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claim with the Social Security Administration which is pending or has been denied and who has also filed a part C claim with the Office of Workers' Compensation Programs, which has been approved, shall be entitled, upon request, to a review of the pending or denied part B claim in light of the BLBRA of 1977 by either the Social Security Administration or the Office of Workers' Compensation Programs, in accordance with this subpart.

(c) Pending or denied by the Social Security Administration and the Office of Workers' Compensation Programs. A person who has filed a claim both with the Social Security Administration and the Office of Workers' Compensation Programs and whose claims are either pending with or have been denied by both agencies shall have the claim reviewed under the BLBRA of 1977 by the Social Security Administration if such review is requested by the claimant. If the claim is not approved by the Social Security Administration it shall be forwarded to the Office of Workers' Compensation Programs for further review as provided in § 410.704(e)(2). During the pendency of review proceedings by the Social Security Administration, if any, no action shall be taken by the Secretary of Labor with respect to the part C claim which is pending or has been denied by DOL. If the claimant does not respond to notification of his or her right to review by the Social Security Administration within 6 months of the notice (see § 410.704(c)) unless the period is enlarged for good cause shown, the Office of Workers' Compensation Programs shall proceed under DOL's regulations at 20 CFR part 727 to review the claim originally filed with the Secretary of Labor. If the claimant, upon notification by the Social Security Administration of his or her right to review (see § 410.704(a)) requests that the claim originally filed with the Social Security Administration be forwarded to the Office of Workers' Compensation Programs for review, or if more than one claim has been filed with the Secretary of Labor by the same claimant, such claims shall be merged and processed with the first claim filed with the Office of Workers' Compensation Programs.

§ 410.706 Effect of the Social Security Administration determination of entitlement.

Under section 435 of the BLBRA of 1977 a determination of entitlement made by the Social Security Administration under this subpart G is binding on the Office of Workers' Compensation Programs as an initial determination of eligibility.

§ 410.707 Hearings and appeals.

The review of any determination made by the Social Security Administration of a claim under this subpart will be made by the Office of Workers' Compensation Programs. If the Social Security Administration does not approve the claim following its review under this subpart, the claim will be referred to the Office of Worker's Compensation Programs, and the Office of Workers' Compensation Programs will automatically review the claim. The Office of Workers' Compensation Programs will provide an opportunity for the claimant to submit additional evidence if it is needed to approve the claim. See § 410.704(e)(2) of this subpart. If the Social Security Administration approves the claim but the claimant disagrees with any part of the Social Security Administration's determination, he or she may request the Office of Workers' Compensation Programs to review the Social Security Administration's determination. See § 410.704 (e)(1) of this subpart.

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

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Subpart A—Introduction, General Provisions and Definitions

AUTHORITY: Secs. 702(a)(5) and 1601–1635 of the Social Security Act (42 U.S.C. 902(a)(5) and 1381–1383d); sec. 212, Pub. L. 93–66, 87 Stat. 155 (42 U.S.C. 1382 note); sec. 502(a), Pub. L. 94–241, 90 Stat. 268 (48 U.S.C. 1681 note).

SOURCE: 39 FR 28625, Aug. 9, 1974, unless otherwise noted.

§ 416.101 Introduction.

The regulations in this part 416 (Regulations No. 16 of the Social Security Administration) relate to the provisions of title XVI of the Social Security Act as amended by section 301 of Pub. L. 92–603 enacted October 30, 1972, and as may thereafter be amended. Title XVI (Supplemental Security Income For The Aged, Blind, and Disabled) of the Social Security Act, as amended, established a national program, effective January 1, 1974, for the purpose of providing supplemental security income to individuals who have attained age 65 or are blind or disabled. The regulations in this part are divided into the following subparts according to subject content:

(a) This subpart A contains this introduction, a statement of the general purpose underlying the supplemental security income program, general provisions applicable to the program and its administration, and definitions and use of terms occurring throughout this part.

(b) Subpart B of this part covers in general the eligibility requirements which must be met for benefits under the supplemental security income program. It sets forth the requirements regarding residence, citizenship, age, disability, or blindness, and describes the conditions which bar eligibility and generally points up other conditions of eligibility taken up in greater detail elsewhere in the regulations (e.g., limitations on income and resources, receipt of support and maintenance, etc.).

(c) Subpart C of this part sets forth the rules with respect to the filing of applications, requests for withdrawal of applications, cancellation of withdrawal requests and other similar requests.

(d) Subpart D of this part sets forth the rules for computing the amount of benefits payable to an eligible individual and eligible spouse.

(e) Subpart E of this part covers provisions with respect to periodic payment of benefits, joint payments, payment of emergency cash advances, payment of benefits prior to a determination of disability, prohibition against transfer or assignment of benefits, adjustment and waiver of overpayments, and payment of underpayments.

(f) Subpart F of this part contains provisions with respect to the selection of representative payees to receive benefits on behalf of and for the use of recipients and to the duties and responsibilities of representative payees.

(g) Subpart G of this part sets forth rules with respect to the reporting of events and circumstances affecting eligibility or the amount of benefits payable.

(h) Subpart H of this part sets forth rules and guidelines for the submittal and evaluation of evidence of age where age is pertinent to establishing eligibility or the amount of benefits payable.

(i) Subpart I of this part sets forth the rules for establishing disability or blindness where the establishment of disability or blindness is pertinent to eligibility.

(j) Subpart J of this part sets forth the 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.

(k) Subpart K of this part defines *income*, *earned income*, and *unearned income* and sets forth the statutory exclusions applicable to earned and unearned income for the purpose of establishing eligibility for and the amount of benefits payable.

(l) Subpart L of this part defines the term *resources* and sets forth the statutory exclusions applicable to resources for the purpose of determining eligibility.

(m) Subpart M of this part deals with events or circumstances requiring suspension or termination of benefits.

(n) Subpart N of this part contains provisions with respect to procedures for making determinations with respect to eligibility, amount of benefits, representative payment, etc., notices of determinations, rights of appeal and procedures applicable thereto, and other procedural due process provisions.

(o) Subpart O of this part contains provisions applicable to attorneys and other individuals who represent applicants in connection with claims for benefits.

(p) Subpart P of this part sets forth the residence and citizenship requirements that are pertinent to eligibility.

(q) Subpart Q of this part contains provisions with respect to the referral of individuals for vocational rehabilitation, treatment for alcoholism and drug addiction, and application for other benefits to which an applicant may be potentially entitled.

(r) Subpart R of this part sets forth the rules for determining marital and other family relationships where pertinent to the establishment of eligibility for or the amount of benefits payable.

(s) Subpart S of this part explains interim assistance and how benefits may

be withheld to repay such assistance given by the State.

(t) Subpart T of this part contains provisions with respect to the supplementation of Federal supplemental security income payments by States, agreements for Federal administration of State supplementation programs, and payment of State supplementary payments.

(u) Subpart U of this part contains provisions with respect to agreements with States for Federal determination of Medicaid eligibility of applicants for supplemental security income.

(v) Subpart V of this part explains when payments are made to State vocational rehabilitation agencies (or alternate participants) for vocational rehabilitation services.

[39 FR 28625, Aug. 9, 1974, as amended at 51 FR 11718, Apr. 7, 1986]

§ 416.105 Administration.

The Supplemental Security Income for the Aged, Blind, and Disabled program is administered by the Social Security Administration under authority delegated by the Secretary of Health and Human Services.

[51 FR 11718, Apr. 7, 1986]

§ 416.110 Purpose of program.

The basic purpose underlying the supplemental security income program is to assure a minimum level of income for people who are age 65 or over, or who are blind or disabled and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level. The supplemental security income program replaces the financial assistance programs for the aged, blind, and disabled in the 50 States and the District of Columbia for which grants were made under the Social Security Act. Payments are financed from the general funds of the United States Treasury. Several basic principles underlie the program:

(a) *Objective tests.* The law provides that payments are to be made to aged, blind, and disabled people who have income and resources below specified amounts. This provides objective measurable standards for determining each person's benefits.

(b) *Legal right to payments.* A person's rights to supplemental security income payments—how much he gets and under what conditions—are clearly defined in the law. The area of administrative discretion is thus limited. If an applicant disagrees with the decision on his claim, he can obtain an administrative review of the decision and if still not satisfied, he may initiate court action.

(c) *Protection of personal dignity.* Under the Federal program, payments are made under conditions that are as protective of people's dignity as possible. No restrictions, implied or otherwise, are placed on how recipients spend the Federal payments.

(d) *Nationwide uniformity of standards.* The eligibility requirements and the Federal minimum income level are identical throughout the 50 States and the District of Columbia. This provides assurance of a minimum income base on which States may build supplementary payments.

(e) *Incentives to work and opportunities for rehabilitation.* Payment amounts are not reduced dollar-for-dollar for work income but some of an applicant's income is counted toward the eligibility limit. Thus, recipients are encouraged to work if they can. Blind and disabled recipients with vocational rehabilitation potential are referred to the appropriate State vocational rehabilitation agencies that offer rehabilitation services to enable them to enter the labor market.

(f) *State supplementation and Medicaid determinations.* (1) Federal supplemental security income payments lessen the variations in levels of assistance and provide a basic level of assistance throughout the nation. States are required to provide mandatory minimum State supplementary payments beginning January 1, 1974, to aged, blind, or disabled recipients of assistance for the month of December 1973 under such State's plan approved under title I, X, XIV, or XVI of the Act in order for the State to be eligible to receive title XIX funds (see subpart T of this part). These payments must be in an amount sufficient to ensure that individuals who are converted to the new program will not have their income reduced

below what it was under the State program for December 1973. In addition, each State may choose to provide more than the Federal supplemental security income and/or mandatory minimum State supplementary payment to whatever extent it finds appropriate in view of the needs and resources of its citizens or it may choose to provide no more than the mandatory minimum payment where applicable. States which provide State supplementary payments can enter into agreements for Federal administration of the mandatory and optional State supplementary payments with the Federal Government paying the administrative costs. A State which elects Federal administration of its supplementation program must apply the same eligibility criteria (other than those pertaining to income) applied to determine eligibility for the Federal portion of the supplemental security income payment, except as provided in sec. 1616(c) of the Act (see subpart T of this part). There is a limitation on the amount payable to the Secretary by a State for the amount of the supplementary payments made on its behalf for any fiscal year pursuant to the State's agreement with the Secretary. Such limitation on the amount of reimbursement is related to the State's payment levels for January 1972 and its total expenditures for calendar year 1972 for aid and assistance under the appropriate State plan(s) (see subpart T of this part).

(2) States with Medicaid eligibility requirements for the aged, blind, and disabled that are identical (except as permitted by § 416.2111) to the supplemental security income eligibility requirements may elect to have the Social Security Administration determine Medicaid eligibility under the State's program for recipients of supplemental security income and recipients of a federally administered State supplementary payment. The State would pay half of Social Security Administration's incremental administrative costs arising from carrying out the agreement.

[39 FR 28625, Aug. 9, 1974, as amended at 53 FR 12941, Apr. 20, 1988]

§ 416.120 General definitions and use of terms.

(a) *Terms relating to acts and regulations.* As used in this part:

(1) *The Act* means the Social Security Act as amended (42 U.S.C. Chap. 7).

(2) Wherever a title is referred to, it means such title of the Act.

(3) Vocational Rehabilitation Act means the act approved June 2, 1920 (41 Stat. 735), 29 U.S.C. 31–42, as amended, and as may be amended from time to time hereafter.

(b) *Secretary; Commissioner; Appeals Council; defined.* As used in this part:

(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.

(c) *Miscellaneous.* As used in this part unless otherwise indicated:

(1) *Supplemental security income benefit* means the amount to be paid to an eligible individual (or eligible individual and his eligible spouse) under title XVI of the Act.

(2) *Income* means the receipt by an individual of any property or service which he can apply, either directly or by sale or conversion, to meeting his basic needs (see subpart K of this part).

(3) *Resources* means cash or other liquid assets or any real or personal property that an individual owns and could convert to cash to be used for support and maintenance (see § 416.1201(a)).

(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) *Couple* means an eligible individual and his eligible spouse.

(6) *Institution* (see § 416.201).

(7) *Public institution* (see § 416.201).

(8) *Resident of a public institution* (see § 416.201).

(9) *State,* unless otherwise indicated, means a State of the United States, the District of Columbia, or effective January 9, 1978, the Northern Mariana Islands.

(10) The term *United States* when used in a geographical sense means the 50 States, the District of Columbia, and effective January 9, 1978, the Northern Mariana Islands.

