for the Secretary under section 218(s) of the Act as it read prior to the enactment of Pub. L. 99–509 concerning the assessment of an amount due, the allowance of a credit or refund, or the disallowance of a claim for credit or refund.

(b) *Where the civil action must be filed.* A State must file the civil action in the district court of the United States for the judicial district in which the State's capital is located. If the civil action is brought by an interstate instrumentality, it must file the civil action in the district court of the United States for the judicial district in which the instrumentality's principal office is located. The district court's judgment is final except that it is subject to review in the same manner as judgments of the court in other civil actions.

(c) *No interest on credit or refund of overpayment.* SSA has no authority to pay interest to a State after final judgment of a court involving a credit or refund of an overpayment made under section 218 of the Act.

§404.1298 Time for filing civil action—for wages paid prior to 1987.

(a) *Time for filing.* The State must file the civil action for a redetermination of the correctness of the assessment, allowance or disallowance within 2 years from the date the Commissioner mails to the State the notice of the decision under §404.1296. Where the 2-year period ends on a Saturday, Sunday,

legal holiday or Federal nonwork day, an action filed on the next Federal workday is considered timely filed.

(b) *Extension of time for filing.* The Commissioner, for good cause shown, may upon written application by a State filed prior to the end of the two-year period, extend the time for filing the civil action.

§ 404.1299 Final judgments—for wages paid prior to 1987.

(a) *Overpayments.* Payment of amounts due to a State required as the result of a final judgment of the court shall be adjusted under §§ 404.1271 and 404.1272.

(b) *Underpayments.* Wage reports and contribution returns required as the result of a final judgment of the court shall be filed under §§ 404.1237–404.1251. We will assess interest under § 404.1265 where, based upon a final judgment of the court, contributions are due from a State because the amount of contributions assessed was not paid by the State or the State had used an allowance of a credit or refund of an overpayment.

Subpart N—Wage Credits for Veterans and Members of the Uniformed Services

AUTHORITY: Secs. 205(a) and (p), 210(l) and (m), 215(h), 217, 229, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a) and (p), 410(l) and (m), 415(h), 417, 429, and 902(a)(5)).

SOURCE: 45 FR 16464, Mar. 14, 1980, unless otherwise noted.

GENERAL

§ 404.1301 Introduction.

(a) The Social Security Act (Act), under section 217, provides for noncontributory wage credits to veterans who served in the active military or naval service of the United States from September 16, 1940, through December 31, 1956. These individuals are considered World War II or post-World War II veterans. The Act also provides for noncontributory wage credits to certain individuals who served in the active military or naval service of an allied country during World War II. These individuals are considered World War II veterans. In addition, certain individuals get wage credits, under section 229 of the Act, for service as members of the uniformed services on active duty or active duty for training beginning in 1957 when that service was first covered for social security purposes on a contributory basis. These individuals are considered members of the uniformed services.

(b) World War II or post-World War II veterans receive wage credits based on the length of active military or naval service, type of separation from service and, in some cases, whether the veteran is receiving another Federal benefit. However, a member of a uniformed service receives wage credits regardless of length of service, type of separation, or receipt of another Federal benefit.

(c) The Social Security Administration (SSA) uses these wage credits, along with any covered wages or self-employment income of the veteran or member of a uniformed service, to determine entitlement to, and the amount of, benefits and the lump-sum death payment that may be paid to them, their dependents or survivors under the old-age, survivors', and disability insurance programs. These wage credits can also be used by the veteran or member of the uniformed service to meet the insured status and quarters of coverage requirements for a period of disability.

(d) This subpart tells how veterans or members of the uniformed services obtain wage credits, what evidence of service SSA requires, how SSA uses the wage credits, and how the wage credits are affected by payment of other benefits.

(e) This subpart explains that certain World War II veterans who die are considered (deemed) fully insured. This gives those veterans' survivors the same benefit rights as if the veterans were actually fully insured when they died.

(f) The rules are organized in the following manner:

(1) Sections 404.1310 through 404.1313 contain the rules on World War II veterans. We discuss who may qualify as a World War II veteran, how we determine whether the 90-day active service requirement for a World War II veteran is met, what we consider to be World War II active military or naval service,

and what we do not consider to be World War II active military or naval service.

(2) Sections 404.1320 through 404.1323 contain the rules on post-World War II veterans. We discuss who may qualify as a post-World War II veteran, how we determine whether the 90-day active service requirement for a post-World War II veteran is met, what we consider to be post-World War II active military or naval service, and what we do not consider to be post-World War II active military or naval service.

(3) In § 404.1325 we discuss what is a *separation under conditions other than dishonorable.* The law requires that a World War II or post-World War II veteran's separation from active military or naval service be other than dishonorable for the veteran to get wage credits.

(4) Section 404.1330 contains the rules on members of the uniformed services. We discuss who may qualify as a member of a uniformed service.

(5) In §§ 404.1340 through 404.1343, we discuss the amount of wage credits for veterans and members of the uniformed services, situations which may limit the use of wage credits for World War II and post-World War II veterans, and situations in which the limits do not apply.

(6) Sections 404.1350 through 404.1352 contain the rules on deemed insured status for World War II veterans. We discuss when deemed insured status applies, the amount of wage credits used for deemed insured World War II veterans, how the wage credits affect survivors' social security benefits, and when deemed insured status does not apply.

(7) Sections 404.1360 through 404.1363 contain the rules on the effect of other benefits on the payment of social security benefits and lump-sum death payments based on wage credits for veterans. We discuss what happens when we learn of a determination that a Veterans Administration pension or compensation is payable or that a Federal benefit is payable before or after we determine entitlement to a montly benefit or lump-sum death payment based on the death of the veteran.

(8) Sections 404.1370 and 404.1371 contain the rules on what we accept as evidence of a World War II and post-World War II veteran's active military or naval service, including date and type of separation, and what we accept as evidence of entitlement to wage credits for membership in a uniformed service during the years 1957 through 1967.

§ 404.1302 Definitions.

As used in this subpart—

Act means the Social Security Act, as amended.

Active duty means periods of time an individual is on full-time duty in the active military or naval service after 1956 and includes active duty for training after 1956.

Active service means periods of time prior to 1957 an individual was on full-time duty in the active military or naval service. It does not include totaling periods of active duty for training purposes before 1957 which are less than 90 days.

Allied country means a country at war on September 16, 1940, with a country with which the United States was at war during the World War II period. Each of the following countries is considered an allied country: Australia, Belgium, Canada, Czechoslovakia, Denmark, France, India, Luxembourg, the Netherlands, New Zealand, Norway, Poland, Union of South Africa, and the United Kingdom.

Domiciled in the United States means an individual has a true, fixed, and permanent home in the United States to which the individual intends to return whenever he or she is absent.

Federal benefit means a benefit which is payable by another Federal agency (other than the Veterans Administration) or an instrumentality owned entirely by the United States under any law of the United States or under a program or pension system set up by the agency or instrumentality.

Post-World War II period means the time period July 25, 1947, through December 31, 1956.

Reserve component means Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve, Coast Guard Reserve, National Guard of the United States or Air National Guard of the United States.

Resided in the United States means an individual had a place where he or she

lived, whether permanently or temporarily, in the United States and was bodily present in that place.

Survivor means you are a parent, widow, divorced wife, widower, or child of a deceased veteran or member of a uniformed service.

United States means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Veteran means an individual who served in the active military or naval service of the United States and was discharged or released from that service under conditions other than dishonorable. For a more detailed definition of the World War II veteran and a post-World War II veteran, see §§ 404.1310 and 404.1320.

Wage credit means a dollar amount we add to the earnings record of a veteran of the World War II or the post-World War II period. It is also a dollar amount we add to the earnings record of a member of a uniformed service who was on active duty after 1956. The amount is set out in the Act and is added for each month, calendar quarter, or calendar year of service as required by law.

We, us, or *our* means the Social Security Administration.

World War II period means the time period September 16, 1940, through July 24, 1947.

You or *your* means a veteran, a veteran's survivor or a member of a uniformed service applying for or entitled to a social security benefit or a lump-sum death payment.

WORLD WAR II VETERANS

§ 404.1310 Who is a World War II veteran.

You are a World War II veteran if you were in the active service of the United States during the World War II period and, if no longer in active service, you were separated from that service under conditions other than dishonorable after at least 90 days of active service. The 90-day active service requirement is discussed in § 404.1311.

§ 404.1311 Ninety-day active service requirement for World War II veterans.

(a) The 90 days of active service required for World War II veterans do not have to be consecutive if the 90 days were in the World War II period. The 90-day requirement cannot be met by totaling the periods of active duty for training purposes which were less than 90 days.

(b) If, however, all of the 90 days of active service required for World War II veterans were not in the World War II period, the 90 days must (only in those circumstances) be consecutive if the 90 days began before September 16, 1940, and ended on or after that date, or began before July 25, 1947, and ended on or after that date.

(c) The 90 days of active service is not required if the World War II veteran died in service or was separated from service under conditions other than dishonorable because of a disability or injury which began or worsened while performing service duties.

§ 404.1312 World War II service included.

Your service was in the active service of the United States during the World War II period if you were in the—

(a) Army, Navy, Marine Corps, or Coast Guard, or any part of them;

(b) Commissioned corps of the United States Public Health Service and were—

(1) On active commissioned service during the period beginning September 16, 1940, through July 28, 1945, and the active service was done while on detail to the Army, Navy, Marine Corps, or Coast Guard; or

(2) On active commissioned service during the period beginning July 29, 1945, through July 24, 1947, regardless of whether on detail to the Army, Navy, Marine Corps, or Coast Guard;

(c) Commissioned corps of the United States Coast and Geodetic Survey and were—

(1) During the World War II period—

(i) Transferred to active service with the Army, Navy, Marine Corps, or Coast Guard; or

(ii) Assigned to active service on military projects in areas determined

by the Secretary of Defense to be areas of immediate military hazard; or

(2) On active service in the Philippine Islands on December 7, 1941; or

(3) On active service during the period beginning July 29, 1945, through July 24, 1947;

(d) Philippine Scouts and performed active service during the World War II period under the direct supervision of recognized military authority;

(e) Active service of an allied country during the World War II period and—

(1) Had entered into that active service before December 9, 1941;

(2) Were a citizen of the United States throughout that period of active service or lost your United States citizenship solely because of your entrance into that service;

(3) Had resided in the United States for a total of four years during the five-year period ending on the day you entered that active service; and

(4) Were domiciled in the United States on that day; or

(f) Women's Army Auxiliary Corps, during the period May 14, 1942, through September 29, 1943, and performed active service with the Army, Navy, Marine Corps, or Coast Guard after September 29, 1943.

§404.1313 World War II service excluded.

Your service was not in the active service of the United States during the World War II period if, for example, you were in the—

(a) Women's Army Auxiliary Corps, except as described in §404.1312(f);

(b) Coast Guard Auxiliary;

(c) Coast Guard Reserve (Temporary) unless you served on active full-time service with military pay and allowances;

(d) Civil Air Patrol; or

(e) Civilian Auxiliary to the Military Police.

POST-WORLD WAR II VETERANS

§404.1320 Who is a post-World War II veteran.

You are a post-World War II veteran if you were in the active service of the United States during the post-World War II period and, if no longer in active service, you were separated from the service under conditions other than dishonorable after at least 90 days of active service. The 90-day active service requirement is discussed in §404.1321.

§404.1321 Ninety-day active service requirement for post-World War II veterans.

(a) The 90 days of active service required for post-World War II veterans do not have to be consecutive if the 90 days were in the post-World War II period. The 90-day requirement cannot be met by totaling the periods of active duty for training purposes before 1957 which were less than 90 days.

(b) If, however, all of the 90 days of active service required for post-World War II veterans were not in the post-World War II period, the 90 days must (only in those circumstances) be consecutive if the 90 days began before July 25, 1947, and ended on or after that date, or began before January 1, 1957, and ended on or after that date.

(c) The 90 days of active service is not required if the post-World War II veteran died in service or was separated from service under conditions other than dishonorable because of a disability or injury which began or worsened while performing service duties.

§404.1322 Post-World War II service included.

Your service was in the active service of the United States during the post-World War II period if you were in the—

(a) Air Force, Army, Navy, Marine Corps, Coast Guard, or any part of them;

(b) Commissioned corps of the United States Public Health Service and were on active service during that period;

(c) Commissioned corps of the United States Coast and Geodetic Survey and were on active service during that period; or

(d) Philippine Scouts and performed active service during the post-World War II period under the direct supervision of recognized military authority.

§ 404.1323 Post-World War II service excluded.

Your service was not in the active service of the United States during the post-World War II period if, for example, you were in the—

(a) Coast Guard Auxiliary;

(b) Coast Guard Reserve (Temporary) unless you served on active full-time service with military pay and allowances;

(c) Civil Air Patrol; or

(d) Civilian Auxiliary to the Military Police.

SEPARATION FROM ACTIVE SERVICE

§ 404.1325 Separation from active service under conditions other than dishonorable.

Separation from active service under conditions other than dishonorable means any discharge or release from the active service except—

(a) A discharge or release for desertion, absence without leave, or fraudulent entry;

(b) A dishonorable or bad conduct discharge issued by a general court martial of the Army, Navy, Air Force, Marine Corps, or Coast Guard of the United States, or by the active service of an allied country during the World War II period;

(c) A dishonorable discharge issued by the United States Public Health Service or the United States Coast and Geodetic Survey;

(d) A resignation by an officer for the good of the service;

(e) A discharge or release because the individual was a conscientious objector; or

(f) A discharge or release because the individual was convicted by a civil court for treason, sabotage, espionage, murder, rape, arson, burglary, robbery, kidnapping, assault with intent to kill, assault with a deadly weapon, or because of an attempt to commit any of these crimes.

[45 FR 16464, Mar. 14, 1980; 45 FR 22023, Apr. 3, 1980]

MEMBERS OF THE UNIFORMED SERVICES

§ 404.1330 Who is a member of a uniformed service.

A member of a uniformed service is an individual who served on active duty after 1956. You are a member of a uniformed service if you—

(a) Are appointed, enlisted, or inducted into—

(1) The Air Force, Army, Navy, Coast Guard, or Marine Corps; or

(2) A reserve component of the uniformed services in paragraph (a)(1) of this section (except the Coast Guard Reserve as a temporary member);

(b) Served in the Army or Air Force under call or conscription;

(c) Are a commissioned officer of the National Oceanic and Atmospheric Administration or its predecessors, the Environmental Science Services Administration and the Coast and Geodetic Survey;

(d) Are a commissioned officer of the Regular or Reserve Corps of the Public Health Service;

(e) Are a retired member of any of the above services;

(f) Are a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(g) Are a cadet at the United States Military Academy, Air Force Academy, or Coast Guard Academy, or a midshipman at the United States Naval Academy; or

(h) Are a member of the Reserve Officers Training Corps of the Army, Navy or Air Force, when ordered to annual training duty for at least 14 days and while performing official travel to and from that duty.

AMOUNTS OF WAGE CREDITS AND LIMITS ON THEIR USE

§ 404.1340 Wage credits for World War II and post-World War II veterans.

In determining your entitlement to, and the amount of, your monthly benefit or lump-sum death payment based on your active service during the World War II period or the post-World War II period, and for establishing a period of disability as discussed in §§ 404.132 and 404.133, we add the (deemed) amount of $160 for each month during a part of

which you were in the active service as described in § 404.1312 or § 404.1322. For example, if you were in active service from October 11, 1942, through August 10, 1943, we add the (deemed) amount of $160 for October 1942 and August 1943 as well as November 1942 through July 1943. The amount of wage credits that are added in a calendar year cannot cause the total amount credited to your earnings record to exceed the annual earnings limitation explained in §§ 404.1047 and 404.1096(b).

§ 404.1341 Wage credits for a member of a uniformed service.

(a) *General.* In determining your entitlement to, and the amount of your monthly benefit (or lump sum death payment) based on your wages while on active duty as a member of the uniformed service after 1956, and for establishing a period of disability as discussed in § 404.132, we add wage credits to the wages paid you as a member of that service. The amount of the wage credits, the applicable time periods, the wage credit amount limits, and the requirement of a minimum period of active duty service for granting these wage credits, are discussed in paragraphs (b), (c), and (d) of this section.

(b) *Amount of wage credits.* The amount of wage credits added is—

(1) $100 for each $300 in wages paid to you for your service in each calender year after 1977; and

(2) $300 for each calendar quarter in 1957 through 1977, regardless of the amount of wages actually paid you during that quarter for your service.

(c) *Limits on wage credits.* The amount of these wage credits cannot exceed—

(1) $1200 for any calendar year, or

(2) An amount which when added to other earnings causes the total earnings for the year to exceed the annual earnings limitation explained in §§ 404.1047 and 404.1096(b).

(d) *Minimum active-duty service requirement.* (1) If you enlisted for the first time in a regular component of the Armed Forces on or after September 8, 1980, you must complete the shorter of 24 months of continuous active duty or the full period that you were called to active duty to receive these wage credits, unless:

(i) You are discharged or released from active duty for the convenience of the government in accordance with section 1171 of title 10 U.S.C. or because of hardship as specified in section 1173 of title 10 U.S.C.;

(ii) You are discharged or released from active duty for a disability incurred or aggravated in line of duty;

(iii) You are entitled to compensation for service-connected disability or death under chapter 11 of title 38 U.S.C.;

(iv) You die during your period of enlistment; or

(v) You were discharged prior to October 14, 1982, and your discharge was—

(A) Under chapter 61 of title 10 U.S.C.; or

(B) Because of a disability which resulted from an injury or disease incurred in or aggravated during your enlistment which was not the result of your intentional misconduct and did not occur during a period of unauthorized absence.

(2) If you entered on active duty as a member of the uniformed services as defined in § 404.1330 *on or after* October 14, 1982, having neither previously completed a period of 24 months' active duty nor been discharged or released from this period of active duty under section 1171, title 10 U.S.C. (i.e., convenience of the government), you must complete the shorter of 24 months of continuous active duty or the full period you were called or ordered to active duty to receive these wage credits, unless:

(i) You are discharged or released from active duty for the convenience of the government in accordance with section 1171 of title 10 U.S.C. or because of hardship as specified in section 1173 of title 10 U.S.C.;

(ii) You are discharged or released from active duty for a disability incurred or aggravated in line of duty;

(iii) You are entitled to compensation for service-connected disability or death under chapter 11 of title 38 U.S.C.; or

(iv) You die during your period of active service.

[45 FR 16464, Mar. 14, 1980, as amended at 52 FR 29663, Aug. 11, 1987]

§ 404.1342 Limits on granting World War II and post-World War II wage credits.

(a) You get wage credits for World War II or post-World War II active service only if the use of the wage credits results in entitlement to a monthly benefit, a higher monthly benefit, or a lump-sum death payment.

(b) You may get wage credits for active service in July 1947 for either the World War II period or the post-World War II period but not for both. If your active service is before and on or after July 25, 1947, we add the $160 wage credit to the period which is most advantageous to you.

(c) You do not get wage credits for the World War II period if another Federal benefit (other than one payable by the Veterans Administration) is determined by a Federal agency or an instrumentality owned entirely by the United States to be payable to you, even though the Federal benefit is not actually paid or is paid and then terminated, based in part on your active service during the World War II period except as explained in § 404.1343.

(d) You do not get wage credits for the post-World War II period if another Federal benefit (other than one payable by the Veterans Administration) is determined by a Federal agency or an instrumentality owned entirely by the United States to be payable to you, even though the Federal benefit is not actually paid or is paid and then terminated, based in part on your active service during the post-World War II period except as explained in § 404.1343.

§ 404.1343 When the limits on granting World War II and post-World War II wage credits do not apply.

The limits on granting wage credits described in § 404.1342 (c) and (d) do not apply—

(a) If the wage credits are used solely to meet the insured status and quarters of coverage requirements for a period of disability as described in §§ 404.132 and 404.133;

(b) If you are the surviving spouse or child of a veteran of the World War II period or post-World War II period and you are entitled under the Civil Service Retirement Act of 1930 to a survivor's annuity based on the veteran's active service and—

(1) You give up your right to receive the survivor's annuity;

(2) A benefit under the Civil Service Retirement Act of 1930 based on the veteran's active service was not payable to the veteran; and

(3) Another Federal benefit is not payable to the veteran or his or her survivors except as described in paragraph (c) of this section; or

(c) For the years 1951 through 1956, if another Federal benefit is payable by the Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey, or the Public Health Service based on post-World War II active service but only if the veteran was also paid wages as a member of a uniformed service after 1956.

[45 FR 16464, Mar. 14, 1980, as amended at 49 FR 24118, June 12, 1984]

DEEMED INSURED STATUS FOR WORLD II VETERANS

§ 404.1350 Deemed insured status.

(a) *When deemed insured status applies.* If you are the survivor of a World War II veteran, we consider the veteran to have died fully insured as discussed in § 404.111 and we include wage credits in determining your monthly benefit or lump-sum death payment if—

(1) The veteran was separated from active service of the United States before July 27, 1951; and

(2) The veteran died within 3 years after separation from active service and before July 27, 1954.

(b) *Amount of credit given for deemed insured World War II veterans.* (1) When we compute a survivor's benefit or lump-sum death payment, we give credit for—

(i) $200 (for increment year purposes) for each calendar year in which the veteran had at least 30 days of active service beginning September 16, 1940, through 1950; and

(ii) An average monthly wage of $160.

(2) If the World War II veteran was fully or currently insured without the wage credits, we add increment years (years after 1936 and prior to 1951 in which the veteran had at least $200 in creditable earnings) to the increment years based on the veteran's wages.

§404.1351 When deemed insured status does not apply.

As a survivor of a World War II veteran, you cannot get a monthly benefit or lump-sum death payment based on the veteran's deemed insured status as explained in §404.1350 if—

(a) Your monthly benefit or lump-sum death payment is larger without using the wage credits;

(b) The Veterans Administration has determined that a pension or compensation is payable to you based on the veteran's death;

(c) The veteran died while in the active service of the United States;

(d) The veteran was first separated from active service after July 26, 1951;

(e) The veteran died after July 26, 1954; or

(f) The veteran's only service during the World War II period was by enlistment in the Philippine Scouts as authorized by the Armed Forces Voluntary Recruitment Act of 1945 (Pub. L. 190 of the 79th Congress).

§404.1352 Benefits and payments based on deemed insured status.

(a) *Our determination.* We determine your monthly benefit or lump-sum death payment under the deemed insured status provisions in §§404.1350 and 404.1351 regardless of whether the Veterans Administration has determined that any pension or compensation is payable to you.

(b) *Certification for payment.* If we determine that you can be paid a monthly benefit or lump-sum death payment, we certify these benefits for payment. However, the amount of your monthly benefit or lump-sum death payment may be changed if we are informed by the Veterans Administration that a pension or compensation is payable because of the veteran's death as explained in §404.1360.

(c) *Payments not considered as pension or compensation.* We do not consider as pension or compensation—

(1) National Service Life Insurance payments;

(2) United States Government Life Insurance payments; or

(3) Burial allowance payments made by the Veterans Administration.

EFFECT OF OTHER BENEFITS ON PAYMENT OF SOCIAL SECURITY BENEFITS AND PAYMENTS

§404.1360 Veterans Administration pension or compensation payable.

(a) *Before we determine and certify payment.* If we are informed by the Veterans Administration that a pension or compensation is payable to you before we determine and certify payment of benefits based on deemed insured status, we compute your monthly benefit or lump-sum death payment based on the death of the World War II veteran without using the wage credits discussed in §404.1350.

(b) *After we determine and certify payment.* If we are informed by the Veterans Administration that a pension or compensation is payable to you after we determine and certify payment of benefits based on deemed insured status, we—

(1) Stop payment of your benefits or recompute the amount of any further benefits that can be paid to you; and

(2) Determine whether you were erroneously paid and the amount of any erroneous payment.

§404.1361 Federal benefit payable other than by Veterans Administration.

(a) *Before we determine and certify payment.* If we are informed by another Federal agency or instrumentality of the United States (other than the Veterans Administration) that a Federal benefit is payable to you by that agency or instrumentality based on the veteran's World War II or post-World War II active service before we determine and certify your monthly benefit or lump-sum death payment, we compute your monthly benefit or lump-sum death payment without using the wage credits discussed in §404.1340.

(b) *After we determine and certify payment.* If we are informed by another Federal agency or instrumentality of the United States (other than the Veterans Administration) that a Federal benefit is payable to you by that agency or instrumentality based on the veteran's World War II or post-World War II active service after we determine and certify payment, we—

(1) Stop payment of your benefits or recompute the amount of any further benefits that can be paid to you; and

(2) Determine whether you were erroneously paid and the amount of any erroneous payment.

§ 404.1362 Treatment of social security benefits or payments where Veterans Administration pension or compensation payable.

(a) *Before we receive notice from the Veterans Administration.* If we certify your monthly benefit or a lump-sum death payment as determined under the deemed insured status provisions in §404.1350 before we receive notice from the Veterans Administration that a pension or compensation is payable to you, our payments to you are erroneous only to the extent that they exceed the amount of the accrued pension of compensation payable.

(b) *After we receive notice from the Veterans Administration.* If we certify your monthly benefit or lump-sum death payment as determined under the deemed insured status provisions in § 404.1350 after we receive notice from the Veterans Administration that a pension or compensation is payable to you, our payments to you are erroneous whether or not they exceed the amount of the accrued pension or compensation payable.

§ 404.1363 Treatment of social security benefits or payments where Federal benefit payable other than by Veterans Administration.

If we certify your monthly benefit or lump-sum death payment based on World War II or post-World War II wage credits after we receive notice from another Federal agency or instrumentality of the United States (other than the Veterans Administration) that a Federal benefit is payable to you by that agency or instrumentality based on the veteran's World War II or post-World War II active service, our payments to you are erroneous to the extent the payments are based on the World War II or post-World War II wage credits. The payments are erroneous beginning with the first month you are eligible for the Federal benefit.

EVIDENCE OF ACTIVE SERVICE AND MEMBERSHIP IN A UNIFORMED SERVICE

§ 404.1370 Evidence of active service and separation from active service.

(a) *General.* When you file an application for a monthly benefit or lump-sum death payment based on the active service of a World War II or post-World War II veteran, you must submit evidence of—

(1) Your entitlement as required by subpart H of this part or other evidence that may be expressly required;

(2) The veteran's period in active service of the United States; and

(3) The veteran's type of separation from active service of the United States.

(b) *Evidence we accept.* We accept as proof of a veteran's active service and separation from active service—

(1) An original certificate of discharge, or an original certificate of service, from the appropriate military service, from the United States Public Health Service, or from the United States Coast and Geodetic Survey;

(2) A certified copy of the original certificate of discharge or service made by the State, county, city agency or department in which the original certificate is recorded;

(3) A certification from the appropriate military service, United States Public Health Service, or United States Coast and Geodetic Survey showing the veteran's period of active service and type of separation;

(4) A certification from a local selective service board showing the veteran's period of active service and type of separation; or

(5) Other evidence that proves the veteran's period of active service and type of separation.

§ 404.1371 Evidence of membership in a uniformed service during the years 1957 through 1967.

(a) *General.* When you file an application for a monthly benefit or lump-sum death payment based on the services of a member of a uniformed service during the years 1957 through 1967, you should submit evidence identifying the member's uniformed service and showing the period(s) he or she was on active duty during those years.

(b) *Evidence we accept.* The evidence we will accept includes any official correspondence showing the member's status as an active service member during the appropriate period, a certification of service by the uniformed service, official earnings statements, copies of the member's Form W–2, and military orders, for the appropriate period.

Subpart O—Interrelationship of Old-Age, Survivors and Disability Insurance Program With the Railroad Retirement Program

AUTHORITY: Secs. 202(l), 205(a), (c)(5)(D), (i), and (o), 210(a)(9) and (l)(4), 211(c)(3), and 702(a)(5) of the Social Security Act (42 U.S.C. 402(l), 405(a), (c)(5)(D), (i), and (o), 410(a)(9) and (l)(4), 411(c)(3), and 902(a)(5)).

CROSS REFERENCE: For regulations under the Railroad Retirement Act, see chapter II of this title.

§ 404.1401 General relationship of Railroad Retirement Act with the old-age, survivors and disability insurance program of the Social Security Act.

The Railroad Retirement Act sets up a system of benefits for railroad employees, their dependents and survivors, and has been integrated with the Social Security Act to provide a coordinated system of retirement, survivor, dependent and disability benefits payable on the basis of an individual's work in the railroad industry and in employment and self-employment covered by the Social Security Act. With respect to the coordination between the two programs, the Railroad Retirement Act distinguishes between ''career'' railroad workers and those individuals who may be considered ''casual'' railroad workers. The line of demarcation is generally 10 years of service in the railroad industry, including service prior to 1937. The Railroad Retirement Act transfers to the old-age, survivors and disability insurance system the compensation records of individuals who at the time of retirement, onset of disability or death have less than 10 years of service in the railroad industry and meet certain other requirements. Any compensation paid to such individuals for such service after 1936 becomes wages under the Social Security Act (to the extent they do not exceed the annual wage limitations described in § 404.1027(a)). Whatever benefits are payable to them, their dependents, and their survivors are computed on the basis of the combined compensation and social security covered earnings creditable to the individuals' records. The compensation paid to individuals with 10 or more years of railroad service remain under the Railroad Retirement Act, but in certain circumstances, the compensation of such workers who die may be transferred to the old-age, survivors, and disability insurance program (see §§ 404.1402(b) and 404.1407). Under certain circumstances (see § 404.1413), certification of benefits payable under the provisions of the Social Security Act will be made to the Railroad Retirement Board. The Railroad Board will certify such benefits to the Secretary of the Treasury.

[42 FR 18272, Apr. 6. 1977]

§ 404.1402 When services in the railroad industry are covered.

Services performed by an individual in the railroad industry which would, but for the provisions of this section, be excepted from ''employment'' by reason of § 404.1017 shall be considered to be included under ''employment'' as defined in section 210 of the Act in the following situations:

(a) For the purpose of determining entitlement to, or the amount of, any monthly benefits or lump-sum death payment on the basis of the wages and self-employment income of an individual where the years of service in the railroad industry are less than 10;

(b) For the purpose of determining entitlement to, or the amount of, any survivor monthly benefit or any lump-sum death payment on the basis of the wages and self-employment income of an individual whose years of service in the railroad industry were 10 or more but a ''current connection'', as defined in section 1(o) of the Railroad Retirement Act of 1974 (45 U.S.C. 228a), with the railroad industry did not exist at the time of death; (in such cases, survivor benefits are not payable under the Railroad Retirement Act);

(c) For the purpose of determining entitlement to a period of disability (see subpart B of this part) on the basis of the wages and self-employment income of an individual; or

(d) For the purpose of applying the provisions of section 203 of the Act concerning deductions from benefits under the retirement test (see subpart E of this part).

[42 FR 18273, Apr. 6, 1977]

§ 404.1403 Definition of "years of service".

The term ''years of service'' as used in this subpart has the same meaning as assigned to it by section 1(f) of the Railroad Retirement Act.

[18 FR 8694, Dec. 24, 1953, as amended at 25 FR 5182, June 10, 1960]

§ 404.1404 Effective date of coverage of railroad services under the act.

Coverage under the act of services performed after 1936 by an individual in the railroad industry is effective as follows:

(a) The provisions of paragraphs (a) and (b) of § 404.1402 insofar as they relate to survivor monthly benefits are effective for months after December 1946 and insofar as they relate to lump-sum death payments are effective with respect to deaths after 1946;

(b) The provisions of paragraph (a) of § 404.1402 insofar as they relate to old-age insurance benefits or monthly benefits of dependents of old-age insurance beneficiaries are effective November 1, 1951; insofar as they relate to disability insurance benefits are effective for months after June 1957; and insofar as they relate to monthly benefits for dependents of disability insurance beneficiaries are effective for months after August 1958;

(c) The provisions of paragraph (c) of § 404.1402 are effective for benefits for months after June 1955; and

(d) The provisions of paragraph (d) of § 404.1402 are effective November 1, 1951.

[25 FR 5182, June 10, 1960]

§ 404.1405 When the provisions of § 404.1402 do not apply.

(a) *Awards by the Railroad Retirement Board prior to October 30, 1951.* The provisions of § 404.1402(a) shall not apply with respect to the wages and self-employment income of an individual if, prior to October 30, 1951, the Railroad Retirement Board has awarded under the Railroad Retirement Act a retirement annuity to such individual or a survivor annuity with respect to the death of such individual and such retirement or survivor annuity, as the case may be, was payable at the time an application for benefits is filed under the Social Security Act on the basis of the wages and self-employment income of such individual. A pension payable under section 6 of the Railroad Retirement Act of 1937 as in effect prior to the Railroad Retirement Act of 1974, or an annuity paid in a lump sum equal to its commuted value under section 3(i) of the Railroad Retirement Act in effect prior to the Social Security Act of October 30, 1951, is not a ''retirement or survivor annuity'' for the purpose of this paragraph.

(b) *Individual continues to work in railroad industry after establishing entitlement to benefits under section 202(a).* An individual's service in the railroad industry used, pursuant to the provisions of § 404.1402, to establish entitlement to or to determine the amount of, his old-age insurance benefits under section 202(a) shall not be deemed to be in ''employment'' as defined in section 210 of the Act, if he renders service in the railroad industry after the effective date of such benefits and his years of service attributable thereto when added to his years of service prior to such effective date are 10 or more. Such benefits and any benefits payable to the spouse or child of such individual under section 202(b), (c), or (d) of the Act on the basis of his wages and self-employment income shall be terminated with the month preceding the month in which such individual acquires his tenth year of service. If, however, an insured status (see subpart B of this part) exists without the use of compensation, such benefits shall, in lieu of termination, be recalculated without using such compensation and the recalculated benefits shall be payable with the month in which the tenth year of service was acquired. Any monthly benefits paid prior to such month shall not be deemed erroneous

by reason of the use of such compensation.

[18 FR 8694, Dec. 24, 1953, as amended at 25 FR 5182, June 10, 1960; 42 FR 18273, Apr. 6, 1977]

§404.1406 Eligibility to railroad retirement benefits as a bar to payment of social security benefits.

Notwithstanding the fact that, pursuant to the preceding provisions of this subpart, services rendered by an individual in the railroad industry are in employment, no lump-sum death payment or survivor monthly benefits shall be paid (except as provided in §404.1407) under the regulations in this part on the basis of such individual's wages and self-employment income if any person, upon filing application therefor, would be entitled to an annuity under section 2 of the Railroad Retirement Act of 1974 or a lump-sum payment under section 6(b) of such Act with respect to the death of that individual; or for periods prior to 1975, would have been entitled to an annuity under section 5 or a lump-sum payment under section 5(f)(1) of the Railroad Retirement Act of 1937 with respect to the death of that individual.

[42 FR 18273, Apr. 6, 1977]

§404.1407 When railroad retirement benefits do not bar payment of social security benefits.

The provisions of §404.1406 shall not operate if:

(a) The survivor is, or upon filing application would be, entitled to a monthly benefit with respect to the death of an insured individual for a month prior to January 1947, if such monthly benefit is greater in amount than the survivor annuity payable to such survivor after 1946 under the Railroad Retirement Act; or

(b) The residual lump-sum payment provided by section 6(c) of the Railroad Retirement Act of 1974 (or section 5(f)(2) of the Railroad Retirement Act of 1937 prior to the 1974 Act) with respect to the death of an insured individual is paid by the Railroad Retirement Board pursuant to an irrevocable election filed with the Board by the widow, widower, or parent of such individual to waive all future annuities or benefits based on the combined record of earnings and compensation to which such widow, widower or parent might become entitled, but only to the extent that widow's, widower's or parent's benefits may be payable under the regulations of this part to such widow, widower or parent, as the case may be, solely on the basis of the wages and self-employment income of such deceased individual and without regard to any compensation which may be treated as wages pursuant to §404.1408.

[42 FR 18273, Apr. 6, 1977]

§404.1408 Compensation to be treated as wages.

Where, pursuant to the preceding provisions of this subpart, services rendered by an individual in the railroad industry are considered to be in employment as defined in section 210 of the Social Security Act (see subpart K of this part) any compensation (as defined in section 1(h) of the Railroad Retirement Act of 1974 or prior to the 1974 Act, section 1(h) of the Railroad Retirement Act of 1937) received by such individual for such services shall constitute wages provided that the provisions of §404.1406 do not operate to bar the payment of benefits under title II of the Social Security Act; except that any compensation attributable as having been paid during any month on account of military service creditable under section 1 of the Railroad Retirement Act of 1974 (or section 4 of the Railroad Retirement Act of 1937 prior to the 1974 Act) shall not constitute wages for purposes of title II of the Social Security Act if, based on such military service, wages are deemed to have been paid to such individual during such month under the provisions described in §404.1308 or §404.1309.

[42 FR 18273, Apr. 6, 1977]

§404.1409 Purposes of using compensation.

Compensation which is treated as wages under §404.1408 shall be used, together with wages (see subpart K of this part) and self-employment income (see subpart K of this part), for purposes of:

(a) Determining an individual's insured status for monthly benefits or

the lump-sum death payment (see subpart B of this part);

(b) Computing such individual's primary insurance amount (see subpart C of this part);

(c) Determining an individual's entitlement to the establishment of a period of disability (see subpart B of this part for disability insured status requirements); and

(d) Applying the deduction provisions of section 203 of the act (see subpart E of this part).

[25 FR 5183, June 10, 1960]

§ 404.1410 Presumption on basis of certified compensation record.

(a) *Years prior to 1975.* Where the Railroad Retirement Board certifies to the Social Security Administration a report of record of compensation, which is treated as wages under § 404.1408, and periods of service which do not identify the months or quarters in which such compensation was paid, the sum of the compensation quarters of coverage (see § 404.1412) will be presumed, in the absence of evidence to the contrary, to represent an equivalent number of quarters of coverage (see §§ 404.103 and 404.104). No more than four quarters of coverage shall be credited to an individual in a single calendar year.

(b) *Years after 1974.* Compensation paid in a calendar year will, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee will have been in railroad service. (For years prior to 1975, see § 404.1412.)

(c) *Allocation of compensation to months of service.* If by means of the presumptions in this section an individual does not have an insured status (see subpart B of this part) on the basis of quarters of coverage with which he is credited, or a deceased individual's primary insurance amount (see § 404.201) may be affected because he attained age 22 after 1936, the Administration may request the Railroad Retirement Board to furnish a report of the months in which such individual rendered service for compensation which is treated as wages under § 404.1408 if it appears the identification of such months may result in an insured status or if it will affect such primary insurance amount.

(d) *Effect of self-employment income and maximum earnings.* However, if such individual also had self-employment income for a taxable year and the sum of such income and wages (including compensation which is treated as wages under § 404.1408) paid to or received by him during such taxable year equals the following amounts, each calendar quarter any part of which falls in such taxable year, shall be a quarter of coverage:

(1) After 1950 and prior to 1955, equals $3,600 of remuneration;

(2) After 1954 and prior to 1959, equals $4,200 of remuneration;

(3) After 1958 and prior to 1966, equals $4,800 of remuneration;

(4) After 1965 and prior to 1968, equals $6,600 of remuneration;

(5) After 1967 and beginning prior to 1972, equals $7,800 of remuneration (including a fiscal year which began in 1971 and ended in 1972);

(6) Beginning after 1971 and prior to 1973, equals $9,000 of remuneration;

(7) Beginning after 1972 and prior to 1974, equals $10,800 of remuneration;

(8) Beginning after 1973 and prior to 1975, equals $13,200 of remuneration;

(9) Beginning after 1974 and prior to 1976, equals $14,100 of remuneration;

(10) Beginning after 1975 and prior to 1977, equals $15,300 of remuneration; or

(11) Beginning after 1976, and amount equal to the contribution and benefit base as determined under section 230 of the Social Security Act which is effective for such calendar year.

This subsection is an exception to the rule in paragraph (a) of this section concerning a presumption applicable to conversion of railroad compensation into quarters of coverage for years prior to 1975.

[42 FR 18273, Apr. 6, 1977]

§ 404.1412 Compensation quarters of coverage.

As used in this subpart, a compensation quarter of coverage is any quarter of coverage computed with respect to compensation paid to an individual for railroad employment after 1936 and prior to 1975 in accordance with the provisions for determining such quarters of coverage as contained in section

5(l)(4) of the Railroad Retirement Act of 1937. (For years beginning 1975, see § 404.1410(b)).

[42 FR 18274, Apr. 6, 1977]

§ 404.1413 Certification of payment to Railroad Retirement Board.

Certification of benefits shall be made to the Railroad Retirement Board upon final decision of the Secretary of Health, Education, and Welfare that any person is entitled to any payment or payments under title II and that certification shall include the name and address of the person so entitled to receive such payment or payments, the amount of such payment or payments, and the time at which such payment or payments should be made which shall provide for payment on behalf of the Managing Trustee if:

(a) The claimant will have completed 10 years of service under the Railroad Retirement Act of 1937, the Railroad Retirement Act of 1974, or any combination of service under such Acts; or

(b) The claimant is the wife or husband of an individual who has completed 10 years of service under the Railroad Retirement Act of 1937, the Railroad Retirement Act of 1974, or any combination of service under such Acts; or

(c) The claimant is the survivor of an individual who had completed 10 years of service under the Railroad Retirement Act of 1937, the Railroad Retirement Act of 1974, or any combination of service under such Acts, if such survivor is entitled, or could upon application be entitled to an annuity under section 2 of the Railroad Retirement Act of 1974; or

(d) The claimant is entitled to benefits under section 202 of the Social Security Act on the basis of the wages and self-employment income of an individual who has 10 years of railroad service (except a survivor of such individual if such individual did not have a *current connection*, as defined in section 1(o) of the Railroad Retirement Act of 1974 (45 U.S.C. 228a) with the railroad industry at the time of his death).

The applicability limitations identified in paragraphs (a) through (d) of this section affects any claimant who first becomes entitled to benefits under title II of the Social Security Act after 1974. (See also § 404.968.)

[42 FR 18274, Apr. 6, 1977]

Subpart P—Determining Disability and Blindness

AUTHORITY: Secs. 202, 205(a), (b), and (d)–(h), 216(i), 221(a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a), (b), and (d)–(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)).

SOURCE: 45 FR 55584, Aug. 20, 1980, unless otherwise noted.

GENERAL

§ 404.1501 Scope of subpart.

In order for you to become entitled to any benefits based upon disability or blindness or to have a period of disability established, you must be disabled or blind as defined in title II of the Social Security Act. This subpart explains how we determine whether you are disabled or blind. We discuss a *period of disability* in subpart D of this part. We have organized the rules in the following way.

(a) We define general terms, then discuss who makes our disability determinations and state that disability determinations made under other programs are not binding on our determinations.

(b) We explain the term *disability* and note some of the major factors that are considered in determining whether you are disabled in §§ 404.1505 through 404.1510.

(c) Sections 404.1512 through 404.1518 contain our rules on evidence. We explain your responsibilities for submitting evidence of your impairment, state what we consider to be acceptable sources of medical evidence, and describe what information should be included in medical reports.

(d) Our general rules on evaluating disability if you are filing a new application are stated in §§ 404.1520 through 404.1523. We describe the steps that we go through and the order in which they are considered.

(e) Our rules on medical considerations are found in §§ 404.1525 through 404.1530. We explain in these rules—

(1) The purpose of the Listing of Impairments found in appendix 1 of this subpart and how to use it;

(2) What we mean by the term *medical equivalence* and how we determine medical equivalence;

(3) The effect of a conclusion by your physician that you are disabled;

(4) What we mean by symptoms, signs, and laboratory findings;

(5) How we evaluate pain and other symptoms; and

(6) The effect on your benefits if you fail to follow treatment that is expected to restore your ability to work, and how we apply the rule.

(f) In §§ 404.1545 through 404.1546 we explain what we mean by the term *residual functional capacity,* state when an assessment of residual functional capacity is required, and who may make it.

(g) Our rules on vocational considerations are found in §§ 404.1560 through 404.1569a. We explain when vocational factors must be considered along with the medical evidence, discuss the role of residual functional capacity in evaluating your ability to work, discuss the vocational factors of age, education, and work experience, describe what we mean by work which exists in the national economy, discuss the amount of exertion and the type of skill required for work, describe and tell how to use the Medical-Vocational Guidelines in appendix 2 of this subpart, and explain when, for purposes of applying the guidelines in appendix 2, we consider the limitations or restrictions imposed by your impairment(s) and related symptoms to be exertional, nonexertional, or a combination of both.

(h) Our rules on substantial gainful activity are found in §§ 404.1571 through 404.1574. These explain what we mean by substantial gainful activity and how we evaluate your work activity.

(i) In §§ 404.1577, 404.1578, and 404.1579, we explain the special rules covering disability for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991, and in §§ 404.1581 through 404.1587 we discuss disability due to blindness.

(j) Our rules on when disability continues and stops are contained in § 404.1579 and §§ 404.1588 through 404.1598. We explain what your responsibilities are in telling us of any events that may cause a change in your disability status, when you may have a trial work period, and when we will review to see if you are still disabled. We also explain how we consider the issue of medical improvement (and the exceptions to medical improvement) in deciding whether you are still disabled.

[45 FR 55584, Aug. 20, 1980, as amended at 50 FR 50126, Dec. 6, 1985; 56 FR 57941, Nov. 14, 1991; 57 FR 30120, July 8, 1992]

§ 404.1502 General definitions and terms for this subpart.

As used in the subpart—

Medical sources refers to treating sources, sources of record, and consultative examiners for us. See § 404.1513.

Secretary means the Secretary of Health and Human Services.

Source of record means a hospital, clinic or other source that has provided you with medical treatment or evaluation, as well as a physician or psychologist who has treated or evaluated you but does not have or did not have an ongoing treatment relationship with you.

State agency means that agency of a State which has been designated by the State to carry out the disability or blindness determination function.

Treating source means your own physician or psychologist who has provided you with medical treatment or evaluation and who has or has had an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with a physician or psychologist when the medical evidence establishes that you see or have seen the physician or psychologist with a frequency consistent with accepted medical practice for the type of treatment and evaluation required for your medical condition(s). We may consider a physician or psychologist who has treated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment is typical for your condition(s). We will not consider a physician or psychologist to be your treating physician if your relationship with the physician or psychologist is

not based on your need for treatment, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the physician or psychologist to be a consulting physician or psychologist.

We or *us* refers to either the Social Security Administration or the State agency making the disability or blindness determination.

You refers to the person who has applied for benefits or for a period of disability or is receiving benefits based on disability or blindness.

[56 FR 36954, Aug. 1, 1991]

DETERMINATIONS

§ 404.1503 Who makes disability and blindness determinations.

(a) *State agencies.* State agencies make disability and blindness determinations for the Secretary for most persons living in the State. State agencies make these disability and blindness determinations under regulations containing performance standards and other administrative requirements relating to the disability and blindness determination function. States have the option of turning the function over to the Federal Government if they no longer want to make disability determinations. Also, the Secretary may take the function away from any State which has substantially failed to make disability and blindness determinations in accordance with these regulations. Subpart Q of this part contains the rules the States must follow in making disability and blindness determinations.

(b) *Social Security Administration.* The Social Security Administration will make disability and blindness determinations for the Secretary for—

(1) Any person living in a State which is not making for the Secretary any disability and blindness determinations or which is not making those determinations for the class of claimants to which that person belongs; and

(2) Any person living outside the United States.

(c) *What determinations are authorized.* The Secretary has authorized the State agencies and the Social Security Administration to make determinations about—

(1) Whether you are disabled or blind;

(2) The date your disability or blindness began; and

(3) The date your disability or blindness stopped.

(d) *Review of State Agency determinations.* On review of a State agency determination or redetermination of disability or blindness we may find that—

(1) You are, or are not, disabled or blind, regardless of what the State agency found;

(2) Your disability or blindness began earlier or later than the date found by the State agency; and

(3) Your disability or blindness stopped earlier or later than the date found by the State agency.

(e) *Initial determinations for mental impairments.* An initial determination by a State agency or the Social Security Administration that you are not disabled (or a Social Security Administration review of a State agency's initial determination), in any case where there is evidence which indicates the existence of a mental impairment, will be made only after every reasonable effort has been made to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment. (See § 404.1616 for the qualifications we consider necessary for a psychologist to be a psychological consultant and § 404.1617 for what we consider *reasonable effort*.) If the services of qualified psychiatrists or psychologists cannot be obtained because of impediments at the State level, the Secretary may contract directly for the services. In a case where there is evidence of mental and nonmental impairments and a qualified psychologist serves as a psychological consultant, the psychologist will evaluate only the mental impairment, and a physician will evaluate the nonmental impairment. The overall determination of impairment severity in combined mental and nonmental impairment cases will be made by a medical consultant and not a psychological consultant unless the mental impairment alone would justify a finding of disability.

[46 FR 29204, May 29, 1981, as amended at 52 FR 33926, Sept. 9, 1987]

§ 404.1503a Program integrity.

We will not use in our program any individual or entity, except to provide existing medical evidence, who is currently excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally-assisted program; whose license to provide health care services is currently revoked or suspended by any State licensing authority pursuant to adequate due process procedures for reasons bearing on professional competence, professional conduct, or financial integrity; or who, until a final determination is made, has surrendered such a license while formal disciplinary proceedings involving professional conduct are pending. By individual or entity we mean a medical or psychological consultant, consultative examination provider, or diagnostic test facility. Also see §§ 404.1519 and 404.1519g(b).

[56 FR 36954, Aug. 1, 1991]

§ 404.1504 Determinations by other organizations and agencies.

A decision by any nongovernmental agency or any other governmental agency about whether you are disabled or blind is based on its rules and is not our decision about whether you are disabled or blind. We must make a disability or blindness determination based on social security law. Therefore, a determination made by another agency that you are disabled or blind is not binding on us.

DEFINITION OF DISABILITY

§ 404.1505 Basic definition of disability.

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment, which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy. To determine whether you are able to do any other work, we consider your residual functional capacity and your age, education, and work experience. We will use this definition of disability if you are applying for a period of disability, or disability insurance benefits as a disabled worker, or child's insurance benefits based on disability before age 22 or, with respect to disability benefits payable for months after December 1990, as a widow, widower, or surviving divorced spouse.

(b) There are different rules for determining disability for individuals who are statutorily blind. We discuss these in §§ 404.1581 through 404.1587. There are also different rules for determining disability for widows, widowers, and surviving divorced spouses for monthly benefits for months prior to January 1991. We discuss these rules in §§ 404.1577, 404.1578, and 404.1579.

[45 FR 55584, Aug. 20, 1980, as amended at 51 FR 10616, Mar. 28, 1986; 57 FR 30120, July 8, 1992]

§ 404.1506 When we will not consider your impairment.

(a) *Permanent exclusion of felony-related impairment.* In determining whether you are under a disability, we will not consider any physical or mental impairment, or any increase in severity (aggravation) of a preexisting impairment, which arises in connection with your commission of a felony after October 19, 1980, if you are subsequently convicted of this crime.Your subsequent conviction will invalidate any prior determination establishing disability if that determination was based upon any impairment, or aggravation, which we must exclude under this rule.

(b) *Limited use of impairment arising in prison.* In determining whether you are under a disability for purposes of benefit payments, we will not consider any physical or mental impairment, or any increase in severity (aggravation) of a preexisting impairment, which arises in connection with your confinement in a jail, prison, or other penal institution or correctional facility for conviction of a felony committed after October 19, 1980. The exclusion of the impairment, or aggravation, applies in determining disability for benefits payable for any month during which you

are confined. This rule does not preclude the establishment of a period of disability based upon the impairment or aggravation. You may become entitled to benefits upon release from prison provided that you apply and are under a disability at the time.

(c) *Felonious offenses.* We will consider an offense a felony if—

(1) It is a felony under applicable law; or

(2) In a jurisdiction which does not classify any crime as a felony, it is an offense punishable by death or imprisonment for a term exceeding one year.

(d) *Confinement.* In general, a jail, prison, or other penal institution or correctional facility is a facility which is under the control and jurisdiction of the agency in charge of the penal system or in which convicted criminals can be incarcerated. Confinement in such a facility continues as long as you are under a sentence of confinement and have not been released due to parole or pardon. You are considered confined even though you are temporarily or intermittently outside of the facility (e.g., on work release, attending school, or hospitalized).

[48 FR 5714, Feb. 8, 1983]

§404.1508 What is needed to show an impairment.

If you are not doing substantial gainful activity, we always look first at your physical or mental impairment(s) to determine whether you are disabled or blind. Your impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms (see §404.1527). (See §404.1528 for further information about what we mean by symptoms, signs, and laboratory findings.)

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 36954, Aug. 1, 1991]

§404.1509 How long the impairment must last.

Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

§404.1510 Meaning of substantial gainful activity.

Substantial gainful activity means work that—

(a) Involves doing significant and productive physical or mental duties; and

(b) Is done (or intended) for pay or profit.

(See §404.1572 for further details about what we mean by substantial gainful activity.)

§404.1511 Definition of a disabling impairment.

(a) *Disabled workers, persons disabled since childhood and, for months after December 1990, disabled widows, widowers, and surviving divorced spouses.* If you are entitled to disability cash benefits as a disabled worker, or to child's insurance benefits, or, for monthly benefits payable after December 1990, to widow's, widower's, or surviving divorced spouse's monthly benefits, a disabling impairment is an impairment (or combination of impairments) which, of itself, is so severe that it meets or equals a set of criteria in the Listing of Impairments in appendix 1 of this subpart or which, when considered with your age, education, and work experience, would result in a finding that you are disabled under §404.1594. In determining whether you have a disabling impairment, earnings are not considered.

(b) *Disabled widows, widowers, and surviving divorced spouses, for monthly benefits for months prior to January 1991.* If you have been entitled to disability benefits as a disabled widow, widower, or surviving divorced spouse and we must decide whether you had a disabling impairment for any time prior to January 1991, a disabling impairment is an impairment (or combination of impairments) which, of itself, was so severe that it met or equaled a set of criteria in the Listing of Impairments in appendix 1 of this subpart, or results in a finding that you were disabled under §404.1579. In determining

whether you had a disabling impairment, earnings are not considered.

[57 FR 30120, July 8, 1992]

EVIDENCE

§ 404.1512 Evidence of your impairment.

(a) *General.* In general, you have to prove to us that you are blind or disabled. Therefore, you must bring to our attention everything that shows that you are blind or disabled. This means that you must furnish medical and other evidence that we can use to reach conclusions about your medical impairment(s) and, if material to the determination of whether you are blind or disabled, its effect on your ability to work on a sustained basis. We will consider only impairment(s) you say you have or about which we receive evidence.

(b) *What we mean by ''evidence.''* Evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. This includes, but is not limited to:

(1) Objective medical evidence, that is, medical signs and laboratory findings as defined in § 404.1528 (b) and (c);

(2) Other evidence from medical sources, such as medical history, opinions, and statements about treatment you have received;

(3) Statements you or others make about your impairment(s), your restrictions, your daily activities, your efforts to work, or any other relevant statements you make to medical sources during the course of examination or treatment, or to us during interviews, on applications, in letters, and in testimony in our administrative proceedings;

(4) Information from other sources, as described in § 404.1513(e);

(5) Decisions by any governmental or nongovernmental agency about whether you are disabled or blind; and

(6) At the administrative law judge and Appeals Council levels, certain findings, other than the ultimate determination about whether you are disabled, made by State agency medical or psychological consultants and other program physicians or psychologists, and opinions expressed by medical advisors based on their review of the evidence in your case record. See § 404.1527(f) (2) and (3).

(c) *Your responsibility.* You must provide medical evidence showing that you have an impairment(s) and how severe it is during the time you say that you are disabled. If we ask you, you must also provide evidence about:

(1) Your age;

(2) Your education and training;

(3) Your work experience;

(4) Your daily activities both before and after the date you say that you became disabled;

(5) Your efforts to work; and

(6) Any other factors showing how your impairment(s) affects your ability to work. In §§ 404.1560 through 404.1569, we discuss in more detail the evidence we need when we consider vocational factors.

(d) *Our responsibility.* Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports.

(1) ''Every reasonable effort'' means that we will make an initial request for evidence from your medical source and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one followup request to obtain the medical evidence necessary to make a determination. The medical source will have a minimum of 10 calendar days from the date of our followup request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(2) By ''complete medical history,'' we mean the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete

medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier. If applicable, we will develop your complete medical history for the 12-month period prior to (1) the month you were last insured for disability insurance benefits (see § 404.130), (2) the month ending the 7-year period you may have to establish your disability and you are applying for widow's or widower's benefits based on disability (see § 404.335(c)(1)), or (3) the month you attain age 22 and you are applying for child's benefits based on disability (see § 404.350(e)).

(e) *Recontacting medical sources.* When the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled, we will need additional information to reach a determination or a decision. To obtain the information, we will take the following actions.

(1) We will first recontact your treating physician or psychologist or other medical source to determine whether the additional information we need is readily available. We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques. We may do this by requesting copies of your medical source's records, a new report, or a more detailed report from your medical source, including your treating source, or by telephoning your medical source. In every instance where medical evidence is obtained over the telephone, the telephone report will be sent to the source for review, signature and return.

(2) We may not seek additional evidence or clarification from a medical source when we know from past experience that the source either cannot or will not provide the necessary findings.

(f) *Need for consultative examination.* If the information we need is not readily available from the records of your medical treatment source, or we are unable to seek clarification from your medical source, we will ask you to attend one or more consultative examinations at our expense. See §§ 404.1517 through 404.1519t for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. However, in some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

[56 FR 36954, Aug. 1, 1991]

§ 404.1513 Medical evidence of your impairment.

(a) *Acceptable sources.* We need reports about your impairments from acceptable medical sources. Acceptable medical sources are—

(1) Licensed physicians;

(2) Licensed osteopaths;

(3) Licensed or certified psychologists;

(4) Licensed optometrists for the measurement of visual acuity and visual fields (we may need a report from a physician to determine other aspects of eye diseases); and

(5) Persons authorized to send us a copy or summary of the medical records of a hospital, clinic, sanitorium, medical institution, or health care facility. Generally, the copy or summary should be certified as accurate by the custodian or by any authorized employee of the Social Security Administration, Veterans' Administration, or State agency. However, we will not return an uncertified copy or summary for certification unless there is some question about the document.

(b) *Medical reports.* Medical reports should include—

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, x-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed with response, and prognosis; and

(6) A statement about what you can still do despite your impairment(s) based on the medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section (except in statutory blindness claims). Although we will request a medical source statement about what you can still do despite your impairment(s), the lack of the medical source statement will not make the report incomplete. See § 404.1527.

(c) *Statements about what you can still do.* Statements about what you can still do (based on the medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section) should describe, but are not limited to, the kinds of physical and mental capabilities listed below. See §§ 404.1527 and 404.1545(c).

(1) The medical source's opinion about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(2) In cases of mental impairment(s), the medical source's opinion about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting.

(d) *Completeness.* The medical evidence, including the clinical and laboratory findings, must be complete and detailed enough to allow us to make a determination about whether you are disabled or blind. It must allow us to determine—

(1) The nature and limiting effects of your impairment(s) for any period in question;

(2) The probable duration of your impairment; and

(3) Your residual functional capacity to do work-related physical and mental activities.

(e) *Information from other sources.* Information from other sources may also help us to understand how your impairment affects your ability to work. Other sources include—

(1) Public and private social welfare agencies;

(2) Observations by non-medical sources; and

(3) Other practitioners (for example, naturopaths, chiropractors, audiologists, etc.).

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 36955, Aug. 1, 1991]

§ 404.1514 When we will purchase existing evidence.

We need specific medical evidence to determine whether you are disabled or blind. You are responsible for providing that evidence. However, we will pay physicians not employed by the Federal government and other non-Federal providers of medical services for the reasonable cost of providing us with existing medical evidence that we need and ask for after November 30, 1980.

[46 FR 45757, Sept. 15, 1981]

§ 404.1515 Where and how to submit evidence.

You may give us evidence about your impairment at any of our offices or at the office of any State agency authorized to make disability determinations. You may also give evidence to one of our employees authorized to accept evidence at another place. For more information about this, see subpart H of this part.

§ 404.1516 If you fail to submit medical and other evidence.

If you do not give us the medical and other evidence that we need and request, we will have to make a decision based on information available in your case. We will not excuse you from giving us evidence because you have religious or personal reasons against medical examinations, tests, or treatment.

§ 404.1517 Consultative examination at our expense.

If your medical sources cannot or will not give us sufficient medical evidence about your impairment for us to determine whether you are disabled or blind, we may ask you to have one or more physical or mental examinations or tests. We will pay for these examinations. However, we will not pay for any medical examination arranged by you

or your representative without our advance approval. If we arrange for the examination or test, we will give you reasonable notice of the date, time, and place the examination or test will be given, and the name of the person or facility who will do it. We will also give the examiner any necessary background information about your condition.

[56 FR 36956, Aug. 1, 1991]

§404.1518 If you do not appear at a consultative examination.

(a) *General.* If you are applying for benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arrange for you to get information we need to determine your disability or blindness, we may find that you are not disabled or blind. If you are already receiving benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arranged for you, we may determine that your disability or blindness has stopped because of your failure or refusal. Therefore, if you have any reason why you cannot go for the scheduled appointment, you should tell us about this as soon as possible before the examination date. If you have a good reason, we will schedule another examination. We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have a good reason for failing to attend a consultative examination.

(b) *Examples of good reasons for failure to appear.* Some examples of what we consider good reasons for not going to a scheduled examination include—

(1) Illness on the date of the scheduled examination or test;

(2) Not receiving timely notice of the scheduled examination or test, or receiving no notice at all;

(3) Being furnished incorrect or incomplete information, or being given incorrect information about the physician involved or the time or place of the examination or test, or;

(4) Having had death or serious illness occur in your immediate family.

(c) *Objections by your physician.* If any of your treating physicians tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your physician may agree to another type of examination for the same purpose.

[45 FR 55584, Aug. 20, 1980, as amended at 59 FR 1635, Jan. 12, 1994]

STANDARDS TO BE USED IN DETERMINING WHEN A CONSULTATIVE EXAMINATION WILL BE OBTAINED IN CONNECTION WITH DISABILITY DETERMINATIONS

§404.1519 The consultative examination.

A consultative examination is a physical or mental examination or test purchased for you at our request and expense from a treating physician or psychologist, another source of record, or an independent source, including a pediatrician when appropriate. The decision to purchase a consultative examination will be made on an individual case basis in accordance with the provisions of §§404.1519a through 404.1519f. Selection of the source for the examination will be consistent with the provisions of §404.1503a and §§404.1519g through 404.1519j. The rules and procedures for requesting consultative examinations set forth in §§404.1519a and 404.1519b are applicable at the reconsideration and hearing levels of review, as well as the initial level of determination.

[56 FR 36956, Aug. 1, 1991]

§404.1519a When we will purchase a consultative examination and how we will use it.

(a)(1) *General.* The decision to purchase a consultative examination for you will be made after we have given full consideration to whether the additional information needed (e.g., clinical findings, laboratory tests, diagnosis, and prognosis) is readily available from the records of your medical sources. See §404.1512 for the procedures we will follow to obtain evidence from your medical sources. Before purchasing a consultative examination, we will consider not only existing medical reports, but also the disability interview form containing your allegations

as well as other pertinent evidence in your file.

(2) When we purchase a consultative examination, we will use the report from the consultative examination to try to resolve a conflict or ambiguity if one exists. We will also use a consultative examination to secure needed medical evidence the file does not contain such as clinical findings, laboratory tests, a diagnosis or prognosis necessary for decision.

(b) *Situations requiring a consultative examination.* A consultative examination may be purchased when the evidence as a whole, both medical and nonmedical, is not sufficient to support a decision on your claim. Other situations, including but not limited to the situations listed below, will normally require a consultative examination:

(1) The additional evidence needed is not contained in the records of your medical sources;

(2) The evidence that may have been available from your treating or other medical sources cannot be obtained for reasons beyond your control, such as death or noncooperation of a medical source;

(3) Highly technical or specialized medical evidence that we need is not available from your treating or other medical sources;

(4) A conflict, inconsistency, ambiguity or insufficiency in the evidence must be resolved, and we are unable to do so by recontacting your medical source; or

(5) There is an indication of a change in your condition that is likely to affect your ability to work, but the current severity of your impairment is not established.

[56 FR 36956, Aug. 1, 1991]

§ 404.1519b When we will not purchase a consultative examination.

We will not purchase a consultative examination in situations including, but not limited to, the following situations:

(a) In period of disability and disability insurance benefit claims, when you do not meet the insured status requirement in the calendar quarter you allege you became disabled or later and there is no possibility of establishing an earlier onset;

(b) In claims for widow's or widower's benefits based on disability, when your alleged month of disability is after the end of the 7-year period specified in § 404.335(c)(1) and there is no possibility of establishing an earlier onset date, or when the 7-year period expired in the past and there is no possibility of establishing an onset date prior to the date the 7-year period expired;

(c) In disability insurance benefit claims, when your insured status expired in the past and there is no possibility of establishing an onset date prior to the date your insured status expired;

(d) When any issues about your actual performance of substantial gainful activity or gainful activity have not been resolved;

(e) In claims for child's benefits based on disability, when it is determined that your alleged disability did not begin before the month you attained age 22, and there is no possibility of establishing an onset date earlier than the month in which you attained age 22;

(f) In claims for child's benefits based on disability that are filed concurrently with the insured individual's claim and entitlement cannot be established for the insured individual;

(g) In claims for child's benefits based on disability where entitlement is precluded based on other nondisability factors.

[56 FR 36956, Aug. 1, 1991]

STANDARDS FOR THE TYPE OF REFERRAL AND FOR REPORT CONTENT

§ 404.1519f Type of purchased examinations.

We will purchase only the specific examinations and tests we need to make a determination in your claim. For example, we will not authorize a comprehensive medical examination when the only evidence we need is a special test, such as an X-ray, blood studies, or an electrocardiogram.

[56 FR 36956, Aug. 1, 1991]

§ 404.1519g Who we will select to perform a consultative examination.

(a) We will purchase a consultative examination only from a qualified medical source. The medical source

may be your own physician or psychologist, or another source. If you are a child, the medical source we choose may be a pediatrician. For a more complete list of medical sources, see §404.1513(a).

(b) By ''qualified,'' we mean that the medical source must be currently licensed in the State and have the training and experience to perform the type of examination or test we will request; the medical source must not be barred from participation in our programs under the provisions of §404.1503a. The medical source must also have the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

(c) The physician or psychologist we choose may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse) must meet appropriate licensing or certification requirements of the State. See §404.1503a.

[56 FR 36957, Aug. 1, 1991]

§404.1519h Your treating physician or psychologist.

When in our judgment your treating physician or psychologist is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment, and generally furnishes complete and timely reports, your treating physician or psychologist will be the preferred source to do the purchased examination. Even if only a supplemental test is required, your treating physician or psychologist is ordinarily the preferred source.

[56 FR 36957, Aug. 1, 1991]

§404.1519i Other sources for consultative examinations.

We will use a source other than your treating physician or psychologist for a purchased examination or test in situations including, but not limited to, the following situations:

(a) Your treating physician or psychologist prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your treating physician or psychologist;

(c) You prefer a source other than your treating physician or psychologist and have a good reason for your preference;

(d) We know from prior experience that your treating physician or psychologist may not be a productive source, e.g., he or she has consistently failed to provide complete or timely reports.

[56 FR 36957, Aug. 1, 1991]

§404.1519j Objections to the designated physician or psychologist.

You or your representative may object to your being examined by a designated physician or psychologist. If there is a good reason for the objection, we will schedule the examination with another physician or psychologist. A good reason may be that the consultative examination physician or psychologist had previously represented an interest adverse to you. For example, the physician or psychologist may have represented your employer in a workers' compensation case or may have been involved in an insurance claim or legal action adverse to you. Other things we will consider include: the presence of a language barrier, the physician's or psychologist's office location (e.g., 2nd floor, no elevator), travel restrictions, and whether the physician or psychologist had examined you in connection with a previous disability determination or decision that was unfavorable to you. If your objection is because a physician or psychologist allegedly ''lacks objectivity'' in general, but not in relation to you personally, we will review the allegations. See §404.1519s. To avoid a delay in processing your claim, the consultative examination in your case will be changed to another physician or psychologist while a review is being conducted. We will handle any objection to use of the substitute physician or psychologist in the same manner. However, if we had previously conducted such a review and found that

the reports of the consultative physician or psychologist in question conformed to our guidelines, we will not change your examination.

[56 FR 36957, Aug. 1, 1991]

§ 404.1519k Purchase of medical examinations, laboratory tests, and other services.

We may purchase medical examinations, including psychiatric and psychological examinations, X-rays and laboratory tests (including specialized tests such as pulmonary function studies, electrocardiograms, stress tests, etc.) from a licensed physician or psychologist, hospital or clinic.

(a) The rate of payment to be used for purchasing medical or other services necessary to make determinations of disability may not exceed the highest rate paid by Federal or public agencies in the State for the same or similar types of service. See §§ 404.1624 and 404.1626.

(b) If a physician's bill or a request for payment for a physician's services includes a charge for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

(1) If the bill or request for payment indicates that the test was personally performed or supervised by the physician who submitted the bill (or for whose services the request for payment was made) or by another physician with whom that physician shares his or her practice, the payment will be based on the physician's usual and customary charge for the test or the rates of payment which the State uses for purchasing such services, whichever is the lesser amount.

(2) If the bill or request for payment indicates that the test was performed by an independent laboratory, the amount of reimbursement will not exceed the billed cost of the independent laboratory or the rate of payment which the State uses for purchasing such services, whichever is the lesser amount. A nominal payment may be made to the physician for collecting, handling and shipping a specimen to the laboratory if the physician bills for such a service. The total reimbursement may not exceed the rate of payment which the State uses for purchasing such services.

(c) The State will assure that it can support the rate of payment it uses. The State shall also be responsible for monitoring and overseeing the rate of payment it uses to ensure compliance with paragraphs (a) and (b) of this section.

[56 FR 36957, Aug. 1, 1991]

§ 404.1519m Diagnostic tests or procedures.

We will request the results of any diagnostic tests or procedures that have been performed as part of a workup by your treating physician or psychologist or other medical source and will use the results to help us evaluate impairment severity or prognosis. However, we will not order diagnostic tests or procedures that involve significant risk to you, such as myelograms, arteriograms, or cardiac catheterizations for the evaluation of disability under the Social Security program. Also, a State agency medical consultant must approve the ordering of any diagnostic test or procedure when there is a chance it may involve significant risk. The responsibility for deciding whether to perform the examination rests with the consultative examining physician or psychologist.

[56 FR 36957, Aug. 1, 1991]

§ 404.1519n Informing the examining physician or psychologist of examination scheduling, report content, and signature requirements.

The physicians or psychologists who perform consultative examinations will have a good understanding of our disability programs and their evidentiary requirements. They will be made fully aware of their responsibilities and obligations regarding confidentiality as described in § 401.105(e). We will fully inform consulting physicians or psychologists at the time we first contact them, and at subsequent appropriate intervals, of the following obligations:

(a) In scheduling full consultative examinations, sufficient time should be allowed to permit the examining physician or psychologist to take a case history and perform the examination, including any needed tests. The following minimum scheduling intervals (i.e.,

time set aside for the individual, not the actual duration of the consultative examination) should be used.

(1) Comprehensive general medical examination—at least 30 minutes;

(2) Comprehensive musculoskeletal or neurological examination—at least 20 minutes;

(3) Comprehensive psychiatric examination—at least 40 minutes;

(4) Psychological examination—at least 60 minutes (Additional time may be required depending on types of psychological tests administered); and

(5) All others—at least 30 minutes, or in accordance with accepted medical practices.

We recognize that actual practice will dictate that some examinations may require longer scheduling intervals depending on the circumstances in a particular situation. We also recognize that these minimum intervals may have to be adjusted to allow for those claimants who do not attend their scheduled examination. The purpose of these minimum scheduling timeframes is to ensure that such examinations are complete and that sufficient time is made available to obtain the information needed to make an accurate determination in your case. State agencies will monitor the scheduling of examinations (through their normal consultative examination oversight activities) to ensure that any overscheduling is avoided, as overscheduling may lead to examinations that are not thorough.

(b) *Report content.* The reported results of your medical history, examination, requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The facts in a particular case and the information and findings already reported in the medical and other evidence of record will dictate the extent of detail needed in the consultative examination report for that case. Thus, the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. The reporting of information will differ from one type of examination to another when the requested examination relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. The medical report must be complete enough to help us determine the nature, severity, and duration of the impairment, and residual functional capacity. The report should reflect your statements of your symptoms, not simply the physician's or psychologist's statements or conclusions. The examining physician's or psychologist's report of the consultative examination should include the objective medical facts as well as observations and opinions.

(c) *Elements of a complete consultative examination.* A complete consultative examination is one which involves all the elements of a standard examination in the applicable medical specialty. When the report of a complete consultative examination is involved, the report should include the following elements:

(1) Your major or chief complaint(s);

(2) A detailed description, within the area of specialty of the examination, of the history of your major complaint(s);

(3) A description, and disposition, of pertinent ''positive'' and ''negative'' detailed findings based on the history, examination and laboratory tests related to the major complaint(s), and any other abnormalities or lack thereof reported or found during examination or laboratory testing;

(4) The results of laboratory and other tests (e.g., X-rays) performed according to the requirements stated in the Listing of Impairments (see appendix 1 of this subpart P);

(5) The diagnosis and prognosis for your impairment(s);

(6) A statement about what you can still do despite your impairment(s), unless the claim is based on statutory blindness. This statement should describe the opinion of the consultative physician or psychologist about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and, in cases of mental impairment(s), the opinion of the consultative physician or psychologist about your ability to understand, to carry out and remember instructions, and to respond appropriately to

supervision, coworkers and work pressures in a work setting; and

(7) In addition, the consultative physician or psychologist will consider, and provide some explanation or comment on, your major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The history, examination, evaluation of laboratory test results, and the conclusions will represent the information provided by the physician or psychologist who signs the report.

(d) *When a complete consultative examination is not required.* When the evidence we need does not require a complete consultative examination (for example, we need only a specific laboratory test result to complete the record), we may not require a report containing all of the elements in paragraph (c).

(e) *Signature requirements.* All consultative examination reports will be personally reviewed and signed by the physician or psychologist who actually performed the examination. This attests to the fact that the physician or psychologist doing the examination or testing is solely responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory test results. The signature of the examining physician or psychologist on a report annotated ''not proofed'' or ''dictated but not read'' is not acceptable. A rubber stamp signature of a physician or psychologist or the physician's or psychologist's signature entered by any other person is not acceptable.

[56 FR 36958, Aug. 1, 1991]

§ 404.1519o When a properly signed consultative examination report has not been received.

If a consultative examination report is received unsigned or improperly signed we will take the following action.

(a) *When we will make determinations and decisions without a properly signed report.* We will make a determination or decision in the circumstances specified in paragraphs (a)(1) and (a)(2) of this section without waiting for a properly signed consultative examination report. After we have made the determination or decision, we will obtain a properly signed report and include it in the file unless the physician or psychologist who performed the original consultative examination has died.

(1) Continuous period of disability allowance with an onset date as alleged or earlier than alleged; or

(2) Continuance of disability.

(b) *When we will not make determinations and decisions without a properly signed report.* We will not use an unsigned or improperly signed consultative examination report to make the determinations or decisions specified in paragraphs (b)(1), (b)(2), (b)(3), and (b)(4) of this section. When we need a properly signed consultative examination report to make these determinations or decisions, we must obtain such a report. If the signature of the physician or psychologist who performed the original examination cannot be obtained because the physician or psychologist is out of the country for an extended period of time, on an extended vacation, seriously ill, deceased, or for any other reason, the consultative examination will be rescheduled with another physician or psychologist.

(1) Denial; or

(2) Cessation; or

(3) Allowance of a period of disability which has ended; or

(4) Allowance with an onset date later than alleged.

[56 FR 36958, Aug. 1, 1991]

§ 404.1519p Reviewing reports of consultative examinations.

(a) We will review the report of the consultative examination to determine whether the specific information requested has been furnished. We will consider the following factors in reviewing the report:

(1) Whether the report provides evidence which serves as an adequate basis for decisionmaking in terms of the impairment it assesses;

(2) Whether the report is internally consistent; Whether all the diseases, impairments and complaints described in the history are adequately assessed and reported in the clinical findings; Whether the conclusions correlate the findings from your medical history,

clinical examination and laboratory tests and explain all abnormalities;

(3) Whether the report is consistent with the other information available to us within the specialty of the examination requested; Whether the report fails to mention an important or relevant complaint within that specialty that is noted in other evidence in the file (e.g., your blindness in one eye, amputations, pain, alcoholism, depression);

(4) Whether this is an adequate report of examination as compared to standards set out in the course of a medical education; and

(5) Whether the report is properly signed.

(b) If the report is inadequate or incomplete, we will contact the examining consultative physician or psychologist, give an explanation of our evidentiary needs, and ask that the physician or psychologist furnish the missing information or prepare a revised report.

(c) With your permission, or where the examination discloses new diagnostic information or test results that reveal potentially life-threatening situations, we will refer the consultative examination report to your treating physician or psychologist. When we refer the consultative examination report to your treating physician or psychologist without your permission, we will notify you that we have done so.

(d) We will perform ongoing special management studies on the quality of consultative examinations purchased from major medical sources and the appropriateness of the examinations authorized.

(e) We will take steps to ensure that consultative examinations are scheduled only with medical sources who have access to the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

[56 FR 36959, Aug. 1, 1991]

§ 404.1519q Conflict of interest.

All implications of possible conflict of interest between medical or psychological consultants and their medical or psychological practices will be avoided. Such consultants are not only those physicians and psychologists who work for us directly but are also those who do review and adjudication work in the State agencies. Physicians and psychologists who work for us directly as employees or under contract will not work concurrently for a State agency. Physicians and psychologists who do review work for us will not perform consultative examinations for us without our prior approval. In such situations, the physician or psychologist will disassociate himself or herself from further involvement in the case and will not participate in the evaluation, decision, or appeal actions. In addition, neither they, nor any member of their families, will acquire or maintain, either directly or indirectly, any financial interest in a medical partnership, corporation, or similar relationship in which consultative examinations are provided. Sometimes physicians and psychologists who do review work for us will have prior knowledge of a case; for example, when the claimant was a patient. Where this is so, the physician or psychologist will not participate in the review or determination of the case. This does not preclude the physician or psychologist from submitting medical evidence based on treatment or examination of the claimant.

[56 FR 36959, Aug. 1, 1991]

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

§ 404.1519s Authorizing and monitoring the consultative examination.

(a) Day-to-day responsibility for the consultative examination process rests with the State agencies that make disability determinations for us.

(b) The State agency will maintain a good working relationship with the medical community in order to recruit sufficient numbers of physicians and other providers of medical services to ensure ready availability of consultative examination providers.

(c) Consistent with Federal and State laws, the State agency administrator will work to achieve appropriate rates of payment for purchased medical services.

(d) Each State agency will be responsible for comprehensive oversight management of its consultative examination program, with special emphasis on key providers.

(e) A key consultative examination provider is a provider that meets at least one of the following conditions:

(1) Any consultative examination provider with an estimated annual billing to the Social Security disability programs of at least $100,000; or

(2) Any consultative examination provider with a practice of medicine, osteopathy, or psychology directed primarily towards evaluation examinations rather than the treatment of patients; or

(3) Any consultative examination provider that does not meet the above criteria, but is one of the top five consultative examination providers in the State by dollar volume, as evidenced by prior year data.

(f) State agencies have flexibility in managing their consultative examination programs, but at a minimum will provide:

(1) An ongoing active recruitment program for consultative examination providers;

(2) A process for orientation, training, and review of new consultative examination providers, with respect to SSA's program requirements involving consultative examination report content and not with respect to medical techniques;

(3) Procedures for control of scheduling consultative examinations;

(4) Procedures to ensure that close attention is given to specific evaluation issues involved in each case;

(5) Procedures to ensure that only required examinations and tests are authorized in accordance with the standards set forth in this subpart;

(6) Procedures for providing medical or supervisory approval for the authorization or purchase of consultative examinations and for additional tests or studies requested by consulting physicians and psychologists. This includes physician approval for the ordering of any diagnostic test or procedure where the question of significant risk to the claimant/beneficiary might be raised. See § 404.1519m.

(7) Procedures for the ongoing review of consultative examination results to ensure compliance with written guidelines;

(8) Procedures to encourage active participation by physicians in the consultative examination oversight program;

(9) Procedures for handling complaints;

(10) Procedures for evaluating claimant reactions to key providers; and

(11) A program of systematic, onsite reviews of key providers that will include annual onsite reviews of such providers when claimants are present for examinations. This provision does not contemplate that such reviews will involve participation in the actual examinations but, rather, offer an opportunity to talk with claimants at the provider's site before and after the examination and to review the provider's overall operation.

(g) The State agencies will cooperate with us when we conduct monitoring activities in connection with their oversight management of their consultative examination programs.

[56 FR 36959, Aug. 1, 1991]

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

§ 404.1519t Consultative examination oversight.

(a) We will ensure that referrals for consultative examinations and purchases of consultative examinations are made in accordance with our policies. We will also monitor both the referral processes and the product of the consultative examinations obtained. This monitoring may include reviews by independent medical specialists under direct contract with SSA.