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

(12) *Section* means a section of the regulations in part 416 of this chapter unless the context indicates otherwise.

(13) *Eligible individual* means an aged, blind, or disabled individual who meets all the requirements for eligibility for benefits under the supplemental security income program.

(14) *Eligible spouse* means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual and who is living with that individual (see § 416.1801(c)).

(d) *Periods of limitation ending on nonwork days.* Pursuant to the Act, where any provision of title XVI, 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 XVI, or any regulation of the Secretary issued under title XVI, 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 title XVI or is necessary to establish or protect any rights under title XVI 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 nonworkday 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 nonworkday 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 an application for benefits or payments may be accepted as such an application pursuant to subpart C of this part.

[39 FR 28625, Aug. 9, 1974, as amended at 43 FR 25091, June 9, 1978; 51 FR 11719, Apr. 7, 1986; 60 FR 16374, Mar. 30, 1995]

§ 416.121 Receipt of aid or assistance for December 1973 under an approved State plan under title I, X, XIV, or XVI of the Social Security Act.

(a) *Recipient of aid or assistance defined.* As used in this part 416, the term *individual who was a recipient of aid or assistance for December 1973* under a State plan approved under title I, X, XIV, or XVI of the Social Security Act means an individual who correctly received aid or assistance under such plan for December 1973 even though such aid or assistance may have been received subsequent to December 1973. It also includes an individual who filed an application prior to January 1974 and was otherwise eligible for aid or assistance for December 1973 under the provisions of such State plan but did not in fact receive such aid or assistance. It does not include an individual who received aid or assistance because of the provisions of 45 CFR 205.10(a) (pertaining to continuation of assistance until a fair hearing decision is rendered), as in effect in December 1973, and with respect to whom it is subsequently determined that such aid or assistance would not have been received without application of the provisions of such 45 CFR 205.10(a).

(b) *Aid or assistance defined.* As used in this part 416, the term *aid or assistance* means aid or assistance as defined in titles I, X, XIV, and XVI of the Social Security Act, as in effect in December 1973, and such aid or assistance is eligible for Federal financial participation in accordance with those titles and the provisions of 45 CFR Chapter II as in effect in December 1973.

(c) *Determinations of receipt of aid or assistance for December 1973.* For the purpose of application of the provisions of this part 416, the determination as to whether an individual was a recipient of aid or assistance for December 1973 under a State plan approved under title I, X, XIV, or XVI of the Social Security Act will be made by the Social

Security Administration. In making such determination, the Social Security Administration may take into consideration a prior determination by the appropriate State agency as to whether the individual was eligible for aid or assistance for December 1973 under such State plan. Such prior determination, however, shall not be considered as conclusive in determining whether an individual was a recipient of aid or assistance for December 1973 under a State plan approved under title I, X, XIV, or XVI of the Social Security Act for purposes of application of the provisions of this part 416.

(d) *Special provision for disabled recipients.* For purposes of § 416.907, the criteria and definitions enumerated in paragraphs (a) through (c) of this section are applicable in determining whether an individual was a recipient of aid or assistance (on the basis of disability) under a State plan approved under title XIV or XVI of the Act for a month prior to July 1973. It is not necessary that the aid or assistance for December 1973 and for a month prior to July 1973 have been paid under the State plan of the same State.

[39 FR 32024, Sept. 4, 1974; 39 FR 33207, Sept. 16, 1974, as amended at 51 FR 11719, Apr. 7, 1986]

Subpart B—Eligibility

AUTHORITY: Secs. 702(a)(5), 1110(b), 1602, 1611, 1614, 1615(c), 1619(a), 1631, and 1634 of the Social Security Act (42 U.S.C. 902(a)(5), 1310(b), 1381a, 1382, 1382c, 1382d(c), 1382h(a), 1383, and 1383c); secs. 211 and 212, Pub. L. 93–66, 87 Stat. 154 and 155 (42 U.S.C. 1382 note); sec. 502(a), Pub. L. 94–241, 90 Stat. 268 (48 U.S.C. 1681 note); sec. 2, Pub. L. 99–643, 100 Stat. 3574 (42 U.S.C. 1382h note).

SOURCE: 47 FR 3103, Jan. 22, 1982, unless otherwise noted.

GENERAL

§ 416.200 Introduction.

You are eligible for SSI benefits if you meet all the basic requirements listed in § 416.202. You must give us any information we request and show us necessary documents or other evidence to prove that you meet these requirements. We determine your eligibility for each month on the basis of your countable income in that month. You continue to be eligible unless you lose your eligibility because you no longer meet the basic requirements or because of one of the reasons given in §§ 416.210 through 416.214.

[50 FR 48570, Nov. 26, 1985]

§ 416.201 General definitions and terms used in this subpart.

Any 9-month period means any period of 9 full calendar months ending with any full calendar month throughout which (as defined in § 416.211) an individual is residing in a public emergency shelter for the homeless (as defined in this section) and including the immediately preceding 8 consecutive full calendar months. January 1988 is the earliest possible month in any 9-month period.

Educational or vocational training means a recognized program for the acquisition of knowledge or skills to prepare an individual for gainful employment. For purposes of these regulations, educational or vocational training does not include programs limited to the acquisition of basic life skills including but not limited to eating and dressing.

Emergency shelter means a shelter for individuals whose homelessness poses a threat to their lives or health.

Homeless individual is one who is not in the custody of any public institution and has no currently usable place to live. By *custody* we mean the care and control of an individual in a mandatory residency where the individual's freedom to come and go as he or she chooses is restricted. An individual in a public institution awaiting discharge and placement in the community is in the custody of that institution until discharged and is not homeless for purposes of this provision.

Institution means an establishment that makes available some treatment or services in addition to food and shelter to four or more persons who are not related to the proprietor.

Medical care facility means a hospital (defined in section 1861(e) of the Act), a skilled nursing facility (defined in section 1861(j) of the Act), or an intermediate care facility (defined in section 1905(c) of the Act).

Public emergency shelter for the homeless means a public institution or that part of a public institution used as an emergency shelter by the Federal government, a State, or a political subdivision of a State, primarily for making available on a temporary basis a place to sleep, food, and some services or treatment to homeless individuals. A medical facility (as defined in § 416.201) or any holding facility, detoxification center, foster care facility, or the like that has custody of the individual is not a public emergency shelter for the homeless. Similarly, transitional living arrangements such as a halfway house that are part of an insitution's plan to facilitate the individual's adjustment to community living are not public emergency shelters for the homeless.

Public institution means an institution that is operated by or controlled by the Federal government, a State, or a political subdivision of a State such as a city or county. The term *public institution* does not include a publicly operated community residence which serves 16 or fewer residents.

Resident of a public institution means a person who can receive substantially all of his or her food and shelter while living in a public institution. The person need not be receiving treatment and services available in the institution and is a resident regardless of whether the resident or anyone else pays for all food, shelter, and other services in the institution. A person is not a resident of a public institution if he or she is living in a public educational institution for the primary purpose of receiving educational or vocational training as defined in this section. A *resident* of a public institution means the same thing as an *inmate* of a public institution as used in section 1611(e)(1)(A) of the Social Security Act. (See § 416.211(b), (c), and (d) of this subpart for exceptions to the general limitation on the eligibility for Supplemental Security Income benefits of individuals who are residents of a public institution.)

SSI means supplemental security income.

State assistance means payments made by a State to an aged, blind, or disabled person under a State plan approved under title I, X, XIV, or XVI (AABD) of the Social Security Act which was in effect before the SSI Program.

We or *Us* means the Social Security Administration.

You or *Your* means the person who applies for or receives SSI benefits or the person for whom an application is filed.

[47 FR 3103, Jan. 22, 1982, as amended at 49 FR 19639, May 19, 1984; 50 FR 48570, Nov. 26, 1985; 50 FR 51517, Dec. 18, 1985; 54 FR 19164, May 4, 1989]

§ 416.202 Who may get SSI benefits.

You are eligible for SSI benefits if you meet all of the following requirements:

(a) You are—

(1) Aged 65 or older (subpart H);

(2) Blind (subpart I); or

(3) Disabled (subpart I).

(b) You are a resident of the United States (§ 416.1603), and—

(1) A citizen or a national of the United States (§ 416.1610);

(2) An alien lawfully admitted for permanent residence in the United States (§ 416.1615);

(3) An alien permanently residing in the United States under color of law (§ 416.1618); or

(4) A child of armed forces personnel living overseas as described in § 416.216.

(c) You do not have more income than is permitted (subparts K and D).

(d) You do not have more resources than are permitted (subpart L).

(e) You are disabled, drug addiction or alcoholism is a contributing factor material to the determination of disability (see § 416.935), and you have not previously received a total of 36 months of Social Security benefit payments when appropriate treatment was available or 36 months of SSI benefits on the basis of disability where drug addiction or alcoholism was a contributing factor material to the determination of disability.

(f) You file an application for SSI benefits (subpart C).

[47 FR 3103, Jan. 22, 1982, as amended at 58 FR 4897, Jan. 19, 1993; 60 FR 8149, Feb. 10, 1995; 61 FR 10277, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10277, Mar. 13, 1996, in § 416.202 paragraph (b)(4) was revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.202 Who may get SSI benefits.

* * * * *

(b) * * *

(4) A child of armed forces personnel living overseas as described in § 416.215.

* * * * *

§ 416.203 Initial determinations of SSI eligibility.

(a) *What happens when you apply for SSI benefits.* When you apply for SSI benefits we will ask you for documents and any other information we need to make sure you meet all the requirements. We will ask for information about your income and resources and about other eligibility requirements and you must answer completely. We will help you get any documents you need but do not have.

(b) *How we determine your eligibility for SSI benefits.* We determine that you are eligible for SSI benefits for a given month if you meet the requirements in § 416.202 in that month. However, we usually determine the amount of your SSI benefits for that month based on your income in an earlier month (see § 416.420). Thus, it is possible for you to meet the eligibility requirements in the given month but receive no benefit payment for that month.

[47 FR 3103, Jan. 22, 1982, as amended at 50 FR 48570, Nov. 26, 1985]

§ 416.204 Redeterminations of SSI eligibility.

(a) *Redeterminations defined.* A redetermination is a review of your eligibility to make sure that you are still eligible and that you are receiving the right amount of SSI benefits. This review deals with the requirements for eligibility other than whether you are still disabled or blind. Continuation of disability or blindness reviews are discussed in §§ 416.989 and 416.990.

(b) *When we make redeterminations.* (1) We redetermine your eligibility on a scheduled basis at periodic intervals. The length of time between scheduled redeterminations varies depending on the likelihood that your situation may change in a way that affects your benefits.

(2) We may also redetermine your eligibility when you tell us (or we otherwise learn) of a change in your situation which affects your eligibility or the amount of your benefit.

(c) *The period for which a redetermination applies:* (1) The first redetermination applies to—

(i) The month in which we make the redetermination;

(ii) All months beginning with the first day of the latest of the following:

(A) The month of first eligibility or re-eligibility; or

(B) The month of application; or

(C) The month of deferred or updated development; and

(iii) Future months until the second redetermination.

(2) All other redeterminations apply to—

(i) The month in which we make the redetermination;

(ii) All months beginning with the first day of the month the last redetermination was initiated; and

(iii) Future months until the next redetermination.

(3) If we made two redeterminations which cover the same month, the later redetermination is the one we apply to that month.

[47 FR 3103, Jan. 22, 1982, as amended at 50 FR 48570, Nov. 26, 1985; 58 FR 64893, Dec. 10, 1993]

REASONS WHY YOU MAY NOT GET SSI BENEFITS FOR WHICH YOU ARE OTHERWISE ELIGIBLE

§ 416.210 You do not apply for other benefits.

(a) *General rule.* You are not eligible for SSI benefits if you do not apply for all other benefits for which you may be eligible.

(b) *What ''other benefits'' includes.* ''Other benefits'' includes any payments for which you can apply that are available to you on an ongoing or one-time basis of a type that includes annuities, pensions, retirement benefits, or disability benefits. For example, ''other benefits'' includes veterans' compensation and pensions, workers'

compensation payments, Social Security insurance benefits and unemployment insurance benefits. ''Other benefits'' for which you are required to apply do not include payments that you may be eligible to receive from a fund established by a State to aid victims of crime. (See § 416.1124(c)(17).)

(c) *Our notice to you.* We will give you a dated, written notice that will tell you about any other benefits that we think you are likely to be eligible for. In addition, the notice will explain that your eligibility for SSI benefits will be affected if you do not apply for those other benefits.

(d) *What you must do to apply for other benefits.* In order to apply for other benefits, you must file any required applications and do whatever else is needed so that your eligibility for the other benefits can be determined. For example, if any documents (such as a copy of a birth certificate) are required in addition to the application, you must submit them.

(e) *What happens if you do not apply for the other benefits.* (1) If you do not apply for the other benefits within 30 days from the day that you receive our written notice, you are not eligible for SSI benefits. This means that if you are applying for SSI benefits, you cannot receive them. If you are receiving SSI benefits, your SSI benefits will stop. In addition, you will have to repay us for any SSI benefits that you received beginning with the month that you received our written notice. We assume (unless you prove otherwise) that you received our written notice 5 days after the date shown on the notice. We will also find that you are not eligible for SSI benefits if you file the required application for other benefits but do not take other necessary steps to obtain them.

(2) We will not find you ineligible for SSI benefits if you have a good reason for not applying for the other benefits within the 30-day period or taking other necessary steps to obtain them. In determining whether a good reason exists, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which may have caused you to fail to apply for other benefits. You may have a good reason if, for example—

(i) You are incapacitated (because of illness you were not able to apply); or

(ii) It would be useless for you to apply (you once applied for the benefits and the reasons why you were turned down have not changed).

[47 FR 3103, Jan. 22, 1982, as amended at 50 FR 5573, Feb. 11, 1985; 50 FR 14211, April 11, 1985; 59 FR 1635, Jan. 12, 1994; 61 FR 1712, Jan. 23, 1996]

§ 416.211 You are a resident of a public institution.

(a) *General rule.* (1) Subject to the exceptions described in paragraphs (b), (c), and (d) of this section and § 416.212, you are not eligible for SSI benefits for any month throughout which you are a resident of a public institution as defined in § 416.201. In addition, if you are a resident of a public institution when you apply for SSI benefits and meet all other eligibility requirements, you cannot be eligible for benefits until the day of your release from the institution. The amount of your SSI benefits for the month of your release will be prorated (see subpart D of this part) beginning with the date of your release.

(2) By *throughout a month* we mean that you reside in an institution as of the beginning of a month and stay the entire month. If you have been a resident of a public institution, you remain a resident if you are transferred from one public institution to another or if you are temporarily absent for a period of not more than 14 consecutive days. A person also is a resident of an institution throughout a month if he or she is born in the institution during the month and resides in the institution the rest of the month or resides in the institution as of the beginning of a month and dies in the institution during the month.

(b) *Exception—SSI benefits payable at a reduced rate.* You may be eligible for SSI benefits at a reduced rate described in § 416.414, if—

(1)(i) The public institution in which you reside throughout a month is a medical care facility for which Medicaid (title XIX of the Social Security Act) pays a substantial part (more than 50 percent) of the cost of your care; or

(ii) You reside for part of a month in a public institution and the rest of the month in a public institution or private medical facility where Medicaid pays more than 50 percent of the cost of your care; and

(2) You are ineligible in that month for a benefit described in § 416.212 that is payable to a person temporarily confined in a medical facility.

(c) *Exception for publicly operated community residences which serve no more than 16 residents.* (1) *General rule.* If you are a resident of a publicly operated community residence which serves no more than 16 residents, you may be eligible for SSI benefits.

(2) *Services that a facility must provide in order to be a community residence.* To be a community residence, a facility must provide food and shelter. In addition, it must make available some other services. For example, the other services could be—

(i) Social services;

(ii) Help with personal living activities;

(iii) Training in socialization and life skills; or

(iv) Providing occasional or incidental medical or remedial care.

(3) *Serving no more than 16 residents.* A community residence serves no more than 16 residents if—

(i) It is designed and planned to serve no more than 16 residents, or the design and plan were changed to serve no more than 16 residents; and

(ii) It is in fact serving 16 or fewer residents.

(4) *Publicly operated.* A community residence is publicly operated if it is operated or controlled by the Federal government, a State, or a political subdivision of a State such as a city or county.

(5) *Facilities which are not a publicly operated community residence.* If you live in any of the following facilities, you are not a resident of a publicly operated community residence:

(i) A residential facility which is on the grounds of or next to a large institution or multipurpose complex;

(ii) An educational or vocational training institution whose main function is to provide an approved, accredited, or recognized program to some or all of those who live there;

(iii) A jail or other facility where the personal freedom of anyone who lives there is restricted because that person is a prisoner, is being held under court order, or is being held until charges against that person are disposed of; or

(iv) A medical care facility (defined in § 416.201).

(d) *Exception for residents of public emergency shelters for the homeless.* For months after December 1987, if you are a resident of a public emergency shelter for the homeless (defined in § 416.201) you may be eligible for SSI benefits for any 6 months throughout which you reside in a shelter in any 9-month period (defined in § 416.201). The 6 months do not need to be consecutive and we will not count as part of the 6 months any prior months throughout which you lived in the shelter but did not receive SSI benefits. We will also not count any months throughout which you lived in the shelter and received SSI benefits prior to January 1988.

Example: You are receiving SSI benefits when you lose your home and enter a public emergency shelter for the homeless on March 10, 1988. You remain a resident of a shelter until October 10, 1988. Since you were not in the shelter throughout the month of March, you are eligible to receive your benefit for March without having this month count towards the 6-month period. The last full month throughout which you reside in the shelter is September 1988. Therefore, if you meet all eligibility requirements, you will also be paid benefits for April through September (6 months during the 9-month period September 1988 back through January 1988). If you are otherwise eligible, you will receive your SSI benefit for October when you left the shelter, since you were not a resident of the shelter throughout that month.

[47 FR 3103, Jan. 22, 1982, as amended at 50 FR 51518, Dec. 18, 1985; 51 FR 13492, Apr. 21, 1986; 51 FR 17332, May 12, 1986; 51 FR 34464, Sept. 29, 1986; 54 FR 19164, May 4, 1989; 61 FR 10277, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10277, Mar. 13, 1996, in § 416.211 paragraphs (a)(1) and (b) were revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.211 You are a resident of a public institution.

(a) * * * (1) You are not eligible for SSI benefits for any month throughout which you

are a resident of a public institution (defined in § 416.201). In addition, if you are a resident of a public institution when you first apply for SSI benefits and meet all other eligibility requirements you cannot be eligible until the day of your release from the institution. The amount of SSI benefits for the month of your release will be prorated (see subpart D) beginning with the date of your release.

* * * * *

(b) *Exception for medical care facilities.* You may be eligible for SSI benefits at the reduced rate described in § 416.414 if—

(1) The public institution in which you reside throughout a month—

(i) Is a medical care facility; and

(ii) Medicaid (title XIX of the Act) pays a substantial part (more than 50 percent) of the cost of your care; or

(2) You reside for part of a month in a public institution and for the rest of the month are in a public or private medical care facility where Medicaid pays more than 50 percent of the cost of your care.

* * * * *

§ 416.212 Continuation of full benefits in certain cases of medical confinement.

(a) *Benefits payable under section 1611(e)(1)(E) of the Social Security Act.* Subject to eligibility and regular computation rules (see subparts B and D of this part), you are eligible for the benefits payable under section 1611(e)(1)(E) of the Social Security Act for up to 2 full months of medical confinement during which your benefits would otherwise be suspended because of residence in a public institution or reduced because of residence in a public or private institution where Medicaid pays over 50 percent of the cost of your care if—

(1) You were eligible under either section 1619(a) or section 1619(b) of the Social Security Act in the month before the first full month of residence in an institution;

(2) The institution agrees that no portion of these benefits will be paid to or retained by the institution excepting nominal sums for reimbursement of the institution for any outlay for a recipient's personal needs (e.g., personal hygiene items, snacks, candy); and

(3) The month of your institutionalization is one of the first 2 full months of a continuous period of confinement.

(b) *Benefits payable under section 1611(e)(1)(G) of the Social Security Act.* (1) Subject to eligibility and regular computation rules (see subparts B and D of this part), you are eligible for the benefits payable under section 1611(e)(1)(G) of the Social Security Act for up to 3 full months of medical confinement during which your benefits would otherwise be suspended because of residence in a public institution or reduced because of residence in a public or private institution where Medicaid pays over 50 percent of the cost if—

(i) You were eligible for SSI cash benefits and/or federally administered State supplementary payments for the month immediately prior to the first full month you were a resident in such institution;

(ii) The month of your institutionalization is one of the first 3 full months of a continuous period of confinement;

(iii) A physician certifies, in writing, that you are not likely to be confined for longer than 90 full consecutive days following the day you entered the institution, and the certification is submitted to SSA no later than the day of discharge or the 90th full day of confinement, whichever is earlier; and

(iv) You need to pay expenses to maintain the home or living arrangement to which you intend to return after institutionalization and evidence regarding your need to pay these expenses is submitted to SSA no later than the day of discharge or the 90th full day of confinement, whichever is earlier.

(2) We will determine the date of submission of the evidence required in paragraphs (b)(1) (iii) and (iv) of this section to be the date we receive it or, if mailed, the date of the postmark.

(c) *Prohibition against using benefits for current maintenance.* If the recipient is a resident in an institution, the recipient or his or her representative payee will not be permitted to pay the institution any portion of benefits payable under section 1611(e)(1)(G) excepting nominal sums for reimbursement of the institution for any outlay for the recipient's personal needs (e.g., personal hygiene items, snacks, candy). If

the institution is the representative payee, it will not be permitted to retain any portion of these benefits for the cost of the recipient's current maintenance excepting nominal sums for reimbursement for outlays for the recipient's personal needs.

[61 FR 10277, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10277, Mar. 13, 1996, § 416.212 was redesignated as § 416.213 and a new § 416.212 was added, effective May 13, 1996.

§ 416.213 You do not accept vocational rehabilitation services.

If you are disabled or blind, you must accept any appropriate vocational rehabilitation services offered to you by the State agency to which we refer you. If you refuse these services, you are not eligible for benefits unless you have a good reason for not accepting them. The rules on vocational rehabilitation services are in subpart Q.

[47 FR 3103, Jan. 22, 1982. Redesignated at 61 FR 10277, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10277, Mar. 13, 1996, § 416.212 was redesignated as § 416.213, effective May 13, 1996.

§ 416.214 You are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) *If you do not comply with treatment requirements.* If you receive benefits because you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability (see § 416.935), you must avail yourself of any appropriate treatment for your drug addiction or alcoholism at an approved institution or facility when this treatment is available and make progress in your treatment. You are not eligible for SSI benefits beginning with the month after the month you are notified in writing that we determined that you have failed to comply with the treatment requirements. If your benefits are suspended because you failed to comply with treatment requirements, you will not be eligible to receive benefits until you have demonstrated compliance with treatment for a period of time, as specified in § 416.1326. The rules regarding treatment for drug addiction and alcoholism are in subpart I of this part.

(b) *If you previously received 36 months of SSI or Social Security benefits.* You are not eligible for SSI benefits by reason of disability on the basis of drug addiction or alcoholism as described in § 416.935 if—

(1) You previously received a total of 36 months of SSI benefits on the basis of disability and drug addiction or alcoholism was a contributing factor material to the determination of disability for months beginning March 1995, as described in § 416.935. Not included in these 36 months are months before March 1995 and months for which your benefits were suspended for any reason. The 36-month limit is no longer effective for months beginning after September 2004; or

(2) You previously received a total of 36 months of Social Security benefits counted in accordance with the provisions of §§ 404.316, 404.337, and 404.352 by reason of disability on the basis of drug addiction or alcoholism as described in § 404.1535.

[60 FR 8149, Feb. 10, 1995. Redesignated at 61 FR 10277, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10277, Mar. 13, 1996, § 416.213 was redesignated as § 416.214, effective May 13, 1996.

§ 416.215 You leave the United States.

You lose your eligibility for SSI benefits for any month during all of which you are outside of the United States. If you are outside of the United States for 30 days or more in a row, you are not considered to be back in the United States until you are back for 30 days in a row. You may again be eligible for SSI benefits in the month in which the 30 days end if you continue to meet all other eligibility requirements.

By *United States*, we mean the 50 States, the District of Columbia, and the Northern Mariana Islands.

[47 FR 3103, Jan. 22, 1982. Redesignated at 61 FR 10277, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10277, Mar. 13, 1996, § 416.214 was redesignated as § 416.215, effective May 13, 1996.

§ 416.216 You are a child of armed forces personnel living overseas.