(b) Through our regional offices, we will undertake periodic comprehensive reviews of each State agency to evaluate each State's management of the consultative examination process. The review will involve visits to key providers, with State staff participating, including a program physician when the visit will deal with medical techniques or judgment, or factors that go to the core of medical professionalism.

(c) We will also perform ongoing special management studies of the quality

of consultative examinations purchased from key providers and other sources and the appropriateness of the examinations authorized.

[56 FR 36960, Aug. 1, 1991]

EVALUATION OF DISABILITY

§ 404.1520 Evaluation of disability in general.

(a) *Steps in evaluating disability.* We consider all evidence in your case record when we make a determination or decision whether you are disabled. When you file a claim for a period of disability and/or disability insurance benefits or for child's benefits based on disability, we use the following evaluation process. If you are doing substantial gainful activity, we will determine that you are not disabled. If you are not doing substantial gainful activity, we will first consider the effect of your physical or mental impairment; if you have more than one impairment, we will also consider the combined effect of your impairments. Your impairment(s) must be severe and meet the duration requirement before we can find you to be disabled. We follow a set order to determine whether you are disabled. We review any current work activity, the severity of your impairment(s), your residual functional capacity, your past work, and your age, education, and work experience. If we can find that you are disabled or not disabled at any point in the review, we do not review your claim further. Once you have been found entitled to disability benefits, we follow a somewhat different order of evaluation to determine whether your entitlement continues, as explained in § 404.1594(f)(6).

(b) *If you are working.* If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.

(c) *You must have a severe impairment.* If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience. However, it is possible for you to have a period of disability for a time in the past even though you do not now have a severe impairment.

(d) *When your impairment(s) meets or equals a listed impairment in appendix 1.* If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience.

(e) *Your impairments(s) must prevent you from doing past relevant work.* If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment(s), we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled.

(f) *Your impairment(s) must prevent you from doing any other work.* (1) If you cannot do any work you have done in the past because you have a severe impairment(s), we will consider your residual functional capacity and your age, education, and past work experience to see if you can do other work. If you cannot, we will find you disabled.

(2) If you have only a marginal education, and long work experience (i.e., 35 years or more) where you only did arduous unskilled physical labor, and you can no longer do this kind of work, we use a different rule (see § 404.1562).

[50 FR 8727, Mar. 5, 1985; 50 FR 19164, May 7, 1985, as amended at 56 FR 36960, Aug. 1, 1991]

§ 404.1520a Evaluation of mental impairments.

(a) *General.* The steps outlined in § 404.1520 apply to the evaluation of physical and mental impairments. In addition, in evaluating the severity of mental impairments for adults (persons age 18 and over) and in persons under age 18 when Part A of the Listing of Impairments is used, a special procedure must be followed by us at each level of adminstrative review. Following this procedure will assist us in:

(1) Identifying additional evidence necessary for the determination of impairment severity;

(2) Considering and evaluating aspects of the mental disorder(s) relevant to your ability to work; and

(3) Organizing and presenting the findings in a clear, concise, and consistent manner.

(b) *Use of the procedure to record pertinent findings and rate the degree of functional loss.* (1) This procedure requires us to record the pertinent signs, symptoms, findings, functional limitations, and effects of treatment contained in your case record. This will assist us in determining if a mental impairment(s) exists. Whether or not a mental impairment(s) exists is decided in the same way the question of a physical impairment is decided, i.e., the evidence must be carefully reviewed and conclusions supported by it. The mental status examination and psychiatric history will ordinarily provide the needed information. (See § 404.1508 for further information about what is needed to show an impairment.)

(2) If we determine that a mental impairment(s) exists, this procedure then requires us to indicate whether certain medical findings which have been found especially relevant to the ability to work are present or absent.

(3) The procedure then requires us to rate the degree of functional loss resulting from the impairment(s). Four areas of function considered by us as essential to work have been identified, and the degree of functional loss in those areas must be rated on a scale that ranges from no limitation to a level of severity which is incompatible with the ability to perform those work-related functions. For the first two areas (activities of daily living and social functioning), the rating of limitation must be done based upon the following five point scale: none, slight, moderate, marked, and extreme. For the third area (concentration, persistence, or pace) the following five point scale must be used: never, seldom, often, frequent, and constant. For the fourth area (deterioration or decompensation in work or work-like settings), the following four point scale must be used: never, once or twice, repeated (three or more), and continual. The last two points for each of these scales represent a degree of limitation which is incompatible with the ability to perform the work-related function.

(c) *Use of the procedure to evaluate mental impairments.* Following the rating of the degree of functional loss resulting from the impairment, we must then determine the severity of the mental impairment(s).

(1) If the four areas considered by us as essential to work have been rated to indicate a degree of limitation as *none* or *slight* in the first and second areas, *never* or *seldom* in the third area, and *never* in the fourth area, we can generally conclude that the impairment is not severe, unless the evidence otherwise indicates there is significant limitation of your mental ability to do basic work activities (see § 404.1521).

(2) If your mental impairment(s) is severe, we must then determine if it meets or equals a listed mental disorder. This is done by comparing our prior conclusions based on this procedure (i.e., the presence of certain medical findings considered by us as especially relevant to your ability to work and our rating of functional loss resulting from the mental impairment(s)) against the paragraph A and B criteria of the appropriate listed mental disorder(s). If we determine that paragraph C criteria will be used in lieu of paragraph B criteria (see listings 12.03 and 12.06), we will, by following this procedure, indicate on the document whether the evidence is sufficient to establish the presence or absence of the criteria. (See paragraph (d) of this section).

(3) If you have a severe impairment(s), but the impairment(s) neither meets nor equals the listings, we must then do a residual functional capacity assessment.

(4) At all adjudicative levels we must, in each case, incorporate the pertinent findings and conclusions based on this procedure in our decision rationale. Our rationale must show the significant history, including examination, laboratory findings, and functional limitations that we considered in reaching conclusions about the severity of the mental impairment(s).

(d) *Preparation of the document.* A standard document outlining the steps of this procedure must be completed by

us in each case at the initial, reconsideration, administrative law judge hearing, and Appeals Council levels (when the Appeals Council issues a decision).

(1) At the initial and reconsideration levels the standard document must be completed and signed by our medical consultant. At the administrative law judge hearing level, several options are available:

(i) The administrative law judge may complete the document without the assistance of a medical advisor;

(ii) The administrative law judge may call a medical advisor for assistance in preparing the document; or

(iii) Where new evidence is received that is not merely cumulative of evidence already in your case file or where the issue of a mental impairment arises for the first time at the administrative law judge hearing level, the administrative law judge may decide to remand the case to the State agency for completion of the document and a new determination. Remand may also be made in situations where the services of a medical advisor are determined necessary but unavailable to the administrative law judge. In such circumstances, however, a remand may ordinarily be made only once.

(2) For all cases involving mental disorders at the administrative law judge hearing or Appeals Council levels, the standard document will be appended to the decision.

(Approved by the Office of Management and Budget under control number 0960–0413)

[50 FR 35065, Aug. 28, 1985, as amended at 55 FR 51229, Dec. 12, 1990; 57 FR 30120, July 8, 1992]

§404.1521 What we mean by an impairment(s) that is not severe.

(a) *Non-severe impairment(s).* An impairment or combination of impairments is not severe if it does not significantly limit your physical or mental ability to do basic work activities.

(b) *Basic work activities.* When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these 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, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

[50 FR 8728, Mar. 5, 1985]

§404.1522 When you have two or more unrelated impairments—initial claims.

(a) *Unrelated severe impairments.* We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.

(b) *Concurrent impairments.* If you have two or more concurrent impairments which, when considered in combination, are severe, we must also determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test.

[50 FR 8728, Mar. 5, 1985]

§404.1523 Multiple impairments.

In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, the combined

impact of the impairments will be considered throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see § 404.1520).

[50 FR 8728, Mar. 5, 1985]

MEDICAL CONSIDERATIONS

§ 404.1525 Listing of Impairments in Appendix 1.

(a) *Purpose of the Listing of Impairments.* The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

(b) *Adult and childhood diseases.* The Listing of Impairments consists of two parts:

(1) *Part A* contains medical criteria that apply to adult persons age 18 and over. The medical criteria in part A may also be applied in evaluating impairments in persons under age 18 if the disease processes have a similar effect on adults and younger persons.

(2) *Part B* contains additional medical criteria that apply only to the evaluation of impairments of persons under age 18. Certain criteria in part A do not give appropriate consideration to the particular effects of the disease processes in childhood; i.e., when the disease process is generally found only in children or when the disease process differs in its effect on children than on adults. Additional criteria are included in part B, and the impairment categories are, to the extent possible, numbered to maintain a relationship with their counterparts in part A. In evaluating disability for a person under age 18, part B will be used first. If the medical criteria in part B do not apply, then the medical criteria in part A will be used.

(c) *How to use the Listing of Impairments.* Each section of the Listing of Impairments has a general introduction containing definitions of key concepts used in that section. Certain specific medical findings, some of which are required in establishing a diagnosis or in confirming the existence of an impairment for the purpose of this Listing, are also given in the narrative introduction. If the medical findings needed to support a diagnosis are not given in the introduction or elsewhere in the listing, the diagnosis must still be established on the basis of medically acceptable clinical and laboratory diagnostic techniques. Following the introduction in each section, the required level of severity of impairment is shown under ''Category of Impairments'' by one or more sets of medical findings. The medical findings consist of symptoms, signs, and laboratory findings.

(d) *Diagnosis of impairments.* We will not consider your impairment to be one listed in appendix 1 solely because it has the diagnosis of a listed impairment. It must also have the findings shown in the Listing of that impairment.

(e) *Addiction to alcohol or drugs.* If you have a condition diagnosed as addiction to alcohol or drugs, this will not, by itself, be a basis for determining whether you are, or are not, disabled. As with any other medical condition, we will decide whether you are disabled based on symptoms, signs, and laboratory findings.

(f) *Symptoms as criteria of listed impairment(s).* Some listed impairment(s) include symptoms usually associated with those impairment(s) as criteria. Generally, when a symptom is one of the criteria in a listed impairment, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence or limiting effects of the symptom as long as all other findings required by the specific listing are present.

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 57941, Nov. 14, 1991]

§ 404.1526 Medical equivalence.

(a) *How medical equivalence is determined.* We will decide that your

impairment(s) is medically equivalent to a listed impairment in appendix 1 if the medical findings are at least equal in severity and duration to the listed findings. We will compare the symptoms, signs, and laboratory findings about your impairment(s), as shown in the medical evidence we have about your claim, with the medical criteria shown with the listed impairment. If your impairment is not listed, we will consider the listed impairment most like your impairment to decide whether your impairment is medically equal. If you have more than one impairment, and none of them meets or equals a listed impairment, we will review the symptoms, signs, and laboratory findings about your impairments to determine whether the combination of your impairments is medically equal to any listed impairment.

(b) *Medical equivalence must be based on medical findings.* We will always base our decision about whether your impairment(s) is medically equal to a listed impairment on medical evidence only. Any medical findings in the evidence must be supported by medically acceptable clinical and laboratory diagnostic techniques. We will also consider the medical opinion given by one or more medical or psychological consultants designated by the Secretary in deciding medical equivalence. (See § 404.1616.)

(c) *Who is a designated medical or psychological consultant.* A medical or psychological consultant designated by the Secretary includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. A medical consultant must be a physician. A psychological consultant used in cases where there is evidence of a mental impairment must be a qualified psychologist. (See § 404.1616 for the qualifications we consider necessary for a psychologist to be a consultant.)

[45 FR 55584, Aug. 20, 1980, as amended at 52 FR 33926, Sept. 9, 1987]

§ 404.1527 Evaluating medical opinions about your impairment(s) or disability.

(a) *General.* (1) You can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See § 404.1505. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. See § 404.1508.

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) *How we consider medical opinions.* In deciding whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive.

(c) *Making disability determinations.* After we review all of the evidence relevant to your claim, including medical opinions, we make findings about what the evidence shows.

(1) If all of the evidence we receive, including all medical opinion(s), is consistent, and there is sufficient evidence for us to decide whether you are disabled, we will make our determination or decision based on that evidence.

(2) If any of the evidence in your case record, including any medical opinion(s), is inconsistent with other evidence or is internally inconsistent, we will weigh all of the evidence and see whether we can decide whether you are disabled based on the evidence we have.

(3) If the evidence is consistent but we do not have sufficient evidence to decide whether you are disabled, or if after weighing the evidence we decide

we cannot reach a conclusion about whether you are disabled, we will try to obtain additional evidence under the provisions of §§ 404.1512 and 404.1519 through 404.1519h. We will request additional existing records, recontact your treating sources or any other examining sources, ask you to undergo a consultative examination at our expense, or ask you or others for more information. We will consider any additional evidence we receive together with the evidence we already have.

(4) When there are inconsistencies in the evidence that cannot be resolved, or when despite efforts to obtain additional evidence the evidence is not complete, we will make a determination or decision based on the evidence we have.

(d) *How we weigh medical opinions.* Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed below, as well as the factors in paragraphs (d) (3) through (5) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including

opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion.

(e) *Medical source opinions on issues reserved to the Secretary.*

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are ''disabled'' or ''unable to work'' does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Secretary. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from treating and examining sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 of this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Secretary. We will not give any special significance to the source of the opinion on these issues.

(f) *Opinions of nonexamining medical and psychological consultants and other nonexamining physicians and psychologists.* We consider all evidence from nonexamining physicians and psychologists to be opinion evidence. When we consider the opinions of nonexamining sources on the nature and severity of your impairments, we apply the rules set forth in paragraphs (a) through (e) of this section. In addition, the following rules apply to State agency medical and psychological consultants, and to medical advisors we consult in connection with administrative law judge hearings and Appeals Council review.

(1) At the initial and reconsideration steps in the administrative review process, except in disability hearings, State agency medical and psychological consultants are members of the teams that make the determinations of disability. A State agency medical or psychological consultant will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or equals the requirements for any impairment listed in Appendix 1 to this subpart, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case record but are not themselves evidence at these steps.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. Administrative law judges are not bound by any findings made by State agency medical or psychological consultants. However, these findings are considered at the hearing level. See § 404.1512(b)(6). When administrative law judges consider these findings, they will evaluate them using the rules set forth in paragraphs (a) through (e) of this section. Also, administrative law judges may ask for and consider the opinions of medical advisors on the nature and severity of your impairment(s) and whether your impairment(s) equals the requirements of any listed impairment in appendix 1 to this subpart.

(3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as administrative law judges follow.

[56 FR 36960, Aug. 1, 1991]

§ 404.1528 Symptoms, signs, and laboratory findings.

Medical findings consist of symptoms, signs, and laboratory findings:

(a) *Symptoms* are your own description of your physical or mental impairment. Your statements alone are not enough to establish that there is a physical or mental impairment.

(b) *Signs* are anatomical, physiological, or psychological abnormalities which can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Pyschiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation and contact with reality. They must also be shown by observable facts that can be medically described and evaluated.

(c) *Laboratory findings* are anatomical, physiological, or psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.), roentgenological studies (X-rays), and psychological tests.

§ 404.1529 How we evaluate symptoms, including pain.

(a) *General.* In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. By objective medical evidence, we mean medical signs and laboratory findings as defined in § 404.1528 (b) and (c). By other evidence, we mean the kinds of evidence described in §§ 404.1512(b) (2) through (6) and 404.1513(b) (1), (4), and (5) and (e). These include statements or reports from you, your treating or examining physician or psychologist, and others about your medical history, diagnosis, prescribed treatment, daily activities, efforts to work, and any other evidence showing how your impairment(s) and any related symptoms affect your ability to work. We will consider all of your statements about your symptoms, such as pain, and any description you, your physician, your psychologist, or other persons may provide about how the symptoms affect your activities of daily living and your ability to work. However, statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings and statements about how your symptoms affect you. (Section 404.1527 explains how we consider opinions of your treating source and other medical opinions on the existence and severity of your symptoms, such as pain.) We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work.

(b) *Need for medically determinable impairment that could reasonably be expected to produce your symptoms, such as pain.* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect your ability to do basic work activities unless medical signs or laboratory findings show that a medically determinable impairment(s) is present. Medical signs and laboratory findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptoms alleged. At the

initial or reconsideration step in the administrative review process (except in disability hearings), a State agency medical or psychological consultant (or other medical or psychological consultant designated by the Secretary) directly participates in determining whether your medically determinable impairment(s) could reasonably be expected to produce your alleged symptoms. In the disability hearing process, a medical or psychological consultant may provide an advisory assessment to assist a disability hearing officer in determining whether your impairment(s) could reasonably be expected to produce your alleged symptoms. At the administrative law judge hearing or Appeals Council level, the administrative law judge or the Appeals Council may ask for and consider the opinion of a medical advisor concerning whether your impairment(s) could reasonably be expected to produce your alleged symptoms. The finding that your impairment(s) could reasonably be expected to produce your pain or other symptoms does not involve a determination as to the intensity, persistence, or functionally limiting effects of your symptoms. We will develop evidence regarding the possibility of a medically determinable mental impairment when we have information to suggest that such an impairment exists, and you allege pain or other symptoms but the medical signs and laboratory findings do not substantiate any physical impairment(s) capable of producing the pain or other symptoms.

(c) *Evaluating the intensity and persistence of your symptoms, such as pain, and determining the extent to which your symptoms limit your capacity for work*—(1) *General.* When the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain, we must then evaluate the intensity and persistence of your symptoms so that we can determine how your symptoms limit your capacity for work. In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements from you, your treating or examining physician or psychologist, or other persons about how your symptoms affect you. We also consider the medical opinions of your treating source and other medical opinions as explained in § 404.1527. Paragraphs (c)(2) through (c)(4) of this section explain further how we evaluate the intensity and persistence of your symptoms and how we determine the extent to which your symptoms limit your capacity for work, when the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain.

(2) *Consideration of objective medical evidence.* Objective medical evidence is evidence obtained from the application of medically acceptable clinical and laboratory diagnostic techniques, such as evidence of reduced joint motion, muscle spasm, sensory deficit or motor disruption. Objective medical evidence of this type is a useful indicator to assist us in making reasonable conclusions about the intensity and persistence of your symptoms and the effect those symptoms, such as pain, may have on your ability to work. We must always attempt to obtain objective medical evidence and, when it is obtained, we will consider it in reaching a conclusion as to whether you are disabled. However, we will not reject your statements about the intensity and persistence of your pain or other symptoms or about the effect your symptoms have on your ability to work solely because the available objective medical evidence does not substantiate your statements.

(3) *Consideration of other evidence.* Since symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that you, your treating or examining physician or psychologist, or other persons provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your

pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which you, your treating or examining physician or psychologist, or other persons report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your treating, examining or consulting physician or psychologist, and observations by our employees and other persons. Section 404.1527 explains in detail how we consider and weigh treating source and other medical opinions about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

(i) Your daily activities;

(ii) The location, duration, frequency, and intensity of your pain or other symptoms;

(iii) Precipitating and aggravating factors;

(iv) The type, dosage, effectiveness, and side effects of any medication you take or have taken to alleviate your pain or other symptoms;

(v) Treatment, other than medication, you receive or have received for relief of your pain or other symptoms;

(vi) Any measures you use or have used to relieve your pain or other symptoms (e.g., lying flat on your back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and

(vii) Other factors concerning your functional limitations and restrictions due to pain or other symptoms.

(4) *How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities.* In determining the extent to which your symptoms, such as pain, affect your capacity to perform basic work activities, we consider all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section. We will consider your statements about the intensity, persistence, and limiting effects of your symptoms, and we will evaluate your statements in relation to the objective medical evidence and other evidence, in reaching a conclusion as to whether you are disabled. We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your medical history, the medical signs and laboratory findings, and statements by your treating or examining physician or psychologist or other persons about how your symptoms affect you. Your symptoms, including pain, will be determined to diminish your capacity for basic work activities to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.

(d) *Consideration of symptoms in the disability determination process.* We follow a set order of steps to determine whether you are disabled. If you are not doing substantial gainful activity, we consider your symptoms, such as pain, to evaluate whether you have a severe physical or mental impairment(s), and at each of the remaining steps in the process. Sections 404.1520 and 404.1520a explain this process in detail. We also consider your symptoms, such as pain, at the appropriate steps in our review when we consider whether your disability continues. Sections 404.1579 and 404.1594 explain the procedure we follow in reviewing whether your disability continues.

(1) *Need to establish a severe medically determinable impairment(s).* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, are considered in making a determination as to whether your impairment or combination of impairment(s) is severe. (See § 404.1520(c).)

(2) *Decision whether the Listing of Impairments is met.* Some listed impairment(s) include symptoms, such as pain, as criteria. Section 404.1525(f)

explains how we consider your symptoms when your symptoms are included as criteria for a listed impairment.

(3) *Decision whether the Listing of Impairments is equaled.* If your impairment is not the same as a listed impairment, we must determine whether your impairment(s) is medically equivalent to a listed impairment. Section 404.1526 explains how we make this determination. Under §404.1526(b), we will consider equivalence based on medical evidence only. In considering whether your symptoms, signs, and laboratory findings are medically equal to the symptoms, signs, and laboratory findings of a listed impairment, we will look to see whether your symptoms, signs, and laboratory findings are at least equal in severity to the listed criteria. However, we will not substitute your allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of your impairment(s) to that of a listed impairment. If the symptoms, signs, and laboratory findings of your impairment(s) are equivalent in severity to those of a listed impairment, we will find you disabled. If it does not, we will consider the impact of your symptoms on your residual functional capacity. (See paragraph (d)(4) of this section.)

(4) *Impact of symptoms (including pain) on residual functional capacity.* If you have a medically determinable severe physical or mental impairment(s), but your impairment(s) does not meet or equal an impairment listed in Appendix 1 of this subpart, we will consider the impact of your impairment(s) and any related symptoms, including pain, on your residual functional capacity. (See §404.1545.)

[56 FR 57941, Nov. 14, 1991]

§404.1530 Need to follow prescribed treatment.

(a) *What treatment you must follow.* In order to get benefits, you must follow treatment prescribed by your physician if this treatment can restore your ability to work.

(b) *When you do not follow prescribed treatment.* If you do not follow the prescribed treatment without a good reason, we will not find you disabled or, if you are already receiving benefits, we will stop paying you benefits.

(c) *Acceptable reasons for failure to follow prescribed treatment.* We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have an acceptable reason for failure to follow prescribed treatment. The following are examples of a good reason for not following treatment:

(1) The specific medical treatment is contrary to the established teaching and tenets of your religion.

(2) The prescribed treatment would be cataract surgery for one eye, when there is an impairment of the other eye resulting in a severe loss of vision and is not subject to improvement through treatment.

(3) Surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

(4) The treatment because of its magnitude (e.g. open heart surgery), unusual nature (e.g., organ transplant), or other reason is very risky for you; or

(5) The treatment involves amputation of an extremity, or a major part of an extremity.

[45 FR 55584, Aug. 20, 1980, as amended at 59 FR 1635, Jan. 12, 1994]

§404.1535 How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) *General.* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(b) *Process we will follow when we have medical evidence of your drug addiction or alcoholism.* (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.

(2) In making this determination, we will evaluate which of your current physical and mental limitations, upon

which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.

(i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.

[60 FR 8147, Feb. 10, 1995]

§ 404.1536 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) If we determine that you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535), you must avail yourself of appropriate treatment for your drug addiction or alcoholism at an institution or facility approved by us when this treatment is available and make progress in your treatment. Generally, you are not expected to pay for this treatment. You will not be paid benefits for any month after the month we have notified you in writing that—

(1) You did not comply with the terms, conditions and requirements of the treatment which has been made available to you; or

(2) You did not avail yourself of the treatment after you had been notified that it is available to you.

(b) If your benefits are suspended for failure to comply with treatment requirements, your benefits can be reinstated in accordance with the rules in § 404.470.

[60 FR 8147, Feb. 10, 1995]

§ 404.1537 What we mean by appropriate treatment.

By appropriate treatment, we mean treatment for drug addiction or alcoholism that serves the needs of the individual in the least restrictive setting possible consistent with your treatment plan. These settings range from outpatient counseling services through a variety of residential treatment settings including acute detoxification, short-term intensive residential treatment, long-term therapeutic residential treatment, and long-term recovery houses. Appropriate treatment is determined with the involvement of a State licensed or certified addiction professional on the basis of a detailed assessment of the individual's presenting symptomatology, psychosocial profile, and other relevant factors. This assessment may lead to a determination that more than one treatment modality is appropriate for the individual. The treatment will be provided or overseen by an approved institution or facility. This treatment may include (but is not limited to)—

(a) Medical examination and medical management;

(b) Detoxification;

(c) Medication management to include substitution therapy (e.g., methadone);

(d) Psychiatric, psychological, psychosocial, vocational, or other substance abuse counseling in a residential or outpatient treatment setting; or

(e) Relapse prevention.

[60 FR 8148, Feb. 10, 1995]

§ 404.1538 What we mean by approved institutions or facilities.

Institutions or facilities that we may approve include—

(a) An institution or facility that furnishes medically recognized treatment for drug addiction or alcoholism in conformity with applicable Federal or State laws and regulations;

(b) An institution or facility used by or licensed by an appropriate State agency which is authorized to refer persons for treatment of drug addiction or alcoholism;

(c) State licensed or certified care providers;

(d) Programs accredited by the Commission on Accreditation for Rehabilitation Facilities (CARF) and/or the Joint Commission for the Accreditation of Healthcare Organizations

(JCAHO) for the treatment of drug addiction or alcoholism;

(e) Medicare or Medicaid certified care providers; or

(f) Nationally recognized self-help drug addiction or alcoholism recovery programs (e.g., Alcoholics Anonymous or Narcotics Anonymous) when participation in these programs is specifically prescribed by a treatment professional at an institution or facility described in paragraphs (a) through (e) of this section as part of an individual's treatment plan.

[60 FR 8148, Feb. 10, 1995]

§ 404.1539 How we consider whether treatment is available.

Our determination about whether treatment is available to you for your drug addiction or your alcoholism will depend upon—

(a) The capacity of an approved institution or facility to admit you for appropriate treatment;

(b) The location of the approved institution or facility, or the place where treatment, services or resources could be provided to you;

(c) The availability and cost of transportation for you to the place of treatment;

(d) Your general health, including your ability to travel and capacity to understand and follow the prescribed treatment;

(e) Your particular condition and circumstances; and

(f) The treatment that is prescribed for your drug addiction or alcoholism.

[60 FR 8148, Feb. 10, 1995]

§ 404.1540 Evaluating compliance with the treatment requirements.

(a) *General.* Generally, we will consider information from the treatment institution or facility to evaluate your compliance with your treatment plan. The treatment institution or facility will:

(1) Monitor your attendance at and participation in treatment sessions;

(2) Provide reports of the results of any clinical testing (such as, hematological or urinalysis studies for individuals with drug addiction and hematological studies and breath analysis for individuals with alcoholism) when such tests are likely to yield important information;

(3) Provide observational reports from the treatment professionals familiar with your individual case (subject to verification and Federal confidentiality requirements); or

(4) Provide their assessment or views on your noncompliance with treatment requirements.

(b) *Measuring progress.* Generally, we will consider information from the treatment institution or facility to evaluate your progress in completing your treatment plan. Examples of milestones for measuring your progress with the treatment which has been prescribed for your drug addiction or alcoholism may include (but are not limited to)—

(1) Abstinence from drug or alcohol use (initial progress may include significant reduction in use);

(2) Consistent attendance at and participation in treatment sessions;

(3) Improved social functioning and levels of gainful activity;

(4) Participation in vocational rehabilitation activities; or

(5) Avoidance of criminal activity.

[60 FR 8148, Feb. 10, 1995]

§ 404.1541 Establishment and use of referral and monitoring agencies.

We will contract with one or more agencies in each of the States, Puerto Rico and the District of Columbia to provide services to individuals whose disabilities are based on a determination that drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535) and to submit information to us which we will use to make decisions about these individuals' benefits. These agencies will be known as referral and monitoring agencies. Their duties and responsibilities include (but are not limited to)—

(a) Identifying appropriate treatment placements for individuals we refer to them;

(b) Referring these individuals for treatment;

(c) Monitoring the compliance and progress with the appropriate treatment of these individuals; and

(d) Promptly reporting to us any individual's failure to comply with treatment requirements as well as failure to achieve progress through the treatment.

[60 FR 8148, Feb. 10, 1995]

RESIDUAL FUNCTIONAL CAPACITY

§ 404.1545 Your residual functional capacity.

(a) *General.* Your impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what you can do in a work setting. Your residual functional capacity is what you can still do despite your limitations. If you have more than one impairment, we will consider all of your impairment(s) of which we are aware. We will consider your ability to meet certain demands of jobs, such as physical demands, mental demands, sensory requirements, and other functions, as described in paragraphs (b), (c), and (d) of this section. Residual functional capacity is an assessment based upon all of the relevant evidence. It may include descriptions (even your own) of limitations that go beyond the symptoms, such as pain, that are important in the diagnosis and treatment of your medical condition. Observations by your treating or examining physicians or psychologists, your family, neighbors, friends, or other persons, of your limitations, in addition to those observations usually made during formal medical examinations, may also be used. These descriptions and observations, when used, must be considered along with your medical records to enable us to decide to what extent your impairment(s) keeps you from performing particular work activities. This assessment of your remaining capacity for work is not a decision on whether you are disabled, but is used as the basis for determining the particular types of work you may be able to do despite your impairment(s). Then, using the guidelines in §§ 404.1560 through 404.1569a, your vocational background is considered along with your residual functional capacity in arriving at a disability determination or decision. In deciding whether your disability continues or ends, the residual functional capacity assessment may also be used to determine whether any medical improvement you have experienced is related to your ability to work as discussed in § 404.1594.

(b) *Physical abilities.* When we assess your physical abilities, we first assess the nature and extent of your physical limitations and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to perform certain physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping or crouching), may reduce your ability to do past work and other work.

(c) *Mental abilities.* When we assess your mental abilities, we first assess the nature and extent of your mental limitations and restrictions and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, co-workers, and work pressures in a work setting, may reduce your ability to do past work and other work.

(d) *Other abilities affected by impairment(s).* Some medically determinable impairment(s), such as skin impairment(s), epilepsy, impairment(s) of vision, hearing or other senses, and impairment(s) which impose environmental restrictions, may cause limitations and restrictions which affect other work-related abilities. If you have this type of impairment(s), we consider any resulting limitations and restrictions which may reduce your ability to do past work and other work in deciding your residual functional capacity.

(e) *Total limiting effects.* When you have a severe impairment(s), but your symptoms, signs, and laboratory findings do not meet or equal those of a listed impairment in Appendix 1 of this subpart, we will consider the limiting effects of all your impairment(s), even those that are not severe, in determining your residual functional capacity.

Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; e.g., someone with a low back disorder may be fully capable of the physical demands consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis. In assessing the total limiting effects of your impairment(s) and any related symptoms, we will consider all of the medical and nonmedical evidence, including the information described in § 404.1529(c).

[56 FR 57943, Nov, 14, 1991]

§ 404.1546 Responsibility for assessing and determining residual functional capacity.

The State agency staff medical or psychological consultants or other medical or psychological consultants designated by the Secretary are responsible for ensuring that the State agency makes a decision about your residual functional capacity. In cases where the State agency makes the disability determination, a State agency staff medical or psychological consultant must assess residual functional capacity where it is required. This assessment is based on all of the evidence we have, including any statements regarding what you can still do that have been provided by treating or examining physicians, consultative physicians, or any other medical or psychological consultant designated by the Secretary. See § 404.1545. For cases in the disability hearing process, the responsibility for deciding your residual functional capacity rests with either the disability hearing officer or, if the disability hearing officer's reconsidered determination is changed under § 404.918, with the Director of the Office of Disability Hearings or his or her delegate. For cases at the Administrative Law Judge hearing or Appeals Council level, the responsibility for deciding your residual functional capacity rests with the Administrative Law Judge or Appeals Council.

[56 FR 36962, Aug. 1, 1991]

VOCATIONAL CONSIDERATIONS

§ 404.1560 When your vocational background will be considered.

(a) *General.* If you are applying for a period of disability, or disability insurance benefits as a disabled worker, or child's insurance benefits based on disability which began before age 22, or widow's or widower's benefits based on disability for months after December 1990, and we cannot decide whether you are disabled on medical evidence alone, we will consider your residual functional capacity together with your vocational background.

(b) *Past relevant work.* We will first compare your residual functional capacity with the physical and mental demands of the kind of work you have done in the past. If you still have the residual functional capacity to do your past relevant work, we will find that you can still do your past work, and we will determine that you are not disabled, without considering your vocational factors of age, education, and work experience.

(c) *Other work.* If we find that you can no longer do the kind of work you have done in the past, we will then consider your residual functional capacity together with your vocational factors of age, education, and work experience to determine whether you can do other work. By other work we mean jobs that exist in significant numbers in the national economy.

[55 FR 11011, Mar. 26, 1990, as amended at 57 FR 30120, July 8, 1992]

§ 404.1561 Your ability to do work depends upon your residual functional capacity.

If you can do your previous work (your usual work or other applicable past work), we will determine that you are not disabled. However, if your residual functional capacity is not enough to enable you to do any of your previous work, we must still decide if you can do any other work. To do this, we consider your residual functional capacity, and your age, education, and work experience. Any work (jobs) that

you can do must exist in significant numbers in the national economy (either in the region where you live or in several regions of the country). Sections 404.1563 through 404.1565 explain how we evaluate your age, education, and work experience when we are deciding whether or not you are able to do other work.

§ 404.1562 If you have done only arduous unskilled physical labor.

If you have only a marginal education and work experience of 35 years or more during which you did arduous unskilled physical labor, and you are not working and are no longer able to do this kind of work because of a severe impairment(s), we will consider you unable to do lighter work, and therefore, disabled. However, if you are working or have worked despite your impairment(s) (except where the work is sporadic or is not medically advisable), we will review all the facts in your case, and we may find that you are not disabled. In addition, we will consider that you are not disabled if the evidence shows that you have training or past work experience which enables you to do substantial gainful activity in another occupation with your impairment, either on a full-time or a reasonably regular part-time basis.

Example: B is a 60-year-old miner with a fourth grade education who has a life-long history of arduous physical labor. B says that he is disabled because of arthritis of the spine, hips, and knees, and other impairments. Medical evidence shows a combination of impairments and establishes that these impairments prevent B from performing his usual work or any other type of arduous physical labor. His vocational background does not show that he has skills or capabilities needed to do lighter work which would be readily transferable to another work setting. Under these circumstances, we will find that B is disabled.

§ 404.1563 Your age as a vocational factor.

(a) *General. Age* refers to how old you are (your chronological age) and the extent to which your age affects your ability to adapt to a new work situation and to do work in competition with others. However, we do not determine disability on your age alone. We must also consider your residual functional capacity, education, and work experience. If you are unemployed because of your age and you can still do a significant number of jobs which exist in the national economy, we will find that you are not disabled. We explain in detail how we consider your age as a vocational factor in appendix 2. However, we will not apply these age categories mechanically in a borderline situation.

(b) *Younger person.* If you are under age 50, we generally do not consider that your age will seriously affect your ability to adapt to a new work situation. In some circumstances, however, we consider age 45 a handicap in adapting to a new work setting (see Rule 201.17 in appendix 2).

(c) *Person approaching advanced age.* If you are closely approaching advanced age (50–54), we will consider that your age, along with a severe impairment and limited work experience, may seriously affect your ability to adjust to a significant number of jobs in the national economy.

(d) *Person of advanced age.* We consider that advanced age (55 or over) is the point where age significantly affects a person's ability to do substantial gainful activity. If you are severely impaired and of advanced age and you cannot do medium work (see § 404.1567(c)), you may not be able to work unless you have skills that can be used in (transferred to) less demanding jobs which exist in significant numbers in the national economy. If you are close to retirement age (60–64) and have a severe impairment, we will not consider you able to adjust to sedentary or light work unless you have skills which are highly marketable.

(e) *Information about your age.* We will usually not ask you to prove your age. However, if we need to know your exact age to determine whether you get disability benefits or if the amount of your benefit will be affected, we will ask you for evidence of your age.

§ 404.1564 Your education as a vocational factor.

(a) *General. Education* is primarily used to mean formal schooling or other training which contributes to your ability to meet vocational requirements, for example, reasoning ability,

communication skills, and arithmetical ability. However, if you do not have formal schooling, this does not necessarily mean that you are uneducated or lack these abilities. Past work experience and the kinds of responsibilities you had when you were working may show that you have intellectual abilities, although you may have little formal education. Your daily activities, hobbies, or the results of testing may also show that you have significant intellectual ability that can be used to work.

(b) *How we evaluate your education.* The importance of your educational background may depend upon how much time has passed between the completion of your formal education and the beginning of your physical or mental impairment(s) and by what you have done with your education in a work or other setting. Formal education that you completed many years before your impairment began, or unused skills and knowledge that were a part of your formal education, may no longer be useful or meaningful in terms of your ability to work. Therefore, the numerical grade level that you completed in school may not represent your actual educational abilities. These may be higher or lower. However, if there is no other evidence to contradict it, we will use your numerical grade level to determine your educational abilities. The term *education* also includes how well you are able to communicate in English since this ability is often acquired or improved by education. In evaluating your educational level, we use the following categories:

(1) *Illiteracy.* Illiteracy means the inability to read or write. We consider someone illiterate if the person cannot read or write a simple message such as instructions or inventory lists even though the person can sign his or her name. Generally, an illiterate person has had little or no formal schooling.

(2) *Marginal education.* Marginal education means ability in reasoning, arithmetic, and language skills which are needed to do simple, unskilled types of jobs. We generally consider that formal schooling at a 6th grade level or less is a marginal education.

(3) *Limited education.* Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex job duties needed in semi-skilled or skilled jobs. We generally consider that a 7th grade through the 11th grade level of formal education is a limited education.

(4) *High school education and above.* High school education and above means abilities in reasoning, arithmetic, and language skills acquired through formal schooling at a 12th grade level or above. We generally consider that someone with these educational abilities can do semi-skilled through skilled work.

(5) *Inability to communicate in English.* Since the ability to speak, read and understand English is generally learned or increased at school, we may consider this an educational factor. Because English is the dominant language of the country, it may be difficult for someone who doesn't speak and understand English to do a job, regardless of the amount of education the person may have in another language. Therefore, we consider a person's ability to communicate in English when we evaluate what work, if any, he or she can do. It generally doesn't matter what other language a person may be fluent in.

(6) *Information about your education.* We will ask you how long you attended school and whether you are able to speak, understand, read and write in English and do at least simple calculations in arithmetic. We will also consider other information about how much formal or informal education you may have had through your previous work, community projects, hobbies, and any other activities which might help you to work.

§ 404.1565 Your work experience as a vocational factor.

(a) *General. Work experience* means skills and abilities you have acquired through work you have done which show the type of work you may be expected to do. Work you have already been able to do shows the kind of work that you may be expected to do. We

consider that your work experience applies when it was done within the last 15 years, lasted long enough for you to learn to do it, and was substantial gainful activity. We do not usually consider that work you did 15 years or more before the time we are deciding whether you are disabled (or when the disability insured status requirement was last met, if earlier) applies. A gradual change occurs in most jobs so that after 15 years it is no longer realistic to expect that skills and abilities acquired in a job done then continue to apply. The 15-year guide is intended to insure that remote work experience is not currently applied. If you have no work experience or worked only ''off-and-on'' or for brief periods of time during the 15-year period, we generally consider that these do not apply. If you have acquired skills through your past work, we consider you to have these work skills unless you cannot use them in other skilled or semi-skilled work that you can now do. If you cannot use your skills in other skilled or semi-skilled work, we will consider your work background the same as unskilled. However, even if you have no work experience, we may consider that you are able to do unskilled work because it requires little or no judgment and can be learned in a short period of time.

(b) *Information about your work.* Under certain circumstances, we will ask you about the work you have done in the past. If you cannot give us all of the information we need, we will try, with your permission, to get it from your employer or other person who knows about your work, such as a member of your family or a co-worker. When we need to consider your work experience to decide whether you are able to do work that is different from what you have done in the past, we will ask you to tell us about all of the jobs you have had in the last 15 years. You must tell us the dates you worked, all of the duties you did, and any tools, machinery, and equipment you used. We will need to know about the amount of walking, standing, sitting, lifting and carrying you did during the work day, as well as any other physical or mental duties of your job. If all of your work in the past 15 years has been arduous and unskilled, and you have very little education, we will ask you to tell us about all of your work from the time you first began working. This information could help you to get disability benefits.

§ 404.1566 Work which exists in the national economy.

(a) *General.* We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country. It does not matter whether—

(1) Work exists in the immediate area in which you live;

(2) A specific job vacancy exists for you; or

(3) You would be hired if you applied for work.

(b) *How we determine the existence of work.* Work exists in the national economy when there is a significant number of jobs (in one or more occupations) having requirements which you are able to meet with your physical or mental abilities and vocational qualifications. Isolated jobs that exist only in very limited numbers in relatively few locations outside of the region where you live are not considered ''work which exists in the national economy''. We will not deny you disability benefits on the basis of the existence of these kinds of jobs. If work that you can do does not exist in the national economy, we will determine that you are disabled. However, if work that you can do does exist in the national economy, we will determine that you are not disabled.

(c) *Inability to obtain work.* We will determine that you are not disabled if your residual functional capacity and vocational abilities make it possible for you to do work which exists in the national economy, but you remain unemployed because of—

(1) Your inability to get work;

(2) Lack of work in your local area;

(3) The hiring practices of employers;

(4) Technological changes in the industry in which you have worked;

(5) Cyclical economic conditions;

(6) No job openings for you;

(7) You would not actually be hired to do work you could otherwise do; or

(8) You do not wish to do a particular type of work.

(d) *Administrative notice of job data.* When we determine that unskilled, sedentary, light, and medium jobs exist in the national economy (in significant numbers either in the region where you live or in several regions of the country), we will take administrative notice of reliable job information available from various governmental and other publications. For example, we will take notice of—

(1) *Dictionary of Occupational Titles,* published by the Department of Labor;

(2) *County Business Patterns,* published by the Bureau of the Census;

(3) *Census Reports,* also published by the Bureau of the Census;

(4) *Occupational Analyses,* prepared for the Social Security Administration by various State employment agencies; and

(5) *Occupational Outlook Handbook,* published by the Bureau of Labor Statistics.

(e) *Use of vocational experts and other specialists.* If the issue in determining whether you are disabled is whether your work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, we may use the services of a vocational expert or other specialist. We will decide whether to use a vocational expert or other specialist.

§ 404.1567 Physical exertion requirements.

To determine the physical exertion requirements of work in the national economy, we classify jobs as *sedentary, light, medium, heavy,* and *very heavy.* These terms have the same meaning as they have in the *Dictionary of Occupational Titles,* published by the Department of Labor. In making disability determinations under this subpart, we use the following definitions:

(a) *Sedentary work.* Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) *Light work.* Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

(c) *Medium work.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work.

(d) *Heavy work.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work.

(e) *Very heavy work.* Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, we determine that he or she can also do heavy, medium, light and sedentary work.

§ 404.1568 Skill requirements.

In order to evaluate your skills and to help determine the existence in the national economy of work you are able to do, occupations are classified as unskilled, semi-skilled, and skilled. In classifying these occupations, we use materials published by the Department of Labor. When we make disability determinations under this subpart, we use the following definitions:

(a) *Unskilled work.* Unskilled work is work which needs little or no judgment to do simple duties that can be learned

on the job in a short period of time. The job may or may not require considerable strength. For example, we consider jobs unskilled if the primary work duties are handling, feeding and offbearing (that is, placing or removing materials from machines which are automatic or operated by others), or machine tending, and a person can usually learn to do the job in 30 days, and little specific vocational preparation and judgment are needed. A person does not gain work skills by doing unskilled jobs.

(b) *Semi-skilled work.* Semi-skilled work is work which needs some skills but does not require doing the more complex work duties. Semi-skilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage or injury; or other types of activities which are similarly less complex than skilled work, but more complex than unskilled work. A job may be classified as semi-skilled where coordination and dexterity are necessary, as when hands or feet must be moved quickly to do repetitive tasks.

(c) *Skilled work.* Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled work may require laying out work, estimating quality, determining the suitability and needed quantities of materials, making precise measurements, reading blueprints or other specifications, or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.

(d) *Skills that can be used in other work (transferability)*—(1) *What we mean by transferable skills.* We consider you to have skills that can be used in other jobs, when the skilled or semi-skilled work activities you did in past work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupationally significant work activities among different jobs.

(2) *How we determine skills that can be transferred to other jobs.* Transferability is most probable and meaningful among jobs in which—

(i) The same or a lesser degree of skill is required;

(ii) The same or similar tools and machines are used; and

(iii) The same or similar raw materials, products, processes, or services are involved.

(3) *Degrees of transferability.* There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all three factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture, or fishing) that they are not readily usable in other industries, jobs, and work settings, we consider that they are not transferable.

§ 404.1569 Listing of Medical-Vocational Guidelines in Appendix 2.

The Dictionary of Occupational Titles includes information about jobs (classified by their exertional and skill requirements) that exist in the national economy. Appendix 2 provides rules using this data reflecting major functional and vocational patterns. We apply these rules in cases where a person is not doing substantial gainful activity and is prevented by a severe medically determinable impairment from doing vocationally relevant past work. The rules in appendix 2 do not cover all possible variations of factors. Also, as we explain in § 200.00 of appendix 2, we do not apply these rules if one of the findings of fact about the person's vocational factors and residual functional capacity is not the same as the corresponding criterion of a rule. In these instances, we give full consideration to all relevant facts in accordance with the definitions and discussions under vocational considerations. However, if the findings of fact made about all factors are the same as the rule, we use that rule to decide whether a person is disabled.

§404.1569a Exertional and nonexertional limitations.

(a) *General.* Your impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit your ability to meet certain demands of jobs. These limitations may be exertional, nonexertional, or a combination of both. Limitations are classified as exertional if they affect your ability to meet the strength demands of jobs. The classification of a limitation as exertional is related to the United States Department of Labor's classification of jobs by various exertional levels (sedentary, light, medium, heavy, and very heavy) in terms of the strength demands for sitting, standing, walking, lifting, carrying, pushing, and pulling. Sections 404.1567 and 404.1569 explain how we use the classification of jobs by exertional levels (strength demands) which is contained in the Dictionary of Occupational Titles published by the Department of Labor, to determine the exertional requirements of work which exists in the national economy. Limitations or restrictions which affect your ability to meet the demands of jobs other than the strength demands, that is, demands other than sitting, standing, walking, lifting, carrying, pushing or pulling, are considered nonexertional. Sections 404.1520(f) and 404.1594(f)(8) explain that if you can no longer do your past relevant work because of a severe medically determinable impairment(s), we must determine whether your impairment(s), when considered along with your age, education, and work experience, prevents you from doing any other work which exists in the national economy in order to decide whether you are disabled (§404.1520(f)) or continue to be disabled (§404.1594(f)(8)). Paragraphs (b), (c), and (d) of this section explain how we apply the medical-vocational guidelines in Appendix 2 of this subpart in making this determination, depending on whether the limitations or restrictions imposed by your impairment(s) and related symptoms, such as pain, are exertional, nonexertional, or a combination of both.

(b) *Exertional limitations.* When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), we consider that you have only exertional limitations. When your impairment(s) and related symptoms only impose exertional limitations and your specific vocational profile is listed in a rule contained in Appendix 2 of this subpart, we will directly apply that rule to decide whether you are disabled.

(c) *Nonexertional limitations.* (1) When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the demands of jobs other than the strength demands, we consider that you have only nonexertional limitations or restrictions. Some examples of nonexertional limitations or restrictions include the following:

(i) You have difficulty functioning because you are nervous, anxious, or depressed;

(ii) You have difficulty maintaining attention or concentrating;

(iii) You have difficulty understanding or remembering detailed instructions;

(iv) You have difficulty in seeing or hearing;

(v) You have difficulty tolerating some physical feature(s) of certain work settings, e.g., you cannot tolerate dust or fumes; or

(vi) You have difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching.

(2) If your impairment(s) and related symptoms, such as pain, only affect your ability to perform the nonexertional aspects of work-related activities, the rules in appendix 2 do not direct factual conclusions of disabled or not disabled. The determination as to whether disability exists will be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in appendix 2.

(d) *Combined exertional and nonexertional limitations.* When the limitations and restrictions imposed by

your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we consider that you have a combination of exertional and nonexertional limitations or restrictions. If your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we will not directly apply the rules in appendix 2 unless there is a rule that directs a conclusion that you are disabled based upon your strength limitations; otherwise the rules provide a framework to guide our decision.

[56 FR 57943, Nov, 14, 1991]

SUBSTANTIAL GAINFUL ACTIVITY

§ 404.1571 General.

The work that you have done during any period in which you believe you are disabled may show that you are able to do work at the substantial gainful activity level. If you are able to engage in substantial gainful activity, we will find that you are not disabled. (We explain the rules for persons who are statutorily blind in § 404.1584.) Even if the work you have done was not substantial gainful activity, it may show that you are able to do more work than you actually did. We will consider all of the medical and vocational evidence in your file to decide whether or not you have the ability to engage in substantial gainful activity.

§ 404.1572 What we mean by substantial gainful activity.

Substantial gainful activity is work activity that is both substantial and gainful:

(a) *Substantial work activity.* Substantial work activity is work activity that involves doing significant physical or mental activities. Your work may be substantial even if it is done on a part-time basis or if you do less, get paid less, or have less responsibility than when you worked before.

(b) *Gainful work activity.* Gainful work activity is work activity that you do for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.

(c) *Some other activities.* Generally, we do not consider activities like taking care of yourself, household tasks, hobbies, therapy, school attendance, club activities, or social programs to be substantial gainful activity.

§ 404.1573 General information about work activity.

(a) *The nature of your work.* If your duties require use of your experience, skills, supervision and responsibilities, or contribute substantially to the operation of a business, this tends to show that you have the ability to work at the substantial gainful activity level.

(b) *How well you perform.* We consider how well you do your work when we determine whether or not you are doing substantial gainful activity. If you do your work satisfactorily, this may show that you are working at the substantial gainful activity level. If you are unable, because of your impairments, to do ordinary or simple tasks satisfactorily without more supervision or assistance than is usually given other people doing similar work, this may show that you are not working at the substantial gainful activity level. If you are doing work that involves minimal duties that make little or no demands on you and that are of little or no use to your employer, or to the operation of a business if you are self-employed, this does not show that you are working at the substantial gainful activity level.

(c) *If your work is done under special conditions.* Even though the work you are doing takes into account your impairment, such as work done in a sheltered workshop or as a patient in a hospital, it may still show that you have the necessary skills and ability to work at the substantial gainful activity level.

(d) *If you are self-employed.* Supervisory, managerial, advisory or other significant personal services that you perform as a self-employed individual may show that you are able to do substantial gainful activity.

(e) *Time spent in work.* While the time you spend in work is important, we will not decide whether or not you are doing substantial gainful activity only

on that basis. We will still evaluate the work to decide whether it is substantial and gainful regardless of whether you spend more time or less time at the job than workers who are not impaired and who are doing similar work as a regular means of their livelihood.

§ 404.1574 Evaluation guides if you are an employee.

(a) *General.* We use several guides to decide whether the work you have done shows that you are able to do substantial gainful activity.

(1) *Your earnings may show you have done substantial gainful activity.* The amount of your earnings from work you have done may show that you have engaged in substantial gainful activity. Generally, if you worked for substantial earnings, this will show that you are able to do substantial gainful activity. On the other hand, the fact that your earnings are not substantial will not necessarily show that you are not able to do substantial gainful activity. We will generally consider work that you are forced to stop after a short time because of your impairment as an unsuccessful work attempt and your earnings from that work will not show that you are able to do substantial gainful activity.

(2) *We consider only the amounts you earn.* We do not consider any income not directly related to your productivity when we decide whether you have done substantial gainful activity. If your earnings are being subsidized, the amount of the subsidy is not counted when we determine whether or not your work is substantial gainful activity. Thus, where work is done under special conditions, we only consider the part of your pay which you actually *earn*. For example, where a handicapped person does simple tasks under close and continuous supervision, we would not determine that the person worked at the substantial gainful activity level only on the basis of the amount of pay. An employer may set a specific amount as a subsidy after figuring the reasonable value of the employee's services. If your work is subsidized and your employer does not set the amount of the subsidy or does not adequately explain how the subsidy was figured, we will investigate to see how much your work is worth.

(3) *If you are working in a sheltered or special environment.* If you are working in a sheltered workshop, you may or may not be earning the amounts you are being paid. The fact that the sheltered workshop or similar facility is operating at a loss or is receiving some charitable contributions or governmental aid does not establish that you are not earning all you are being paid. Since persons in military service being treated for severe impairments usually continue to receive full pay, we evaluate work activity in a therapy program or while on limited duty by comparing it with similar work in the civilian work force or on the basis of reasonable worth of the work, rather than on the actual amount of the earnings.

(b) *Earnings guidelines.* (1) *General.* If you are an employee, we first consider the criteria in paragraph (a) of this section and § 404.1576, and then the guides in paragraphs (b) (2), (3), (4), (5), and (6) of this section.

(2) *Earnings that will ordinarily show that you have engaged in substantial gainful activity.* We will consider that your earnings from your work activities as an employee show that you have engaged in substantial gainful activity if—

(i) Your earnings averaged more than $200 a month in calendar years prior to 1976;

(ii) Your earnings averaged more than $230 a month in calendar year 1976;

(iii) Your earnings averaged more than $240 a month in calendar year 1977;

(iv) Your earnings averaged more than $260 a month in calendar year 1978;

(v) Your earnings averaged more than $280 a month in calendar year 1979;

(vi) Your earnings averaged more than $300 a month in calendar years after 1979 and before 1990; or

(vii) Your earnings averaged more than $500 a month in calendar years after 1989.

(3) *Earnings that will ordinarily show that you have not engaged in substantial gainful activity.* We will generally consider that the earnings from your work

as an employee will show that you have not engaged in substantial gainful activity if—

(i) Your earnings averaged less than $130 a month in calendar years before 1976;

(ii) Your earnings averaged less than $150 a month in calendar year 1976;

(iii) Your earnings averaged less than $160 a month in calendar year 1977;

(iv) Your earnings averaged less than $170 a month in calendar year 1978;

(v) Your earnings averaged less than $180 a month in calendar year 1979;

(vi) Your earnings averaged less than $190 a month in calendar years after 1979 and before 1990; or

(vii) Your earnings averaged less than $300 a month in calendar years after 1989.

(4) *If you work in a sheltered workshop.* If you are working in a sheltered workshop or a comparable facility especially set up for severely impaired persons, your earnings and activities will ordinarily establish that you have not done substantial gainful activity if—

(i) Your average earnings are not greater than $200 a month in calendar years prior to 1976;

(ii) Your average earnings are not greater than $230 a month in calendar year 1976;

(iii) Your average earnings are not greater than $240 a month in calendar year 1977;

(iv) Your average earnings are not greater than $260 a month in calendar year 1978;

(v) Your average earnings are not greater than $280 a month in calendar year 1979;

(vi) Your average earnings are not greater than $300 a month in calendar years after 1979 and before 1990; or

(vii) Your average earnings are not greater than $500 a month in calendar years after 1989.

(5) *If there is evidence showing that you may have done substantial gainful activity.* If there is evidence showing that you may have done substantial gainful activity, we will apply the criteria in paragraph (b)(6) of this section regarding comparability and value of services.

(6) *Earnings that are not high or low enough to show whether you engaged in substantial gainful activity.* If your earnings, on the average, are between the amounts shown in paragraphs (b)(2) and (3) of this section, we will generally consider other information in addition to your earnings, such as whether—

(i) Your work is comparable to that of unimpaired people in your community who are doing the same or similar occupations as their means of livelihood, taking into account the time, energy, skill, and responsibility involved in the work, or

(ii) Your work, although significantly less than that done by unimpaired people, is clearly worth the amounts shown in paragraph (b)(2) of this section, according to pay scales in your community.

[46 FR 4869, Jan. 19, 1981, as amended at 48 FR 21936, May 16, 1983; 49 FR 22272, May 29, 1984; 54 FR 53605, Dec. 29, 1989]

§ 404.1575 Evaluation guides if you are self-employed.

(a) *If you are a self-employed person.* We will consider your activities and their value to your business to decide whether you have engaged in substantial gainful activity if you are self-employed. We will not consider your income alone since the amount of income you actually receive may depend upon a number of different factors like capital investment, profit sharing agreements, etc. We will generally consider work that you are forced to stop after a short time because of your impairment as an unsuccessful work attempt and your income from that work will not show that you are able to do substantial gainful activity. We will evaluate your work activity on the value to the business of your services regardless of whether you receive an immediate income for your services. We consider that you have engaged in substantial gainful activity if—

(1) Your work activity, in terms of factors such as hours, skills, energy output, efficiency, duties, and responsibilities, is comparable to that of unimpaired individuals in your community who are in the same or similar businesses as their means of livelihood;

(2) Your work activity, although not comparable to that of unimpaired individuals, is clearly worth the amount

shown in § 404.1574(b)(2) when considered in terms of its value to the business, or when compared to the salary that an owner would pay to an employee to do the work you are doing; or

(3) You render services that are significant to the operation of the business and receive a substantial income from the business.

(b) *What we mean by significant services.* (1) If you are not a farm landlord and you operate a business entirely by yourself, any services that you render are significant to the business. If your business involves the services of more than one person, we will consider you to be rendering significant services if you contribute more than half the total time required for the management of the business, or you render management services for more than 45 hours a month regardless of the total management time required by the business.

(2) If you are a farm landlord, that is, you rent farm land to another, we will consider you to be rendering significant services if you materially particpate in the production or the management of the production of the things raised on the rented farm. (See § 404.1082 of this chapter for an explanation of *material participation*.) If you were given social security earnings credits because you materially participated in the activities of the farm and you continue these same activities, we will consider you to be rendering significant services.

(c) *What we mean by substantial income.* After your normal business expenses are deducted from your gross income to determine net income, we will deduct the reasonable value of any unpaid help, any soil bank payments that were included as farm income, and impairment-related work expenses described in § 404.1576 that have not been deducted in determining your net earnings from self-employment. We will consider the resulting amount of income from the business to be substantial if—

(1) It averages more than the amounts described in § 404.1574(b)(2); or

(2) It averages less than the amounts described in § 404.1574(b)(2) but the livelihood which you get from the business is either comparable to what it was before you became severely impaired or is comparable to that of unimpaired self-employed persons in your community who are in the same or similar business as their means of livelihood.

[46 FR 4870, Jan. 19, 1981, as amended at 48 FR 21936, May 16, 1983; 49 FR 22272, May 29, 1984]

§ 404.1576 Impairment-related work expenses.

(a) *General.* When we figure your earnings in deciding if you have done substantial gainful activity, we will subtract the reasonable costs to you of certain items and services which, because of your impairment(s), you need and use to enable you to work. The costs are deductible even though you also need or use the items and services to carry out daily living functions unrelated to your work. Paragraph (b) of this section explains the conditions for deducting work expenses. Paragraph (c) of this section describes the expenses we will deduct. Paragraph (d) of this section explains when expenses may be deducted. Paragraph (e) of this section describes how expenses may be allocated. Paragraph (f) of this section explains the limitations on deducting expenses. Paragraph (g) of this section explains our verification procedures.

(b) *Conditions for deducting impairment-related work expenses.* We will deduct impairment-related work expenses if—

(1) You are otherwise disabled as defined in §§ 404.1505, 404.1577 and 404.1581–404.1583;

(2) The severity of your impairment(s) requires you to purchase (or rent) certain items and services in order to work;

(3) You pay the cost of the item or service. No deduction will be allowed to the extent that payment has been or will be made by another source. No deduction will be allowed to the extent that you have been, could be, or will be reimbursed for such cost by any other source (such as through a private insurance plan, Medicare or Medicaid, or other plan or agency). For example, if you purchase crutches for $80 but you were, could be, or will be reimbursed $64 by some agency, plan, or program, we will deduct only $16;

(4) You pay for the item or service in a month you are working (in accordance with paragraph (d) of this section); and

(5) Your payment is in cash (including checks or other forms of money). Payment in kind is not deductible.

(c) *What expenses may be deducted*—(1) *Payments for attendant care services.* (i) If because of your impairment(s) you need assistance in traveling to and from work, or while at work you need assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating), the payments you make for those services may be deducted.

(ii) If because of your impairment(s) you need assistance with personal functions (e.g., dressing, administering medications) at home in preparation for going to and assistance in returning from work, the payments you make for those services may be deducted.

(iii)(A) We will deduct payments you make to a family member for attendant care services only if such person, in order to perform the services, suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked.

(B) We consider a family member to be anyone who is related to you by blood, marriage or adoption, whether or not that person lives with you.

(iv) If only part of your payment to a person is for services that come under the provisions of paragraph (c)(1) of this section, we will only deduct that part of the payment which is attributable to those services. For example, an attendant gets you ready for work and helps you in returning from work, which takes about 2 hours a day. The rest of his or her 8 hour day is spent cleaning your house and doing your laundry, etc. We would only deduct one-fourth of the attendant's daily wages as an impairment-related work expense.

(2) *Payments for medical devices.* If your impairment(s) requires that you utilize medical devices in order to work, the payments you make for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment which can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.

(3) *Payments for prosthetic devices.* If your impairment(s) requires that you utilize a prosthetic device in order to work, the payments you make for that device may be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs and other parts of the body.

(4) *Payments for equipment.* (i) *Work-related equipment.* If your impairment(s) requires that you utilize special equipment in order to do your job, the payments you make for that equipment may be deducted. Examples of work-related equipment are one-hand typewriters, vision aids, sensory aids for the blind, telecommunication devices for the deaf and tools specifically designed to accommodate a person's impairment(s).

(ii) *Residential modifications.* If your impairment(s) requires that you make modifications to your residence, the location of your place of work will determine if the cost of these modifications will be deducted. If you are employed away from home, only the cost of changes made outside of your home to permit you to get to your means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of your home will not be deducted. If you work at home, the costs of modifying the inside of your home in order to create a working space to accommodate your impairment(s) will be deducted to the extent that the changes pertain specifically to the space in which you work. Examples of such changes are the enlargement of a doorway leading into the workspace or modification of the workspace to accommodate problems in dexterity. However, if you are self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(iii) *Nonmedical appliances and equipment.* Expenses for appliances and equipment which you do not ordinarily use for medical purposes are generally not deductible. Examples of these items are portable room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners. However, expenses for such items may be deductible when unusual circumstances clearly establish an impairment-related and medically verified need for such an item because it is essential for the control of your disabling condition, thus enabling you to work. To be considered essential, the item must be of such a nature that if it were not available to you there would be an immediate adverse impact on your ability to function in your work activity. In this situation, the expense is deductible whether the item is used at home or in the working place. An example would be the need for an electric air cleaner by an individual with severe respiratory disease who cannot function in a non-purified air environment. An item such as an exercycle is not deductible if used for general physical fitness. If it is prescribed and used as necessary treatment of your impairment and necessary to enable you to work, we will deduct payments you make toward its cost.

(5) *Payments for drugs and medical services.* (i) If you must use drugs or medical services (including diagnostic procedures) to control your impairment(s) the payments you make for them may be deducted. The drugs or services must be prescribed (or utilized) to reduce or eliminate symptoms of your impairment(s) or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

(ii) Examples of deductible drugs and medical services are anticonvulsant drugs to control epilepsy or anticonvulsant blood level monitoring; antidepressant medication for mental disorders; medication used to allay the side effects of certain treatments; radiation treatment or chemotherapy for cancer patients; corrective surgery for spinal disorders; electroencephalograms and brain scans related to a disabling epileptic condition; tests to determine the efficacy of medication on a diabetic condition; and immunosuppressive medications that kidney transplant patients regularly take to protect against graft rejection.

(iii) We will only deduct the costs of drugs or services that are directly related to your impairment(s). Examples of non-deductible items are routine annual physical examinations, optician services (unrelated to a disabling visual impairment) and dental examinations.

(6) *Payments for similar items and services*—(i) *General.* If you are required to utilize items and services not specified in paragraphs (c) (1) through (5) of this section but which are directly related to your impairment(s) and which you need to work, their costs are deductible. Examples of such items and services are medical supplies and services not discussed above, the purchase and maintenance of a dog guide which you need to work, and transportation.

(ii) *Medical supplies and services not described above.* We will deduct payments you make for expendable medical supplies, such as incontinence pads, catheters, bandages, elastic stockings, face masks, irrigating kits, and disposable sheets and bags. We will also deduct payments you make for physical therapy which you require because of your impairment(s) and which you need in order to work.

(iii) *Payments for transportation costs.* We will deduct transportation costs in these situations:

(A) Your impairment(s) requires that in order to get to work you need a vehicle that has structural or operational modifications. The modifications must be critical to your operation or use of the vehicle and directly related to your impairment(s). We will deduct the costs of the modifications, but not the cost of the vehicle. We will also deduct a mileage allowance for the trip to and from work. The allowance will be based on data compiled by the Federal Highway Administration relating to vehicle operating costs.

(B) Your impairment(s) requires you to use driver assistance, taxicabs or other hired vehicles in order to work.

We will deduct amounts paid to the driver and, if your own vehicle is used, we will also deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(C) Your impairment(s) prevents your taking available public transportation to and from work and you must drive your (unmodified) vehicle to work. If we can verify through your physician or other sources that the need to drive is caused by your impairment(s) (and not due to the unavailability of public transportation), we will deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(7) *Payments for installing, maintaining, and repairing deductible items.* If the device, equipment, appliance, etc., that you utilize qualifies as a deductible item as described in paragraphs (c) (2), (3), (4) and (6) of this section, the costs directly related to installing, maintaining and repairing these items are also deductible. (The costs which are associated with modifications to a vehicle are deductible. Except for a mileage allowance, as provided for in paragraph (c)(6)(iii) of this section, the costs which are associated with the vehicle itself are not deductible.)

(d) *When expenses may be deducted.* (1) *Effective date.* To be deductible an expense must be incurred after November 30, 1980. An expense may be considered incurred after that date if it is paid thereafter even though pursuant to a contract or other arrangement entered into before December 1, 1980.

(2) *Payments for services.* A payment you make for services may be deducted if the services are received while you are working and the payment is made in a month you are working. We consider you to be working even though you must leave work temporarily to receive the services.

(3) *Payments for items.* A payment you make toward the cost of a deductible item (regardless of when it is acquired) may be deducted if payment is made in a month you are working. See paragraph (e)(4) of this section when purchases are made in anticipation of work.

(e) *How expenses are allocated.* (1) *Recurring expenses.* You may pay for services on a regular periodic basis, or you may purchase an item on credit and pay for it in regular periodic installments or you may rent an item. If so, each payment you make for the services and each payment you make toward the purchase or rental (including interest) is deductible in the month it is made.

Example. B starts work in October 1981 at which time she purchases a medical device at a cost of $4,800 plus interest charges of $720. Her monthly payments begin in October. She earns and receives $400 a month. The term of the installment contract is 48 months. No downpayment is made. The monthly allowable deduction for the item would be $115 ($5520 divided by 48) for each month of work during the 48 months.

(2) *Nonrecurring expenses.* Part or all of your expenses may not be recurring. For example, you may make a one-time payment in full for an item or service or make a downpayment. If you are working when you make the payment we will either deduct the entire amount in the month you pay it or allocate the amount over a 12 consecutive month period beginning with the month of payment, whichever you select.

Example A begins working in October 1981 and earns $525 a month. In the same month he purchases and pays for a deductible item at a cost of $250. In this situation we could allow a $250 deduction for October 1981, reducing A's earnings below the SGA level for that month.

If A's earnings had been $15 above the SGA earnings amount, A probably would select the option of projecting the $250 payment over the 12-month period, October 1981–September 1982, giving A an allowable deduction of $20.83 a month for each month of work during that period. This deduction would reduce A's earnings below the SGA level for 12 months.

(3) *Allocating downpayments.* If you make a downpayment we will, if you choose, make a separate calculation for the downpayment in order to provide for uniform monthly deductions. In these situations we will determine the total payment that you will make over a 12 consecutive month period beginning with the month of the downpayment and allocate that amount over the 12 months. Beginning with the 13th month, the regular monthly payment will be deductible. This allocation process will be for a shorter period

if your regular monthly payments will extend over a period of less than 12 months.

Example 1. C starts working in October 1981, at which time he purchases special equipment at a cost of $4,800, paying $1,200 down. The balance of $3,600, plus interest of $540, is to be repaid in 36 installments of $115 a month beginning November 1981. C earns $500 a month. He chooses to have the downpayment allocated. In this situation we would allow a deduction of $205.42 a month for each month of work during the period October 1981 through September 1982. After September 1982, the deduction amount would be the regular monthly payment of $115 for each month of work during the remaining installment period.

Explanation:

Downpayment in 10/81	$1,200	
Monthly payments 11/81 through 09/82	1,265	
	12) 2,465	=$205.42

Example 2. D, while working, buys a deductible item in July 1981, paying $1,450 down. However, his first monthly payment of $125 is not due until September 1981. D chooses to have the downpayment allocated. In this situation we would allow a deduction of $225 a month for each month of work during the period July 1981 through June 1982. After June 1982, the deduction amount would be the regular monthly payment of $125 for each month of work.

Explanation:

Downpayment in 07/81	$1,450	
Monthly payments 09/81 through 06/82	1,250	
	12) 2,700	=$225

(4) *Payments made in anticipation of work.* A payment toward the cost of a deductible item that you made in any of the 11 months preceding the month you started working will be taken into account in determining your impairment-related work expenses. When an item is paid for in full during the 11 months preceding the month you started working the payment will be allocated over the 12-consecutive month period beginning with the month of the payment. However, the only portion of the payment which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for with a one-time payment of $600, the deductible amount would be $450 ($600 divided by 12, multiplied by 9). Installment payments (including a downpayment) that you made for a particular item during the 11 months preceding the month you started working will be totaled and considered to have been made in the month of your first payment for that item within this 11 month period. The sum of these payments will be allocated over the 12-consecutive month period beginning with the month of your first payment (but never earlier than 11 months before the month work began). However, the only portion of the total which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for in 3 monthly installments of $200 each, the total payment of $600 will be considered to have been made in the month of the first payment, that is, 3 months before the month work began. The deductible amount would be $450 ($600 divided by 12, multiplied by 9). The amount, as determined by these formulas, will then be considered to have been paid in the first month of work. We will deduct either this entire amount in the first month of work or allocate it over a 12-consecutive month period beginning with the first month of work, whichever you select. In the above examples, the individual would have the choice of having the entire $450 deducted in the first month of work or of having $37.50 a month ($450 divided by 12) deducted for each month that he works over a 12-consecutive month period, beginning with the first month of work. To be deductible the payments must be for durable items such as medical devices, prostheses, work-related equipment, residential modifications, nonmedical appliances and vehicle modifications. Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies and vehicle operating costs are not deductible for purposes of this paragraph.

(f) *Limits on deductions.* (1) We will deduct the actual amounts you pay towards your impairment-related work

expenses unless the amounts are unreasonable. With respect to durable medical equipment, prosthetic devices, medical services, and similar medically-related items and services, we will apply the prevailing charges under Medicare (part B of title XVIII, Health Insurance for the Aged and Disabled) to the extent that this information is readily available. Where the Medicare guides are used, we will consider the amount that you pay to be reasonable if it is no more than the prevailing charge for the same item or service under the Medicare guidelines. If the amount you actually pay is more than the prevailing charge for the same item under the Medicare guidelines, we will deduct from your earnings the amount you paid to the extent you establish that the amount is consistent with the standard or normal charge for the same or similar item or service in your community. For items and services that are not listed in the Medicare guidelines, and for items and services that are listed in the Medicare guidelines but for which such guides cannot be used because the information is not readily available, we will consider the amount you pay to be reasonable if it does not exceed the standard or normal charge for the same or similar item(s) or service(s) in your community.

(2) Impairment-related work expenses are not deducted in computing your earnings for purposes of determining whether your work was ''services'' as described in § 404.1592(b).

(3) The decision as to whether you performed substantial gainful activity in a case involving impairment-related work expenses for items or services necessary for you to work generally will be based upon your ''earnings'' and not on the value of ''services'' you rendered. (See §§ 404.1574(b)(6) (i) and (ii), and 404.1575(a)). This is not necessarily so, however, if you are in a position to control or manipulate your earnings.

(4) The amount of the expenses to be deducted must be determined in a uniform manner in both the disability insurance and SSI programs.

(5) No deduction will be allowed to the extent that any other source has paid or will pay for an item or service. No deduction will be allowed to the extent that you have been, could be, or will be, reimbursed for payments you made. (See paragraph (b)(3) of this section.)

(6) The provisions described in the foregoing paragraphs of this section are effective with respect to expenses incurred on and after December 1, 1980, although expenses incurred after November 1980 as a result of contractual or other arrangements entered into before December 1980, are deductible. For months before December 1980 we will deduct impairment-related work expenses from your earnings only to the extent they exceeded the normal work-related expenses you would have had if you did not have your impairment(s). We will not deduct expenses, however, for those things which you needed even when you were not working.

(g) *Verification.* We will verify your need for items or services for which deductions are claimed, and the amount of the charges for those items or services. You will also be asked to provide proof that you paid for the items or services.

[48 FR 21936, May 16, 1983]

WIDOWS, WIDOWERS, AND SURVIVING DIVORCED SPOUSES

§ 404.1577 Disability defined for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991.

For monthly benefits payable for months prior to January 1991, the law provides that to be entitled to a widow's or widower's benefit as a disabled widow, widower, or surviving divorced spouse, you must have a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. The impairment(s) must have been of a level of severity to prevent a person from doing any gainful activity. To determine whether you were disabled, we consider only your physical or mental impairment(s). We do not consider your age, education, and work experience. We also do not consider certain felony-related and prison-related impairments, as explained in § 404.1506. (For

monthly benefits payable for months after December 1990, see § 404.1505(a).)

[57 FR 30120, July 8, 1992]

§ 404.1578 How we determine disability for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991.

(a) For monthly benefits payable for months prior to January 1991, we will find that you were disabled and pay you widow's or widower's benefits as a widow, widower, or surviving divorced spouse if—

(1) Your impairment(s) had specific clinical findings that were the same as those for any impairment in the Listing of Impairments in appendix 1 of this subpart or were medically equivalent to those for any impairment shown there;

(2) Your impairment(s) met the duration requirement.

(b) However, even if you met the requirements in paragraphs (a) (1) and (2) of this section, we will not find you disabled if you were doing substantial gainful activity.

[57 FR 30121, July 8, 1992]

§ 404.1579 How we will determine whether your disability continues or ends.

(a) *General.* (1) The rules for determining whether disability continues for widow's or widower's monthly benefits for months after December 1990 are discussed in §§ 404.1594 through 404.1598. The rules for determining whether disability continues for monthly benefits for months prior to January 1991 are discussed in paragraph (a)(2) of this section and paragraphs (b) through (h) of this section.

(2) If you are entitled to disability benefits as a disabled widow, widower, or surviving divorced spouse, and we must decide whether your disability continued or ended for monthly benefits for months prior to January 1991, there are a number of factors we consider in deciding whether your disability continued. We must determine if there has been any medical improvement in your impairment(s) and, if so, whether this medical improvement is related to your ability to work. If your impairment(s) has not so medically improved, we must address whether one or more exceptions applies. If medical improvement related to your ability to work has not occurred and no exception applies, your benefits will continue. Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases (see paragraph (e) of this section for exceptions) before we can find that you are no longer disabled, we must also show that your impairment(s), as shown by current medical evidence, is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity.

(b) *Terms and definitions.* There are several terms and definitions which are important to know in order to understand how we review your claim to determine whether your disability continues.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs and/or laboratory findings (see § 404.1528) associated with your impairment(s).

Example 1: You were awarded disability benefits due to a herniated nucleus pulposus which was determined to equal the level of severity contemplated by Listing 1.05.C. At the time of our prior favorable decision, you had had a laminectomy. Postoperatively, a myelogram still showed evidence of a persistent deficit in your lumbar spine. You had pain in your back, and pain and a burning sensation in your right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in your back and leg. When we reviewed your claim your treating physician reported that he had seen you regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. Your doctor further reported a moderately decreased range of motion in your back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has *not* occurred because there has been no decrease in the severity of your back impairment as

shown by changes in symptoms, signs, or laboratory findings.

Example 2: You were awarded disability benefits due to rheumatoid arthritis of a severity as described in Listing 1.02 of appendix 1 of this subpart. At the time, laboratory findings were positive for this condition. Your doctor reported persistent swelling and tenderness of your fingers and wrists and that you complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, your impairment has responded favorably to therapy so that for the last year your fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of your impairment as documented by the current symptoms and signs reported by your physician. Although your impairment is subject to temporary remissions and exacerbations the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. We would then determine if this medical improvement is related to your ability to work.

(2) *Determining whether medical improvement is related to your ability to work.* If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the listing section which was used in making our most recent favorable decision, we will find that the medical improvement was related to your ability to work. We make this finding because the criteria in appendix 1 of this subpart are related to ability to work because they reflect impairments which are considered severe enough to prevent a person from doing any gainful work. We must, of course, also establish that, considering all of your current impairments not just those which existed at the time of the most recent prior favorable medical decision, your condition does not meet or equal the requirements of appendix 1 before we could find that your disability has ended. If there has been any medical improvement in your impairment(s), but it is not related to your ability to do work and none of the exceptions applies, your benefits will be continued.

(3) *Determining whether your impairment(s) is deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity.* Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases before we can find that you are no longer disabled, we must also show that your impairment(s) is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. All current impairments will be considered, not just the impairment(s) present at the time of our most recent favorable determination. Sections 404.1525, 404.1526, and 404.1578 set out how we will decide whether your impairment(s) meets or equals the requirements of appendix 1 of this subpart.

(4) *Evidence and basis for our decision.* Our decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that you have previously been determined to be disabled. We will consider all evidence you submit, as well as all evidence we obtain from your treating physician(s) and other medical or nonmedical sources. What constitutes ''evidence'' and our procedures for obtaining it are set out in §§ 404.1512 through 404.1518. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(5) *Point of comparison.* For purposes of determining whether medical improvement has occurred, we will compare the current severity of that impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled to the medical severity of that impairment(s) at that time. If medical improvement has occurred, we will determine whether the medical improvement is related to your ability to do work based on this previously existing impairment(s). The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether you were disabled or continued to be disabled which became final.

(c) *Determining medical improvement and its relationship to your ability to do work.* Paragraphs (b) (1) and (2) of this section discuss what we mean by medical improvement and how we determine whether medical improvement is related to your ability to work.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of impairment(s) present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. Whether medical improvement has occurred is determined by a comparison of prior and current medical evidence which must show that there have been changes (improvement) in the symptoms, signs or laboratory findings associated with that impairment(s).

(2) *Determining whether medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the signs, symptoms and laboratory findings, we then must determine if it is related to your ability to do work, as explained in paragraph (b)(2) of this section. In determining if the medical improvement that has occurred is related to your ability to work, we will assess whether the previously existing impairments still meet or equal the level of severity contemplated by the same listing section in appendix 1 of this subpart which was used in making our most recent favorable decision. Appendix 1 of this subpart describes impairments which, if severe enough, affect a person's ability to work. If the appendix level of severity is met or equaled, the individual is deemed, in the absence of evidence of the contrary, to be unable to engage in gainful activity. If there has been medical improvement to the degree that the requirement of the listing section is no longer met or equaled, then the medical improvement is related to your ability to work. Unless an objective assessment shows that the listing requirement is no longer met or equaled based on actual changes shown by the medical evidence, the medical improvement that has occurred will not be considered to be related to your ability to work.

(3) *Prior file cannot be located.* If the prior file cannot be located, we will first determine whether your current impairment(s) is deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. (In this way, we will be able to determine that your disability continues at the earliest time without addressing the issue of reconstructing prior evidence which can be a lengthy process.) If so, your benefits will continue unless one of the second group of exceptions applies (see paragraph (e) of this section). If not, we will determine whether an attempt should be made to reconstruct those portions of the file that were relevant to our most recent favorable medical decision (e.g., medical evidence from treating sources and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation, etc.; and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed either because it is determined not to attempt reconstruction or because such efforts fail, medical improvement cannot be found. The documentation of your current impairments will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any decision under this section in accordance with the rules in § 404.988.

(4) *Impairment(s) subject to temporary remission.* In some cases the evidence shows that an individual's impairment is subject to temporary remission. In assessing whether medical improvement has occurred in persons with this type of impairment, we will be careful to consider the longitudinal history of the impairment(s), including the occurrence of prior remissions, and prospects for future worsening of the impairment(s). Improvement in such impairments that is only temporary will not warrant a finding of medical improvement.

(5) *Applicable listing has been revised since the most recent favorable medical decision.* When determining whether any medical improvement is related to your ability to work, we use the same listing section in appendix 1 of this subpart which was used to make our prior favorable decision. We will use the listing as it appeared at the time of the prior decision, even where the requirement(s) of the listing was subsequently changed. The current revised listing requirement will be used if we

determine that you have medically improved and it is necessary to determine whether you are now considered unable to engage in gainful activity.