(a) *General rule.* You may be eligible for continuation of SSI benefits if you live overseas and if—

(1) You are a child as described in § 416.1856;

(2) You are a citizen of the United States;

(3) You are living with a parent as described in § 416.1881 who is a member of the armed forces of the United States assigned to permanent duty ashore outside the United States; and

(4) You were eligible for an SSI benefit (including any federally administered State supplementary payment) for the month before your parent reported for such duty.

(b) *Living with.* You are considered to be living with your parent who is a member of the armed forces if—

(1) You physically live with the parent who is a member of the armed forces overseas; or

(2) You are not living in the same household as the military parent but your presence overseas is due to his or her permanent duty assignment.

[58 FR 4897, Jan. 19, 1993; 58 FR 9597, Feb. 22, 1993, as amended at 59 FR 41400, Aug. 12, 1994. Redesignated at 61 FR 10277, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10277, Mar. 13, 1996, § 416.215 was redesignated as § 416.216, effective May 13, 1996.

ELIGIBILITY FOR INCREASED BENEFITS BECAUSE OF ESSENTIAL PERSONS

§ 416.220 General.

If you are a *qualified* individual and have an essential person you may be eligible for increased benefits. You may be a qualified individual and have an essential person only if you received benefits under a State assistance plan approved under title I, X, XIV, or XVI (AABD) of the Act for December 1973. Definitions and rules that apply to qualified individuals and essential persons are discussed in §§ 416.221 through 416.223.

§ 416.221 Who is a qualified individual.

You are a qualified individual if—

(a) You received aid or assistance for the month of December 1973 under a State plan approved under title I, X, XIV, or XVI (AABD) of the Act;

(b) The State took into account the needs of another person in deciding your need for the State assistance for December 1973;

(c) That other person was living in your home in December 1973; and

(d) That other person was not eligible for State assistance for December 1973.

§ 416.222 Who is an essential person.

(a) *General rule.* A person is an essential person if—

(1) That person has continuously lived in the home of the same qualified individual since December 1973;

(2) That person was not eligible for State assistance for December 1973;

(3) That person was never eligible for SSI benefits in his or her own right or as an eligible spouse; and

(4) There are State records which show that under a State plan in effect for June 1973, the State took that person's needs into account in determining the qualified individual's need for State assistance for December 1973.

Any person who meets these requirements is an essential person. This means that the qualified individual can have more than one essential person.

(b) *Absence of an essential person from the home of a qualified individual.* An essential person may be temporarily absent from the house of a qualified individual and still be an essential person. For example, the essential person could be hospitalized. We consider an absence to temporary if—

(1) The essential person intends to return;

(2) The facts support this intention;

(3) It is likely that he or she will return; and

(4) The absence is not longer than 90 days.

(c) *Absence of a qualified individual from his or her home.* You may be temporarily absent from your home and still have an essential person. For example, you could be hospitalized. We consider an absence to be temporary if—

(1) You intend to return;

(2) The facts support your intention;

(3) It is likely that you will return; and

(4) Your absence does not exceed six months.

(d) *Essential person becomes eligible for SSI benefits.* If an essential person becomes eligible for SSI benefits, he or she will no longer be an essential person beginning with the month that he

or she becomes eligible for the SSI benefits.

§ 416.223 What happens if you are a qualified individual.

(a) *Increased SSI benefits.* We may increase the amount of your SSI benefits if—

(1) You are a qualified individual; and

(2) You have one or more essential persons in your home.

In subpart D, we explain how these increased benefits are calculated.

(b) *Income and resource limits.* If you are a qualified individual, we consider the income and resources of an essential person in your home to be yours. You are eligible for increased SSI benefits if—

(1) Your resources which are counted do not exceed the limit for SSI eligibility purposes (see subpart L); and

(2) Your income which is counted for SSI eligibility purposes (see subpart K) does not exceed the sum of—

(i) The SSI Federal benefit rate (see subpart D); and

(ii) The proper number of essential person increments (for the value of an essential person increment see subpart D). One essential person increment is added to the SSI Federal benefit rate for each essential person in your home.

(c) *Excluding the income and resources of an essential person.* (1) While an essential person increment increases your SSI Federal benefit rate, that person's income which we consider to be yours may actually result in a lower monthly payment to you. We will discuss this with you and explain how an essential person affects your benefit. If you choose to do so, you may ask us in writing to determine your eligibility without your essential person or, if you have more than one essential person, without one or more of your essential persons. We will then figure the amount of your SSI benefits without counting as your own income and resources of the essential persons that you specify and we will end the essential person increment for those essential persons. You should consider this carefully because once you make the request, you cannot withdraw it. We will make the change beginning with the month following the month that you make the request.

(2) We will not include the income and resources of the essential person if the person's income or resources would cause you to lose your eligibility. The loss of the essential person increment will be permanent.

§ 416.250 Experimental, pilot, and demonstration projects in the SSI program.

(a) *Authority and purpose.* Section 1110(b) of the Act authorizes the Secretary to develop and conduct experimental, pilot, and demonstration projects to promote the objectives or improve the administration of the SSI program. These projects will test the advantages of altering certain requirements, conditions, or limitations for recipients and test different administrative methods that apply to title XVI applicants and recipients.

(b) *Altering benefit requirements, limitations or conditions.* Notwithstanding any other provision of this part, the Secretary is authorized to waive any of the requirements, limitations or conditions established under title XVI of the Act and impose additional requirements, limitations or conditions for the purpose of conducting experimental, pilot, or demonstration projects. The projects will alter the provisions that currently apply to applicants and recipients to test their effect on the program. If, as a result of participation in a project under this section, a project participant becomes ineligible for Medicaid benefits, the Secretary shall make arrangements to extend Medicaid coverage to such participant and shall reimburse the States for any additional expenses incurred due to such continued participation.

(c) *Applicability and scope*—(1) *Participants and nonparticipants.* If you are selected to participate in an experimental, pilot, or demonstration project, we may temporarily set aside one or more current requirements, limitations or conditions of eligibility and apply alternative provisions to you. We may also modify current methods of administering title XVI 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 substantially reduce your total income

or resources as a result of your participation or disadvantage you in comparison to current provisions, policies, or procedures. If you are not selected to participate in the experimental, or pilot, or demonstration projects (or if you are placed in a control group which is not subject to the alternative requirements, limitations, or conditions) we will continue to apply the current requirements, limitations or conditions of eligibility to you.

(2) *Alternative provisions or methods of administration.* The alternative requirements, limitations or conditions that apply to you in an experimental, pilot, or demonstration project may include any of the factors needed for aged, blind, or disabled persons to be eligible for SSI benefits. Experiments that we conduct will include, to the extent feasible, applicants and recipients who are under age 18 as well as adults and will include projects to ascertain the feasibility of treating drug addicts and alcoholics.

(d) *Selection of participants.* Participation in the SSI project will be on a voluntary basis. The voluntary written consent necessary in order to participate in any experimental, pilot, or demonstration project may be revoked by the participant at any time.

(e) *Duration of experimental, pilot, and demonstration projects.* A notice describing each experimental, pilot, or demonstration project will be published in the FEDERAL REGISTER before each project is placed in operation. Each experimental, pilot and demonstration project will have a termination date (up to 10 years from the start of the project).

[48 FR 7576, Feb. 23, 1983, as amended at 52 FR 37605, Oct. 8, 1987]

SPECIAL PROVISIONS FOR PEOPLE WHO WORK DESPITE A DISABLING IMPAIRMENT

§ 416.260 General.

The regulations in §§ 416.260 through 416.269 describe the rules for determining eligibility for special SSI cash benefits and for special SSI eligibility status for an individual who works despite a disabling impairment. Under these rules an individual who works despite a disabling impairment may qualify for special SSI cash benefits and in most cases for Medicaid benefits when his or her gross earned income exceeds the applicable dollar amount which ordinarily represents SGA described in § 416.974(b)(2). The calculation of this gross earned income amount, however, is not to be considered an actual SGA determination. Also, for purposes of determining eligibility or continuing eligibility for Medicaid benefits, a blind or disabled individual (no longer eligible for regular SSI benefits or for special SSI cash benefits) who, except for earnings, would otherwise be eligible for SSI cash benefits may be eligible for a special SSI eligibility status under which he or she is considered to be a blind or disabled individual receiving SSI benefits. We explain the rules for eligibility for special SSI cash benefits in §§ 416.261 and 416.262. We explain the rules for the special SSI eligibility status in §§ 416.264 through 416.269.

[59 FR 41403, Aug. 12, 1994]

§ 416.261 What are special SSI cash benefits and when are they payable.

Special SSI cash benefits are benefits that we may pay you in lieu of regular SSI benefits because your gross earned income in a month of initial eligibility for regular SSI benefits exceeds the amount ordinarily considered to represent SGA under § 416.974(b)(2). You must meet the eligibility requirements in § 416.262 in order to receive special SSI cash benefits. Special SSI cash benefits are not payable for any month in which your countable income exceeds the limits established for the SSI program (see subpart K of this part). If you are eligible for special SSI cash benefits, we consider you to be a disabled individual receiving SSI benefits for purposes of eligibility for Medicaid. We compute the amount of special SSI cash benefits according to the rules in subpart D of this part. If your State makes supplementary payments which we administer under a Federal-State agreement, and if your State elects to supplement the special SSI cash benefits, the rules in subpart T of this part will apply to these payments.

[47 FR 15324, Apr. 9, 1982, as amended at 50 FR 46763, Nov. 13, 1985; 59 FR 41403, Aug. 12, 1994]

§ 416.262 Eligibility requirements for special SSI cash benefits.

You are eligible for special SSI cash benefits if you meet the following requirements—

(a) You were eligible for a regular SSI benefit or a federally administered State supplementary payment (see § 416.2001) in a month before the month for which we are determining your eligibility for special SSI cash benefits as long as that month was not in a prior period of eligibility which has terminated according to §§ 416.1331 through 416.1335;

(b) In the month for which we are making the determination, your gross earned income exceeds the amount ordinarily considered to represent SGA under § 416.974(b)(2);

(c) You continue to have a disabling impairment;

(d) If your disability is based on a determination that drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 416.935, you have not yet received SSI cash benefits, special SSI cash benefits, or special SSI eligibility status for a total of 36 months, or Social Security benefit payments when treatment was available for a total of 36 months; and

(e) You meet all the nondisability requirements for eligibility for SSI benefits (see § 416.202).

We will follow the rules in this subpart in determining your eligibility for special SSI cash benefits.

[47 FR 15324, Apr. 9, 1982, as amended at 59 FR 41404, Aug. 12, 1994; 60 FR 8149, Feb. 10, 1995]

§ 416.263 No additional application needed.

We do not require you to apply for special cash benefits nor is it necessary for you to apply to have the special SSI eligibility status determined. We will make these determinations automatically.

[47 FR 15324, Apr. 9, 1982]

§ 416.264 When does the special SSI eligibility status apply.

The special SSI eligibility status applies for the purposes of establishing or maintaining your eligibility for Medicaid. For these purposes we continue to consider you to be a blind or disabled individual receiving benefits even though you are in fact no longer receiving regular SSI benefits or special SSI cash benefits. You must meet the eligibility requirements in § 416.265 in order to qualify for the special SSI eligibility status. Special SSI eligibility status also applies for purposes of reacquiring status as eligible for regular SSI benefits or special SSI cash benefits.

[59 FR 41404, Aug. 12, 1994]

§ 416.265 Requirements for the special SSI eligibility status.

In order to be eligible for the special SSI eligibility status, you must have been eligible to receive a regular SSI benefit or a federally administered State supplementary payment (see § 416.2001) in a month before the month for which we are making the special SSI eligibility status determination. The month you were eligible for a regular SSI benefit or a federally administered State supplementary payment may not be in a prior period of eligibility which has been terminated according to §§ 416.1331 through 416.1335. For periods prior to May 1, 1991, you must be under age 65. Also, we must establish that:

(a) You are blind or you continue to have a disabling impairment which, if drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 416.935, has not resulted in your receiving SSI cash benefits, special SSI cash benefits, or special SSI eligibility status for a total of 36 months, or Social Security benefit payments when treatment was available for a total of 36 months;

(b) Except for your earnings, you meet all the nondisability requirements for eligibility for SSI benefits (see § 416.202);

(c) The termination of your eligibility for Medicaid would seriously inhibit your ability to continue working (see § 416.268); and

(d) Your earnings after the exclusions in § 416.1112(c) (6), (8), and (9) are not sufficient to allow you to provide yourself with a reasonable equivalent of the

benefits (SSI benefits, federally administered State supplementary payments, Medicaid, and publicly-funded attendant care services, including personal care assistance under § 416.269(d)) which would be available to you if you did not have those earnings (see § 416.269).

[47 FR 15324, Apr. 9, 1982, as amended at 59 FR 41404, Aug. 12, 1994; 59 FR 49291, Sept. 27, 1994; 60 FR 8149, Feb. 10, 1995]

§ 416.266 Continuation of SSI status for Medicaid

If we stop your benefits because of your earnings and you are potentially eligible for the special SSI eligibility status you will continue to be considered an SSI recipient for purposes of eligibility for Medicaid during the time it takes us to determine whether the special eligibility status applies to you.

[47 FR 15324, Apr. 9, 1982]

§ 416.267 General.

We determine whether the special SSI eligibility status applies to you by verifying that you continue to be blind or have a disabling impairment by applying the rules in subpart I of this part, and by following the rules in this subpart to determine whether you meet the requirements in § 416.265(b). If you do not meet these requirements we determine that the special eligibility status does not apply. If you meet these requirements, then we apply special rules to determine if you meet the requirements of § 416.265(c) and (d). If for the period being evaluated, you meet all of the requirements in § 416.265 we determine that the special status applies to you.

[47 FR 15324, Apr. 9, 1982]

§ 416.268 What is done to determine if you must have Medicaid in order to work.

For us to determine that you need Medicaid benefits in order to continue to work, you must establish:

(a) That you are currently using or have received services which were paid for by Medicaid during the period which began 12 months before our first contact with you to discuss this use; or

(b) That you expect to use these services within the next 12 months; or

(c) That you would need Medicaid to pay for unexpected medical expenses in the next 12 months.

[59 FR 41404, Aug. 12, 1994]

§ 416.269 What is done to determine whether your earnings are too low to provide comparable benefits and services you would receive in the absence of those earnings.

(a) *What we determine.* We must determine whether your earnings are too low to provide you with benefits and services comparable to the benefits and services you would receive if you did not have those earnings (see § 416.265(d)).

(b) *How the determination is made.* In determining whether your earnings are too low to provide you with benefits and services comparable to the benefits and services you would receive if you did not have those earnings, we compare your anticipated gross earnings (or a combination of anticipated and actual gross earnings, as appropriate) for the 12-month period beginning with the month for which your special SSI eligibility status is being determined to a threshold amount for your State of residence. This threshold amount consists of the sum for a 12-month period of two items, as follows:

(1) The amount of gross earnings including amounts excluded under § 416.1112(c) (4), (5) and (7) that would reduce to zero the Federal SSI benefit and the optional State supplementary payment for an individual with no other income living in his or her own household in the State where you reside. This amount will vary from State to State depending on the amount of the State supplementary payment; and

(2) The average expenditures for Medicaid benefits for disabled and blind SSI cash recipients, including recipients of federally administered State supplementary payments only, in your State of residence.

(c) *How the eligibility requirements are met.* (1) You meet the requirements in § 416.265(d) if the comparison shows that your gross earnings are equal to or less than the applicable threshold amount for your State, as determined under paragraphs (b) (1) and (2) of this section. However, if the comparison shows that these earnings exceed the

applicable threshold amount for your State, we will establish (and use in a second comparison) an individualized threshold taking into account the total amount of:

(i) The amount determined under paragraph (b)(1) of this section that would reduce to zero the Federal SSI benefit and State supplementary payment for your actual living arrangement;

(ii) The average Medicaid expenditures for your State of residence under paragraph (b)(2) of this section or, if higher, your actual medical expenditures in the appropriate 12-month period;

(iii) Any amounts excluded from your income as impairment-related work expenses (see § 416.1112(c)(6)), work expenses of the blind (see § 416.1112(c)(8)), and income used or set aside for use under an approved plan for achieving self support (see § 416.1112(c)(9)); and

(iv) the value of any publicly-funded attendant care services as described in paragraph (d) of this section (including personal care assistance).

(2) If you have already completed the 12-month period for which we are determining your eligibility, we will consider only the expenditures made in that period.

(d) *Attendant care services.* Expenditures for attendant care services (including personal care assistance) which would be available to you in the absence of earnings that make you ineligible for SSI cash benefits will be considered in the individualized threshold (as described in paragraph (c)(1) of this section) if we establish that they are:

(1) Provided by a paid attendant;

(2) Needed to assist with work-related and/or personal functions; and

(3) Paid from Federal, State, or local funds.

(e) *Annual update of information.* The threshold amounts used in determinations of sufficiency of earnings will be based on information and data updated no less frequently than annually.

[59 FR 41404, Aug. 12, 1994; 59 FR 49291, Sept. 27, 1994]

Subpart C—Filing of Applications

AUTHORITY: Secs. 702(a)(5), 1611, and 1631 (a), (d), and (e) of the Social Security Act (42 U.S.C. 902(a)(5), 1382, and 1383 (a), (d), and (e)).

SOURCE: 45 FR 48120, July 18, 1980, unless otherwise noted.

GENERAL PROVISIONS

§ 416.301 Introduction.

This subpart contains the rules for filing a claim for supplemental security income (SSI) benefits. It tells you what an application is, who may sign it, who must file one to be eligible for benefits, the period of time it is in effect, and how it may be withdrawn. It also tells you when a written statement or an oral inquiry may be considered to establish an application filing date.

§ 416.302 Definitions.

For the purpose of this subpart—

Benefits means any payments made under the SSI program. SSI benefits also include any federally administered State supplementary payments.

Claimant means the person who files an application for himself or herself or the person on whose behalf an application is filed.

We or *us* means the Social Security Administration (SSA).

You or *your* means the person who applies for benefits, the person for whom an application is filed or anyone who may consider applying for benefits.

§ 416.305 You must file an application to receive supplemental security income benefits.

(a) *General rule.* In addition to meeting other requirements, you must file an application to become eligible to receive benefits. If you believe you may be eligible, you should file an application as soon as possible. Filing an application will—

(1) Permit us to make a formal determination whether or not you are eligible to receive benefits;

(2) Assure that you receive benefits for any months you are eligible; and

(3) Give you the right to appeal if you disagree with the determination.

(b) *Exceptions.* You need not file a new application if—

(1) You have been receiving benefits as an eligible spouse and are no longer living with your husband or wife;

(2) You have been receiving benefits as an eligible spouse of an eligible individual who has died;

(3) You have been receiving benefits because you are disabled or blind and you are 65 years old before the date we determine that you are no longer blind or disabled.

(4) A redetermination of your eligibility is being made and it is found that you were not eligible for benefits during any part of a period for which we are making a redetermination but you currently meet the requirements for eligibility;

(5) You are notified that your payments of SSI benefits will be stopped because you are no longer eligible and you again meet the requirements for eligibility before your appeal rights are exhausted.

[45 FR 48120, July 18, 1980, as amended at 60 FR 16374, Mar. 30, 1995]

APPLICATIONS

§ 416.310 What makes an application a claim for benefits.

An application will be considered a claim for benefits, if the following requirements are met:

(a) An application form prescribed by us must be filled out.

(b) It must be filed at a social security office, at another Federal or State office we have designated to receive applications for us, or with a person we have authorized to receive applications for us. See § 416.325.

(c) The claimant or someone who may sign an application for the claimant must sign the application. See §§ 416.315 and 416.320.

(d) The claimant must be alive at the time the application is filed. See §§ 416.340, 416.345, and 416.351 for exceptions.

[45 FR 48120, July 18, 1980, as amended at 59 FR 44926, Aug. 31, 1994]

§ 416.315 Who may sign an application.

We will determine who may sign an application according to the following rules:

(a) If you are 18 years old or over, mentally competent, and physically able, you must sign your own application. If you are 16 years old or older and under age 18, you may sign the application if you are mentally competent, have no court appointed representative, and are not in the care of any other person or institution.

(b) If the claimant is under age 18, or is mentally incompetent, or is physically unable to sign the application, a court appointed representative or a person who is responsible for the care of the claimant, including a relative, may sign the application. If the claimant is in the care of an institution, the manager or principal officer of the institution may sign the application.

(c) To prevent a claimant from losing benefits because of a delay in filing an application when there is a good reason why the claimant cannot sign an application, we may accept an application signed by someone other than a person described in this section.

Example: Mr. Smith comes to a Social Security office to file an application for SSI disability benefits for Mr. Jones. Mr. Jones, who lives alone, just suffered a heart attack and is in the hospital. He asked Mr. Smith, whose only relationship is that of a neighbor and friend, 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 at this time. SSI benefits are payable starting with the day an application is filed or the date all other requirements for eligibility are met, whichever is later. If Mr. Smith could not sign an application for Mr. Jones, a loss of benefits would result if it is later determined that Mr. Jones is in fact disabled.

[45 FR 48120, July 18, 1980, as amended at 51 FR 13492, Apr. 21, 1986]

§ 416.320 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. If the person signing is the manager or principal officer of an institution he or she should show his or her title.

(b) We may, at any time, require additional evidence to establish the authority of a person to sign an application for someone else.

[45 FR 48120, July 18, 1980, as amended at 51 FR 13493, Apr. 21, 1986]

§ 416.325 When an application is considered filed.

(a) *General rule.* We consider an application for SSI benefits filed on the day it is received by an employee at any social security office, by someone at another Federal or State office designated to receive applications for us, or by a person we have authorized to receive applications for us.

(b) *Exceptions.* (1) When we receive an application that is mailed, we will use the date shown by the United States postmark as the filing date if using the date the application is received will result in a loss of benefits. If the postmark is unreadable or there is no postmark, we will use the date the application is signed (if dated) or 5 days before the day we receive the signed application, whichever date is later.

(2) We consider an application to be filed on the date of the filing of a written statement or the making of an oral inquiry under the conditions in §§ 416.340, 416.345 and 416.350.

(3) We will establish a ''deemed'' filing date of an application in a case of misinformation under the conditions described in § 416.351. The filing date of the application will be a date determined under § 416.351(b).

[45 FR 48120, July 18, 1980, as amended at 51 FR 13493, Apr. 21, 1986; 59 FR 44926, Aug. 31, 1994]

EFFECTIVE FILING PERIOD OF APPLICATION

§ 416.330 Filing before the first month you meet the requirements for eligibility.

If you file an application for SSI benefits before the first month you meet all the other requirements for eligibility, the application will remain in effect until we make a final determination on your application unless there is a hearing decision on your application. If there is a hearing decision, your application will remain in effect until the hearing decision is issued.

(a) If you meet all the requirements for eligibility while your application is in effect, we will pay you benefits from the first month that you meet all the requirements. The amount of such benefits is based on the number of days you meet all eligibility requirements beginning with the first day you meet all of the requirements through the end of the month.

(b) If you first meet all the requirements for eligibility after the period for which your application was in effect, you must file a new application for benefits. In this case, we will pay you benefits only from the first month that you meet all the requirements based on the new application. The amount of such benefits is calculated as in § 416.330(a) above.

[51 FR 13493, Apr. 21, 1986]

§ 416.335 Filing in or after the month you meet the requirements for eligibility.

When you file an application in the month that you meet all the other requirements for eligibility, your application is good for payment as of the first day in the month that you meet all eligibility requirements. If you file an application after the month you first meet all the other requirements for eligibility, you cannot be paid for any months before the month you filed an application. See §§ 416.340, 416.345 and 416.350 on how a written statement or an oral inquiry made before the filing of the application form may affect the filing date of the application. The amount of SSI benefits you are paid in

the first month that you meet all eligibility requirements is based on the number of days you meet all such requirements, starting with the first day on which you meet all eligibility requirements through the end of the month.

[51 FR 13493, Apr. 21, 1986]

FILING DATE BASED UPON A WRITTEN STATEMENT OR ORAL INQUIRY

§ 416.340 Use of date of written statement as application filing date.

We will use the date a written statement, such as a letter, an SSA questionnaire or some other writing, is received at a social security office, at another Federal or State office designated by us, or by a person we have authorized to receive applications for us as the filing date of an application for benefits, only if the use of that date will result in your eligibility for additional benefits. If the written statement is mailed, we will use the date the statement was mailed to us as shown by a United States postmark. If the postmark is unreadable or there is no postmark, we will use the date the statement is signed (if dated) or 5 days before the day we receive the written statement, whichever date is later, as the filing date of an application for benefits. In order for us to use your written statement to protect your filing date, the following requirements must be met:

(a) The written statement shows an intent to claim benefits for yourself or for another person.

(b) You, your spouse or a person who may sign an application for you signs the statement.