(d) *First group of exceptions to medical improvement.* The law provides for certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if your impairment(s) is no longer considered, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, before we can find you are no longer disabled, we must also show that, taking all your current impairment(s) into account, not just those that existed at the time of our most recent favorable medical decision, your impairment(s) is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. As part of the review process, you will be asked about any medical therapy you received or are receiving. Your answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception does or does not apply.

(1) *Substantial evidence shows that you are the beneficiary of advances in medical therapy or technology (related to your ability to work).* Advances in medical therapy or technology are improvements in treatment or rehabilitative methods which have favorably affected the severity of your impairment(s). We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment(s). This decision will be based on new medical evidence. In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(2) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable medical decision, such evidence may serve as a basis for finding that you are no longer disabled, if your impairment(s) is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable medical decision.

(i) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(ii) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(A) Some of the future changes in the Listing of Impairments in appendix 1 of this subpart will be based on new or improved diagnostic or evaluative techniques. Such listing changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved technique will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(B) A cumulative list since 1970 of new or improved diagnostic techniques or evaluations, how they changed the evaluation of the applicable impairment and the month and year they became generally available, will be published in the *Notices* section of the FEDERAL REGISTER. Included will be any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 which are reflective of new or improved techniques. No cases will be processed under this exception until this cumulative listing is so published. Subsequent changes to the list will be published periodically. The period will be determined by the volume of changes needed.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of your last favorable medical decision. Current evidence could show that your condition, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all your current impairments into account, you are now able to engage in gainful activity, this exception would be used to find that you are no longer disabled even if medical improvement has not occurred.

(3) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 of this subpart was misapplied).

Example: You were granted benefits when it was determined that your epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of your seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether you were still considered to be disabled would be based on whether your current impairment(s) meets or equals the requirements of appendix 1 of this subpart.

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

(iii) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: You were previously granted disability benefits on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments. The prior record shows that you had ''brittle'' diabetes for which you were taking insulin. Your urine was 3+ for sugar, and you alleged occasional hypoglycemic attacks caused by exertion. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator believes, however, that your impairment does not equal the severity contemplated by the listings. Error *cannot* be found because it would represent a substitution of current judgment for that of

the prior adjudicator that your impairment equaled a listing.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see § 404.988) are met.

(4) *You are currently engaging in substantial gainful activity.* If you are currently engaging in substantial gainful activity before we determine whether you are no longer disabled because of your work activity, we will consider whether you are entitled to a trial work period as set out in § 404.1592. We will find that your disability has ended in the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply in determining whether you continue to have a disabling impairment(s) (§ 404.1511) for purposes of deciding your eligibility for a reentitlement period (§ 404.1592a).

(e) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations the decision will be made without a determination that you have medically improved or can engage in gainful activity.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in § 404.988. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will determine that your disability has ended. The month your disability ends will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see § 404.1530(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(f) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may stop and benefits may be *continued* at any point if we determine there is sufficient evidence to find that you are still unable to engage in gainful activity. The steps are:

(1) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended.

(2) If you are not, has there been medical improvement as defined in paragraph (b)(1) of this section? If there has been medical improvement as

shown by a decrease in medical severity, see step (3). If there has been no decrease in medical severity, there has been no medical improvement. (see step (4).)

(3) If there has been medical improvement, we must determine (in accordance with paragraph (b)(2) of this section) whether it is related to your ability to work. If medical improvement is *not* related to your ability to do work, see step (4). If medical improvement is related to your ability to do work, see step (5).

(4) If we found at step (2) that there has been no medical improvement or if we found at step (3) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (d) and (e) of this section apply. If none of them apply, your disability will be found to continue. If one of the first group of exceptions to medical improvement (see paragraph (d) of this section) applies, we will proceed to step (5). If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

(5) If medical improvement is related to your ability to work or if one of the first group of exceptions to medical improvement applies, we will determine (considering all your impairments) whether the requirements of appendix 1 of this subpart are met or equaled. If your impairment(s) meets or equals the requirements of appendix 1 of this subpart, your disability will be found to continue. If not, your disability will be found to have ended.

(g) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the earliest of the following months—

(1) The month the evidence shows you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(2) The month the evidence shows you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) The month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period); however, we may pay you benefits for certain months in and after the reentitlement period which follows the trial work period. (See § 404.1592 for a discussion of the trial work period, § 404.1592a for a discussion of the reentitlement period, and § 404.337 for when your benefits will end.);

(4) The month in which you return to full-time work, with no significant medical restrictions and acknowledge that medical improvement has occurred, as long as we expected your impairment(s) to improve (see § 404.1591);

(5) The first month in which you failed to do what we asked, without good cause when the rule set out in paragraph (e)(2) of this section applies;

(6) The first month in which the question of continuing disability arose and we could not find you, when the rule set out in paragraph (e)(3) of this section applies;

(7) The first month in which you failed to follow prescribed treatment without good cause, when the rule set out in paragraph (e)(4) of this section applies; or

(8) The first month you were told by your physician that you could return to work provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity for work and the earlier date is supported by medical evidence.

(h) *Before we stop your benefits.* Before we determine you are no longer disabled, we will give you a chance to explain why we should not do so. Sections 404.1595 and 404.1597 describe your rights (including appeal rights) and the procedures we will follow.

[50 FR 50126, Dec. 6, 1985; 51 FR 7063, Feb. 28, 1986; 51 FR 16015, Apr. 30, 1986, as amended at 57 FR 30121, July 8, 1992; 59 FR 1635, Jan. 12, 1994]

BLINDNESS

§ 404.1581 Meaning of blindness as defined in the law.

We will consider you blind under the law for a period of disability and for payment of disability insurance benefits if we determine that you are statutorily blind. Statutory blindness is defined in the law as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less. Your blindness must meet the duration requirement in § 404.1509. We do not consider certain felony-related and prison-related impairments, as explained in § 404.1506.

[45 FR 55584, Aug. 20, 1980, as amended at 48 FR 5715, Feb. 8, 1983]

§ 404.1582 A period of disability based on blindness.

If we find that you are blind and you meet the insured status requirement, we may establish a period of disability for you regardless of whether you can do substantial gainful activity. A period of disability protects your earnings record under Social Security so that the time you are disabled will not count against you in determining whether you will have worked long enough to qualify for benefits and the amount of your benefits. However, you will not necessarily be entitled to receive disability insurance cash benefits even though you are blind. If you are a blind person under age 55, you must be unable to do any substantial gainful activity in order to be paid disability insurance cash benefits.

§ 404.1583 How we determine disability for blind persons who are age 55 or older.

We will find that you are eligible for disability insurance benefits even though you are still engaging in substantial gainful activity, if—

(a) You are blind;

(b) You are age 55 or older; and

(c) You are unable to use the skills or abilities like the ones you used in any substantial gainful activity which you did regularly and for a substantial period of time. (However, you will not be paid any cash benefits for any month in which you are doing substantial gainful activity.)

§ 404.1584 Evaluation of work activity of blind people.

(a) *General.* If you are blind (as explained in § 404.1581), we will consider the earnings from the work you are doing to determine whether or not you should be paid cash benefits.

(b) *Under Age 55.* If you are under age 55, we will evaluate the work you are doing using the guides in paragraph (d) of this section to determine whether or not your work shows that you are doing substantial gainful activity. If you are not doing substantial gainful activity, we will pay you cash benefits. If you are doing substantial gainful activity, we will not pay you cash benefits. However, you will be given a period of disability as described in subpart D of this part.

(c) *Age 55 or older.* If you are age 55 or older, we will evaluate your work using the guides in paragraph (d) of this section to determine whether or not your work shows that you are doing substantial gainful activity. If you have not shown this ability, we will pay you cash benefits. If you have shown an ability to do substantial gainful activity, we will evaluate your work activity to find out how your work compares with the work you did before. If the skills and abilities of your new work are about the same as those you used in the work you did before, we will not pay you cash benefits. However, if your new work requires skills and abilities which are less than or different than those you used in the work you did before, we will pay you cash benefits, but not for any month in which you actually perform substantial gainful activity.

(d) *Evaluation of earnings.* The law provides a different earnings test for substantial gainful activity of people who are blind. We will not consider that you are able to engage in substantial gainful activity on the basis of earnings unless your monthly earnings average more than $334.00 in 1978; $375.00 in 1979; $417.00 in 1980; $459.00 in 1981; and $500.00 in 1982. (Sections

404.1574(a)(2), 404.1575(c) and 404.1576 are applicable in determining the amount of your earnings.) Thereafter, an increase in the substantial gainful activity amount will depend on increases in the cost of living. For work activity performed in taxable years before 1978, the earnings considered enough to show an ability to do substantial gainful activity are the same for blind people as for others.

[45 FR 55584, Aug. 20, 1980, as amended at 48 FR 21939, May 16, 1983]

§ 404.1585 Trial work period for persons age 55 or older who are blind.

If you become eligible for disability benefits even though you were doing substantial gainful activity because you are blind and age 55 or older, you are entitled to a trial work period if—

(a) You later return to substantial gainful activity that requires skills or abilities comparable to those required in the work you regularly did before you became blind or became 55 years old, whichever is later; or

(b) Your last previous work ended because of an impairment and the current work requires a significant vocational adjustment.

§ 404.1586 Why and when we will stop your cash benefits.

(a) *When you are not entitled to benefits.* If you become entitled to disability cash benefits as a statutorily blind person, we will find that you are no longer entitled to benefits beginning with the earliest of—

(1) The month your vision, based on current medical evidence, does not meet the definition of blindness and your disability does not continue under the rules in § 404.1594 and you were disabled only for a specified period of time in the past;

(2) The month your vision, based on current medical evidence, does not meet the definition of blindness and your disability does not continue under the rules in § 404.1594, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) If you are under age 55, the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period); however, we may pay you benefits for certain months in and after the reentitlement period which follows the trial work period. (See § 404.1592a for a discussion of the reentitlement period, and § 404.316 on when your benefits will end.); or

(4) If you are age 55 or older, the month (following completion of a trial work period) when your work activity shows you are able to use, in substantial gainful activity, skills and abilities comparable to those of some gainful activity which you did with some regularity and over a substantial period of time. The skills and abilities are compared to the activity you did prior to age 55 or prior to becoming blind, whichever is later.

(b) *If we find that you are not entitled to disability cash benefits.* If we find that you are not entitled to disability cash benefits on the basis of your work activity but your visual impairment is sufficiently severe to meet the definition of blindness, the period of disability that we established for you will continue.

(c) *If you do not follow prescribed treatment.* If treatment has been prescribed for you that can restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have a good reason for failing to follow that treatment (see § 404.1530(c)), we will find that your disability has ended. The month in which your disability will be found to have ended will be the first month in which you failed to follow the prescribed treatment.

(d) *If you do not cooperate with us.* If we ask you to give us medical or other evidence or to go for a medical examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability will be found to have ended will be the month in which you failed to do what we asked.

(e) *If we are unable to find you.* If there is a question about whether you continue to be disabled by blindness and we are unable to find you to resolve the question, we will find that your disability, has ended. The month it ends will be the first month in which the question arose and we could not find you.

(f) *Before we stop your benefits.* Before we stop your benefits or period of disability, we will give you a chance to give us your reasons why we should not stop your benefits or your period of disability. Section 404.1595 describes your rights and the procedures we will follow.

(g) *If you are in an appropriate vocational rehabilitation program.* (1) Your benefits, and those of your dependents, may be continued for months after November 1980 after your impairment is no longer disabling if—

(i) Your disability did not end before December 1980;

(ii) You are participating in an appropriate program of vocational rehabilitation, that is, one that has been approved under a State plan approved under title I of the Rehabilitation Act of 1973 and which meets the requirements outlined in 34 CFR part 361 for a rehabilitation program;

(iii) You began the program before your disability ended; and

(iv) We have determined that your completion of the program, or your continuation in the program for a specified period of time, will significantly increase the likelihood that you will not have to return to the disability benefit rolls.

(2) Your benefits generally will be stopped with the month—

(i) You complete the program;

(ii) You stop participating in the program for any reason; or

(iii) We determine that your continuing participation in the program will no longer significantly increase the likelihood that you will be permanently removed from the disability benefit rolls.

Exception: In no case will your benefits be stopped with a month earlier than the second month after your disability ends.

[45 FR 55584, Aug. 20, 1980, as amended at 47 FR 31543, July 21, 1982; 47 FR 52693, Nov. 23, 1982; 49 FR 22272, May 29, 1984; 50 FR 50130, Dec. 6, 1985; 51 FR 17617, May 14, 1986; 59 FR 1635, Jan. 12, 1994]

§ 404.1587 Circumstances under which we may suspend your benefits before we make a determination.

We will suspend your benefits if all of the information we have clearly shows that you are not disabled and we will be unable to complete a determination soon enough to prevent us from paying you more monthly benefits than you are entitled to. This may occur when you are blind as defined in the law and age 55 or older and you have returned to work similar to work you previously performed.

CONTINUING OR STOPPING DISABILITY

§ 404.1588 Your responsibility to tell us of events that may change your disability status.

If you are entitled to cash benefits or to a period of disability because you are disabled, you should promptly tell us if—

(a) Your condition improves;

(b) You return to work;

(c) You increase the amount of your work; or

(d) Your earnings increase.

§ 404.1589 We may conduct a review to find out whether you continue to be disabled.

After we find that you are disabled, we must evaluate your impairment(s) from time to time to determine if you are still eligible for disability cash benefits. We call this evaluation a continuing disability review. We may begin a continuing disability review for any number of reasons including your failure to follow the provisions of the Social Security Act or these regulations. When we begin such a review, we will notify you that we are reviewing your eligibility for disability benefits, why we are reviewing your eligibility, that in medical reviews the medical improvement review standard will apply, that our review could result in the termination of your benefits, and

that you have the right to submit medical and other evidence for our consideration during the continuing disability review. In doing a medical review, we will develop a complete medical history of at least the preceding 12 months in any case in which a determination is made that you are no longer under a disability. If this review shows that we should stop payment of your benefits, we will notify you in writing and give you an opportunity to appeal. In §404.1590 we describe those events that may prompt us to review whether you continue to be disabled.

[51 FR 16825, May 7, 1986]

§404.1590 When and how often we will conduct a continuing disability review.

(a) *General.* We conduct continuing disability reviews to determine whether or not you continue to meet the disability requirements of the law. Payment of cash benefits or a period of disability ends if the medical or other evidence shows that you are not disabled as determined under the standards set out in section 223(f) of the Social Security Act.

(b) *When we will conduct a continuing disability review.* A continuing disability review will be started if—

(1) You have been scheduled for a medical improvement expected diary review;

(2) You have been scheduled for a periodic review (medical improvement possible or medical improvement not expected) in accordance with the provisions of paragraph (d) of this section;

(3) We need a current medical or other report to see if your disability continues. (This could happen when, for example, an advance in medical technology, such as improved treatment for Alzheimer's disease or a change in vocational therapy or technology raises a disability issue.);

(4) You return to work and successfully complete a period of trial work;

(5) Substantial earnings are reported to your wage record;

(6) You tell us that you have recovered from your disability or that you have returned to work;

(7) Your State Vocational Rehabilitation Agency tells us that—

(i) The services have been completed; or

(ii) You are now working; or

(iii) You are able to work;

(8) Someone in a position to know of your physical or mental condition tells us that you are not disabled, that you are not following prescribed treatment, that you have returned to work, or that you are failing to follow the provisions of the Social Security Act or these regulations, and it appears that the report could be substantially correct;

(9) Evidence we receive raises a question as to whether your disability continues; or

(10) You have been scheduled for a vocational reexamination diary review.

(c) *Definitions.* As used in this section—

Medical improvement expected diary—refers to a case which is scheduled for review at a later date because the individual's impairment(s) is expected to improve. Generally, the diary period is set for not less than 6 months or for not more than 18 months. Examples of cases likely to be scheduled for medical improvement expected diary are fractures and cases in which corrective surgery is planned and recovery can be anticipated.

Permanent impairment—medical improvement not expected—refers to a case in which any medical improvement in the person's impairment(s) is not expected. This means an extremely severe condition determined on the basis of our experience in administering the disability programs to be at least static, but more likely to be progressively disabling either by itself or by reason of impairment complications, and unlikely to improve so as to permit the individual to engage in substantial gainful activity. The interaction of the individual's age, impairment consequences and lack of recent attachment to the labor market may also be considered in determining whether an impairment is permanent. Improvement which is considered temporary under §404.1579(c)(4) or §404.1594(c)(3)(iv), as appropriate, will not be considered in deciding if an impairment is permanent. Examples of permanent impairments taken from the list contained in our other written

guidelines which are available for public review are as follows and are not intended to be all inclusive:

(1) Parkinsonian Syndrome which has reached the level of severity necessary to meet the Listing in appendix 1.

(2) Amyotrophic Lateral Sclerosis which has reached the level of severity necessary to meet the Listing in appendix 1.

(3) Diffuse pulmonary fibrosis in an individual age 55 or over which has reached the level of severity necessary to meet the Listing in appendix 1.

(4) Amputation of leg at hip.

Nonpermanent impairment—refers to a case in which any medical improvement in the person's impairment(s) is possible. This means an impairment for which improvement cannot be predicted based on current experience and the facts of the particular case but which is not at the level of severity of an impairment that is considered permanent. Examples of nonpermanent impairments are: regional enteritis, hyperthyroidism, and chronic ulcerative colitis.

Vocational reexamination diary—refers to a case which is scheduled for review at a later date because the individual is undergoing vocational therapy, training or an educational program which may improve his or her ability to work so that the disability requirement of the law is no longer met. Generally, the diary period will be set for the length of the training, therapy, or program of education.

(d) *Frequency of review*. If your impairment is expected to improve, generally we will review your continuing eligibility for disability benefits at intervals from 6 months to 18 months following our most recent decision. Our notice to you about the review of your case will tell you more precisely when the review will be conducted. If your disability is not considered permanent but is such that any medical improvement in your impairment(s) cannot be accurately predicted, we will review your continuing eligibility for disability benefits at least once every 3 years. If your disability is considered permanent, we will review your continuing eligibility for benefits no less frequently than once every 7 years but no more frequently than once every 5 years. Regardless of your classification, we will conduct an immediate continuing disability review if a question of continuing disability is raised pursuant to paragraph (b) of this section.

(e) *Change in classification of impairment*. If the evidence developed during a continuing disability review demonstrates that your impairment has improved, is expected to improve, or has worsened since the last review, we may reclassify your impairment to reflect this change in severity. A change in the classification of your impairment will change the frequency with which we will review your case. We may also reclassify certain impairments because of improved tests, treatment, and other technical advances concerning those impairments.

(f) *Review after administrative appeal*. If you were found eligible to receive or to continue to receive disability benefits on the basis of a decision by an administrative law judge, the Appeals Council or a Federal court, we will not conduct a continuing disability review earlier than 3 years after that decision unless your case should be scheduled for a medical improvement expected or vocational reexamination diary review or a question of continuing disability is raised pursuant to paragraph (b) of this section.

(g) *Waiver of timeframes*. All cases involving a nonpermanent impairment will be reviewed by us at least once every 3 years unless we, after consultation with the State agency, determine that the requirement should be waived to ensure that only the appropriate number of cases are reviewed. The appropriate number of cases to be reviewed is to be based on such considerations as the backlog of pending reviews, the projected number of new applications, and projected staffing levels. Such waiver shall be given only after good faith effort on the part of the State to meet staffing requirements and to process the reviews on a timely basis. Availability of independent medical resources may also be a factor. A *waiver* in this context refers to our administrative discretion to determine the appropriate number of cases to be reviewed on a State by

State basis. Therefore, your continuing disability review may be delayed longer than 3 years following our original decision or other review under certain circumstances. Such a delay would be based on our need to ensure that backlogs, reviews required to be performed by the Social Security Disability Benefits Reform Act of 1984 (Pub. L. 98–460), and new disability claims workloads are accomplished within available medical and other resources in the State agency and that such reviews are done carefully and accurately.

[51 FR 16825, May 7, 1986]

§ 404.1591 If your medical recovery was expected and you returned to work.

If your impairment was expected to improve and you returned to full-time work with no significant medical limitations and acknowledge that medical improvement has occurred, we may find that your disability ended in the month you returned to work. Unless there is evidence showing that your disability has not ended, we will use the medical and other evidence already in your file and the fact that you returned to full-time work without significant limitations to determine that you are no longer disabled. (If your impairment is not expected to improve, we will not ordinarily review your claim until the end of the trial work period, as described in § 404.1592.)

Example: Evidence obtained during the processing of your claim showed that you had an impairment that was expected to improve about 18 months after your disability began. We, therefore, told you that your claim would be reviewed again at that time. However, before the time arrived for your scheduled medical re-examination, you told us that you had returned to work and your impairment had improved. We investigated immediately and found that, in the 16th month after your disability began, you returned to full-time work without any significant medical restrictions. Therefore, we would find that your disability ended in the first month you returned to full-time work.

[50 FR 50130, Dec. 6, 1985]

§ 404.1592 The trial work period.

(a) *Definition of the trial work period.* The trial work period is a period during which you may test your ability to work and still be considered disabled. It begins and ends as described in paragraph (e) of this section. During this period, you may perform *services* (see paragraph (b) of this section) in as many as 9 months, but these months do not have to be consecutive. We will not consider those services as showing that your disability has ended until you have performed services in at least 9 months. However, after the trial work period has ended we will consider the work you did during the trial work period in determining whether your disability ended at any time after the trial work period.

(b) *What we mean by services.* When used in this section, *services* means any activity, even though it is not substantial gainful activity, which is done by a person in employment or self-employment for pay or profit, or is the kind normally done for pay or profit. If you are an employee, we will consider your work to be *services* if in any calendar year after 1989 you earn more than $200 a month ($75 a month is the amount for calendar years 1979 through 1989, and $50 a month is the amount for calendar years before 1979). If you are self-employed, we will consider your activities *services* if in any calendar year after 1989, your net earnings are more than $200 a month ($75 a month is the amount for calendar years 1979 through 1989, and $50 a month is the amount for calendar years before 1979), or you work more than 40 hours a month in the business in any calendar year after 1989 (15 hours a month is the figure for calendar years before 1990). We generally do not consider work to be *services* when it is done without remuneration or merely as therapy or training, or when it is work usually done in a daily routine around the house, or in self-care.

(c) *Limitations on the number of trial work periods.* You may have only one trial work period during a period of entitlement to cash benefits.

(d) *Who is and is not entitled to a trial work period.* (1) Those who are receiving disability insurance benefits, child's benefits based on disability and, beginning December 1, 1980, those who are receiving widows' or widowers' benefits

based on disability, or surviving divorced spouses' benefits based on disability, generally are entitled to a trial work period.

(2) You are not entitled to a trial work period if—

(i) You are entitled to a period of disability but not to disability insurance cash benefits; or

(ii) You are receiving disability insurance benefits in a second period of disability for which you did not have to complete a waiting period.

(e) *When the trial work period begins and ends.* The trial work period begins with the month in which you become entitled to disability insurance cash benefits, to child's cash benefits based on disability or to widow's, widower's, or surviving divorced spouse's cash benefits based on disability. It cannot begin before the month in which you file your application for benefits and for widows, widowers, and surviving divorced spouses, it cannot begin before December 1, 1980. It ends with the close of whichever of the following calendar months is the earlier:

(1) The 9th month (whether or not the months have been consecutive) in which you have performed services; or

(2) The month in which new evidence, other than evidence relating to any work you did during the trial work period, shows that you are not disabled, even though you have not worked a full 9 months. We may find that your disability has ended at any time during the trial work period if the medical or other evidence shows that you are no longer disabled (see § 404.1594).

[45 FR 55584, Aug. 20, 1980, as amended at 49 FR 22273, May 29, 1984; 50 FR 50130, Dec. 6, 1985; 54 FR 53605, Dec. 29, 1989]

§ 404.1592a The reentitlement period.

(a) *General.* The reentitlement period is an additional period after 9 months of trial work during which you may continue to test your ability to work if you have a disabling impairment. You will not be paid benefits for any month, after the third month, in this period in which you do substantial gainful activity and you will be paid benefits for months in which you do not do substantial gainful activity. (See §§ 404.316, 404.337, 404.352 and 404.401a.) If anyone else is receiving monthly benefits based on your earnings record, that individual will not be paid benefits for any month for which you cannot be paid benefits during the reentitlement period. If your benefits are stopped because you do substantial gainful activity they may be started again without a new application and a new determination of disability if you discontinue doing substantial gainful activity during this period. In determining, for reentitlement benefit purposes, whether you do substantial gainful activity in a month, we consider only your work in or earnings for that month; we do not consider the average amount of your work or earnings over a period of months.

(b) *When the reentitlement period begins and ends.* The reentitlement period begins with the first month following completion of 9 months of trial work but cannot begin earlier than December 1, 1980. It ends with whichever is earlier—

(1) The month before the first month in which your impairment no longer exists or is not medically disabling; or

(2) The last day of the 15th month following the end of your trial work period. (See §§ 404.316, 404.337, and 404.352 for when your benefits end.)

(c) *When you are not entitled to a reentitlement period.* You are not entitled to a reentitlement period if:

(1) You are entitled to a period of disability, but not to disability insurance cash benefits;

(2) You are not entitled to a trial work period;

(3) Your entitlement to disability insurance benefits ended before you completed 9 months of trial work in that period of disability.

[49 FR 22273, May 29, 1984, as amended at 58 FR 64883, Dec. 10, 1993]

§ 404.1593 Medical evidence in continuing disability review cases.

(a) *General.* If you are entitled to benefits or if a period of disability has been established for you because you are disabled, we will have your case file with the supporting medical evidence previously used to establish or continue your entitlement. Generally, therefore, the medical evidence we will need for a continuing disability review will be that required to make a current

determination or decision as to whether you are still disabled, as defined under the medical improvement review standard. See §§404.1579 and 404.1594.

(b) *Obtaining evidence from your medical sources.* You must provide us with reports from your physician, psychologist, or others who have treated or evaluated you, as well as any other evidence that will help us determine if you are still disabled. See §404.1512. You must have a good reason for not giving us this information or we may find that your disability has ended. See §404.1594(e)(2). If we ask you, you must contact your medical sources to help us get the medical reports. We will make every reasonable effort to help you in getting medical reports when you give us permission to request them from your physician, psychologist, or other medical sources. See §404.1512(d)(1) concerning what we mean by every reasonable effort. In some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. Before deciding that your disability has ended, we will develop a complete medical history covering at least the 12 months preceding the date you sign a report about your continuing disability status. See §404.1512(c).

(c) *When we will purchase a consultative examination.* A consultative examination may be purchased when we need additional evidence to determine whether or not your disability continues. As a result, we may ask you, upon our request and reasonable notice, to undergo consultative examinations and tests to help us determine if you are still disabled. See §404.1517. We will decide whether or not to purchase a consultative examination in accordance with the standards in §§404.1519a through 404.1519b.

[56 FR 36962, Aug. 1, 1991]

§404.1594 How we will determine whether your disability continues or ends.

(a) *General.* There is a statutory requirement that, if you are entitled to disability benefits, your continued entitlement to such benefits must be reviewed periodically. If you are entitled to disability benefits as a disabled worker or as a person disabled since childhood, or, for monthly benefits payable for months after December 1990, as a disabled widow, widower, or surviving divorced spouse, there are a number of factors we consider in deciding whether your disability continues. We must determine if there has been any medical improvement in your impairment(s) and, if so, whether this medical improvement is related to your ability to work. If your impairment(s) has not medically improved we must consider whether one or more of the exceptions to medical improvement applies. If medical improvement related to your ability to work has not occurred and no exception applies, your benefits will continue. Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases (see paragraph (e) of this section for exceptions), we must also show that you are currently able to engage in substantial gainful activity before we can find that you are no longer disabled.

(b) *Terms and definitions.* There are several terms and definitions which are important to know in order to understand how we review whether your disability continues.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs and/or laboratory findings associated with your impairment(s) (see §404.1528).

Example 1: You were awarded disability benefits due to a herniated nucleus pulposus. At the time of our prior decision granting you benefits you had had a laminectomy. Postoperatively, a myelogram still shows evidence of a persistent deficit in your lumbar spine. You had pain in your back, and pain and a burning sensation in your right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in your back and leg. When we reviewed your claim your treating physician reported that he had seen you regularly

every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. Your doctor further reported a moderately decreased range of motion in your back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has *not* occurred because there has been no decrease in the severity of your back impairment as shown by changes in symptoms, signs or laboratory findings.

Example 2: You were awarded disability benefits due to rheumatoid arthritis. At the time, laboratory findings were positive for this condition. Your doctor reported persistent swelling and tenderness of your fingers and wrists and that you complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, your impairment has responded favorably to therapy so that for the last year your fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of your impairment as documented by the current symptoms and signs reported by your physician. Although your impairment is subject to temporary remission and exacerbations, the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. We would then determine if this medical improvement is related to your ability to work.

(2) *Medical improvement not related to ability to do work.* Medical improvement is not related to your ability to work if there has been a decrease in the severity of the impairment(s) as defined in paragraph (b)(1) of this section, present at the time of the most recent favorable medical decision, but *no* increase in your functional capacity to do basic work activities as defined in paragraph (b)(4) of this section. If there has been any medical improvement in your impairment(s), but it is not related to your ability to do work and none of the exceptions applies, your benefits will be continued.

Example: You are 65 inches tall and weighed 246 pounds at the time your disability was established. You had venous insufficiency and persistent edema in your legs. At the time, your ability to do basic work activities was affected because you were able to sit for 6 hours, but were able to stand or walk only occasionally. At the time of our continuing disability review, you had undergone a vein stripping operation. You now weigh 220 pounds and have intermittent edema. You are still able to sit for 6 hours at a time and to stand or walk only occasionally although you report less discomfort on walking. Medical improvement has occurred because there has been a decrease in the severity of the existing impairment as shown by your weight loss and the improvement in your edema. This medical improvement is not related to your ability to work, however, because your functional capacity to do basic work activities (i.e., the ability to sit, stand and walk) has not increased.

(3) *Medical improvement that is related to ability to do work.* Medical improvement is related to your ability to work if there has been a decrease in the severity, as defined in paragraph (b)(1) of this section, of the impairment(s) present at the time of the most recent favorable medical decision *and* an increase in your functional capacity to do basic work activities as discussed in paragraph (b)(4) of this section. A determination that medical improvement related to your ability to do work has occurred does not, necessarily, mean that your disability will be found to have ended unless it is also shown that you are currently able to engage in substantial gainful activity as discussed in paragraph (b)(5) of this section.

Example 1: You have a back impairment and had a laminectomy to relieve the nerve root impingement and weakness in your left leg. At the time of our prior decision, basic work activities were affected because you were able to stand less than 6 hours, and sit no more than ½ hour at a time. You had a successful fusion operation on your back about 1 year before our review of your entitlement. At the time of our review, the weakness in your leg has decreased. Your functional capacity to perform basic work activities now is unimpaired because you now have no limitation on your ability to sit, walk, or stand. Medical improvement has occurred because there has been a decrease in the severity of your impairment as demonstrated by the decreased weakness in your leg. This medical improvement is related to your ability to work because there has also been an increase in your functional capacity to perform basic work activities (or residual functional capacity) as shown by the absence of limitation on your ability to sit, walk, or stand. Whether or not your disability is found to have ended, however, will depend on our determination as to whether you can currently engage in substantial gainful activity.

Example 2: You were injured in an automobile accident receiving a compound fracture to your right femur and a fractured pelvis. When you applied for disability benefits

10 months after the accident your doctor reported that neither fracture had yet achieved solid union based on his clinical examination. X-rays supported this finding. Your doctor estimated that solid union and a subsequent return to full weight bearing would not occur for at least 3 more months. At the time of our review 6 months later, solid union had occurred and you had been returned to full weight-bearing for over a month. Your doctor reported this and the fact that your prior fractures no longer placed any limitation on your ability to walk, stand, lift, etc., and, that in fact, you could return to fulltime work if you so desired.

Medical improvement has occurred because there has been a decrease in the severity of your impairments as shown by X-ray and clinical evidence of solid union and your return to full weight-bearing. This medical improvement is related to your ability to work because you no longer meet the same listed impairment in appendix 1 of this subpart (see paragraph (c)(3)(i) of this section). In fact, you no longer have an impairment which is severe (see § 404.1521) and your disability will be found to have ended.

(4) *Functional capacity to do basic work activities.* Under the law, disability is defined, in part, as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment(s). In determining whether you are disabled under the law, we must measure, therefore, how and to what extent your impairment(s) has affected your ability to do work. We do this by looking at how your functional capacity for doing basic work activities has been affected. Basic work activities means the abilities and aptitudes necessary to do most jobs. Included are exertional abilities such as walking, standing, pushing, pulling, reaching and carrying, and nonexertional abilities and aptitudes such as seeing, hearing, speaking, remembering, using judgment, dealing with changes and dealing with both supervisors and fellow workers. A person who has no impairment(s) would be able to do all basic work activities at normal levels; he or she would have an unlimited functional capacity to do basic work activities. Depending on its nature and severity, an impairment will result in some limitation to the functional capacity to do one or more of these basic work activities. Diabetes, for example, can result in circulatory problems which could limit the length of time a person could stand or walk and damage to his or her eyes as well, so that the person also had limited vision. What a person can still do despite an impairment, is called his or her residual functional capacity. How the residual functional capacity is assessed is discussed in more detail in § 404.1545. Unless an impairment is so severe that it is deemed to prevent you from doing substantial gainful activity (see §§ 404.1525 and 404.1526), it is this residual functional capacity that is used to determine whether you can still do your past work or, in conjunction with your age, education and work experience, any other work.

(i) A decrease in the severity of an impairment as measured by changes (improvement) in symptoms, signs or laboratory findings can, if great enough, result in an increase in the functional capacity to do work activities. Vascular surgery (e.g., femoropopliteal bypass) may sometimes reduce the severity of the circulatory complications of diabetes so that better circulation results and the person can stand or walk for longer periods. When new evidence showing a change in signs, symptoms and laboratory findings establishes that both medical improvement has occurred and your functional capacity to perform basic work activities, or residual functional capacity, has increased, we say that medical improvement which is related to your ability to do work has occurred. A residual functional capacity assessment is also used to determine whether you can engage in substantial gainful activity and, thus, whether you continue to be disabled (see paragraph (b)(5) of this section).

(ii) Many impairment-related factors must be considered in assessing your functional capacity for basic work activities. Age is one key factor. Medical literature shows that there is a gradual decrease in organ function with age; that major losses and deficits become irreversible over time and that maximum exercise performance diminishes with age. Other changes related to sustained periods of inactivity and the aging process include muscle atrophy, degenerative joint changes, decrease in range of motion, and changes in the

cardiac and respiratory systems which limit the exertional range.

(iii) Studies have also shown that the longer an individual is away from the workplace and is inactive, the more difficult it becomes to return to ongoing gainful employment. In addition, a gradual change occurs in most jobs so that after about 15 years, it is no longer realistic to expect that skills and abilities acquired in these jobs will continue to apply to the current workplace. Thus, if you are age 50 or over and have been receiving disability benefits for a considerable period of time, we will consider this factor along with your age in assessing your residual functional capacity. This will ensure that the disadvantages resulting from inactivity and the aging process during a long period of disability will be considered. In some instances where available evidence does not resolve what you can or cannot do on a sustained basis, we will provide special work evaluations or other appropriate testing.

(5) *Ability to engage in substantial gainful activity.* In most instances, we must show that you are able to engage in substantial gainful activity before your benefits are stopped. When doing this, we will consider all your current impairments not just that impairment(s) present at the time of the most recent favorable determination. If we cannot determine that you are still disabled based on medical considerations alone (as discussed in §§ 404.1525 and 404.1526), we will use the new symptoms, signs and laboratory findings to make an objective assessment of your functional capacity to do basic work activities or residual functional capacity and we will consider your vocational factors. See §§ 404.1545 through 404.1569.

(6) *Evidence and basis for our decision.* Our decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that you have previously been determined to be disabled. We will consider all evidence you submit, as well as all evidence we obtain from your treating physician(s) and other medical or nonmedical sources. What constitutes *evidence* and our procedures for obtaining it are set out in §§ 404.1512 through 404.1518. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(7) *Point of comparison.* For purposes of determining whether medical improvement has occurred, we will compare the current medical severity of that impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled to the medical severity of that impairment(s) at that time. If medical improvement has occurred, we will compare your current functional capacity to do basic work activities (i.e., your residual functional capacity) based on this previously existing impairment(s) with your prior residual functional capacity in order to determine whether the medical improvement is related to your ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether you were disabled or continued to be disabled which became final.

(c) *Determining medical improvement and its relationship to your abilities to do work.* Paragraphs (b) (1) through (3) of this section discuss what we mean by medical improvement, medical improvement not related to your ability to work and medical improvement that is related to your ability to work. How we will arrive at the decision that medical improvement has occurred and its relationship to the ability to do work, is discussed below.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of impairment(s) present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled and is determined by a comparison of prior and current medical evidence which must show that there have been changes (improvement) in the symptoms, signs or laboratory findings associated with that impairment(s).

(2) *Determining if medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, we then must determine if it

is related to your ability to do work. In paragraph (b)(4) of this section, we explain the relationship between medical severity and limitation on functional capacity to do basic work activities (or residual functional capacity) and how changes in medical severity can affect your residual functional capacity. In determining whether medical improvement that has occurred is related to your ability to do work, we will assess your residual functional capacity (in accordance with paragraph (b)(4) of this section) based on the current severity of the impairment(s) which was present at your last favorable medical decision. Your new residual functional capacity will then be compared to your residual functional capacity at the time of our most recent favorable medical decision. Unless an increase in the current residual functional capacity is based on changes in the signs, symptoms, or laboratory findings, any medical improvement that has occurred will not be considered to be related to your ability to do work.

(3) Following are some additional factors and considerations which we will apply in making these determinations.

(i) *Previous impairment met or equaled listings.* If our most recent favorable decision was based on the fact that your impairment(s) at the time met or equaled the severity contemplated by the Listing of Impairments in appendix 1 of this subpart, an assessment of your residual functional capacity would not have been made. If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the same listing section used to make our most recent favorable decision, we will find that the medical improvement was related to your ability to work. Appendix 1 of this subpart describes impairments which, if severe enough, affect a person's ability to work. If the appendix level of severity is met or equaled, the individual is deemed, in the absence of evidence to the contrary, to be unable to engage in substantial gainful activity. If there has been medical improvement to the degree that the requirement of the listing section is no longer met or equaled, then the medical improvement is related to your ability to work. We must, of course, also establish that you can currently engage in gainful activity before finding that your disability has ended.

(ii) *Prior residual functional capacity assessment made.* The residual functional capacity assessment used in making the most recent favorable medical decision will be compared to the residual functional capacity assessment based on current evidence in order to determine if your functional capacity for basic work activities has increased. There will be no attempt made to reassess the prior residual functional capacity.

(iii) *Prior residual functional capacity assessment should have been made, but was not.* If the most recent favorable medical decision should have contained an assessment of your residual functional capacity (i.e., your impairments did not meet or equal the level of severity contemplated by the Listing of Impairments in appendix 1 of this subpart) but does not, either because this assessment is missing from your file or because it was not done, we will reconstruct the residual functional capacity. This reconstructed residual functional capacity will accurately and objectively assess your functional capacity to do basic work activities. We will assign the maximum functional capacity consistent with an allowance.

Example: You were previously found to be disabled on the basis that ''while your impairment did not meet or equal a listing, it did prevent you from doing your past or any other work.'' The prior adjudicator did not, however, include a residual functional capacity assessment in the rationale of this decision and a review of the prior evidence does not show that such an assessment was ever made. If a decrease in medical severity, i.e., medical improvement, has occurred, the residual functional capacity based on the current level of severity of your impairment will have to be compared with your residual functional capacity based on its prior severity in order to determine if the medical improvement is related to your ability to do work. In order to make this comparison, we will review the prior evidence and make an objective assessment of your residual functional capacity at the time of our most recent favorable medical determination, based on the symptoms, signs and laboratory findings as they then existed.

(iv) *Impairment subject to temporary remission.* In some cases the evidence shows that an individual's impairments are subject to temporary remission. In

assessing whether medical improvement has occurred in persons with this type of impairment, we will be careful to consider the longitudinal history of the impairments, including the occurrence of prior remission, and prospects for future worsenings. Improvement in such impairments that is only temporary will not warrant a finding of medical improvement.

(v) *Prior file cannot be located.* If the prior file cannot be located, we will first determine whether you are able to now engage in substantial gainful activity based on all your current impairments. (In this way, we will be able to determine that your disability continues at the earliest point without addressing the often lengthy process of reconstructing prior evidence.) If you cannot engage in substantial gainful activity currently, your benefits will continue unless one of the second group of exceptions applies (see paragraph (e) of this section). If you are able to engage in substantial gainful activity, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable medical decision (e.g., work history, medical evidence from treating sources and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation; and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed either because it is determined not to attempt reconstruction or because such efforts fail, medical improvement cannot be found. The documentation of your current impairments will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any decision under this section in accordance with the rules in § 404.988.

(d) *First group of exceptions to medical improvement.* The law provides for certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if you can engage in substantial gainful activity. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that, taking all your current impairment(s) into account, not just those that existed at the time of our most recent favorable medical decision, you are now able to engage in substantial gainful activity before your disability can be found to have ended. As part of the review process, you will be asked about any medical or vocational therapy you received or are receiving. Your answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that you are the beneficiary of advances in medical or vocational therapy or technology (related to your ability to work).* Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have increased your ability to do basic work activities. We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment or your ability to do basic work activities. This decision will be based on new medical evidence and a new residual functional capacity assessment. (See § 404.1545.) In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(2) *Substantial evidence shows that you have undergone vocational therapy (related to your ability to work).* Vocational therapy (related to your ability to work) may include, but is not limited to, additional education, training, or work experience that improves your ability to meet the vocational requirements of more jobs. This decision will

be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment. (See § 404.1545.) If, at the time of our review you have not completed vocational therapy which could affect the continuance of your disability, we will review your claim upon completion of the therapy.

Example 1: You were found to be disabled because the limitations imposed on you by your impairment allowed you to only do work that was at a sedentary level of exertion. Your prior work experience was work that required a medium level of exertion. Your age and education at the time would not have qualified you for work that was below this medium level of exertion. You enrolled in and completed a specialized training course which qualifies you for a job in data processing as a computer programmer in the period since you were awarded benefits. On review of your claim, current evidence shows that there is no medical improvement and that you can still do only sedentary work. As the work of a computer programmer is sedentary in nature, you are now able to engage in substantial gainful activity when your new skills are considered.

Example 2: You were previously entitled to benefits because the medical evidence and assessment of your residual functional capacity showed you could only do light work. Your prior work was considered to be heavy in nature and your age, education and the nature of your prior work qualified you for work which was no less than medium in exertion. The current evidence and residual functional capacity show there has been no medical improvement and that you can still do only light work. Since you were originally entitled to benefits, your vocational rehabilitation agency enrolled you in and you successfully completed a trade school course so that you are now qualified to do small appliance repair. This work is light in nature, so when your new skills are considered, you are now able to engage in substantial gainful activity even though there has been no change in your residual functional capacity.

(3) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable medical decision, such evidence may serve as a basis for finding that you are no longer disabled, if you can currently engage in substantial gainful activity. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable medical decision.

(i) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(ii) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(A) Some of the future changes in the Listing of Impairments in appendix 1 of this subpart will be based on new or improved diagnostic or evaluative techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved technique will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(B) A cumulative list since 1970 of new or improved diagnostic techniques or evaluations, how they changed the

evaluation of the applicable impairment and the month and year they became generally available, will be published in the *Notices* section of the FEDERAL REGISTER. Included will be any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 which are reflective of new or improved techniques. No cases will be processed under this exception until this cumulative listing is so published. Subsequent changes to the list will be published periodically. The period will be determined by the volume of changes needed.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of your last favorable medical decision. Current evidence could show that your condition, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all your current impairments into account, you are now able to engage in substantial gainful activity, this exception would be used to find that you are no longer disabled even if medical improvement has not occurred.

(4) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 or a medical/vocational rule in appendix 2 of this subpart was misapplied).

Example 1: You were granted benefits when it was determined that your epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of your seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether you were still considered to be disabled would be based on whether you could currently engage in substantial gainful activity.

Example 2: Your prior award of benefits was based on vocational rule 201.12 in appendix 2 of this subpart. This rule applies to a person age 50–54 who has at least a high school education, whose previous work was entirely at a semiskilled level, and who can do only sedentary work. On review, it is found that at the time of the prior determination you were actually only age 46 and vocational rule 201.21 should have been used. This rule would have called for a denial of your claim and the prior decision is found to have been in error. Continuation of your disability would depend on a finding of your current ability to engage in substantial gainful activity.

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

Example: You were found disabled on the basis of chronic obstructive pulmonary disease. The severity of your impairment was documented primarily by pulmonary function testing results. The evidence showed that you could do only light work. Spirometric tracings of this testing, although required, were not obtained, however. On review, the original report is resubmitted by the consultative examining physician along with the corresponding spirometric tracings. A review of the tracings shows that the test was invalid. Current pulmonary function testing supported by spirometric tracings reveals that your impairment does not limit your ability to perform basic work activities in any way. Error is found based on the fact that required, material evidence which was originally missing now becomes available and shows that if it had been available at the time of the prior determination, disability would not have been found.

(iii) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the claim would not have

been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: You were previously found entitled to benefits on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments. The prior record shows that you had ''brittle'' diabetes for which you were taking insulin. Your urine was 3+ for sugar, and you alleged occasional hypoglycemic attacks caused by exertion. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator feels, however, that your impairment clearly does not equal the severity contemplated by the listings. Error *cannot* be found because it would represent a substitution of current judgment for that of the prior adjudicator that your impairment equaled a listing.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see § 404.988) are met.

(5) *You are currently engaging in substantial gainful activity.* If you are currently engaging in substantial gainful activity before we determine whether you are no longer disabled because of your work activity, we will consider whether you are entitled to a trial work period as set out in § 404.1592. We will find that your disability has ended in the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply in determining whether you continue to have a disabling impairment(s) (§ 404.1511) for purposes of deciding your eligibility for a reentitlement period (§ 404.1592a).

(e) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations the decision will be made without a determination that you have medically improved or can engage in substantial gainful activity.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in § 404.988. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will determine that your disability has ended. The month your disability ends will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in substantial gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see § 404.1530(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(f) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively

efficient way, and that any decisions to stop disability benefits are made objectively, neutrally and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may cease and benefits may be *continued* at any point if we determine there is sufficient evidence to find that you are still unable to engage in substantial gainful activity. The steps are:

(1) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended (see paragraph (d)(5) of this section).

(2) If you are not, do you have an impairment or combination of impairments which meets or equals the severity of an impairment listed in appendix 1 of this subpart? If you do, your disability will be found to continue.

(3) If you do not, has there been medical improvement as defined in paragraph (b)(1) of this section? If there has been medical improvement as shown by a decrease in medical severity, see step (4). If there has been no decrease in medical severity, there has been no medical improvement. (See step (5).)

(4) If there has been medical improvement, we must determine whether it is related to your ability to do work in accordance with paragraphs (b)(1) through (4) of this section; i.e., whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to your ability to do work, see step (5). If medical improvement *is* related to your ability to do work, see step (6).

(5) If we found at step (3) that there has been no medical improvement or if we found at step (4) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (d) and (e) of this section apply. If none of them apply, your disability will be found to continue. If one of the first group of exceptions to medical improvement applies, see step (6). If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

(6) If medical improvement is shown to be related to your ability to do work or if one of the first group of exceptions to medical improvement applies, we will determine whether all your current impairments in combination are severe (see § 404.1521). This determination will consider all your current impairments and the impact of the combination of those impairments on your ability to function. If the residual functional capacity assessment in step (4) above shows significant limitation of your ability to do basic work activities, see step (7). When the evidence shows that all your current impairments in combination do not significantly limit your physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature. If so, you will no longer be considered to be disabled.

(7) If your impairment(s) is severe, we will assess your current ability to engage in substantial gainful activity in accordance with § 404.1561. That is we will assess your residual functional capacity based on all your current impairments and consider whether you can still do work you have done in the past. If you can do such work, disability will be found to have ended.

(8) If you are not able to do work you have done in the past, we will consider one final step. Given the residual functional capacity assessment and considering your age, education and past work experience, can you do other work? If you can, disability will be found to have ended. If you cannot, disability will be found to continue.

(g) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the earliest of the following months.

(1) The month the evidence shows you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(2) The month the evidence shows you are no longer disabled under the rules set out in this section, but not earlier than the month in which we

mail you a notice saying that the information we have shows that you are not disabled;

(3) The month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period); however, we may pay you benefits for certain months in and after the reentitlement period which follows the trial work period. (See § 404.1592a for a discussion of the reentitlement period. If you are receiving benefits on your own earnings record, see § 404.316 for when your benefits will end. See § 404.352 if you are receiving benefits on a parent's earnings as a disabled adult child.);

(4) The month in which you actually do substantial gainful activity (where you are not entitled to a trial work period);

(5) The month in which you return to full-time work, with no significant medical restrictions and acknowledge that medical improvement has occurred, and we expected your impairment(s) to improve (see § 404.1591);

(6) The first month in which you failed without good cause to do what we asked, when the rule set out in paragraph (e)(2) of this section applies;

(7) The first month in which the question of continuing disability arose and we could not find you, when the rule set out in paragraph (e)(3) of this section applies;

(8) The first month in which you failed without good cause to follow prescribed treatment, when the rule set out in paragraph (e)(4) of this section applies; or

(9) The first month you were told by your physician that you could return to work provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity for work and the earlier date is supported by the medical evidence.

(h) *Before we stop your benefits.* Before we stop your benefits or a period of disability, we will give you a chance to explain why we should not do so. Sections 404.1595 and 404.1597 describe your rights (including appeal rights) and the procedures we will follow.

[50 FR 50130, Dec. 6, 1985; 51 FR 7063, Feb. 28, 1986; 51 FR 16015, Apr. 30, 1986, as amended at 52 FR 44971, Nov. 24, 1987; 57 FR 30121, July 8, 1992; 59 FR 1635, Jan. 12, 1994]

§ 404.1595 When we determine that you are not now disabled.

(a) *When we will give you advance notice.* Except in those circumstances described in paragraph (d) of this section, we will give you advance notice when we have determined that you are not now disabled because the information we have conflicts with what you have told us about your disability. If your dependents are receiving benefits on your Social Security number and do not live with you, we will also give them advance notice. To give you advance notice, we will contact you by mail, telephone or in person.

(b) *What the advance notice will tell you.* We will give you a summary of the information we have. We will also tell you why we have determined that you are not now disabled, and will give you a chance to reply. If it is because of—

(1) *Medical reasons.* The advance notice will tell you what the medical information in your file shows;

(2) *Your work activity.* The advance notice will tell you what information we have about the work you are doing or have done, and why this work shows that you are not disabled; or

(3) *Your failure to give us information we need or do what we ask.* The advance notice will tell you what information we need and why we need it or what you have to do and why.

(c) *What you should do if you receive an advance notice.* If you agree with the advance notice, you do not need to take any action. If you desire further information or disagree with what we have told you, you should immediately write or telephone the State agency or the social security office that gave you the advance notice or you may visit any social security office. If you believe you are now disabled, you should tell us why. You may give us any additional or new information, including reports from your doctors, hospitals, employers or others, that you believe we should have. You should send these as soon as possible to the local social

security office or to the office that gave you the advance notice. We consider 10 days to be enough time for you to tell us, although we will allow you more time if you need it. You will have to ask for additional time beyond 10 days if you need it.

(d) *When we will not give you advance notice.* We will not give you advance notice when we determine that you are not disabled if—

(1) We recently told you that the information we have shows that you are not now disabled, that we were gathering more information, and that your benefits will stop; or

(2) We are stopping your benefits because you told us you are not now disabled; or

(3) We recently told you that continuing your benefits would probably cause us to overpay you and you asked us to stop your benefits.

§ 404.1596 Circumstances under which we may suspend your benefits before we make a determination.

(a) *General.* Under some circumstances, we may stop your benefits before we make a determination. Generally, we do this when the information we have clearly shows you are not now disabled but we cannot determine when your disability ended. These situations are described in paragraph (b)(1) and other reasons are given in paragraph (b)(2) of this section. We refer to this as a suspension of benefits. Your benefits, as well as those of your dependents (regardless of where they receive their benefits), may be suspended. When we do this we will give you advance notice. (See § 404.1595.) We will contact your spouse and children if they are receiving benefits on your Social Security number, and the benefits are being mailed to an address different from your own.

(b) *When we will suspend your benefits*—(1) *You are not now disabled.* We will suspend your benefits if the information we have clearly shows that you are not disabled and we will be unable to complete a determination soon enough to prevent us from paying you more monthly benefits than you are entitled to. This may occur when—

(i) New medical or other information clearly shows that you are able to do substantial gainful activity and your benefits should have stopped more than 2 months ago;

(ii) You completed a 9-month period of trial work more than 2 months ago and you are still working;

(iii) At the time you filed for benefits your condition was expected to improve and you were expected to be able to return to work. You subsequently did return to work more than 2 months ago with no significant medical restrictions; or

(iv) You are not entitled to a trial work period and you are working.

(2) *Other reasons.* We will also suspend your benefits if—

(i) You have failed to respond to our request for additional medical or other evidence and we are satisfied that you received our request and our records show that you should be able to respond.

(ii) We are unable to locate you and your checks have been returned by the Post Office as undeliverable; or

(iii) You refuse to accept vocational rehabilitation services without a good reason. Section 404.422 gives you examples of good reasons for refusing to accept vocational rehabilitation services.

(c) *When we will not suspend your cash benefits.* We will not suspend your cash benefits if—

(1) The evidence in your file does not clearly show that you are not disabled;

(2) We have asked you to furnish additional information;

(3) You have become disabled by another impairment; or

(4) After November 1980, even though your impairment is no longer disabling,

(i) You are participating in an appropriate vocational rehabilitation program (that is, one that has been approved under a State plan approved under title I of the Rehabilitation Act of 1973 and which meets the requirements outlined in 34 CFR part 361) which you began during your disability,

(ii) Your disability did not end before December 1, 1980, and

(iii) We have determined that your completion of the program, or your continuation in the program for a specified period of time, will significantly increase the likelihood that you will

not have to return to the disability benefit rolls.

[45 FR 55584, Aug. 20, 1980, as amended at 47 FR 31543, July 21, 1982; 47 FR 52693, Nov. 23, 1982; 51 FR 17617, May 14, 1986]

§404.1597 After we make a determination that you are not now disabled.

(a) *General.* If we determine that you do not meet the disability requirements of the law, your benefits generally will stop. We will send you a formal written notice telling you why we believe you are not disabled and when your benefits should stop. If your spouse and children are receiving benefits on your Social Security number, we will also stop their benefits and tell them why. The notices will explain your right to reconsideration if you disagree with our determination. However, your benefits may continue after November 1980 even though your impairment is no longer disabling, if your disability did not end before December 1980, and you are particpating in an appropriate vocational rehabilitation program as described in §404.1596 which you began before your disability ended. In addition, we must have determined that your completion of the program, or your continuation in the program for a specified period of time, will significantly increase the likelihood that you will not have to return to the disability benefit rolls. You may still appeal our determination that you are not disabled even though your benefits are continuing because of your participation in an appropriate vocational rehabilitation program. You may also appeal a determination that your completion or of continuation for a specified period of time in an appropriate vocational rehabilitation program will not significantly increase the likelihood that you will not have to return to the disability benefit rolls and, therefore, you are not entitled to continue to receive benefits.

(b) *If we make a determination that your physical or mental impairment(s) has ceased, did not exist, or is no longer disabling (Medical Cessation Determination).* If we make a determination that the physical or mental impairment(s) on the basis of which benefits were payable has ceased, did not exist, or is no longer disabling (a medical cessation determination), your benefits will stop. As described in paragraph (a) of this section, you will receive a written notice explaining this determination and the month your benefits will stop. The written notice will also explain your right to appeal if you disagree with our determination and your right to request that your benefits and the benefits, if any, of your spouse or children, be continued under §404.1597a. For the purpose of this section, *benefits* means disability cash payments and/or Medicare, if applicable. The continued benefit provisions of this section do not apply to an initial determination on an application for disability benefits, or to a determination that you were disabled only for a specified period of time.

[47 FR 31544, July 21, 1982, as amended at 51 FR 17618, May 14, 1986; 53 FR 29020, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988]

§404.1597a Continued benefits pending appeal of a medical cessation determination.

(a) *General.* If we determine that you are not entitled to benefits because the physical or mental impairment(s) on the basis of which such benefits were payable is found to have ceased, not to have existed, or to no longer be disabling, and you appeal that determination, you may choose to have your benefits continued pending reconsideration and/or a hearing before an administrative law judge on the disability cessation determination. For the purpose of this entire section, the election of *continued benefits* means the election of disability cash payments and/or Medicare, if applicable. You can also choose to have the benefits continued for anyone else receiving benefits based on your wages and self-employment income (and anyone else receiving benefits because of your entitlement to benefits based on disability). If you appeal a medical cessation under both title II and title XVI (a concurrent case), the title II claim will be handled in accordance with title II regulations while the title XVI claim will be handled in accordance with the title XVI regulations.

(b) *When the provisions of this section are available.* (1) Benefits may be continued under this section only if the

determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling is made on or after January 12, 1983 (or before January 12, 1983, and a timely request for reconsideration or a hearing before an administrative law judge is pending on that date).

(2) Benefits may be continued under this section only for months beginning with January 1983, or the first month for which benefits are no longer otherwise payable following our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, whichever is later.

(3) Continued payment of benefits under this section will stop effective with the earlier of:

(i) The month before the month in which an administrative law judge's hearing decision finds that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling or the month before the month of a new administrative law judge decision (or final action by the Appeals Council on the administrative law judge's recommended decision) if your case was sent back to an administrative law judge for further action; or

(ii) The month before the month no timely request for a reconsideration or a hearing before an administrative law judge is pending. These continued benefits may be stopped or adjusted because of certain events (such as work and earnings or receipt of worker's compensation) which occur while you are receiving these continued benefits and affect your right to receive continued benefits.

These continued benefits may be stopped or adjusted because of certain events (such as work and earning or receipt of worker's compensation) which occur while you are receiving these continued benefits and affect your right to receive continued benefits.

(c) *Continuation of benefits for anyone else pending your appeal.* (1) When you file a request for reconsideration or hearing before an administrative law judge on our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, or your case has been sent back (remanded) to an administrative law judge for further action, you may also choose to have benefits continue for anyone else who is receiving benefits based on your wages and self-employment income (and for anyone else receiving benefits because of your entitlement to benefits based on disability), pending the outcome of your appeal.

(2) If anyone else is receiving benefits based on your wages and self-employment income, we will notify him or her of the right to choose to have his or her benefits continue pending the outcome of your appeal. Such benefits can be continued for the time period in paragraph (b) of this section only if he or she chooses to have benefits continued and you also choose to have his or her benefits continued.

(d) *Statement of choice.* When you or another party request reconsideration under § 404.908(a) or a hearing before an administrative law judge under § 404.932(a) on our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, or if your case is sent back (remanded) to an administrative law judge for further action, we will explain your right to receive continued benefits and ask you to complete a statement specifying which benefits you wish to have continued pending the outcome of the reconsideration or hearing before an administrative law judge. You may elect to receive only Medicare benefits during appeal even if you do not want to receive continued disability benefits. If anyone else is receiving benefits based on your wages and self-employment income (or because of your entitlement to benefits based on disability), we will ask you to complete a statement specifying which benefits you wish to have continued for them, pending the outcome of the request for reconsideration or hearing before an administrative law judge. If you request appeal but you do not want to receive continued benefits, we will ask you to complete a statement declining continued benefits indicating that you do not want to have your benefits and those of your family, if any, continued during the appeal.

(e) *Your spouse's or children's statement of choice.* If you request, in accordance with paragraph (d) of this section, that benefits also be continued for anyone who had been receiving benefits based on your wages and self-employment, we will send them a written notice. The notice will explain their rights and ask them to complete a statement either declining continued benefits, or specifying which benefits they wish to have continued, pending the outcome of the request for reconsideration or a hearing before an administrative law judge.

(f) *What you must do to receive continued benefits pending notice of our reconsideration determination.* (1) If you want to receive continued benefits pending the outcome of your request for reconsideration, you must request reconsideration and continuation of benefits no later than 10 days after the date you receive the notice of our initial determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. Reconsideration must be requested as provided in § 404.909, and you must request continued benefits using a statement in accordance with paragraph (d) of this section.

(2) If you fail to request reconsideration and continued benefits within the 10-day period required by paragraph (f)(1) of this section, but later ask that we continue your benefits pending a reconsidered determination, we will use the rules in § 404.911 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the notice of the initial cessation determination. If you request continued benefits after the 10-day period, we will consider the request to be timely and will pay continued benefits only if good cause for delay is established.

(g) *What you must do to receive continued benefits pending an administrative law judge's decision.* (1) To receive continued benefits pending an administrative law judge's decision on our reconsideration determination, you must request a hearing and continuation of benefits no later than 10 days after the date you receive the notice of our reconsideration determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. A hearing must be requested as provided in § 404.933, and you must request continued benefits using a statement in accordance with paragraph (d) of this section.

(2) If you request continued benefits pending an administrative law judge's decision but did not request continued benefits while we were reconsidering the initial cessation determination, your benefits will begin effective the month of the reconsideration determination.

(3) If you fail to request continued payment of benefits within the 10-day period required by paragraph (g)(1) of this section, but you later ask that we continue your benefits pending an administrative law judge's decision on our reconsidered determination, we will use the rules as provided in § 404.911 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the reconsideration determination. If you request continued benefits after the 10-day period, we will consider the request to be timely and will pay continued benefits only if good cause for delay is established.

(h) *What anyone else must do to receive continued benefits pending our reconsideration determination or an administrative law judge's decision.* (1) When you or another party (see §§ 404.908(a) and 404.932(a)) request a reconsideration or a hearing before an administrative law judge on our medical cessation determination or when your case is sent back (remanded) to an administrative law judge for further action, you may choose to have benefits continue for anyone else who is receiving benefits based on your wages and self-employment income. An eligible individual must also choose whether or not to have his or her benefits continue pending your appeal by completing a separate statement of election as described in paragraph (e) of this section.

(2) He or she must request continuation of benefits no later than 10 days after the date he or she receives notice of termination of benefits. He or she will then receive continued benefits beginning with the later of January 1983, or the first month for which benefits

are no longer otherwise payable following our initial or reconsideration determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. Continued benefits will continue until the earlier of:

(i) The month before the month in which an administrative law judge's hearing decision finds that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling or the month before the month of the new administrative law judge decision (or final action is taken by the Appeals Council on the administrative law judge's recommended decision) if your case was sent back to an administrative law judge for further action; or

(ii) The month before the month no timely request for a reconsideration or a hearing before an administrative law judge is pending. These continued benefits may be stopped or adjusted because of certain events (such as work and earnings or payment of worker's compensation) which occur while an eligible individual is receiving continued benefits and affect his or her right to receive continued benefits.

These continued benefits may be stopped or adjusted because of certain events (such as work and earnings or payment of workers compensation) which occur while an eligible individual is receiving continued benefits and affect his or her right to receive continued benefits.

(3) If he or she fails to request continuation of benefits within the 10-day period required by this paragraph, but requests continuation of benefits at a later date, we will use the rules as provided in § 404.911 to determine whether good cause exists for his or her failure to request continuation of benefits within 10 days after receipt of the notice of termination of his or her benefits. His or her late request will be considered to be timely and we will pay him or her continued benefits only if good cause for delay is established.

(4) If you choose not to have benefits continued for anyone else who is receiving benefits based on your wages and self-employment income, pending the appeal on our determination, we will not continue benefits to him or her.

(i) *What you must do when your case is remanded to an administrative law judge.* If we send back (remand) your case to an administrative law judge for further action under the rules provided in § 404.977, and the administrative law judge's decision or dismissal order issued on your medical cessation appeal is vacated and is no longer in effect, continued benefits are payable pending a new decision by the administrative law judge or final action is taken by the Appeals Council on the administrative law judge's recommended decision.

(1) If you (and anyone else receiving benefits based on your wages and self-employment income or because of your disability) previously elected to receive continued benefits pending the administrative law judge's decision, we will automatically start these same continued benefits again. We will send you a notice telling you this, and that you do not have to do anything to have these same benefits continued until the month before the month the new decision of order of dismissal is issued by the administrative law judge or until the month before the month the Appeals Council takes final action on the administrative law judge's recommended decision. These benefits will begin again with the first month of nonpayment based on the prior administrative law judge hearing decision or dismissal order. Our notice explaining reinstatement of continued benefits will also tell you to report to us any changes or events that affect your receipt of benefits.

(2) After we automatically reinstate your continued benefits as described in paragraph (h)(1) of this section, we will contact you to determine if any adjustment is required to the amount of continued benefits payable due to events that affect the right to receive benefits involving you, your spouse and/or children. If you have returned to work, we will request additional information about this work activity. If you are working, your continued benefits will not be stopped while your appeal of the medical cessation of disability is still pending unless you have completed a trial work period and are engaging in substantial gainful activity. In this

event, we will suspend your continued benefits. If any other changes have occurred which would require a reduction in benefit amounts, or nonpayment of benefits, we will send an advance notice to advise of any adverse change before the adjustment action is taken. The notice will also advise you of the right to explain why these benefits should not be adjusted or stopped. You will also receive a written notice of our determination. The notice will also explain your right to reconsideration if you disagree with this determination.

(3) If the final decision on your appeal of your medical cessation is a favorable one, we will send you a written notice in which we will advise you of your right to benefits, if any, before you engaged in substantial gainful activity and to reentitlement should you stop performing substantial gainful activity. If you disagree with our determination, you will have the right to appeal this decision.

(4) If the final decision on your appeal of your medical cessation is an unfavorable one (the cessation is affirmed), you will also be sent a written notice advising you of our determination, and your right to appeal if you think we are wrong.

(5) If you (or the others receiving benefits based on your wages and self-employment income or because of your disability) did not previously elect to have benefits continued pending an administrative law judge decision, and you now want to elect continued benefits, you must request to do so no later than 10 days after you receive our notice telling you about continued benefits. If you fail to request continued benefits within the 10-day period required by paragraph (f)(1) of this section, but later ask that we continue your benefits pending an administrative law judge remand decision, we will use the rules in § 404.911 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the notice telling you about benefit continuation. We will consider the request to be timely and will pay continued benefits only if good cause for delay is established. If you make this new election, benefits may begin with the month of the order sending (remanding) your case back to the administrative law judge. Before we begin to pay you continued benefits as described in paragraph (h)(1) of this section we will contact you to determine if any adjustment is required to the amount of continued benefits payable due to events which may affect your right to benefits. If you have returned to work, we will request additional information about this work activity. If you are working, continued benefits may be started and will not be stopped because of your work while your appeal of the medical cessation of your disability is still pending unless you have completed a trial work period and are engaging in substantial gainful activity. If any changes have occurred which establish a basis for not paying continued benefits or a reduction in benefit amount, we will send you a notice explaining the adjustment or the reason why we cannot pay continued benefits. The notice will also explain your right to reconsideration if you disagree with this determination. If the final decision on your appeal of your medical cessation is a favorable one, we will send you a written notice in which we will advise you of your right to benefits, if any, before you engaged in substantial gainful activity and to reentitlement should you stop performing substantial gainful activity. If you disagree with our determination, you will have the right to appeal this decision. If the final decision on your appeal of your medical cessation is an unfavorable one (the cessation is affirmed), you will also be sent a written notice advising you of our determination, and your right to appeal if you think we are wrong.

(6) If a court orders that your case be sent back to us (remanded) and your case is sent to an administrative law judge for further action under the rules provided in § 404.983, the administrative law judge's decision or dismissal order on your medical cessation appeal is vacated and is no longer in effect. Continued benefits are payable to you and anyone else receiving benefits based on your wages and self-employment income or because of your disability pending a new decision by the administrative law judge or final action is taken by the Appeals Council on the

administrative law judge's recommended decision. In these court-remanded cases reaching the administrative law judge, we will follow the same rules provided in paragraphs (i) (1), (2), (3), (4) and (5) of this section.

(j) *Responsibility to pay back continued benefits.* (1) If the final decision of the Secretary affirms the determination that you are not entitled to benefits, you will be asked to pay back any continued benefits you receive. However, as described in the overpayment recovery and waiver provisions of subpart F of this part, you will have the right to ask that you not be required to pay back the benefits. You will not be asked to pay back any Medicare benefits you received during the appeal.

(2) Anyone else receiving benefits based on your wages and self-employment income (or because of your disability) will be asked to pay back any continued benefits he or she received if the determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, is not changed by the final decision of the Secretary. However, he or she will have the right to ask that he or she not be required to pay them back, as described in the overpayment recovery and waiver provisions of subpart F of this part. He or she will not be asked to pay back any Medicare benefits he or she received during the appeal.

(3) Waiver of recovery of an overpayment resulting from the continued benefits paid to you or anyone else receiving benefits based on your wages and self-employment income (or because of your disability) may be considered as long as the determination was appealed in good faith. It will be assumed that such appeal is made in good faith and, therefore, any overpaid individual has the right to waiver consideration *unless* such individual fails to cooperate in connection with the appeal, e.g., if the individual fails (without good reason) to give us medical or other evidence we request, or to go for a physical or mental examination when requested by us, in connection with the appeal. In determining whether an individual has good cause for failure to cooperate and, thus, whether an appeal was made in good faith, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have which may have caused the individual's failure to cooperate.

[53 FR 29020, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988, as amended at 57 FR 1383, Jan. 14, 1992; 59 FR 1635, Jan. 12, 1994]

§ 404.1598 If you become disabled by another impairment(s).

If a new severe impairment(s) begins in or before the month in which your last impairment(s) ends, we will find that your disability is continuing. The new impairment(s) need not be expected to last 12 months or to result in death, but it must be severe enough to keep you from doing substantial gainful activity, or severe enough so that you are still disabled under § 404.1594.

[50 FR 50136, Dec. 6, 1985]

§ 404.1599 Work incentive experiments and rehabilitation demonstration projects in the disability program.

(a) *Authority and purpose.* Section 505(a) of the Social Security Disability Amendments of 1980, Pub. L. 96–265, directs the Secretary to develop and conduct experiments and demonstration projects designed to provide more cost-effective ways of encouraging disabled beneficiaries to return to work and leave benefit rolls. These experiments and demonstration projects will test the advantages and disadvantages of altering certain limitations and conditions that apply to title II disabled beneficiaries. The objective of all work incentive experiments or rehabilitation demonstrations is to determine whether the alternative requirements will save Trust Fund monies or otherwise improve the administration of the disability program established under title II of the Act.

(b) *Altering benefit requirements, limitations or conditions.* Notwithstanding any other provision of this part, the Secretary may waive compliance with the entitlement and payment requirements for disabled beneficiaries to carry our experiments and demonstration projects in the title II disability program. The projects involve altering certain limitations and conditions that

currently apply to applicants and beneficiaries to test their effect on the program.

(c) *Applicability and scope*—(1) *Participants and nonparticipants.* If you are selected to participate in an experiment or demonstration project, we may temporarily set aside one or more of the current benefit entitlement or payment requirements, limitations or conditions and apply alternative provisions to you. We may also modify current methods of administering the Act as part of a project and apply alternative procedures or policies to you. The alternative provisions or methods of administration used in the projects will not disadvantage you in contrast to current provisions, procedures or policies. If you are not selected to participate in the experiments or demonstration projects (or if you are placed in a control group which is not subject to alternative requirements and methods) we will continue to apply to you the current benefit entitlement and payment requirements, limitations and conditions and methods of administration in the title II disability program.

(2) *Alternative provisions or methods of administration.* The alternative provisions or methods of administration that apply to you in an experiment or demonstration project may include (but are not limited to) one or more of the following:

(i) Reducing your benefits (instead of not paying) on the basis of the amount of your earnings in excess of the SGA amount;

(ii) Extending your benefit eligibility period that follows 9 months of trial work, perhaps coupled with benefit reductions related to your earnings;

(iii) Extending your Medicare benefits if you are severely impaired and return to work even though you may not be entitled to monthly cash benefits;

(iv) Altering the 24-month waiting period for Medicare entitlement; and

(v) Stimulating new forms of rehabilitation.

(d) *Selection of participants.* We will select a probability sample of participants for the work incentive experiments and demonstration projects from newly awarded beneficiaries who meet certain pre-selection criteria (for example, individuals who are likely to be able to do substantial work despite continuing severe impairments). These criteria are designed to provide larger subsamples of beneficiaries who are not likely either to recover medically or die. Participants may also be selected from persons who have been receiving DI benefits for 6 months or more at the time of selection.

(e) *Duration of experiments and demonstration projects.* A notice describing each experiment or demonstration project will be published in the FEDERAL REGISTER before each experiment or project is placed in operation. The work incentive experiments and rehabilitation demonstrations will be activated in 1982. A final report on the results of the experiments and projects is to be completed and transmitted to Congress by June 9, 1993. However, the authority for the experiments and demonstration projects will not terminate at that time. Some of the alternative provisions or methods of administration may continue to apply to participants in an experiment or demonstration project beyond that date in order to assure the validity of the research. Each experiment and demonstration project will have a termination date (up to 10 years from the start of the experiment or demonstration project).

[48 FR 7575, Feb. 23, 1983, as amended at 52 FR 37605, Oct. 8, 1987; 55 FR 51687, Dec. 17, 1990]

APPENDIX 1 TO SUBPART P—LISTING OF IMPAIRMENTS

The body system listings in parts A and B of the Listing of Impairments will no longer be effective on the following dates unless extended by the Commissioner or revised and promulgated again.

1. Growth Impairment (100.00): December 6, 1996.
2. Musculoskeletal System (1.00 and 101.00): June 6, 1996.
3. Special Senses and Speech (2.00 and 102.00): December 4, 1998.
4. Respiratory System (3.00 and 103.00): October 7, 2000.
5. Cardiovascular System (4.00 and 104.00): February 10, 1998.
6. Digestive System (5.00 and 105.00): December 5, 1997.
7. Genito-Urinary System (6.00 and 106.00): December 5, 1997.
8. Hemic and Lymphatic System (7.00 and 107.00): June 6, 1997.

9. Skin (8.00): June 6, 1997.
10. Endocrine System and Obesity (9.00) and Endocrine System (109.00): June 6, 1997.
11. Multiple Body Systems (110.00): July 2, 1998.
12. Neurological (11.00 and 111.00): June 5, 1998.
13. Mental Disorders (12.00): August 28, 1997.
14. Mental Disorders (112.00): June 12, 1997.
15. Neoplastic Diseases, Malignant (13.00 and 113.00): June 6, 1997.
16. Immune System (14.00 and 114.00): July 2, 1998.

Part A

Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

Sec.
1.00 Musculoskeletal System.
2.00 Special Senses and Speech.
3.00 Respiratory System.
4.00 Cardiovascular System.
5.00 Digestive System.
6.00 Genito-Urinary System.
7.00 Hemic and Lymphatic System.
8.00 Skin.
9.00 Endocrine System and Obesity.
10.00 [Reserved]
11.00 Neurological.
12.00 Mental Disorders.
13.00 Neoplastic Diseases, Malignant.
14.00 Immune System.

1.00 MUSCULOSKELETAL SYSTEM

A. *Loss of function* may be due to amputation or deformity. Pain may be an important factor in causing functional loss, but it must be associated with relevant abnormal signs or laboratory findings. Evaluations of musculoskeletal impairments should be supported where applicable by detailed descriptions of the joints, including ranges of motion, condition of the musculature, sensory or reflex changes, circulatory deficits, and X-ray abnormalities.

B. *Disorders of the spine,* associated with vertebrogenic disorders as in 1.05C, result in impairment because of distortion of the bony and ligamentous architecture of the spine or impingement of a herniated nucleus pulposus or bulging annulus on a nerve root. Impairment caused by such abnormalities usually improves with time or responds to treatment. Appropriate abnormal physical findings must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that severe impairment will last for a continuous period of 12 months. This may occur in cases with unsuccessful prior surgical treatment.

Evaluation of the impairment caused by disorders of the spine requires that a clinical diagnosis of the entity to be evaluated first must be established on the basis of adequate history, physical examination, and roentgenograms. The specific findings stated in 1.05C represent the level required for that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. Furthermore, while neurological examination findings are required, they are not to be interpreted as a basis for evaluating the magnitude of any neurological impairment. Neurological impairments are to be evaluated under 11.00–11.19.

The history must include a detailed description of the character, location, and radiation of pain; mechanical factors which incite and relieve pain; prescribed treatment, including type, dose, and frequency of analgesic; and typical daily activities. Care must be taken to ascertain that the reported examination findings are consistent with the individual's daily activities.

There must be a detailed description of the orthopedic and neurologic examination findings. The findings should include a description of gait, limitation of movement of the spine given quantitatively in degrees from the vertical position, motor and sensory abnormalities, muscle spasm, and deep tendon reflexes. Observations of the individual during the examination should be reported; e.g., how he or she gets on and off the examining table. Inability to walk on heels or toes, to squat, or to arise from a squatting position, where appropriate, may be considered evidence of significant motor loss. However, a report of atrophy is not acceptable as evidence of significant motor loss without circumferential measurements of both thighs and lower legs (or upper or lower arms) at a stated point above and below the knee or elbow given in inches or centimeters. A specific description of atrophy of hand muscles is acceptable without measurements of atrophy but should include measurements of grip strength.

These physical examination findings must be determined on the basis of objective observations during the examination and not simply a report of the individual's allegation, e.g., he says his leg is weak, numb, etc. Alternative testing methods should be used to verify the objectivity of the abnormal findings, e.g., a seated straight-leg raising test in addition to a supine straight-leg raising test. Since abnormal findings may be intermittent, their continuous presence over a period of time must be established by a record of ongoing treatment. Neurological abnormalities may not completely subside after surgical or nonsurgical treatment, or with the passage of time. Residual neurological abnormalities, which persist after it has been determined clinically or by direct surgical or other observation that the ongoing or progressive condition is no longer present, cannot be considered to satisfy the required findings in 1.05C.

Where surgical procedures have been performed, documentation should include a copy of the operative note and available pathology reports.

Electrodiagnostic procedures and myelography may be useful in establishing the clinical diagnosis, but do not constitute alternative criteria to the requirements in 1.05C.

C. *After maximum benefit from surgical therapy* has been achieved in situations involving fractures of an upper extremity (see 1.12) or soft tissue injuries of a lower or upper extremity (see 1.13), i.e., there have been no significant changes in physical findings or X-ray findings for any 6-month period after the last definitive surgical procedure, evaluation should be made on the basis of demonstrable residuals.

D. *Major joints* as used herein refer to hip, knee, ankle, shoulder, elbow, or wrist and hand. (Wrist and hand are considered together as one major joint.)

E. *The measurements of joint motion are* based on the techniques described in the ''Joint Motion Method of Measuring and Recording,'' published by the American Academy of Orthopedic Surgeons in 1965, or the ''Guides to the Evaluation of Permanent Impairment—The Extremities and Back'' (Chapter I); American Medical Association, 1971.

1.01 Category of Impairments, Musculoskeletal

1.02 *Active rheumatoid arthritis and other inflammatory arthritis.*

With both A and B.

A. History of persistent joint pain, swelling, and tenderness involving multiple major joints (see 1.00D) and with signs of joint inflammation (swelling and tenderness) on current physical examination despite prescribed therapy for at least 3 months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last at least 12 months; and

B. Corroboration of diagnosis at some point in time by either.

1. Positive serologic test for rheumatoid factor; or

2. Antinuclear antibodies; or

3. Elevated sedimentation rate; or

4. Characteristic histologic changes in biopsy of synovial membrane or subcutaneous nodule (obtained independent of Social Security disability evaluation).

1.03 *Arthritis of a major weight-bearing joint (due to any cause):*

With history of persistent joint pain and stiffness with signs of marked limitation of motion or abnormal motion of the affected joint on current physical examination. With:

A. Gross anatomical deformity of hip or knee (e.g, subluxation, contracture, bony or fibrous ankylosis, instability) supported by X-ray evidence of either significant joint space narrowing or significant bony destruction and markedly limiting ability to walk and stand; or

B. Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint and return to full weight-bearing status did not occur, or is not expected to occur, within 12 months of onset.

1.04 *Arthritis of one major joint in each of the upper extremities (due to any cause):*

With history of persistent joint pain and stiffness, signs of marked limitation of motion of the affected joints on current physical examination, and X-ray evidence of either significant joint space narrowing or significant bony destruction. With:

A. Abduction and forward flexion (elevation) of both arms at the shoulders, including scapular motion, restricted to less than 90 degrees; or

B. Gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability, ulnar deviation) and enlargement or effusion of the affected joints.