(c) An application form signed by you or by a person who may sign an application for you is filed with us within 60 days after the date of a notice we will send telling of the need to file an application. The notice will say that we will make an initial determination of eligibility for SSI benefits if an application form is filed within 60 days after the date of the notice. (We will send the notice to the claimant, or where he or she is a minor or incompetent, to the person who gave us the written statement.)

(d)(1) The claimant is alive when the application is filed on a prescribed form, or

(2) If the claimant dies after the written statement is filed, the deceased claimant's surviving spouse or parent(s) who could be paid the claimant's benefits under § 416.542(b), or someone on behalf of the surviving spouse or parent(s) files an application form. If we learn that the claimant has died before the notice is sent or within 60 days after the notice but before an application form is filed, we will send a notice to such a survivor. The notice will say that we will make an initial determination of eligibility for SSI benefits only if an application form is filed on behalf of the deceased within 60 days after the date of the notice to the survivor.

[45 FR 48120, July 18, 1980, as amended at 51 FR 13493, Apr. 21, 1986; 58 FR 52912, Oct. 13, 1993]

§ 416.345 Use of date of oral inquiry as application filing date.

We will use the date of an oral inquiry about SSI benefits as the filing date of an application for benefits only if the use of that date will result in your eligibility for additional benefits and the following requirements are met:

(a) The inquiry asks about the claimant's eligibility for SSI benefits.

(b) The inquiry is made by the claimant, the claimant's spouse, or a person who may sign an application on the claimant's behalf as described in § 416.315.

(c) The inquiry, whether in person or by telephone, is directed to an office or an official described in § 416.310(b).

(d) The claimant or a person on his or her behalf as described in § 416.315 files an application on a prescribed form within 60 days after the date of the notice we will send telling of the need to file an application. The notice will say that we will make an initial determination of eligibility for SSI benefits if an application form is filed within 60 days after the date of the notice. (We will send the notice to the claimant or, where he or she is a minor or incompetent, to the person who made the inquiry.)

(e)(1) The claimant is alive when the application is filed on a prescribed form, or

(2) If the claimant dies after the oral inquiry is made, the deceased claimant's surviving spouse or parent(s) who could be paid the claimant's benefits under § 416.542(b), or someone on behalf of the surviving spouse or parent(s) files an application form. If we learn that the claimant has died before the notice is sent or within 60 days after the notice but before an application form is filed, we will send a notice to such a survivor. The notice will say that we will make an initial determination of eligibility for SSI benefits only if an application form is filed on behalf of the deceased within 60 days after the date of the notice to the survivor.

[45 FR 48120, July 18, 1980, as amended at 51 FR 13493, Apr. 21, 1986; 58 FR 52912, Oct. 13, 1993]

§ 416.350 Treating a title II application as an oral inquiry about SSI benefits.

(a) When a person applies for benefits under title II (retirement, survivors, or disability benefits) we will explain the requirements for receiving SSI benefits and give the person a chance to file an application for them if—

(1) The person is within 2 months of age 65 or older or it looks as if the person might qualify as a blind or disabled person, and

(2) It is not clear that the person's title II benefits would prevent him or her from receiving SSI or any State supplementary benefits handled by the Social Security Administration.

(b) If the person applying for title II benefits does not file an application for SSI on a prescribed form when SSI is explained to him or her, we will treat his or her filing of an application for title II benefits as an oral inquiry about SSI, and the date of the title II application form may be used to establish the SSI application date if the requirements of § 416.345(d) and (e) are met.

DEEMED FILING DATE BASED ON MISINFORMATION

§ 416.351 Deemed filing date in a case of misinformation.

(a) *General.* You may have considered applying for SSI 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: Ms. Jones calls a Social Security office to inquire about filing an application for SSI benefits. During her conversation with an SSA employee, she tells the employee about her resources. The SSA employee tells Ms. Jones that because her countable resources are above the allowable limit, she would be ineligible for SSI benefits. The employee fails to consider certain resource exclusions under the SSI program which would have reduced Ms. Jones' countable resources below the allowable limit, making her eligible for benefits. Because Ms. Jones thought that she would be ineligible, she decides not to file an application for SSI benefits. Ms. Jones later reads about resource exclusions under the SSI program. She recontacts the Social Security office to file an SSI application, and alleges that she had been previously misinformed about her eligibility for SSI benefits. She files an application for SSI 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 upon her receipt of misinformation.

Example 2: Mr. Adams resides in a State which provides State supplementary payments that are administered by SSA under the SSI program. He telephones a Social Security office and tells an SSA employee that he does not have enough income to live on and wants to file for SSI benefits. Mr. Adams states that his only income is his monthly Social Security benefit check. The SSA employee checks Mr. Adams' Social Security record and advises him that he is ineligible for SSI benefits based on the amount of his

monthly Social Security benefit. The employee does not consider whether Mr. Adams would be eligible for State supplementary payments. Because Mr. Adams was told that he would not be eligible for benefits under the SSI program, he does not file an application. The employee does not make a record of Mr. Adams' oral inquiry or take any other action. A year later, Mr. Adams speaks to a neighbor who receives the same Social Security benefit amount that Mr. Adams does, but also receives payments under the SSI program. Thinking the law may have changed, Mr. Adams recontacts a Social Security office and learns from an SSA employee that he would be eligible for State supplementary payments under the SSI program and that he could have received these payments earlier had he filed an application. Mr. Adams explains that he did not file an application earlier because he was told by an SSA employee that he was not eligible for SSI benefits. Mr. Adams files an application for the 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 him 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 SSI benefits under the following provisions.

(1)(i) If we determine that you failed to apply for SSI 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 eligibility for 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 § 416.315 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 a person who would be qualified under § 416.542(b) to receive any benefits due you, or someone on his or her behalf, files an application for the benefits.

(2)(i) If you had authority under § 416.315 to sign an application for benefits for another person, and we determine that you failed to apply for SSI 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 eligibility for 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 § 416.315 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 a person who would be qualified under § 416.542(b) to receive any benefits due the deceased person, or someone on his behalf, files an application for the benefits.

(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 SSI Benefit Estimate Letter that is based on an individual's reported and projected income 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 SSI 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 eligible for benefits (or again could be eligible for 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 § 416.1488; 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 eligible for benefits or for 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 § 416.1488.

(g) *Effective date.* This section applies only to misinformation which we provided on or after December 19, 1989. In addition, this section is effective only for benefits payable for months after December 1989.

[59 FR 44926, Aug. 31, 1994]

WITHDRAWAL OF APPLICATION

§ 416.355 Withdrawal of an application.

(a) *Request for withdrawal filed before we make a determination.* If you make a request to withdraw your application before we make a determination on your claim, we will approve the request if the following requirements are met:

(1) You or a person who may sign an application for you signs a written request to withdraw the application and files it at a place described in § 416.325.

(2) You are alive when the request is filed.

(b) *Request for withdrawal filed after a determination is made.* If you make a request to withdraw your application after we make a determination on your claim, we will approve the request if the following requirements are met:

(1) The conditions in paragraph (a) of this section are met.

(2) Every other person who may lose benefits because of the withdrawal consents in writing (anyone who could sign an application for that person may give the consent).

(3) All benefits already paid based on the application are repaid or we are satisfied that they will be repaid.

(c) *Effect of withdrawal.* If we approve your request to withdraw an application, we will treat the application as though you never filed it. If we disapprove your request for withdrawal, we will treat the application as though you never requested the withdrawal.

§ 416.360 Cancellation of a request to withdraw.

You may cancel your request to withdraw your application and your application will still be good if the following requirements are met:

(a) You or a person who may sign an application for you signs a written request for cancellation and files it at a place described in § 416.325.

(b) You are alive at the time the request for cancellation is filed.

(c) For a cancellation request received after we have approved the withdrawal, the cancellation request is filed no later than 60 days after the date of the notice of approval of the withdrawal request.

Subpart D—Amount of Benefits

AUTHORITY: Secs. 702(a)(5), 1611 (a), (b), (c), and (e), 1612, 1617, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1382 (a), (b), (c), and (e), 1382a, 1382f, and 1383).

§ 416.401 Scope of subpart.

This subpart D sets forth basic guidelines for establishing the amount of monthly benefits payable to an eligible individual or couple (as defined in § 416.120(c)(5)). This subpart does not contain provisions with respect to establishing the amount of State supplementary payments payable in accordance with an agreement entered into between a State and the Administration under the provisions of subpart T of this part. Provisions with respect to determination and payment of State supplementary payments under such agreements will be administered by the Administration in accordance with the terms set forth in such agreements.

[39 FR 23053, June 26, 1974]

§ 416.405 Cost-of-living adjustments in benefits.

Whenever benefit amounts under title II of the Act (part 404 of this chapter) are increased by any percentage effective with any month as a result of a determination made under Section 215(i) of the Act, each of the dollar amounts in effect for such month under §§ 416.410, 416.412, and 416.413, as specified in such sections or as previously increased under this section or under any provision of the Act, will be increased. We will increase the unrounded yearly SSI benefit amount by the same percentage by which the title II benefits are being increased based on the Consumer Price Index, or, if greater, the percentage they would be increased if the rise in the Consumer Price Index were currently the basis for the title II increase. (See §§ 404.270–404.277 for an explanation of how the title II cost-of-living adjustment is computed.) If the increased annual SSI benefit amount is not a multiple of $12, it will be rounded to the next lower multiple of $12.

[51 FR 12606, Apr. 21, 1986; 51 FR 16016, Apr. 30, 1986]

§ 416.410 Amount of benefits; eligible individual.

The benefit under this part for an eligible individual (including the eligible individual receiving benefits payable under the § 416.212 provisions) who does not have an eligible spouse, who is not subject to either benefit suspension under § 416.1325 or benefit reduction under § 416.414, and who is not a qualified individual (as defined in § 416.221) shall be payable at the rate of $5,640 per year ($470 per month) effective for the period beginning January 1, 1996. This rate is the result of a 2.6 percent cost-of-living adjustment (see § 416.405) to the December 1995 rate. For the period January 1, through December 31, 1995, the rate payable, as increased by the 2.8 percent cost-of-living adjustment, was $5,496 per year ($458 per month). For the period January 1, through December 31, 1994, the rate payable, as increased by the 2.6 percent cost-of-living adjustment, was $5,352 per year ($446 per month). The monthly rate is reduced by the amount of the individual's income which is not excluded pursuant to subpart K of this part.

[61 FR 10278, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10278, Mar. 13, 1996, § 416.410 was revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.410 Amounts of benefits; eligible individual.

The benefit under this part for an eligible individual who does not have an eligible spouse, who is not in a certain kind of institution (see § 416.211), and who is not a qualified individual (as defined in § 416.221), shall be payable at the rate of $4,032 per year ($336 per month) after rounding, effective for the period beginning January 1, 1986. This rate is the result of a 3.1 percent cost-of-living adjustment (see § 416.405) to the December 1985 rate. For the period January 1, 1985 through December 31, 1985, the rate payable, as increased by the 3.5 percent cost-of-living adjustment, was $3900 ($325 per month). For the period January 1, 1984 through December 31, 1984, the rate payable, as increased by the 3.5 percent cost-of-living adjustment, was $3,768 per year ($314 per month). For the period of July 1, 1983, through December 31, 1983, the rate payable was $3,651.60 per year ($304.30 per month), as provided by the Social Security Amendments of 1983 (Pub. L. 98–21, section 401). For the period July 1, 1982, through

June 30, 1983 the rate, as increased by the 7.4 percent cost-of-living adjustment, was $3,411.60 yearly ($284.30 monthly). The monthly rate is reduced by the amount of the individual's income which is not excluded pursuant to subpart K of this part.

[51 FR 12606, Apr. 21, 1986]

§ 416.412 Amount of benefits; eligible couple.

The benefit under this part for an eligible couple (including couples where one or both members of the couple are receiving benefits payable under the § 416.212 provisions), neither of whom is subject to suspension of benefits based on § 416.1325 or reduction of benefits based on § 416.414 nor is a qualified individual (as defined in § 416.221) shall be payable at the rate of $8,460 per year ($705 per month), effective for the period beginning January 1, 1996. This rate is the result of a 2.6 percent cost-of-living adjustment (see § 416.405) to the December 1995 rate. For the period January 1, through December 31, 1995, the rate payable, as increased by the 2.8 percent cost-of-living adjustment, was $8,224 per year ($687 per month). For the period January 1, through December 31, 1994, the rate payable, as increased by the 2.6 percent cost-of-living adjustment, was $8,028 per year ($669 per month). The monthly rate is reduced by the amount of the couple's income which is not excluded pursuant to subpart K of this part.

[61 FR 10278, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10278, Mar. 13, 1996, § 416.412 was revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.412 Amount of benefits; eligible couple.

The benefit under this part for an eligible couple, neither of whom is temporarily residing in a medical care facility as described in § 416.1149(c)(1) nor is a qualified individual (as defined in § 416.211), shall be payable at the following rate:

Effective date	Percentage increase	Rate per year	Rate per month
07/82	7.4	$5,116.80	$426.40
07/83	3.5	5,476.80	456.40
01/84	3.5	5,664.00	472.00
01/85	3.5	5,856.00	488.00
01/86	3.1	6,048.00	504.00
01/87	1.3	6,120.00	510.00
01/88	4.2	6,384.00	532.00
01/89	4.0	6,636.00	553.00
01/90	4.7	6,948.00	579.00
01/91	5.4	7,320.00	610.00
01/92	3.7	7,596.00	633.00
01/93	3.0	7,824.00	652.00
01/94	2.6	8,028.00	669.00
01/95	2.8	8,244.00	687.00

The monthly rate is reduced by the amount of the couple's income which is not excluded pursuant to subpart K of this part.

[60 FR 16374, Mar. 30, 1995]

§ 416.413 Amount of benefits; qualified individual.

The benefit under this part for a qualified individual (defined in § 416.221) is payable at the rate for an eligible individual or eligible couple plus an increment for each essential person (defined in § 416.222) in the household, reduced by the amount of countable income of the eligible individual or eligible couple as explained in § 416.420. A qualified individual will receive an increment of $2,820 per year ($235 per month), effective for the period beginning January 1, 1996. This rate is the result of the 2.6 percent cost-of-living adjustment (see § 416.405) to the December 1995 rate, and is for each essential person (as defined in § 416.222) living in the household of a qualified individual. (See § 416.532.) For the period January 1, through December 31, 1995, the rate payable, as increased by the 2.8 percent cost-of-living adjustment, was $2,748 per year ($229 per month). For the period January 1, through December 31, 1994, the rate payable, as increased by the 2.6 percent cost-of-living adjustment, was $2,676 per year ($223 per month). The total benefit rate, including the increment, is reduced by the amount of the individual's or couple's income that is not excluded pursuant to subpart K of this part.

[61 FR 10278, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10278, Mar. 13, 1996, § 416.413 was revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.413 Amount of benefits; qualified individual.

The benefit under this part for a qualified individual (defined in § 416.221) is payable at the rate for an eligible individual or eligible couple plus an increment for each essential

person (defined in § 416.222) in the household, reduced by the amount of countable income of the eligible individual or eligible couple as explained in § 416.420. A qualified individual will receive an increment of $2,016 per year ($168 per month) after rounding, effective for the period beginning January 1, 1986. This rate is the result of a 3.1 percent cost-of-living adjustment (see § 416.405) to the December 1985 rate, and is for each essential person (as defined in § 416.222) living in the household of a qualified individual. (See § 416.532.) For the period January 1, 1985 through December 31, 1985, the rate payable, as increased by the 3.5 percent cost-of-living adjustment, was $1,956 ($163 per month). For the period January 1, 1984 through December 31, 1984, the rate payable, as increased by the 3.5 percent cost-of-living adjustment, was $1,884 per year ($157 per month). For the period July 1, 1983, through December 31, 1983, the rate was $1,830 per year ($152.50 per month), as provided by the Social Security Amendments of 1983 (Pub. L. 98–21, section 401). For the period July 1, 1982, through June 30, 1983, the rate, as increased by the 7.4 percent cost-of-living adjustment, was $1,710 yearly ($142.50 monthly). The total benefit rate, including the increment, is reduced by the amount of the individual's or couple's income that is not excluded pursuant to subpart K of this part.

[51 FR 12606, Apr. 21, 1986]

§ 416.414 Amount of benefits; eligible individual or eligible couple in a medical care facility.

(a) *General rule.* Except where the § 416.212 provisions provide for payment of benefits at the rates specified under §§ 416.410 and 416.412, reduced SSI benefits are payable to persons and couples who are in medical care facilities where more than 50 percent of the cost of their care is paid by a State plan under title XIX of the Social Security Act (Medicaid). This reduced SSI benefit rate also applies to persons who are in medical care facilities where more than 50 percent of the cost would have been paid by an approved Medicaid State plan but for the application of section 1917(c) of the Social Security Act due to a transfer of assets for less than fair market value. Persons and couples to whom these reduced benefits apply are—

(1) Those who are otherwise eligible and who are in the medical care facility throughout a month (By *throughout a month* we mean that you are in the medical care facility as of the beginning of the month and stay the entire month. If you are in a medical care facility you will be considered to have continuously been staying there if you are transferred from one medical care facility to another or if you are temporarily absent for a period of not more than 14 consecutive days.); and

(2) Those who reside for part of a month in a public institution and for the rest of the month are in a public or private medical care facility where Medicaid pays or would have paid (but for the application of section 1917(c) of the Act) more than 50 percent of the cost of their care.

(b) *The benefit rates are*—(1) *Eligible individual.* For months after June 1988, the benefit rate for an eligible individual with no eligible spouse is $30 per month. The benefit payment is figured by subtracting the eligible individual's countable income (see subpart K) from the benefit rate as explained in § 416.420.

(2) *Eligible couple both of whom are temporarily absent from home in medical care facilities as described in § 416.1149(c)(1).* For months after June 1988, the benefit rate for a couple is $60 a month. The benefit payment is figured by subtracting the couple's countable income (see subpart K) from the benefit rate as explained in § 416.420.

(3) *Eligible couple with one spouse who is temporarily absent from home as described in § 416.1149(c)(1).* The couple's benefit rate equals:

(i) For months after June 1988, $30 per month for the spouse in the medical care facility; plus

(ii) The benefit rate for an eligible individual (see § 416.410) for the spouse who is not in the medical care facility. The benefit payment for each spouse is figured by subtracting each individual's own countable income in the appropriate month (see § 416.420) from his or her portion of the benefit rate shown in paragraphs (b)(3)(i) and (ii).

(c) *Definition.* For purposes of this section a *medical care facility* means a hospital (see section 1861(e) of the Act), a skilled nursing facility (see section 1861(j) of the Act) or an intermediate

care facility (see section 1905(c) of the Act).

[47 FR 3106, Jan. 22, 1982, as amended at 50 FR 48571, Nov. 26, 1985; 50 FR 51514, Dec. 18, 1985; 54 FR 19164, May 4, 1989; 58 FR 64894, Dec. 10, 1993; 60 FR 16374, Mar. 30, 1995; 61 FR 10278, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10278, Mar. 13, 1996, in § 416.414, paragraph (a) introductory text was revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.414 Amount of benefits; eligible individual or eligible couple in a medical care facility.

(a) *General rule.* There is a reduced SSI benefit rate for persons who are in medical care facilities where more than 50 percent of the cost of their care is paid under a State plan approved under title XIX of the Social Security Act (Medicaid). This reduced SSI benefit rate also applies to persons who are in medical care facilities where more than 50 percent of the cost of care would have been paid under an approved Medicaid State plan but for the application of section 1917(c) of the Act due to a transfer of assets for less than fair market value. Persons to whom this benefit rate applies are—

* * * * *

§ 416.415 Amount of benefits; eligible individual is disabled child under age 18.

(a) If you are a disabled child under age 18 and meet the conditions in § 416.1165(i) for waiver of deeming, your parents' income will not be deemed to you and your benefit rate will be $30 a month.

(b) If you are a disabled child under age 18 and do not meet the conditions in § 416.1165(i) only because your parents' income is not high enough to make you ineligible for SSI but deeming of your parents' income would result in an SSI benefit less than the amount payable if you received benefits as a child under § 416.1165(i), your benefit will be the amount payable if you received benefits as a child under § 416.1165(i).

[60 FR 361, Jan. 4, 1995]

§ 416.420 Determination of benefits; general.

Benefits shall be determined for each month. The amount of the monthly payment will be computed by reducing the benefit rate (see §§ 416.410, 416.412, 416.413, and 416.414) by the amount of countable income as figured under the rules in subpart K of this part. The appropriate month's countable income to be used to determine how much your benefit payment will be for the current month (the month for which a benefit is payable) will be determined as follows:

(a) *General rule.* We use the amount of your countable income in the second month prior to the current month to determine how much your benefit amount will be for the current month. However, if you have been receiving an SSI benefit and receiving a social security insurance benefit and the latter is increased on the basis of the cost-of-living adjustment or because your benefit is recomputed, we will compute the amount of your SSI benefit for January, the month of an SSI benefit increase by including in your income the amount by which your social security benefit in January exceeds the amount of your social security benefit in November. Similarly, we will compute the amount of your SSI benefit for February by including in your income the amount by which your social security benefit in February exceeds the amount of your social security benefit in December.

Example 1. Mrs. X's benefit amount is being determined for September (the current month). Mrs. X's countable income in July is used to determine the benefit amount for September.

Example 2. Mr. Y's SSI benefit amount is being determined for January (the current month). Mr. Y has social security income of $100 in November, $100 in December, and $105 in January. We find the amount by which his social security income in January exceeds his social security income in November ($5) and add that to his income in November to determine the SSI benefit amount for January.

(b) *Exceptions to the general rule*—(1) *First month of eligibility or eligibility after a month of ineligibility.* We use your countable income in the current month to determine your benefit amount for the first month you are eligible for SSI benefits or for the first month you become eligible for SSI benefits after at least a month of ineligibility. Your payment for such month will be prorated according to the number of days in the month that you are

eligible beginning with the date of your application or the date on which you attain (or reattain) eligibility, whichever is later.

Example: Mrs. Y applies for SSI benefits in September. We use Mrs. Y's countable income in September to determine the amount of her benefit for September. The same would be true if Mrs. Y had been ineligible for SSI benefits in August and again became eligible for such benefits in September.

(2) *Second month of initial eligibility or eligibility after a month of ineligibility.* We use your countable income in the first month prior to the current month to determine how much your benefit amount will be for the current month when the current month is the second month of initial eligibility or the second month following at least a month of ineligibility. However, if you have been receiving both an SSI benefit and a social security insurance benefit and the latter is increased on the basis of the cost-of-living adjustment or because your benefit is recomputed, we will compute the amount of your SSI benefit for January, the month of an SSI benefit increase, by including in your income the amount by which your social security benefit in January exceeds the amount of your social security benefit in December.

Example: Mrs. Y was initially eligible for SSI benefits in September. Her benefit amount for October will be based on her countable income in September (first prior month).

(3) *Third month of initial eligibility or eligibility after a month of ineligibility.* We use your countable income according to the rule set out in paragraph (a) of this section to determine how much your benefit amount will be for the third month of initial eligibility or the third month after at least a month of ineligibility.

Example: Mrs. Y was initially eligible for SSI benefits in September. Her benefit amount for November will be based on her countable income in September (second prior month).

(4) *Income derived from certain assistance payments.* We use your income in the current month from the programs listed below to determine your benefit amount for that same month. The assistance programs are as follows:

(i) Aid to Families with Dependent Children under title IV–A of the Social Security Act (the Act);

(ii) Foster Care under title IV–E of the Act;

(iii) Refugee Cash Assistance pursuant to section 412(e) of the Immigration and Nationality Act;

(iv) Cuban and Haitian Entrant Assistance pursuant to section 501(a) of Pub. L. 96–422; and

(v) Bureau of Indian Affairs general assistance and child welfare assistance pursuant to 42 Stat. 208 as amended.

(c) *Payment of benefits.* See subpart E of this part for the rules on payments and the minimum monthly benefit (as explained in § 416.503).

[50 FR 48571, Nov. 26, 1985; 50 FR 51514, Dec. 18, 1985, as amended at 54 FR 31657, Aug. 1, 1989]

§ 416.421 Determination of benefits; computation of prorated benefits.

(a) In the month you are first eligible for benefits, your benefit will be prorated according to the number of days in the month that you are eligible beginning with the date of application or the date on which you meet all eligibility requirements, whichever is later. In the month that you reacquire eligibility after a month or more of ineligibility (see § 416.1321(b)), your benefit will be prorated according to the number of days in the month that you are eligible beginning with the date on which you meet all eligibility requirements.