1.05 *Disorders of the spine:*

A. Arthritis manifested by ankylosis or fixation of the cervical or dorsolumbar spine at 30° or more of flexion measured from the neutral postion, with X-ray evidence of:

1. Calcification of the anterior and lateral ligaments; or

2. Bilateral ankylosis of the sacroiliac joints with abnormal apophyseal articulations; or

B. Osteoporosis, generalized (established by X-ray) manifested by pain and limitation of back motion and paravertebral muscle spasm with X-ray evidence of either:

1. Compression fracture of a vertebral body with loss of at least 50 percent of the estimated height of the vertebral body prior to the compression fracture, with no intervening direct traumatic episode; or

2. Multiple fractures of vertebrae with no intervening direct traumatic episode; or

C. Other vertebrogenic disorders (e.g., herniated nucleus puplosus, spinal stenosis) with the following persisting for at least 3 months despite prescribed therapy and expected to last 12 months. With both 1 and 2:

1. Pain, muscle spasm, and significant limitation of motion in the spine; and

2. Appropriate radicular distribution of significant motor loss with muscle weakness and sensory and reflex loss.

1.08 *Osteomyelitis or septic arthritis (established by X-ray):*

A. Located in the pelvis, vertebra, femur, tibia, or a major joint of an upper or lower extremity, with persistent activity or occurrence of at least two episodes of acute activity within a 5-month period prior to adjudication, manifested by local inflammatory, and systemic signs and laboratory findings (e.g., heat, redness, swelling, leucocytosis, or increased sedimentation rate) and expected to last at least 12 months despite prescribed therapy; or

B. Multiple localizations and systemic manifestations as in A above.

1.09 *Amputation or anatomical deformity of (i.e., loss of major function due to degenerative changes associated with vascular or neurological deficits, traumatic loss of muscle mass or tendons and X-ray evidence of bony ankylosis at an unfavorable angle, joint subluxation or instability):*

A. Both hands; or

B. Both feet; or

C. One hand and one foot.

1.10 *Amputation of one lower extremity (at or above the tarsal region):*

A. Hemipelvectomy or hip disarticulation; or

B. Amputation at or above the tarsal region due to peripheral vascular disease or diabetes mellitus; or

C. Inability to use a prosthesis effectively, without obligatory assistive devices, due to one of the following:

1. Vascular disease; or

2. Neurological complications (e.g., loss of position sense); or

3. Stump too short or stump complications persistent, or are expected to persist, for at least 12 months from onset; or

4. Disorder of contralateral lower extremity which markedly limits ability to walk and stand.

1.11 *Fracture of the femur, tibia, tarsal bone of pelvis* with solid union not evident on X-ray and not clinically solid, when such determination is feasible, and return to full weight-bearing status did not occur or is not expected to occur within 12 months of onset.

1.12 *Fractures of an upper extremity* with non-union of a fracture of the shaft of the humerus, radius, or ulna under continuing surgical management directed toward restoration of functional use of the extremity and such function was not restored or expected to be restored within 12 months after onset.

1.13 *Soft tissue injuries of an upper or lower extremity* requiring a series of staged surgical procedures within 12 months after onset for salvage and/or restoration of major function of the extremity, and such major function was not restored or expected to be restored within 12 months after onset.

2.00 Special Senses and Speech

A. *Ophthalmology*

1. *Causes of impairment.* Diseases or injury of the eyes may produce loss of central or peripheral vision. Loss of central vision results in inability to distinguish detail and prevents reading and fine work. Loss of peripheral vision restricts the ability of an individual to move about freely. The extent of impairment of sight should be determined by visual testing.

2. *Central visual acuity.* A loss of central visual acuity may be caused by impaired distant and/or near vision. However, for an individual to meet the level of severity described in 2.02 and 2.04, only the remaining central visual acuity for distance of the better eye with best correction based on the Snellen test chart measurement may be used. Correction obtained by special visual aids (e.g., contact lenses) will be considered if the individual has the ability to wear such aids.

3. *Field of vision.* Impairment of peripheral vision may result if there is contraction of the visual fields. The contraction may be either symmetrical or irregular. The extent of the remaining peripheral visual field will be determined by usual perimetric methods at a distance of 330 mm. under illumination of not less than 7-foot candles. For the phakic eye (the eye with a lens), a 3 mm. white disc target will be used, and for the aphakic eye (the eye without the lens), a 6 mm. white disc target will be used. In neither instance should corrective spectacle lenses be worn during the examination but if they have been used, this fact must be stated.

Measurements obtained on comparable perimetric devices may be used; this does not include the use of tangent screen measurements. For measurements obtained using the Goldmann perimeter, the object size designation III and the illumination designation 4 should be used for the phakic eye, and the object size designation IV and illumination designation 4 for the aphakic eye.

Field measurements must be accompanied by notated field charts, a description of the type and size of the target and the test distance. Tangent screen visual fields are not acceptable as a measurement of peripheral field loss.

Where the loss is predominantly in the lower visual fields, a system such as the weighted grid scale for perimetric fields described by B. Esterman (see Grid for Scoring Visual Fields, II. Perimeter, *Archives of Ophthalmology*, 79:400, 1968) may be used for determining whether the visual field loss is comparable to that described in Table 2.

4. *Muscle function.* Paralysis of the third cranial nerve producing ptosis, paralysis of accommodation, and dilation and immobility of the pupil may cause significant visual impairment. When all the muscle of the eye are paralyzed including the iris and ciliary body (total ophthalmoplegia), the condition is considered a severe impairment provided it is bilateral. A finding of severe impairment based primarily on impaired muscle function must be supported by a report of an actual measurement of ocular motility.

5. *Visual efficiency.* Loss of visual efficiency may be caused by disease or injury resulting in a reduction of central visual acuity or visual field. The visual efficiency of one eye is the product of the percentage of central visual efficiency and the percentage of visual field efficiency. (See Tables No. 1 and 2, following 2.09.)

6. *Special situations.* Aphakia represents a visual handicap in addition to the loss of central visual acuity. The term monocular aphakia would apply to an individual who has had the lens removed from one eye, and who still retains the lens in his other eye, or to an individual who has only one eye which is aphakic. The term binocular aphakia would apply to an individual who has had both lenses removed. In cases of binocular aphakia, the central efficiency of the better eye will be accepted as 75 percent of its value. In cases of monocular aphakia, where the better eye is aphakic, the central visual efficiency will be accepted as 50 percent of the value. (If an individual has binocular aphakia, and the central visual acuity in the poorer eye can be corrected only to 20/200, or less, the central visual efficiency of the better eye will be accepted as 50 percent of its value.)

Ocular symptoms of systemic disease may or may not produce a disabling visual impairement. These manifestations should be evaluated as part of the underlying disease entity by reference to the particular body system involved.

7. *Statutory blindness.* The term ''statutory blindness'' refers to the degree of visual impairment which defines the term ''blindness'' in the Social Security Act. Both 2.02 and 2.03 A and B denote statutory blindness.

B. *Otolaryngology*

1. *Hearing impairment.* Hearing ability should be evaluated in terms of the person's ability to hear and distinguish speech.

Loss of hearing can be quantitatively determined by an audiometer which meets the standards of the American National Standards Institute (ANSI) for air and bone conducted stimuli (i.e., ANSI S 3.6–1969 and ANSI S 3.13–1972, or subsequent comparable revisions) and performing all hearing measurements in an environment which meets the ANSI standard for maximal permissible background sound (ANSI S 3.1–1977).

Speech discrimination should be determined using a standardized measure of speech discrimination ability in quiet at a test presentation level sufficient to ascertain maximum discrimination ability. The speech discrimination measure (test) used, and the level at which testing was done, must be reported.

Hearing tests should be preceded by an otolaryngologic examination and should be performed by or under the supervision of an otolaryngologist or audiologist qualified to perform such tests.

In order to establish an independent medical judgment as to the level of impairment in a claimant alleging deafness, the following examinations should be reported: Otolaryngologic examination, pure tone air and bone audiometry, speech reception threshold (SRT), and speech discrimination testing. A copy of reports of medical examination and audiologic evaluations must be submitted.

Cases of alleged ''deaf mutism'' should be documented by a hearing evaluation. Records obtained from a speech and hearing rehabilitation center or a special school for the deaf may be acceptable, but if these reports are not available, or are found to be inadequate, a current hearing evaluation should be submitted as outlined in the preceding paragraph.

2. *Vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease.* These disturbances of balance are characterized by an hallucination of motion or loss of position sense and a sensation of dizziness which may be constant or may occur in paroxysmal attacks. Nausea, vomiting, ataxia, and incapacitation are frequently observed, particularly during the acute attack. It is important to differentiate the report of rotary vertigo from that of ''dizziness'' which is described as lightheadedness, unsteadiness, confusion, or syncope.

Meniere's disease is characterized by paroxysmal attacks of vertigo, tinnitus, and fluctuating hearing loss. Remissions are unpredictable and irregular, but may be longlasting; hence, the severity of impairment is best determined after prolonged observation and serial reexaminations.

The diagnosis of a vestibular disorder requires a comprehensive neuro-otolaryngologic examination with a detailed description of the vertiginous episodes, including notation of frequency, severity, and duration of the attacks. Pure tone and speech audiometry with the appropriate special examinations, such as Bekesy audiometry, are necessary. Vestibular functions is assessed by positional and caloric testing, preferably by electronystagmography. When polytograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to reports of skull and temporal bone X-rays.

3. *Organic loss of speech.* Glossectomy or laryngectomy or cicatricial laryngeal stenosis due to injury or infection results in loss of voice production by normal means. In evaluating organic loss of speech (see 2.09), ability to produce speech by any means includes the use of mechanical or electronic devices. Impairment of speech due to neurologic disorders should be evaluated under 11.00–11.19.

2.01 Category of Impairments, Special Senses and Speech

2.02 *Impairment of central visual acuity.* Remaining vision in the better eye after best correction is 20/200 or less.

2.03 *Contraction of peripheral visual fields in the better eye.*

A. To 10° or less from the point of fixation; or

B. So the widest diameter subtends an angle no greater than 20°; or

C. To 20 percent or less visual field efficiency.

2.04 *Loss of visual efficiency*. Visual efficiency of better eye after best correction 20 percent or less. (The percent of remaining visual efficiency=the product of the percent of remaining central visual efficiency and the percent of remaining visual field efficiency.)

2.05 *Complete homonymous hemianopsia* (with or without macular sparing). Evaluate under 2.04.

2.06 *Total bilateral ophthalmoplegia*.

2.07 *Disturbance of labyrinthine-vestibular function (including Meniere's disease),* characterized by a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing. With both A and B:

A. Disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests; and

B. Hearing loss established by audiometry.

2.08 *Hearing impairments* (hearing not restorable by a hearing aid) manifested by:

A. Average hearing threshold sensitivity for air conduction of 90 decibels or greater and for bone conduction to corresponding maximal levels, in the better ear, determined by the simple average of hearing threshold levels at 500, 1000 and 2000 hz. (see 2.00B1); or

B. Speech discrimination scores of 40 percent or less in the better ear;

2.09 *Organic loss of speech* due to any cause with inability to produce by any means speech which can be heard, understood, and sustained.

TABLE NO. 1—PERCENTAGE OF CENTRAL VISUAL EFFICIENCY CORRESPONDING TO CENTRAL VISUAL ACUITY NOTATIONS FOR DISTANCE IN THE PHAKIC AND APHAKIC EYE (BETTER EYE)

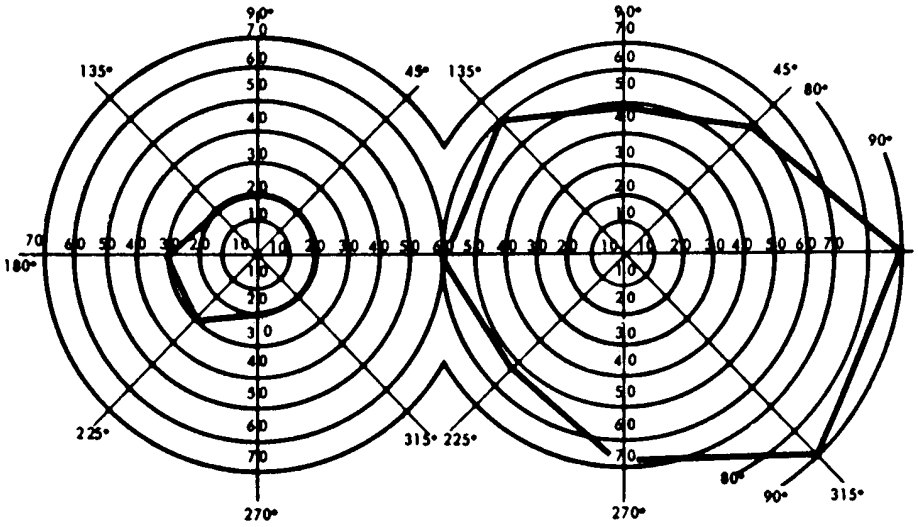
Snellen		Percent central visual efficiency		
English	Metric	Phakic [1]	Aphakic monocular [2]	Aphakic binocular [3]
20/16	6/5	100	50	75
20/20	6/6	100	50	75
20/25	6/7.5	95	47	71
20/32	6/10	90	45	67
20/40	6/12	85	42	64
20/50	6/15	75	37	56
20/64	6/20	65	32	49
20/80	6/24	60	30	45
20/100	6/30	50	25	37
20/125	6/38	40	20	30
20/160	6/48	30	.....	22
20/200	6/60	20	.....	.....

Column and Use.

[1] Phakic.—1. A lens is present in both eyes. 2. A lens is present in the better eye and absent in the poorer eye. 3. A lens is present in one eye and the other eye is enucleated.

[2] Monocular.—1. A lens is absent in the better eye and present in the poorer eye. 2. The lenses are absent in both eyes; however, the central visual acuity in the poorer eye after best correction in 20/200 or less. 3. A lens is absent from one eye and the other eye is enucleated.

[3] Binocular.—1. The lenses are absent from both eyes and the central visual acuity in the poorer eye after best correction is greater than 20/200.



1. Diagram of right eye illustrates extent of normal visual field as tested on standard perimeter at 3/330 (3 mm. white disc at a distance of 330 mm.) under 7 foot-candles illumination. The sum of the eight principal meridians of this field total 500°.

2. The percent of visual field efficiency is obtained by adding the number of degrees of the eight principal meridians of the contracted field and dividing by 500. Diagram of left eye illustrates visual field contracted to 30° in the temporal and down and out meridians and to 20° in the remaining six meridians. The percent of visual field efficiency of this field is: $6 \times 20 + 2 \times 30 = 180 \div 500 = 0.36$ or 36 percent remaining visual field efficiency, or 64 percent loss.

3.00 Respiratory System

A. *Introduction.* The listings in this section describe impairments resulting from respiratory disorders based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of treatment prescribed by a treating source. Respiratory disorders along with any associated impairment(s) must be established by medical evidence. Evidence must be provided in sufficient detail to permit an independent reviewer to evaluate the severity of the impairment.

Many individuals, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is evidence of such treatment, the longitudinal clinical record must include a description of the treatment prescribed by the treating source and response in addition to information about the nature and severity of the impairment. It is important to document any prescribed treatment and response, because this medical management may have improved the individual's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some individuals will not have received ongoing treatment or have an ongoing relationship with the medical community, despite the existence of a severe impairment(s). An individual who does not receive treatment may or may not be able to show the existence of an impairment that meets the criteria of these listings. Even if an individual does not show that his or her impairment meets the criteria of these listings, the individual may have an impairment(s) equivalent in severity to one of the listed impairments or be disabled because of a limited residual functional capacity. Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the level of the individual's

functioning, and the frequency, severity, and duration of symptoms. Also, the asthma listing specifically includes a requirement for continuing signs and symptoms despite a regimen of prescribed treatment.

Impairments caused by chronic disorders of the respiratory system generally produce irreversible loss of pulmonary function due to ventilatory impairments, gas exchange abnormalities, or a combination of both. The most common symptoms attributable to these disorders are dyspnea on exertion, cough, wheezing, sputum production, hemoptysis, and chest pain. Because these symptoms are common to many other diseases, a thorough medical history, physical examination, and chest x-ray or other appropriate imaging technique are required to establish chronic pulmonary disease. Pulmonary function testing is required to assess the severity of the respiratory impairment once a disease process is established by appropriate clinical and laboratory findings.

Alterations of pulmonary function can be due to obstructive airway disease (e.g., emphysema, chronic bronchitis, asthma), restrictive pulmonary disorders with primary loss of lung volume (e.g., pulmonary resection, thoracoplasty, chest cage deformity as in kyphoscoliosis or obesity), or infiltrative interstitial disorders (e.g., diffuse pulmonary fibrosis). Gas exchange abnormalities without significant airway obstruction can be produced by interstitial disorders. Disorders involving the pulmonary circulation (e.g., primary pulmonary hypertension, recurrent thromboembolic disease, primary or secondary pulmonary vasculitis) can produce pulmonary vascular hypertension and, eventually, pulmonary heart disease (cor pulmonale) and right heart failure. Persistent hypoxemia produced by any chronic pulmonary disorder also can result in chronic pulmonary hypertension and right heart failure. Chronic infection, caused most frequently by mycobacterial or mycotic organisms, can produce extensive and progressive lung destruction resulting in marked loss of pulmonary function. Some disorders, such as bronchiectasis, cystic fibrosis, and asthma, can be associated with intermittent exacerbations of such frequency and intensity that they produce a disabling impairment, even when pulmonary function during periods of relative clinical stability is relatively well-maintained.

Respiratory impairments usually can be evaluated under these listings on the basis of a complete medical history, physical examination, a chest x-ray or other appropriate imaging techniques, and spirometric pulmonary function tests. In some situations, most typically with a diagnosis of diffuse interstitial fibrosis or clinical findings suggesting cor pulmonale, such as cyanosis or secondary polycythemia, an impairment may be underestimated on the basis of spirometry alone. More sophisticated pulmonary function testing may then be necessary to determine if gas exchange abnormalities contribute to the severity of a respiratory impairment. Additional testing might include measurement of diffusing capacity of the lungs for carbon monoxide or resting arterial blood gases. Measurement of arterial blood gases during exercise is required infrequently. In disorders of the pulmonary circulation, right heart catheterization with angiography and/or direct measurement of pulmonary artery pressure may have been done to establish a diagnosis and evaluate severity. When performed, the results of the procedure should be obtained. Cardiac catheterization will not be purchased.

These listings are examples of common respiratory disorders that are severe enough to prevent a person from engaging in any gainful activity. When an individual has a medically determinable impairment that is not listed, an impairment which does not meet a listing, or a combination of impairments no one of which meets a listing, we will consider whether the individual's impairment or combination of impairments is medically equivalent in severity to a listed impairment. Individuals who have an impairment(s) with a level of severity which does not meet or equal the criteria of the listings may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful activity. Evaluation of the impairment(s) of these individuals will proceed through the final steps of the sequential evaluation process.

B. *Mycobacterial, mycotic, and other chronic persistent infections of the lung.* These disorders are evaluated on the basis of the resulting limitations in pulmonary function. Evidence of chronic infections, such as active mycobacterial diseases or mycoses with positive cultures, drug resistance, enlarging parenchymal lesions, or cavitation, is not, by itself, a basis for determining that an individual has a disabling impairment expected to last 12 months. In those unusual cases of pulmonary infection that persist for a period approaching 12 consecutive months, the clinical findings, complications, therapeutic considerations, and prognosis must be carefully assessed to determine whether, despite relatively well-maintained pulmonary function, the individual nevertheless has an impairment that is expected to last for at least 12 consecutive months and prevent gainful activity.

C. *Episodic respiratory disease.* When a respiratory impairment is episodic in nature, as can occur with exacerbations of asthma, cystic fibrosis, bronchiectasis, or chronic

asthmatic bronchitis, the frequency and intensity of episodes that occur despite prescribed treatment are often the major criteria for determining the level of impairment. Documentation for these exacerbations should include available hospital, emergency facility and/or physician records indicating the dates of treatment; clinical and laboratory findings on presentation, such as the results of spirometry and arterial blood gas studies (ABGS); the treatment administered; the time period required for treatment; and the clinical response. Attacks of asthma, episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum), or respiratory failure as referred to in paragraph B of 3.03, 3.04, and 3.07, are defined as prolonged symptomatic episodes lasting one or more days and requiring intensive treatment, such as intravenous bronchodilator or antibiotic administration or prolonged inhalational bronchodilator therapy in a hospital, emergency room or equivalent setting. Hospital admissions are defined as inpatient hospitalizations for longer than 24 hours. The medical evidence must also include information documenting adherence to a prescribed regimen of treatment as well as a description of physical signs. For asthma, the medical evidence should include spirometric results obtained between attacks that document the presence of baseline airflow obstruction.

D. *Cystic fibrosis* is a disorder that affects either the respiratory or digestive body systems or both and is responsible for a wide and variable spectrum of clinical manifestations and complications. Confirmation of the diagnosis is based upon an elevated sweat sodium concentration or chloride concentration accompanied by one or more of the following: the presence of chronic obstructive pulmonary disease, insufficiency of exocrine pancreatic function, meconium ileus, or a positive family history. The quantitative pilocarpine iontophoresis procedure for collection of sweat content must be utilized. Two methods are acceptable: the ''Procedure for the Quantitative Iontophoretic Sweat Test for Cystic Fibrosis'' published by the Cystic Fibrosis Foundation and contained in, ''A Test for Concentration of Electrolytes in Sweat in Cystic Fibrosis of the Pancreas Utilizing Pilocarpine Iontophoresis,'' Gibson, I.E., and Cooke, R.E., *Pediatrics*, Vol. 23: 545, 1959; or the ''Wescor Macroduct System.'' To establish the diagnosis of cystic fibrosis, the sweat sodium or chloride content must be analyzed quantitatively using an acceptable laboratory technique. Another diagnostic test is the ''CF gene mutation analysis'' for homozygosity of the cystic fibrosis gene. The pulmonary manifestations of this disorder should be evaluated under 3.04. The nonpulmonary aspects of cystic fibrosis should be evaluated under the digestive body system (5.00). Because cystic fibrosis may involve the respiratory and digestive body systems, the combined effects of the involvement of these body systems must be considered in case adjudication.

E. *Documentation of pulmonary function testing.* The results of spirometry that are used for adjudication under paragraphs A and B of 3.02 and paragraph A of 3.04 should be expressed in liters (L), body temperature and pressure saturated with water vapor (BTPS). The reported one-second forced expiratory volume (FEV_1) and forced vital capacity (FVC) should represent the largest of at least three satisfactory forced expiratory maneuvers. Two of the satisfactory spirograms should be reproducible for both pre-bronchodilator tests and, if indicated, post-bronchodilator tests. A value is considered reproducible if it does not differ from the largest value by more than 5 percent or 0.1 L, whichever is greater. The highest values of the FEV_1 and FVC, whether from the same or different tracings, should be used to assess the severity of the respiratory impairment. Peak flow should be achieved early in expiration, and the spirogram should have a smooth contour with gradually decreasing flow throughout expiration. The zero time for measurement of the FEV_1 and FVC, if not distinct, should be derived by linear back-extrapolation of peak flow to zero volume. A spirogram is satisfactory for measurement of the FEV_1 if the expiratory volume at the back-extrapolated zero time is less than 5 percent of the FVC or 0.1 L, whichever is greater. The spirogram is satisfactory for measurement of the FVC if maximal expiratory effort continues for at least 6 seconds, or if there is a plateau in the volume-time curve with no detectable change in expired volume (VE) during the last 2 seconds of maximal expiratory effort.

Spirometry should be repeated after administration of an aerosolized bronchodilator under supervision of the testing personnel if the pre-bronchodilator FEV_1 value is less than 70 percent of the predicted normal value. Pulmonary function studies should not be performed unless the clinical status is stable (e.g., the individual is not having an asthmatic attack or suffering from an acute respiratory infection or other chronic illness). Wheezing is common in asthma, chronic bronchitis, or chronic obstructive pulmonary disease and does not preclude testing. The effect of the administered bronchodilator in relieving bronchospasm and improving ventilatory function is assessed by spirometry. If a bronchodilator is not administered, the reason should be clearly stated in the report. Pulmonary function studies performed to assess airflow obstruction without testing after bronchodilators cannot be used to assess levels of impairment in the range that prevents any gainful work activity, unless the use of bronchodilators is contraindicated. Post-

bronchodilator testing should be performed 10 minutes after bronchodilator administration. The dose and name of the bronchodilator administered should be specified. The values in paragraphs A and B of 3.02 must only be used as criteria for the level of ventilatory impairment that exists during the individual's most stable state of health (i.e., any period in time except during or shortly after an exacerbation).

The appropriately labeled spirometric tracing, showing the claimant's name, date of testing, distance per second on the abscissa and distance per liter (L) on the ordinate, must be incorporated into the file. The manufacturer and model number of the device used to measure and record the spirogram should be stated. The testing device must accurately measure both time and volume, the latter to within 1 percent of a 3 L calibrating volume. If the spirogram was generated by any means other than direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show a recorded calibration of volume units using a mechanical volume input such as a 3 L syringe.

If the spirometer directly measures flow, and volume is derived by electronic integration, the linearity of the device must be documented by recording volume calibrations at three different flow rates of approximately 30 L/min (3 L/6 sec), 60 L/min (3 L/3 sec), and 180 L/min (3 L/sec). The volume calibrations should agree to within 1 percent of a 3 L calibrating volume. The proximity of the flow sensor to the individual should be noted, and it should be stated whether or not a BTPS correction factor was used for the calibration recordings and for the individual's actual spirograms.

The spirogram must be recorded at a speed of at least 20 mm/sec, and the recording device must provide a volume excursion of at least 10 mm/L. If reproductions of the original spirometric tracings are submitted, they must be legible and have a time scale of at least 20 mm/sec and a volume scale of at least 10 mm/L to permit independent measurements. Calculation of FEV_1 from a flow-volume tracing is not acceptable, i.e., the spirogram and calibrations must be presented in a volume-time format at a speed of at least 20 mm/sec and a volume excursion of at least 10 mm/L to permit independent evaluation.

A statement should be made in the pulmonary function test report of the individual's ability to understand directions as well as his or her effort and cooperation in performing the pulmonary function tests.

The pulmonary function tables in 3.02 and 3.04 are based on measurement of standing height without shoes. If an individual has marked spinal deformities (e.g., kyphoscoliosis), the measured span between the fingertips with the upper extremities abducted 90 degrees should be substituted for height when this measurement is greater than the standing height without shoes.

F. *Documentation of chronic impairment of gas exchange.*

1. *Diffusing capacity of the lungs for carbon monoxide (DLCO).* A diffusing capacity of the lungs for carbon monoxide study should be purchased in cases in which there is documentation of chronic pulmonary disease, but the existing evidence, including properly performed spirometry, is not adequate to establish the level of functional impairment. Before purchasing DLCO measurements, the medical history, physical examination, reports of chest x-ray or other appropriate imaging techniques, and spirometric test results must be obtained and reviewed because favorable decisions can often be made based on available evidence without the need for DLCO studies. Purchase of a DLCO study may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided.

The DLCO should be measured by the single breath technique with the individual relaxed and seated. At sea level, the inspired gas mixture should contain approximately 0.3 percent carbon monoxide (CO), 10 percent helium (He), 21 percent oxygen (O_2), and the balance nitrogen. At altitudes above sea level, the inspired O_2 concentration may be raised to provide an inspired O_2 tension of approximately 150 mm Hg. Alternatively, the sea level mixture may be employed at altitude and the measured DLCO corrected for ambient barometric pressure. Helium may be replaced by another inert gas at an appropriate concentration. The inspired volume (VI) during the DLCO maneuver should be at least 90 percent of the previously determined vital capacity (VC). The inspiratory time for the VI should be less than 2 seconds, and the breath-hold time should be between 9 and 11 seconds. The washout volume should be between 0.75 and 1.00 L, unless the VC is less than 2 L. In this case, the washout volume may be reduced to 0.50 L; any such change should be noted in the report. The alveolar sample volume should be between 0.5 and 1.0 L and be collected in less than 3 seconds. At least 4 minutes should be allowed for gas washout between repeat studies.

A DLCO should be reported in units of ml CO, standard temperature, pressure, dry (STPD)/min/mm Hg uncorrected for hemoglobin concentration and be based on a single-breath alveolar volume determination. Abnormal hemoglobin or hematocrit values, and/or carboxyhemoglobin levels should be reported along with diffusing capacity.

The DLCO value used for adjudication should represent the mean of at least two acceptable measurements, as defined above. In addition, two acceptable tests should be within 10 percent of each other or 3 ml

CO(STPD)/min/mm Hg, whichever is larger. The percent difference should be calculated as 100×(test 1−test 2)/average DLCO.

The ability of the individual to follow directions and perform the test properly should be described in the written report. The report should include tracings of the VI, breath-hold maneuver, and VE appropriately labeled with the name of the individual and the date of the test. The time axis should be at least 20 mm/sec and the volume axis at least 10 mm/L. The percentage concentrations of inspired O_2, and inspired and expired CO and He for each of the maneuvers should be provided, and the algorithm used to calculate test results noted. Sufficient data must be provided to permit independent calculation of results (and, if necessary, calculation of corrections for anemia and/or carboxyhemoglobin).

2. *Arterial blood gas studies (ABGS).* An ABGS performed at rest (while breathing room air, awake and sitting or standing) or during exercise should be analyzed in a laboratory certified by a State or Federal agency. If the laboratory is not certified, it must submit evidence of participation in a national proficiency testing program as well as acceptable quality control at the time of testing. The report should include the altitude of the facility and the barometric pressure on the date of analysis.

Purchase of resting ABGS may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided. If the results of a DLCO study are greater than 40 percent of predicted normal but less than 60 percent of predicted normal, purchase of resting ABGS should be considered. Before purchasing resting ABGS, a program physician, preferably one experienced in the care of patients with pulmonary disease, must review all clinical and laboratory data short of this procedure, including spirometry, to determine whether obtaining the test would present a significant risk to the individual.

3. *Exercise testing.* Exercise testing with measurement of arterial blood gases during exercise may be appropriate in cases in which there is documentation of chronic pulmonary disease, but full development, short of exercise testing, is not adequate to establish if the impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided. In this context, ''full development'' means that results from spirometry and measurement of DLCO and resting ABGS have been obtained from treating sources or through purchase. Exercise arterial blood gas measurements will be required infrequently and should be purchased only after careful review of the medical history, physical examination, chest x-ray or other appropriate imaging techniques, spirometry, DLCO, electrocardiogram (ECG), hematocrit or hemoglobin, and resting blood gas results by a program physician, preferably one experienced in the care of patients with pulmonary disease, to determine whether obtaining the test would presents a significant risk to the individual. Oximetry and capillary blood gas analysis are not acceptable substitutes for the measurement of arterial blood gases. Arterial blood gas samples obtained after the completion of exercise are not acceptable for establishing an individual's functional capacity.

Generally, individuals with a DLCO greater than 60 percent of predicted normal would not be considered for exercise testing with measurement of blood gas studies. The exercise test facility must be provided with the claimant's clinical records, reports of chest x-ray or other appropriate imaging techniques, and any spirometry, DLCO, and resting blood gas results obtained as evidence of record. The testing facility must determine whether exercise testing present a significant risk to the individual; if it does, the reason for not performing the test must be reported in writing.

4. *Methodology.* Individuals considered for exercise testing first should have resting arterial blood partial pressure of oxygen (PO_2), resting arterial blood partial pressure of carbon dioxide (PCO_2) and negative log of hydrogen ion concentration (pH) determinations by the testing facility. The sample should be obtained in either the sitting or standing position. The individual should then perform exercise under steady state conditions, preferably on a treadmill, breathing room air, for a period of 4 to 6 minutes at a speed and grade providing an oxygen consumption of approximately 17.5 ml/kg/min (5 METs). If a bicycle ergometer is used, an exercise equivalent of 5 METs (e.g., 450 kpm/min, or 75 watts, for a 176 pound (80 kilogram) person) should be used. If the individual is able to complete this level of exercise without achieving listing-level hypoxemia, then he or she should be exercised at higher workloads to determine exercise capacity. A warm-up period of treadmill walking or cycling may be performed to acquaint the individual with the exercise procedure. If during the warm-up period the individual cannot achieve an exercise level of 5 METs, a lower workload may be selected in keeping with the estimate of exercise capacity. The individual should be monitored by ECG throughout the exercise and in the immediate post-exercise period. Blood pressure and an ECG should be recorded during each minute of exercise. During the final 2 minutes of a specific level of steady state exercise, an arterial blood sample should be drawn and analyzed for oxygen pressure (or tension) (PO_2), carbon dioxide pressure (or tension) (PCO_2), and pH. At the discretion of the testing facility, the

sample may be obtained either from an indwelling arterial catheter or by direct arterial puncture. If possible, in order to evaluate exercise capacity more accurately, a test site should be selected that has the capability to measure minute ventilation, O_2 consumption, and carbon dioxide (CO_2) production. If the claimant fails to complete 4 to 6 minutes of steady state exercise, the testing laboratory should comment on the reason and report the actual duration and levels of exercise performed. This comment is necessary to determine if the individual's test performance was limited by lack of effort or other impairment (e.g., cardiac, peripheral vascular, musculoskeletal, neurological).

The exercise test report should contain representative ECG strips taken before, during and after exercise; resting and exercise arterial blood gas values; treadmill speed and grade settings, or, if a bicycle ergometer was used, exercise levels expressed in watts or kpm/min; and the duration of exercise. Body weight also should be recorded. If measured, O_2 consumption (STPD), minute ventilation (BTPS), and CO_2 production (STPD) also should be reported. The altitude of the test site, its normal range of blood gas values, and the barometric pressure on the test date must be noted.

G. *Chronic cor pulmonale and pulmonary vascular disease.*

The establishment of an impairment attributable to irreversible cor pulmonale secondary to chronic pulmonary hypertension requires documentation by signs and laboratory findings of right ventricular overload or failure (e.g., an early diastolic right-sided gallop on auscultation, neck vein distension, hepatomegaly, peripheral edema, right ventricular outflow tract enlargement on x-ray or other appropriate imaging techniques, right ventricular hypertrophy on ECG, and increased pulmonary artery pressure measured by right heart catheterization available from treating sources). Cardiac catheterization will not be purchased. Because hypoxemia may accompany heart failure and is also a cause of pulmonary hypertension, and may be associated with hypoventilation and respiratory acidosis, arterial blood gases may demonstrate hypoxemia (decreased PO_2), CO_2 retention (increased PCO_2), and acidosis (decreased pH). Polycythemia with an elevated red blood cell count and hematocrit may be found in the presence of chronic hypoxemia.

P-pulmonale on the ECG does not establish chronic pulmonary hypertension or chronic cor pulmonale. Evidence of florid right heart failure need not be present at the time of adjudication for a listing (e.g., 3.09) to be satisfied, but the medical evidence of record should establish that cor pulmonale is chronic and irreversible.

H. *Sleep-related breathing disorders.*

Sleep-related breathing disorders (sleep apneas) are caused by periodic cessation of respiration associated with hypoxemia and frequent arousals from sleep. Although many individuals with one of these disorders will respond to prescribed treatment, in some, the disturbed sleep pattern and associated chronic nocturnal hypoxemia cause daytime sleepiness with chronic pulmonary hypertension and/or disturbances in cognitive function. Because daytime sleepiness can affect memory, orientation, and personality, a longitudinal treatment record may be needed to evaluate mental functioning. Not all individuals with sleep apnea develop a functional impairment that affects work activity. When any gainful work is precluded, the physiologic basis for the impairment may be chronic cor pulmonale. Chronic hypoxemia due to episodic apnea may cause pulmonary hypertension (see 3.00G and 3.09). Daytime somnolence may be associated with disturbance in cognitive vigilance. Impairment of cognitive function may be evaluated under organic mental disorders (12.02). If the disorder is associated with gross obesity, it should be evaluated under the applicable obesity listing.

3.01 Category of Impairments, Respiratory System.

3.02 *Chronic pulmonary insufficiency.*

A. Chronic obstructive pulmonary disease, due to any cause, with the FEV_1 equal to or less than the values specified in table I corresponding to the person's height without shoes. (In cases of marked spinal deformity, see 3.00E.);

TABLE I

Height without shoes (centimeters)	Height without shoes (inches)	FEV_1 equal to or less than (L, BTPS)
154 or less	60 or less	1.05
155–160	61–63	1.15
161–165	64–65	1.25
166–170	66–67	1.35
171–175	68–69	1.45
176–180	70–71	1.55
181 or more	72 or more	1.65

Or

B. Chronic restrictive ventilatory disease, due to any cause, with the FVC equal to or less than the values specified in Table II corresponding to the person's height without shoes. (In cases of marked spinal deformity, see 3.00E.);

TABLE II

Height without shoes (centimeters)	Height without shoes (inches)	FVC equal to or less than (L, BTPS)
154 or less	60 or less	1.25
155–160	61–63	1.35
161–165	64–65	1.45
166–170	66–67	1.55
171–175	68–69	1.65
176–180	70–71	1.75
181 or more	72 or more	1.85

Or

C. Chronic impairment of gas exchange due to clinically documented pulmonary disease. With:

1. Single breath DLCO (see 3.00F1) less than 10.5 ml/min/mm Hg or less than 40 percent of the predicted normal value. (Predicted values must either be based on data obtained at the test site or published values from a laboratory using the same technique as the test site. The source of the predicted values should be reported. If they are not published, they should be submitted in the form of a table or nomogram); or

2. Arterial blood gas values of PO_2 and simultaneously determined PCO_2 measured while at rest (breathing room air, awake and sitting or standing) in a clinically stable condition on at least two occasions, three or more weeks apart within a 6-month period, equal to or less than the values specified in the applicable table III–A or III–B or III–C:

TABLE III.—A

[Applicable at test sites less than 3,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

TABLE III.—B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56

TABLE III.—B—Continued

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
35	55
36	54
37	53
38	52
39	51
40 or above	50

TABLE III.—C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 or equal to or less than (mm. Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

Or

3. Arterial blood gas values of PO_2 and simultaneously determined PCO_2 during steady state exercise breathing room air (level of exercise equivalent to or less than 17.5 ml O_2 consumption/kg/min or 5 METs) equal to or less than the values specified in the applicable table III–A or III–B or III–C in 3.02C2.

3.03 Asthma. With:

A. Chronic asthmatic bronchitis. Evaluate under the criteria for chronic obstructive pulmonary disease in 3.02A;

Or

B. Attacks (as defined in 3.00C), in spite of prescribed treatment and requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each in-patient hospitalization for longer than 24 hours for control of asthma counts as two attacks, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of attacks.

3.04 Cystic fibrosis. With:

A. An FEV_1 equal to or less than the appropriate value specified in table IV corresponding to the individual's height without shoes. (In cases of marked spinal deformity, see 3.00E.);

Or

B. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure (documented according to 3.00C), requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for treatment counts as two episodes, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of episodes;

Or

C. Persistent pulmonary infection accompanied by superimposed, recurrent, symptomatic episodes of increased bacterial infection occurring at least once every 6 months and requiring intravenous or nebulization antimicrobial therapy.

TABLE IV

[Applicable only for evaluation under 3.04A—cystic fibrosis]

Height without shoes (centimeters)	Height without shoes (inches)	FEV_1 equal to or less than (L, BTPS)
154 or less	60 or less	1.45
155–159	61–62	1.55
160–164	63–64	1.65
165–169	65–66	1.75
170–174	67–68	1.85
175–179	69–70	1.95
180 or more	71 or more	2.05

3.05 [Reserved]

3.06 *Pneumoconiosis* (demonstrated by appropriate imaging techniques). Evaluate under the appropriate criteria in 3.02.

3.07 *Bronchiectasis* (demonstrated by appropriate imaging techniques). With:

A. Impairment of pulmonary function due to extensive disease. Evaluate under the appropriate criteria in 3.02;

Or

B. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure (documented according to 3.00C), requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for treatment counts as two episodes, and an evaluation of at least 12 consecutive months must be used to determine the frequency of episodes.

3.08 *Mycobacterial, mycotic, and other chronic persistent infections of the lung* (see 3.00B). Evaluate under the appropriate criteria in 3.02.

3.09 *Cor pulmonale secondary to chronic pulmonary vascular hypertension*. Clinical evidence of cor pulmonale (documented according to 3.00G) with:

A. Mean pulmonary artery pressure greater than 40 mm Hg;

Or

B. Arterial hypoxemia. Evaluate under the criteria in 3.02C2;

Or

C. Evaluate under the applicable criteria in 4.02.

3.10 *Sleep-related breathing disorders*. Evaluate under 3.09 (chronic cor pulmonale), 9.09 (obesity), or 12.02 (organic mental disorders).

4.00 Cardiovascular System

A. *Introduction*. The listings in this section describe impairments resulting from cardiovascular disease based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of therapy prescribed by a treating source. A longitudinal clinical record covering a period of not less than 3 months of observations and therapy is usually necessary for the assessment of severity and expected duration of cardiovascular impairment, unless the claim can be decided favorably on the basis of the current evidence. All relevant evidence must be considered in assessing disability.

Many individuals, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is evidence of such treatment, the longitudinal clinical record must include a description of the therapy prescribed by the treating source and response, in addition to information about the nature and severity of the impairment. It is important to document any prescribed therapy and response because this medical management may have improved the individual's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some individuals will not have received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment(s). Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the degree of recovery from cardiac insult, the level of the individual's functioning, and the frequency, severity, and duration of symptoms. Also, several listings include a requirement for continuing signs and symptoms despite a regimen of prescribed treatment. Even though an individual who does not receive treatment may not be able to show an impairment that meets the criteria of these listings, the individual may have an impairment(s) equivalent in severity to one

of the listed impairments or be disabled because of a limited residual functional capacity.

Indeed, it must be remembered that these listings are only examples of common cardiovascular disorders that are severe enough to prevent a person from engaging in gainful activity. Therefore, in any case in which an individual has a medically determinable impairment that is not listed, or a combination of impairments no one of which meets a listing, we will make a medical equivalence determination. Individuals who have an impairment(s) with a level of severity which does not meet or equal the criteria of the cardiovascular listings may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful activity. Evaluation of the impairment(s) of these individuals should proceed through the final steps of the sequential evaluation process (or, as appropriate, the steps in the medical improvement review standard).

B. *Cardiovascular impairment* results from one or more of four consequences of heart disease:

1. Chronic heart failure or ventricular dysfunction.

2. Discomfort or pain due to myocardial ischemia, with or without necrosis of heart muscle.

3. Syncope, or near syncope, due to inadequate cerebral perfusion from any cardiac cause such as obstruction of flow or disturbance in rhythm or conduction resulting in inadequate cardiac output.

4. Central cyanosis due to right-to-left shunt, arterial desaturation, or pulmonary vascular disease.

Impairment from diseases of arteries and veins may result from disorders of the vasculature in the central nervous system (11.04A, B), eyes (2.02–2.04), kidney (6.02), and other organs.

C. *Documentation*. Each individual's file must include sufficiently detailed reports on history, physical examinations, laboratory studies, and any prescribed therapy and response to allow an independent reviewer to assess the severity and duration of the cardiovascular impairment.

1. Electrocardiography

a. An original or legible copy of the 12-lead electrocardiogram (ECG) obtained at rest must be submitted, appropriately dated and labeled, with the standardization inscribed on the tracing. Alteration in standardization of specific leads (such as to accommodate large QRS amplitudes) must be identified on those leads.

(1) Detailed descriptions or computer-averaged signals without original or legible copies of the ECG as described in subsection 4.00Cla are not acceptable.

(2) The effects of drugs or electrolyte abnormalities must be considered as possible noncoronary causes of ECG abnormalities of ventricular repolarization, i.e., those involving the ST segment and T wave. If available, the predrug (especially digitalis glycoside) ECG should be submitted.

(3) The term ''ischemic'' is used in 4.04A to describe an abnormal ST segment deviation. Nonspecific repolarization abnormalities should not be confused with ''ischemic'' changes.

b. ECGs obtained in conjunction with treadmill, bicycle, or arm exercise tests should meet the following specifications:

(1) ECGs must include the original calibrated ECG tracings or a legible copy.

(2) A 12-lead baseline ECG must be recorded in the upright position before exercise.

(3) A 12-lead ECG should be recorded at the end of each minute of exercise, including at the time the ST segment abnormalities reach or exceed the criteria for abnormality described in 4.04A or the individual experiences chest discomfort or other abnormalities, and also when the exercise test is terminated.

(4) If ECG documentation of the effects of hyperventilation is obtained, the exercise test should be deferred for at least 10 minutes because metabolic changes of hyperventilation may alter the physiologic and ECG response to exercise.

(5) Post-exercise ECGs should be recorded using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice.

(6) All resting, exercise, and recovery ECG strips must have a standardization inscribed on the tracing. The ECG strips should be labeled to indicate the times recorded and the relationship to the stage of the exercise protocol. The speed and grade (treadmill test) or work rate (bicycle or arm ergometric test) should be recorded. The highest level of exercise achieved, blood pressure levels during testing, and the reason(s) for terminating the test (including limiting signs or symptoms) must be recorded.

2. Purchasing Exercise Tests

a. It is well recognized by medical experts that exercise testing is the best tool currently available for estimating maximal aerobic capacity in individuals with cardiovascular impairments. Purchase of an exercise test may be appropriate when there is a question whether an impairment meets or is equivalent in severity to one of the listings, or when there is insufficient evidence in the record to evaluate aerobic capacity, and the claim cannot otherwise be favorably decided. Before purchasing an exercise test, a program physician, preferably one with experience in the care of patients with cardiovascular disease, must review the pertinent

history, physical examinations, and laboratory tests to determine whether obtaining the test would present a significant risk to the individual (see 4.00C2c). Purchase may be indicated when there is no significant risk to exercise testing and there is no timely test of record. An exercise test is generally considered timely for 12 months after the date performed, provided there has been no change in clinical status that may alter the severity of the cardiac impairment.

b. *Methodology*.

(1) When an exercise test is purchased, it should be a ''sign-or symptom-limited'' test characterized by a progressive multistage regimen. A purchased exercise test must be performed using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice. A description of the protocol that was followed must be provided, and the test must meet the requirements of 4.00C1b and this section. A pre-exercise posthyperventilation tracing may be essential for the proper evaluation of an ''abnormal'' test in certain circumstances, such as in women with evidence of mitral valve prolapse.

(2) The exercise test should be paced to the capabilities of the individual and be supervised by a physician. With a treadmill test, the speed, grade (incline) and duration of exercise must be recorded for each exercise test stage performed. Other exercise test protocols or techniques that are used should utilize similar workloads.

(3) Levels of exercise should be described in terms of workload and duration of each stage, e.g., treadmill speed and grade, or bicycle ergometer work rate in kpm/min or watts.

(4) Normally, systolic blood pressure and heart rate increase gradually with exercise. A decrease in systolic blood pressure during exercise below the usual resting level is often associated with ischemia-induced left ventricular dysfunction resulting in decreased cardiac output. Some individuals (because of deconditioning or apprehension) with increased sympathetic responses may increase their systolic blood pressure and heart rate above their usual resting level just before and early into exercise. This occurrence may limit the ability to assess the significance of an early decrease in systolic blood pressure and heart rate if exercise is discontinued shortly after initiation. In addition, isolated systolic hypertension may be a manifestation of arteriosclerosis.

(5) The exercise laboratory's physical environment, staffing, and equipment should meet the generally accepted standards for adult exercise test laboratories.

c. *Risk factors in exercise testing.* The following are examples of situations in which exercise testing will not be purchased: unstable progressive angina pectoris, a history of acute myocardial infarction within the past 3 months, New York Heart Association (NYHA) class IV heart failure, cardiac drug toxicity, uncontrolled serious arrhythmia (including uncontrolled atrial fibrillation, Mobitz II, and third-degree block), Wolff-Parkinson-White syndrome, uncontrolled severe systemic arterial hypertension, marked pulmonary hypertension, unrepaired aortic dissection, left main stenosis of 50 percent or greater, marked aortic stenosis, chronic or dissecting aortic aneurysm, recent pulmonary embolism, hypertrophic cardiomyopathy, limiting neurological or musculoskeletal impairments, or an acute illness. In addition, an exercise test should not be purchased for individuals for whom the performance of the test is considered to constitute a significant risk by a program physician, preferably one experienced in the care of patients with cardiovascular disease, even in the absence of any of the above risk factors. In defining risk, the program physician, in accordance with the regulations and other instructions on consultative examinations, will generally give great weight to the treating physicians' opinions and will generally not override them. In the rare situation in which the program physician does override the treating source's opinion, a written rationale must be prepared documenting the reasons for overriding the opinion.

d. In order to permit maximal, attainable restoration of functional capacity, exercise testing should not be purchased until 3 months after an acute myocardial infarction, surgical myocardial revascularization, or other open-heart surgical procedures. Purchase of an exercise test should also be deferred for 3 months after percutaneous transluminal coronary angioplasty because restenosis with ischemic symptoms may occur within a few months of angioplasty (see 4.00D). Also, individuals who have had a period of bedrest or inactivity (e.g., 2 weeks) that results in a reversible deconditioned state may do poorly if exercise testing is performed at that time.

e. *Evaluation*.

(1) Exercise testing is evaluated on the basis of the work level at which the test becomes abnormal, as documented by onset of signs or symptoms and any ECG abnormalities listed in 4.04A. The ability or inability to complete an exercise test is not, by itself, evidence that a person is free from ischemic heart disease. The results of an exercise test must be considered in the context of all of the other evidence in the individual's case record. If the individual is under the care of a treating physician for a cardiac impairment, and this physician has not performed an exercise test and there are no reported significant risks to testing (see 4.00C2c), a statement should be requested from the treating physician explaining why it was not done or should not be done before deciding

whether an exercise test should be purchased. In those rare situations in which the treating source's opinion is overridden, follow 4.00C2c. If there is no treating physician, the program physician will be responsible for assessing the risk to exercise testing.

(2) Limitations to exercise test interpretation include the presence of noncoronary or nonischemic factors that may influence the hemodynamic and ECG response to exercise, such as hypokalemia or other electrolyte abnormality, hyperventilation, vasoregulatory deconditioning, prolonged periods of physical inactivity (e.g., 2 weeks of bedrest), significant anemia, left bundle branch block pattern on the ECG (and other conduction abnormalities that do not preclude the purchase of exercise testing), and other heart diseases or abnormalities (particularly valvular heart disease). Digitalis glycosides may cause ST segment abnormalities at rest, during, and after exercise. Digitalis or other drug-related ST segment displacement, present at rest, may become accentuated with exercise and make ECG interpretation difficult, but such drugs do not invalidate an otherwise normal exercise test. Diuretic-induced hypokalemia and left ventricular hypertrophy may also be associated with repolarization changes and behave similarly. Finally, treatment with beta blockers slows the heart rate more at near-maximal exertion than at rest; this limits apparent chronotropic capacity.

3. Other Studies

Information from two-dimensional and Doppler echocardiographic studies of ventricular size and function as well as radionuclide (thallium $_{201}$) myocardial ''perfusion'' or radionuclide (technetium 99m) ventriculograms (RVG or MUGA) may be useful. These techniques can provide a reliable estimate of ejection fraction. In selected cases, these tests may be purchased after a medical history and physical examination, report of chest x-rays, ECGs, and other appropriate tests have been evaluated, preferably by a program physician with experience in the care of patients with cardiovascular disease. Purchase should be considered when other information available is not adequate to assess whether the individual may have severe ventricular dysfunction or myocardial ischemia and there is no significant risk involved (follow 4.00C2a guides), and the claim cannot be favorably decided on any other basis.

Exercise testing with measurement of maximal oxygen uptake (VO_2) provides an accurate determination of aerobic capacity. An exercise test without measurement of oxygen uptake provides an estimate of aerobic capacity. When the results of tests with measurement of oxygen uptake are available, every reasonable effort should be made to obtain them.

The recording of properly calibrated ambulatory ECGs for analysis of ST segment signals with a concomitantly recorded symptom and treatment log may permit more adequate evaluation of chest discomfort during activities of daily living, but the significance of these data for disability evaluation has not been established in the absence of symptoms (e.g., silent ischemia). This information (including selected segments of both the ECG recording and summary report of the patient diary) may be submitted for the record.

4. *Cardiac catheterization* will not be purchased by the Social Security Administration.

a. *Coronary arteriography*. If results of such testing are available, the report should be obtained and considered as to the quality and type of data provided and its relevance to the evaluation of the impairment. A copy of the report of the cardiac catheterization and ancillary studies should also be obtained. The report should provide information citing the method of assessing coronary arterial lumen diameter and the nature and location of obstructive lesions. Drug treatment at baseline and during the procedure should be reported. Coronary artery spasm induced by intracoronary catheterization is not to be considered evidence of ischemic disease. Some individuals with significant coronary atherosclerotic obstruction have collateral vessels that supply the myocardium distal to the arterial obstruction so that there is no evidence of myocardial damage or ischemia, even with exercise. When available, quantitative computer measurements and analyses should be considered in the interpretation of severity of stenotic lesions.

b. *Left ventriculography (by angiography)*. The report should describe the wall motion of the myocardium with regard to any areas of hypokinesis, akinesis, or dyskinesis, and the overall contraction of the ventricle as measured by the ejection fraction. Measurement of chamber volumes and pressures may be useful. When available, quantitative computer analysis provides precise measurement of segmental left ventricular wall thickness and motion. There is often a poor correlation between left ventricular function at rest and functional capacity for physical activity.

D. *Treatment and relationship to functional status.*

1. In general, conclusions about the severity of a cardiovascular impairment cannot be made on the basis of type of treatment rendered or anticipated. The overall clinical and laboratory evidence, including the treatment plan(s) or results, should be persuasive that a listing-level impairment exists. The amount of function restored and the time required for improvement after treatment

(medical, surgical, or a prescribed program of progressive physical activity) vary with the nature and extent of the disorder, the type of treatment, and other factors. Depending upon the timing of this treatment in relation to the alleged onset date of disability, impairment evaluation may need to be deferred for a period of up to 3 months from the date of treatment to permit consideration of treatment effects. Evaluation should not be deferred if the claim can be favorably decided based upon the available evidence.

2. The usual time after myocardial infarction, valvular and/or revascularization surgery for adequate assessment of the results of treatment is considered to be 3 months. If an exercise test is performed by a treating source within a week or two after angioplasty, and there is no significant change in clinical status during the 3-month period after the angioplasty that would invalidate the implications of the exercise test results, the exercise test results may be used to reflect functional capacity during the period in question. However, if the test was done immediately following an acute myocardial infarction or during a period of protracted inactivity, the results should not be projected to 3 months even if there is no change in clinical status.

3. An individual who has undergone cardiac transplantation will be considered under a disability for 1 year following the surgery because, during the first year, there is a greater likelihood of rejection of the organ and recurrent infection. After the first year posttransplantation, continuing disability evaluation will be based upon residual impairment as shown by symptoms, signs, and laboratory findings. Absence of symptoms, signs, and laboratory findings indicative of cardiac dysfunction will be included in the consideration of whether medical improvement (as defined in §§404.1579(b)(1) and (c)(1), 404.1594(b)(1) and (c)(1), or 416.994(b)(1)(i) and (b)(2)(i), as appropriate) has occurred.

E. *Clinical syndromes.*

1. Chronic heart failure (ventricular dysfunction) is considered in these listings as one category whatever its etiology, i.e., atherosclerotic, hypertensive, rheumatic, pulmonary, congenital or other organic heart disease. Chronic heart failure may manifest itself by:

a. Pulmonary or systemic congestion, or both; or

b. Symptoms of limited cardiac output, such as weakness, fatigue, or intolerance of physical activity.

For the purpose of 4.02A, pulmonary and systemic congestion are not considered to have been established unless there is or has been evidence of fluid retention, such as hepatomegaly or ascites, or peripheral or pulmonary edema of cardiac origin. The findings of fluid retention need not be present at the time of adjudication because congestion may be controlled with medication. Chronic heart failure due to limited cardiac output is not considered to have been established for the purpose of 4.02B unless symptoms occur with ordinary daily activities, i.e., activity restriction as manifested by a need to decrease activity or pace, or to rest intermittently, and are associated with one or more physical signs or abnormal laboratory studies listed in 4.02B. These studies include exercise testing with ECG and blood pressure recording and/or appropriate imaging techniques, such as two-dimensional echocardiography or radionuclide or contrast ventriculography. The exercise criteria are outlined in 4.02B1. In addition, other abnormal symptoms, signs, or laboratory test results that lend credence to the impression of ventricular dysfunction should be considered.

2. For the purposes of 4.03, hypertensive cardiovascular disease is evaluated by reference to the specific organ system involved (heart, brain, kidneys, or eyes). The presence of organic impairment must be established by appropriate physical signs and laboratory test abnormalities as specified in 4.02 or 4.04, or for the body system involved.

3. Ischemic (coronary) heart disease may result in an impairment due to myocardial ischemia and/or ventricular dysfunction or infarction. For the purposes of 4.04, the clinical determination that discomfort of myocardial ischemic origin (angina pectoris) is present must be supported by objective evidence as described under 4.00Cl, 2, 3, or 4.

a. Discomfort of myocardial ischemic origin (angina pectoris) is discomfort that is precipitated by effort and/or emotion and promptly relieved by sublingual nitroglycerin, other rapidly acting nitrates, or rest. Typically the discomfort is located in the chest (usually substernal) and described as crushing, squeezing, burning, aching, or oppressive. Sharp, sticking, or cramping discomfort is considered less common or atypical. Discomfort occurring with activity or emotion should be described specifically as to timing and usual inciting factors (type and intensity), character, location, radiation, duration, and response to nitrate therapy or rest.

b. So-called anginal equivalent may be localized to the neck, jaw(s), or hand(s) and has the same precipitating and relieving factors as typical chest discomfort. Isolated shortness of breath (dyspnea) is not considered an anginal equivalent for purposes of adjudication.

c. Variant angina of the Prinzmetal type, i.e., rest angina with transitory ST segment elevation on ECG, may have the same significance as typical angina, described in 4.00E3a.

d. If there is documented evidence of silent ischemia or restricted activity to prevent chest discomfort, this information must be

considered along with all available evidence to determine if an equivalence decision is appropriate.

e. Chest discomfort of myocardial ischemic origin is usually caused by coronary artery disease. However, ischemic discomfort may be caused by noncoronary artery conditions, such as critical aortic stenosis, hypertrophic cardiomyopathy, pulmonary hypertension, or anemia. These conditions should be distinguished from coronary artery disease, because the evaluation criteria, management, and prognosis (duration) may differ from that of coronary artery disease.

f. Chest discomfort of nonischemic origin may result from other cardiac conditions such as pericarditis and mitral valve prolapse. Noncardiac conditions may also produce symptoms mimicking that of myocardial ischemia. These conditions include gastrointestinal tract disorders, such as esophageal spasm, esophagitis, hiatal hernia, biliary tract disease, gastritis, peptic ulcer, and pancreatitis, and musculoskeletal syndromes, such as chest wall muscle spasm, chest wall syndrome (especially after coronary bypass surgery), costochondritis, and cervical or dorsal arthritis. Hyperventilation may also mimic ischemic discomfort. Such disorders should be considered before concluding that chest discomfort is of myocardial ischemic origin.

4. Peripheral Arterial Disease

The level of impairment is based on the symptomatology, physical findings, Doppler studies before and after a standard exercise test, or angiographic findings.

The requirements for evaluating peripheral arterial disease in 4.12B are based on the ratio of the systolic blood pressure at the ankle to the systolic blood pressure at the brachial artery, determined in the supine position at the same time. Techniques for obtaining ankle systolic blood pressures include Doppler, plethysmographic studies, or other techniques.

Listing 4.12B1 is met when the resting ankle/brachial systolic blood pressure ratio is less than 0.50. Listing 4.12B2 provides additional criteria for evaluating peripheral arterial impairment on the basis of exercise studies when the resting ankle/brachial systolic blood pressure ratio is 0.50 or above. The decision to obtain exercise studies should be based on an evaluation of the existing clinical evidence, but exercise studies are rarely warranted when the resting ankle-over-brachial systolic blood pressure ratio is 0.80 or above. The results of exercise studies should describe the level of exercise, e.g., speed and grade of the treadmill settings, the duration of exercise, symptoms during exercise, the reasons for stopping exercise if the expected level of exercise was not attained, blood pressures at the ankle and other pertinent sites measured after exercise, and the time required to return the systolic blood pressure toward or to the pre-exercise level. When an exercise Doppler study is purchased by the Social Security Administration, the requested exercise must be on a treadmill at 2 mph on a 10 or 12 percent grade for 5 minutes. Exercise studies should not be performed on individuals for whom exercise poses a significant risk.

Application of the criteria in 4.12B may be limited in individuals who have marked calcific (Monckeberg's) sclerosis of the peripheral arteries or marked small vessel disease associated with diabetes mellitus.

4.01 Category of Impairments, Cardiovascular System

4.02 *Chronic heart failure* while on a regimen of prescribed treatment (see 4.00A if there is no regimen of prescribed treatment). With one of the following:

A. Documented cardiac enlargement by appropriate imaging techniques (e.g., a cardiothoracic ratio of greater than 0.50 on a PA chest x-ray with good inspiratory effort or left ventricular diastolic diameter of greater than 5.5 cm on two-dimensional echocardiography), resulting in inability to carry on any physical activity, and with symptoms of inadequate cardiac output, pulmonary congestion, systemic congestion, or anginal syndrome at rest (e.g., recurrent or persistent fatigue, dyspnea, orthopnea, anginal discomfort);

OR

B. Documented cardiac enlargement by appropriate imaging techniques (see 4.02A) or ventricular dysfunction manifested by S3, abnormal wall motion, or left ventricular ejection fraction of 30 percent or less by appropriate imaging techniques; and

1. Inability to perform on an exercise test at a workload equivalent to 5 METs or less due to symptoms of chronic heart failure, or, in rare instances, a need to stop exercise testing at less than this level of work because of:

a. Three or more consecutive ventricular premature beats or three or more multiform beats; or

b. Failure to increase systolic blood pressure by 10 mmHg, or decrease in systolic pressure below the usual resting level (see 4.00C2b); or

c. Signs attributable to inadequate cerebral perfusion, such as ataxic gait or mental confusion; and

2. Resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest;

OR

C. Cor pulmonale fulfilling the criteria in 4.02A or B.

4.03 *Hypertensive cardiovascular disease.* Evaluate under 4.02 or 4.04, or under the criteria for the affected body system (2.02 through 2.04, 6.02, or 11.04A or B).

4.04 *Ischemic heart disease,* with chest discomfort associated with myocardial ischemia, as described in 4.00E3, while on a regimen of prescribed treatment (see 4.00A if there is no regimen of prescribed treatment). With one of the following:

A. Sign- or symptom-limited exercise test demonstrating at least one of the following manifestations at a workload equivalent to 5 METs or less:

1. Horizontal or downsloping depression, in the absence of digitalis glycoside therapy and/or hypokalemia, of the ST segment of at least −0.10 millivolts (−1.0 mm) in at least 3 consecutive complexes that are on a level baseline in any lead (other than aVR) and that have a typical ischemic time course of development and resolution (progression of horizontal or downsloping ST depression with exercise, and persistence of depression of at least −0.10 millivolts for at least 1 minute of recovery); or

2. An upsloping ST junction depression, in the absence of digitalis glycoside therapy and/or hypokalemia, in any lead (except aVR) of at least −0.2 millivolts or more for at least 0.08 seconds after the J junction and persisting for at least 1 minute of recovery; or

3. At least 0.1 millivolt (1 mm) ST elevation above resting baseline during both exercise and 3 or more minutes of recovery in ECG leads with low R and T waves in the leads demonstrating the ST segment displacement; or

4. Failure to increase systolic pressure by 10 mmHg, or decrease in systolic pressure below usual clinical resting level (see 4.00C2b); or

5. Documented reversible radionuclide ''perfusion'' (thallium^{201}) defect at an exercise level equivalent to 5 METs or less;

OR

B. Impaired myocardial function, documented by evidence (as outlined under 4.00C3 or 4.00C4b) of hypokinetic, akinetic, or dyskinetic myocardial free wall or septal wall motion with left ventricular ejection fraction of 30 percent or less, and an evaluating program physician, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise testing would present a significant risk to the individual, and resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest;

OR

C. Coronary artery disease, demonstrated by angiography (obtained independent of Social Security disability evaluation), and an evaluating program physician, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise testing would present a significant risk to the individual, with both 1 and 2:

1. Angiographic evidence revealing:

a. 50 percent or more narrowing of a nonbypassed left main coronary artery; or

b. 70 percent or more narrowing of another nonbypassed coronary artery; or

c. 50 percent or more narrowing involving a long (greater than 1 cm) segment of a nonbypassed coronary artery; or

d. 50 percent or more narrowing of at least 2 nonbypassed coronary arteries; or

e. Total obstruction of a bypass graft vessel; and

2. Resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest.

4.05 *Recurrent arrhythmias,* not related to reversible causes such as electrolyte abnormalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled repeated episodes of cardiac syncope or near syncope and arrhythmia despite prescribed treatment (see 4.00A if there is no prescribed treatment), documented by resting or ambulatory (Holter) electrocardiography coincident with the occurrence of syncope or near syncope.

4.06 *Symptomatic congenital heart disease* (cyanotic or acyanotic), documented by appropriate imaging techniques (as outlined under 4.00C3) or cardiac catheterization. With one of the following:

A. Cyanosis at rest, and:

1. Hematocrit of 55 percent or greater, or

2. Arterial O_2 saturation of less than 90 percent in room air, or resting arterial PO_2 of 60 Torr or less;

OR

B. Intermittent right-to-left shunting resulting in cyanosis on exertion (e.g., Eisenmenger's physiology) and with arterial PO_2 of 60 Torr or less at a workload equivalent to 5 METs or less;

OR

C. Chronic heart failure with evidence of ventricular dysfunction, as described in 4.02;

OR

D. Recurrent arrhythmias as described in 4.05;

OR

E. Secondary pulmonary vascular obstructive disease with a mean pulmonary arterial pressure elevated to at least 70 percent of the mean systemic arterial pressure.

4.07 *Valvular heart disease or other stenotic defects, or valvular regurgitation,* documented by appropriate imaging techniques or cardiac catheterization. Evaluate under the criteria in 4.02, 4.04, 4.05, or 11.04.

4.08 *Cardiomyopathies*, documented by appropriate imaging techniques or cardiac catheterization. Evaluate under the criteria in 4.02, 4.04, 4.05, or 11.04.

4.09 *Cardiac transplantation*. Consider under a disability for 1 year following surgery; thereafter, reevaluate residual impairment under 4.02 to 4.08.

4.10 *Aneurysm of aorta or major branches*, due to any cause (e.g., atherosclerosis, cystic medial necrosis, Marfan syndrome, trauma), demonstrated by an appropriate imaging technique. With one of the following:

A. Acute or chronic dissection not controlled by prescribed medical or surgical treatment;

OR

B. Chronic heart failure as described under 4.02;

OR

C. Renal failure as described under 6.02;

OR

D. Neurological complications as described under 11.04.

4.11 *Chronic venous insufficiency* of a lower extremity. With incompetency or obstruction of the deep venous system and one of the following:

A. Extensive brawny edema;

OR

B. Superficial varicosities, stasis dermatitis, and recurrent or persistent ulceration which has not healed following at least 3 months of prescribed medical or surgical therapy.

4.12 *Peripheral arterial disease*. With one of the following:

A. Intermittent claudication with failure to visualize (on arteriogram obtained independent of Social Security disability evaluation) the common femoral or deep femoral artery in one extremity;

OR

B. Intermittent claudication with marked impairment of peripheral arterial circulation as determined by Doppler studies showing:

1. Resting ankle/brachial systolic blood pressure ratio of less than 0.50; or

2. Decrease in systolic blood pressure at the ankle on exercise (see 4.00E4) of 50 percent or more of pre-exercise level at the ankle, and requiring 10 minutes or more to return to pre-exercise level;

OR

C. Amputation at or above the tarsal region due to peripheral vascular disease.

5.00 Digestive System

A. *Disorders of the digestive system* which result in a marked impairment usually do so because of interference with nutrition, multiple recurrent inflammatory lesions, or complications of disease, such as fistulae, abscesses, or recurrent obstruction. Such complications usually respond to treatment. These complications must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months.

B. *Malnutrition or weight loss from gastrointestinal disorders*. When the primary disorder of the digestive tract has been established (e.g. enterocolitis, chronic pancreatitis, postgastrointestinal resection, or esophageal stricture, stenosis, or obstruction), the resultant interference with nutrition will be considered under the criteria in 5.08. This will apply whether the weight loss is due to primary or secondary disorders of malabsorption, malassimilation or obstruction. However, weight loss not due to diseases of the digestive tract, but associated with psychiatric or primary endocrine or other disorders, should be evaluated under the appropriate criteria for the underlying disorder.

C. *Surgical diversion of the intestinal tract*, including colostomy or ileostomy, are not listed since they do not represent impairments which preclude all work activity if the individual is able to maintain adequate nutrition and function of the stoma. Dumping syndrome which may follow gastric resection rarely represents a marked impairment which would continue for 12 months. Peptic ulcer disease with recurrent ulceration after definitive surgery ordinarily responds to treatment. A recurrent ulcer after definitive surgery must be demonstrated on repeated upper gastrointestinal roentgenograms or gastroscopic examinations despite therapy to be considered a severe impairment which will last for at least 12 months. Definitive surgical procedures are those designed to control the ulcer disease process (i.e., vagotomy and pyloroplasty, subtotal gastrectomy, etc.). Simple closure of a perforated ulcer does not constitute definitive surgical therapy for peptic ulcer disease.

5.01 Category of Impairments, Digestive System

5.02 *Recurrent upper gastrointestinal hemorrhage from undetermined cause* with anemia manifested by hematocrit of 30 percent or less on repeated examinations.

5.03 *Stricture, stenosis, or obstruction of the esophagus (demonstrated by X-ray or endoscopy)* with weight loss as described under §5.08.

5.04 *Peptic ulcer disease (demonstrated by X-ray or endoscopy)*. With:

A. Recurrent ulceration after definitive surgery persistent despite therapy; or

B. Inoperable fistula formation; or

C. Recurrent obstruction demonstrated by X-ray or endoscopy. or

D. Weight loss as described under §5.08.

5.05 *Chronic liver disease (e.g., portal, postnecrotic, or biliary cirrhosis; chronic active hepatitis; Wilson's disease)*. With:

A. Esophageal varices (demonstrated by X-ray or endoscopy) with a documented history of massive hemorrhage attributable to these

varices. Consider under a disability for 3 years following the last massive hemorrhage; thereafter, evaluate the residual impairment; or

B. Performance of a shunt operation for esophageal varices. Consider under a disability for 3 years following surgery; thereafter, evaluate the residual impairment; or

C. Serum bilirubin of 2.5 mg. per deciliter (100 ml.) or greater persisting on repeated examinations for at least 5 months; or

D. Ascites, not attributable to other causes, recurrent or persisting for at least 5 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

E. Hepatic encephalopathy. Evaluate under the criteria in listing 12.02; or

F. Confirmation of chronic liver disease by liver biopsy (obtained independent of Social Security disability evaluation) and one of the following:

1. Ascites not attributable to other causes, recurrent or persisting for at least 3 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

2. Serum bilirubin of 2.5 mg. per deciliter (100 ml) or greater on repeated examinations for at least 3 months; or

3. Hepatic cell necrosis or inflammation, persisting for at least 3 months, documented by repeated abnormalities of prothrombin time and enzymes indicative of hepatic dysfunction.

5.06 *Chronic ulcerative or granulomatous colitis (demonstrated by endoscopy, barium enema, biopsy, or operative findings).* With:

A. Recurrent bloody stools documented on repeated examinations and anemia manifested by hematocrit of 30 percent or less on repeated examinations; or

B. Persistent or recurrent systemic manifestations, such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess, fistula formation, or stenosis; or

D. Recurrence of findings of A, B, or C above after total colectomy; or

E. Weight loss as described under §5.08.

5.07 *Regional enteritis (demonstrated by operative findings, barium studies, biopsy, or endoscopy).* With:

A. Persistent or recurrent intestinal obstruction evidenced by abdominal pain, distention, nausea, and vomiting and accompanied by stenotic areas of small bowel with proximal intestinal dilation; or

B. Persistent or recurrent systemic manifestations such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess or fistula formation; or

D. Weight loss as described under §5.08.

5.08 *Weight loss due to any persisting gastrointestinal disorder:* (The following weights are to be demonstrated to have persisted for at least 3 months despite prescribed therapy and expected to persist at this level for at least 12 months.) With:

A. Weight equal to or less than the values specified in Table I or II; or

B. Weight equal to or less than the values specified in Table III or IV and one of the following abnormal findings on repeated examinations:

1. Serum albumin of 3.0 gm. per deciliter (100 ml.) or less; or

2. Hematocrit of 30 percent or less; or

3. Serum calcium of 8.0 mg. per deciliter (100 ml.) (4.0 mEq./L) or less; or

4. Uncontrolled diabetes mellitus due to pancreatic dysfunction with repeated hyperglycemia, hypoglycemia, or ketosis; or

5. Fat in stool of 7 gm. or greater per 24-hour stool specimen; or

6. Nitrogen in stool of 3 gm, or greater per 24-hour specimen; or

7. Persistent or recurrent ascites or edema not attributable to other causes.

Tables of weight reflecting malnutrition scaled according to height and sex—To be used only in connection with 5.08.

TABLE I—MEN

Height (inches) [1]	Weight (pounds)
61	90
62	92
63	94
64	97
65	99
66	102
67	106
68	109
69	112
70	115
71	118
72	122
73	125
74	128
75	131
76	134

[1] Height measured without shoes.

TABLE II—WOMEN

Height (inches) [1]	Weight (pounds)
58	77
59	79
60	82
61	84
62	86
63	89
64	91
65	94
66	98
67	101
68	104
69	107

TABLE II—WOMEN—Continued

Height (inches) [1]	Weight (pounds)
70	110
71	114
72	117
73	120

[1] Height measured without shoes.

TABLE III—MEN

Height (inches) [1]	Weight (pounds)
61	95
62	98
63	100
64	103
65	106
66	109
67	112
68	116
69	119
70	122
71	126
72	129
73	133
74	136
75	139
76	143

[1] Height measured without shoes.

TABLE IV—WOMEN

Height (inches) [1]	Weight (pounds)
58	82
59	84
60	87
61	89
62	92
63	94
64	97
65	100
66	104
67	107
68	111
69	114
70	117
71	121
72	124
73	128

[1] Height measured without shoes.

6.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease will be based upon* (1) a history, physical examination, and laboratory evidence of renal disease, and (2) indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Nephrotic Syndrome.* The medical evidence establishing the clinical diagnosis must include the description of extent of tissue edema, including pretibial, periorbital, or presacral edema. The presence of ascites, pleural effusion, pericardial effusion, and hydroarthrosis should be described if present. Results of pertinent laboratory tests must be provided. If a renal biopsy has been performed, the evidence should include a copy of the report of microscopic examination of the specimen. Complications such as severe orthostatic hypotension, recurrent infections or venous thromboses should be evaluated on the basis of resultant impairment.

C. *Hemodialysis, peritioneal dialysis, and kidney transplantation.* When an individual is undergoing periodic dialysis because of chronic renal disease, severity of impairment is reflected by the renal function prior to the institution of dialysis.

The amount of function restored and the time required to effect improvement in an individual treated by renal transplant depend upon various factors, including adequacy of post transplant renal function, incidence and severity of renal infection, occurrence of rejection crisis, the presence of systemic complications (anemia, neunropathy, etc.) and side effects of corticosteroids or immuno-suppressive agents. A convalesent period of at least 12 months is required before it can be reasonably determined whether the individual has reached a point of stable medical improvement.

D. *Evaluate associated disorders and complications* according to the appropriate body system Listing.

6.01 Category of Impairments, Genito-Urinary System

6.02 Impairment of renal function, due to any chronic renal disease expected to last 12 months (e.g., hypertensive vascular disease, chronic nephritis, nephrolithiasis, polycystic disease, bilateral hydronephrosis, etc.) With:

A. Chronic hemodialysis or peritoneal dialysis necessitated by irreversible renal failure; or

B. Kidney transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 6.00C); or

C. Persistent elevation of serum creatine in to 4 mg. per deciliter (100 ml.) or greater or reduction of creatinine clearance to 20 ml. per minute (29 liters/24 hours) or less, over at least 3 months, with one of the following:

1. Renal osteodystrophy manifested by severe bone pain and appropriate radiographic abnormalities (e.g., osteitis fibrosa, marked osteoporosis, pathologic fractures); or

2. A clinical episode of pericarditis; or

3. Persistent motor or sensory neuropathy; or

4. Intractable pruritus; or

5. Persistent fluid overload syndrome resulting in diastolic hypertension (110 mm. or above) or signs of vascular congestion; or

6. Persistent anorexia with recent weight loss and current weight meeting the values in 5.08, Table III or IV; or

7. Persistent hematocrits of 30 percent or less.

6.06 *Nephrotic syndrome, with significant anasarca, persistent for at least 3 months despite prescribed therapy*. With:

A. Serum albumin of 3.0 gm. per deciler (100 ml.) or less *and* protenuria of 3.5 gm. per 24 hours or greater; or

B. Proteinuria of 10.0 gm. per 24 hours or greater.

7.00 HEMIC AND LYMPHATIC SYSTEM

A. *Impairment caused by anemia* should be evaluated according to the ability of the individual to adjust to the reduced oxygen carrying capacity of the blood. A gradual reduction in red cell mass, even to very low values, is often well tolerated in individuals with a healthy cardiovascular system.

B. *Chronicity is indicated by* persistence of the condition for at least 3 months. The laboratory findings cited must reflect the values reported on more than one examination over that 3-month period.

C. *Sickle cell disease* refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis, must be included. Vasoocclusive or aplastic episodes should be documented by description of severity, frequency, and duration.

Major visceral episodes include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genito-urinary involvement, etc.

D. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence. Prophylactic therapy such as with antihemophilic globulin (AHG) concentrate does not in itself imply severity.

E. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The acute phase of chronic myelocytic (granulocytic) leukemia should be considered under the requirements for acute leukemia.

The criteria in 7.11 contain the designated duration of disability implicit in the finding of a listed impairment. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a marked impairment. The level of any remaining impairment must be evaluated on the basis of the medical evidence.

7.01 Category of Impairments, Hemic and Lymphatic System

7.02 *Chronic anemia (hematocrit persisting at 30 percent or less due to any cause).* With:

A. Requirement of one or more blood transfusions on an average of at least once every 2 months; or

B. Evaluation of the resulting impairment under criteria for the affected body system.

7.05 *Sickle cell disease, or one of its variants.* With:

A. Documented painful (thrombotic) crises occurring at least three times during the 5 months prior to adjudication; or

B. Requiring extended hospitalization (beyond emergency care) at least three times during the 12 months prior to adjudication; or

C. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

D. Evaluate the resulting impairment under the criteria for the affected body system.

7.06 *Chronic thrombocytopenia (due to any cause)* with platelet counts repeatedly below 40,000/cubic millimeter. With:

A. At least one spontaneous hemorrhage, requiring transfusion, within 5 months prior to adjudication; or

B. Intracranial bleeding within 12 months prior to adjudication.

7.07 *Hereditary telangiectasia* with hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.08 *Coagulation defects (hemophilia or a similar disorder)* with spontaneous hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.09 *Polycythemia vera (with erythrocytosis, splenomegaly, and leukocytosis or thrombocytosis).* Evaluate the resulting impairment under the criteria for the affected body system.

7.10 *Myelofibrosis (myeloproliferative syndrome).* With:

A. Chronic anemia. Evaluate according to the criteria of §7.02; or

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication; or

C. Intractable bone pain with radiologic evidence of osteosclerosis.

7.11 *Acute leukemia.* Consider under a disability for 2½ years from the time of initial diagnosis.

7.12 *Chronic leukemia.* Evaluate according to the criteria of 7.02, 7.06, 7.10B, 7.11, 7.17, or 13.06A.

7.13 *Lymphomas.* Evaluate under the criteria in 13.06A.

7.14 *Macroglobulinemia or heavy chain disease,* confirmed by serum or urine protein electrophoresis or immunoelectrophoresias. Evaluate impairment under criteria for affected body system or under 7.02, 7.06, or 7.08.

7.15 *Chronic granulocytopenia (due to any cause).* With both A and B:

A. Absolute neutrophil counts repeatedly below 1,000 cells/cubic millimeter; and

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication.

7.16 *Myeloma (confirmed by appropriate serum or urine protein electrophoresis and bone marrow findings).* With:

A. Radiologic evidence of bony involvement with intractable bone pain; or

B. Evidence of renal impairment as described in 6.02; or

C. Hypercalcemia with serum calcium levels persistently greater than 11 mg. per deciliter (100 ml.) for at least 1 month despite prescribed therapy; or

D. Plasma cells (100 or more cells/cubic millimeter) in the peripheral blood.

7.17 *Aplastic anemias or hematologic malignancies (excluding acute leukemia):* With bone marrow transplantation. Consider under a disability for 12 months following transplantation; thereafter, evaluate according to the primary characteristics of the residual impairment.

8.00 SKIN

A. *Skin lesions* may result in a marked, long-lasting impairment if they involve extensive body areas or critical areas such as the hands or feet and become resistant to treatment. These lesions must be shown to have persisted for a sufficient period of time despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months. The treatment for some of the skin diseases listed in this section may require the use of high dosage of drugs with possible serious side effects; these side effects should be considered in the overall evaluation of impairment.

B. *When skin lesions are associated with systemic disease* and where that is the predominant problems, evaluation should occur according to the criteria in the appropriate section. Disseminated (systemic) lupus erythematosus and scleroderma usually involve more than one body system and should be evaluated under 14.02 and 14.04. Neoplastic skin lesions should be evaluated under 13.00ff. When skin lesions (including burns) are associated with contractures or limitation of joint motion, that impairment should be evaluated under 1.00ff.

8.01 Category of Impairments, Skin

8.02 *Exfoliative dermatitis, ichthyosis, ichthyosiform erythroderma.* With extensive lesions not responding to prescribed treatment.

8.03 *Pemphigus, erythema multiforme bullosum, bullous pemphigoid, dermatitis herpetiformis.* With extensive lesions not responding to prescribed treatment.

8.04 *Deep mycotic infections. With extensive fungating, ulcerating lesions not responding to prescribed treatment.*

8.05 *Psoriasis, atopic dermatitis, dyshidrosis.* With extensive lesions, including involvement of the hands or feet which impose a marked limitation of function and which are not responding to prescribed treatment.

8.06 *Hydradenitis suppurative, acne conglobata.* With extensive lesions involving the axillae or perineum not responding to prescribed medical treatment and not amendable to surgical treatment.

9.00 ENDOCRINE SYSTEM AND OBESITY

Cause of impairment. Impairment is caused by overproduction or underproduction of hormones, resulting in structural or functional changes in the body. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

Long-term massive obesity will usually be associated with disorders of the musculoskeletal, cardiovascular, peripheral vascular, and pulmonary systems, and the occurrence of these disorders is the major cause of disability at the listing level. Extreme obesity results in restrictions imposed by body weight and the additional restrictions imposed by disturbances in other body systems.

The weight-bearing criterion in 9.09A refers to the lumbosacral spine. The cervical and thoracic spines are not considered weight-bearing.

9.01 *Category of Impairments, Endocrine System and Obesity*

9.02 *Thyroid Disorders.* With:

A. Progressive exophthalmos as measured by exophthalmometry; or

B. Evaluate the resulting impairment under the criteria for the affected body system.

9.03 *Hyperparathyroidism.* With:

A. Generalized decalcification of bone on X-ray study and elevation of plasma calcium to 11 mg. per deciliter (100 ml.) or greater; or

B. A resulting impairment. Evaluate according to the criteria in the affected body system.

9.04 *Hypoparathyroidism.* With:

A. Severe recurrent tetany; or

B. Recurrent generalized convulsions; or

C. Lenticular cataracts. Evaluate under the criteria in 2.00ff.

9.05 *Neurohypophyseal insufficiency (diabetes insipidus).* With urine specific gravity of 1.005 or below, persistent for at least 3 months and recurrent dehydration.

9.06 *Hyperfunction of the adrenal cortex.* Evaluate the resulting impairment under the criteria for the affected body system.

9.08 *Diabetes mellitus.* With:

A. Neuropathy demonstrated by significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C); or

B. Acidosis occurring at least on the average of once every 2 months documented by appropriate blood chemical tests (pH or pCO2 or bicarbonate levels); or

C. Amputation at, or above, the tarsal region due to diabetic necrosis or peripheral arterial disease; or

D. Retinitis proliferans; evaluate the visual impairment under the criteria in 2.02, 2.03, or 2.04.

9.09 *Obesity*. Weight equal to or greater than the values specified in Table I for males, Table II for females (100 percent above desired level), and one of the following:

A. History of pain and limitation of motion in any weight-bearing joint or the lumbosacral spine (on physical examination) associated with findings on medically acceptable imaging techniques of arthritis in the affected joint or lumbosacral spine; or

B. Hypertension with diastolic blood pressure persistently in excess of 100 mm. Hg measured with appropriate size cuff; or

C. History of congestive heart failure manifested by past evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema; or

D. Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or

E. Respiratory disease with total forced vital capacity equal to or less than 2.0 L. or a level of hypoxemia at rest equal to or less than the values specified in Table III–A or III–B or III–C.

TABLE I.—MEN

[Metric]

Height without shoes (centimeters)	Weight (kilograms)
152	112
155	115
157	117
160	120
163	123
165	125
168	129
170	134
173	137
175	141
178	145
180	149
183	153
185	157
188	162
190	165
193	170

TABLE I.—MEN

Height without shoes (inches)	Weight (pounds)
60	246
61	252
62	258

TABLE I.—MEN—Continued

Height without shoes (inches)	Weight (pounds)
63	264
64	270
65	276
66	284
67	294
68	302
69	310
70	318
71	328
72	336
73	346
74	356
75	364
76	374

TABLE II.—WOMEN

[Metric]

Height without shoes (centimeters)	Weight (kilograms)
142	95
145	96
147	99
150	102
152	105
155	107
157	110
160	114
163	117
165	121
168	125
170	128
173	132
175	135
178	139
180	143
183	146

TABLE II.—WOMEN

Height without shoes (inches)	Weight (pounds)
56	208
57	212
58	218
59	224
60	230
61	236
62	242
63	250
64	258
65	266
66	274
67	282
68	290
69	298
70	306
71	314
72	322

TABLE III—A

[Applicable at test sites less than 3,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

TABLE III—B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

TABLE III—C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

10.00 [RESERVED]

11.00 NEUROLOGICAL

A. *Convulsive disorders.* In convulsive disorders, regardless of etiology degree of impairment will be determined according to type, frequency, duration, and sequelae of seizures. At least one detailed description of a typical seizure is required. Such description includes the presence or absence of aura, tongue bites, sphincter control, injuries associated with the attack, and postictal phenomena. The reporting physician should indicate the extent to which description of seizures reflects his own observations and the source of ancillary information. Testimony of persons other than the claimant is essential for description of type and frequency of seizures if professional observation is not available.

Documentation of epilepsy should include at least one electroencephalogram (EEG).

Under 11.02 and 11.03, the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed anticonvulsive treatment. Adherence to prescribed anticonvulsive therapy can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other anticonvulsive drugs may serve to indicate whether the prescribed medication is being taken. When seizures are occurrring at the frequency stated in 11.02 or 11.03, evalution of the severity of the impairment must include consideration of the serum drug levels. Should serum drug levels appear therapeutically inadequate, consideration should be given as to whether this is caused by individual idiosyncrasy in absorption of metabolism of the drug. Blood drug levels should be evaluated in conjunction with all the other evidence to determine the extent of compliance. When the reported blood drug levels are low, therefore, the information obtained from the treating source should include the physician's statement as to why the levels are low and the results of any relevant diagnostic studies concerning the blood levels. Where adequate seizure control is obtained only with unusually large doses, the possibility of impairment resulting from the side effects of this medication must be also assessed. Where documentation shows that use of alcohol or drugs affects adherence to prescribed therapy or may play a part in the precipitation of seizures, this must also be considered in the overall assessment of impairment level.

B. *Brain tumors.* The diagnosis of malignant brain tumors must be established, and the persistence of the tumor should be evaluated, under the criteria described in 13.00B and C for neoplastic disease.

In histologically malignant tumors, the pathological diagnosis alone will be the decisive criterion for severity and expected duration (see 11.05A). For other tumors of the brain, the severity and duration of the impairment will be determined on the basis of symptoms, signs, and pertinent laboratory findings (11.05B).

C. *Persistent disorganization of motor function* in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory distrubances (any or all of which may be due to cerebral cerbellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combination, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands, and arms.

D. *In conditions which are episodic in character,* such as multiple sclerosis or myasthenia gravis, consideration should be given to frequency and duration of exacerbations, length of remissions, and permanent residuals.

E. *Multiple sclerosis.* The major criteria for evaluating impairment caused by multiple sclerosis are discussed in listing 11.09. Paragraph A provides criteria for evaluating disorganization of motor function and gives reference to 11.04B (11.04B then refers to 11.00C). Paragraph B provides references to other listings for evaluating visual or mental impairments caused by multiple sclerosis. Paragraph C provides criteria for evaluating the impairment of individuals who do not have muscle weakness or other significant disorganization of motor function at rest, but who do develop muscle weakness on activity as a result of fatigue.

Use of the criteria in 11.09C is dependent upon (1) documenting a diagnosis of multiple sclerosis, (2) obtaining a description of fatigue considered to be characteristic of multiple sclerosis, and (3) obtaining evidence that the system has actually become fatigued. The evaluation of the magnitude of the impairment must consider the degree of exercise and the severity of the resulting muscle weakness.

The criteria in 11.09C deals with motor abnormalities which occur on activity. If the disorganization of motor function is present at rest, paragraph A must be used, taking into account any further increase in muscle weakness resulting from activity.

Sensory abnormalities may occur, particularly involving central visual acuity. The decrease in visual acuity may occur after brief attempts at activity involving near vision, such as reading. This decrease in visual acuity may not persist when the specific activity is terminated, as with rest, but is predictably reproduced with resumption of the activity. The impairment of central visual acuity in these cases should be evaluated under the criteria in listing 2.02, taking into account the fact that the decrease in visual acuity will wax and wane.

Clarification of the evidence regarding central nervous system dysfunction responsible for the symptoms may require supporting technical evidence of functional impairment such as evoked response tests during exercise.

11.01 Category of Impairments, Neurological

11.02 *Epilepsy—major motor seizures, (grand mal or psychomotor), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once a month, in spite of at least 3 months of prescribed treatment.* With:

A. Daytime episodes (loss of consciousness and convulsive seizures) or

B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.

11.03 *Epilepsy—Minor motor seizures (petit mal, psychomotor, or focal), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment.* With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

11.04 *Central nervous system vascular accident.* With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.05 *Brain tumors.*

A. Malignant gliomas (astrocytoma—grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, or primary sarcoma; or

B. Astrocytoma (grades I and II), meningioma, pituitary tumors, oligodendroglioma, ependymoma, clivus chordoma, and benign tumors. Evaluate under 11.02, 11.03, 11.04 A, or B, or 12.02.

11.06 *Parkinsonian syndrome* with the following signs: Significant rigidity, brady kinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

11.07 *Cerebral palsy.* With:

A. IQ of 70 or less; or

B. Abnormal behavior patterns, such as destructiveness or emotional instability: or

C. Significant interference in communication due to speech, hearing, or visual defect; or

D. Disorganization of motor function as described in 11.04B.

11.08 *Spinal cord or nerve root lesions, due to any cause* with disorganization of motor function as described in 11.04B.

11.09 *Multiple sclerosis.* With:

A. Disorganization of motor function as described in 11.04B; or

B. Visual or mental impairment as described under the criteria in 2.02, 2.03, 2.04, or 12.02; or

C. Significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.

11.10 *Amyotrophic lateral sclerosis. With:*

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

11.11 *Anterior poliomyelitis.* With:

A. Persistent difficulty with swallowing or breathing; or

B. Unintelligible speech; or

C. Disorganization of motor function as described in 11.04B.

11.12 *Myasthenia gravis.* With:

A. Significant difficulty with speaking, swallowing, or breathing while on prescribed therapy; or

B. Significant motor weakness of muscles of extremities on repetitive activity against resistance while on prescribed therapy.

11.13 *Muscular dystrophy* with disorganization of motor function as described in 11.04B.

11.14 *Peripheral neuropathies.*

With disorganization of motor function as described in 11.04B, in spite of prescribed treatment.

11.15 *Tabes dorsalis.*

With:

A. Tabetic crises occurring more frequently than once monthly; or

B. Unsteady, broad-based or ataxic gait causing significant restriction of mobility substantiated by appropriate posterior column signs.

11.16 *Subacute combined cord degeneration (pernicious anemia) with disorganization of motor function as decribed in 11.04B or 11.15B, not significantly improved by prescribed treatment.*

11.17 *Degenerative disease not elsewhere such as Huntington's chorea, Friedreich's ataxia, and spino-cerebellar degeneration.* With:

A. Disorganization of motor function as described in 11.04B or 11.15B; or

B. Chronic brain syndrome. Evaluate under 12.02.

11.18 *Cerebral trauma:*

Evaluate under the provisions of 11.02, 11.03, 11.04 and 12.02, as applicable.

11.19 *Syringomyelia.*

With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

12.00 MENTAL DISORDERS

The mental disorders listings in 12.00 of the Listing of Impairments will no longer be effective on August 28, 1997, unless extended by the Commissioner or revised and promulgated again.

A. *Introduction:* The evaluation of disability on the basis of mental disorders requires the documentation of a medically determinable impairment(s) as well as consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in eight diagnostic categories: organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation and autism (12.05); anxiety related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); and substance addiction disorders (12.09). Each diagnostic group, except listings 12.05 and 12.09, consists of a set of clinical findings (paragraph A criteria), one or more of which must be met, and which, if met, lead to a test of functional restrictions (paragraph B criteria), two or three of which must also be met. There are additional considerations (paragraph C criteria) in listings 12.03 and 12.06, discussed therein.

The purpose of including the criteria in paragraph A of the listings for mental disorders is to medically substantiate the presence of a mental disorder. Specific signs and symptoms under any of the listings 12.02 through 12.09 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) which is supported by the individual's clinical findings.

The purpose of including the criteria in paragraphs B and C of the listings for mental disorders is to describe those functional limitations associated with mental disorders which are incompatible with the ability to work. The restrictions listed in paragraphs B and C must be the result of the mental disorder which is manifested by the clinical findings outlined in paragraph A. The criteria included in paragraphs B and C of the listings for mental disorders have been chosen because they represent functional areas deemed essential to work. An individual who is severely limited in these areas as the result of an impairment identified in paragraph A is presumed to be unable to work.

The structure of the listing for substance addiction disorders, listing 12.09, is different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to

indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.

The listings for mental disorders are so constructed that an individual meeting or equaling the criteria could not reasonably be expected to engage in gainful work activity.

Individuals who have an impairment with a level of severity which does not meet the criteria of the listings for mental disorders may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful work activity. The determination of mental RFC is crucial to the evaluation of an individual's capacity to engage in substantial gainful work activity when the criteria of the listings for mental disorders are not met or equaled but the impairment is nevertheless severe.

RFC may be defined as a multidimensional description of the work-related abilities which an individual retains in spite of medical impairments. RFC complements the criteria in paragraphs B and C of the listings for mental disorders by requiring consideration of an expanded list of work-related capacities which may be impaired by mental disorder when the impairment is severe but does not meet or equal a listed mental disorder.

B. *Need for Medical Evidence:* The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of clinical signs, symptoms and/or laboratory or psychological test findings. These findings may be intermittent or persistent depending on the nature of the disorder. Clinical signs are medically demonstrable phenomena which reflect specific abnormalities of behavior, affect, thought, memory, orientation, or contact with reality. These signs are typically assessed by a psychiatrist or psychologist and/or documented by psychological tests. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster together to constitute recognizable clinical syndromes (mental disorders). Both symptoms and signs which are part of any diagnosed mental disorder must be considered in evaluating severity.

C. *Assessment of Severity:* For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph B of the listings for mental disorders (descriptions of restrictions of activities of daily living; social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work). Where ''marked'' is used 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, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively. Four areas are considered.

1. *Activities of daily living* include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness and effectiveness. It is necessary to define the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

''Marked'' is not the number of activities which are restricted but the overall degree of restriction or combination of restrictions which must be judged. For example, a person who is able to cook and clean might still have marked restrictions of daily activities if the person were too fearful to leave the immediate environment of home and neighborhood, hampering the person's ability to obtain treatment or to travel away from the immediate living environment.

2. *Social functioning* refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others, e.g., family members, friends, neighbors, grocery clerks, landlords, bus drivers, etc. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strength in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity also need to be considered. 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.

''Marked'' is not the number of areas in which social functioning is impaired, but the overall degree of interference in a particular area or combination of areas of functioning. For example, a person who is highly antagonistic, uncooperative or hostile but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence and pace* refer to the ability to sustain focused attention

sufficiently long to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Deficiencies in concentration, persistence and pace are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing, although mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to adequately perform work-like tasks. On mental status examinations, concentration is assessed by tasks such as having the individual subtract serial sevens from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. In work evaluations, concentration, persistence, and pace are assessed through such tasks as filing index cards, locating telephone numbers, or disassembling and reassembling objects. Strengths and weaknesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and extent to which assistance is required to complete the task.

4. *Deterioration or decompensation in work or work-like settings* refers to repeated failure to adapt to stressful circumstances which cause the individual either to withdraw from that situation or to experience exacerbation of signs and symptoms (i.e., decompensation) with an accompanying difficulty in maintaining activities of daily living, social relationships, and/or maintaining concentration, persistence, or pace (i.e., deterioration which may include deterioration of adaptive behaviors). Stresses common to the work environment include decisions, attendance, schedules, completing tasks, interactions with supervisors, interactions with peers, etc.

D. *Documentation:* The presence of a mental disorder should be documented primarily on the basis of reports from individual providers, such as psychiatrists and psychologists, and facilities such as hospitals and clinics. Adequate descriptions of functional limitations must be obtained from these or other sources which may include programs and facilities where the individual has been observed over a considerable period of time.

Information from both medical and nonmedical sources may be used to obtain detailed descriptions of the individual's activities of daily living; social functioning; concentration, persistance and pace; or ability to tolerate increased mental demands (stress). This information can be provided by programs such as community mental health centers, day care centers, sheltered workshops, etc. It can also be provided by others, including family members, who have knowledge of the individual's functioning. In some cases descriptions of activities of daily living or social functioning given by individuals or treating sources may be insufficiently detailed and/or may be in conflict with the clinical picture otherwise observed or described in the examinations or reports. It is necessary to resolve any inconsistencies or gaps that may exist in order to obtain a proper understanding of the individual's functional restrictions.

An individual's level of functioning may vary considerably over time. The level of functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of the impairment must take any variations in level of functioning into account in arriving at a determination of impairment severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication in order to establish the individual's impairment severity. This evidence should include treatment notes, hospital discharge summaries, and work evaluation or rehabilitation progress notes if these are available.

Some individuals may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work, or it may have been in conjunction with a community mental health or other sheltered program which may have been of either short or long duration. Information concerning the individual's behavior during any attempt to work and the circumstances surrounding termination of the work effort are particularly useful in determining the individual's ability or inability to function in a work setting.

The results of well-standardized psychological tests such as the Wechsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach, and the Thematic Apperception Test (TAT), may be useful in establishing the existence of a mental disorder. For example, the WAIS is useful in establishing mental retardation, and the MMPI, Rorschach, and TAT may provide data supporting several other diagnoses. Broad-based neuropsychological assessments using, for example, the Halstead-Reitan or the Luria-Nebraska batteries may be useful in determining brain function deficiencies, particularly in cases involving subtle findings such as may be seen in traumatic brain injury. In addition, the process of taking a standardized test requires concentration, persistence and pace; performance on such tests may provide useful data. Test results should, therefore, include both the objective data and a narrative description of clinical findings. Narrative reports of intellectual assessment should include a discussion of whether

or not obtained IQ scores are considered valid and consistent with the individual's developmental history and degree of functional restriction.

In cases involving impaired intellectual functioning, a standardized intelligence test, e.g., the WAIS, should be administered and interpreted by a psychologist or psychiatrist qualified by training and experience to perform such an evaluation. In special circumstances, nonverbal measures, such as the Raven Progressive Matrices, the Leiter international scale, or the Arthur adaptation of the Leiter may be substituted.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 70 and below are characteristic of approximately the lowest 2 percent of the general population. In instances where other tests are administered, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores.

In cases where more than one IQ is customarily derived from the test administered, i.e., where verbal, performance, and full-scale IQs are provided as on the WAIS, the lowest of these is used in conjunction with listing 12.05.

In cases where the nature of the individual's intellectual impairment is such that standard intelligence tests, as described above, are precluded, medical reports specifically describing the level of intellectual, social, and physical function should be obtained. Actual observations by Social Security Administration or State agency personnel, reports from educational institutions and information furnished by public welfare agencies or other reliable objective sources should be considered as additional evidence.

E. *Chronic Mental Impairments:* Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Individuals with chronic psychotic disorders commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such individuals may be much more impaired for work than their signs and symptoms would indicate. The results of a single examination may not adequately describe these individuals' sustained ability to function. It is, therefore, vital to review all pertinent information relative to the individual's condition, especially at times of increased stress. It is mandatory to attempt to obtain adequate descriptive information from all sources which have treated the individual either currently or in the time period relevant to the decision.

F. *Effects of Structured Settings:* Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, board and care facility, or other environment that provides similar structure. Highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, overt signs and symptoms of the underlying mental disorder may be minimized. At the same time, however, the individual's ability to function outside of such a structured and/or supportive setting may not have changed. An evaluation of individuals whose symptomatology is controlled or attenuated by psychosocial factors must consider the ability of the individual to function outside of such highly structured settings. (For these reasons the paragraph C criteria were added to Listings 12.03 and 12.06.)

G. *Effects of Medication:* Attention must be given to the effect of medication on the individual's signs, symptoms and ability to function. While psychotropic medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychotropic medications, particular attention must be focused on the functional restrictions which may persist. These functional restrictions are also to be used as the measure of impairment severity. (See the paragraph C criteria in Listings 12.03 and 12.06.)

Neuroleptics, the medicines used in the treatment of some mental illnesses, may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity. Where adverse effects of medications contribute to the impairment severity and the impairment does not meet or equal the listings but is nonetheless severe, such adverse effects must be considered in the assessment of the mental residual functional capacity.

H. *Effect of Treatment:* It must be remembered that with adequate treatment some individuals suffering with chronic mental disorders not only have their symptoms and signs ameliorated but also return to a level of function close to that of their premorbid status. Our discussion here in 12.00H has been designed to reflect the fact that present day treatment of a mentally impaired individual may or may not assist in the achievement of an adequate level of adaptation required in the work place. (See the paragraph C criteria in Listings 12.03 and 12.06.)

I. *Technique for Reviewing the Evidence in Mental Disorders Claims to Determine Level of Impairment Severity:* A special technique has been developed to ensure that all evidence

needed for the evaluation of impairment severity in claims involving mental impairment is obtained, considered and properly evaluated. This technique, which is used in connection with the sequential evaluation process, is explained in §404.1520a and §416.920a.

12.01 Category of Impairments-Mental

12.02 *Organic Mental Disorders:* Psychological or behaviorial abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or

2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or

3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or

4. Change in personality; or

5. Disturbance in mood; or

6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or

7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.03 *Schizophrenic, Paranoid and Other Psychotic Disorders:* Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

a. Blunt affect; or

b. Flat affect; or

c. Inappropriate affect;

or

4. Emotional withdrawal and/or isolation;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of this listing, although these symptoms or signs are currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from that situation or to experience exacerbation of signs or symptoms (which may include deterioration of adaptive behaviors); or

2. Documented current history of two or more years of inability to function outside of a highly supportive living situation.

12.04 *Affective Disorders:* Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

a. Anhedonia or pervasive loss of interest in almost all activites; or

b. Appetite disturbance with change in weight; or

c. Sleep disturbance; or

d. Psychomotor agitation or retardation; or

e. Decreased energy; or

f. Feelings of guilt or worthlessness; or

g. Difficulty concentrating or thinking; or

h. Thoughts of suicide; or

i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

a. Hyperactivity; or

b. Pressure of speech; or

c. Flight of ideas; or

d. Inflated self-esteem; or

e. Decreased need for sleep; or

f. Easy distractability; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions or paranoid thinking;

or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.05 *Mental Retardation and Autism:* Mental retardation refers to a significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22). (Note: The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.) Autism is a pervasive developmental disorder characterized by social and significant communication deficits originating in the developmental period.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;

OR

B. A valid verbal, performance, or full scale IQ of 59 or less;

OR

C. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing additional and significant work-related limitation of function;

OR

D. A valid verbal, performance, or full scale IQ of 60 through 70, or in the case of autism, gross deficits of social and communicative skills, with either condition resulting in two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or eleswhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.06 *Anxiety Related Disorders:* In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

a. Motor tension; or

b. Autonomic hyperactivity; or

c. Apprehensive expectation; or

d. Vigilance and scanning;

or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or eleswhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Resulting in complete inability to function independently outside the area of one's home.

12.07 *Somatoform Disorders:* Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or

2. Persistent nonorganic disturbance of one of the following:

a. Vision; or

b. Speech; or

c. Hearing; or

d. Use of a limb; or

e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or

f. Sensation (e.g., diminished or heightened).

3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury;

AND

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behavior).

12.08 *Personality Disorders:* A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking; or

2. Pathologically inappropriate suspiciousness or hostility; or

3. Oddities of thought, perception, speech and behavior; or

4. Persistent disturbances of mood or affect; or

5. Pathological dependence, passivity, or aggressivity; or

6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

AND

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.09 *Substance Addiction Disorders:* Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.

A. Organic mental disorders. Evaluate under 12.02.

B. Depressive syndrome. Evaluate under 12.04.

C. Anxiety disorders. Evaluate under 12.06.

D. Personality disorders. Evaluate under 12.08.

E. Peripheral neuropathies. Evaluate under 11.14.

F. Liver damage. Evaluate under 5.05.

G. Gastritis. Evaluate under 5.04.

H. Pancreatitis. Evaluate under 5.08.

I. Seizures. Evaluate under 11.02 or 11.03.

13.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction:* The determination of the level of impairment resulting from malignant tumors is made from a consideration of the site of the lesion, the histogenesis of the tumor, the extent of involvement, the apparent adequacy and response to therapy (surgery, irradiation, hormones, chemotherapy, etc.), and the magnitude of the post therapeutic residuals.

B. *Documentation:* The diagnosis of malignant tumors should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen. If these documents are not obtainable, then the summary of hospitalization or a report from the treating physician must include details of the findings at surgery and the results of the pathologist's gross and microscopic examination of the tissues.

For those cases in which a disabling impairment was not established when therapy was begun but progression of the disease is likely, current medical evidence should include a report of a recent examination directed especially at local or regional recurrence, soft part or skeletal metastases, and significant posttherapeutic residuals.

C. *Evaluation*. Usually, when the malignant tumor consists of a local lesion with metastases to the regional lymph nodes which apparently has been completely excised, imminent recurrence or metastases is not anticipated. A number of exceptions are noted in the specific Listings. For adjudicative purposes, ''distant metastases'' or ''metastases beyond the regional lymph nodes'' refers to metastasis beyond the lines of the usual radical en bloc resection.

Local or regional recurrence after radical surgery or pathological evidence of incomplete excision by radical surgery is to be equated with unresectable lesions (except for carcinoma of the breast, 13.09C) and, for the purposes of our program, may be evaluated as ''inoperable.''

Local or regional recurrence after incomplete excision of a localized and still completely resectable tumor is not to be equated with recurrence after radical surgery. In the evaluation of lymphomas, the tissue type and site of involvement are not necessarily indicators of the degree of impairment.

When a malignant tumor has metastasized beyond the regional lymph nodes, the impairment will usually be found to meet the requirements of a specific listing. Exceptions are hormone-dependent tumors, isotope-sensitive metastases, and metastases from seminoma of the testicles which are controlled by definitive therapy.

When the original tumor and any metastases have apparently disappeared and have not been evident for 3 or more years, the impairment does not meet the criteria under this body system.

D. *Effects of therapy*. Significant posttherapeutic residuals, not specifically included in the category of impairments for malignant neoplasms, should be evaluated according to the affected body system.

Where the impairment is not listed in the Listing of Impairments and is not medically equivalent to a listed impairment, the impact of any residual impairment including that caused by therapy must be considered. The therapeutic regimen and consequent adverse response to therapy may vary widely; therefore, each case must be considered on an individual basis. It is essential to obtain a specific description of the therapeutic regimen, including the drugs given, dosage, frequency of drug administration, and plans for continued drug administration. It is necessary to obtain a description of the complications or any other adverse response to therapy such as nausea, vomiting, diarrhea, weakness, dermatologic disorders, or reactive mental disorders. Since the severity of the adverse effects of anticancer chemotherapy may change during the period of drug administration, the decision regarding the impact of drug therapy should be based on a sufficient period of therapy to permit proper consideration.

E. *Onset.* To establish onset of disability prior to the time a malignancy is first demonstrated to be inoperable or beyond control by other modes of therapy (and prior evidence is nonexistent) requires medical judgment based on medically reported symptoms, the type of the specific malignancy, its location, and extent of involvement when first demonstrated.

13.01 Category of Impairments, Neoplastic Diseases—Malignant

13.02 *Head and neck* (except salivary glands—13.07, thyroid gland—13.08, and mandible, maxilla, orbit, or temporal fossa—13.11):

A. Inoperable; or

B. Not controlled by prescribed therapy; or

C. Recurrent after radical surgery or irradiation; or

D. With distant metastases; or

E. Epidermoid carcinoma occurring in the pyriform sinus or posterior third of the tongue.

13.03 *Sarcoma of skin:*

A. Angiosarcoma with metastases to regional lymph nodes or beyond; or

B. Mycosis fungoides with metastases to regional lymph nodes, or with visceral involvement.

13.04 *Sarcoma of soft parts:* Not controlled by prescribed therapy.

13.05 *Malignant melanoma:*

A. Recurrent after wide excision; or

B. With metastases to adjacent skin (satellite lesions) or elsewhere.

13.06 *Lymph nodes:*

A. Hodgkin's disease or non-Hodgkin's lymphoma with progressive disease not controlled by prescribed therapy; or

B. Metastatic carcinoma in a lymph node (except for epidermoid carcinoma in a lymph node in the neck) where the primary site is not determined after adequate search; or

C. Epidermoid carcinoma in a lymph node in the neck not responding to prescribed therapy.

13.07 *Salivary glands*— carcinoma or sarcoma with metastases beyond the regional lymph nodes.

13.08 *Thyroid gland*—carcinoma with metastases beyond the regional lymph nodes, not controlled by prescribed therapy.

13.09 *Breast:*

A. Inoperable carcinoma; or

B. Inflammatory carcinoma; or

C. Recurrent carcinoma, except local recurrence controlled by prescribed therapy; or

D. Distant metastases from breast carcinoma (bilateral breast carcinoma, synchronous or metachronous is usually primary in each breast); or

E. Sarcoma with metastases anywhere.

13.10 *Skeletal system* (exclusive of the jaw):

A. Malignant primary tumors with evidence of metastases and not controlled by prescribed therapy; or

B. Metastatic carcinoma to bone where the primary site is not determined after adequate search.

13.11 *Mandible, maxilla, orbit, or temporal fossa:*

A. Sarcoma of any type with metastases; or

B. Carcinoma of the antrum with extension into the orbit or ethmoid or sphenoid sinus, or with regional or distant metastases; or

C. Orbital tumors with intracranial extension; or

D. Tumors of the temporal fossa with perforation of skull and meningeal involvement; or

E. Adamantinoma with orbital or intracranial infiltration; or

F. Tumors of Rathke's pouch with infiltration of the base of the skull or metastases.

13.12 *Brain or spinal cord:*

A. Metastatic carcinoma to brain or spinal cord.

B. Evaluate other tumors under the criteria described in 11.05 and 11.08.

13.13 *Lungs.*

A. Unresectable or with incomplete excision; or

B. Recurrence or metastases after resection; or

C. Oat cell (small cell) carcinoma; or

D. Squamous cell carcinoma, with metastases beyond the hilar lymph nodes; or

E. Other histologic types of carcinoma, including undifferentiated and mixed-cell types (but excluding oat cell carcinoma, 13.13C, and squamous cell carcinoma, 13.13D), with metastases to the hilar lymph nodes.

13.14 *Pleura or mediastinum:*

A. Malignant mesothelioma of pleura; or

B. Malignant tumors, metastatic to pleura; or

C. Malignant primary tumor of the mediastinum not controlled by prescribed therapy.

13.15 *Abdomen:*

A. Generalized carcinomatosis; or

B. Retroperitoneal cellular sarcoma not controlled by prescribed therapy; or

C. Ascites with demonstrated malignant cells.

13.16 *Esophagus or stomach:*

A. Carcinoma or sarcoma of the esophagus; or

B. Carcinoma of the stomach with metastases to the regional lymph nodes or extension to surrounding structure; or

C. Sarcoma of stomach not controlled by prescribed therapy; or

D. Inoperable carcinoma; or

E. Recurrence or metastases after resection.

13.17 *Small intestine:*

A. Carcinoma, sarcoma, or carcinoid tumor with metastases beyond the regional lymph nodes; or

B. Recurrence of carcinoma, sarcoma, or carcinoid tumor after resection; or

C. Sarcoma, not controlled by prescribed therapy.

13.18 *Large intestine* (from ileocecal valve to and including anal canal)—carcinoma or sarcoma.

A. Unresectable; or

B. Metastases beyond the regional lymph nodes; or

C. Recurrence or metastases after resection.

13.19 *Liver or gallbladder:*

A. Primary or metastatic malignant tumors of the liver; or

B. Carcinoma of the gallbladder; or

C. Carcinoma of the bile ducts.

13.20 *Pancreas:*

A. Carcinoma except islet cell carcinoma; or

B. Islet cell carcinoma which is unresectable and physiologically active.

13.21 *Kidneys, adrenal glands, or ureters—carcinoma:*

A. Unresectable; or

B. With hematogenous spread to distant sites; or

C. With metastases to regional lymph nodes.

13.22 *Urinary bladder—carcinoma.* With:

A. Infiltration beyond the bladder wall; or

B. Metastases to regional lymph nodes; or

C. Unresectable; or

D. Recurrence after total cystectomy; or

E. Evaluate renal impairment after total cystectomy under the criteria in 6.02.

13.23 *Prostate gland*—carcinoma not controlled by prescribed therapy.

13.24 *Testicles:*

A. Choriocarcinoma; or

B. Other malignant primary tumors with progressive disease not controlled by prescribed therapy.

13.25 *Uterus*—carcinoma or sarcoma (corpus or cervix).

A. Inoperable and not controlled by prescribed therapy; or

B. Recurrent after total hysterectomy; or

C. Total pelvic exenteration

13.26 *Ovaries*—all malignant, primary or recurrent tumors. With:

A. Ascites with demonstrated malignant cells; or

B. Unresectable infiltration; or

C. Unresectable metastases to omentum or elsewhere in the peritoneal cavity; or

D. Distant metastases.

13.27 *Leukemia:* Evaluate under the criteria of 7.00ff, Hemic and Lymphatic Sytem.

13.28 *Uterine (Fallopian) tubes—carcinoma or sarcoma:*

A. Unresectable, or

B. Metastases to regional lymph nodes.

13.29 *Penis—carcinoma with metastases to regional lymph nodes.*

13.30 *Vulva—carcinoma, with distant metastases.*

14.00 IMMUNE SYSTEM

A. Listed disorders include impairments involving deficiency of one or more components of the immune system (i.e., antibody-producing B cells; a number of different types of cells associated with cell-mediated immunity including T-lymphocytes, macrophages and monocytes; and components of the complement system).

B. Dysregulation of the immune system may result in the development of a connective tissue disorder. Connective tissue disorders include several chronic multisystem disorders that differ in their clinical manifestation, course, and outcome. They generally evolve and persist for months or years, may result in loss of functional abilities, and may require long-term, repeated evaluation and management.

The documentation needed to establish the existence of a connective tissue disorder is medical history, physical examination, selected laboratory studies, medically acceptable imaging techniques and, in some instances, tissue biopsy. However, the Social Security Administration will not purchase diagnostic tests or procedures that may involve significant risk, such as biopsies or angiograms. Generally, the existing medical evidence will contain this information.

A longitudinal clinical record of at least 3 months demonstrating active disease despite prescribed treatment during this period with the expectation that the disease will remain active for 12 months is necessary for assessment of severity and duration of impairment.

To permit appropriate application of a listing, the specific diagnostic features that should be documented in the clinical record for each of the disorders are summarized for systemic lupus erythematosus (SLE), systemic vasculitis, systemic sclerosis and scleroderma, polymyositis or dermatomyositis, and undifferentiated connective tissue disorders.

In addition to the limitations caused by the connective tissue disorder *per se*, the chronic adverse effects of treatment (e.g., corticosteroid-related ischemic necrosis of bone) may result in functional loss.

These disorders may preclude performance of any gainful activity by reason of severe loss of function in a single organ or body system, or lesser degrees of functional loss in two or more organs/body systems associated with significant constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. We use the term ''severe'' in these listings to describe medical severity; the term does not have the same meaning as it does when we use it in connection with a finding at the second step of the sequential evaluation processes in §§404.1520, 416.920, and 416.924.

1. Systemic lupus erythematosus (14.02)—This disease is characterized clinically by constitutional symptoms and signs (e.g., fever, fatigability, malaise, weight loss), multisystem involvement and, frequently, anemia, leukopenia, or thrombocytopenia. Immunologically, an array of circulating serum auto-antibodies can occur, but are highly variable in pattern. Generally the medical evidence will show that patients with this disease will fulfill The 1982 Revised Criteria for the Classification of Systemic Lupus Erythematosus of the American College of Rheumatology. (Tan, E.M., et al., Arthritis Rheum. 25: 11271–1277, 1982).

2. Systemic vasculitis (14.03)—This disease occurs acutely in association with adverse drug reactions, certain chronic infections and, occasionally, malignancies. More often it is idiopathic and chronic. There are several clinical patterns, including classical polyarteritis nodosa, aortic arch arteritis, giant cell arteritis, Wegener's granulomatosis, and vasculitis associated with other connective tissue disorders (e.g., rheumatoid arthritis, SLE, Sjögren's syndrome, cryoglobulinemia). Cutaneous vasculitis may

or may not be associated with systemic involvement and the patterns of vascular and ischemic involvement are highly variable. The diagnosis is confirmed by angiography or tissue biopsy when the disease is suspected clinically. Most patients who are stated to have this disease will have the results of the confirmatory angiogram or biopsy in their medical records.

3. Systemic sclerosis and scleroderma (14.04)—These disorders constitute a spectrum of disease in which thickening of the skin is the clinical hallmark. Raynaud's phenomena, often severe and progressive, are especially frequent and may be the peripheral manifestation of a generalized vasospastic abnormality in the heart, lungs, and kidneys. The CREST syndrome (calcinosis, Raynaud's phenomena, esophageal dysmotility, sclerodactyly, telangiectasia) is a variant that may slowly progress to the generalized process, systemic sclerosis, over years. In addition to skin and blood vessels, the major organ/body system involvement includes the gastrointestinal tract, lungs, heart, kidneys, and muscle. Although arthritis can occur, joint dysfunction results primarily from soft tissue/cutaneous thickening, fibrosis, and contractures.

4. Polymyositis or dermatomyositis (14.05)—This disorder is primarily an inflammatory process in striated muscle, which can occur alone or in association with other connective tissue disorders or malignancy. Weakness and, less frequently, pain and tenderness of the proximal limb-girdle musculature are the cardinal manifestations. Involvement of the cervical muscles, the cricopharyngeals, the intercostals, and diaphragm may occur in those with listing-level disease. Weakness of the pelvic girdle, as contemplated in Listing 14.05A, may result in significant difficulty climbing stairs or rising from a chair without use of the arms. Proximal limb weakness in the upper extremities may result in inability to lift objects, and interference with dressing and combing hair. Weakness of anterior neck flexors may impair the ability to lift the head from the pillow in bed. The diagnosis is supported by elevated serum muscle enzymes (creatine phosphokinase (CPK), aminotransferases, aldolase), characteristic abnormalities on electromyography, and myositis on muscle biopsy.

5. Undifferentiated connective tissue disorder (14.06)—This listing includes syndromes with clinical and immunologic features of several connective tissue disorders, but that do not satisfy the criteria for any of the disorders described; for instance, the individual may have clinical features of systemic lupus erythematosus and systemic vasculitis and the serologic findings of rheumatoid arthritis. It also includes overlap syndromes with clinical features of more than one established connective tissue disorder. For example, the individual may have features of both rheumatoid arthritis and scleroderma. The correct designation of this disorder is important for assessment of prognosis.

C. Allergic disorders (e.g., asthma or atopic dermatitis) are discussed and evaluated under the appropriate listing of the affected body system.

D. Human immunodeficiency virus (HIV) infection.

1. HIV infection is caused by a specific retrovirus and may be characterized by susceptibility to one or more opportunistic diseases, cancers, or other conditions, as described in 14.08. Any individual with HIV infection, including one with a diagnosis of acquired immunodeficiency syndrome (AIDS), may be found disabled under this listing if his or her impairment meets any of the criteria in 14.08 or is of equivalent severity to any impairment in 14.08.

2. Definitions. In 14.08, the terms ''resistant to treatment,'' ''recurrent,'' and ''disseminated'' have the same general meaning as used by the medical community. The precise meaning of any of these terms will depend upon the specific disease or condition in question, the body system affected, the usual course of the disorder and its treatment, and the other circumstances of the case.

''Resistant to treatment'' means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate, or a course of treatment appropriate, will depend on the facts of the particular case.

''Recurrent'' means that a condition that responded adequately to an appropriate course of treatment has returned after a period of remission or regression. The extent of response (or remission) and the time periods involved will depend on the facts of the particular case.

''Disseminated'' means that a condition is spread widely over a considerable area or body system(s). The type and extent of the spread will depend on the specific disease.

As used in 14.08I, ''significant involuntary weight loss'' does not correspond to a specific minimum amount or percentage of weight loss. Although, for purposes of this listing, an involuntary weight loss of at least 10 percent of baseline is always considered significant, loss of less than 10 percent may or may not be significant, depending on the individual's baseline weight and body habitus. (For example, a 7-pound weight loss in a 100-pound female who is 63 inches tall might be considered significant; but a 14-pound weight loss in a 200-pound female who is the same height might not be significant.)

3. Documentation of HIV infection. The medical evidence must include documentation of HIV infection. Documentation may

be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of HIV infection by definitive diagnosis. A definitive diagnosis of HIV infection is documented by one or more of the following laboratory tests:

i. A serum specimen that contains HIV antibodies. HIV antibodies are usually detected by a screening test. The most commonly used screening test is the ELISA. Although this test is highly sensitive, it may yield false positive results. Therefore, positive results from an ELISA must be confirmed by a more definitive test (e.g., Western blot, immunofluorescence assay).

ii. A specimen that contains HIV antigen (e.g., serum specimen, lymphocyte culture, or cerebrospinal fluid (CSF) specimen).

iii. Other test(s) that are highly specific for detection of HIV (e.g., polymerase chain reaction (PCR)), or that are acceptable methods of detection consistent with the prevailing state of medical knowledge.

When laboratory testing for HIV infection has been performed, every reasonable effort must be made to obtain reports of the results of that testing.

Individuals who have HIV infection or other disorders of the immune system may undergo tests to determine T-helper lymphocyte (CD4) counts. The extent of immune depression correlates with the level or rate of decline of the CD4 count. In general, when the CD4 count is $200/mm^3$ or less (14 percent or less), the susceptibility to opportunistic disease is considerably increased. However, a reduced CD4 count alone does not establish a definitive diagnosis of HIV infection, or document the severity or functional effects of HIV infection.

b. Other acceptable documentation of HIV infection.

HIV infection may also be documented without the definitive laboratory evidence described in paragraph a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, HIV infection may be documented by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. For example, a diagnosis of HIV infection will be accepted without definitive laboratory evidence if the individual has an opportunistic disease (e.g., toxoplasmosis of the brain, pneumocystis carinii pneumonia (PCP)) predictive of a defect in cell-mediated immunity, and there is no other known cause of diminished resistance to that disease (e.g., long-term steroid treatment, lymphoma). In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

4. Documentation of the manifestations of HIV infection. The medical evidence must also include documentation of the manifestations of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of the manifestations of HIV infection by definitive diagnosis.

The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection is by culture, serological test, or microscopic examination of biopsied tissue or other material (e.g., bronchial washings). Therefore, every reasonable effort must be made to obtain specific laboratory evidence of an opportunistic disease or other condition whenever this information is available. If a histological or other test has been performed, the evidence should include a copy of the appropriate report. If the report is not obtainable, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including radiographic studies) or microscopic examination of the appropriate tissues or body fluids.

Although a reduced CD4 lymphocyte count may show that there is an increased susceptibility to opportunistic infections and diseases (see 14.00D3a, above), that alone does not establish the presence, severity, or functional effects of a manifestation of HIV infection.

b. Other acceptable documentation of the manifestations of HIV infection.

Manifestations of HIV infection may also be documented without the definitive laboratory evidence described in paragraph a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, manifestations of HIV infection may be documented by medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

Documentation of cytomegalovirus (CMV) disease (14.08D) presents special problems because diagnosis requires identification of viral inclusion bodies or a positive culture from the affected organ, and the absence of any other infectious agent. A positive serology test identifies infection with the virus, but does not confirm a disease process. With the exception of chorioretinitis (which may be diagnosed by an ophthalmologist), documentation of CMV disease requires confirmation by biopsy or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

5. Manifestations specific to women. Most women with severe immunosuppression secondary to HIV infection exhibit the typical opportunistic infections and other conditions, such as pneumocystis carinii pneumonia (PCP), candida esophagitis, wasting syndrome, cryptococcosis, and toxoplasmosis. However, HIV infection may have different manifestations in women than in men. Adjudicators must carefully scrutinize the medical evidence and be alert to the variety of medical conditions specific to or common in women with HIV infection that may affect their ability to function in the workplace.

Many of these manifestations (e.g. vulvovaginal candidiasis, pelvic inflammatory disease) occur in women with or without HIV infection, but can be more severe or resistant to treatment, or occur more frequently in a woman whose immune system is suppressed. Therefore, when evaluating the claim of a woman with HIV infection, it is important to consider gynecologic and other problems specific to women, including any associated symptoms (e.g., pelvic pain), in assessing the severity of the impairment and resulting functional limitations. Manifestations of HIV infection in women may be evaluated under the specific criteria (e.g., cervical cancer under 14.08E), under an applicable general category (e.g., pelvic inflammatory disease under 14.08A5) or, in appropriate cases, under 14.08N.

6. Evaluation. The criteria in 14.08 do not describe the full spectrum of diseases or conditions manifested by individuals with HIV infection. As in any case, consideration must be given to whether an individual's impairment(s) meets or equals in severity any other listing in appendix 1 of subpart P (e.g., a neoplastic disorder listed in 13.00ff). Although 14.08 includes cross-references to other listings for the more common manifestations of HIV infection, other listings may apply.

In addition, the impact of all impairments, whether or not related to HIV infection, must be considered. For example, individuals with HIV infection may manifest signs and symptoms of a mental impairment (e.g., anxiety, depression), or of another physical impairment. Medical evidence should include documentation of all physical and mental impairments, and the impairment(s) should be evaluated not only under the relevant listing(s) in 14.08, but under any other appropriate listing(s).

It is also important to remember that individuals with HIV infection, like all other individuals, are evaluated under the full five-step sequential evaluation process described in § 404.1520 and § 416.920. If an individual with HIV infection is working and engaging in substantial gainful activity (SGA), or does not have a severe impairment, the case will be decided at the first or second step of the sequential evaluation process, and does not require evaluation under these listings. For an individual with HIV infection who is not engaging in SGA and has a severe impairment, but whose impairment(s) does not meet or equal in severity the criteria of a listing, evaluation must proceed through the final steps of the sequential evaluation process (or, as appropriate, the steps in the medical improvement review standard) before any conclusion can be reached on the issue of disability.

7. Effect of treatment. Medical treatment must be considered in terms of its effectiveness in ameliorating the signs, symptoms, and laboratory abnormalities of the specific disorder, or of the HIV infection itself (e.g., antiretroviral agents) and in terms of any side effects of treatment that may further impair the individual.

Response to treatment and adverse or beneficial consequences of treatment may vary widely. For example, an individual with HIV infection who develops pneumonia or tuberculosis may respond to the same antibiotic regimen used in treating individuals without HIV infection, but another individual with HIV infection may not respond to the same regimen. Therefore, each case must be considered on an individual basis, along with the effects of treatment on the individual's ability to function.

A specific description of the drugs or treatment given (including surgery), dosage, frequency of administration, and a description of the complications or response to treatment should be obtained. The effects of treatment may be temporary or long term. As such, the decision regarding the impact of treatment should be based on a sufficient period of treatment to permit proper consideration.

8. Functional criteria. Paragraph N of 14.08 establishes standards for evaluating manifestations of HIV infection that do not meet the requirements listed in 14.08A–M. Paragraph N is applicable for manifestations that are not listed in 14.08A–M, as well as those listed in 14.08A–M that do not meet the criteria of any of the rules in 14.08A–M.

For individuals with HIV infection evaluated under 14.08N, listing-level severity will be assessed in terms of the functional limitations imposed by the impairment. The full impact of signs, symptoms, and laboratory findings on the claimant's ability to function must be considered. Important factors to be considered in evaluating the functioning of individuals with HIV infection include, but are not limited to: symptoms, such as fatigue and pain; characteristics of the illness, such as the frequency and duration of manifestations or periods of exacerbation and remission in the disease course; and the functional impact of treatment for the disease, including the side effects of medication.

As used in 14.08N, ''repeated'' means that the conditions occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; or the conditions do not last for 2 weeks but occur substantially more frequently than 3 times in a year or once every 4 months; or they occur less often than an average of 3 times a year or once every 4 months but last substantially longer than 2 weeks.

To meet the criteria in 14.08N, an individual with HIV infection must demonstrate a marked level of restriction in one of three general areas of functioning: activities of daily living; social functioning; and difficulties in completing tasks due to deficiencies in concentration, persistence, or pace. Functional restrictions may result from the impact of the disease process itself on mental or physical functioning, or both. This could result from extended or intermittent symptoms, such as depression, fatigue, or pain, resulting in a limitation of the ability to concentrate, to persevere at a task, or to perform the task at an acceptable rate of speed. Limitations may also result from the side effects of medication.

When ''marked'' is used as a standard for measuring the degree of functional limitation, it means more than moderate, but less than extreme. A marked limitation does not represent a quantitative measure of the individual's ability to do an activity for a certain percentage of the time. A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. However, 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. The term ''marked'' does not imply that the impaired individual is confined to bed, hospitalized, or in a nursing home.

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. 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.

Social functioning includes the capacity to interact appropriately and communicate effectively with others. 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 difficulty maintaining social functioning.

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. 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 difficulty completing tasks.

14.01 Category of Impairments, Immune System

14.02 Systemic lupus erythematosus. Documented as described in 14.00B1, with:

A. One of the following:

1. Joint involvement, as described under the criteria in 1.00; or

2. Muscle involvement, as described under the criteria in 14.05; or

3. Ocular involvement, as described under the criteria in 2.00ff; or

4. Respiratory involvement, as described under the criteria in 3.00ff; or

5. Cardiovascular involvement, as described under the criteria in 4.00ff or 14.04D; or

6. Digestive involvement, as described under the criteria in 5.00ff; or

7. Renal involvement, as described under the criteria in 6.00ff; or

8. Skin involvement, as described under the criteria in 8.00ff; or

9. Neurological involvement, as described under the criteria in 11.00ff; or

10. Mental involvement, as described under the criteria in 12.00ff.

or

B. Lesser involvement of two or more organs/body systems listed in paragraph A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

14.03 Systemic vasculitis. Documented as described in 14.00B2, including documentation by angiography or tissue biopsy, with:

A. Involvement of a single organ or body system, as described under the criteria in 14.02A.

or

B. Lesser involvement of two or more organs/body systems listed in 14.02A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

14.04 Systemic sclerosis and scleroderma. Documented as described in 14.00B3, with:

A. One of the following:

1. Muscle involvement, as described under the criteria in 14.05; or

2. Respiratory involvement, as described under the criteria in 3.00ff; or

3. Cardiovascular involvement, as described under the criteria in 4.00ff; or

4. Digestive involvement, as described under the criteria in 5.00ff; or

5. Renal involvement, as described under the criteria in 6.00ff.

or

B. Lesser involvement of two or more organs/body systems listed in paragraph A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

or

C. Generalized scleroderma with digital contractures.

or

D. Severe Raynaud's phenomena, characterized by digital ulcerations, ischemia, or gangrene.

14.05 Polymyositis or dermatomyositis. Documented as described in 14.00B4, with:

A. Severe proximal limb-girdle (shoulder and/or pelvic) muscle weakness, as described in 14.00B4.

or

B. Less severe limb-girdle muscle weakness than in 14.05A, associated with cervical muscle weakness and one of the following to at least a moderate level of severity:

1. Impaired swallowing with dysphagia and episodes of aspiration due to cricopharyngeal weakness, or

2. Impaired respiration due to intercostal and diaphragmatic muscle weakness.

or

C. If associated with malignant tumor, as described under the criteria in 13.00ff.

or

D. If associated with generalized connective tissue disease, described under the criteria in 14.02, 14.03, 14.04, or 14.06.

14.06 Undifferentiated connective tissue disorder. Documented as described in 14.00B5, and with impairment as described under the criteria in 14.02A, 14.02B, or 14.04.

14.07 Immunoglobulin deficiency syndromes or deficiencies of cell-mediated immunity, excepting HIV infection. Associated with documented, recurrent severe infection occurring 3 or more times within a 5-month period.

14.08 Human immunodeficiency virus (HIV) infection. With documentation as described in 14.00D3 and one of the following:

A. 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; or pulmonary tuberculosis resistant to treatment; or

2. Nocardiosis; or

3. Salmonella bacteremia, recurrent nontyphoid; or

4. Syphilis or neurosyphilis—evaluate sequelae under the criteria for the affected body system (e.g., 2.00 Special Senses and Speech, 4.00 Cardiovascular System, 11.00 Neurological); or

5. Multiple or recurrent bacterial infection(s), including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year.

or

B. Fungal infections:

1. Aspergillosis; or

2. Candidiasis, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs; or

3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or

4. Cryptococcosis, at a site other than the lungs (e.g., cryptococcal meningitis); or

5. Histoplasmosis, at a site other than the lungs or lymph nodes; or

6. Mucormycosis.

or

C. Protozoan or helminthic infections:

1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or

2. Pneumocystis carinii pneumonia or extrapulmonary pneumocystis carinii infection; or

3. Strongyloidiasis, extra-intestinal; or

4. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

or

D. Viral infections:

1. Cytomegalovirus disease (documented as described in 14.00D4b) at a site other than the liver, spleen, or lymph nodes; or

2. Herpes simplex virus causing:

a. Mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or

b. Infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or

c. Disseminated infection; or

3. Herpes zoster, either disseminated or with multidermatomal eruptions that are resistant to treatment; or

4. Progressive multifocal leukoencephalopathy; or

5. Hepatitis, as described under the criteria in 5.05.

or

E. Malignant neoplasms:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or

2. Kaposi's sarcoma with:

a. Extensive oral lesions; or

b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or

c. Involvement of the skin or mucous membranes, as described under the criteria in 14.08F; or

3. Lymphoma (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkins lymphoma, Hodgkin's disease); or

4. Squamous cell carcinoma of the anus.

or

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3, above) 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), or evaluate under the criteria in 8.00ff.

or

G. Hematologic abnormalities:

1. Anemia, as described under the criteria in 7.02; or

2. Granulocytopenia, as described under the criteria in 7.15; or

3. Thrombocytopenia, as described under the criteria in 7.06.

or

H. Neurological abnormalities:

1. HIV encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses; or

2. Other neurological manifestations of HIV infection (e.g., peripheral neuropathy) as described under the criteria in 11.00ff.

or

I. HIV wasting syndrome, characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss, as described in 14.00D2) and, in the absence of a concurrent illness that could explain the findings, either:

1. Chronic diarrhea with two or more loose stools daily lasting for 1 month or longer; or

2. Chronic weakness and documented fever greater than 38° C (100.4° F) for the majority of 1 month or longer.

or

J. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

or

K. Cardiomyopathy, as described under the criteria in 4.00ff or 11.04.

or

L. Nephropathy, as described under the criteria in 6.00ff.

or

M. One or more of the following infections (other than described in A–L, above), resistant to treatment or requiring hospitalization or intravenous treatment 3 or more times in 1 year (or evaluate sequelae under the criteria for the affected body system).

1. Sepsis; or

2. Meningitis; or

3. Pneumonia; or

4. Septic arthritis; or

5. Endocarditis; or

6. Radiographically documented sinusitis.

or

N. Repeated (as defined in 14.00D8) manifestations of HIV infection (including those listed in 14.08A–M, but without the requisite findings, e.g., carcinoma of the cervix not meeting the criteria in 14.08E, diarrhea not meeting the criteria in 14.08J, or other manifestations, e.g., oral hairy leukoplakia, myositis) resulting in significant, documented symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats) and one of the following at the marked level (as defined in 14.00D8):

1. Restriction of activities of daily living; or

2. Difficulties in maintaining social functioning; or

3. Difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Part B

Medical criteria for the evaluation of impairments of children under age 18 (where criteria in Part A do not give appropriate consideration to the particular disease process in childhood).

Sec.
100.00 Growth Impairment.
101.00 Musculoskeletal System.
102.00 Special Senses and Speech.
103.00 Respiratory System.
104.00 Cardiovascular System.
105.00 Digestive System.
106.00 Genito-Urinary System.
107.00 Hemic and Lymphatic System.
108.00 [Reserved]
109.00 Endocrine System.
110.00 Multiple Body Systems.
111.00 Neurological.
112.00 Mental and Emotional Disorders.
113.00 Neoplastic Diseases, Malignant.
114.00 Immune System.

100.00 GROWTH IMPAIRMENT

A. *Impairment of growth* may be disabling in itself or it may be an indicator of the severity of the impairment due to a specific disease process.

Determinations of growth impairment should be based upon the comparison of current height with at least three previous determinations, including length at birth, if available. Heights (or lengths) should be plotted

on a standard growth chart, such as derived from the National Center for Health Statistics: NCHS Growth Charts. Height should be measured without shoes. Body weight corresponding to the ages represented by the heights should be furnished. The adult heights of the child's natural parents and the heights and ages of siblings should also be furnished. This will provide a basis upon which to identify those children whose short stature represents a familial characteristic rather than a result of disease. This is particularly true for adjudication under 100.02B.

B. *Bone age determinations* should include a full descriptive report of roentgenograms specifically obtained to determine bone age and must cite the standardization method used. Where roentgenograms must be obtained currently as a basis for adjudication under 100.03, views of the left hand and wrist should be ordered. In addition, roentgenograms of the knee and ankle should be obtained when cessation of growth is being evaluated in an older child at, or past, puberty.

C. The criteria in this section are applicable until closure of the major epiphyses. The cessation of significant increase in height at that point would prevent the application of these criteria.

100.01 Category of Impairments, Growth

100.02 *Growth impairment,* considered to be related to an additional specific medically determinable impairment, and one of the following:

A. Fall of greater than 15 percentiles in height which is sustained; or

B. Fall to, or persistence of, height below the third percentile.

100.03 *Growth impairment,* not identified as being related to an additional, specific medically determinable impairment. With:

A. Fall of greater than 25 percentiles in height which is sustained; and

B. Bone age greater than two standard deviations (2 SD) below the mean for chronological age (see 100.00B).

101.00 Musculoskeletal System

A. *Rheumatoid arthritis.* Documentation of the diagnosis of juvenile rheumatoid arthritis should be made according to an established protocol, such as that published by the Arthritis Foundation, *Bulletin on the Rheumatic Diseases.* Vol. 23, 1972–1973 Series, p 712. Inflammatory signs include persistent pain, tenderness, erythema, swelling, and increased local temperature of a joint.

B. *The measurements of joint motion* are based on the technique for measurements described in the ''Joint Method of Measuring and Recording.'' published by the American Academy of Orthopedic Surgeons in 1965, or ''The Extremities and Back'' in *Guides to the Evaluation of Permanent Impairment,* Chicago, American Medical Association, 1971, Chapter 1, pp. 1–48.

C. *Degenerative arthritis* may be the end stage of many skeletal diseases and conditions, such as traumatic arthritis, collagen disorders septic arthritis, congenital dislocation of the hip, aseptic necrosis of the hip, slipped capital femoral epiphyses, skeletal dysplasias, etc.

101.01 Category of Impairments, Musculoskeletal

101.02 *Juvenile rheumatoid arthritis.* With:

A. Persistence or recurrence of joint inflammation despite three months of medical treatment and one of the following:

1. Limitation of motion of two major joints of 50 percent or greater; or

2. Fixed deformity of two major weight-bearing joints of 30 degrees or more; or

3. Radiographic changes of joint narrowing, erosion, or subluxation; or

4. Persistent or recurrent systemic involvement such as iridocyclitis or pericarditis; or

B. Steroid dependence.

101.03 *Deficit of musculoskeletal function* due to deformity or musculoskeletal disease and one of the following:

A. Walking is markedly reduced in speed or distance despite orthotic or prosthetic devices; or

B. Ambulation is possible only with obligatory bilateral upper limb assistance (e.g., with walker, crutches); or

C. Inability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene.

101.05 *Disorders of the spine.*

A. Fracture of vertebra with cord involvement (substantiated by appropriate sensory and motor loss); or

B. Scoliosis (congenital idiopathic or neuromyopathic). With:

1. Major spinal curve measuring 60 degrees or greater; or

2. Spinal fusion of six or more levels. Consider under a disability for one year from the time of surgery; thereafter evaluate the residual impairment; or

3. FEV (vital capacity) of 50 percent or less of predicted normal values for the individual's measured (actual) height; or

C. Kyphosis or lordosis measuring 90 degrees or greater.

101.08 *Chronic osteomyelitis* with persistence or recurrence of inflammatory signs or drainage for at least 6 months despite prescribed therapy and consistent radiographic findings.

102.00 Special Senses and Speech

A. *Visual impairments in children.* Impairment of central visual acuity should be determined with use of the standard Snellen test chart. Where this cannot be used, as in very young children, a complete description should be provided of the findings using other appropriate methods of examination, including a description of the techniques

used for determining the central visual acuity for distance.

The accommodative reflex is generally not present in children under 6 months of age. In premature infants, it may not be present until 6 months plus the number of months the child is premature. Therefore absence of accommodative reflex will be considered as indicating a visual impairment only in children above this age (6 months).

Documentation of a visual disorder must include description of the ocular pathology.

B. *Hearing impairments in children.* The criteria for hearing impairments in children take into account that a lesser impairment in hearing which occurs at an early age may result in a severe speech and language disorder.

Improvement by a hearing aid, as predicted by the testing procedure, must be demonstrated to be feasible in that child, since younger children may be unable to use a hearing aid effectively.

The type of audiometric testing performed must be described and a copy of the results must be included. The pure tone air conduction hearing levels in 102.08 are based on American National Standard Institute Specifications for Audiometers, S3.6–1969 (ANSI–1969). The report should indicate the specifications used to calibrate the audiometer.

The finding of a severe impairment will be based on the average hearing levels at 500, 1000, 2000, and 3000 Hertz (Hz) in the better ear, and on speech discrimination, as specified in § 102.08.

102.01 Category of Impairments, Special Sense Organs

102.02 *Impairments of central visual acuity.*

A. Remaining vision in the better eye after best correction is 20/200 or less; or

B. For children below 3 years of age at time of adjudication:

1. Absence of accommodative reflex (see 102.00A for exclusion of children under 6 months of age); or

2. Retrolental fibroplasia with macular scarring or neovascularization; or

3. Bilateral congenital cataracts with visualization of retinal red reflex only or when associated with other ocular pathology.

102.08 *Hearing impairments.*

A. For children below 5 years of age at time of adjudication, inability to hear air conduction thresholds at an average of 40 decibels (db) hearing level or greater in the better ear; or

B. For children 5 years of age and above at time of adjudication:

1. Inability to hear air conduction thresholds at an average of 70 decibels (db) or greater in the better ear; or

2. Speech discrimination scores at 40 percent or less in the better ear; or

3. Inability to hear air conduction thresholds at an average of 40 decibels (db) or greater in the better ear, and a speech and language disorder which significantly affects the clarity and content of the speech and is attributable to the hearing impairment.

103.00 Respiratory System

A. *Introduction.* The listings in this section describe impairments resulting from respiratory disorder based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of treatment prescribed by a treating source. Respiratory disorders, along with any associated impairment(s) must be established by medical evidence. Evidence must be provided in sufficient detail to permit an independent reviewer to evaluate the severity of the impairment. Reasonable efforts should be made to ensure evaluation by a program physician specializing in childhood respiratory impairments or a qualified pediatrician.

Many children, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is such evidence, the longitudinal clinical record must include a description of the treatment prescribed by the treating source and response, in addition to information about the nature and severity of the impairment. It is important to document any prescribed treatment and response because this medical management may have improved the child's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some children will not have received ongoing treatment or have an ongoing relationship with the medical community, despite the existence of a severe impairment(s). A child who does not receive treatment may or may not be able to show an impairment that meets the criteria of these listings. Even if a child does not show that his or her impairment meets the criteria of these listings, the child may have an impairment(s) equivalent in severity to one of the listed impairments or be disabled because of a substantial reduction in the ability to function independently, appropriately, and effectively in an age-appropriate manner. Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the level of the child's functioning, and the frequency, severity, and duration of symptoms. Also, the asthma listing specifically includes a requirement for continuing signs and symptoms despite a regimen of prescribed treatment.

Evaluation should include consideration of adverse effects of respiratory impairment in all relevant body systems, and especially on the child's growth and development or mental functioning, as described under the growth impairment (100.00), neurological (111.00), and mental disorders (112.00) listings.

It must be remembered that these listings are only examples of common respiratory disorders that are severe enough to prevent a child from functioning independently, appropriately, and effectively in an age-appropriate manner. When a child has a medically determinable impairment that is not listed, an impairment which does not meet a listing, or a combination of impairments no one of which meets a listing, we may make an equivalence determination on medical or functional grounds. Also, with respect to children claiming SSI benefits under title XVI of the Act who have an impairment(s) with a level of severity which does not meet or equal (medically or functionally) the criteria of the listings, we will determine whether the impairment(s) is of comparable severity to one that would disable an adult. In these cases, we will perform an individualized functional assessment to determine whether the child is disabled.

B. *Documentation of Pulmonary Function Testing.* The results of spirometry that are used for adjudication, under the 103.02 A and B, 103.03, and 103.04 of these listings should be expressed in liters (L), body temperature and pressure saturated with water vapor (BTPS). The reported one-second forced expiratory volume (FEV_1) and forced vital capacity (FVC) should represent the largest of at least three satisfactory forced expiratory maneuvers. Two of the satisfactory spirograms should be reproducible for both pre-bronchodilator tests and, if indicated, post-bronchodilator tests. A value is considered reproducible if it does not differ from the largest value by more than 5 percent or 0.1 L, whichever is greater. The highest values of the FEV_1 and FVC, whether from the same or different tracings, should be used to assess the severity of the respiratory impairment. Peak flow should be achieved early in expiration, and the spirogram should have a smooth contour with gradually decreasing flow throughout expiration. The zero time for measurement of the FEV_1 and FVC, if not distinct, should be derived by linear back-extrapolation of peak flow to zero volume. A spirogram is satisfactory for measurement of the FEV_1 if the expiratory volume at the back-extrapolated zero time is less than 5 percent of the FVC or 0.1 L, whichever is greater. The spirogram is satisfactory for measurement of the FVC if maximal expiratory effort continues for at least 6 seconds, or if there is a plateau in the volume-time curve with no detectable change in expired volume (VE) during the last 2 seconds of maximal expiratory effort.

Spirometry should be repeated after administration of an aerosolized bronchodilator under supervision of the testing personnel if the pre-bronchodilator FEV_1 value is less than the appropriate reference value in table I or III, as appropriate. If a bronchodilator is not administered, the reason should be clearly stated in the report. Pulmonary function studies should not be performed unless the clinical status is stable (e.g., the child is not having an asthmatic attack or suffering from an acute respiratory infection or other chronic illness). Wheezing is common in asthma, chronic bronchitis, or chronic obstructive pulmonary disease and does not preclude testing. Pulmonary function studies performed to assess airflow obstruction without testing after bronchodilators cannot be used to assess levels of impairment in the range that prevents a child from performing age-appropriate activities, unless the use of bronchodilators is contraindicated. Post-bronchodilator testing should be performed 10 minutes after bronchodilator administration. The dose and name of the bronchodilator administered should be specified. The values in 103.02 and 103.04 must only be used as criteria for the level of ventilatory impairment that exists during the child's most stable state of health (i.e., any period in time except during or shortly after an exacerbation).

The appropriately labeled spirometric tracing, showing the child's name, date of testing, distance per second on the abscissa and distance per liter (L) on the ordinate, must be incorporated into the file. The manufacturer and model number of the device used to measure and record the spirogram should be stated. The testing device must accurately measure both time and volume, the latter to within 1 percent of a 3 L calibrating volume. If the spirogram was generated by any means other than direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show a recorded calibration of volume units using a mechanical volume input such as a 3 L syringe.

If the spirometer directly measures flow, and volume is derived by electronic integration, the linearity of the device must be documented by recording volume calibrations at three different flow rates of approximately 30 L/min (3 L/6 sec), 60 L/min (3 L/3 sec), and 180 L/min (3 L/sec). The volume calibrations should agree to within 1 percent of a 3 L calibrating volume. The proximity of the flow sensor to the child should be noted, and it should be stated whether or not a BTPS correction factor was used for the calibration recordings and for the child's actual spirograms.

The spirogram must be recorded at a speed of at least 20 mm/sec and the recording device must provide a volume excursion of at least 10 mm/L. If reproductions of the original spirometric tracings are submitted, they must be legible and have a time scale of at least 20 mm/sec and a volume scale of at least 10 mm/L to permit independent measurements. Calculation of FEV_1 from a flow volume tracing is not acceptable, i.e., the

spirogram and calibrations must be presented in a volume-time format at a speed of at least 20 mm/sec and a volume excursion of at least 10 mm/L to permit independent evaluation.

A statement should be made in the pulmonary function test report of the child's ability to understand directions, as well as his or her efforts and cooperation in performing the pulmonary function tests.

Purchase of a pulmonary function test is appropriate only when the child is capable of performing reproducible forced expiratory maneuvers. This capability usually occurs around age 6. Purchase of a pulmonary function test may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided.

The pulmonary function tables in 103.02 and 103.04 are based on measurement of standing height without shoes. If a child has marked spinal deformities (e.g., kyphoscoliosis), the measured span between the fingertips with the upper extremities abducted 90 degrees should be substituted for height when this measurement is greater than the standing height without shoes.

C. *Documentation of chronic impairment of gas exchange.*

1. *Arterial blood gas studies (ABGS).* An ABGS performed at rest (while breathing room air, awake and sitting or standing) should be analyzed in a laboratory certified by a State or Federal agency. If the laboratory is not certified, it must submit evidence of participation in a national proficiency testing program as well as acceptable quality control at the time of testing. The report should include the altitude of the facility and the barometric pressure on the date of analysis.

Purchase of resting ABGS may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided. Before purchasing resting ABGS, a program physician, preferably one experienced in the care of children with pulmonary disease, must review the clinical and laboratory data short of this procedure, including spirometry, to determine whether obtaining the test would present a significant risk to the child.

2. *Oximetry.* Pulse oximetry may be substituted for arterial blood gases in children under 12 years of age. The oximetry unit should employ the basic technology of spectrophotometric plethysmography as described in Taylor, M.B., and Whitwain, J.G., ''Current Status of Pulse Oximetry,'' ''Anesthesia,'' Vol. 41, No. 9, pp. 943–949, 1986. The unit should provide a visual display of the pulse signal and the corresponding oxygen saturation. A hard copy of the readings (heart rate and saturation) should be provided. Readings should be obtained for a minimum of 5 minutes. The written report should describe patient activity during the recording, i.e., sleep rate, feeding, or exercise. Correlation between the actual heart rate determined by a trained observer and that displayed by the oximeter should be provided. A statement should be made in the report of the child's effort and cooperation during the test.

Purchase of oximetry may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided.

D. *Cystic fibrosis* is a disorder that affects either the respiratory or digestive body systems or both and may impact on a child's growth and development. It is responsible for a wide and variable spectrum of clinical manifestations and complications. Confirmation of the diagnosis is based upon an elevated sweat sodium concentration or chloride concentration accompanied by one or more of the following: the presence of chronic obstructive pulmonary disease, insufficiency of exocrine pancreatic function, meconium ileus, or a positive family history. The quantitative pilocarpine iontophoresis procedure for collection of sweat content must be utilized. Two methods are acceptable: the ''Procedure for the Quantitative Iontophoretic Sweat Test for Cystic Fibrosis,'' published by the Cystic Fibrosis Foundation and contained in, ''A Test for Concentration of Electrolytes in Sweat in Cystic Fibrosis of the Pancreas Utilizing Pilocarpine Iontophoresis,'' Gibson, I.E., and Cooke, R.E., ''Pediatrics,'' Vol 23: 545, 1959; or the ''Wescor Macroduct System.'' To establish the diagnosis of cystic fibrosis, the sweat sodium or chloride content must be analyzed quantitatively using an acceptable laboratory technique. Another diagnostic test is the ''CF gene mutation analysis'' for homozygosity of the cystic fibrosis gene. The pulmonary manifestations of this disorder should be evaluated under 103.04. The nonpulmonary aspects of cystic fibrosis should be evaluated under the listings for the digestive system (105.00) or growth impairments (100.00). Because cystic fibrosis may involve the respiratory and digestive body systems, as well as impact on a child's growth and development, the combined effects of this involvement must be considered in case adjudication.

E. *Bronchopulmonary dysplasia (BPD).* Bronchopulmonary dysplasia is a form of chronic obstructive pulmonary disease that arises as a consequence of acute lung injury in the newborn period and treatment of hyaline membrane disease, meconium aspiration, neonatal pneumonia and apnea of prematurity. The diagnosis is established by the requirement for continuous or nocturnal supplemental oxygen for more than 30 days,

in association with characteristic radiographic changes and clinical signs of respiratory dysfunction, including retractions, rales, wheezing, and tachypnea.

103.01 Category of Impairments, Respiratory System

103.02 *Chronic pulmonary insufficiency*. With:

A. Chronic obstructive pulmonary disease, due to any cause, with the FEV_1 equal to or less than the value specified in Table I corresponding to the child's height without shoes. (In cases of marked spinal deformity, see 103.00B.);

TABLE I

Height without shoes (centimeters)	Height without shoes (inches)	FEV_1 equal to or less than (L, BTPS)
119 or less	46 or less	0.65
120–129	47–50	0.75
130–139	51–54	0.95
140–149	55–58	1.15
150–159	59–62	1.35
160–164	63–64	1.45
165–169	65–66	1.55
170 or more	67 or more	1.65

Or

B. Chronic restrictive ventilatory disease, due to any cause, with the FVC equal to or less than the value specified in table II corresponding to the child's height without shoes. (In cases of marked spinal deformity, see 103.00B.);

TABLE II

Height without shoes (centimeters)	Height without shoes (inches)	FVC equal to or less than (L, BTPS)
119 or less	46 or less	0.65
120–129	47–50	0.85
130–139	51–54	1.05
140–149	55–58	1.25
150–159	59–62	1.45
160–164	63–64	1.65
165–169	65–66	1.75
170 or more	67 or more	2.05

Or

C Frequent need for:

1. Mechanical ventilation; or

2. Nocturnal supplemental oxygen as required by persistent or recurrent episodes of hypoxemia;

Or

D. The presence of a tracheostomy in a child under 3 years of age;

Or

E. Bronchopulmonary dysplasia characterized by two of the following:

1. Prolonged expirations; or

2. Intermittent wheezing or increased respiratory effort as evidenced by retractions, flaring and tachypnea; or

3. Hyperinflation and scarring on a chest radiograph or other appropriate imaging techniques; or

4. Bronchodilator or diuretic dependency; or

5. A frequent requirement for nocturnal supplemental oxygen; or

6. Weight disturbance with:

a. An 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) which persists for 2 months or longer; or

b. An 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) which persists for 2 months or longer;

Or

F. Two required hospital admissions (each longer than 24 hours) within a 6-month period for recurrent lower respiratory tract infections or acute respiratory distress associated with:

1. Chronic wheezing or chronic respiratory distress; or

2. Weight disturbance with:

a. An 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) which persists for 2 months or longer; or

b. An 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) which persists for 2 months or longer;

Or

G. Chronic hypoventilation ($PaCO_2$ greater than 45 mm Hg) or chronic cor pulmonale as described under the appropriate criteria in 104.02;

Or

H. Growth impairment as described under the criteria in 100.00.

103.03 Asthma. With:

A. FEV_1 equal to or less than the value specified in Table I of 103.02A;

Or

B. Attacks (as defined in 3.00C), in spite of prescribed treatment and requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for control of asthma counts as two attacks, and an evaluation period of at

least 12 consecutive months must be used to determine the frequency of attacks;

Or

C. Persistent low-grade wheezing between acute attacks or absence of extended symptom-free periods requiring daytime and nocturnal use of sympathomimetic bronchodilators with one of the following:

1. Persistent prolonged expiration with radiographic or other appropriate imaging techniques evidence of pulmonary hyperinflation or peribronchial disease; or

2. Short courses of corticosteroids that average more than 5 days per month for at least 3 months during a 12-month period;

Or

D. Growth impairment as described under the criteria in 100.00.

103.04 Cystic fibrosis. With:

A. An FEV_1 equal to or less than the appropriate value specified in Table III corresponding to the child's height without shoes. (In cases of marked spinal deformity, see 103.00B.);

Or

B. For children in whom pulmonary function testing cannot be performed, the presence of two of the following:

1. History of dyspnea on exertion or accumulation of secretions as manifested by repetitive coughing or cyanosis; or

2. Persistent bilateral rales and rhonchi or substantial reduction of breath sounds related to mucous plugging of the trachea or bronchi; or

3. Radiographic evidence of extensive disease, such as thickening of the proximal bronchial airways or persistence of bilateral peribronchial infiltrates;

Or

C. Persistent pulmonary infection accompanied by superimposed, recurrent, symptomatic episodes of increased bacterial infection occurring at least once every 6 months and requiring intravenous or nebulization antimicrobial treatment;

Or

D. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure (documented according to 3.00C), requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for treatment counts as two episodes, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of episodes;

Or

E. Growth impairment as described under the criteria in 100.00.

TABLE III

[Applicable only for evaluation under 103.04A—cystic fibrosis]

Height without shoes (centimeters)	Height without shoes (inches)	FEV_1 equal to or less than (L, BTPS)
119 or less	46 or less	0.75
120–129	47–50	0.85
130–139	51–54	1.05
140–149	55–58	1.35
150–159	59–62	1.55
160–164	63–64	1.85
165–169	65–66	2.05
170 or more	67 or more	2.25

104.00 CARDIOVASCULAR SYSTEM

A. *Introduction*

The listings in this section describe childhood impairments resulting from congenital or acquired cardiovascular disease based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of therapy prescribed by a treating source. A longitudinal clinical record covering a period of not less than 3 months of observations and therapy is usually necessary for the assessment of severity and expected duration unless the child is a neonate or the claim can be decided favorably on the basis of the current evidence. All relevant evidence must be considered in assessing a child's disability. Reasonable efforts should be made to ensure evaluation by a program physician specializing in childhood cardiovascular impairments or a qualified pediatrician.

Examples of congenital defects include: abnormalities of cardiac septation, such as ventricular septal defect or atrioventricular (AV) canal; abnormalities resulting in cyanotic heart disease, such as tetralogy of Fallot or transposition of the vessels; valvular defects or obstructions to ventricular outflow, including pulmonary or aortic stenosis and/or coarctation of the aorta; and major abnormalities of ventricular development, including hypoplastic left heart syndrome or pulmonary tricuspid atresia with hypoplastic right ventricle. Acquired heart disease may be due to cardiomyopathy, rheumatic heart disease, Kawasaki syndrome, or other etiologies. Recurrent arrhythmias, severe enough to cause functional impairment, may be seen with congenital or acquired heart disease or, more rarely, in children with structurally normal hearts.

Cardiovascular impairments, especially chronic heart failure and congenital heart disease, may result in impairments in other body systems including, but not limited to, growth, neurological, and mental. Therefore, evaluation should include consideration of

the adverse effects of cardiovascular impairment in all relevant body systems, and especially on the child's growth and development, or mental functioning, as described under the Growth impairment (100.00), Neurological (111.00), and Mental retardation (112.05) listings.

Many children, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is evidence of such treatment, the longitudinal clinical record must include a description of the therapy prescribed by the treating source and response, in addition to information about the nature and severity of the impairment. It is important to document any prescribed therapy and response because this medical management may have improved the child's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some children will not have received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment(s). Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the level of the child's functioning, and the frequency, severity, and duration of symptoms. Also, several listings include a requirement for continuing signs and symptoms despite a regimen of prescribed treatment. Even though a child who does not receive treatment may not be able to show an impairment that meets the criteria of these listings, the child may have an impairment(s) equivalent in severity to one of the listed impairments or be disabled because of a substantial reduction in the ability to function independently, appropriately, and effectively in an age-appropriate manner.

Indeed, it must be remembered that these listings are only examples of common cardiovascular disorders that are severe enough to prevent a child from functioning independently, appropriately, and effectively in an age-appropriate manner. When a child has a medically determinable impairment that is not listed, or a combination of impairments no one of which meets a listing, we will make an equivalence determination. Also, with respect to children claiming SSI benefits under title XVI of the Act who have an impairment(s) with a level of severity which does not meet or equal the criteria of the cardiovascular listings, we will determine whether the impairment(s) is of comparable severity to one that would disable an adult. In these cases, an individualized functional assessment is crucial to the evaluation of a child's ability to function independently, appropriately, and effectively in an age-appropriate manner when the impairment(s) is severe but the criteria of these listings are not met or equaled.

B. Documentation

Each child's file must include sufficiently detailed reports on history, physical examinations, laboratory studies, and any prescribed therapy and response to allow an independent reviewer to assess the severity and duration of the cardiovascular impairment. Data should be obtained preferably from an office or center experienced in pediatric cardiac assessment. The actual electrocardiographic tracing (or adequately marked photocopy) and echocardiogram report with a copy of relevant echocardiographic views should be included (see part A, 4.00C1).

Results of additional studies necessary to substantiate the diagnosis or to document the severity of the impairment, including two-dimensional and Doppler echocardiography, and radionuclide ventriculograms, should be obtained as appropriate according to part A, 4.00C3. Ambulatory electrocardiographic monitoring may also be obtained if necessary to document the presence or severity of an arrhythmia.

Exercise testing, though increasingly used, is still less frequently indicated in children than in adults, and can rarely be successfully performed in children under 6 years of age. It may be of value in the assessment of some arrhythmias, in the assessment of the severity of chronic heart failure, and in the assessment of recovery of function following cardiac surgery or other therapy. It will only be purchased by the Social Security Administration if the case cannot be decided based on the available evidence and, if purchased, must be performed in a specialty center for pediatric cardiology or other facility qualified to perform exercise testing for children.

Purchased exercise tests should be performed using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice. An exercise test should not be purchased for a child for whom the performance of the test is considered to constitute a significant risk by a program physician. See 4.00C2c.

Cardiac catheterization will not be purchased by the Social Security Administration. If the results of catheterization are otherwise available, they should be obtained.

C. Treatment and Relationship to Functional Status

In general, conclusions about the severity of a cardiovascular impairment cannot be made on the basis of type of treatment rendered or anticipated. The overall clinical and laboratory evidence, including the treatment plan(s) or results, should be persuasive that a listing-level impairment exists. The

amount of function restored and the time required for improvement after treatment (medical, surgical, or a prescribed program of progressive physical activity) vary with the nature and extent of the disorder, the type of treatment, and other factors. Depending upon the timing of this treatment in relation to the alleged onset date of disability, impairment evaluation may need to be deferred for a period of up to 3 months from the date of treatment to permit consideration of treatment effects.

Evaluation should not be deferred if the claim can be favorably decided based upon the available evidence.

The most life-threatening forms of congenital heart disease and cardiac impairments, such as those listed in 104.00D, almost always require surgical treatment within the first year of life to prevent early death. Even with surgery, these impairments are so severe that it is likely that the impairment will continue to be disabling long enough to meet the duration requirement because of significant residual impairment post-surgery, or the recovery time from surgery, or a combination of both factors. Therefore, when the impairment is one of those named in 104.00D, or is as severe as one of those impairments, the presence of a listing-level impairment can usually be found on the basis of planned or actual cardiac surgery.

A child who has undergone surgical treatment for life-threatening heart disease will be found under a disability for 12 months following the date of surgery under 104.06H (for infants with life-threatening cardiac disease) or 104.09 (for a child of any age who undergoes cardiac transplantation) because of the uncertainty during that period concerning outcome or long-term results. After 12 months, continuing disability evaluation will be based upon residual impairment, which will consider the clinical course following treatment and comparison of symptoms, signs, and laboratory findings preoperatively and after the specified period. (See §§416.994a, 404.1594, or 416.994, as appropriate, for our rules on medical improvement and whether an individual is no longer disabled.)

D. Congenital Heart Disease

Some congenital defects usually lead to listing-level impairment in the first year of life and require surgery within the first year as a life-saving measure. Examples of impairments that in most instances will require life-saving surgery before age 1, include, but are not limited to, the following: hypoplastic left heart syndrome; critical aortic stenosis with neonatal heart failure; critical coarctation of the aorta, with or without associated anomalies; complete AV canal defects; transposition of the great arteries; tetralogy of Fallot; and pulmonary atresia with intact ventricular septum.

In addition, there are rarer defects which may lead to early mortality and that may require multiple surgical interventions or a combination of surgery and other major interventional procedures (e.g., multiple ''balloon'' catheter procedures). Examples of such defects include single ventricle, tricuspid atresia, and multiple ventricular septal defects.

Pulmonary vascular obstructive disease can cause cardiac impairment in young children. When a large or nonrestrictive septal defect or ductus is present, pulmonary artery mean pressures of at least 70 percent of mean systemic levels are used as a criterion of listing-level impairment. In the absence of such a defect (i.e., with primary pulmonary hypertension, or in some connective tissue disorders with cardiopulmonary involvement and pulmonary vascular destruction), listing-level impairment may be present at lower levels of pulmonary artery pressure, in the range of at least 50 percent of mean systemic levels.

E. Chronic Heart Failure

Chronic heart failure in infants and children may manifest itself by pulmonary or systemic venous congestion, including cardiomegaly, chronic dyspnea, tachypnea, orthopnea, or hepatomegaly; or symptoms of limited cardiac output, such as weakness or fatigue; or a need for cardiotonic drugs. Fatigue or exercise intolerance in an infant may be manifested by prolonged feeding time associated with signs of cardiac impairment, including excessive respiratory effort and sweating. Other manifestations of chronic heart failure during infancy may include failure to gain weight or involuntary loss of weight and repeated lower respiratory tract infections.

Cardiomegaly or ventricular dysfunction must be present and demonstrated by imaging techniques, such as two-dimensional and Doppler echocardiography. (Reference: Feigenbaum, Harvey, ''Echocardiography,'' 4th Edition, Lea and Febiger, 1986, Appendix, pp. 621–639.) Chest x-ray (6 ft. PA film) will be considered indicative of cardiomegaly if the cardiothoracic ratio is over 60 percent at age 1 year or less, or 55 percent at more than 1 year of age.

Findings of cardiomegaly on chest x-ray must be accompanied by other evidence of chronic heart failure or ventricular dysfunction. This evidence may include clinical evidence, such as hepatomegaly, edema, or pulmonary venous congestion; or echocardiographic evidence, such as marked ventricular dilatation above established normals for age, or markedly reduced ejection fraction or shortening fraction.

F. Valvular Heart Disease

Valvular heart disease requires documentation by appropriate imaging techniques, including Doppler echocardiogram studies or cardiac catheterization if catheterization results are available from a treating source or other source of record. Listing-level impairment is usually associated with critical aortic stenosis in a newborn child, persistent heart failure, arrhythmias, or valve replacement and ongoing anticoagulant therapy. The usual time after valvular surgery for adequate assessment of the results of treatment is considered to be 3 months.

G. Rheumatic Heart Disease

The diagnosis should be made in accordance with the current revised Jones criteria for guidance in the diagnosis of rheumatic fever.

104.01 Category of Impairments, Cardiovascular System

104.02 *Chronic heart failure.* Documented by clinical and laboratory findings as described in 104.00E, and with one of the following:

A. Persistent tachycardia at rest (see Table I);

OR

B. Persistent tachypnea at rest (see Table II), or markedly decreased exercise tolerance (see 104.00E);

OR

C. Recurrent arrhythmias, as described in 104.05;

OR

D. Growth disturbance, with:

1. An 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) which persists for 2 months or longer; or

2. An 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) which persists for 2 months or longer; or

3. Growth impairment as described under the criteria in 100.00.

TABLE I—TACHYCARDIA AT REST

Age	Apical heart (beats per minute)
Under 1 yr	150
1 through 3 yrs	130
4 through 9 yrs	120
10 through 15 yrs	110
Over 15 yrs	100

TABLE II—TACHYPNEA AT REST

Age	Respiratory rate over (per minute)
Under 1 yr	40
1 through 5 yrs	35
6 through 9 yrs	30
Over 9 yrs	25

104.03 *Hypertensive cardiovascular disease.* With persistently elevated blood pressure equal to or greater than the 95th percentile for age (see Table III), and one of the following:

A. Impaired renal function, as described in 106.02;

OR

B. Cerebrovascular damage, as described in 111.06;

OR

C. Chronic heart failure as described in 104.02.

TABLE III—ELEVATED BLOOD PRESSURE

Age	Systolic over (mmHg)	*OR*	Diastolic over (mmHg)
Under 1 month	95		—
1 month through 2 yrs	112		74
3 through 5 yrs	116		76
6 through 9 yrs	122		78
10 through 12 yrs	126		82
13 through 15 yrs	136		86
16 to 18 yrs	142		92

104.05 *Recurrent arrhythmias,* such as persistent or recurrent heart block (A–V dissociation), repeated symptomatic tachyarrhythmias or bradyarrhythmias or long QT syndrome arrhythmias, not related to reversible causes such as electrolyte abnormalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled repeated episodes of cardiac syncope or near syncope and arrhythmia despite prescribed treatment, including electronic pacemaker (see 104.00A if there is no

prescribed treatment), and documented by resting or ambulatory (Holter) electrocardiography coincident with the occurrence of syncope or near syncope.

104.06 *Congenital heart disease.* With one of the following:

A. Cyanotic heart disease, with persistent, chronic hypoxemia as manifested by:

1. Hematocrit of 55 percent or greater on two or more evaluations within a 3-month period; or

2. Arterial O_2 saturation of less than 90 percent in room air, or resting PO_2 of 60 Torr or less; or

3. Hypercyanotic spells, syncope, characteristic squatting, or other incapacitating symptoms directly related to documented cyanotic heart disease; or

4. Exercise intolerance with increased hypoxemia on exertion;

OR

B. Chronic heart failure with evidence of ventricular dysfunction, as described in 104.02;

OR

C. Recurrent arrhythmias as described in 104.05;

OR

D. Secondary pulmonary vascular obstructive disease with a mean pulmonary arterial pressure elevated to at least 70 percent of the mean systemic arterial pressure;

OR

E. Congenital valvular or other stenotic defects, or valvular regurgitation, as described in 104.00F and 104.07;

OR

F. Symptomatic acyanotic heart disease, with ventricular dysfunction resulting in significant restriction of age-appropriate activities or inability to complete age-appropriate tasks (see 104.00A);

OR

G. Growth failure, as described in 100.00;

OR

H. For infants under 12 months of age at the time of filing, with life-threatening congenital heart impairment that will or has required surgical treatment in the first year of life, consider the infant to be under a disability until the attainment of age 1 or for 12 months after surgery, whichever is the later event; thereafter, evaluate impairment severity with reference to 104.02 to 104.08.

104.07 *Valvular heart disease or other stenotic defects, or valvular regurgitation,* documented by appropriate imaging techniques or cardiac catheterization.

A. Evaluate according to criteria in 104.02, 104.05, 111.06, or 11.04;

OR

B. Critical aortic stenosis in newborn.

104.08 *Cardiomyopathies,* documented by appropriate imaging techniques, including echocardiography or cardiac catheterization, if catheterization results are available from a treating source. Impairment must be associated with an ejection fraction of 50 percent or less and significant left ventricular dilatation using standardized age-appropriate echocardiographic ventricular cavity measurements. Evaluate under the criteria in 104.02, 104.05, or 111.06.

104.09 *Cardiac transplantation.* Consider under a disability for 1 year following surgery; thereafter, evaluate residual impairment under 104.02 to 104.08.

104.13 *Chronic rheumatic fever or rheumatic heart disease.* Consider under a disability for 18 months from the established onset of impairment with one of the following:

A. Persistence of rheumatic fever activity for 6 months or more which is manifested by significant murmur(s), cardiac enlargement (see 104.00E) or ventricular dysfunction, and other abnormal laboratory findings, as for example, an elevated sedimentation rate or ECG findings;

OR

B. Evidence of chronic heart failure, as described under 104.02;

OR

C. Recurrent arrhythmias, as described under 104.05.

104.14 *Hyperlipidemia.* Documented Type II homozygous hyperlipidemia with repeated plasma cholesterol levels of 500 mg/ml or greater, with one of the following:

A. Myocardial ischemia, as described in 4.04B or 4.04C;

OR

B. Significant aortic stenosis documented by Doppler echocardiographic techniques or cardiac catheterization;

OR

C. Major disruption of normal life activities by repeated hospitalizations for plasmapheresis or other prescribed therapies, including liver transplant;

OR

D. Recurrent pancreatitis complicating hyperlipidemia.

104.15 *Kawasaki syndrome.* With one of the following:

A. Major coronary artery aneurysm;

OR

B. Chronic heart failure, as described in 104.02.

105.00 Digestive System

A. *Disorders of the digestive system* which result in disability usually do so because of interference with nutrition and growth, multiple recurrent inflammatory lesions, or other complications of the disease. Such lesions or complications usually respond to treatment. To constitute a listed impairment, these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Documentation of gastrointestinal impairments* should include pertinent operative findings, radiographic studies, endoscopy,

and biopsy reports. Where a liver biopsy has been performed in chronic liver disease, documentation should include the report of the biopsy.

C. *Growth retardation and malnutrition.* When the primary disorder of the digestive tract has been documented, evaluate resultant malnutrition under the criteria described in 105.08. Evaluate resultant growth impairment under the criteria described in 100.03. Intestinal disorders, including surgical diversions and potentially correctable congenital lesions, do not represent a severe impairment if the individual is able to maintain adequate nutrition growth and development.

D. *Multiple congenital anomalies.* See related criteria, and consider as a combination of impairments.

105.01 Category of Impairments, Digestive.

105.03 *Esophageal obstruction, caused by atresia, stricture, or stenosis* with malnutrition as described under the criteria in 105.08.

105.05 *Chronic liver disease.* With one of the following:

A. Inoperable billiary atresia demonstrated by X-ray or surgery; or

B. Intractable ascites not attributable to other causes, with serum albumin of 3.0 gm./100 ml. or less; or

C. Esophageal varices (demonstrated by angiography, barium swallow, or endoscopy or by prior performance of a specific shunt or plication procedure); or

D. Hepatic coma, documentated by findings from hospital records; or

E. Hepatic encephalopathy. Evaluate under the criteria in 112.02; or

F. Chronic active inflammation or necrosis documented by SGOT persistently more than 100 units or serum bilirubin of 2.5 mg. percent or greater.

105.07 *Chronic inflammatory bowel disease (such as ulcerative colitis, regional enteritis), as documented in 105.00.* With one of the following:

A. Intestinal manifestations or complications, such as obstruction, abscess, or fistula formation which has lasted or is expected to last 12 months; or

B. Malnutrition as described under the criteria in 105.08; or

C. Growth impairment as described under the criteria in 100.03.

105.08 *Malnutrition, due to demonstrable gastrointestinal disease causing either a fall of 15 percentiles of weight which persists or the persistence of weight which is less than the third percentile (on standard growth charts).* And one of the following:

A. Stool fat excretion per 24 hours:

1. More than 15 percent in infants less than 6 months.

2. More than 10 percent in infants 6–18 months.

3. More than 6 percent in children more than 18 months; or

B. Persistent hematocrit of 30 percent or less despite prescribed therapy; or

C. Serum carotene of 40 mcg./100 ml. or less; or

D. Serum albumin of 3.0 gm./100 ml. or less.

106.00 Genito-Urinary System

A. *Determination of the presence of chronic renal disease* will be based upon the following factors:

1. History, physical examination, and laboratory evidence of renal disease.

2. Indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Renal transplant.* The amount of function restored and the time required to effect improvement depend upon various factors including adequacy of post transplant renal function, incidence of renal infection, occurrence of rejection crisis, presence of systemic complications (anemia, neuropathy, etc.) and side effects of corticosteroid or immuno-suppressive agents. A period of at least 12 months is required for the individual to reach a point of stable medical improvement.

C. Evaluate associated disorders and complications according to the appropriate body system listing.

106.01 Category of Impairments, Genito-Urinary.

106.02 *Chronic renal disease.* With:

A. Persistent elevation of serum creatinine to 3 mg. per deciliter (100 ml.) or greater over at least 3 months; or

B. Reduction of creatinine clearance to 30 ml. per minute (43 liters/24 hours) per 1.73 m^2 of body surface area over at least 3 months; or

C. Chronic renal dialysis program for irreversible renal failure; or

D. Renal transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 106.00B).

106.06 Nephrotic syndrome, with edema not controlled by prescribed therapy. And:

A. Serum albumin less than 2 gm./100 ml.; or

B. Proteinuria more than 2.5 gm./1.73m^2/day.

107.00 Hemic and Lymphatic System

A. *Sickle cell disease.* Refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis must be included. Vaso-occlusive, hemolytic, or aplastic episodes

should be documented by description of severity, frequency, and duration.

Disability due to sickle cell disease may be solely the result of a severe, persistent anemia or may be due to the combination of chronic progressive or episodic manifestations in the presence of a less severe anemia.

Major visceral episodes causing disability include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genitourinary involvement, etc.

B. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence such as abnormal thromboplastin generation, coagulation time, or factor assay.

C. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The designated duration of disability implicit in the finding of a listed impairment is contained in 107.11. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of any remaining impairment must be evaluated on the basis of the medical evidence.

107.01 Category of Impairments, Hemic and Lymphatic.

107.03 *Hemolytic anemia (due to any cause).* Manifested by persistence of hematocrit of 26 percent or less despite prescribed therapy, and reticulocyte count of 4 percent or greater.

107.05 *Sickle cell disease.* With:

A. Recent, recurrent, severe vaso-occlusive crises (musculoskeletal, vertebral, abdominal); or

B. A major visceral complication in the 12 months prior to application; or

C. A hyperhemolytic or aplastic crisis within 12 months prior to application; or

D. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

E. Congestive heart failure, cerebrovascular damage, or emotional disorder as described under the criteria in 104.02, 111.00ff, or 112.00ff.

107.06 *Chronic idiopathic thrombocytopenic purpura of childhood* with purpura and thrombocytopenia of 40,000 platelets/cu. mm. or less despite prescribed therapy or recurrent upon withdrawal of treatment.

107.08 *Inherited coagulation disorder.* With:

A. Repeated spontaneous or inappropriate bleeding; or

B. Hemarthrosis with joint deformity.

107.11 *Acute leukemia.* Consider under a disability:

A. For 2½ years from the time of initial diagnosis; or

B. For 2½ years from the time of recurrence of active disease.

108.00 [RESERVED]

109.00 ENDOCRINE SYSTEM

A. *Cause of disability.* Disability is caused by a disturbance in the regulation of the secretion or metabolism of one or more hormones which are not adequately controlled by therapy. Such disturbances or abnormalities usually respond to treatment. To constitute a listed impairment these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Growth.* Normal growth is usually a sensitive indicator of health as well as of adequate therapy in children. Impairment of growth may be disabling in itself or may be an indicator of a severe disorder involving the endocrine system or other body systems. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

C. *Documentation.* Description of characteristic history, physical findings, and diagnostic laboratory data must be included. Results of laboratory tests will be considered abnormal if outside the normal range or greater than two standard deviations from the mean of the testing laboratory. Reports in the file should contain the information provided by the testing laboratory as to their normal values for that test.

D. *Hyperfunction of the adrenal cortex.* Evidence of growth retardation must be documented as described in 100.00. Elevated blood or urinary free cortisol levels are not acceptable in lieu of urinary 17-hydroxycorticosteroid excretion for the diagnosis of adrenal cortical hyperfunction.

E. *Adrenal cortical insufficiency.* Documentation must include persistent low plasma cortisol or low urinary 17-hydroxycorticosteroids or 17-ketogenic steroids and evidence of unresponsiveness to ACTH stimulation.

109.01 Category of Impairments, Endrocrine

109.02 *Thyroid Disorders.*

A. Hyperthyroidism (as documented in 109.00C). With clinical manifestations despite prescribed therapy, and one of the following:

1. Elevated serum thyroxine (T_4) and either elevated free T_4 or resin T_3 uptake; or

2. Elevated thyroid uptake of radioiodine; or

3. Elevated serum triiodothyronine (T_3).

B. *Hypothyroidism.* With one of the following, despite prescribed therapy:

1. IQ of 70 or less; or

2. Growth impairment as described under the criteria in 100.02 A and B; or

3. Precocious puberty.

109.03 *Hyperparathyroidism (as documented in 109.00C).* With:

A. Repeated elevated total or ionized serum calcium; or

B. Elevated serum parathyroid hormone.

109.04 *Hypoparathyroidism or Pseudohypoparathyroidism.* With:

A. Severe recurrent tetany or convulsions which are unresponsive to prescribed therapy; or

B. Growth retardation as described under criteria in 100.02 A and B.

109.05 *Diabetes insipidus, documented by pathologic hypertonic saline or water deprivation test.* And one of the following:

A. Intracranial space-occupying lesion, before or after surgery; or

B. Unresponsiveness to Pitressin; or

C. Growth retardation as described under the criteria in 100.02 A and B; or

D. Unresponsive hypothalmic thirst center, with chronic or recurrent hypernatremia; or

E. Decreased visual fields attributable to a pituitary lesion.

109.06 *Hyperfunction of the adrenal cortex (Primary or secondary).* With:

A. Elevated urinary 17-hyroxycorticosteroids (or 17-ketogenic steroids) as documented in 109.00 C and D; and

B. Unresponsiveness to low-dose dexamethasone suppression.

109.07 *Adrenal cortical insufficiency (as documented in 109.00 C and E)* with recent, recurrent episodes of circulatory collapse.

109.08 *Juvenile diabetes mellitus (as documented in 109.00C) requiring parenteral insulin.* And one of the following, despite prescribed therapy:

A. Recent, recurrent hospitalizations with acidosis; or

B. Recent, recurrent episodes of hypoglycemia; or

C. Growth retardation as described under the criteria in 100.02 A or B; or

D. Impaired renal function as described under the criteria in 106.00ff.

109.09 *Iatrogenic hypercorticoid state.*

With chronic glucocorticoid therapy resulting in one of the following:

A. Osteoporosis; or

B. Growth retardation as described under the criteria in 100.02 A or B; or

C. Diabetes mellitus as described under the criteria in 109.08; or

D. Myopathy as described under the criteria in 111.06; or

E. Emotional disorder as described under the criteria in 112.00ff.

109.10 *Pituitary dwarfism (with documented growth hormone deficiency).* And growth impairment as described under the criteria in 100.02B.

109.11 *Adrenogenital syndrome.* With:

A. Recent, recurrent self-losing episodes despite prescribed therapy; or

B. Inadequate replacement therapy manifested by accelerated bone age and virilization, or

C. Growth impairment as described under the criteria in 100.02 A or B.

109.12 *Hypoglycemia (as documented in 109.00C).* With recent, recurrent hypoglycemic episodes producing convulsion or coma.

109.13 *Gonadal Dysgenesis (Turner's Syndrome), chromosomally proven.* Evaluate the resulting impairment under the criteria for the appropriate body system.

110.00 Multiple Body Systems

A. This section refers to those life-threatening catastrophic congenital abnormalities and other serious hereditary, congenital, or acquired disorders that usually affect two or more body systems and are expected to:

1. Result in early death or developmental attainment of less than 2 years of age as described in listing 110.08 (e.g., anencephaly or Tay-Sachs); or

2. Produce long-term, if not life-long, significant interference with age-appropriate major daily or personal care activities as described in listings 110.06 and 110.07. (Significant interference with age-appropriate activities is considered to exist where the developmental milestone age did not exceed two-thirds of the chronological age at the time of evaluation and such interference has lasted or could be expected to last at least 12 months.) See 112.00C for a discussion of developmental milestone criteria and evaluation of age-appropriate activities.

Down syndrome (except for mosaic Down syndrome, which is to be evaluated under listing 110.07) established by clinical findings, including the characteristic physical features, and laboratory evidence is considered to meet the requirement of listing 110.06 commencing at birth. Examples of disorders that should be evaluated under listing 110.07 include mosaic Down syndrome and chromosomal abnormalities other than Down syndrome, in which a pattern of multiple impairments (including mental retardation) is known to occur, phenylketonuria (PKU), fetal alcohol syndrome, and severe chronic neonatal infections such as toxoplasmosis, rubella syndrome, cytomegalic inclusion disease, and herpes encephalitis.

B. Documentation must include confirmation of a positive diagnosis by a clinical description of the usual abnormal physical findings associated with the condition and definitive laboratory tests, including chromosomal analysis, where appropriate (e.g., Down syndrome). Medical evidence that is persuasive that a positive diagnosis has been confirmed by appropriate laboratory testing, at some time prior to evaluation, is acceptable in lieu of a copy of the actual laboratory report.

C. When multiple body system manifestations do not meet one of the established criteria of one of the listings, the combined impairments must be evaluated together to determine if they are equal in severity to a listed impairment.

110.01 Category of Impairments, Multiple Body Systems

110.06 *Down syndrome (excluding mosaic Down syndrome)* established by clinical and laboratory findings, as described in 110.00B. Consider the child disabled from birth.

110.07 *Multiple body dysfunction* due to any confirmed (see 110.00B) hereditary, congenital, or acquired condition with one of the following:

A. Persistent motor dysfunction as a result of hypotonia and/or musculoskeletal weakness, postural reaction deficit, abnormal primitive reflexes, or other neurological impairment as described in 111.00C, and with significant interference with age-appropriate major daily or personal care activities, which in an infant or young child include such activities as head control, swallowing, following, reaching, grasping, turning, sitting, crawling, walking, taking solids, feeding self; or

B. Mental impairment as described under the criteria in 112.05 or 112.12; or

C. Growth impairment as described under the criteria in 100.02A or B; or

D. Significant interference with communication due to speech, hearing, or visual impairments as described under the criteria in 102.00 and 111.09; or

E. Cardiovascular impairments as described under the criteria in 104.00; or

F. Other impairments such as, but not limited to, malnutrition, hypothyroidism, or seizures should be evaluated under the criteria in 105.08, 109.02 or 111.02 and 111.03, or the criteria for the affected body system.

110.08 *Catastrophic congenital abnormalities or disease.* With:

A. A positive diagnosis (such as anencephaly, trisomy D or E, cyclopia, etc.), generally regarded as being incompatible with extrauterine life; or

B. A positive diagnosis (such as cri du chat, Tay-Sachs Disease) wherein attainment of the growth and development level of 2 years is not expected to occur.

111.00 NEUROLOGICAL

A. *Seizure disorder* must be substantiated by at least one detailed description of a typical seizure. Report of recent documentation should include an electroencephalogram and neurological examination. Sleep EEG is preferable, especially with temporal lobe seizures. Frequency of attacks and any associated phenomena should also be substantiated.

Young children may have convulsions in association with febrile illnesses. Proper use of 111.02 and 111.03 requires that a seizure disorder be established. Although this does not exclude consideration of seizures occurring during febrile illnesses, it does require documentation of seizures during nonfebrile periods.

There is an expected delay in control of seizures when treatment is started, particularly when changes in the treatment regimen are necessary. Therefore, a seizure disorder should not be considered to meet the requirements of 111.02 or 111.03 unless it is shown that seizures have persisted more than three months after prescribed therapy began.

B. *Minor motor seizures.* Classical petit mal seizures must be documented by characteristic EEG pattern, plus information as to age at onset and frequency of clinical seizures. Myoclonic seizures, whether of the typical infantile or Lennox-gastaut variety after infancy, must also be documented by the characteristic EEG pattern plus information as to age at onset and frequency of seizures.

C. *Motor dysfunction.* As described in 111.06, motor dysfunction may be due to any neurological disorder. It may be due to static or progressive conditions involving any area of the nervous system and producing any type of neurological impairment. This may include weakness, spasticity, lack of coordination, ataxia, tremor, athetosis, or sensory loss. Documentation of motor dysfunction must include neurologic findings and description of type of neurologic abnormality (e.g., spasticity, weakness), as well as a description of the child's functional impairment (i.e., what the child is unable to do because of the abnormality). Where a diagnosis has been made, evidence should be included for substantiation of the diagnosis (e.g., blood chemistries and muscle biopsy reports), wherever applicable.

D. *Impairment of communication.* The documentation should include a description of a recent comprehensive evaluation, including all areas of affective and effective communication, performed by a qualified professional.

111.01 Category of Impairment, Neurological

111.02 *Major motor seizure disorder.*

A. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of more than one major motor seizure per month despite at least three months of prescribed treatment. With:

1. Daytime episodes (loss of consciousness and convulsive seizures); or

2. Nocturnal episodes manifesting residuals which interfere with activity during the day.

B. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of a least one major motor seizure in the year prior to application despite at least three months of prescribed treatment. And one of the following:

1. IQ of 70 or less; or

2. Significant interference with communication due to speech, hearing, or visual defect; or

3. Significant emotional disorder; or

4. Where significant adverse effects of medication interfere with major daily activities.

111.03 *Minor motor seizure disorder.* In a child with an established seizure disorder, the occurrence of more than one minor motor seizure per week, with alteration of awareness or loss of consciousness, despite at least three months of prescribed treatment.

111.05 *Brain tumors. A. Malignant* gliomas (astrocytoma—Grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, primary sarcoma or brain stem gliomas; or

B. Evaluate other brain tumors under the criteria for the resulting neurological impairment.

111.06 *Motor dysfunction (due to any neurological disorder).* Persistent disorganization or deficit of motor function for age involving two extremities, which (despite prescribed therapy) interferes with age-appropriate major daily activities and results in disruption of:

A. Fine and gross movements; or

B. Gait and station.

111.07 *Cerebral palsy.* With:

A. Motor dysfunction meeting the requirements of 111.06 or 101.03; or

B. Less severe motor dysfunction (but more than slight) and one of the following:

1. IQ of 70 or less; or

2. Seizure disorder, with at least one major motor seizure in the year prior to application; or

3. Significant interference with communication due to speech, hearing or visual defect; or

4. Significant emotional disorder.

111.08 *Meningomyelocele (and related disorders).* With one of the following despite prescribed treatment:

A. Motor dysfunction meeting the requirements of § 101.03 or § 111.06; or

B. Less severe motor dysfunction (but more than slight), and:

1. Urinary or fecal incontinence when inappropriate for age; or

2. IQ of 70 or less; or

C. Four extremity involvement; or

D. Noncompensated hydrocephalus producing interference with mental or motor developmental progression.

111.09 *Communication impairment, associated with documented neurological disorder.* And one of the following:

A. Documented speech deficit which significantly affects the clarity and content of the speech; or

B. Documented comprehension deficit resulting in ineffective verbal communication for age; or

C. Impairment of hearing as described under the criteria in 102.08.

112.00 MENTAL DISORDERS

A. *Introduction:* The structure of the mental disorders listings for children under age 18 parallels the structure for the mental disorders listings for adults but is modified to reflect the presentation of mental disorders in children. The listings for mental disorders in children are arranged in 11 diagnostic categories: Organic mental disorders (112.02); schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders (112.03); mood disorders (112.04); mental retardation (112.05); anxiety disorders (112.06); somatoform, eating, and tic disorders (112.07); personality disorders (112.08); psychoactive substance dependence disorders (112.09); autistic disorder and other pervasive developmental disorders (112.10); attention deficit hyperactivity disorder (112.11); and developmental and emotional disorders of newborn and younger infants (112.12).

There are significant differences between the listings for adults and the listings for children. There are disorders found in children that have no real analogy in adults; hence, the differences in the diagnostic categories for children. The presentation of mental disorders in children, particularly the very young child, may be subtle and of a character different from the signs and symptoms found in adults. For example, findings such as separation anxiety, failure to mold or bond with the parents, or withdrawal may serve as findings comparable to findings that mark mental disorders in adults. The activities appropriate to children, such as learning, growing, playing, maturing, and school adjustment, are also different from the activities appropriate to the adult and vary widely in the different childhood stages.

Each listing begins with an introductory statement that describes the disorder or disorders addressed by the listing. This is followed (except in listings 112.05 and 112.12) by medical findings (paragraph A criteria), which, if satisfied, lead to an assessment of impairment-related functional limitations (paragraph B criteria). An individual will be found to have a listed impairment when the criteria of both paragraphs A and B of the listed impairment are satisfied.

The purpose of the criteria in paragraph A is to substantiate medically the presence of a particular mental disorder. Specific symptoms and signs under any of the listings 112.02 through 112.12 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) indicated by the medical findings.

Paragraph A of the listings is a composite of medical findings which are used to substantiate the existence of a disorder and may or may not be appropriate for children at specific developmental stages. However, a range of medical findings is included in the listings so that no age group is excluded. For example, in listing 112.02A7, emotional lability and crying would be inappropriate criteria to apply to older infants and toddlers, age 1 to attainment of age 3; whereas in 112.02A1, developmental arrest, delay, or regression are appropriate criteria for older infants and toddlers. Whenever the adjudicator decides that the requirements of paragraph A of a particular mental listing are satisfied, then that listing should be applied regardless of the age of the child to be evaluated.

The purpose of the paragraph B criteria is to describe impairment-related functional limitations which are applicable to children. Standardized tests of social or cognitive function and adaptive behavior are frequently available and appropriate for the evaluation of children and, thus, such tests are included in the paragraph B functional parameters. The functional restrictions in paragraph B must be the result of the mental disorder which is manifested by the medical findings in paragraph A.

We have not included separate C criteria for listings 112.03 and 112.06, as are found in the adult listings, because for the most part we do not believe that categories like residual schizophrenia or agoraphobia are commonly found in children. However, in unusual cases where these disorders are found in children and are comparable to the severity and duration found in adults, the adult 12.03C and 12.06C criteria may be used for evaluation of the cases.

The structure of the listings for Mental Retardation (112.05) and Developmental and Emotional Disorders of Newborn and Younger Infants (112.12) is different from that of the other mental disorders. Listing 112.05 (Mental Retardation) contains six sets of criteria, any one of which, if satisfied, will result in a finding that the child's impairment meets the listing. Listing 112.12 (Developmental and Emotional Disorders of Newborn and Younger Infants) contains five criteria, any one of which, if satisfied, will result in a finding that the infant's impairment meets the listing.

It must be remembered that these listings are examples of common mental disorders which are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed or a combination of impairments no one of which meets a listing, we will make a medical equivalency determination. (See §§404.1526 and 416.926.) This determination can be especially important in older infants and toddlers (age 1 to attainment of age 3), who may be too young for identification of a specific diagnosis, yet demonstrate serious functional limitations. Therefore, the determination of equivalency is necessary to the evaluation of any child's case when the child does not have an impairment that meets a listing.

B. *Need for Medical Evidence:* The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of symptoms, signs, and laboratory findings (including psychological or developmental test findings). Symptoms are complaints presented by the child. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation, development, and contact with reality, as described by an appropriate medical source. Symptoms and signs generally cluster together to constitute recognizable mental disorders described in paragraph A of the listings. These findings may be intermittent or continuous depending on the nature of the disorder.

C. *Assessment of Severity:* In childhood cases, as with adults, severity is measured according to the functional limitations imposed by the medically determinable mental impairment. However, the range of functions used to assess impairment severity for children varies at different stages of maturation. The functional areas that we consider are: Motor function; cognitive/communicative function; social function; personal/behavioral function; and concentration, persistence, and pace. In most functional areas, there are two alternative methods of documenting the required level of severity: (1) Use of standardized tests alone, where appropriate test instruments are available, and (2) use of other medical findings. (See 112.00D for explanation of these documentation requirements.) The use of standardized tests is the preferred method of documentation if such tests are available.

Newborn and younger infants (birth to attainment of age 1) have not developed sufficient personality differentiation to permit formulation of appropriate diagnoses. We have, therefore, assigned listing 112.12 for Developmental and Emotional Disorders of Newborn and Younger Infants for the evaluation of mental disorders of such children. Severity of these disorders is based on measures of development in motor, cognitive/communicative, and social functions. When older infants and toddlers (age 1 to attainment of age 3) do not clearly satisfy the paragraph A criteria of any listing because of insufficient developmental differentiation, they must be evaluated under the rules for equivalency. The principles for assessing the severity of impairment in such children, described in the following paragraphs, must be employed.

In defining the severity of functional limitations, two different sets of paragraph B criteria corresponding to two separate age groupings have been established, in addition to listing 112.12, which is for children who have not attained age 1. These age groups are: older infants and toddlers (age 1 to attainment of age 3) and children (age 3 to attainment of age 18). However, the discussion below in 112.00C1, 2, 3, and 4, on the age-appropriate areas of function, is broken down into four age groupings: older infants and toddlers (age 1 to attainment of age 3), preschool children (age 3 to attainment of age 6), primary school children (age 6 to attainment of age 12), and adolescents (age 12 to attainment of age 18). This was done to provide specific guidance on the age group variances in disease manifestations and methods of evaluation.

Where ''marked'' is used 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 ability to function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis. When standardized tests are used as the measure of functional parameters, a valid score that is two standard deviations below the norm for the test will be considered a marked restriction.

1. *Older infants and toddlers (age 1 to attainment of age 3).* In this age group, impairment severity is assessed in three areas: (a) Motor development, (b) cognitive/communicative function, and (c) social function.

a. *Motor development.* Much of what we can discern about mental function in these children frequently comes from observation of the degree of development of fine and gross motor function. Developmental delay, as measured by a good developmental milestone history confirmed by medical examination, is critical. This information will ordinarily be available in the existing medical evidence from the claimant's treating sources and other medical sources, supplemented by information from nonmedical sources, such as parents, who have observed the child and can provide pertinent historical information. It may also be available from standardized testing. If the delay is such that the older infant or toddler has not achieved motor development generally acquired by children no more than one-half the child's chronological age, the criteria are satisfied.

b. *Cognitive/communicative function.* Cognitive/communicative function is measured using one of several standardized infant scales. Appropriate tests for the measure of such function are discussed in 112.00D. Care should be taken to avoid reliance on screening devices, which are not generally considered to be sufficiently reliable instruments, although such devices may provide some relevant data; however, there will be cases in which the results of such tests show such severe abnormalities that further testing will be unnecessary.

For older infants and toddlers, alternative criteria covering disruption in communication as measured by their capacity to use simple verbal and nonverbal structures to communicate basic needs are provided.

c. *Social function.* Social function in older infants and toddlers is measured in terms of the development of relatedness to people (e.g., bonding and stranger anxiety) and attachment to animate or inanimate objects. Criteria are provided that use standard social maturity scales or alternative criteria that describe marked impairment in socialization.

2. *Preschool children (age 3 to attainment of age 6).* For the age groups including preschool children through adolescence, the functional areas used to measure severity are: (a) Cognitive/communicative function, (b) social function, (c) personal/behavioral function, and (d) deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner. After 36 months, motor function is no longer felt to be a primary determinant of mental function, although, of course, any motor abnormalities should be documented and evaluated.

a. *Cognitive/communicative function.* In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence, although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is a valid verbal, performance, or full scale IQ of 70 or less. The listings also provide alternative criteria, consisting of tests of language development or bizarre speech patterns.

b. *Social function.* Social function is measured by an assessment of a child's relationships with parents, other adults, and peers. These relationships are often observed not only at home but also in preschool programs, where the child's interactions with other children and teachers come under daily scrutiny.

c. *Personal/behavioral function.* This function may be measured by a standardized test of adaptive behavior or by careful description of maladaptive or avoidant behaviors. These behaviors are often observed not only at home but also in preschool programs.

d. *Concentration, persistence, and pace.* This function may be measured through observations of the child in the course of standardized testing and in the course of play.

3. *Primary school children (age 6 to attainment of age 12).* The measures of function here are similar to those for preschool-age children except that the test instruments

may change and the capacity to function in the school setting is supplemental information. Standardized measures of academic achievement, e.g., Wide Range Achievement Test-Revised, Peabody Individual Achievement Test, etc., may be helpful in assessing cognitive impairment. Problems in social functioning, especially in the area of peer relationships, are often observed firsthand by teachers and school nurses. As described in 112.00D, *Documentation*, school records are an excellent source of information concerning function and standardized testing and should always be sought for school-age children.

As it applies to primary school children, the intent of the functional criterion described in paragraph B2d, i.e., deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner, is to identify the child who cannot adequately function in primary school because of a mental impairment. Although grades and the need for special education placement are relevant factors which must be considered in reaching a decision under paragraph B2d, they are not conclusive. There is too much variability from school district to school district in the expected level of grading and in the criteria for special education placement to justify reliance solely on these factors.

4. *Adolescents (age 12 to attainment of age 18).* Functional criteria parallel to those for primary school children (cognitive/communicative; social; personal/behavioral; and concentration, persistence, and pace) are the measure of severity for this age group. Testing instruments appropriate to adolescents should be used where indicated. Comparable findings of disruption of social function must consider the capacity to form appropriate, stable, and lasting relationships. If information is available about cooperative working relationships in school or at part-time or full-time work, or about the ability to work as a member of a group, it should be considered when assessing the child's social and personal/behavioral functioning. Markedly impoverished social contact, isolation, withdrawal, and inappropriate or bizarre behavior under the stress of socializing with others also constitute comparable findings.

In adolescents, the intent of the functional criterion described in paragraph B2d is the same as in primary school children. However, other evidence of this functional impairment may also be available, such as from evidence of the child's performance in work or work-like settings.

D. *Documentation:* The presence of a mental disorder in a child must be documented on the basis of reports from acceptable sources of medical evidence. See §§404.1513 and 416.913. Descriptions of functional limitations may be available from these sources, either in the form of standardized test results or in other medical findings supplied by the sources, or both. (Medical findings consist of symptoms, signs, and laboratory findings.) Whenever possible, a medical source's findings should reflect the medical source's consideration of information from parents or other concerned individuals who are aware of the child's activities of daily living, social functioning, and ability to adapt to different settings and expectations, as well as the medical source's findings and observations on examination, consistent with standard clinical practice. As necessary, information from nonmedical sources, such as parents, should also be used to supplement the record of the child's functioning to establish the consistency of the medical evidence and longitudinality of impairment severity.

For some newborn and younger infants, it may be very difficult to document the presence or severity of a mental disorder. Therefore, with the exception of some genetic diseases and catastrophic congenital anomalies, it may be necessary to defer making a disability decision until the child attains 3 months of age in order to obtain adequate observation of behavior or affect. See, also, 110.00 of this part. This period could be extended in cases of premature infants depending on the degree of prematurity and the adequacy of documentation of their developmental and emotional status.

For infants and toddlers, programs of early intervention involving occupational, physical, and speech therapists, nurses, social workers, and special educators, are a rich source of data. They can provide the developmental milestone evaluations and records on the fine and gross motor functioning of these children. This information is valuable and can complement the medical examination by a physician or psychologist. A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is considered acceptable medical evidence rather than supplemental data.

In children with mental disorders, particularly those requiring special placement, school records are a rich source of data, and the required reevaluations at specified time periods can provide the longitudinal data needed to trace impairment progression over time.

In some cases where the treating sources lack expertise in dealing with mental disorders of children, it may be necessary to obtain evidence from a psychiatrist, psychologist, or pediatrician with experience and skill in the diagnosis and treatment of mental disorders as they appear in children. In these cases, however, every reasonable effort must be made to obtain the records of the treating sources, since these records will help establish a longitudinal picture that cannot be established through a single purchased examination.

A reference to standardized psychological testing indicates the use of a psychological test that has appropriate characertistics of validity, reliability, and norms, administered individually by psychologist, psychiatrist, pediatrician, or other physician specialist qualified by training and experience to perform such an evaluation. Psychological tests are best considered as sets of tasks or questions designed to elicit particular behaviors when presented in a standardized manner.

The salient characteristics of a good test are: (1) Validity, i.e., the test measures what it is supposed to measure, as determined by appropriate methods; (2) reliability, i.e., the consistency of results obtained over time with the same test and the same individual; and (3) appropriate normative data, i.e., individual test scores must be comparable to test data from other individuals or groups of a similar nature, representative of that population. In considering the validity of a test result, any discrepancies between formal test results and the child's customary behavior and daily activities should be duly noted and resolved.

Tests meeting the above requirements are acceptable for the determination of the conditions contained in these listings. The psychologist, psychiatrist, pediatrician, or other physician specialist administering the test must have a sound technical and professional understanding of the test and be able to evaluate the research documentation related to the intended application of the test.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. The IQ scores in listing 112.05 reflect values from tests of general intelligence that have a mean of 100 and a standard deviation of 15, e.g., the Wechsler series and the Revised Stanford-Binet scales. Thus, IQ's below 60 reflect a level of intellectual functioning below 99.5 percent of the general population, and IQ's of 70 and below are characteristic of approximately the lowest 2 percent of the general population. IQ's obtained from standardized tests that deviate significantly from a mean of 100 and standard deviation of 15 require conversion to the corresponding percentile rank in the general population so that the actual degree of impairment reflected by the IQ scores can be determined. In cases where more than one IQ is customarily derived from the test administered, e.g., where verbal, performance, and full scale IQ's are provided, as on the Wechsler series, the lowest of these is used in conjunction with listing 112.05.

IQ test results must also be sufficiently current for accurate assessment under 112.05. Generally, the results of IQ tests tend to stabilize by the age of 16. Therefore, IQ test results obtained at age 16 or older should be viewed as a valid indication of the child's current status, provided they are compatible with the child's current behavior. IQ test results obtained between ages 7 and 16 should be considered current for 4 years when the tested IQ is less than 40, and for 2 years when the IQ is 40 or above. IQ test results obtained before age 7 are current for 2 years if the tested IQ is less than 40 and 1 year if at 40 or above.

Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not covered under the provisions of listings 112.05A, 112.05B, and 112.05F. Listings 112.05A, 112.05B, and 112.05F may be the bases for adjudicating cases where the results of standardized intelligence tests are unavailable, e.g., where the child's young age or condition precludes formal standardized testing.

In conjunction with clinical examinations, sources may report the results of screening tests, i.e., tests used for gross determination of level of functioning. These tests do not have high validity and reliability and generally are not considered appropriate primary evidence for disability determinations. These screening instruments may be useful in uncovering potentially serious impairments, but generally must be supplemented by the use of formal, standardized psychological testing for the purposes of a disability determination, unless the determination is to be made on the basis of findings other than psychological test data; however, there will be cases in which the results of screening tests show such obvious abnormalities that further testing will clearly be unnecessary.

Where reference is made to developmental milestones, this is defined as the attainment of particular mental or motor skills at an age-appropriate level, i.e., the skills achieved by an infant or toddler sequentially and within a given time period in the motor and manipulative areas, in general understanding and social behavior, in self-feeding, dressing, and toilet training, and in language. This is sometimes expressed as a developmental quotient (DQ), the relation between developmental age and chronological age as determined by specific standardized measurements and observations. Such tests include, but are not limited to, the Cattell Infant Intelligence Scale, the Bayley Scales of Infant Development, and the Revised Stanford-Binet. Formal tests of the attainment of developmental milestones are generally used in the clinical setting for determination of the developmental status of infants and toddlers.

Formal psychological tests of cognitive functioning are generally in use for preschool children, for primary school children, and for adolescents except for those instances noted below.

Exceptions to formal standardized psychological testing may be considered when a psychologist, psychiatrist, pediatrician, or

other physician specialist who is qualified by training and experience to perform such an evaluation is not readily available. In such instances, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination.

Exceptions may also be considered in the case of ethnic/cultural minorities where the native language or culture is not principally English-speaking. In such instances, psychological tests that are culture-free, such as the Leiter International Performance Scale or the Scale of Multi-Culture Pluralistic Assessment (SOMPA) may be substituted for the standardized tests described above. Any required tests must be administered in the child's principal language. When this is not possible, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination. Furthermore, in evaluating mental impairments in children from a different culture, the best indicator of severity is often the level of adaptive functioning and how the child performs activities of daily living and social functioning.

Neuropsychological testing refers to the administration of standardized tests that are reliable and valid with respect to assessing impairment in brain functioning. It is intended that the psychologist or psychiatrist using these tests will be able to evaluate the following functions: Attention/concentration, problem-solving, language, memory, motor, visual-motor and visual-perceptual, laterality, and general intelligence (if not previously obtained).

E. *Effect of Hospitalization or Residential Placement:* As with adults, children with mental disorders may be placed in a variety of structured settings outside the home as part of their treatment. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes, and workshop facilities. The reduced mental demands of such structured settings may attenuate overt symptomatology and superficially make the child's level of adaptive functioning appear better than it is. Therefore, the capacity of the child to function outside highly structured settings must be considered in evaluating impairment severity. This is done by determining the degree to which the child can function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis outside the highly structured setting.

On the other hand, there may be a variety of causes for placement of a child in a structured setting which may or may not be directly related to impairment severity and functional ability. Placement in a structured setting in and of itself does not equate with a finding of disability. The severity of the impairment must be compared with the requirements of the appropriate listing.

F. *Effects of Medication:* Attention must be given to the effect of medication on the child's signs, symptoms, and ability to function. While psychoactive medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychoactive medications, particular attention must be focused on the functional limitations which may persist. These functional limitations must be considered in assessing impairment severity.

Psychotropic medicines used in the treatment of some mental illnesses may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity.

112.01 CATEGORY OF IMPAIRMENTS, MENTAL

112.02 *Organic Mental Disorders:* Abnormalities in perception, cognition, affect, or behavior associated with dysfunction of the brain. The history and physical examination or laboratory tests, including psychological or neuropsychological tests, demonstrate or support the presence of an organic factor judged to be etiologically related to the abnormal mental state and associated deficit or loss of specific cognitive abilities, or affective changes, or loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence of at least one of the following:

1. Developmental arrest, delay or regression; or

2. Disorientation to time and place; or

3. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or

4. Perceptual or thinking disturbance (e.g., hallucinations, delusions, illusions, or paranoid thinking); or

5. Disturbance in personality (e.g., apathy, hostility); or

6. Disturbance in mood (e.g., mania, depression); or

7. Emotional lability (e.g., sudden crying); or

8. Impairment of impulse control (e.g., disinhibited social behavior, explosive temper outbursts); or

9. Impairment of cognitive function, as measured by clinically timely standardized psychological testing; or

10. Disturbance of concentration, attention, or judgment;

AND

B. Select the appropriate age group to evaluate the severity of the impairment:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the following:

a. Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or

(2) Other medical findings (see 112.00C); or

b. Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or

(2) Other medical findings of equivalent cognitive/communicative abnormality, such as the inability to use simple verbal or nonverbal behavior to communicate basic needs or concepts; or

c. Social function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or

(2) Other medical findings of an equivalent abnormality of social functioning, exemplified by serious inability to achieve age-appropriate autonomy as manifested by excessive clinging or extreme separation anxiety; or

d. 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 a., b., or c., as measured by an appropriate standardized test or other appropriate medical findings.

2. For children (age 3 to attainment of age 18), resulting in at least two of the following:

a. Marked impairment in age-appropriate cognitive/communicative function, documented by medical findings (including consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized psychlogical tests, or for children under age 6, by appropriate tests of language and communication; or

b. Marked impairment in age-appropriate social functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized tests; or

c. Marked impairment in personal/behavioral function, as evidenced by:

(1) Marked restriction of age-appropriate activities of daily living, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, appropriate standardized tests; or

(2) Persistent serious maladaptive behaviors destructive to self, others, animals, or property, requiring protective intervention; or

d. Deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner.

112.03 *Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders:* Onset of psychotic features, characterized by a marked disturbance of thinking, feeling, and behavior, with deterioration from a previous level of functioning or failure to achieve the expected level of social functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, for at least 6 months, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic, bizarre, or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech; or

4. Flat, blunt, or inappropriate affect; or

5. Emotional withdrawal, apathy, or isolation;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.04 *Mood Disorders:* Characterized by a disturbance of mood (referring to a prolonged emotion that colors the whole psychic life, generally involving either depression or elation), accompanied by a full or partial manic or depressive syndrome.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Major depressive syndrome, characterized by at least five of the following, which must include either depressed or irritable mood or markedly diminished interest or pleasure:

a. Depressed or irritable mood; or

b. Markedly diminished interest or pleasure in almost all activities; or

c. Appetite or weight increase or decrease, or failure to make expected weight gains; or

d. Sleep disturbance; or

e. Psychomotor agitation or retardation; or

f. Fatigue or loss of energy; or

g. Feelings of worthlessness or guilt; or

h. Difficulty thinking or concentrating; or

i. Suicidal thoughts or acts; or

j. Hallucinations, delusions, or paranoid thinking;

OR

2. Manic syndrome, characterized by elevated, expansive, or irritable mood, and at least three of the following:

a. Increased activity or psychomotor agitation; or

b. Increased talkativeness or pressure of speech; or

c. Flight of ideas or subjectively experienced racing thoughts; or

d. Inflated self-esteem or grandiosity; or

e. Decreased need for sleep; or

f. Easy distractibility; or

g. Involvement in activities that have a high potential of painful consequences which are not recognized; or

h. Hallucinations, delusions, or paranoid thinking;

OR

3. Bipolar or cyclothymic syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently or most recently characterized by the full or partial symptomatic picture of either or both syndromes);

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.05 *Mental Retardation:* Characterized by significantly subaverage general intellectual functioning with deficits in adaptive functioning.

The required level of severity for this disorder is met when the requirements in A, B, C, D, E, or F are satisfied.

A. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02;

OR

B. Mental incapacity evidenced by dependence upon others for personal needs (grossly in excess of age-appropriate dependence) and inability to follow directions such that the use of standardized measures of intellectual functioning is precluded;

OR

C. A valid verbal, performance, or full scale IQ of 59 or less;

OR

D. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing additional and significant limitation of function;

OR

E. A valid verbal, performance, or full scale IQ of 60 through 70 and:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in either paragraphs B1a or B1c of 112.02; or

2. For children (age 3 to attainment of age 18), resulting in at least one of paragraphs B2b or B2c or B2d of 112.02;

OR

F. Select the appropriate age group:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in paragraph B1b of 112.02, and a physical or other mental impairment imposing additional and significant limitations of function;

OR

2. For children (age 3 to attainment of age 18), resulting in the satisfaction of 112.02B2a, and a physical or other mental impairment imposing additional and significant limitations of function.

112.06 *Anxiety Disorders:* In these disorders, anxiety is either the predominant disturbance or is experienced if the individual attempts to master symptoms, e.g., confronting the dreaded object or situation in a phobic disorder, attempting to go to school in a separation anxiety disorder, resisting the obsessions or compulsions in an obsessive compulsive disorder, or confronting strangers or peers in avoidant disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least one of the following:

1. Excessive anxiety manifested when the child is separated, or separation is threatened, from a parent or parent surrogate; or

2. Excessive and persistent avoidance of strangers; or

3. Persistent unrealistic or excessive anxiety and worry (apprehensive expectation), accompanied by motor tension, autonomic hyperactivity, or vigilance and scanning; or

4. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

5. Recurrent severe panic attacks, manifested by a sudden unpredictable onset of intense apprehension, fear, or terror, often with a sense of impending doom, occurring on the average of at least once a week; or

6. Recurrent obsessions or compulsions which are a source of marked distress; or

7. Recurrent and intrusive recollections of a traumatic experience, including dreams, which are a source of marked distress;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.07 *Somatoform, Eating, and Tic Disorders:* Manifested by physical symptoms for which there are no demonstrable organic findings or known physiologic mechanisms; or eating or tic disorders with physical manifestations.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of one of the following:

1. An unrealistic fear and perception of fatness despite being underweight, and persistent refusal to maintain a body weight which is greater than 85 percent of the average weight for height and age, as shown in the most recent edition of the *Nelson Textbook of Pediatrics*, Richard E. Behrman and Victor C. Vaughan, III, editors, Philadelphia: W. B. Saunders Company; or

2. Persistent and recurrent involuntary, repetitive, rapid, purposeless motor movements affecting multiple muscle groups with multiple vocal tics; or

3. Persistent nonorganic disturbance of one of the following:

a. Vision; or

b. Speech; or

c. Hearing; or

d. Use of a limb; or

e. Movement and its control (e.g., coordination disturbance, psychogenic seizures); or

f. Sensation (diminished or heightened); or

g. Digestion or elimination; or

4. Preoccupation with a belief that one has a serious disease or injury;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.08 *Personality Disorders:* Manifested by pervasive, inflexible, and maladaptive personality traits, which are typical of the child's long-term functioning and not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior, associated with one of the following:

1. Seclusiveness or autistic thinking; or

2. Pathologically inappropriate suspiciousness or hostility; or

3. Oddities of thought, perception, speech, and behavior; or

4. Persistent disturbances of mood or affect; or

5. Pathological dependence, passivity, or aggressiveness; or

6. Intense and unstable interpersonal relationships and impulsive and exploitative behavior; or

7. Pathological perfectionism and inflexibility;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.09 *Psychoactive Substance Dependence Disorders:* Manifested by a cluster of cognitive, behavioral, and physiologic symptoms that indicate impaired control of psychoactive substance use with continued use of the substance despite adverse consequences.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least four of the following:

1. Substance taken in larger amounts or over a longer period than intended and a great deal of time is spent in recovering from its effects; or

2. Two or more unsuccessful efforts to cut down or control use; or

3. Frequent intoxication or withdrawal symptoms interfering with major role obligations; or

4. Continued use despite persistent or recurring social, psychological, or physical problems; or

5. Tolerance, as characterized by the requirement for markedly increased amounts of substance in order to achieve intoxication; or

6. Substance taken to relieve or avoid withdrawal symptoms;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least

two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.10 *Autistic Disorder and Other Pervasive Developmental Disorders:* Characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Often, there is a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of the following:

1. For autistic disorder, all of the following:

a. Qualitative deficits in the development of reciprocal social interaction; and

b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity; and

c. Markedly restricted repertoire of activities and interests;

OR

2. For pervasive developmental disorders, both of the following:

a. Qualitative deficits in the development of social interaction; and

b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraphs B2 of 112.02.

112.11 *Attention Deficit Hyperactivity Disorder:* Manifested by developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of all three of the following:

1. Marked inattention; and

2. Marked impulsiveness; and

3. Marked hyperactivity;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.12 *Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to attainment of age 1):* Developmental or emotional disorders of infancy are evidenced by a deficit or lag in the areas of motor, cognitive/communicative, or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors.

The required level of severity for these disorders is met when the requirements of A, B, C, D, or E are satisfied.

A. Cognitive/communicative functioning generally acquired by children no more than one-half the child's chronological age, as documented by appropriate medical findings (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) including, if necessary, a standardized test;

OR

B. Motor development generally acquired by children no more than one-half the child's chronological age, documented by appropriate medical findings, including if necessary, a standardized test;

OR

C. Apathy, over-excitability, or fearfulness, demonstrated by an absent or grossly excessive response to one of the following:

1. Visual stimulation; or

2. Auditory stimulation; or

3. Tactile stimulation;

OR

D. Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by:

1. Inability by 6 months to participate in vocal, visual, and motoric exchanges (including facial expressions); or

2. Failure by 9 months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger; or

3. 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

E. 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), documented by appropriate medical findings, including if necessary, standardized testing.

113.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction.* Determination of disability in the growing and developing child with a malignant neoplastic disease is based upon the combined effects of:

1. The pathophysiology, histology, and natural history of the tumor; and

2. The effects of the currently employed aggressive multimodal therapeutic regimens.

Combinations of surgery, radiation, and chemotherapy or prolonged therapeutic

schedules impart significant additional morbidity to the child during the period of greatest risk from the tumor itself. This period of highest risk and greatest therapeutically-induced morbidity defines the limits of disability for most of childhood neoplastic disease.

B. *Documentation.* The diagnosis of neoplasm should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen, along with all pertinent laboratory and X-ray reports. The evidence should also include a recent report directed especially at describing whether there is evidence of local or regional recurrence, soft part or skeletal metastases, and significant post therapeutic residuals.

C. *Malignant solid tumors,* as listed under 113.03, include the histiocytosis syndromes except for solitary eosinophilic granuloma. Thus, 113.03 should not be used for evaluating brain tumors (see 111.05) or thyroid tumors, which must be evaluated on the basis of whether they are controlled by prescribed therapy.

D. *Duration of disability* from malignant neoplastic tumors is included in 113.02 and 113.03. Following the time periods designated in these sections, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of a remaining impairment must be evaluated on the basis of the medical evidence.

113.01 Category of Impairments, Neoplastic Diseases—Malignant

113.02 *Lymphoreticular malignant neoplasms.*

A. Hodgkin's disease with progressive disease not controlled by prescribed therapy; or

B. Non-Hodgkin's lymphoma. Consider under a disability:

1. For 2½ years from time of initial diagnosis; or

2. For 2½ years from time of recurrence of active disease.

113.03 *Malignant solid tumors.* Consider under a diability:

A. For 2 years from the time of initial diagnosis; or

B. For 2 years from the time of recurrence of active disease.

113.04 *Neuroblastoma.* With one of the following:

A. Extension across the midline; or

B. Distant metastases; or

C. Recurrence; or

D. Onset at age 1 year or older.

113.05 *Retinoblastoma.* With one of the following:

A. Bilateral involvement; or

B. Metastases; or

C. Extension beyond the orbit; or

D. Recurrence.

114.00 IMMUNE SYSTEM

A. Listed disorders include impairments involving deficiency of one or more components of the immune system (i.e., antibody-producing B cells; a number of different types of cells associated with cell-mediated immunity including T-lymphocytes, macrophages and monocytes; and components of the complement system).

B. Dysregulation of the immune system may result in the development of a connective tissue disorder. Connective tissue disorders include several chronic multisystem disorders that differ in their clinical manifestation, course, and outcome. These disorders are described in part A, 14.00B.

Some of the features of connective tissue disorders in children may differ from the features in adults. When the clinical features are the same as that seen in adults, the principles and concepts in part A, 14.00B apply.

The documentation needed to establish the existence of a connective tissue disorder is medical history, physical examination, selected laboratory studies, medically acceptable imaging techniques and, in some instances, tissue biopsy. However, the Social Security Administration will not purchase diagnostic tests or procedures that may involve significant risk, such as biopsies or angiograms. Generally, the existing medical evidence will contain this information.

In addition to the limitations caused by the connective tissue disorder *per se,* the chronic adverse effects of treatment (e.g., corticosteroid-related ischemic necrosis of bone) may result in functional loss.

A longitudinal clinical record of at least 3 months demonstrating active disease despite prescribed treatment during this period with the expectation that the disease will remain active for 12 months is necessary for assessment of severity and duration of impairment.

In children the impairment may affect growth, development, attainment of age-appropriate skills, and performance of age-appropriate activities. The limitations may be the result of loss of function or failure in a single organ or body system, or a lesser degree of functional loss in two or more organs/body systems that, in combination with significant constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss, results in listing-level limitations. We use the term ''severe'' in these listings to describe medical severity; the term does not have the same meaning as it does when we use it in connection with a finding at the second step of the sequential evaluation processes in §§404.1520, 416.920, and 416.924.

C. Allergies, growth impairments and Kawasaki disease.

1. Allergic disorders (e.g., asthma or atopic dermatitis) are discussed and evaluated under the appropriate listing of the affected body system.

2. If growth is affected by the disorder or its treatment by immunosuppressive drugs, 100.00 may apply.

3. Kawasaki disease, also known as mucocutaneous lymph node syndrome, is characterized by multisystem manifestations, but significant functional impairment is usually due to disease of the coronary arteries, which should be evaluated under 104.00.

D. Human immunodeficiency virus (HIV) infection.

1. HIV infection is caused by a specific retrovirus and may be characterized by susceptibility to one or more opportunistic diseases, cancers, or other conditions, as described in 114.08. Any child with HIV infection, including one with a diagnosis of acquired immunodeficiency syndrome (AIDS), may be found disabled under this listing if his or her impairment meets any of the criteria in 114.08 or is of equivalent severity to an impairment in 114.08.

2. Definitions. In 114.08, the terms ''resistant to treatment,'' ''recurrent,'' and ''disseminated'' have the same general meaning as used by the medical community. The precise meaning of any of these terms will depend upon the specific disease or condition in question, the body system affected, the usual course of the disorder and its treatment, and the other circumstances of the case.

''Resistant to treatment'' means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate, or a course of treatment appropriate, will depend on the facts of the particular case.

''Recurrent'' means that a condition that responded adequately to an appropriate course of treatment has returned after a period of remission or regression. The extent of response (or remission) and the time periods involved will depend on the facts of the particular case.

''Disseminated'' means that a condition is spread widely over a considerable area or body system(s). The type and extent of the spread will depend on the specific disease.

3. Documentation of HIV infection in children. The medical evidence must include documentation of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of HIV infection in children by definitive diagnosis. A definitive diagnosis of HIV infection in children is documented by one or more of the following laboratory tests:

i. For a child 24 months of age or older, a serum specimen that contains HIV antibodies. HIV antibodies are usually detected by a screening test. The most commonly used screening test is the ELISA. Although this test is highly sensitive, it may yield false positive results. Therefore, positive results from an ELISA must be confirmed by a more definitive test (e.g., Western blot, immunofluorescence assay). (See paragraph b, below, for information about HIV antibody testing in children younger than 24 months of age).

ii. A specimen that contains HIV antigen (e.g., serum specimen, lymphocyte culture, or cerebrospinal fluid (CSF) specimen).

iii. An immunoglobulin A (IgA) serological assay specific for HIV.

iv. Other test(s) that are highly specific for detection of HIV in children (e.g., polymerase chain reaction (PCR)), or that are acceptable methods of detection consistent with the prevailing state of medical knowledge.

When laboratory testing for HIV infection has been performed, every reasonable effort must be made to obtain reports of the results of that testing.

b. Other acceptable documentation of HIV infection in children.

As noted in paragraph a, above, HIV infection is not documented in children under 24 months of age by a serum specimen containing HIV antibodies. This is because women with HIV infection often transfer HIV antibodies to their newborns. The mother's antibodies can persist in the infant for up to 24 months, even if the infant is not HIV-infected. Only 20 to 30 percent of such infants are actually infected. Therefore, the presence of serum HIV antibodies alone does not establish the presence of HIV infection in a child under 24 months of age. However, the presence of HIV antibodies accompanied by evidence of significantly depressed T-helper lymphocytes (CD4), an abnormal CD4/CD8 ratio, or abnormal immunoglobulin G (IgG) may be used to document HIV infection in a child under 24 months of age, even though such testing is not a basis for a definitive diagnosis.

For children from birth to the attainment of 24 months of age who have tested positive for HIV antibodies (see D3a above), HIV infection may be documented by one or more of the following:

i. For an infant 12 months of age or less, a CD4 (T4) count of 1500/mm^3 or less, or a CD4 count less than or equal to 20 percent of total lymphocytes.

ii. For an infant from 12 to 24 months of age, a CD4 (T4) count of 750/mm^3 or less, or a CD4 count less than or equal to 20 percent of total lymphocytes.

iii. An abnormal CD4/CD8 ratio.

iv. An IgG significantly greater than or less than the normal range for age.

HIV infection in children may also be documented without the definitive laboratory evidence described in paragraph a, or the other laboratory evidence discussed above, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If such laboratory evidence is not available, HIV infection may be documented by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. For example, a diagnosis of HIV infection in children will be accepted without definitive laboratory evidence if the child has an opportunistic disease (e.g., Pneumocystis carinii pneumonia (PCP)) predictive of a defect in cell-mediated immunity, and there is no other known cause of diminished resistance to that disease (e.g., long-term steroid treatment, lymphoma). In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

4. Documentation of the manifestations of HIV infection in children. The medical evidence must also include documentation of the manifestations of HIV infection in children. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of the manifestations of HIV infection in children by definitive diagnosis.

The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection in children is by culture, serological test, or microscopic examination of biopsied tissue or other material (e.g., bronchial washings). Therefore, every reasonable effort must be made to obtain specific laboratory evidence of an opportunistic disease or other condition whenever this information is available. If a histological or other test has been performed, the evidence should include a copy of the appropriate report. If the report is not obtainable, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including radiographic studies) or microscopic examination of the appropriate tissues or body fluids.

Although a reduced CD4 lymphocyte count in a child may show that there is an increased susceptibility to opportunistic infections and diseases, that alone does not document the presence, severity, or functional effects of a manifestation of HIV infection in a child.

b. Other acceptable documentation of the manifestations of HIV infection in children.

Manifestations of HIV infection in children may also be documented without the definitive laboratory evidence described in paragraph a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, manifestations of HIV infection may be documented by medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

Documentation of cytomegalovirus (CMV) disease (114.08D) presents special problems because diagnosis requires identification of viral inclusion bodies or a positive culture from the affected organ, and the absence of any other infectious agent. A positive serology test identifies infection with the virus, but does not confirm a disease process. With the exception of chorioretinitis (which may be diagnosed by an ophthalmologist), documentation of CMV disease requires confirmation by biopsy or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

5. HIV infection in children. The clinical manifestation and course of disease in children who become infected with HIV perinatally or in the first 6 years of life may differ from that in older children and adults. In addition, survival times are shorter for children infected in the first year of life compared to those who become infected as older children or as adults. Infants may present with failure to thrive or pneumocystis carinii pneumonia (PCP); young children may present with recurrent infections, neurological problems, or developmental abnormalities. Older children may also exhibit neurological abnormalities, such as HIV encephalopathy, or failure to thrive.

The methods of identifying and evaluating neurological abnormalities may vary depending on a child's age. For example, in an infant, impaired brain growth can be documented by a decrease in the growth rate of the head. In older children, impaired brain growth can be documented by brain atrophy on a CAT scan. Neurological abnormalities can also be observed in a younger child in the loss of previously acquired, or marked delays in achieving, developmental milestones. In an older child, this type of neurological abnormality would generally be demonstrated by the loss of previously acquired intellectual abilities. Although loss of previously acquired intellectual abilities can be documented by a decrease in intelligence quotient (IQ) scores or demonstrated if a child forgets information he or she previously learned, it can also be shown if the child is unable to learn new information. This could include the sudden acquisition of a new learning disability.

Children with HIV infection may contract any of a broad range of bacterial infections. Certain major infections caused by pyogenic

bacteria, e.g., some pneumonias, can be severely limiting, especially in pre-adolescent children. These major bacterial infections should be evaluated under 114.08A5, which requires two or more such infections within a 2-year period. Although 114.08A5 applies only to children less than 13 years of age, an older child may be found to have an impairment of equivalent severity if the circumstances of the case warrant (e.g., delayed puberty).

Otherwise, bacterial infections are evaluated under 114.08A6. The criteria of the listing are met if one or more bacterial infection(s) occurs and requires hospitalization or intravenous antibiotic treatment 3 or more times in 1 year. Pelvic inflammatory disease in older female children should be evaluated under multiple or recurrent bacterial infections (114.08A6).

6. Evaluation of HIV infection in children. The criteria in 114.08 do not describe the full spectrum of diseases or conditions manifested by children with HIV infection. As in any case, consideration must be given to whether a child's impairment(s) meets or equals in severity any other listing in appendix 1 of subpart P (e.g., a neoplastic disorder listed in 113.00ff). Although 114.08 includes cross-references to other listings for the more common manifestations of HIV infection, additional listings may also apply.

In addition, the impact of all impairments, whether or not related to the HIV infection, must be considered. Children with HIV infection may manifest signs and symptoms of a mental impairment (e.g., anxiety, depression), or of another physical impairment. Medical evidence should include documentation of all physical and mental impairments and the impairment(s) should be evaluated not only under the relevant listing(s) in 114.08, but under any other appropriate listing(s).

It is also important to remember that children with HIV infection, like all others, are evaluated under the full sequential evaluation process described in §416.924. If a child with HIV infection is working and engaging in substantial gainful activity (SGA), or does not have a severe impairment, the case will be decided at the first or second step of the sequential evaluation process, and does not require evaluation under these listings. For a child with HIV infection who is not engaging in SGA and has a severe impairment, but whose impairment(s) does not meet the criteria of a listing, consideration will be given to whether the child's impairment or combination of impairments is either medically or functionally equivalent in severity to any listed impairment. If the child's impairment or impairments do not meet or equal a listing in severity, evaluation must proceed through the final step(s) of the sequential evaluation process (or, as appropriate, the steps in the medical improvement review standard) before any conclusion can be reached on the issue of disability.

7. Effect of treatment. Medical treatment must be considered in terms of its effectiveness in ameliorating the signs, symptoms, and laboratory abnormalities of the specific disorder, or of the HIV infection itself (e.g. antiretroviral agents) and in terms of any side effects of treatment that may further impair the child.

Response to treatment and adverse or beneficial consequences of treatment may vary widely. For example, a child with HIV infection who develops otitis media may respond to the same antibiotic regimen used in treating children without HIV infection, but another child with HIV infection may not respond to the same regimen. Therefore, each case must be considered on an individual basis, along with the effects of treatment on the child's ability to function.

A specific description of the drugs or treatment given (including surgery), dosage, frequency of administration, and a description of the complications or response to treatment should be obtained. The effects of treatment may be temporary or long-term. As such, the decision regarding the impact of treatment should be based on a sufficient period of treatment to permit proper consideration.

8. Functional criteria. Paragraph O of 114.08 establishes standards for evaluating manifestations of HIV infection that do not meet the requirements listed in 114.08A-N. Paragraph O is applicable for manifestations that are not listed in 114.08A-N, as well as those listed in 114.08A-N that do not meet the criteria of any of the rules in 114.08A-N.

For children with HIV infection evaluated under 114.08O, listing-level severity will be assessed in terms of the functional limitations imposed by the impairment. The full impact of signs, symptoms, and laboratory findings on the child's ability to function must be considered. Important factors to be considered in evaluating the functioning of children with HIV infection include, but are not limited to: symptoms, such as fatigue and pain; characteristics of the illness, such as the frequency and duration of manifestations or periods of exacerbation and remission in the disease course; and the functional impact of treatment for the disease, including the side effects of medication.

To meet the criteria in 114.08O, a child with HIV infection must demonstrate a level of restriction in either one or two (depending on the child's age) of the general areas of functioning applicable to the child's age group. (See 112.00C for additional discussion of these areas of functioning).

114.01 Category of Impairments, Immune System

114.02 Systemic lupus erythematosus. Documented as described in 14.00B1 and 114.00B, with:

A. One of the following:

1. Growth impairment, as described under the criteria in 100.00ff; or

2. Musculoskeletal involvement, as described under the criteria in 101.00ff; or

3. Muscle involvement, as described under the criteria in 14.05; or

4. Ocular involvement, as described under the criteria in 102.00ff; or

5. Respiratory involvement, as described under the criteria in 103.00ff; or

6. Cardiovascular involvement, as described under the criteria in 104.00ff or 14.04D; or

7. Digestive involvement, as described under the criteria in 105.00ff; or

8. Renal involvement, as described under the criteria in 106.00ff; or

9. Hematologic involvement, as described under the criteria in 107.00ff; or

10. Skin involvement, as described under the criteria in 8.00ff; or

11. Endocrine involvement, as described under the criteria in 109.00ff; or

12. Neurological involvement, as described under the criteria in 111.00ff; or

13. Mental involvement, as described under the criteria in 112.00ff.

or

B. Lesser involvement of two or more organs/body systems listed in paragraph A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

114.03 Systemic vasculitis. As described under the criteria in 14.03 or, if growth impairment, as described under the criteria in 100.00ff.

114.04 Systemic sclerosis and scleroderma. Documented as described in 14.00B3 and 114.00B, and:

A. As described under the criteria in 14.04 or, if growth impairment, as described under the criteria in 100.00ff.

or

B. Linear scleroderma, with one of the following:

1. Fixed valgus or varus deformities of both hands or both feet; or

2. Marked destruction or marked atrophy of an extremity; or

3. Facial disfigurement from hypoplasia of the mandible, maxilla, or zygoma resulting in an impairment as described under the criteria in 112.00ff; or

4. Seizure disorder, as described under the criteria in 111.00ff.

114.05 Polymyositis or dermatomyositis. Documented as described in 14.00B4 and 114.00B, and:

A. As described under the criteria in 14.05.

or

B. With one of the following:

1. Multiple joint contractures; or

2. Diffuse cutaneous calcification with formation of an exoskeleton; or

3. Systemic vasculitis as described under the criteria in 14.03.

114.06 Undifferentiated connective tissue disorder. As described under the criteria in 114.02 or 114.04.

114.07 Congenital immune deficiency disease.

A. Hypogammaglobulinemia or dysgammaglobulinemia, with:

1. Documented, recurrent severe infections occurring 3 or more times within a 5-month period; or

2. An associated disorder such as growth retardation, chronic lung disease, collagen disorder or tumor. Evaluate according to the appropriate body system listing.

or

B. Thymic dysplastic syndromes (such as Swiss, diGeorge).

114.08 Human immunodeficiency virus (HIV) infection. With documentation as described in 114.00D3 and one of the following:

A. 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; or pulmonary tuberculosis resistant to treatment; or

2. Nocardiosis; or

3. Salmonella bacteremia, recurrent nontyphoid.

4. Syphilis or neurosyphilis—evaluate sequelae under the criteria for the affected body system (e.g., 102.00 Special Senses and Speech, 104.00 Cardiovascular System, 111.00 Neurological); or

5. 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; or

6. Other multiple or recurrent bacterial infection(s), including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year.

or

B. Fungal infections:

1. Aspergillosis; or

2. Candidiasis, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs; or

3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or

4. Cryptococcosis, at a site other than the lungs (e.g., cryptococcal meningitis); or

5. Histoplasmosis, at a site other than the lungs or lymph nodes; or

6. Mucormycosis.

or

C. Protozoan or helminthic infections:

1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or

2. Pneumocystis carinii pneumonia or extrapulmonary pneumocystis carinii infection; or

3. Strongyloidiasis, extra-intestinal; or

4. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

or

D. Viral infections:

1. Cytomegalovirus disease (documented as described in 114.00D4b) at a site other than the liver, spleen, or lymph nodes; or

2. Herpes simplex virus causing:

a. Mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or

b. Infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or

c. Disseminated infection; or

3. Herpes zoster, either disseminated or with multidermatomal eruptions that are resistant to treatment; or

4. Progressive multifocal leukoencephalopathy; or

5. Hepatitis, as described under the criteria of 105.05.

or

E. Malignant neoplasms:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or

2. Karposi's sarcoma with:

a. Extensive oral lesions; or

b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or

c. Involvement of the skin or mucous membranes as described under the criteria of 114.08F; or

3. Lymphoma (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other Non-Hodgkin's lymphoma, Hodgkin's disease); or

4. Squamous cell carcinoma of the anus.

or

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3 above) 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), or evaluate under the criteria in 8.00ff.

or

G. Hematologic abnormalities:

1. Anemia, as described under the criteria in 7.02; or

2. Granulocytopenia, as described under the criteria in 7.15; or

3. Thrombocytopenia, as described under the criteria of 107.06 or 7.06.

or

H. Neurological manifestations of HIV infection (e.g., HIV encephalopathy, peripheral neuropathy), as described under the criteria in 111.00ff, or resulting in one or more of the following:

1. Loss of previously acquired, or marked delay in achieving, developmental milestones or intellectual ability (including the sudden acquisition of a new learning disability); or

2. Impaired brain growth (acquired microcephaly or brain atrophy—see 114.00D5); or

3. Progressive motor dysfunction affecting gait and station or fine and gross motor skills.

or

I. Growth disturbance, with:

1. An 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; or

2. An 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; or

3. Involuntary weight loss greater than 10 percent of baseline that persists for 2 months or longer; or

4. Growth impairment as described under the criteria in 100.00ff.

or

J. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

or

K. Cardiomyopathy, as described under the criteria in 104.00ff or 11.04.

or

L. 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.

or

M. Nephropathy, as described under the criteria in 106.00.

or

N. One or more of the following infections (other than described in A–M, above), resistant to treatment or requiring hospitalization or intravenous treatment 3 or more times in 1 year (or evaluate sequelae under the criteria for the affected body system):

1. Sepsis;
2. Meningitis; or
3. Pneumonia; or
4. Septic arthritis; or
5. Endocarditis; or
6. Radiographically documented sinusitis.

or

O. Any other manifestation(s) of HIV infection (including any listed in 114.08A–N, but without the requisite findings, e.g., oral candidiasis not meeting the criteria in 114.08F, diarrhea not meeting the criteria in 114.08J, or any other manifestation(s), e.g., oral hairy leukoplakia, hepatomegaly), resulting in one of the following:

1. For children from birth to attainment of age 1, at least one of the criteria in paragraphs A–E of 112.12; or
2. For children age 1 to attainment of age 3, at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or
3. For children age 3 to attainment of age 18, at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

[50 FR 35066, Aug. 28, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting appendix 1 to subpart P of part 404, see the List of CFR Sections Affected in the Finding Aids section of this volume.

APPENDIX 2 TO SUBPART P—MEDICAL-VOCATIONAL GUIDELINES

Sec.
200.00 Introduction.
201.00 Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).
202.00 Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).
203.00 Maximum sustained work capability limited to medium work as a result of severe medically determinable impairment(s).
204.00 Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).

200.00 *Introduction.* (a) The following rules reflect the major functional and vocational patterns which are encountered in cases which cannot be evaluated on medical considerations alone, where an individual with a severe medically determinable physical or mental impairment(s) is not engaging in substantial gainful activity and the individual's impairment(s) prevents the performance of his or her vocationally relevant past work. They also reflect the analysis of the various vocational factors (i.e., age, education, and work experience) in combination with the individual's residual functional capacity (used to determine his or her maximum sustained work capability for sedentary, light, medium, heavy, or very heavy work) in evaluating the individual's ability to engage in substantial gainful activity in other than his or her vocationally relevant past work. Where the findings of fact made with respect to a particular individual's vocational factors and residual functional capacity coincide with all of the criteria of a particular rule, the rule directs a conclusion as to whether the individual is or is not disabled. However, each of these findings of fact is subject to rebuttal and the individual may present evidence to refute such findings. Where any one of the findings of fact does not coincide with the corresponding criterion of a rule, the rule does not apply in that particular case and, accordingly, does not direct a conclusion of disabled or not disabled. In any instance where a rule does not apply, full consideration must be given to all of the relevant facts of the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations.

(b) The existence of jobs in the national economy is reflected in the ''Decisions'' shown in the rules; i.e., in promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels (sedentary, light, medium, heavy, and very heavy) as supported by the ''Dictionary of Occupational Titles'' and the ''Occupational Outlook Handbook,'' published by the Department of Labor; the ''County Business Patterns'' and ''Census Surveys'' published by the Bureau of the Census; and occupational surveys of light and sedentary jobs prepared for the Social Security Administration by various State employment agencies. Thus, when all factors coincide with the criteria of a rule, the existence of such jobs is established. However, the existence of such jobs for individuals whose remaining functional capacity or other factors do not coincide with the criteria of a rule must be further considered in terms of what kinds of jobs or types of work may be either additionally indicated or precluded.

(c) In the application of the rules, the individual's residual functional capacity (i.e., the maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs), age, education, and work experience

must first be determined. When assessing the person's residual functional capacity, we consider his or her symptoms (such as pain), signs, and laboratory findings together with other evidence we obtain.

(d) The correct disability decision (i.e., on the issue of ability to engage in substantial gainful activity) is found by then locating the individual's specific vocational profile. If an individual's specific profile is not listed within this appendix 2, a conclusion of disabled or not disabled is not directed. Thus, for example, an individual's ability to engage in substantial gainful work where his or her residual functional capacity falls between the ranges of work indicated in the rules (e.g., the individual who can perform more than light but less than medium work), is decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific case situations in this appendix 2. These rules represent various combinations of exertional capabilities, age, education and work experience and also provide an overall structure for evaluation of those cases in which the judgments as to each factor do not coincide with those of any specific rule. Thus, when the necessary judgments have been made as to each factor and it is found that no specific rule applies, the rules still provide guidance for decisionmaking, such as in cases involving combinations of impairments. For example, if strength limitations resulting from an individual's impairment(s) considered with the judgments made as to the individual's age, education and work experience correspond to (or closely approximate) the factors of a particular rule, the adjudicator then has a frame of reference for considering the jobs or types of work precluded by other, nonexertional impairments in terms of numbers of jobs remaining for a particular individual.

(e) Since the rules are predicated on an individual's having an impairment which manifests itself by limitations in meeting the strength requirements of jobs, they may not be fully applicable where the nature of an individual's impairment does not result in such limitations, e.g., certain mental, sensory, or skin impairments. In addition, some impairments may result solely in postural and manipulative limitations or environmental restrictions. Environmental restrictions are those restrictions which result in inability to tolerate some physical feature(s) of work settings that occur in certain industries or types of work, e.g., an inability to tolerate dust or fumes.

(1) In the evaluation of disability where the individual has solely a nonexertional type of impairment, determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in this appendix 2. The rules do not direct factual conclusions of disabled or not disabled for individuals with solely nonexertional types of impairments.

(2) However, where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules in this subpart are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Also, in these combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules in this appendix 2, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor.

201.00 *Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).* (a) Most sedentary occupations fall within the skilled, semi-skilled, professional, administrative, technical, clerical, and benchwork classifications. Approximately 200 separate unskilled sedentary occupations can be identified, each representing numerous jobs in the national economy. Approximately 85 percent of these jobs are in the machine trades and benchwork occupational categories. These jobs (unskilled sedentary occupations) may be performed after a short demonstration or within 30 days.

(b) These unskilled sedentary occupations are standard within the industries in which they exist. While sedentary work represents a significantly restricted range of work, this range in itself is not so prohibitively restricted as to negate work capability for substantial gainful activity.

(c) Vocational adjustment to sedentary work may be expected where the individual has special skills or experience relevant to sedentary work or where age and basic educational competences provide sufficient occupational mobility to adapt to the major segment of unskilled sedentary work. Inability to engage in substantial gainful activity would be indicated where an individual who is restricted to sedentary work because of a severe medically determinable impairment lacks special skills or experience relevant to sedentary work, lacks educational qualifications relevant to most sedentary work (e.g.,

has a limited education or less) and the individual's age, though not necessarily advanced, is a factor which significantly limits vocational adaptability.

(d) The adversity of functional restrictions to sedentary work at advanced age (55 and over) for individuals with no relevant past work or who can no longer perform vocationally relevant past work and have no transferable skills, warrants a finding of disabled in the the absence of the rare situation where the individual has recently completed education which provides a basis for direct entry into skilled sedentary work. Advanced age and a history of unskilled work or no work experience would ordinarily offset any vocational advantages that might accrue by reason of any remote past education, whether it is more or less than limited education.

(e) The presence of acquired skills that are readily transferable to a significant range of skilled work within an individual's residual functional capacity would ordinarily warrant a finding of ability to engage in substantial gainful activity regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) In order to find transferability of skills to skilled sedentary work for individuals who are of advanced age (55 and over), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) Individuals approaching advanced age (age 50–54) may be significantly limited in vocational adaptability if they are restricted to sedentary work. When such individuals have no past work experience or can no longer perform vocationally relevant past work and have no transferable skills, a finding of disabled ordinarily obtains. However, recently completed education which provides for direct entry into sedentary work will preclude such a finding. For this age group, even a high school education or more (ordinarily completed in the remote past) would have little impact for effecting a vocational adjustment unless relevant work experience reflects use of such education.

(h) The term *younger individual* is used to denote an individual age 18 through 49. For those within this group who are age 45–49, age is a less positive factor than for those who are age 18–44. Accordingly, for such individuals; (1) who are restricted to sedentary work, (2) who are unskilled or have no transferable skills, (3) who have no relevant past work or who can no longer perform vocationally relevant past work, and (4) who are either illiterate or unable to communicate in the English language, a finding of disabled is warranted. On the other hand, age is a more positive factor for those who are under age 45 and is usually not a significant factor in limiting such an individual's ability to make a vocational adjustment, even an adjustment to unskilled sedentary work, and even where the individual is illiterate or unable to communicate in English. However, a finding of disabled is not precluded for those individuals under age 45 who do not meet all of the criteria of a specific rule and who do not have the ability to perform a full range of sedentary work. The following examples are illustrative: Example 1: An individual under age 45 with a high school education can no longer do past work and is restricted to unskilled sedentary jobs because of a severe medically determinable cardiovascular impairment (which does not meet or equal the listings in appendix 1). A permanent injury of the right hand limits the individual to sedentary jobs which do not require bilateral manual dexterity. None of the rules in appendix 2 are applicable to this particular set of facts, because this individual cannot perform the full range of work defined as sedentary. Since the inability to perform jobs requiring bilateral manual dexterity significantly compromises the only range of work for which the individual is otherwise qualified (i.e., sedentary), a finding of disabled would be appropriate. Example 2: An illiterate 41 year old individual with mild mental retardation (IQ of 78) is restricted to unskilled sedentary work and cannot perform vocationally relevant past work, which had consisted of unskilled agricultural field work; his or her particular characteristics do not specifically meet any of the rules in appendix 2, because this individual cannot perform the full range of work defined as sedentary. In light of the adverse factors which further narrow the range of sedentary work for which this individual is qualified, a finding of disabled is appropriate.

(i) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. Thus, the functional capability for a full range of sedentary work represents sufficient numbers of jobs to indicate substantial vocational scope for those individuals age 18–44 even if they are illiterate or unable to communicate in English.

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
201.01	Advanced age	Limited or less	Unskilled or none	Disabled.
201.02	do	do	Skilled or semiskilled—skills not transferable [1].	Do.
201.03	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled.
201.04	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled.
201.05	do	High school graduate or more—provides for direct entry into skilled work [2].	do	Not disabled.
201.06	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable [1].	Disabled.
201.07	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled.
201.08	do	High school graduate or more—provides for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable [1].	Do.
201.09	Closely approaching advanced age.	Limited or less	Unskilled or none	Disabled.
201.10	do	do	Skilled or semiskilled—skills not transferable.	Do.
201.11	do	do	Skilled or semiskilled—skills transferable.	Not disabled.
201.12	do	High school graduate or more—does not provide for direct entry into skilled work [3].	Unskilled or none	Disabled.
201.13	do	High school graduate or more—provides for direct entry into skilled work [3].	do	Not disabled.
201.14	do	High school graduate or more—does not provide for direct entry into skilled work [3].	Skilled or semiskilled—skills not transferable.	Disabled.
201.15	do	do	Skilled or semiskilled—skills transferable.	Not disabled.
201.16	do	High school graduate or more—provides for direct entry into skilled work [3].	Skilled or semiskilled—skills not transferable.	Do.
201.17	Younger individual age 45–49.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled.
201.18	do	Limited or less—at least literate and able to communicate in English.	do	Not disabled.
201.19	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
201.20	do	do	Skilled or semiskilled—skills transferable.	Do.
201.21	do	High school graduate or more	Skilled or semiskilled—skills not transferable.	Do.
201.22	do	do	Skilled or semiskilled—skills transferable.	Do.
201.23	Younger individual age 18–44.	Illiterate or unable to communicate in English.	Unskilled or none	Do.[4]
201.24	do	Limited or less—at least literate and able to communicate in English.	do	Do.[4]
201.25	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.[4]
201.26	do	do	Skilled or semiskilled—skills transferable.	Do.[4]
201.27	do	High school graduate or more	Unskilled or none	Do.[4]
201.28	do	do	Skilled or semiskilled—skills not transferable.	Do.[4]

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
201.29	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.[4]

[1] See 201.00(f).
[2] See 201.00(d).
[3] See 201.00(g).
[4] See 201.00(h).

202.00 *Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).* (a) The functional capacity to perform a full range of light work includes the functional capacity to perform sedentary as well as light work. Approximately 1,600 separate sedentary and light unskilled occupations can be identified in eight broad occupational categories, each occupation representing numerous jobs in the national economy. These jobs can be performed after a short demonstration or within 30 days, and do not require special skills or experience.

(b) The functional capacity to perform a wide or full range of light work represents substantial work capability compatible with making a work adjustment to substantial numbers of unskilled jobs and, thus, generally provides sufficient occupational mobility even for severely impaired individuals who are not of advanced age and have sufficient educational competences for unskilled work.

(c) However, for individuals of advanced age who can no longer perform vocationally relevant past work and who have a history of unskilled work experience, or who have only skills that are not readily transferable to a significant range of semi-skilled or skilled work that is within the individual's functional capacity, or who have no work experience, the limitations in vocational adaptability represented by functional restriction to light work warrant a finding of disabled. Ordinarily, even a high school education or more which was completed in the remote past will have little positive impact on effecting a vocational adjustment unless relevant work experience reflects use of such education.

(d) Where the same factors in paragraph (c) of this section regarding education and work experience are present, but where age, though not advanced, is a factor which significantly limits vocational adaptability (i.e., closely approaching advanced age, 50–54) and an individual's vocational scope is further significantly limited by illiteracy or inability to communicate in English, a finding of disabled is warranted.

(e) The presence of acquired skills that are readily transferable to a significant range of semi-skilled or skilled work within an individual's residual functional capacity would ordinarily warrant a finding of not disabled regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) For a finding of transferability of skills to light work for individuals of advanced age who are closely approaching retirement age (age 60–64), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly, the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. The capability for light work, which includes the ability to do sedentary work, represents the capability for substantial numbers of such jobs. This, in turn, represents substantial vocational scope for younger individuals (age 18–49) even if illiterate or unable to communicate in English.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
202.01	Advanced age	Limited or less	Unskilled or none	Disabled.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
202.02	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
202.03	.....do	.....do	Skilled or semiskilled—skills transferable [1].	Not disabled.
202.04	.....do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled.
202.05	.....do	High school graduate or more—provides for direct entry into skilled work [2].	.....do	Not disabled.
202.06	.....do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Disabled.
202.07	.....do	.....do	Skilled or semiskilled—skills transferable [2].	Not disabled.
202.08	.....do	High school graduate or more—provides for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Do.
202.09	Closely approaching advanced age.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled.
202.10	.....do	Limited or less—at least literate and able to communicate in English.	.....do	Not disabled.
202.11	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.12	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
202.13	.....do	High school graduate or more	Unskilled or none	Do.
202.14	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
202.15	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
202.16	Younger individual	Illiterate or unable to communicate in English.	Unskilled or none	Do.
202.17	.....do	Limited or less—at least literate and able to communicate in English.	.....do	Do.
202.18	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.19	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
202.20	.....do	High school graduate or more	Unskilled or none	Do.
202.21	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
202.22	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.

[1] See 202.00(f).
[2] See 202.00(c).

203.00 *Maximum sustained work capability limited to medium work as a result of severe medically determinable impair- ment(s).* (a) The functional capacity to perform medium work includes the functional capacity to perform sedentary, light, and medium work. Approximately 2,500 separate sedentary, light, and medium occupations can be identified, each occupation representing numerous jobs in the national economy which do not require skills or previous experience and which can be performed after a short demonstration or within 30 days.

(b) The functional capacity to perform medium work represents such substantial work capability at even the unskilled level that a finding of disabled is ordinarily not warranted in cases where a severely impaired individual retains the functional capacity to perform medium work. Even the adversity of advanced age (55 or over) and a work history of unskilled work may be offset by the substantial work capability represented by the functional capacity to perform medium work. However, an individual with a marginal education and long work experience (i.e., 35 years or more) limited to the performance of arduous unskilled labor, who is not working and is no longer able to perform this labor because of a severe impairment(s),

may still be found disabled even though the individual is able to do medium work.

(c) However, the absence of any relevant work experience becomes a more significant adversity for individuals of advanced age (55 and over). Accordingly, this factor, in combination with a limited education or less, militates against making a vocational adjustment to even this substantial range of work and a finding of disabled is appropriate. Further, for individuals closely approaching retirement age (60–64) with a work history of unskilled work and with marginal education or less, a finding of disabled is appropriate.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
203.01	Closely approaching retirement age.	Marginal or none	Unskilled or none	Disabled.
203.02	do	Limited or less	None	Do.
203.03	do	Limited	Unskilled	Not disabled.
203.04	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
203.05	do	do	Skilled or semiskilled—skills transferable.	Do.
203.06	do	High school graduate or more	Unskilled or none	Do.
203.07	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.08	do	do	Skilled or semiskilled—skills transferable.	Do.
203.09	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.10	Advanced age	Limited or less	None	Disabled.
203.11	do	do	Unskilled	Not disabled.
203.12	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.13	do	do	Skilled or semiskilled—skills transferable.	Do.
203.14	do	High school graduate or more	Unskilled or none	Do.
203.15	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.16	do	do	Skilled or semiskilled—skills transferable.	Do.
203.17	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.18	Closely approaching advanced age.	Limited or less	Unskilled or none	Do.
203.19	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.20	do	do	Skilled or semiskilled—skills transferable.	Do.
203.21	do	High school graduate or more	Unskilled or none	Do.
203.22	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.23	do	do	Skilled or semiskilled—skills transferable.	Do.
203.24	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.25	Younger individual	Limited or less	Unskilled or none	Do.
203.26	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.27	do	do	Skilled or semiskilled—skills transferable.	Do.
203.28	do	High school graduate or more	Unskilled or none	Do.
203.29	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.30	do	do	Skilled or semiskilled—skills transferable.	Do.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
203.31	.....do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.

204.00 *Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).* The residual functional capacity to perform heavy work or very heavy work includes the functional capability for work at the lesser functional levels as well, and represents substantial work capability for jobs in the national economy at all skill and physical demand levels. Individuals who retain the functional capacity to perform heavy work (or very heavy work) ordinarily will not have a severe impairment or will be able to do their past work—either of which would have already provided a basis for a decision of ''not disabled''. Environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work). Thus an impairment which does not preclude heavy work (or very heavy work) would not ordinarily be the primary reason for unemployment, and generally is sufficient for a finding of not disabled, even though age, education, and skill level of prior work experience may be considered adverse.

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 57944, Nov. 14, 1991]

Subpart Q—Determinations of Disability

AUTHORITY: Secs. 205(a), 221, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 421, and 902(a)(5)).

SOURCE: 46 FR 29204, May 29, 1981, unless otherwise noted.

GENERAL PROVISIONS

§ 404.1601 Purpose and scope.

This subpart describes the standards of performance and administrative requirements and procedures for States making determinations of disability for the Secretary under title II of the Act. It also establishes the Secretary's responsibilities in carrying out the disability determination function.

(a) Sections 404.1601 through 404.1603 describe the purpose of the regulations and the meaning of terms frequently used in the regulations. They also briefly set forth the responsibilities of the Secretary and the States covered in detail in other sections.

(b) Sections 404.1610 through 404.1618 describe the Secretary's and the State's responsibilities in performing the disability determination function.

(c) Sections 404.1620 through 404.1633 describe the administrative responsibilities and requirements of the States. The corresponding role of the Secretary is also set out.

(d) Sections 404.1640 through 404.1650 describe the performance accuracy and processing time standards for measuring State agency performance.

(e) Sections 404.1660 through 404.1661 describe when and what kind of assistance the Secretary will provide State agencies to help them improve performance.

(f) Sections 404.1670 through 404.1675 describe the level of performance below which the Secretary will consider a State agency to be substantially failing to make disability determinations consistent with the regulations and other written guidelines and the resulting action the Secretary will take.

(g) Sections 404.1680 through 404.1683 describe the rules for resolving disputes concerning fiscal issues and providing hearings when we propose to find that a State is in substantial failure.

(h) Sections 404.1690 through 404.1694 describe when and what action the Secretary will take and what action the State will be expected to take if the Secretary assumes the disability determination function from a State agency.

§ 404.1602 Definitions.

For purposes of this subpart:

Act means the Social Security Act, as amended.

Class or classes of cases means the categories into which disability claims are divided according to their characteristics.

Determination of disability or *disability determination* means one or more of the following decisions:

(a) Whether or not a person is under a disability;

(b) The date a person's disability began; or

(c) The date a person's disability ended.

Disability means *disability* or *blindness* as defined in sections 216(i) and 223 of the Act or as defined in title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Disability determination function means making determinations as to disability and carrying out related administrative and other responsibilities.

Disability program means, as appropriate, the Federal programs for providing disability insurance benefits under title II of the Act and disability benefits under title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Initial means the first level of disability adjudication.

Other written guidelines means written issuances such as Social Security Rulings and memoranda by the Commissioner of Social Security, the Deputy Commissioner for Programs, or the Associate Commissioner for Disability and the procedures, guides, and operating instructions in the Disability Insurance sections of the Program Operations Manual System, that are instructive, interpretive, clarifying, and/or administrative and not designated as advisory or discretionary. The purpose of including the foregoing material in the definition is to assure uniform national application of program standards and service delivery to the public.

Regulations means regulations in this subpart issued under sections 205(a), 221 and 1102 of the Act, unless otherwise indicated.

Secretary means the Secretary of the Department of Health and Human Services or the Secretary's delegate.

State means any of the 50 States of the United States, the Commonwealth of Puerto Rico, the District of Columbia, or Guam. It includes the State agency.

State agency means that agency of a State which has been designated by the State to carry out the disability determination function.

We, us, and *our* refers to the Social Security Administration (SSA) or the Secretary, as appropriate.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11018, Mar. 14, 1991]

§ 404.1603 Basic responsibilities for us and the State.

(a) *General.* We will work with the State to provide and maintain an effective system for processing claims of those who apply for and who are receiving benefits under the disability program. We will provide program standards, leadership, and oversight. We do not intend to become involved in the State's ongoing management of the program except as is necessary and in accordance with these regulations. The State will comply with our regulations and other written guidelines.

(b) *Our responsibilities.* We will:

(1) Periodically review the regulations and other written guidelines to determine whether they insure effective and uniform administration of the disability program. To the extent feasible, we will consult with and take into consideration the experience of the States in issuing regulations and guidelines necessary to insure effective and uniform administration of the disability program;

(2) Provide training materials or in some instances conduct or specify training, see § 404.1622;

(3) Provide funds to the State agency for the necessary cost of performing the disability determination function, see § 404.1626;

(4) Monitor and evaluate the performance of the State agency under the established standards, see §§ 404.1644 and 404.1645; and

(5) Maintain liaison with the medical profession nationally and with national organizations and agencies whose interests or activities may affect the disability program.

(c) *Responsibilities of the State.* The State will:

(1) Provide management needed to insure that the State agency carries

out the disability determination function so that disability determinations are made accurately and promptly;

(2) Provide an organizational structure, adequate facilities, qualified personnel, medical consultant services, and a quality assurance function (§§ 404.1620 through 404.1624);

(3) Furnish reports and records relating to the administration of the disability program (§ 404.1625);

(4) Submit budgets (§ 404.1626);

(5) Cooperate with audits (§ 404.1627);

(6) Insure that all applicants for and recipients of disability benefits are treated equally and courteously;

(7) Be responsible for property used for disability program purposes (§ 404.1628);

(8) Take part in the research and demonstration projects (§ 404.1629);

(9) Coordinate with other agencies (§ 404.1630);

(10) Safeguard the records created by the State in performing the disability determination function (§ 404.1631);

(11) Comply with other provisions of the Federal law and regulations that apply to the State in performing the disability determination function;

(12) Comply with other written guidelines (§ 404.1633);

(13) Maintain liaison with the medical profession and organizations that may facilitate performing the disability determination function; and

(14) Assist us in other ways that we determine may promote the objectives of effective and uniform administration.

RESPONSIBILITIES FOR PERFORMING THE DISABILITY DETERMINATION FUNCTION

§ 404.1610 How a State notifies us that it wishes to perform the disability determination function.

(a) *Deemed notice.* Any State that has in effect as of June 1, 1981, an agreement with us to make disability determinations will be deemed to have given us notice that it wishes to perform the disability determination function, in lieu of continuing the agreement in effect after June 1, 1981.

(b) *Written notice.* After June 1, 1981, a State not making disability determinations that wishes to perform the disability determination function under these regulations must notify us in writing. The notice must be from an official authorized to act for the State for this purpose. The State will provide an opinion from the State's Attorney General verifying the authority of the official who sent the notice to act for the State.

§ 404.1611 How we notify a State whether it may perform the disability determination function.

(a) If a State notifies us in writing that it wishes to perform the disability determination function, we will notify the State in writing whether or not it may perform the function. The State will begin performing the disability determination function beginning with the month we and the State agree upon.

(b) If we have previously found that a State agency has substantially failed to make disability determinations in accordance with the law or these regulations and other written guidelines or if the State has previously notified us in writing that it does not wish to make disability determinations, the notice will advise the State whether the State agency may again make the disability determinations and, if so, the date and the conditions under which the State may again make them.

§ 404.1613 Disability determinations the State makes.

(a) *General rule.* A State agency will make determinations of disability with respect to all persons in the State except those individuals whose cases are in a class specifically excluded by our written guidelines. A determination of disability made by the State is the determination of the Secretary, except as described in § 404.1503(d)(1).

(b) *New classes of cases.* Where any new class or classes of cases arise requiring determinations of disability, we will determine the conditions under which a State may choose not to make the disability determinations. We will provide the State with the necessary funding to do the additional work.

(c) *Temporary transfer of classes of cases.* We will make disability determinations for classes of cases temporarily transferred to us by the State agency if the State agency asks us to do so and we agree. The State agency

will make written arrangements with us which will specify the period of time and the class or classes of cases we will do.

§404.1614 Responsibilities for obtaining evidence to make disability determinations.

(a) The State agency will secure from the claimant, or other sources, any evidence it needs to make a disability determination.

(b) We will secure from the claimant or other special arrangement sources, any evidence we can obtain as adequately and more readily than the State agency. We will furnish the evidence to the State agency for use in making a disability determination.

(c) At our request, the State agency will obtain and furnish medical or other evidence and provide assistance as may be necessary for us to carry out our responsibilities—

(1) For making disability determinations in those classes of cases described in the written guidelines for which the State agency does not make the determination; or

(2) Under international agreements with respect to social security benefits payable under section 233 of the Act.

§404.1615 Making disability determinations.

(a) When making a disability determination, the State agency will apply subpart P, part 404, of our regulations.

(b) The State agency will make disability determinations based only on the medical and nonmedical evidence in its files.

(c) Disability determinations will be made by either:

(1) A State agency medical or psychological consultant and a State agency disability examiner;

(2) A State agency disability examiner alone when there is no medical evidence to be evaluated (i.e., no medical evidence exists or we are unable, despite making every reasonable effort, to obtain any medical evidence that may exist) and the individual fails or refuses, without a good reason, to attend a consultative examination (see §404.1518); or

(3) A State agency disability hearing officer.

See §404.1616 for the definition of medical or psychological consultant and §404.915 for the definition of disability hearing officer. The State agency disability examiner and disability hearing officer must be qualified to interpret and evaluate medical reports and other evidence relating to the claimant's physical or mental impairments and as necessary to determine the capacities of the claimant to perform substantial gainful activity.

See §404.1572 for what we mean by substantial gainful activity.

(d) An initial determination by the State agency that an individual is not disabled, in any case where there is evidence which indicates the existence of a mental impairment, will be made only after every reasonable effort has been made to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment. (See §404.1616 for the qualifications we consider necessary for a psychologist to be a psychological consultant and §404.1617 for what we mean by ''reasonable effort''.) If the services of qualified psychiatrists or psychologists cannot be obtained because of impediments at the State level, the Secretary may contract directly for the services. In a case where there is evidence of mental and nonmental impairments and a qualified psychologist serves as a psychological consultant, the psychologist will evaluate only the mental impairment, and a physician will evaluate the nonmental impairment. The overall determination of impairment severity in combined mental and nonmental impairment cases will be made by a medical consultant and not a psychological consultant unless the mental impairment alone would justify a finding of disability.

(e) The State agency will certify each determination of disability to us on forms we provide.

(f) The State agency will furnish us with all the evidence it considered in making its determination.

(g) The State agency will not be responsible for defending in court any determination made, or any procedure for

making determinations, under these regulations.

[52 FR 33926, Sept. 9, 1987, as amended at 56 FR 11018, Mar. 14, 1991; 61 FR 11135, Mar. 19, 1996]

EFFECTIVE DATE NOTE: At 61 FR 11135, Mar. 19, 1996, § 404.1615 was amended by removing the ''or'' at the end of paragraph (c)(1), by adding a semicolon after paragraph (c)(1), by redesignating paragraph (c)(2) as paragraph (c)(3), and by adding a new paragraph (c)(2), effective April 18, 1996.

§ 404.1616 Medical or psychological consultant.

A medical consultant must be a physician. A psychological consultant used in cases where there is evidence of a mental impairment must be a qualified psychologist. For disability program purposes a psychologist will not be considered qualified unless he or she:

(a) Is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and

(b) (1) Possesses a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; or

(2) Is listed in a national register of health service providers in psychology which the Secretary of Health and Human Services deems appropriate; and

(c) Possesses 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post masters degree.

[52 FR 33927, Sept. 9, 1987]

§ 404.1617 Reasonable efforts to obtain review by a qualified psychiatrist or psychologist.

(a) The State agency must determine if additional qualified psychiatrists and psychologists are needed to make the necessary reviews (see § 404.1615(d)). Where it does not have sufficient resources to make the necessary reviews, the State agency must attempt to obtain the resources needed. If the State agency is unable to obtain additional psychiatrists and psychologists because of low salary rates or fee schedules it should attempt to raise the State agency's levels of compensation to meet the prevailing rates for psychiatrists' and psychologists' services. If these efforts are unsuccessful, the State agency will seek assistance from us. We will assist the State agency as necessary. We will also monitor the State agency's efforts and where the State agency is unable to obtain the necessary services, we will make every reasonable effort to provide the services using Federal resources.

(b) Federal resources may include the use of Federal contracts for the services of qualified psychiatrists and psychologists to review mental impairment cases. Where Federal resources are required to perform these reviews, which are a basic State agency responsibility, and where appropriate, the State agency's budget will be reduced accordingly.

(c) Where every reasonable effort is made to obtain the services of a qualified psychiatrist or psychologist to review a mental impairment case, but the professional services are not obtained, a physician who is not a psychiatrist will review the mental impairment case. For these purposes, every reasonable effort to ensure that a qualified psychiatrist or psychologist review mental impairment cases will be considered to have been made only after efforts by both State and Federal agencies as set forth in paragraphs (a) and (b) of this section are made.

[52 FR 33927, Sept. 9, 1987]

§ 404.1618 Notifying claimants of the disability determination.

The State agency will prepare denial notices in accordance with subpart J of this part whenever it makes a disability determination which is wholly or partly unfavorable to the claimant.

ADMINISTRATIVE RESPONSIBILITIES AND REQUIREMENTS

§ 404.1620 General administrative requirements.

(a) The State will provide the organizational structure, qualified personnel, medical consultant services, and a quality assurance function sufficient to ensure that disability determinations are made accurately and promptly. We may impose specific administrative requirements in these areas and in those

under ''Administrative Responsibilities and Requirements'' in order to establish uniform, national administrative practices or to correct the areas of deficiencies which may later cause the State to be substantially failing to comply with our regulations or other written guidelines. We will notify the State, in writing, of the administrative requirements being imposed and of any administrative deficiencies it is required to correct. We will allow the State 90 days from the date of this notice to make appropriate corrections. Once corrected, we will monitor the State's administrative practices for 180 days. If the State does not meet the requirements or correct all of the deficiencies, or, if some of the deficiencies recur, we may initiate procedures to determine if the State is substantially failing to follow our regulations or other written guidelines.

(b) The State is responsible for making accurate and prompt disability determinations.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11018, Mar. 14, 1991]

§ 404.1621 Personnel.

(a) *Equal employment opportunity*. The State will comply with all applicable Federal statutes, executive orders and regulations concerned with equal employment opportunities.

(b) *Selection, tenure, and compensation*. The State agency will, except as may be inconsistent with paragraph (a) of this section, adhere to applicable State approved personnel standards in the selection, tenure, and compensation of any individual employed in the disability program.

(c) *Travel*. The State will make personnel available to attend meetings or workshops as may be sponsored or approved by us for furthering the purposes of the disability program.

(d) *Restrictions*. Subject to appropriate Federal funding, the State will, to the best of its ability, facilitate the processing of disability claims by avoiding personnel freezes, restrictions against overtime work, or curtailment of facilities or activities.

§ 404.1622 Training.

The State will insure that all employees have an acceptable level of competence. We will provide training and other instructional materials to facilitate basic and advanced technical proficiency of disability staff in order to insure uniformity and effectiveness in the administration of the disability program. We will conduct or specify training, as appropriate, but only if:

(a) A State agency's performance approaches unacceptable levels; or

(b) The material required for the training is complex or the capacity of the State to deliver the training is in doubt and uniformity of the training is essential.

§ 404.1623 Facilities.

(a) *Space, equipment, supplies, and other services*. Subject to appropriate Federal funding, the State will provide adequate space, equipment, supplies, and other services to facilitate making accurate and prompt disability determinations.

(b) *Location of facilities*. Subject to appropriate Federal funding, the State will determine the location where the disability determination function is to be performed so that disability determinations are made accurately and promptly.

(c) *Access*. The State will permit us access to the premises where the disability determination function is performed and also where it is managed for the purposes of inspecting and obtaining information about the work and activities required by our regulations and assuring compliance with pertinent Federal statutes and regulations. Access includes personal onsite visits and other means, such as telecommunications, of contacting the State agency to obtain information about its functions. We will contact the State agency and give reasonable prior notice of the times and purposes of any visits.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11019, Mar. 14, 1991]

§ 404.1624 Medical and other purchased services.

The State will determine the rates of payment to be used for purchasing medical or other services necessary to make determinations of disability. The rates may not exceed the highest rate paid by Federal or other agencies in

the State for the same or similar type of service. The State will maintain documentation to support the rates of payment it uses.

§ 404.1625 Records and reports.

(a) The State will establish and maintain the records and furnish the schedules, financial, cost, and other reports relating to the administration of the disability programs as we may require.

(b) The State will permit us and the Comptroller General of the United States (including duly authorized representatives) access to and the right to examine records relating to the work which the State performs under these regulations. These records will be retained by the State for the periods of time specified for retention of records in the Federal Procurement Regulations (41 CFR parts 1–20).

§ 404.1626 Fiscal.

(a) We will give the State funds, in advance or by way of reimbursement, for necessary costs in making disability determinations under these regulations. Necessary costs are direct as well as indirect costs as defined in 41 CFR part 1–15, subpart 1–15.7 of the Federal Procurement Regulations System for costs incurred before April 1, 1984; and 48 CFR part 31, subpart 31.6 of the Federal Acquisition Regulations System and Federal Management Circular A–74–4[1] as amended or superseded for costs incurred after March 31, 1984.

(b) The State will submit estimates of anticipated costs in the form of a budget at the time and in the manner we require.

(c) We will notify the State of the amount which will be made available to it as well as what anticipated costs are being approved.

(d) The State may not incur or make expenditures for items of cost not approved by us or in excess of the amount we make available to the State.

(e) After the close of a period for which funds have been made available to the State, the State will submit a report of its expenditures. Based on an audit arranged by the State under Pub. L. 98–502, the Single Audit Act of 1984, or by the Inspector General of the Department of Health and Human Services or based on an audit or review by the Social Security Administration (see § 404.1627), we will determine whether the expenditures were consistent with cost principles described in 41 CFR part 1–15, subpart 1–15.7 for costs incurred before April 1, 1984; and 48 CFR part 31, subpart 31.6 and Federal Management Circular A–741–4 for costs incurred after March 31, 1984: and in other applicable written guidelines in effect at the time the expenditures were made or incurred.

(f) Any monies paid to the State which are used for purposes not within the scope of these regulations will be paid back to the Treasury of the United States.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11019, Mar. 14, 1991]

§ 404.1627 Audits.

(a) *Audits performed by the State*—(1) *Generally*. Audits of accounts and records pertaining to the administration of the disability program under the Act, will be performed by the States in accordance with the Single Audit Act of 1984 (Pub. L. 98–502) which establishes audit requirements for States receiving Federal assistance. If the audit performed by the State meets our program requirements, we will accept the findings and recommendations of the audit. The State will make every effort to act upon and resolve any items questioned in the audit.

(2) *Questioned items.* Items questioned as a result of an audit under the Single Audit Act of 1984 of a cross-cutting nature will be resolved by the Department of Health and Human Services, Office of Grant and Contract Financial Management. A cross-cutting issue is one that involves more than one Federal awarding agency. Questioned items affecting only the disability program will be resolved by SSA in accord with paragraph (b)(2) of this section,

(3) *State appeal of audit determinations.* The Office of Grant and Contract Financial Management will notify the State of its determination on questioned cross-cutting items. If the State

[1] The circular is available from the Office of Administration, Publications Unit, Rm. G–236, New Executive Office Bldg., Washington, DC 20503.

disagrees with that determination, it may appeal in writing within 60 days of receiving the determination. State appeals of a cross-cutting issue as a result of an audit under the Single Audit Act of 1984 will be made to the Department of Health and Human Services' Departmental Appeals Board. The rules for hearings and appeals are provided in 45 CFR part 16.

(b) *Audits performed by the Secretary*—(1) *Generally*. If the State does not perform an audit under the Single Audit Act of 1984 or the audit performed is not satisfactory for disability program purposes, the books of account and records in the State pertaining to the administrations of the disability programs under the Act will be audited by the Department of Health and Human Services' Inspector General or audited or reviewed by SSA as appropriate. These audits or reviews will be conducted to determine whether the expenditures were made for the intended purposes and in amounts necessary for the proper and efficient administration of the disability programs. Audits or reviews will also be made to inspect the work and activities required by the regulations to ensure compliance with pertinent Federal statutes and regulations. The State will make every effort to act upon and resolve any items questioned in an audit or review.

(2) *Questioned items.* Expenditures of State agencies will be audited or reviewed, as appropriate, on the basis of cost principles and written guidelines in effect at the time the expenditures were made or incurred. Both the State and the State agency will be informed and given a full explanation of any items questioned. They will be given reasonable time to explain items questioned. Any explanation furnished by the State or State agency will be given full consideration before a final determination is made on the audit or review report.

(3) *State appeal of audit determinations.* The appropriate Social Security Administration Regional Commissioner will notify the State of his or her determination on the audit or review report. If the State disagrees with that determination, the State may request reconsideration in writing within 60 days of the date of the Regional Commissioner's notice of the determination. The written request may be made, through the Associate Commissioner, Office of Disability, to the Commissioner of Social Security, room 900, Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235. The Commissioner will make a determination and notify the State of the decision in writing no later than 90 days from the date the Social Security Administration receives the State's appeal and all supporting documents. The decision by the Commissioner on other than monetary disallowances will be final and binding upon the State. The decision by the Commissioner on monetary disallowances will be final and binding upon the State unless the State appeals the decision in writing to the Department of Health and Human Services, Departmental Appeals Board within 30 days after receiving the Commissioner's decision. See §404.1683.

[56 FR 11019, Mar. 14, 1991]

§404.1628 Property.

The State will have title to equipment purchased for disability program purposes. The State will be responsible for maintaining all property it acquires or which we furnish to it for performing the disability determination function. The State will identify the equipment by labeling and by inventory and will credit the SSA account with the fair market value of disposed property.

In the event we assume the disability determination function from a State, ownership of all property and equipment acquired with SSA funds will be transferred to us effective on the date the State is notified that we are assuming the disability determination function or we are notified that the State is terminating the relationship.

§404.1629 Participation in research and demonstration projects.

We will invite State participation in federally funded research and demonstration projects to assess the effectiveness of the disability program and to ascertain the effect of program policy changes. Where we determine that State participation is necessary for the project to be complete, for example, to provide national uniformity in a

claims process, State participation is mandatory.

§ 404.1630 Coordination with other agencies.

(a) The State will establish cooperative working relationships with other agencies concerned with serving the disabled and, insofar as practicable, use their services, facilities, and records to:

(1) Assist the State in developing evidence and making determinations of disability; and

(2) Insure that referral of disabled or blind persons for rehabilitation services will be carried out effectively.

(b) The State may pay these agencies for the services, facilities, or records they provide. The State will include these costs in its estimates of anticipated costs and reports of actual expenditures.

§ 404.1631 Confidentiality of information and records.

The State will comply with the confidentiality of information, including the security of systems, and records requirements described in 20 CFR part 401 and pertinent written guidelines (see § 404.1633).

§ 404.1632 Other Federal laws and regulations.

The State will comply with the provisions of other Federal laws and regulations that directly affect its responsibilities in carrying out the disability determination function; for example, Treasury Department regulations on letters of credit (31 CFR part 205).

§ 404.1633 Policies and operating instructions.

(a) We will provide the State agency with written guidelines necessary for it to carry out its responsibilities in performing the disability determination function.

(b) The State agency making determinations of disability will comply with our written guidelines that are not designated as advisory or discretionary. (See § 404.1602 for what we mean by written guidelines.)

(c) A representative group of State agencies will be given an opportunity to participate in formulating disability program policies that have an affect on their role in carrying out the disability determination function. State agencies will also be given an opportunity to comment before changes are made in written guidelines unless delay in issuing a change may impair service to the public.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

PERFORMANCE STANDARDS

§ 404.1640 General.

The following sections provide the procedures and guidelines we use to determine whether the State agency is substantially complying with our regulations and other written guidelines, including meeting established national performance standards. We use performance standards to help assure effective and uniform administration of our disability programs and to measure whether the performance of the disability determination function by each State agency is acceptable. Also, the standards are designed to improve overall State agency performance in the disability determination process and to ensure that benefits are made available to all eligible persons in an accurate and efficient manner. We measure the performance of a State agency in two areas—processing time and quality of documentation and decisions on claims. State agency compliance is also judged by State agency adherence to other program requirements.

[56 FR 11020, Mar. 14, 1991]

§ 404.1641 Standards of performance.

(a) *General.* The performance standards include both a target level of performance and a threshold level of performance for the State agency. The target level represents a level of performance that we and the States will work to attain in the future. The threshold level is the minimum acceptable level of performance. Performance below the threshold level will be the basis for the Secretary's taking from the State agency partial or complete

responsibility for performing the disability determination function. Intermediate State agency goals are designed to help each State agency move from its current performance levels to the target levels.

(b) *The target level.* The target level is the optimum level of performance. There are three targets—one for combined title II and title XVI initial performance accuracy, one for title II initial processing time, and one for title XVI initial processing time.

(c) *The threshold level.* The threshold level is the minimum acceptable level of performance. There are three thresholds—one for combined title II and title XVI initial performance accuracy, one for title II initial processing time, and one for title XVI initial processing time.

(d) *Intermediate goals.* Intermediate goals are levels of performance between the threshold levels and the target levels established by our appropriate Regional Commissioner after negotiation with each State agency. The intermediate goals are designed to help the State agencies reach the target levels. Failure to meet these goals is not a cause for considering the State agency to be substantially failing to comply with the performance standards. However, failure to meet the intermediate goals may result in consultation and an offer of optional performance support depending on the availability of our resources.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

§ 404.1642 Processing time standards.

(a) *General.* Title II processing time refers to the average number of days, including Saturdays, Sundays, and holidays, it takes a State agency to process an initial disability claim from the day the case folder is received in the State agency until the day it is released to us by the State agency. Title XVI processing time refers to the average number of days, including Saturdays, Sundays, and holidays, from the day of receipt of the initial disability claim in the State agency until systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) *Target levels.* The processing time target levels are:

(1) 37 days for title II initial claims.

(2) 43 days for title XVI initial claims.

(c) *Threshold levels.* The processing time threshold levels are:

(1) 49.5 days for title II initial claims.

(2) 57.9 days for title XVI initial claims.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

§ 404.1643 Performance accuracy standard.

(a) *General.* Performance accuracy refers to the percentage of cases that do not have to be returned to State agencies for further development or correction of decisions based on evidence in the files and as such represents the reliability of State agency adjudication. The definition of performance accuracy includes the measurement of factors that have a potential for affecting a decision, as well as the correctness of the decision. For example, if a particular item of medical evidence should have been in the file but was not included, even though its inclusion does not change the result in the case, that is a performance error. Performance accuracy, therefore, is a higher standard than decisional accuracy. As a result, the percentage of correct decisions is significantly higher than what is reflected in the error rate established by SSA's quality assurance system.

(b) *Target level.* The State agency initial performance accuracy target level for combined title II and title XVI cases is 97 percent with a corresponding decision accuracy rate of 99 percent.

(c) *Intermediate Goals.* These goals will be established annually by SSA's regional commissioner after negotiation with the State and should be used as stepping stones to progress towards our targeted level of performance.

(d) *Threshold levels.* The State agency initial performance accuracy threshold level for combined title II and title XVI cases is 90.6 percent.

§ 404.1644 How and when we determine whether the processing time standards are met.

(a) *How we determine processing times.* For all initial title II cases, we calculate the mean number of days, including Saturdays, Sundays and holidays, from the day the case folder is received in the State agency until the day it is released to us by the State agency. For initial title XVI cases, we calculate the mean number of days, including Saturdays, Sundays, and holidays, from the day the case folder is received in the State agency until the day there is a systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) *Frequency of review.* Title II processing times and title XVI processing times are monitored separately on a quarterly basis. The determination as to whether or not the processing time thresholds have been met is made at the end of each quarter each year. Quarterly State-by-State mean processing times are compared with the threshold levels for both title II and title XVI.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

§ 404.1645 How and when we determine whether the performance accuracy standard is met.

(a) *How we determine performance accuracy.* We determine a State agency's performance accuracy rate on the basis of decision and documentation errors identified in our review of the sample cases.

(b) *Frequency of review.* Title II and title XVI initial performance accuracy are monitored together on a quarterly basis. The determinations as to whether the performance accuracy threshold has been met is made at the end of each quarter each year. Quarterly State-by-State combined initial performance accuracy rates are compared to the established threshold level.

§ 404.1650 Action we will take if a State agency does not meet the standards.

If a State agency does not meet two of the three established threshold levels (one of which must be performance accuracy) for two or more consecutive calendar quarters, we will notify the State agency in writing that it is not meeting the standards. Following our notification, we will provide the State agency appropriate performance support described in §§ 404.1660, 404.1661 and 404.1662 for a period of up to 12 months.

[56 FR 11020, Mar. 14, 1991]

PERFORMANCE MONITORING AND SUPPORT

§ 404.1660 How we will monitor.

We will regularly analyze State agency combined title II and title XVI initial performance accuracy rate, title II initial processing time, and title XVI initial processing time. Within budgeted resources, we will also routinely conduct fiscal and administrative management reviews and special onsite reviews. A fiscal and administrative management review is a fact-finding mission to review particular aspects of State agency operations. During these reviews we will also review the quality assurance function. This regular monitoring and review program will allow us to determine the progress each State is making and the type and extent of performance support we will provide to help the State progress toward threshold, intermediate, and/or target levels.

[56 FR 11020, Mar. 14, 1991]

§ 404.1661 When we will provide performance support.

(a) *Optional support.* We may offer, or a State may request, performance support at any time that the regular monitoring and review process reveals that support could enhance performance. The State does not have to be below the initial performance accuracy rate of 90.6 percent to receive performance support. Support will be offered, or granted upon request, based on available resources.

(b) *Mandatory support.* (1) We will provide a State agency with mandatory performance support if regular monitoring and review reveal that two of three threshold levels (one of which must be performance accuracy) are not met for two consecutive calendar quarters.

(2) We may also decide to provide a State agency with mandatory performance support if regular monitoring and review reveal that any one of the three threshold levels is not met for two consecutive calendar quarters. Support will be provided based on available resources.

(3) The threshold levels are:

(i) Combined title II and title XVI initial performance accuracy rate—90.6 percent,

(ii) Title II initial processing time—49.5 days, and

(iii) Title XVI initial processing time—57.9 days.

[56 FR 11020, Mar. 14, 1991]

§404.1662 What support we will provide.

Performance support may include, but is not limited to, any or all of the following:

(a) An onsite review of cases processed by the State agency emphasizing adherence to written guidelines.

(b) A request that necessary administrative measures be implemented (e.g., filling staffing vacancies, using overtime, assisting with training activities, etc.).

(c) Provisions for Federal personnel to perform onsite reviews, conduct training, or perform other functions needed to improve performance.

(d) Provisions for fiscal aid to allow for overtime, temporary hiring of additional staff, etc., above the authorized budget.

[56 FR 11020, Mar. 14, 1991]

SUBSTANTIAL FAILURE

§404.1670 General.

After a State agency falls below two of three established threshold levels, one being performance accuracy, for two consecutive quarters, and after the mandatory performance support period, we will give the State agency a 3-month adjustment period. During this 3-month period we will not require the State agency to meet the threshold levels. Following the adjustment period, if the State agency again falls below two of three threshold levels, one being performance accuracy, in two consecutive quarters during the next 12 months, we will notify the State that we propose to find that the State agency has substantially failed to comply with our standards and advise it that it may request a hearing on that issue. After giving the State notice and an opportunity for a hearing, if it is found that a State agency has substantially failed to make disability determinations consistent with the Act, our regulations or other written guidelines, we will assume partial or complete responsibility for performing the disability determination function after we have complied with §§404.1690 and 404.1692.

[56 FR 11021, Mar. 14, 1991]

§404.1671 Good cause for not following the Act, our regulations, or other written guidelines.

If a State has good cause for not following the Act, our regulations, or other written guidelines, we will not find that the State agency has substantially failed to meet our standards. We will determine if good cause exists. Some of the factors relevant to good cause are:

(a) Disasters such as fire, flood, or civil disorder, that—

(1) Require the diversion of significant personnel normally assigned to the disability determination function, or

(2) Destroyed or delayed access to significant records needed to make accurate disability determinations;

(b) Strikes of State agency staff or other government or private personnel necessary to the performance of the disability determination function;

(c) Sudden and unanticipated workload changes which result from changes in Federal law, regulations, or written guidelines, systems modification or systems malfunctions, or rapid, unpredictable caseload growth for a 6-month period or longer.

[56 FR 11021, Mar. 14, 1991]

§404.1675 Finding of substantial failure.

A finding of substantial failure with respect to a State may not be made unless and until the State is afforded an opportunity for a hearing.

HEARINGS AND APPEALS

§ 404.1680 Notice of right to hearing on proposed finding of substantial failure.

If, following the mandatory performance support period and the 3-month adjustment period, a State agency again falls below two of three threshold levels (one being performance accuracy) in two consecutive quarters in the succeeding 12 months, we will notify the State in writing that we will find that the State agency has substantially failed to meet our standards unless the State submits a written request for a hearing with the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving the notice. The notice will identify the threshold levels that were not met by the State agency, the period during which the thresholds were not met and the accuracy and processing time levels attained by the State agency during this period. If a hearing is not requested, the State agency will be found to have substantially failed to meet our standards, and we will implement our plans to assume the disability determination function.

[56 FR 11021, Mar. 14, 1991]

§ 404.1681 Disputes on matters other than substantial failure.

Disputes concerning monetary disallowances will be resolved in proceedings before the Department of Health and Human Services' Departmental Appeals Board if the issue cannot be resolved between us and the State. Disputes other than monetary disallowances will be resolved through an appeal to the Commissioner of Social Security, who will make the final decision. (See § 404.1627.)

[56 FR 11021, Mar. 14, 1991]

§ 404.1682 Who conducts the hearings.

If a hearing is required, it will be conducted by the Health and Human Services Departmental Grant Appeals Board (the Board).

§ 404.1683 Hearings and appeals process.

The rules for hearings and appeals before the Board are provided in 45 CFR part 16. A notice under § 404.1680 of this subpart will be considered a ''final written decision'' for purposes of Board review.

ASSUMPTION OF DISABILITY DETERMINATION FUNCTION

§ 404.1690 Assumption when we make a finding of substantial failure.

(a) *Notice to State.* When we find that substantial failure exists, we will notify the State in writing that we will assume responsibility for performing the disability determination function from the State agency, whether the assumption will be partial or complete, and the date on which the assumption will be effective.

(b) *Effective date of assumption.* The date of any partial or complete assumption of the disability determination function from a State agency may not be earlier than 180 days after our finding of substantial failure, and not before compliance with the requirements of § 404.1692.

§ 404.1691 Assumption when State no longer wishes to perform the disability determination function.

(a) *Notice to the Secretary.* If a State no longer wishes to perform the disability determination function, it will notify us in writing. The notice must be from an official authorized to act for the State for this purpose. The State will provide an opinion from the State's Attorney General verifying the authority of the official who gave the notice.

(b) *Effective date of assumption.* The State agency will continue to perform whatever activities of the disability determination function it is performing at the time the notice referred to in paragraph (a) of this section is given for not less than 180 days or, if later, until we have complied with the requirements of § 404.1692. For example, if the State is not making disability determinations (because we previously assumed responsibility for making them) but is performing other activities related to the disability determination function at the time it gives notice, the State will continue to do these activities until the requirements of this paragraph are met. Thereafter, we will assume complete responsibility

for performing the disability determination function.

§404.1692 Protection of State employees.

(a) *Hiring preference.* We will develop and initiate procedures to implement a plan to partially or completely assume the disability determination function from the State agency under §404.1690 or §404.1691, as appropriate. Except for the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent), we will give employees of the State agency who are capable of performing duties in the disability determination function preference over any other persons in filling positions with us for which they are qualified. We may also give a preference in hiring to the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent). We will establish a system for determining the hiring priority among the affected State agency employees in those instances where we are not hiring all of them.

(b) *Determination by Secretary of Labor.* We will not assume responsibility for performing the disability determination function from a State until the Secretary of Labor determines that the State has made fair and equitable arrangements under applicable Federal, State and local law to protect the interests of employees who will be displaced from their employment because of the assumption and who we will not hire.

§404.1693 Limitation on State expenditures after notice.

The State agency may not, after it receives the notice referred to in §404.1690, or gives the notice referred to in §404.1691, make any new commitments to spend funds allocated to it for performing the disability determination function without the approval of the appropriate SSA regional commissioner. The State will make every effort to close out as soon as possible all existing commitments that relate to performing the disability determination function.

§404.1694 Final accounting by the State.

The State will submit its final claims to us as soon as possible, but in no event later than 1 year from the effective date of our assumption of the disability determination function unless we grant an extension of time. When the final claim(s) is submitted, a final accounting will be made by the State of any funds paid to the State under §404.1626 which have not been spent or committed prior to the effective date of our assumption of the disability determination function. Disputes concerning final accounting issues which cannot be resolved between the State and us will be resolved in proceedings before the Grant Appeals Board as described in 45 CFR part 16.

Subpart R—Representation of Parties

AUTHORITY: Secs. 205(a), 206, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 406, and 902(a)(5)).

SOURCE: 45 FR 52090, Aug. 5, 1980, unless otherwise noted.

§404.1700 Introduction.

You may appoint someone to represent you in any of your dealings with us. This subpart explains, among other things—

(a) Who may be your representative and what his or her qualifications must be;

(b) How you appoint a representative;

(c) The payment of fees to a representative;

(d) Our rules that representatives must follow; and

(e) What happens to a representative who breaks the rules.

§404.1703 Definitions.

As used in this subpart—

Past-due benefits means the total amount of benefits payable under title II of the Act to all beneficiaries that has accumulated because of a favorable administrative or judicial determination or decision, up to but not including the month the determination or decision is made.

Representative means an attorney who meets all of the requirements of §404.1705(a), or a person other than an

attorney who meets all of the requirements of § 404.1705(b), and whom you appoint to represent you in dealings with us.

We, our, or *us* refers to the Social Security Administration.

You or *your* refers to any person claiming a right under the old-age, disability, dependents', or survivors' benefits program.

§ 404.1705 Who may be your representative.

(a) *Attorney.* You may appoint as your representative in dealings with us, any attorney in good standing who—

(1) Has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States;

(2) Is not disqualified or suspended from acting as a representative in dealings with us; and

(3) Is not prohibited by any law from acting as a representative.

(b) *Person other than attorney.* You may appoint any person who is not an attorney to be your representative in dealings with us if he or she—

(1) Is generally known to have a good character and reputation;

(2) Is capable of giving valuable help to you in connection with your claim;

(3) Is not disqualified or suspended from acting as a representative in dealings with us; and

(4) Is not prohibited by any law from acting as a representative.

§ 404.1706 Notification of options for obtaining attorney representation.

If you are not represented by an attorney and we make a determination or decision that is subject to the administrative review process provided under subpart J of this part and it does not grant all of the benefits or other relief you requested or it adversely affects any entitlement to benefits that we have established or may establish for you, we will include with the notice of that determination or decision information about your options for obtaining an attorney to represent you in dealing with us. We will also tell you that a legal services organization may provide you with legal representation free of charge if you satisfy the qualifying requirements applicable to that organization.

[58 FR 64886, Dec. 10, 1993]

§ 404.1707 Appointing a representative.

We will recognize a person as your representative if the following things are done:

(a) You sign a written notice stating that you want the person to be your representative in dealings with us.

(b) That person signs the notice, agreeing to be your representative, if the person is not an attorney. An attorney does not have to sign a notice of appointment.

(c) The notice is filed at one of our offices if you have initially filed a claim or have requested reconsideration; with an administrative law judge if you requested a hearing; or with the Appeals Council if you have requested a review of the administrative law judge's decision.

§ 404.1710 Authority of a representative.

(a) *What a representative may do.* Your representative may, on your behalf—

(1) Obtain information about your claim to the same extent that you are able to do;

(2) Submit evidence;

(3) Make statements about facts and law; and

(4) Make any request or give any notice about the proceedings before us.

(b) *What a representative may not do.* A representative may not sign an application on behalf of a claimant for rights or benefits under title II of the Act unless authorized to do so under § 404.612.

§ 404.1715 Notice or request to a representative.

(a) We shall send your representative—

(1) Notice and a copy of any administrative action, determination, or decision; and

(2) Requests for information or evidence.

(b) A notice or request sent to your representative, will have the same force and effect as if it had been sent to you.

§404.1720 Fee for a representative's services.

(a) *General.* A representative may charge and receive a fee for his or her services as a representative only as provided in paragraph (b) of this section.

(b) *Charging and receiving a fee.* (1) The representative must file a written request with us before he or she may charge or receive a fee for his or her services.

(2) We decide the amount of the fee, if any, a representative may charge or receive.

(3) A representative shall not charge or receive any fee unless we have approved it, and he or she shall not charge or receive any fee that is more than the amount we approve. This rule applies whether the fee is charged to or received from you or from someone else.

(4) If the representative is an attorney and the claimant is entitled to past-due benefits, we will pay the authorized fee, or a part of the authorized fee, directly to the attorney out of the past-due benefits, subject to the limitations described in §404.1730(b)(1). If the representative is not an attorney, we assume no responsibility for the payment of any fee that we have authorized.

(c) *Notice of fee determination.* We shall mail to both you and your representative at your last known address a written notice of what we decide about the fee. We shall state in the notice—

(1) The amount of the fee that is authorized;

(2) How we made that decision;

(3) That we are not responsible for paying the fee, except when we may pay an attorney from past-due benefits; and

(4) That within 30 days of the date of the notice, either you or your representative may request us to review the fee determination.

(d) *Review of fee determination*—(1) *Request filed on time.* We will review the decision we made about a fee if either you or your representative files a written request for the review at one of our offices within 30 days after the date of the notice of the fee determination. Either you or your representative, whoever requests the review, shall mail a copy of the request to the other person. An authorized official of the Social Security Administration who did not take part in the fee determination being questioned will review the determination. This determination is not subject to further review. The official shall mail a written notice of the decision made on review both to you and to your representative at your last known address.

(2) *Request not filed on time.* (i) If you or your representative requests a review of the decision we made about a fee, but does so more than 30 days after the date of the notice of the fee determination, whoever makes the request shall state in writing why it was not filed within the 30-day period. We will review the determination if we decide that there was good cause for not filing the request on time.

(ii) Some examples of good cause follow:

(A) Either you or your representative was seriously ill and the illness prevented you or your representative from contacting us in person or in writing.

(B) There was a death or serious illness in your family or in the family of your representative.

(C) Material records were destroyed by fire or other accidental cause.

(D) We gave you or your representative incorrect or incomplete information about the right to request review.

(E) You or your representative did not timely receive notice of the fee determination.

(F) You or your representative sent the request to another government agency in good faith within the 30-day period, and the request did not reach us until after the period had ended.

(3) *Payment of fees.* We assume no responsibility for the payment of a fee based on a revised determination if the request for administrative review was not filed on time.

§404.1725 Request for approval of a fee.

(a) *Filing a request.* In order for your representative to obtain approval of a fee for services he or she performed in dealings with us, he or she shall file a written request with one of our offices.

This should be done after the proceedings in which he or she was a representative are completed. The request must contain—

(1) The dates the representative's services began and ended;

(2) A list of the services he or she gave and the amount of time he or she spent on each type of service;

(3) The amount of the fee he or she wants to charge for the services;

(4) The amount of fee the representative wants to request or charge for his or her services in the same matter before any State or Federal court;

(5) The amount of and a list of any expenses the representative incurred for which he or she has been paid or expects to be paid;

(6) A description of the special qualifications which enabled the representative, if he or she is not an attorney, to give valuable help in connection with your claim; and

(7) A statement showing that the representative sent a copy of the request for approval of a fee to you.

(b) *Evaluating a request for approval of a fee.* (1) When we evaluate a representative's request for approval of a fee, we consider the purpose of the social security program, which is to provide a measure of economic security for the beneficiaries of the program, together with—

(i) The extent and type of services the representative performed;

(ii) The complexity of the case;

(iii) The level of skill and competence required of the representative in giving the services;

(iv) The amount of time the representative spent on the case;

(v) The results the representative achieved;

(vi) The level of review to which the claim was taken and the level of the review at which the representative became your representative; and

(vii) The amount of fee the representative requests for his or her services, including any amount authorized or requested before, but not including the amount of any expenses he or she incurred.

(2) Although we consider the amount of benefits, if any, that are payable, we do not base the amount of fee we authorize on the amount of the benefit alone, but on a consideration of all the factors listed in this section. The benefits payable in any claim are determined by specific provisions of law and are unrelated to the efforts of the representative. We may authorize a fee even if no benefits are payable.

§ 404.1728 Proceedings before a State or Federal court.

(a) *Representation of a party in court proceedings.* We shall not consider any service the representative gave you in any proceeding before a State or Federal court to be services as a representative in dealings with us. However, if the representative also has given service to you in the same connection in any dealings with us, he or she must specify what, if any, portion of the fee he or she wants to charge is for services performed in dealings with us. If the representative charges any fee for those services, he or she must file the request and furnish all of the information required by § 404.1725.

(b) *Attorney fee allowed by a Federal court.* If a Federal court in any proceeding under title II of the Act makes a judgment in favor of a claimant who was represented before the court by an attorney, and the court, under section 206(b) of the Act, allows to the attorney as part of its judgment a fee not in excess of 25 percent of the total of past-due benefits to which the claimant is entitled by reason of the judgment, we may pay the attorney the amount of the fee out of, but not in addition to, the amount of the past-due benefits payable. We will not certify for direct payment any other fee your representative may request.

§ 404.1730 Payment of fees.

(a) *Fees allowed by a Federal court.* We will pay a representative who is an attorney, out of the claimant's past-due benefits, the amount of fee allowed by a Federal court in a proceeding under title II of the Act. The payment we make to the attorney is subject to the limitations described in paragraph (b)(1) of this section.

(b) *Fees we may authorize*—(1) *Attorneys.* Except as provided in paragraph (c) of this section, if we make a determination or decision in favor of a claimant who was represented by an

attorney, and as a result of the determination or decision past-due benefits are payable, we will pay the attorney out of the past-due benefits the smallest of—

(i) Twenty-five percent of the total of the past-due benefits;

(ii) The amount of the fee that we set; or

(iii) The amount agreed upon between the attorney and the claimant represented.

(2) *Persons other than attorneys.* If the representative is not an attorney, we assume no responsibility for the payment of any fee that we have authorized. We will not deduct the fee from any benefits payable to the claimant represented.

(c) *Time limit for filing request for approval of attorney fee.* (1) In order to receive direct payment of a fee from a claimant's past-due benefits, an attorney should file a request for approval of a fee, or written notice of the intent to file a request, at one of our offices within 60 days of the date the notice of the favorable determination is mailed.

(2)(i) If no request is filed within 60 days of the date the notice of the favorable determination is mailed, we will mail a written notice to the attorney and to the claimant, at their last known addresses. The notice will inform the attorney and the claimant that unless the attorney files, within 20 days from the date of the notice, a written request for approval of a fee under §404.1725, or a written request for an extension of time, we will pay all the past-due benefits to the claimant.

(ii) The attorney must send the claimant a copy of any request made to us for an extension of time. If the request is not filed within 20 days of the date of the notice, or by the last day of any extension we approved, we will pay all past-due benefits to the claimant. Any fee the attorney charges after that time must be approved by us, but the collection of any approved fee is a matter between the attorney and the claimant represented.

§404.1735 Services in a proceeding under title II of the Act.

Services provided a claimant in any dealing with us under title II of the Act consist of services performed for that claimant in connection with any claim he or she may have before the Secretary of Health, and Human Services under title II of the Act. These services include any in connection with any asserted right a claimant may have calling for an initial or reconsidered determination by us, and a decision or action by an administrative law judge or by the Appeals Council.

§404.1740 Rules governing representatives.

No attorney or other person representing a claimant shall—

(a) With intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten by word, circular, letter, or advertisement, either oral or written, any claimant or prospective claimant or beneficiary regarding benefits, or other initial or continued right under the Act;

(b) Knowingly charge or collect, or make any agreement to charge or collect, directly or indirectly, any fee in any amount in excess of that allowed by us or by the court;

(c) Knowingly make or participate in the making or presentation of any false statement, representation, or claim about any material fact affecting the rights of any person under title II of the Act; or

(d) Divulge, except as may be authorized by regulations prescribed by us, any information we furnish or disclose about the claim or prospective claim of another person.

§404.1745 What happens to a representative who breaks the rules.

The Deputy Commissioner for Programs, or his or her designee, may begin proceedings to suspend or disqualify a person from acting as a representative in dealings with us if it appears that he or she—

(a) Has violated any of the rules in §404.1740;

(b) Has been convicted of a violation under section 206 of the Act; or

(c) Has otherwise refused to comply with our rules and regulations on representing claimants in dealings with us.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24131, May 29, 1991]

§ 404.1750 Notice of charges against a representative.

(a) The Deputy Commissioner for Programs, or his or her designee, will prepare a notice containing a statement of charges that constitutes the basis for the proceeding against the representative.

(b) We will send this notice to the representative either by certified or registered mail, to his or her last known address, or by personal delivery.

(c) We will advise the representative to file an answer, within 30 days from the date of the notice, or from the date the notice was delivered personally, stating why he or she should not be suspended or disqualified from acting as a representative in dealings with us.

(d) The Deputy Commissioner for Programs, or his or her designee, may extend the 30-day period for good cause.

(e) The representative must—

(1) Answer the notice in writing under oath (or affirmation); and

(2) File the answer with the Social Security Administration, Office of Hearings and Appeals, Attention: Special Counsel Staff, within the 30-day time period.

(f) If the representative does not file an answer within the 30-day time period, he or she does not have the right to present evidence, except as may be provided in § 404.1765(g).

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24131, May 29, 1991]

§ 404.1755 Withdrawing charges against a representative.

We may withdraw charges against a representative. We will do this if the representative files an answer, or we obtain evidence, that satisfies us that there is reasonable doubt about whether he or she should be suspended or disqualified from acting as a representative in dealings with us. If we withdraw the charges, we shall notify the representative by mail at his or her last known address.

§ 404.1765 Hearing on charges.

(a) *Scheduling the hearing.* If the Deputy Commissioner for Programs, or his or her designee, does not take action to withdraw the charges within 15 days after the date on which the representative filed an answer, we will hold a hearing and make a decision on the charges.

(b)(1) *Hearing officer.* The Associate Commissioner for Hearings and Appeals, or his or her designee, shall assign an administrative law judge, designated to act as a hearing officer, to hold a hearing on the charges.

(2) No hearing officer shall hold a hearing in a case in which he or she is prejudiced or partial about any party, or has any interest in the matter.

(3) If the representative or any party to the hearing objects to the hearing officer who has been named to hold the hearing, we must be notified at the earliest opportunity. The hearing officer shall consider the objection(s) and either proceed with the hearing or withdraw from it.

(4) If the hearing officer withdraws from the hearing, another one will be named.

(5) If the hearing officer does not withdraw, the representative or any other person objecting may, after the hearing, present his or her objections to the Appeals Council explaining why he or she believes the hearing officer's decision should be revised or a new hearing held by another administrative law judge designated to act as a hearing officer.

(c) *Time and place of hearing.* The hearing officer shall mail the parties a written notice of the hearing at their last known addresses, at least 20 days before the date set for the hearing.

(d) *Change of time and place for hearing.* (1) The hearing officer may change the time and place for the hearing. This may be done either on his or her own initiative, or at the request of the representative or the other party to the hearing.

(2) The hearing officer may adjourn or postpone the hearing.

(3) The hearing officer may reopen the hearing for the receipt of additional evidence at any time before mailing notice of the decision.

(4) The hearing officer shall give the representative and the other party to the hearing reasonable notice of any change in the time or place for the hearing, or of an adjournment or reopening of the hearing.

(e) *Parties.* The representative against whom charges have been made is a party to the hearing. The Deputy Commissioner for Programs, or his or her designee, shall also be a party to the hearing.

(f) *Subpoenas.* (1) The representative or the other party to the hearing may request the hearing officer to issue a subpoena for the attendance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to any matter being considered at the hearing. The hearing officer may, on his or her own initiative, issue subpoenas for the same purposes when the action is reasonably necessary for the full presentation of the facts.

(2) The representative or the other party who wants a subpoena issued shall file a written request with the hearing officer. This must be done at least 5 days before the date set for the hearing. The request must name the documents to be produced, and describe the address or location in enough detail to permit the witnesses or documents to be found.

(3) The representative or the other party who wants a subpoena issued shall state in the request for a subpoena the material facts that he or she expects to establish by the witness or document, and why the facts could not be established by the use of other evidence which could be obtained without use of a subpoena.

(4) We will pay the cost of the issuance and the fees and mileage of any witness subpoenaed, as provided in section 205(d) of the Act.

(g) *Conduct of the hearing.* (1) The hearing officer shall make the hearing open to the representative, to the other party, and to any persons the hearing officer or the parties consider necessary or proper. The hearing officer shall inquire fully into the matters being considered, hear the testimony of witnesses, and accept any documents that are material.

(2) If the representative did not file an answer to the charges, he or she has no right to present evidence at the hearing. The hearing officer may make or recommend a decision on the basis of the record, or permit the representative to present a statement about the sufficiency of the evidence or the validity of the proceedings upon which the suspension or disqualification, if it occurred, would be based.

(3) If the representative did not file an answer to the charges, and if the hearing officer believes that there is material evidence available that was not presented at the hearing, the hearing officer may at any time before mailing notice of the hearing decisions reopen the hearing to accept the additional evidence.

(4) The hearing officer has the right to decide the order in which the evidence and the allegations will be presented and the conduct of the hearing.

(h) *Evidence.* The hearing officer may accept evidence at the hearing, even though it is not admissible under the rules of evidence that apply to Federal court procedure.

(i) *Witnesses.* Witnesses who testify at the hearing shall do so under oath or affirmation. Either the representative or a person representing him or her may question the witnesses. The other party and that party's representative must also be allowed to question the witnesses. The hearing officer may also ask questions as considered necessary, and shall rule upon any objection made by either party about whether any question is proper.

(j) *Oral and written summation.* (1) The hearing officer shall give the representative and the other party a reasonable time to present oral summation and to file briefs or other written statements about proposed findings of fact and conclusions of law if the parties request it.

(2) The party that files briefs or other written statements shall provide enough copies so that they may be made available to any other party to the hearing who requests a copy.

(k) *Record of hearing.* In all cases, the hearing officer shall have a complete record of the proceedings at the hearing made.

(l) *Representation.* The representative, as the person charged, may appear in person and may be represented by an attorney or other representative.

(m) *Failure to appear.* If the representative or the other party to the hearing fails to appear after being notified of the time and place, the hearing

officer may hold the hearing anyway so that the party present may offer evidence to sustain or rebut the charges. The hearing officer shall give the party who failed to appear an opportunity to show good cause for failure to appear. If the party fails to show good cause, he or she is considered to have waived the right to be present at the hearing. If the party shows good cause, the hearing officer may hold a supplemental hearing.

(n) *Dismissal of charges.* The hearing officer may dismiss the charges in the event of the death of the representative.

(o) *Cost of transcript.* If the representative or the other party to a hearing requests a copy of the transcript of the hearing, the hearing officer will have it prepared and sent to the party upon payment of the cost, unless the payment is waived for good cause.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24131, 24132, May 29, 1991]

§ 404.1770 Decision by hearing officer.

(a) *General.* (1) After the close of the hearing, the hearing officer shall issue a decision or certify the case to the Appeals Council. The decision must be in writing, will contain findings of fact and conclusions of law, and be based upon the evidence of record.

(2) If the hearing officer finds that the charges against the representative have been sustained, he or she shall either—

(i) Suspend the representative for a specified period of not less than 1 year, nor more than 5 years, from the date of the decision; or

(ii) Disqualify the representative from acting as a representative in dealings with us until he or she may be reinstated under § 404.1799.

(3) The hearing officer shall mail a copy of the decision to the representative at his or her last known address and to the Deputy Commissioner (Operations) or the Director (or Deputy Director) of the Office of Insurance Programs. The notice will inform the parties of the right to request the Appeals Council to review the decision.

(b) *Effect of hearing officer's decision.* (1) The hearing officer's decision is final and binding unless reversed or modified by the Appeals Council upon review.

(2) If the final decision is that a person is disqualified from being a representative in dealings with us, he or she will not be permitted to represent anyone in dealings with us until authorized to do so under the provisions of § 404.1799.

(3) The hearing officer shall mail a copy of the decision to the parties at their last known addresses. The notice will inform the parties of the right to request the Appeals Council to review the decision.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991]

§ 404.1775 Requesting review of the hearing officer's decision.

(a) *General.* After the hearing officer issues a decision, either the representative or the other party to the hearing may ask the Appeals Council to review the decision.

(b) *Time and place of filing request for review.* The party requesting review shall file the request for review in writing with the Appeals Council within 30 days from the date the hearing officer mailed the notice. The party requesting review shall certify that a copy of the request for review and of any documents that are submitted have been mailed to the opposing party.

§ 404.1776 Assignment of request for review of the hearing officer's decision.

Upon receipt of a request for review of the hearing officer's decision, the matter will be assigned to a panel consisting of three members of the Appeals Council none of whom shall be the Chair of the Appeals Council. The panel shall jointly consider and rule by majority opinion on the request for review of the hearing officer's decision, including a determination to dismiss the request for review. Matters other than a final disposition of the request for review may be disposed of by the member designated chair of the panel.

[56 FR 24132, May 29, 1991]

§ 404.1780 Appeals Council's review of hearing officer's decision.

(a) Upon request, the Appeals Council shall give the parties a reasonable time

to file briefs or other written statements as to fact and law, and to appear before the Appeals Council to present oral argument.

(b) If a party files a brief or other written statement with the Appeals Council, he or she shall send a copy to the opposing party and certify that the copy has been sent.

§404.1785 Evidence permitted on review.

(a) *General.* Generally, the Appeals Council will not consider evidence in addition to that introduced at the hearing. However, if the Appeals Council believes that the evidence offered is material to an issue it is considering, the evidence will be considered.

(b) *Individual charged filed an answer.* (1) When the Appeals Council believes that additional material evidence is available, and the representative has filed an answer to the charges, the Appeals Council shall require that the evidence be obtained. The Appeals Council may name an administrative law judge or a member of the Appeals Council to receive the evidence.

(2) Before additional evidence is admitted into the record, the Appeals Council shall mail a notice to the parties, telling them that evidence about certain issues will be obtained, unless the notice is waived. The Appeals Council shall give each party a reasonable opportunity to comment on the evidence and to present other evidence that is material to an issue it is considering.

(c) *Individual charged did not file an answer.* If the representative did not file an answer to the charges, the Appeals Council will not permit the introduction of evidence that was not considered at the hearing.

§404.1790 Appeals Council's decision.

(a) The Appeals Council shall base its decision upon the evidence in the hearing record and any other evidence it may permit on review. The Appeals Council shall either—

(1) Affirm, reverse, or modify the hearing officer's decision; or

(2) Return a case to the hearing officer when the Appeals Council considers it appropriate.

(b) The Appeals Council, in changing a hearing officer's decision to suspend a representative for a specified period, shall in no event reduce the period of suspension to less than 1 year. In modifying a hearing officer's decision to disqualify a representative, the Appeals Council shall in no event impose a period of suspension of less than 1 year.

(c) If the Appeals Council affirms or changes a hearing officer's decision, the period of suspension or the disqualification is effective from the date of the Appeals Council's decision.

(d) If the hearing officer did not impose a period of suspension or a disqualification, and the Appeals Council decides to impose one or the other, the suspension or disqualification is effective from the date of the Appeals Council's decision.

(e) The Appeals Council shall make its decision in writing and shall mail a copy of the decision to the parties at their last known addresses.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991]

§404.1795 When the Appeals Council will dismiss a request for review.

The Appeals Council may dismiss a request for the review of any proceeding to suspend or disqualify a representative in any of the following circumstances:

(a) *Upon request of party.* The Appeals Council may dismiss a request for review upon written request of the party or parties who filed the request if there is no other party who objects to the dismissal.

(b) *Death of party.* The Appeals Council may dismiss a request for review in the event of the death of the representative.

(c) *Request for review not timely filed.* The Appeals Council will dismiss a request for review if a party failed to file a request for review within the 30-day time period and the Appeals Council does not extend the time for good cause.

§404.1797 Reinstatement after suspension—period of suspension expired.

We shall automatically allow a person to serve again as a representative in dealings with us at the end of any suspension.

§ 404.1799 Reinstatement after suspension or disqualification—period of suspension not expired.

(a) After more than one year has passed, a person who has been suspended or disqualified, may ask the Appeals Council for permission to serve as a representative again.

(b) The suspended or disqualified person shall submit any evidence he or she wishes to have considered along with the request to be allowed to serve as a representative again.

(c) The Appeals Council shall allow the Deputy Commissioner for Programs, or his or her designee, upon notification of receipt of the request, 30 days in which to present a written report of any experiences with the suspended or disqualified person subsequent to that person's suspension or disqualification. The Appeals Council shall make available to the suspended or disqualified person a copy of the report.

(d) The Appeals Council shall not grant the request unless it is reasonably satisfied that the person will in the future act according to the provisions of section 206(a) of the Act, and to our rules and regulations.

(e) The Appeals Council shall mail a notice of its decision on the request to the suspended or disqualified person. It shall also mail a copy to the Deputy Commissioner for Programs.

(f) If the Appeals Council decides not to grant the request, it shall not consider another request before the end of 1 year from the date of the notice of the previous denial.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991]

Subpart S—Payment Procedures

AUTHORITY: Secs. 205(a) and (n), 207, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a) and (n), 407, and 902(a)(5)).

SOURCE: 45 FR 52095, Aug. 5, 1980, unless otherwise noted.

§ 404.1800 Introduction.

After we have made a determination or decision that you are entitled to benefits under title II of the Act, we begin paying those benefits to you as soon as possible. This subpart explains—

(a) What we must do so that your benefits begin promptly;

(b) When and how you may request that payment of benefits be expedited;

(c) When we may cause your benefits to be withheld;

(d) Our obligation not to assign or transfer your benefits to someone; and

(e) When we will use one check to pay benefits to two or more persons in a family.

§ 404.1805 Paying benefits.

(a) As soon as possible after we have made a determination or decision that you are entitled to benefits, we certify to the Secretary of the Treasury, who is the Managing Trustee of the Trust Funds—

(1) Your name and address, or the name and address of the person to be paid if someone receives your benefits on your behalf as a representative payee;

(2) The amount of the payment or payments to be made from the appropriate Trust Fund; and

(3) The time at which the payment or payments should be made.

(b) Under certain circumstances when you have had railroad employment, we will certify the information to the Railroad Retirement Board.

§ 404.1810 Expediting benefit payments.

(a) *General.* We have established special procedures to expedite the payment of benefits in certain initial and subsequent claims. This section tells how you may request an expedited payment and when we will be able to hasten your payments by means of this process.

(b) *Applicability of section.* (1) This section applies to monthly benefits payable under title II of the Act, except as indicated in paragraph (b)(2) of this section; and to those cases where we certify information to the Railroad Retirement Board.

(2) This section does not apply—

(i) If an initial determination has been made and a request for a reconsideration, a hearing, a review by the Appeals Council, or review by a Federal

court is pending on any issue of entitlement to or payment of a benefit;

(ii) To any benefit for which a check has been cashed; or

(iii) To any benefit based on an alleged disability.

(c) *Request for payment.* (1) You shall submit to us a written request for payment of benefits in accordance with paragraph (c)(2) or (c)(3) of this section. Paragraph (c)(2) of this section applies if you were receiving payments regularly and you then fail to receive payment for one or more months. Paragraph (c)(3) of this section applies if we have not made a determination about your entitlement to benefits, or if we have suspended or withheld payment due, for example, to excess earnings or recovery of an overpayment.

(2) If you received a regular monthly benefit in the month before the month in which a payment was allegedly due, you may make a written request for payment any time 30 days after the 15th day of the month in which the payment was allegedly due. If you request is made before the end of the 30-day period, we will consider it to have been made at the end of the period.

(3)(i) If you did not receive a regular monthly benefit in the month before the month in which a payment was allegedly due, you may make a written request for payment any time 90 days after the later of—

(A) The date on which the benefit is alleged to have been due; or

(B) The date on which you furnished us the last information we requested from you.

(ii) If your request is made before the end of the 90-day period we will consider it to have been made at the end of the period.

(d) *Certification for payment.* If we find that benefits are due, we shall certify the benefits for payment in sufficient time to permit the payment to be made within 15 days after the request for expedited payment is made, or considered to have been made, as provided in paragraph (c) of this section.

(e) *Preliminary certification for payment.* If we determine that there is evidence, although additional evidence may be required for a final decision, that a monthly benefit due to you in a particular month was not paid, we may make preliminary certification of payment even though the 30-day or 90-day periods described in paragraph (c) of this section have not elapsed.

§ 404.1815 Withholding certification or payments.

(a) *When certification may be withheld.* After a determination or decision, we may withhold certification to the Managing Trustee, or, if we have already made certification, we may notify the Managing Trustee to withhold payments. We may do this if a question about the validity of the payment or payments to be made under the determination or decision arises as the result of one of the following events:

(1) A reconsideration (whether at the request of a claimant or on our own motion), hearing, or review is being conducted, or a civil action has been filed in a Federal district court concerning the determination or decision.

(2) An application or request is pending concerning the payment of benefits or a lump sum to another person, and the application or request is inconsistent, in whole or in part, with the payment or payments under the determination or decision.

(b) *When certification will not be withheld.* We will not withhold certification or payment as explained in paragraph (a) of this section unless evidence is submitted with the request or application that is sufficient to raise a reasonable question about the validity of the payment or payments under the determination or decision. We will not withhold certification of any amount of the payment or payments not in question. Your acceptance of any payment or payments will not affect your right to reconsideration, hearing, or review about any additional payment or payments you may claim.

§ 404.1820 Transfer or assignment of payments.

(a) *General.* We shall not certify payment to—

(1) Any person designated as your assignee or transferee; or

(2) Any person claiming payment because of an execution, levy, attachment, garnishment, or other legal process, or because of any bankruptcy or

insolvency proceeding against or affecting you.

(b) *Enforcement of a child support or alimony obligation.* If you have a legal obligation to provide child support or make alimony payments and legal process is issued to enforce this obligation, the provisions of paragraph (a) of this section do not apply.

§ 404.1825 Joint payments to a family.

(a) *Two or more beneficiaries in same family.* If an amount is payable under title II of the Act for any month to two or more persons who are members of the same family, we may certify any two or more of the individuals for joint payment of the total benefits payable to them for the month.

(b) *Joint payee dies before cashing a check.* (1) If a check has been issued for joint payment to an individual and spouse residing in the same household, and one of the joint payees dies before the check has been cashed, we may authorize the surviving payee to cash the check. We make the authorization by placing on the face of the check a stamped legend signed by an official of the Social Security Administration or the Treasury Disbursing Office redesignating the survivor as the payee of the check.

(2) If the uncashed check represents benefits for a month after the month of death, we will not authorize the surviving payee to cash the check unless the proceeds of the check are necessary to meet the ordinary and necessary living expenses of the surviving payee.

(c) *Adjustment or recovery of overpayment.* If a check representing payment of benefits to an individual and spouse residing in the same household is cashed by the surviving payee under the authorization in paragraph (b) of this section, and the amount of the check exceeds the amount to which the surviving payee is entitled, we shall make appropriate adjustment or recovery of the excess amount.

Subpart T—Totalization Agreements

AUTHORITY: Secs. 205(a), 233, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 433, and 902(a)(5)).

SOURCE: 44 FR 42964, July 23, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 404.1901 Introduction.

(a) Under section 233 of the Social Security Act, the President may enter into an agreement establishing a totalization arrangement between the social security system of the United States and the social security system of a foreign country. An agreement permits entitlement to and the amount of old-age, survivors, disability, or derivative benefits to be based on a combination of a person's periods of coverage under the social security system of the United States and the social security system of the foreign country. An agreement also provides for the precluding of dual coverage and dual social security taxation for work covered under both systems. An agreement may provide that the provisions of the social security system of each country will apply equally to the nationals of both countries (regardless of where they reside). For this purpose, refugees, stateless persons, and other nonnationals who derive benefit rights from nationals, refugees, or stateless persons may be treated as nationals if they reside within one of the countries.

(b) The regulations in this subpart provide definitions and principles for the negotiation and administration of totalization agreements. Where necessary to accomplish the purposes of totalization, we will apply these definitions and principles, as appropriate and within the limits of the law, to accommodate the widely diverse characteristics of foreign social security systems.

§ 404.1902 Definitions.

For purposes of this subpart—

Act means the Social Security Act (42 U.S.C. 301 *et seq.*).

Agency means the agency responsible for the specific administration of a social security system including responsibility for implementing an agreement; the Social Security Administration (SSA) is the *agency* in the U.S.

Agreement means the agreement negotiated to provide coordination between the social security systems of the countries party to the agreement.

The term agreement includes any administrative agreements concluded for purposes of administering the agreement.

Competent authority means the official with overall responsibility for administration of a country's social security system including applicable laws and international social security agreements; the Secretary of HEW is the *competent authority* in the U.S.

Period of coverage means a period of payment of contributions or a period of earnings based on wages for employment or on self-employment income, or any similar period recognized as equivalent under the social security system of the U.S. or under the social security system of the foreign country which is a party to an agreement.

Residence or *ordinarily resides,* when used in agreements, has the following meaning for the U.S. *Residence* or *ordinarily resides* in a country means that a person has established a home in that country intending to remain there permanently or for an indefinite period of time. Generally, a person will be considered to have established a home in a country if that person assumes certain economic burdens, such as the purchase of a dwelling or establishment of a business, and participates in the social and cultural activities of the community. If residence in a country is established, it may continue even though the person is temporarily absent from that country. Generally, an absence of six months or less will be considered temporary. If an absence is for more than six months, residence in the country will generally be considered to continue only if there is sufficient evidence to establish that the person intends to maintain the residence. Sufficient evidence would include the maintenance of a home or apartment in that country, the departure from the country with a reentry permit, or similar acts. The existence of business or family associations sufficient to warrant the person's return would also be considered.

Social security system means a social insurance or pension system which is of general application and which provides for paying periodic benefits, or the actuarial equivalent, because of old-age, death, or disability.

§404.1903 Negotiating totalization agreements.

An agreement shall be negotiated with the national government of the foreign country for the entire country. However, agreements may only be negotiated with foreign countries that have a social security system of general application in effect. The system shall be considered to be in effect if it is collecting social security taxes or paying social security benefits.

§404.1904 Effective date of a totalization agreement.

Section 233 of the Social Security Act provides that a totalization agreement shall become effective on any date provided in the agreement if—

(a) The date occurs after the expiration of a period during which at least one House of Congress has been in session on each of 60 days following the date on which the agreement is transmitted to Congress by the President; and

(b) Neither House of Congress adopts a resolution of disapproval of the agreement within the 60-day period described in paragraph (a) of this section.

[49 FR 29775, July 24, 1984]

§404.1905 Termination of agreements.

Each agreement shall contain provisions for its possible termination. If an agreement is terminated, entitlement to benefits and coverage acquired by an individual before termination shall be retained. The agreement shall provide for notification of termination to the other party and the effective date of termination.

BENEFIT PROVISIONS

§404.1908 Crediting foreign periods of coverage.

(a) *General.* To have foreign periods of coverage combined with U.S. periods of coverage for purposes of determining entitlement to and the amount of benefits payable under title II, an individual must have at least 6 quarters of coverage, as defined in section 213 of the Social Security Act, under the U.S. system. As a rule, SSA will accept foreign coverage information, as certified by the foreign country's agency, unless otherwise specified by the agreement.

No credit will be given, however, for periods of coverage acquired before January 1, 1937.

(b) *For quarters of coverage purposes.* (1) Generally, a quarter of coverage (QC) will be credited for every 3 months (or equivalent period), or remaining fraction of 3 months, of coverage in a reporting period certified to SSA by the other country's agency. A reporting period used by a foreign country may be one calendar year or some other period of time. QCs based on foreign periods of coverage may be credited as QCs only to calender quarters not already QCs under title II. The QCs will be assigned chronologically beginning with the first calendar quarter (not already a QC under title II) within the reporting period and continuing until all the QCs are assigned, or the reporting period ends. Example: Country XYZ, which has an annual reporting period, certifies to SSA that a worker has 8 months of coverage in 1975, from January 1 to August 25. The worker has no QCs under title II in that year. Since 8 months divided by 3 months equals 2 QCs with a remainder of 2 months, the U.S. will credit the worker with 3 QCs. The QCs will be credited to the first 3 calendar quarters in 1975.

(2) If an individual fails to meet the requirements for currently insured status or the insured status needed for establishing a period of disability solely because of the assignment of QCs based on foreign coverage to calendar quarters chronologically, the QCs based on foreign coverage may be assigned to different calendar quarters within the beginning and ending dates of the reporting period certified by the foreign country, but only as permitted under paragraph (b)(1) of this section.

§ 404.1910 Person qualifies under more than one totalization agreement.

(a) An agreement may not provide for combining periods of coverage under more than two social security systems.

(b) If a person qualifies under more than one agreement, the person will receive benefits from the U.S. only under the agreement affording the most favorable treatment.

(c) In the absence of evidence to the contrary, the agreement that affords the most favorable treatment for purposes of paragraph (b) of this section will be determined as follows:

(1) If benefit amounts are the same under all such agreements, benefits will be paid only under the agreement which affords the earliest month of entitlement.

(2) If benefit amounts and the month of entitlement are the same under all such agreements, benefits will be paid only under the agreement under which all information necessary to pay such benefits is first available.

(3) If benefit amounts under all such agreements are not the same, benefits will be paid only under the agreement under which the highest benefit is payable. However, benefits may be paid under an agreement under which a lower benefit is payable for months prior to the month of first entitlement to such higher benefit.

[44 FR 42964, July 23, 1979, as amended at 49 FR 29775, July 24, 1984]

§ 404.1911 Effects of a totalization agreement on entitlement to hospital insurance benefits.

A person may not become entitled to hospital insurance benefits under section 226 or section 226A of the Act by combining the person's periods of coverage under the social security system of the United States with the person's periods of coverage under the social security system of the foreign country. Entitlement to hospital insurance benefits is not precluded if the person otherwise meets the requirements.

COVERAGE PROVISIONS

§ 404.1913 Precluding dual coverage.

(a) *General.* Employment or self-employment or services recognized as equivalent under the Act or the social security system of the foreign country shall, on or after the effective date of the agreement, result in a period of coverage under the U.S. system or under the foreign system, but not under both. Methods shall be set forth in the agreement for determining under which system the employment, self-employment, or other service shall result in a period of coverage.

(b) *Principles for precluding dual coverage.* (1) An agreement precludes dual

coverage by assigning responsibility for coverage to the U.S. or a foreign country. An agreement may modify the coverage provisions of title II of the Act to accomplish this purpose. Where an agreement assigns coverage to the foreign country, it may exempt from coverage services otherwise covered by the Act. Where an agreement assigns coverage to the U.S., it may extend coverage to services not otherwise covered by the Act but only for taxable years beginning on or after April 20, 1983.

(2) If the work would otherwise be covered by both countries, an agreement will exempt it from coverage by one of the countries.

(3) Generally, an agreement will provide that a worker will be covered by the country in which he or she is employed and will be exempt from coverage by the other country.

Example: A U.S. national employed in XYZ country by an employer located in the United States will be covered by XYZ country and exempt from U.S. coverage.

(4) An agreement may provide exceptions to the principle stated in paragraph (b)(3) of this section so that a worker will be covered by the country to which he or she has the greater attachment.

Example: A U.S. national sent by his employer located in the United States to work temporarily for that employer in XYZ country will be covered by the United States and will be exempt from coverage by XYZ country.

(5) Generally, if a national of either country resides in one country and has self employment income that is covered by both countries, an agreement will provide that the person will be covered by the country in which he or she resides and will be exempt from coverage by the other country.

(6) Agreements may provide for variations from the general principles for precluding dual coverage to avoid inequitable or anomalous coverage situations for certain workers. However, in all cases coverage must be provided by one of the countries.

[44 FR 42964, July 23, 1979, as amended at 50 FR 36575, Sept. 9, 1985]

§404.1914 Certificate of coverage.

Under some agreements, proof of coverage under one social security system may be required before the individual may be exempt from coverage under the other system. Requests for certificates of coverage under the U.S. system may be submitted by the employer, employee, or self-employed individual to SSA.

§404.1915 Payment of contributions.

On or after the effective date of the agreement, to the extent that employment or self-employment (or service recognized as equivalent) under the U.S. social security system or foreign system is covered under the agreement, the agreement shall provide that the work or equivalent service be subject to payment of contributions or taxes under only one system (see sections 1401(c), 3101(c), and 3111(c) of the Internal Revenue Code of 1954). The system under which contributions or taxes are to be paid is the system under which there is coverage pursuant to the agreement.

COMPUTATION PROVISIONS

§404.1918 How benefits are computed.

(a) *General.* Unless otherwise provided in an agreement, benefits will be computed in accordance with this section. Benefits payable under an agreement are based on a pro rata primary insurance amount (PIA), which we determine as follows:

(1) We establish a theoretical earnings record for a worker which attributes to all computation base years (see §§404.211(b) and 404.241(c)) the same relative earnings position (REP) as he or she has in the years of his or her actual U.S. covered work. As explained in paragraph (b)(3) of this section, the REP is derived by determining the ratio of the worker's actual U.S. covered earnings in each year to the average of the total U.S. covered wages of all workers for that year, and then averaging the ratios for all such years. This average is the REP and is expressed as a percentage.

(2) We compute a theoretical PIA as prescribed in §404.1918(c) based on the theoretical earnings record and the provisions of subpart C of this part.

(3) We multiply the theoretical PIA by a fraction equal to the number of quarters of coverage (QC's) which the

worker completed under the U.S. Social Security system over the number of calendar quarters in the worker's coverage lifetime (see paragraph (d)(2) of this section). See § 404.140 for the definition of QC.

(4) If the pro rata PIA is higher than the PIA which would be computed if the worker were insured under the U.S. system without totalization, the pro rata PIA will be reduced to the later PIA.

(b) *Establishing a theoretical earnings record.* (1) To establish a worker's theoretical earnings record, we divide his or her U.S. earnings in each year credited with at least one U.S. QC by the average of the total wages of all workers for that year and express the quotient as a percentage. For the years 1937 through 1950, the average of the total wages is as follows:

Year	Average of the total wages of all workers
1937	$1,137.96
1938	1,053.24
1939	1,142.36
1940	1,195.00
1941	1,276.04
1942	1,454.28
1943	1,713.52
1944	1,936.32
1945	2,021.40
1946	1,891.76
1947	2,175.32
1948	2,361.64
1949	2,483.20
1950	2,543.96

(2) For years after 1950, the average of the total wages is as prescribed in § 404.211(c). If a worker has earnings in the year preceding the year of eligibility or death, or in a later year, we may not have been able to establish the average of the total wages of all workers for that year. Therefore, we will divide a worker's actual earnings in these years by the average of the total wages for the latest year for which that information is available. Average wage information is considered available on January 1 of the year following the year in which it is published in the FEDERAL REGISTER.

(3) The percentages for all years of actual covered earnings are then averaged to give the worker's REP for the entire period of work in the U.S. In determining the percentages for all years of covered earnings and the REP, we make adjustments as necessary to take account of the fact that the covered earnings for some years may have involved less than four U.S. QC's. The actual earnings that are taken into account in determining the percentage for any year with 1, 2, or 3 QC's cannot exceed ¼, ½, or ¾, respectively, of the maximum creditable earnings for that year. When we determine the REP from the percentages for all years, we add the percentages for all years, divide this sum by the total number of QC's credited to the worker, and multiply this quotient by 4 (see Example 1 of paragraph (d) of this section). This has the effect of calculating the REP on a quarterly basis.

(4) For each of the worker's computation base years (see §§ 404.211(b), 404.221(b) and 404.241(c)), we multiply the average of the total wages of all workers for that year by the worker's REP. The product is the amount of earnings attributed to the worker for that year, subject to the annual wage limitation (see § 404.1047). The worker's theoretical earnings record consists of his or her attributed earnings based on his or her REP for all computation base years. However, we do not attribute earnings to computation base years before the year of attainment of age 22 or to computation base years beginning with the year of attainment of retirement age (or the year in which a period of disability begins), unless the worker is actually credited with U.S. earnings in those years. In death cases, earnings for the year of death will be attributed only through the quarter of death, on a proportional basis.

(c) *Determining the theoretical PIA.* We determine the worker's theoretical PIA based on his or her theoretical earnings record by applying the same computation method that would have applied under subpart C if the worker had these theoretical earnings and had qualified for benefits without application of an agreement. However, when the criteria in § 404.210(a) for the Average Indexed Monthly Earnings (AIME) computation method are met, only that method is used. If these criteria are not met but the criteria in § 404.220(a) for the Average Monthly Wage method are met, then only that

method is used. If neither of these criteria are met, then the old-start method described in § 404.241 is used. If a theoretical PIA is to be determined based on a worker's AIME, theoretical earnings amounts for each year, determined under paragraph (b) of this section, are indexed in determining the AIME under § 404.211.

(d) *Determining the pro rata PIA.* We then determine a pro rata PIA from the theoretical PIA. The pro rata PIA is the product of—

(1) The theoretical PIA; and

(2) The ratio of the worker's actual number of U.S. QC's to the number of calendar quarters in the worker's coverage lifetime. A coverage lifetime means the worker's benefit computation years as determined under § 404.211(e), § 404.221(c), or § 404.241(d).

Example 1: C attains age 62 in 1982 and needs 31 QC's to be insured. C worked under the U.S. system from July 1, 1974 to December 31, 1980 and therefore has only 6½ years during which he worked under the U.S. system (26 QC's). C, however, has worked under the Social Security system of a foreign country that is party to a totalization agreement, and his total U.S. and foreign work, combined as described in § 404.1908, equals more than 31 QC's. Thus, the combined coverage gives C insured status. The benefit is computed as follows:

Step 1: Establish C's theoretical earnings record:

The following table shows: (1) C's actual U.S. covered earnings for each year, (2) the average of the total wages of all workers for that year and (3) the ratio of (1) to (2):

Year	QC's	C's actual U.S. covered earnings	National average wage	Percentage ratio of (1) to (2)
		(1)	(2)	(3)
1974	2	$2,045.08	$8,030.76	25.46558
1975	4	7,542.00	8,630.92	87.38350
1976	4	9,016.00	9,226.48	97.71874
1977	4	9,952.00	9,779.44	101.76452
1978	4	10,924.00	10,556.03	103.48587
1979	4	12,851.00	11,479.46	111.94777
1980	4	11,924.00	12,513.46	95.28939

C's REP is the average of the ratios in column 3, adjusted to take account of the fact that C had only 2 QC's in 1974. Thus, the REP equals the sum of the figures in column 3 (623.05537), divided by the total number of C's QC's (26) and multiplied by 4, or 95.85467 percent.

Since C attained age 62 in 1982, his computation base years are 1951 through 1981. To establish his theoretical earnings record we use 95.85467 percent of the national average wage for each of the years 1951 through 1981. Since national average wage data is not available for 1981, for that year we attribute 95.85467 percent of the national average wage for 1980 or $11,994.74. His theoretical earnings record would look like this:

1951	$2,683.13
1952	2,850.07
1953	3,009.30
1954	3,024.83
1955	3,164.58
1956	3,385.93
1957	3,490.76
1958	3,521.51
1959	3,695.96
1960	3,841.01
1961	3,917.35
1962	4,113.51
1963	4,214.38
1964	4,386.62
1965	4,465.60
1966	4,733.65
1967	4,997.33
1968	5,340.79
1969	5,649.44
1970	5,929.80
1971	6,227.75
1972	6,838.08
1973	7,265.94
1974	7,697.86
1975	8,273.14
1976	8,844.01
1977	9,374.05
1978	10,118.45
1979	11,003.60
1980	11,994.74
1981	11,994.74

Step 2: Compute the theoretical PIA: Since C attains age 62 in 1982, we determine his theoretical PIA using an AIME computation. In applying the AIME computation, we index each year's earnings on the theoretical earnings record in accordance with § 404.211(d). In this example, the theoretical PIA is $453.

Step 3: Compute the pro rata PIA:

$$\frac{\text{Theoretical PIA} - \text{Actual U.S. QC's}}{\text{calendar quarters in benefit computation years}}$$

$$\frac{\$453 - 26 \text{ QC's } (6\tfrac{1}{2} \text{ years})}{104 \text{ quarters } (26 \text{ years})}$$

=$113.20 pro rata PIA

Example 2: M needs 27 QC's to be insured, but she has only 3 years of work (12 QC's) under the U.S. system. M has enough foreign work, however, to be insured. She attained age 62 in 1978, and her U.S. covered earnings were in 1947, 1948 and 1949. Based on M's date of birth, her theoretical PIA can be computed, in accordance with § 404.220, under a new start method. If M's earnings in 1947, 1948, and 1949 were 50 percent, 60 percent and

70 percent, respectively, of the average wage for each year, her REP would be 60 percent. For each year in the computation period, 60 percent of the average wage for that year will be attributed as M's assumed earnings. The theoretical PIA will then be computed as described in §§ 404.220 through 404.222.

To determine M's pro rata PIA, the theoretical PIA will be multiplied by the ratio of the actual number of U.S. QC's to the number of calendar quarters in the benefit computation years. There are 22 benefit computation years, or 88 quarters. The pro rata PIA would, therefore, be 12/88 x theoretical PIA.

(e) *Rounding of benefits.* (1) If the effective date of the pro rata PIA is before June 1982, we will round to the next higher multiple of 10 cents if it is not already a multiple of 10 cents.

(2) If the effective date of the pro rata PIA is June 1982 or later, we will round to the next lower multiple of 10 cents if it is not already a multiple of 10 cents.

(f) *Auxiliary and survivors benefits; reductions; family maximum.* We will determine auxiliary and survivors benefit amounts (see subpart D) on the basis of the pro rata PIA. We will apply the regular reductions for age under section 202(q) of the Act to the benefits of the worker or to any auxiliaries or survivors which are based on the pro rata PIA (see § 404.410). Benefits will be payable subject to the family maximum (see § 404.403) derived from the pro rata PIA. If the pro rata PIA is less than the minimum PIA, the family maximum will be 1½ times the pro rata PIA.

[49 FR 29775, July 24, 1984]

§ 404.1919 How benefits are recomputed.

Unless otherwise provided in an agreement, we will recompute benefits in accordance with this section. We will recompute the pro rata PIA only if the inclusion of the additional earnings results in an increase in the benefits payable by the U.S. to all persons receiving benefits on the basis of the worker's earnings. Subject to this limitation, the pro rata PIA will be automatically recomputed (see § 404.285) to include additional earnings under the U.S. system. In so doing, a new REP will be established for the worker, taking the additional earnings into account, and assumed earnings in the computation base years used in the original computation will be refigured using the new REP. Assumed earnings will also be determined for the year of additional earnings using the new REP. The additional U.S. earnings will also be used in refiguring the ratio described in § 404.1918(d)(2).

[49 FR 29777, July 24, 1984]

§ 404.1920 Supplementing the U.S. benefit if the total amount of the combined benefits is less than the U.S. minimum benefit.

If a resident of the U.S. receives benefits under an agreement from both the U.S. and from the foreign country, the total amount of the two benefits may be less than the amount for which the resident would qualify under the U.S. system based on the minimum PIA as in effect for persons first becoming eligible for benefits before January 1982. An agreement may provide that in the case of an individual who first becomes eligible for benefits before January 1982, the U.S. will supplement the total amount to raise it to the amount for which the resident would have qualified under the U.S. system based on the minimum PIA. (The minimum benefit will be based on the first figure in column IV in the table in section 215(a) of the Act for a person becoming eligible for the benefit before January 1, 1979, or the PIA determined under section 215(a)(1)(C)(i)(I) of the Act (as in effect in December 1981) for a person becoming eligible for the benefit after December 31, 1978.)

[49 FR 29777, July 24, 1984]

§ 404.1921 Benefits of less than $1 due.

If the monthly benefit amount due an individual (or several individuals, e.g., children, where several benefits are combined in one check) as a result of a claim filed under an agreement is less than $1, the benefits may be accumulated until they equal or exceed $5.

OTHER PROVISIONS

§ 404.1925 Applications.

(a)(1) An application, or written statement requesting benefits, filed with the competent authority or agency of a country with which the U.S. has

concluded an agreement shall be considered an application for benefits under title II of the Act as of the date it is filed with the competent authority or agency if—(i) An applicant expresses or implies an intent to claim benefits from the U.S. under an agreement; and

(ii) The applicant files an application that meets the requirements in subpart G of this part.

(2) The application described in paragraph (a)(1)(ii) of this section must be filed, even if it is not specifically provided for in the agreement.

(b) Benefits under an agreement may not be paid on the basis of an application filed before the effective date of the agreement.

§404.1926 Evidence.

(a) An applicant for benefits under an agreement shall submit the evidence needed to establish entitlement, as provided in subpart H of this part. Special evidence requirements for disability benefits are in subpart P of this part.

(b) Evidence submitted to the competent authority or agency of a country with which the U.S. has concluded an agreement shall be considered as evidence submitted to SSA. SSA shall use the rules in §§404.708 and 404.709 to determine if the evidence submitted is sufficient, or if additional evidence is needed to prove initial or continuing entitlement to benefits.

(c) If an application is filed for disability benefits, SSA shall consider medical evidence submitted to a competent authority or agency, as described in paragraph (b) of this section, and use the rules of subpart P of this part for making a disability determination.

§404.1927 Appeals.

(a) A request for reconsideration, hearing, or Appeals Council review of a determination that is filed with the competent authority or agency of a country with which the U.S. has concluded an agreement, shall be considered to have been timely filed with SSA if it is filed within the 60-day time period provided in §§404.911, 404.918, and 404.946.

(b) A request for reconsideration, hearing, or Appeals Council review of a determination made by SSA resulting from a claim filed under an agreement shall be subject to the provisions in subpart J of this part. The rules governing administrative finality in subpart J of this part shall also apply.

§404.1928 Effect of the alien non-payment provision.

An agreement may provide that a person entitled to benefits under title II of the Social Security Act may receive those benefits while residing in the foreign country party to the agreement, regardless of the alien non-payment provision (see §404.460).

§404.1929 Overpayments.

An agreement may not authorize the adjustment of title II benefits to recover an overpayment made under the social security system of a foreign country (see §404.501). Where an overpayment is made under the U.S. system, the provisions in subpart F of this part will apply.

§404.1930 Disclosure of information.

The use of information furnished under an agreement generally shall be governed by the national statutes on confidentiality and disclosure of information of the country that has been furnished the information. (The U.S. will be governed by pertinent provisions of the Social Security Act, the Freedom of Information Act, the Privacy Act, the Tax Reform Act, and other related statutes.) In negotiating an agreement, consideration, should be given to the compatibility of the other country's laws on confidentiality and disclosure to those of the U.S. To the extent possible, information exchanged between the U.S. and the foreign country should be used exclusively for purposes of implementing the agreement and the laws to which the agreement pertains.

Subpart U—Representative Payment

AUTHORITY: Secs. 205 (a), (j), and (k), and 702(a)(5) of the Social Security Act (42 U.S.C. 405 (a), (j), and (k), and 902(a)(5)).

SOURCE: 47 FR 30472, July 14, 1982, unless otherwise noted.

§ 404.2001 Introduction.

(a) *Explanation of representative payment.* This subpart explains the principles and procedures that we follow in determining whether to make representative payment and in selecting a representative payee. It also explains the responsibilities that a representative payee has concerning the use of the funds he or she receives on behalf of a beneficiary. A representative payee may be either a person or an organization selected by us to receive benefits on behalf of a beneficiary. A representative payee will be selected if we believe that the interest of a beneficiary will be served by representative payment rather than direct payment of benefits. Generally, we appoint a representative payee if we have determined that the beneficiary is not able to manage or direct the management of benefit payments in his or her interest.

(b) *Policy used to determine whether to make representative payment.* (1) Our policy is that every beneficiary has the right to manage his or her own benefits. However, some beneficiaries due to a mental or physical condition or due to their youth may be unable to do so. Under these circumstances, we may determine that the interests of the beneficiary would be better served if we certified benefit payments to another person as a representative payee.

(2) If we determine that representative payment is in the interest of a beneficiary, we will appoint a representative payee. We may appoint a representative payee even if the beneficiary is a legally competent individual. If the beneficiary is a legally incompetent individual, we may appoint the legal guardian or some other person as a representative payee.

(3) If payment is being made directly to a beneficiary and a question arises concerning his or her ability to manage or direct the management of benefit payments, we will, if the beneficiary is 18 years old or older and has not been adjudged legally incompetent, continue to pay the beneficiary until we make a determination about his or her ability to manage or direct the management of benefit payments and the selection of a representative payee.

§ 404.2010 When payment will be made to representative payee.

(a) We pay benefits to a representative payee on behalf of a beneficiary 18 years old or older when it appears to us that this method of payment will be in the interest of the beneficiary. We do this if we have information that the beneficiary is—

(1) Legally incompetent or mentally incapable of managing benefit payments; or

(2) Physically incapable of managing or directing the management of his or her benefit payments.

(b) Generally, if a beneficiary is under age 18, we will pay benefits to a representative payee. However, in certain situations, we will make direct payments to a beneficiary under age 18 who shows the ability to manage the benefits. For example, we make direct payments to a beneficiary under age 18 if the beneficiary is—

(1) Receiving disability insurance benefits on his or her own Social Security earnings record; or

(2) Serving in the military services; or

(3) Living alone and supporting himself or herself; or

(4) A parent and files for himself or herself and/or his or her child and he or she has experience in handling his or her own finances; or

(5) Capable of using the benefits to provide for his or her current needs and no qualified payee is available; or

(6) Within 7 months of attaining age 18 and is initially filing an application for benefits.

[47 FR 30472, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989]

§ 404.2015 Information considered in determining whether to make representative payments.

In determining whether to make representative payment we consider the following information:

(a) *Court determinations.* If we learn that a beneficiary has been found to be legally incompetent, a certified copy of the court's determination will be the basis of our determination to make representative payment.

(b) *Medical evidence.* When available, we will use medical evidence to determine if a beneficiary is capable of managing or directing the management of benefit payments. For example, a statement by a physician or other medical professional based upon his or her recent examination of the beneficiary and his or her knowledge of the beneficiary's present condition will be used in our determination, if it includes information concerning the nature of the beneficiary's illness, the beneficiary's chances for recovery and the opinion of the physician or other medical professional as to whether the beneficiary is able to manage or direct the management of benefit payments.

(c) *Other evidence.* We will also consider any statements of relatives, friends and other people in a position to know and observe the beneficiary, which contain information helpful to us in deciding whether the beneficiary is able to manage or direct the management of benefit payments.

§ 404.2020 Information considered in selecting a representative payee.

In selecting a payee we try to select the person, agency, organization or institution that will best serve the interest of the beneficiary. In making our selection we consider—

(a) The relationship of the person to the beneficiary;

(b) The amount of interest that the person shows in the beneficiary;

(c) Any legal authority the person, agency, organization or institution has to act on behalf of the beneficiary;

(d) Whether the potential payee has custody of the beneficiary; and

(e) Whether the potential payee is in a position to know of and look after the needs of the beneficiary.

§ 404.2021 Order of preference in selecting a representative payee.

As a guide in selecting a representative payee, categories of preferred payees have been established. These preferences are flexible. Our primary concern is to select the payee who will best serve the beneficiary's interest. The preferences are:

(a) For beneficiaries 18 years old or older, our preference is—

(1) A legal guardian, spouse (or other relative) who has custody of the beneficiary or who demonstrates strong concern for the personal welfare of the beneficiary;

(2) A friend who has custody of the beneficiary or demonstrates strong concern for the personal welfare of the beneficiary;

(3) A public or nonprofit agency or institution having custody of the beneficiary;

(4) A private institution operated for profit and licensed under State law, which has custody of the beneficiary; and

(5) Persons other than above who are qualified to carry out the responsibilities of a payee and who are able and willing to serve as a payee for a beneficiary; e.g., members of community groups or organizations who volunteer to serve as payee for a beneficiary.

(b) For beneficiaries under age 18, our preference is—

(1) A natural or adoptive parent who has custody of the beneficiary, or a guardian;

(2) A natural or adoptive parent who does not have custody of the beneficiary, but is contributing toward the beneficiary's support and is demonstrating strong concern for the beneficiary's well being;

(3) A natural or adoptive parent who does not have custody of the beneficiary and is not contributing toward his or her support but is demonstrating strong concern for the beneficiary's well being;

(4) A relative or stepparent who has custody of the beneficiary;

(5) A relative who does not have custody of the beneficiary but is contributing toward the beneficiary's support and is demonstrating concern for the beneficiary's well being;

(6) A relative or close friend who does not have custody of the beneficiary but is demonstrating concern for the beneficiary's well being; and

(7) An authorized social agency or custodial institution.

[47 FR 30472, July 14, 1982; 47 FR 32936, July 30, 1982]

§ 404.2025 Information to be submitted by a representative payee.

(a) Before we select a representative payee, the payee applicant must give us information showing his or her relationship to the beneficiary and his or her responsibility for the care of the beneficiary.

(b) Anytime after we have selected a payee, we may ask the payee to give us information showing a continuing relationship to the beneficiary and a continuing responsibility for the care of the beneficiary. If the payee does not give us the requested information within a reasonable period of time, we may stop paying the payee unless we determine that the payee had a good reason for not complying with our request, and we receive the information requested.

§ 404.2030 Advance notice of the determination to make representative payment.

(a) Generally, whenever we intend to make representative payment and to name a payee, we notify the beneficiary or the individual acting on his or her behalf, of our proposed actions. In this notice we tell the person that we plan to name a representative payee and who that payee will be. We also ask the person to contact us if he or she objects to either proposed action. If he or she objects to either proposed action, the person may—

(1) Review the evidence upon which the proposed actions will be based; and

(2) Submit any additional evidence regarding the proposed actions.

(b) If the person objects to the proposed actions, we will review our proposed determinations and consider any additional information given to us. We will then issue our determinations. If the person is dissatisfied with either determination, he or she may request a reconsideration.

(c) If the person does not object to the proposed actions, we will issue our determinations. If the person is dissatisfied with either determination, he or she may request a reconsideration.

[47 FR 30472, July 14, 1982; 47 FR 32936, July 30, 1982]

§ 404.2035 Responsibilities of a representative payee.

A representative payee has a responsibility to—

(a) Use the payments he or she receives only for the use and benefit of the beneficiary in a manner and for the purposes he or she determines, under the guidelines in this subpart, to be in the best interests of the beneficiary;

(b) Notify us of any event that will affect the amount of benefits the beneficiary receives or the right of the beneficiary to receive benefits;

(c) Submit to us, upon our request, a written report accounting for the benefits received; and

(d) Notify us of any change in his or her circumstances that would affect performance of the payee responsibilities.

§ 404.2040 Use of benefit payments.

(a) *Current maintenance.* (1) We will consider that payments we certify to a representative payee have been used for the use and benefit of the beneficiary if they are used for the beneficiary's current maintenance. Current maintenance includes cost incurred in obtaining food, shelter, clothing, medical care, and personal comfort items.

Example: An aged beneficiary is entitled to a monthly Social Security benefit of $400. Her son, who is her payee, disburses her benefits in the following manner:

Rent and utilities	$200
Medical	25
Food	60
Clothing (coat)	55
Savings	30
Miscellaneous	30

The above expenditures would represent proper disbursements on behalf of the beneficiary.

(2) Notwithstanding the provisions of paragraph (a)(1) of this section, if a beneficiary is a member of an Aid to Families With Dependent Children (AFDC) assistance unit, we do not consider it inappropriate for a representative payee to make the benefit payments available to the AFDC assistance unit.

(b) *Institutional care.* If a beneficiary is receiving care in a Federal, State, or private institution because of mental

or physical incapacity, current maintenance includes the customary charges made by the institution, as well as expenditures for those items which will aid in the beneficiary's recovery or release from the institution or expenses for personal needs which will improve the beneficiary's conditions while in the institution.

Example: An institutionalized beneficiary is entitled to a monthly Social Security benefit of $320. The institution charges $700 a month for room and board. The beneficiary's brother, who is the payee, learns the beneficiary needs new shoes and does not have any funds to purchase miscellaneous items at the institution's canteen.

The payee takes his brother to town and buys him a pair of shoes for $29. He also takes the beneficiary to see a movie which costs $3. When they return to the institution, the payee gives his brother $3 to be used at the canteen.

Although the payee normally withholds only $25 a month from Social Security benefit for the beneficiary's personal needs, this month the payee deducted the above expenditures and paid the institution $10 less than he usually pays.

The above expenditures represent what we would consider to be proper expenditures for current maintenance.

(c) *Support of legal dependents.* If the current maintenance needs of the beneficiary are met, the payee may use part of the payments for the support of the beneficiary's legally dependent spouse, child, and/or parent.

Example: A disabled beneficiary receives a Veterans Administration (VA) benefit of $325 and a Social Security benefit of $525. The beneficiary resides in a VA hospital and his VA benefits are sufficient to provide for all of his needs; i.e., cost of care and personal needs. The beneficiary's legal dependents—his wife and two children—have a total income of $250 per month in Social Security benefits. However, they have expenses of approximately $450 per month.

Because the VA benefits are sufficient to meet the beneficiary's needs, it would be appropriate to use part of his Social Security benefits to support his dependents.

(d) *Claims of creditors.* A payee may not be required to use benefit payments to satisfy a debt of the beneficiary, if the debt arose prior to the first month for which payments are certified to a payee. If the debt arose prior to this time, a payee may satisfy it only if the current and reasonably foreseeable needs of the beneficiary are met.

Example: A retroactive Social Security check in the amount of $1,640, representing benefits due for July 1980 through January 1981, was issued on behalf of the beneficiary to the beneficiary's aunt who is the representative payee. The check was certified in February 1981.

The nursing home, where the beneficiary resides, submitted a bill for $1,139 to the payee for maintenance expenses the beneficiary incurred during the period from June 1980 through November 1980. (Maintenance charges for December 1980 through February 1981 had previously been paid.)

Because the benefits were not required for the beneficiary's current maintenance, the payee had previously saved over $500 for the beneficiary and the beneficiary had no foreseeable needs which would require large disbursements, the expenditure for the maintenance charges would be consistent with our guidelines.

[47 FR 30472, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989]

§ 404.2040a Compensation for qualified organizations serving as representative payees.

(a) *General.* A community-based, nonprofit social service agency which meets the requirements set out in paragraph (b) of this section may request our authorization to collect a monthly fee from a beneficiary for providing representative payee services.

(b) *Organizations that may request compensation.* We will authorize an organization to collect a fee if all the following requirements are met.

(1) It is community-based, i.e., serves or represents one or more neighborhoods, city or county locales and is located within its service area.

(2) It is a nonprofit social service organization founded for religious, charitable or social welfare purposes and is tax exempt under section 501(c) of the Internal Revenue Code.

(3) It is bonded or licensed in the State in which it serves as representative payee.

(4) It regularly provides representative payee services concurrently to at least five beneficiaries. An organization which has received our authorization to collect a fee for representative payee services, but is temporarily not a payee for at least five beneficiaries, may request our approval to continue to collect fees.

(5) It was in existence on October 1, 1988.

(6) It is not a creditor of the beneficiary. See paragraph (c) of this section for exceptions to this requirement.

(c) *Creditor relationship.* If an organization has a creditor relationship with a beneficiary, we may, on a case-by-case basis, authorize the organization to collect a fee for payee services notwithstanding this relationship. To provide this authorization, we will review all of the evidence submitted by the organization and authorize collection of a fee when:

(1) The services provided by the organization help to meet the current needs of the beneficiary; and

(2) The amount the organization charges the beneficiary for these services is commensurate with the beneficiary's ability to pay.

(d) *Authorization process.* (1) An organization must request in writing and receive an authorization from us before it may collect a fee.

(2) An organization seeking authorization to collect a fee must also give us evidence to show that it is qualified, pursuant to paragraphs (b) and (c) of this section, to collect a fee.

(3) If the evidence provided to us by the organization shows that the requirements of this section are met, we will notify the organization in writing that it is authorized to collect a fee. If we need more evidence, or if we are not able to authorize the collection of a fee, we will also notify the organization in writing that we have not authorized the collection of a fee.

(e) *Revocation, cancellation and expiration of the authorization.* (1) We will revoke an authorization to collect a fee if we have evidence which establishes that an organization no longer meets the requirements of this section. We will issue a written notice to the organization explaining the reason(s) for the revocation.

(2) An organization may cancel its authorization at any time upon written notice to us.

(f) *Notices.* The written notice we will send to an organization authorizing the collection of a fee will contain an effective date for the collection of a fee pursuant to paragraphs (b) and (c) of this section. The effective date will be no earlier than the month in which the organization asked for authorization to collect a fee. The notice will be applicable to all beneficiaries for whom the organization was payee at the time of our authorization and all beneficiaries for whom the organization becomes payee while the authorization is in effect.

(g) *Limitation on fees.* (1) An organization authorized to collect a fee pursuant to this section may collect from a beneficiary a monthly fee for expenses (including overhead) it has incurred in providing payee services to a beneficiary if the fee does not exceed the lesser of—

(i) 10 percent of the beneficiary's monthly benefit payments; or

(ii) $25.00 per month.

(2) Any agreement providing for a fee in excess of the amount permitted under paragraph (g)(1) of this section shall be void and treated as misuse of benefits by the organization of the individual's benefits under § 404.2041.

(3) A fee may be collected for any month during which the organization—

(i) Provides representative payee services;

(ii) Receives a benefit payment for the beneficiary; and

(iii) Is authorized to receive a fee for representative payee services.

(4) Fees for services may not be taken from any funds conserved for the beneficiary by a payee in accordance with § 404.2045.

(5) Generally, an organization may not collect a fee for months in which it does not receive a benefit payment. However, an organization will be allowed to collect a fee for months in which it did not receive a payment if we later issue payments for these months and the organization:

(i) Received our approval to collect a fee for the months for which payment is made;

(ii) Provided payee services in the months for which payment is made; and

(iii) Was the payee when the retroactive payment was paid by us.

(6) An authorized organization may not collect a fee for the expenses it incurred in providing representative payee services if these expenses are paid from another source.

[57 FR 23057, June 1, 1992]

§404.2041 Liability for misuse of benefit payments.

Our obligation to the beneficiary is completely discharged when we make a correct payment to a representative payee on behalf of the beneficiary. The payee in his or her personal capacity, and not SSA, may be liable if the payee misuses the beneficiary's benefits.

§404.2045 Conservation and investment of benefit payments.

(a) *General.* After the representative payee has used benefit payments consistent with the guidelines in this subpart (see §404.2040 regarding use of benefits), any remaining amount shall be conserved or invested on behalf of the beneficiary. Conserved funds should be invested in accordance with the rules followed by trustees. Any investment must show clearly that the payee holds the property in trust for the beneficiary.

Example: A State institution for mentally retarded children, which is receiving Medicaid funds, is representative payee for several Social Security beneficiaries. The checks the payee receives are deposited into one account which shows that the benefits are held in trust for the beneficiaries. The institution has supporting records which show the share each individual has in the account. Funds from this account are disbursed fairly quickly after receipt for the current support and maintenance of the beneficiaries as well as for miscellaneous needs the beneficiaries may have. Several of the beneficiaries have significant accumulated resources in this account. For those beneficiaries whose benefits have accumulated over $150, the funds should be deposited in an interest-bearing account or invested relatively free of risk on behalf of the beneficiaries.

(b) *Preferred investments.* Preferred investments for excess funds are U.S. Savings Bonds and deposits in an interest or dividend paying account in a bank, trust company, credit union, or savings and loan association which is insured under either Federal or State law. The account must be in a form which shows clearly that the representative payee has only a fiduciary and not a personal interest in the funds. If the payee is the legally appointed guardian or fiduciary of the beneficiary, the account may be established to indicate this relationship. If the payee is not the legally appointed guardian or fiduciary, the accounts may be established as follows:

(1) For U.S. Savings Bonds—

_____ (Name of beneficiary) _____ (Social Security Number), for whom _____ (Name of payee) is representative payee for Social Security benefits;

(2) For interest or dividend paying accounts—

_____ (Name of beneficiary) by _____ (Name of payee), representative payee.

(c) *Interest and dividend payments.* The interest and dividends which result from an investment are the property of the beneficiary and may not be considered to be the property of the payee.

[47 FR 30472, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989]

§404.2050 When a new representative payee will be selected.

When we learn that the interests of the beneficiary are not served by continuing payment to the present payee or that the present payee is no longer able to carry out the payee responsibilities, we try to find a new payee. We will select a new payee if we find a preferred payee or if the present payee—

(a) Has not used the benefit payments on the beneficiary's behalf in accordance with the guidelines in this subpart;

(b) Has not carried out the other responsibilities described in this subpart;

(c) Dies;

(d) No longer wishes to be payee;

(e) Is unable to manage the benefit payments; or

(f) Fails to cooperate, within a reasonable time, in providing evidence, accounting, or other information which we request.

§404.2055 When representative payment will be stopped.

If a beneficiary receiving representative payment shows us that he or she is mentally and physically able to manage or direct the management of benefit payments, we will make direct payment. Information which the beneficiary may give us to support his or her request for direct payment include the following—

(a) A physician's statement regarding the beneficiary's condition, or a statement by a medical officer of the institution where the beneficiary is or was confined, showing that the beneficiary is able to manage or direct the management of his or her funds; or

(b) A certified copy of a court order restoring the beneficiary's rights in a case where a beneficiary was adjudged legally incompetent; or

(c) Other evidence which establishes the beneficiary's ability to manage or direct the management of benefits.

§ 404.2060 Transfer of accumulated benefit payments.

A representative payee who has conserved or invested benefit payments shall transfer these funds, and the interest earned from the invested funds, to either a successor payee or to us, as we will specify. If the funds and the earned interest are returned to us, we will recertify them to a successor representative payee or to the beneficiary.

[47 FR 30472, July 14, 1982; 47 FR 34781, Aug. 11, 1982]

§ 404.2065 Accounting for benefit payments.

A representative payee is accountable for the use of benefits. We may require periodic written reports from representative payees. We may also, in certain situations, verify how a representative payee used the funds. A representative payee should keep records of what was done with the benefit payments in order to make accounting reports. We may ask the following questions—

(a) The amount of benefit payments on hand at the beginning of the accounting period;

(b) How the benefit payments were used;

(c) How much of the benefit payments were saved and how the savings were invested;

(d) Where the beneficiary lived during the accounting period; and

(e) The amount of the beneficiary's income from other sources during the accounting period. We ask for information about other funds to enable us to evaluate the use of benefit payments.

Subpart V—Payments for Vocational Rehabilitation Services

AUTHORITY: Secs. 205(a), 222, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 422, and 902(a)(5)).

SOURCE: 48 FR 6293, Feb. 10, 1983, unless otherwise noted.

GENERAL PROVISIONS

404.2101 General.

Section 222(d) of the Social Security Act authorizes the transfer from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund of such sums as may be necessary to pay for the reasonable and necessary costs of vocational rehabilitation (VR) services provided certain disabled individuals entitled under section 223, 225(b), 202(d), 202(e) or 202(f) of the Social Security Act. The purpose of this provision is to make VR services more readily available to disabled individuals, help State VR agencies and alternate participants to recover some of their costs in VR refusal situations as described in § 404.2113, and ensure that savings accrue to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund. Payment will be made for VR services provided on behalf of such an individual in cases where—

(a) The furnishing of the VR services results in the individual's completion of a continuous 9-month period of substantial gainful activity (SGA) as specified in §§ 404.2110 through 404.2111;

(b) The individual continues to receive disability payments from us, even though his or her disability has ceased, because of his or her continued participation in an approved VR program which we have determined will increase the likelihood that he or she will not return to the disability rolls (see § 404.2112); or

(c) The individual refuses, without good cause, to continue or to cooperate in a VR program in such a manner as to preclude his or her successful rehabilitation (see § 404.2113).

[55 FR 8453, Mar. 8, 1990]

§404.2102 Purpose and scope.

This subpart describes the rules under which the Secretary will pay the State VR agencies or alternate participants for VR services. Payment will be provided for VR services provided on behalf of disabled individuals under one or more of the three provisions discussed in §404.2101.

(a) Sections 404.2101 through 404.2103 describe the purpose of these regulations and the meaning of terms we frequently use in them.

(b) Section 404.2104 explains how State VR agencies or alternate participants may participate in the payment program under this subpart.

(c) Section 404.2106 describes the basic qualifications for alternate participants.

(d) Sections 404.2108 through 404.2109 describe the requirements and conditions under which we will pay a State VR agency or alternate participant under this subpart.

(e) Sections 404.2110 through 404.2111 describe when an individual has completed a continuous period of SGA and when VR services will be considered to have contributed to that period.

(f) Sections 404.2112 and 404.2113 describe when payment will be made to a VR agency or alternate participant because an individual's disability benefits are continued based on his or her participation in a VR program which we have determined will increase the likelihood that he or she will not return to the disability rolls; and when payment will be made to a VR agency or alternate participant when an individual, without good cause, refuses to continue to participate in a VR program or fails to cooperate in such a manner as to preclude his or her successful rehabilitation.

(g) Sections 404.2114 through 404.2115 describe services for which payment will be made.

(h) Section 404.2116 describes the filing deadlines for claims for payment for VR services.

(i) Section 404.2117 describes the payment conditions.

(j) Section 404.2118 describes the applicability of these regulations to alternate participants.

(k) Section 404.2119 describes how we will make payment to State VR agencies or alternate participants for rehabilitation services.

(l) Sections 404.2120 and 404.2121 describe the audits and the prepayment and postpayment validation reviews we will conduct.

(m) Section 404.2122 discusses confidentiality of information and records.

(n) Section 404.2123 provides for the applicability of other Federal laws and regulations.

(o) Section 404.2127 provides for the resolution of disputes.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990; 59 FR 11912, Mar. 15, 1994]

§404.2103 Definitions.

For purposes of this subpart:

Accept the beneficiary as a client for VR services means that the State VR agency determines that the individual is eligible for VR services and places the individual into an active caseload status for development of an individualized written rehabilitation program.

Act means the Social Security Act, as amended.

Alternate participants means any public or private agencies (except participating State VR agencies (see §404.2104)), organizations, institutions, or individuals with whom the Commissioner has entered into an agreement or contract to provide VR services.

Commissioner means the Commissioner of Social Security or the Commissioner's designee.

Disability means ''disability'' or ''blindness'' as defined in sections 216(i) and 223 of the Act.

Disability beneficiary means a disabled individual who is entitled to benefits under section 223, 202(d), 202(e) or 202(f) of the act or is continuing to receive payment under section 225(b) of the Act after his or her disabling physical or mental impairments have ceased.

Good cause for VR refusal (as described in §404.2113) is defined in §404.422(e) of this part.

Medical recovery for purposes of this subpart is established when a beneficiary's disability entitlement ceases for any medical reason (other than death). The determination of medical recovery is made by the Commissioner in deciding a beneficiary's continuing entitlement to benefits.

Place the beneficiary into an extended evaluation process means that the State VR agency determines that an extended evaluation of the individual's VR potential is necessary to determine whether the individual is eligible for VR services and places the individual into an extended evaluation status.

Secretary means the Secretary of the Department of Health and Human Services or the Secretary's designee.

SGA means substantial gainful activity performed by an individual as defined in §§ 404.1571 through 404.1575 or § 404.1584 of this subpart.

State means any of the 50 States of the United States, the Commonwealth of Puerto Rico, the District of Columbia, the Virgin Islands, or Guam. It includes the State VR agency.

Trust Funds means the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund.

Vocational rehabilitation services has the meaning assigned to it under title I of the Rehabilitation Act of 1973.

VR agency means an agency of the State which has been designated by the State to provide vocational rehabilitation services under title I of the Rehabilitation Act of 1973.

Waiting period means a five consecutive calendar month period throughout which an individual must be under a disability and which must be served before disability benefits can be paid (see § 404.315(d)).

We, us and our refer to the Social Security Administration (SSA) or the Secretary, as appropriate.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990; 59 FR 11912, Mar. 15, 1994]

§ 404.2104 Participation by State VR agencies or alternate participants.

(a) *General.* In order to participate in the payment program under this subpart through its VR agency(ies), a State must have a plan which meets the requirements of title I of the Rehabilitation Act of 1973, as amended. An alternate participant must have a similar plan and otherwise qualify under § 404.2106.

(b) *Participation by States.* (1) The opportunity to participate through its VR agency(ies) with respect to disability beneficiaries in the State will be offered first to the State in accordance with paragraph (c) of this section, unless the State has notified us in advance under paragraph (e)(1) of this section of its decision not to participate or to limit such participation.

(2) A State with one or more approved VR agencies may choose to limit participation of those agencies to a certain class(es) of disability beneficiaries. For example, a State with separate VR agencies for the blind and disabled may choose to limit participation to the VR agency for the blind. In such a case, we would give the State, through its VR agency for the blind, the opportunity to participate with respect to blind disability beneficiaries in the State in accordance with paragraph (d) of this section. We would arrange for VR services for non-blind disability beneficiaries in the State through an alternate participant(s). A State that chooses to limit participation of its VR agency(ies) must notify us in advance under paragraph (e)(1) of this section of its decision to limit such participation.

(3) If a State chooses to participate by using a State agency other than a VR agency with a plan for VR services approved under title I of the Rehabilitation Act of 1973, as amended, that State agency may participate only as an alternate participant.

(c) *Opportunity for participation through State VR agencies.* (1) Unless a State has decided not to participate or to limit participation, we will give the State the opportunity to participate through its VR agency(ies) with respect to disability beneficiaries in the State by referring such beneficiaries first to the State VR agency(ies) for necessary VR services. A State, through its VR agency(ies), may participate with respect to any beneficiary so referred by accepting the beneficiary as a client for VR services or placing the beneficiary into an extended evaluation process and notifying us under paragraph (c)(2) of this section of such acceptance or placement.

(2)(i) In order for the State to participate with respect to a disability beneficiary whom we referred to a State VR

agency, the State VR agency must notify the appropriate Regional Commissioner (SSA) in writing or through electronic notification of its decision either to accept the beneficiary as a client for VR services or to place the beneficiary into an extended evaluation process. The notice must be received by the appropriate Regional Commissioner (SSA) no later than the close of the fourth month following the month in which we referred the beneficiary to the State VR agency. If we do not receive such notice with respect to a beneficiary whom we referred to the State VR agency, we may arrange for VR services for that beneficiary through an alternate participant.

(ii) In any case in which a State VR agency notifies the appropriate Regional Commissioner (SSA) in writing within the stated time period under paragraph (c)(2)(i) of this section of its decision to place the beneficiary into an extended evaluation process, the State VR agency also must notify that Regional Commissioner in writing upon completion of the evaluation of its decision whether or not to accept the beneficiary as a client for VR services. If we receive a notice of a decision by the State VR agency to accept the beneficiary as a client for VR services following the completion of the extended evaluation, the State may continue to participate with respect to such beneficiary. If we receive a notice of a decision by the State VR agency not to accept the beneficiary as a client for VR services following the completion of the extended evaluation, we may arrange for VR services for that beneficiary through an alternate participant.

(d) *Opportunity for limited participation through State VR agencies.* If a State has decided under paragraph (e)(1) of this section to limit participation of its VR agency(ies) to a certain class(es) of disability beneficiaries in the State, we will give the State the opportunity to participate with respect to such class(es) of disability beneficiaries by referring such beneficiaries first to the State VR agency(ies) for necessary VR services. The State, through its VR agency(ies), may participate with respect to any beneficiary so referred by accepting the beneficiary as a client for VR services or placing the beneficiary into an extended evaluation process and notifying us under paragraph (c)(2) of this section of such acceptance or placement.

(e) *Decision of a State not to participate or to limit participation.* (1) A State may choose not to participate through its VR agency(ies) with respect to any disability beneficiaries in the State, or it may choose to limit participation of its VR agency(ies) to a certain class(es) of disability beneficiaries in the State. A State which decides not to participate or to limit participation must provide advance written notice of that decision to the appropriate Regional Commissioner (SSA). Unless a State specifies a later month, a decision not to participate or to limit participation will be effective beginning with the third month following the month in which the notice of the decision is received by the appropriate Regional Commissioner (SSA). The notice of the State decision must be submitted by an official authorized to act for the State for this purpose. A State must provide to the appropriate Regional Commissioner (SSA) an opinion from the State's Attorney General verifying the authority of the official who sent the notice to act for the State. This opinion will not be necessary if the notice is signed by the Governor of the State.

(2)(i) If a State has decided not to participate through its VR agency(ies), we may arrange for VR services through an alternate participant(s) for disability beneficiaries in the State.

(ii) If a State has decided to limit participation of its VR agency(ies) to a certain class(es) of disability beneficiaries, we may arrange for VR services through an alternate participant(s) for the class(es) of disability beneficiaries in the State excluded from the scope of the State's participation.

(3) A State which has decided not to participate or to limit participation may participate later through its VR agency(ies) in accordance with paragraph (c) of this section, provided that such participation will not conflict with any previous commitment which we may have made to an alternate participant(s) under paragraph (e)(2) of

this section. A State which decides to resume participation under paragraph (c) of this section must provide advance written notice of that decision to the appropriate Regional Commissioner (SSA). Unless a commitment to an alternate participant(s) requires otherwise, a decision of a State to resume participation under paragraph (c) of this section will be effective beginning with the third month following the month in which the notice of the decision is received by the appropriate Regional Commissioner (SSA) or, if later, with a month specified by the State. The notice of the State decision must be submitted by an official authorized to act for the State as explained in paragraph (e)(1) of this section.

(f) *Use of alternate participants.* The Commissioner, by written agreement or contract, may arrange for VR services through an alternate participant(s) for any disability beneficiary in the State with respect to whom the State is unwilling to participate through its VR agency(ies). In such a case, we may refer the beneficiary to such alternate participant for necessary VR services. The Commissioner will find that a State is unwilling to participate with respect to any of the following disability beneficiaries in that State:

(1) A disability beneficiary whom we referred to a State VR agency under paragraph (c) or (d) of this section if we do not receive a notice within the stated time period under paragraph (c)(2)(i) of this section of a decision by the VR agency either to accept the beneficiary as a client for VR services or to place the beneficiary into an extended evaluation process;

(2) A disability beneficiary with respect to whom we receive a notice under paragraph (c)(2)(ii) of this section of a decision by the VR agency not to accept the beneficiary as a client for VR services following the completion of the extended evaluation;

(3) The class(es) of disability beneficiaries excluded from the scope of the State's participation if the State has decided to limit participation of its VR agency(ies); and

(4) All disability beneficiaries in the State if the State has decided not to participate through its VR agency(ies).

[59 FR 11912, Mar. 15, 1994]

§ 404.2106 Basic qualifications for alternate participants.

(a) *General.* We may arrange for VR services through an alternate participant by written agreement or contract as explained in § 404.2104(f). An alternate participant may be a public or private agency, organization, institution or individual (that is, any entity whether for-profit or not-for-profit), other than a State VR agency.

(1) An alternate participant must—

(i) Be licensed, certified, accredited, or registered, as appropriate, to provide VR services in the State in which it provides services; and

(ii) Under the terms of the written contract or agreement, have a plan similar to the State plan described in § 404.2104(a) which shall govern the provision of VR services to individuals.

(2) We will not use as an alternate participant any agency, organization, institution, or individual—

(i) Whose license, accreditation, certification, or registration is suspended or revoked for reasons concerning professional competence or conduct or financial integrity;

(ii) Who has surrendered such license, accreditation, certification, or registration pending a final determination of a formal disciplinary proceeding; or

(iii) Who is precluded from Federal procurement or nonprocurement programs.

(b) *Standards for the provision of VR services.* An alternate participant's plan must provide, among other things, that the provision of VR services to individuals will meet certain minimum standards, including, but not limited to, the following:

(1) All medical and related health services furnished will be prescribed by, or provided under the formal supervision of, persons licensed to prescribe or supervise the provision of these services in the State;

(2) Only qualified personnel and rehabilitation facilities will be used to furnish VR services; and

(3) No personnel or rehabilitation facility described in paragraph (a)(2) (i),

(ii), or (iii) of this section will be used to provide VR services.

[59 FR 11914, Mar. 15, 1994]

PAYMENT PROVISIONS

§ 404.2108 Requirements for payment.

(a) The State VR agency or alternate participant must file a claim for payment in each individual case within the time periods specified in § 404.2116;

(b) The claim for payment must be in a form prescribed by us and contain the following information:

(1) A description of each service provided;

(2) When the service was provided; and

(3) The cost of the service;

(c) The VR services for which payment is being requested must have been provided during the period specified in § 404.2115;

(d) The VR services for which payment is being requested must have been provided under a State plan for VR services approved under title I of the Rehabilitation Act of 1973, as amended, or, in the case of an alternate participant, under a negotiated plan, and must be services that are described in § 404.2114;

(e) The individual must meet one of the VR payment provisions specified in § 404.2101;

(f) The State VR agency or alternate participant must maintain, and provide as we may require, adequate documentation of all services and costs for all disability beneficiaries with respect to whom a State VR agency or alternate participant could potentially request payment for services and costs under this subpart; and

(g) The amount to be paid must be reasonable and necessary and be in compliance with the cost guidelines specified in § 404.2117.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990; 59 FR 11914, Mar. 15, 1994

§ 404.2109 Responsibility for making payment decisions.

The Commissioner will decide—

(a) Whether a continuous period of 9 months of SGA has been completed;

(b) Whether a disability beneficiary whose disability has ceased should continue to receive benefits under § 404.316(c), 404.337(c), or 404.352(c) for a month after October 1984, based on his or her continued participation in a VR program;

(c) Whether an individual, without good cause, refused to continue to accept VR services or failed to cooperate in a VR program for a month(s) after October 1984, and whether deductions should be imposed against the individual's disability benefits;

(d) If and when medical recovery has occurred;

(e) Whether documentation of VR services and expenditures is adequate;

(f) If payment is to be based on completion of a continuous 9-month period of SGA, whether the VR services contributed to the continuous period of SGA;

(g) Whether a VR service is a service described in § 404.2114; and

(h) What VR costs were reasonable and necessary and will be paid.

[55 FR 8454, Mar. 8, 1990, as amended at 59 FR 11914, Mar. 15, 1994]

§ 404.2110 What we mean by "SGA" and by "a continuous period of 9 months".

(a) *What we mean by ''SGA''.* In determining whether an individual's work is SGA, we will follow the rules in §§ 404.1572 through 404.1575. We will follow these same rules for individuals who are statutorily blind, but we will evaluate the earnings in accordance with the rules in § 404.1584(d).

(b) *What we mean by ''a continuous period of 9 months''.* A continuous period of 9 months ordinarily means a period of 9 consecutive calendar months. Exception: When an individual does not perform SGA in 9 consecutive calendar months, he or she will be considered to have done so if—

(1) The individual performs 9 months of SGA within 10 consecutive months and has monthly earnings that meet or exceed the guidelines in § 404.1574(b)(2), or § 404.1584(d) if the individual is statutorily blind; or

(2) The individual performs at least 9 months of SGA within 12 consecutive months, and the reason for not performing SGA in 2 or 3 of those months was due to circumstances beyond his or

her control and unrelated to the impairment (e.g., the employer closed down for 3 months).

(c) *What work we consider.* In determining if a continuous period of SGA has been completed, all of an individual's work activity may be evaluated for purposes of this section, including work performed before October 1981, during the waiting period, during the trial work period and after entitlement to disability benefits terminated. We will ordinarily consider only the first 9 months of SGA that occur. The exception will be if an individual who completed 9 months of SGA later stops performing SGA, receives VR services and then performs SGA for a 9-month period. See § 404.2115 for the use of the continuous period in determining payment for VR services.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990]

§ 404.2111 Criteria for determining when VR services will be considered to have contributed to a continuous period of 9 months.

The State VR agency or alternate participant may be paid for VR services if such services contribute to the individual's performance of a continuous 9-month period of SGA. The following criteria apply to individuals who received more than just evaluation services. If a State VR agency or alternate participant claims payment for services to an individual who received only evaluation services, it must establish that the individual's continuous period or medical recovery (if medical recovery occurred before completion of a continuous period) would not have occurred without the services provided. In applying the criteria below, we will consider services described in § 404.2114 that were initiated, coordinated or provided, including services before October 1, 1981.

(a) *Continuous period without medical recovery.* If an individual who has completed a ''continuous period'' of SGA has not medically recovered as of the date of completion of the period, the determination as to whether VR services contributed will depend on whether the continuous period began one year or less after VR services ended or more than one year after VR services ended.

(1) *One year or less.* Any VR services which significantly motivated or assisted the individual in returning to, or continuing in, SGA will be considered to have contributed to the continuous period.

(2) *More than one year.* (i) If the continuous period was preceded by transitional work activity (employment or self-employment which gradually evolved, with or without periodic interruption, into SGA), and that work activity began less than a year after VR services ended, any VR services which significantly motivated or assisted the individual in returning to, or continuing in, SGA will be considered to have contributed to the continuous period.

(ii) If the continuous period was not preceded by transitional work activity that began less than a year after VR services ended, VR services will be considered to have contributed to the continuous period only if it is reasonable to conclude that the work activity which constitutes a continuous period could not have occurred without the VR services (e.g., training).

(b) *Continuous period with medical recovery occurring before completion.* (1) If an individual medically recovers before a continuous period has been completed, VR services under paragraph (a) of this section will not be payable unless some VR services contributed to the medical recovery. VR services will be considered to have contributed to the medical recovery if—

(i) The individualized written rehabilitation program (IWRP) or, in the case of an alternate participant, a similar document, included medical services; and

(ii) The medical recovery occurred, at least in part, because of these medical services. (For example, the individual's medical recovery was based on improvement in a back condition which, at least in part, stemmed from surgery initiated, coordinated or provided under an IWRP).

(2) In some instances, the State VR agency or alternate participant will not have provided, initiated, or coordinated medical services. If this happens, payment for VR services may still be possible under paragraph (a) of this

section if: (i) The medical recovery was not expected by us; and (ii) the individual's impairment is determined by us to be of such a nature that any medical services provided would not ordinarily have resulted in, or contributed to, the medical cessation.

[48 FR 6293, Feb. 10, 1983, as amended at 59 FR 11914, Mar. 15, 1994]

§404.2112 Payment for VR services in a case where an individual continues to receive disability payments based on participation in an approved VR program.

Sections 404.1586(g), 404.316(c), 404.337(c), and 404.352(c) explain the criteria we will use in determining if an individual whose disability has ceased should continue to receive disability benefits from us because of his or her continued participation in a VR program. A VR agency or alternate participant can be paid for the cost of VR services provided to an individual if the individual was receiving benefits in a month or months, after October 1984, based on §404.316(c), 404.337(c), or 404.352(c). If this requirement is met, a VR agency or alternate participant can be paid for the costs of VR services provided within the period specified in §404.2115, subject to the other payment and administrative provisions of this subpart.

[55 FR 8455, Mar. 8, 1990]

§404.2113 Payment for VR services in a case of VR refusal.

(a) For purposes of this section, *VR refusal* means an individual's refusal to continue to accept VR services or failure to cooperate in such a manner as to preclude the individual's successful rehabilitation.

(b) No later than the 60th day after the State VR agency or alternate participant makes a preliminary finding that an individual refuses to continue to accept VR services or fails to cooperate in a VR program, the State VR agency or alternate participant shall report to the appropriate Regional Commissioner (SSA) in writing such individual's VR refusal so that we may make the determination described in §404.2109(c).

(c) Payment can be made to a State VR agency or alternate participant for the costs of VR services provided to an individual who, after filing an application with the State VR agency or alternate participant for rehabilitation services, without good cause, refuses to continue to accept VR services or fails to cooperate in such a manner as to preclude the individual's successful rehabilitation. A State VR agency or alternate participant may be paid, subject to the provisions of this subpart, for the costs of VR services provided to an individual if deductions have been imposed against the individual's monthly disability benefits for a month or months after October 1984 because of VR refusal.

[59 FR 11915, Mar. 15, 1994]

§404.2114 Services for which payment may be made.

(a) *General.* Payment may be made for VR services provided by a State VR agency in accordance with title I of the Rehabilitation Act of 1973, as amended, or by an alternate participant under a negotiated plan, subject to the limitations and conditions in this subpart. VR services for which payment may be made under this subpart include only those services described in paragraph (b) of this section which are—

(1) Necessary to determine an individual's eligibility for VR services or the nature and scope of the services to be provided; or

(2) Provided by a State VR agency under an IWRP, or by an alternate participant under a similar document, but only if the services could reasonably be expected to motivate or assist the individual in returning to, or continuing in, SGA.

(b) *Specific services.* Payment may be made under this subpart only for the following VR services:

(1) An assessment for determining an individual's eligibility for VR services and vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology, and which includes determining—

(i) The nature and extent of the physical or mental impairment(s) and the resultant impact on the individual's employability;

(ii) The likelihood that an individual will benefit from vocational rehabilitation services in terms of employability; and

(iii) An employment goal consistent with the capacities of the individual and employment opportunities;

(2) Counseling and guidance, including personal adjustment counseling, and those referrals and other services necessary to help an individual secure needed services from other agencies;

(3) Physical and mental restoration services necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive and which constitutes an impediment to suitable employment at or above the SGA level;

(4) Vocational and other training services, including personal and vocational adjustment, books, tools, and other training materials, except that training or training services in institutions of higher education will be covered under this section only if maximum efforts have been made by the State VR agency or alternate participant to secure grant assistance in whole or in part from other sources;

(5) Maintenance expenses that are extra living expenses over and above the individual's normal living expenses and that are incurred solely because of and while the individual is participating in the VR program and that are necessary in order for the individual to benefit from other necessary VR services;

(6) Travel and related expenses necessary to transport an individual for purpose of enabling the individual's participation in other necessary VR services;

(7) Services to family members of a disabled individual only if necessary to the successful vocational rehabilitation of that individual;

(8) Interpreter services and note-taking services for an individual who is deaf and tactile interpreting for an individual who is deaf and blind;

(9) Reader services, rehabilitation teaching services, note-taking services, and orientation and mobility services for an individual who is blind;

(10) Telecommunications, sensory, and other technological aids and devices;

(11) Work-related placement services to secure suitable employment;

(12) Post-employment services necessary to maintain, regain or advance into suitable employment at or above the SGA level;

(13) Occupational licenses, tools, equipment, initial stocks, and supplies;

(14) Rehabilitation technology services; and

(15) Other goods and services that can reasonably be expected to motivate or assist the individual in returning to, or continuing in, SGA.

[59 FR 11915, Mar. 15, 1994]

§ 404.2115 When services must have been provided.

(a) In order for the VR agency or alternate participant to be paid, the services must have been provided—

(1) After September 30, 1981;

(2) No earlier than the beginning of the waiting period or the first month of entitlement, if no waiting period is required; and

(3) Before completion of a continuous 9-month period of SGA or termination (suspension of benefits in cases described in § 404.2113) of payments to the individual, whichever occurs first.

(b) Where disability or blindness payments are made simultaneously to an individual based on the provisions of both this part and part 416, the determination as to when services must have been provided may be made under this section or § 416.2215, whichever is advantageous to the State VR agency or alternate participant that is participating in both VR programs.

[55 FR 8455, Mar. 8, 1990]

§ 404.2116 When claims for payment for VR services must be made (filing deadlines).

The State VR agency or alternate participant must file a claim for payment in each individual case within the following time periods:

(a) A claim for payment for VR services based on the individual's completion of a continuous 9-month period of SGA must be filed within 12 months after the month in which the continuous 9-month period of SGA is completed.

(b) A claim for payment for VR services provided to an individual whose

disability benefits were continued after disability has ceased because of that individual's continued participation in a VR program must be filed as follows:

(1) If a written notice requesting that a claim be filed was sent to the State VR agency or alternate participant, a claim must be filed within 90 days following the month in which VR services end, or if later, within 90 days after receipt of the notice.

(2) If no written notice was sent to the State VR agency or alternate participant, a claim must be filed within 12 months after the month in which VR services end or, if later, within 12 months after the month of publication of this section.

(c) A claim for payment based on an individual's refusal, without good cause, to continue or cooperate in a VR program must be filed—

(1) Within 90 days after the VR agency or alternate participant receives our written request to file a claim for payment; or

(2) If no written notice was sent to the State VR agency or alternate participant, a claim must be filed within 12 months after the month for which disability benefit payments are suspended because of VR refusal, or if later, within 12 months after the month of publication of this section.

[55 FR 8455, Mar. 8, 1990]

§ 404.2117 What costs will be paid.

In accordance with section 222(d) of the Social Security Act, the Secretary will pay the State VR agency or alternate participant for the VR services described in § 404.2114 which were provided during the period described in § 404.2115 and which meet the criteria in § 404.2111, § 404.2112, or § 404.2113, but subject to the following limitations:

(a) The cost must have been incurred by the State VR agency or alternate participant;

(b) The cost must not have been paid or be payable from some other source. For this purpose, State VR agencies or alternate participants will be required to seek payment or services from other sources in accordance with the ''similar benefit'' provisions under 34 CFR part 361, including making maximum efforts to secure grant assistance in whole or part from other sources for training or training services in institutions of higher education. Alternate participants will not be required to consider State VR services a similar benefit.

(c)(1) The cost must be reasonable and necessary, in that it complies with the written cost-containment policies of the State VR agency or, in the case of an alternate participant, it complies with similar written policies established under a negotiated plan. A cost which complies with these policies will be considered necessary only if the cost is for a VR service described in § 404.2114. The State VR agency or alternate participant must maintain and use these cost-containment policies, including any reasonable and appropriate fee schedules, to govern the costs incurred for all VR services, including the rates of payment for all purchased services, for which payment will be requested under this subpart. For the purpose of this subpart, the written cost-containment policies must provide guidelines designed to ensure—

(i) The lowest reasonable cost for such services; and

(ii) Sufficient flexibility so as to allow for an individual's needs.

(2) The State VR agency shall submit to us before the end of the first calendar quarter of each year a written statement certifying that cost-containment policies are in effect and are adhered to in procuring and providing goods and services for which the State VR agency requests payment under this subpart. Such certification must be signed by the State's chief financial official or the head of the VR agency. Each certification must specify the basis upon which it is made, e.g., a recent audit by an authorized State, Federal or private auditor (or other independent compliance review) and the date of such audit (or compliance review). In the case of an alternate participant, these certification requirements shall be incorporated into the negotiated agreement or contract. We may request the State VR agency or alternate participant to submit to us a copy(ies) of its specific written cost-containment policies and procedures (e.g., any guidelines and fee schedules for a given year) if we determine that

such additional information is necessary to ensure compliance with the requirements of this subpart. The State VR agency or alternate participant shall provide such information when requested by us.

(d) The total payment in each case, including any prior payments related to earlier continuous 9-month periods of SGA made under this subpart, must not be so high as to preclude a ''net saving'' to the trust funds (a ''net saving'' is the difference between the estimated saving to the trust funds, if disability benefits eventually terminate, and the total amount we pay to the State VR agency or alternate participant);

(e) Any payment to the State VR agency for either direct or indirect VR expenses must be consistent with the cost principles described in OMB Circular No. A–87, published at 46 FR 9548 on January 28, 1981 (see § 404.2118(a) for cost principles applicable to alternate participants);

(f) Payment for VR services or costs may be made under more than one of the VR payment provisions described in §§ 404.2111 through 404.2113 of this subpart and similar provisions in §§ 416.2211 through 416.2213 of subpart V of part 416. However, payment will not be made more than once for the same VR service or cost. For example, payment to a VR agency based upon the completion of a continuous 9-month period of SGA which was made after an earlier payment based upon VR refusal, would only include payment for those VR costs incurred or services provided after the individual resumed VR services after refusal; and

(g) Payment will be made for administrative costs and for counseling and placement costs. This payment may be on a formula basis, or on an actual cost basis, whichever the State VR agency prefers. The formula will be negotiated. The payment will also be subject to the preceding limitations.

[48 FR 6293, Feb. 10, 1983. Redesignated and amended at 55 FR 8454, 8455, Mar. 8, 1990; 59 FR 11915, Mar. 15, 1994]

ADMINISTRATIVE PROVISIONS

§ 404.2118 Applicability of these provisions to alternate participants.

When an alternate participant provides rehabilitation services under this subpart, the payment procedures stated herein shall apply except that:

(a) Payment must be consistent with the cost principles described in 45 CFR part 74 or 41 CFR parts 1–15 as appropriate; and

(b) Any disputes, including appeals of audit determinations, shall be resolved in accordance with applicable statutes and regulations which will be specified in the negotiated agreement or contract.

[48 FR 6293, Feb. 10, 1983. Redesignated at 55 FR 8454, Mar. 8, 1990]

§ 404.2119 Method of payment.

Payment to the State VR agencies or alternate participants pursuant to this subpart will be made either by advancement of funds or by payment for services provided (with necessary adjustments for any overpayments and underpayments), as decided by the Commissioner.

[55 FR 8455, Mar. 8, 1990]

§ 404.2120 Audits.

(a) *General.* The State or alternate participant shall permit us and the Comptroller General of the United States (including duly authorized representatives) access to and the right to examine records relating to the services and costs for which payment was requested or made under these regulations. These records shall be retained by the State or alternate participant for the periods of time specified for retention of records in the Federal Procurement Regulations (41 CFR parts 1–20).

(b) *Audit basis.* Auditing will be based on cost principles and written guidelines in effect at the time services were provided and costs were incurred. The State VR agency or alternate participant will be informed and given a full explanation of any questioned items. It

will be given a reasonable time to explain questioned items. Any explanation furnished by the State VR agency or alternate participant will be given full consideration before a final determination is made on questioned items in the audit report.

(c) *Appeal of audit determinations.* The appropriate SSA Regional Commissioner will notify the State VR agency or alternate participant in writing of his or her final determination on the audit report. If the State VR agency (see §404.2118(b) for alternate participants) disagrees with that determination, it may request reconsideration in writing within 60 days after receiving the Regional Commissioner's notice of the determination. The Commissioner will make a determination and notify the State VR agency of that decision in writing, usually, no later than 45 days from the date of appeal. The decision by the Commissioner will be final and conclusive unless the State VR agency appeals that decision in writing in accordance with 45 CFR part 16 to the Department of Health and Human Services Departmental Grant Appeals Board within 30 days after receiving it.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990]

§404.2121 Validation reviews.

(a) *General.* We will conduct a validation review of a sample of the claims for payment filed by each State VR agency or alternate participant. We will conduct some of these reviews on a prepayment basis and some on a postpayment basis. We may review a specific claim, a sample of the claims, or all the claims filed by any State VR agency or alternate participant, if we determine that such review is necessary to ensure compliance with the requirements of this subpart. For each claim selected for review, the State VR agency or alternate participant must submit such records of the VR services and costs for which payment has been requested or made under this subpart, or copies of such records, as we may require to ensure that the services and costs meet the requirements for payment. For claims for cases described in §404.2101(a), a clear explanation or existing documentation which demonstrates how the service contributed to the individual's performance of a continuous 9-month period of SGA must be provided. For claims for cases described in §404.2101(b) or (c), a clear explanation or existing documentation which demonstrates how the service was reasonably expected to motivate or assist the individual to return to or continue in SGA must be provided. If we find in any prepayment validation review, that the scope or content of the information is inadequate, we will request additional information and will withhold payment until adequate information has been provided. The State VR agency or alternate participant shall permit us (including duly authorized representatives) access to, and the right to examine, any records relating to such services and costs. Any review performed under this section will not be considered an audit for purposes of this subpart.

(b) *Purpose.* The primary purpose of these reviews is—

(1) To ensure that the VR services and costs meet the requirements for payment under this subpart;

(2) To assess the validity of our documentation requirements; and

(3) To assess the need for additional validation reviews or additional documentation requirements for any State VR agency or alternate participant to ensure compliance with the requirements under this subpart.

(c) *Determinations.* In any validation review, we will determine whether the VR services and costs meet the requirements for payment and determine the amount of payment. We will notify in writing the State VR agency or alternate participant of our determination. If we find in any postpayment validation review that more or less than the correct amount of payment was made for a claim, we will determine that an overpayment or underpayment has occurred and will notify the State VR agency or alternate participant that we will make the appropriate adjustment.

(d) *Appeals.* If the State VR agency or alternate participant disagrees with our determination under this section, it may appeal that determination in accordance with §404.2127. For purposes of this section, an appeal must be filed

within 60 days after receiving the notice of our determination.

[59 FR 11916, Mar. 15, 1994]

§ 404.2122 Confidentiality of information and records.

The State or alternate participant shall comply with the provisions for confidentiality of information, including the security of systems, and records requirements described in 20 CFR part 401 and pertinent written guidelines (see § 404.2123).

§ 404.2123 Other Federal laws and regulations.

Each State VR agency and alternate participant shall comply with the provisions of other Federal laws and regulations that directly affect its responsibilities in carrying out the vocational rehabilitation function.

§ 404.2127 Resolution of disputes.

(a) *Disputes on the amount to be paid.* The appropriate SSA official will notify the State VR agency or alternative participant in writing of his or her determination concerning the amount to be paid. If the State VR agency (see § 404.2118(b) for alternate participants) disagrees with that determination, the State VR agency may request reconsideration in writing within 60 days after receiving the notice of determination. The Commissioner will make a determination and notify the State VR agency of that decision in writing, usually no later than 45 days from the date of the State VR agency's appeal. The decision by the Commissioner will be final and conclusive upon the State VR agency unless the State VR agency appeals that decision in writing in accordance with 45 CFR part 16 to the Department of Health and Human Services Departmental Grant Appeals Board within 30 days after receiving the Commissioner's decision.

(b) *Disputes on whether there was a continuous period of SGA and whether VR services contributed to a continuous period of SGA.* The rules in paragraph (a) of this section will apply, except that the Commissioner's decision will be final and conclusive. There is no right of appeal to the Grant Appeals Board.

(c) *Disputes on determinations made by the Secretary which affect a disability beneficiary's rights to benefits.* Determinations made by the Secretary which affect an individual's right to benefits (e.g., determinations that disability benefits should be terminated, denied, suspended, continued or begun at a different date than alleged) cannot be appealed by a State VR agency or alternate participant. Because these determinations are an integral part of the disability benefits claims process, they can only be appealed by the beneficiary or applicant whose rights are affected or by his or her authorized representative. However, if an appeal of an unfavorable determination is made by the individual and is successful, the new determination would also apply for purposes of this subpart. While a VR agency or alternate participant cannot appeal a determination made by the Secretary which affects a beneficiary's or applicant's rights, the VR agency can furnish any evidence it may have which would support a revision of a determination.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990]

PART 410—FEDERAL COAL MINE HEALTH AND SAFETY ACT OF 1969, TITLE IV—BLACK LUNG BENEFITS (1969–)

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