(b) In determining the amount of your benefit for a month in which benefits are to be prorated, we first compute the amount of the benefit that you would receive for the month as if proration did not apply. We then determine the date on which you meet all factors of eligibility. (The income limits must be met based on the entire month and the resource limit must be as of the first day of the month.) We then count the number of days in the month beginning with the day on which you first meet all factors of eligibility through the end of the month. We then multiply the amount of your unprorated benefit for the month by the number of days for which you are eligible for benefits and divide that figure by the number of days in

the month for which your benefit is being determined. The result is the amount of the benefit that you are due for the month in which benefits are to be prorated.

Example Mr. X applies for SSI on April 16, 1984. He has no income. He first meets all factors of eligibility on April 16, 1984. His Federal benefit rate is $314 per month. Mr. X's unprorated benefit for April is $314. The number of days from when he first meets all factors of eligibility (including that day) through the end of the month is 15. The unprorated benefit ($314) multiplied by the number of days for which he is eligible for benefits (15) is $4710. That amount divided by the number of days in April (30) is $157. This is the amount that Mr. X is due for the month of April.

[51 FR 13493, Apr. 14, 1986]

§ 416.426 Change in status involving an individual; ineligibility occurs.

Whenever benefits are suspended or terminated for an individual because of ineligibility, no benefit is payable for that month.

[50 FR 48571, Nov. 26, 1985]

§ 416.428 Eligible individual without an eligible spouse has an essential person in his home.

When an eligible individual without an eligible spouse has an essential person (as defined in § 416.222) in his home, the amount by which his rate of payment is increased is determined in accordance with §§ 416.531 and 416.532. The essential person's income is deemed to be that of the eligible individual, and the provisions of §§ 416.401 through 416.426 will apply in determining the benefit of such eligible individual.

[39 FR 23053, June 26, 1974, as amended at 51 FR 10616, Mar. 28, 1986]

§ 416.430 Eligible individual with eligible spouse; essential person(s) present.

(a) When an eligible individual with an eligible spouse has an essential person (§ 416.222) living in his or her home, or when both such persons each has an essential person, the increase in the rate of payment is determined in accordance with §§ 416.413 and 416.532. The income of the essential person(s) is included in the income of the couple and the payment due will be equally divided between each member of the eligible couple.

(b) When one member of an eligible couple is temporarily absent in accordance with § 416.1149(c)(1) and § 416.222(c) and either one or both individuals has an essential person, add the essential person increment to the benefit rate for the member of the couple who is actually residing with the essential person and include the income of the essential person in that member's income. See § 416.414(b)(3).

[60 FR 16375, Mar. 30, 1995]

§ 416.432 Change in status involving a couple; eligibility continues.

When there is a change in status which involves the formation or dissolution of an eligible couple (for example, marriage, divorce), a redetermination of the benefit amount shall be made for the months subsequent to the month of such formation or dissolution of the couple in accordance with the following rules:

(a) When there is a dissolution of an eligible couple and each member of the couple becomes an eligible individual, the benefit amount for each person shall be determined individually for each month beginning with the first month after the month in which the dissolution occurs. This shall be done by determining the applicable benefit rate for an eligible individual with no eligible spouse according to §§ 416.410 or 416.413 and 416.414 and applying § 416.420(a). See § 416.1147a for the applicable income rules when in-kind support and maintenance is involved.

(b) When two eligible individuals become an eligible couple, the benefit amount will be determined for the couple beginning with the first month following the month of the change. This shall be done by determining which benefit rate to use for an eligible couple according to §§ 416.412 or 416.413 and 416.414 and applying the requirements in § 416.420(a).

[60 FR 16375, Mar. 30, 1995]

§ 416.435 Change in status involving a couple; ineligibility occurs.

Whenever benefits are suspended or terminated for both members of a couple because of ineligibility, no benefits

are payable for that month. However, when benefits are suspended or terminated for one member of a couple because of ineligibility for a month, the member who remains eligible assumes the eligibility status of an eligible individual without an eligible spouse for such month and the benefit rate and payment amount will be determined as an eligible individual for the month.

[50 FR 48572, Nov. 26, 1985]

Subpart E—Payment of Benefits, Overpayments, and Underpayments

AUTHORITY: Secs. 702(a)(5), 1601, 1602, 1611 (c) and (e), and 1631 (a)–(d) and (g) of the Social Security Act (42 U.S.C. 902(a)(5), 1381, 1381a, 1382 (c) and (e), and 1383 (a)–(d) and (g)).

§ 416.501 Payment of benefits: General.

Payment of SSI benefits will be made for the month of initial eligibility and each subsequent month provided all requirements for eligibility (see § 416.202) and payment (see § 416.420) are met. In the month the individual first meets all eligibility requirements and the month in which an individual re-establishes eligibility after at least a month of ineligibility, benefits are paid for such a month beginning with the date in the month on which the individual meets all eligibility requirements. In some months, while the factors of eligibility based on the current month may be established, it is possible to receive no payment for that month if the factors of eligibility for payment are not met. Payment of benefits may not be made for any period that precedes the date on which an application is filed or, if later, the date all conditions for eligibility and payment are met. It is possible for a couple to become eligible in the same month but as of different dates and receive different payment amounts for that month if they file their applications on different dates or if they meet the necessary requirements (for example, age) on different dates.

[50 FR 48572, Nov. 26, 1985]

§ 416.502 Manner of payment.

For the month an individual first meets all eligibility requirements or reestablishes eligibility after a month of ineligibility, an SSI payment will be made on or after the day of the month on which the individual becomes eligible or reeligible to receive benefits. In all other months, a payment will be made on the first day of each month and represents payment for that month. If the first day of the month falls on a Saturday, Sunday, or legal holiday, payments will be made on the first day preceding such day which is not a Saturday, Sunday, or legal holiday. Unless otherwise indicated, the monthly amount for an eligible couple will be divided equally and paid separately to each individual. Section 416.520 explains emergency advance payments.

[55 FR 4422, Feb. 8, 1990]

§ 416.503 Minimum monthly benefit amount.

If you receive an SSI benefit that does not include a State supplement the minimum monthly SSI benefit amount payable is $1. When an SSI benefit amount of less than $1 is payable, the benefit amount will be increased to $1. If you receive an SSI benefit that does include a State supplement and the SSI benefit amount is less than $1 but when added to the State supplement exceeds $1, the SSI benefit amount will not be increased to $1. Rather, we pay the actual amount of the SSI benefit plus the State supplement.

[50 FR 48572, Nov. 26, 1985]

§ 416.520 Emergency advance payments.

(a) *General.* Before we make a determination on an application, we may pay a one-time emergency advance payment to an individual who is presumptively eligible for SSI benefits and who has a financial emergency. The amount of this payment cannot exceed the Federal benefit rate (see §§ 416.410 through 416.414) plus the State supplementary payment, if any (see § 416.2020), which apply for the month in which payment is made. *Emergency advance payment* is defined in paragraph

(b)(1) of this section. The actual payment amount is computed as explained in paragraph (c) of this section. An emergency advance payment is an advance of benefits expected to be due that is recoverable as explained in paragraphs (d) and (e) of this section.

(b) *Definition of terms.* For purposes of this subpart—

(1) *Emergency advance payment* means a direct, expedited payment by a Social Security Administration district or branch office to an individual or spouse who is initially applying (see paragraph (b)(3) of this section) and has not been determined eligible, who is presumptively eligible (see paragraph (b)(4) of this section), and who has a financial emergency (see paragraph (b)(2) of this section).

(2) *Financial emergency* is the financial status of an individual who has insufficient income or resources to meet an immediate threat to health or safety, such as the lack of food, clothing, shelter, or medical care.

(3) *Initially applying* means the filing of an application (see § 416.310) which requires an initial determination of eligibility, such as the first application for SSI benefits or an application filed subsequent to a prior denial or termination of a prior period of eligibility for payment. An individual or spouse who previously received an emergency advance payment in a prior period of eligibility which terminated may again receive such a payment if he or she reapplies for SSI and meets the other conditions for an emergency advance payment under this section.

(4) *Presumptively eligible* is the status of an individual or spouse who presents strong evidence of the likelihood of meeting the income and resources tests of eligibility (see subparts K and L of this part), categorical eligibility (age, disability, or blindness), and technical eligibility (United States residency and citizenship or alien status—see subpart P).

(c) *Computation of payment amount.* To compute the emergency advance payment amount, the maximum amount described in paragraph (a) of this section is compared to both the expected benefit payable for the month the payment is made (see paragraph (c)(1) of this section) and the amount the applicant requested to meet the emergency. The actual payment amount is no more than the least of these three amounts.

(1) In computing the emergency advance payment amount, we apply the monthly income counting and proration rules apppropriate for the month in which the advance is paid, as explained in §§ 416.420 and 416.421.

(2) For a couple, we separately compute each member's emergency advance payment amount.

(d) *Recovery of emergency advance payment where eligibility is established.* The amount of an emergency advance payment is deducted from payment(s) certified to the United States Treasury when the individual or spouse is determined to be eligible. (See paragraph (e) of this section if the individual or spouse is determined to be ineligible.)

(e) *Disposition of emergency advance payments where eligibility is not established.* If a presumptively eligible individual (or spouse) or couple is determined to be ineligible, the emergency advance payment constitutes a recoverable overpayment. (See the exception in § 416.537(b)(1) when payment is made on the basis of presumptive disability or presumptive blindness.)

[55 FR 4422, Feb. 8, 1990; 55 FR 7411, Mar. 1, 1990]

§ 416.525 Reimbursement to States for interim assistance payments.

Notwithstanding § 416.542, the Social Security Administration may, in accordance with the provisions of subpart S of this part, withhold supplemental security income benefits due with respect to an individual and may pay to a State (or political subdivision thereof, if agreed to by the Social Security Administration and the State) from the benefits withheld, an amount sufficient to reimburse the State (or political subdivision) for interim assistance furnished on behalf of the individual.

[41 FR 20872, May 21, 1976]

§ 416.532 Method of payment when the essential person resides with more than one eligible person.

(a) When an essential person lives with an eligible individual and an eligible spouse, the State may report that the person is essential to one or both

members of the couple. In either event, the income and resources of the essential person will be considered to be available to the family unit. The payment increment attributable to the essential person will be added to the rate of payment for the couple, the countable income subtracted, and the resulting total benefit divided equally between the eligible individual and the eligible spouse.

(b) Where the essential person lives with two eligible individuals (as opposed to an eligible individual and eligible spouse), one of whom has been designated the qualified individual, the income and resources of the essential person will be considered to be available only to the qualified individual (as defined in § 416.221) and any increase in payment will be made to such qualified individual.

(c) In those instances where the State has designated the essential person as essential to two or more eligible individuals so that both are qualified individuals, the payment increment attributable to the essential person must be shared equally, and the income and resources of the essential person divided and counted equally against each qualified individual.

(d) When an essential person lives with an eligible individual and an eligible spouse (or two or more eligible individuals) only one of whom is the qualified individual, essential person status is not automatically retained upon the death of the qualified individual or upon the separation from the qualified individual. A review of the State records established on or before December 31, 1973, will provide the basis for a determination as to whether the remaining eligible individual or eligible spouse meets the definition of qualified individual. Payment in consideration of the essential person will be dependent on whether the essential person continues to live with a qualified individual. If the essential person does reside with a qualified individual, status as an essential person is retained.

[39 FR 33796, Sept. 20, 1974, as amended at 50 FR 48572, Nov. 26, 1985; 51 FR 10616, Mar. 28, 1986; 60 FR 16375, Mar. 30, 1995]

§ 416.533 Transfer or assignment of benefits.

Except as provided in § 416.525 and subpart S of this part, the Social Security Administration will not certify payment of supplemental security income benefits to a transferee or assignee of a person eligible for such benefits under the Act or of a person qualified for payment under § 416.542. The Social Security Administration shall not certify payment of supplemental security income benefits to any person claiming such payment by virtue of an execution, levy, attachment, garnishment, or other legal process or by virtue of any bankruptcy or insolvency proceeding against or affecting the person eligible for benefits under the Act.

[41 FR 20873, May 21, 1976, as amended at 58 FR 52912, Oct. 13, 1993]

§ 416.535 Underpayments and overpayments.

(a) *General.* When an individual receives SSI benefits of less than the correct amount, adjustment is effected as described in §§ 416.542 and 416.543. When an individual receives more than the correct amount of SSI benefits, adjustment is effected as described in § 416.570. Refund of overpayments is discussed in § 416.560 and waiver of recovery of overpayments is discussed in §§ 416.550 through 416.555.

(b) *Additional rules for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.* When an individual whose drug addiction or alcoholism is a contributing factor material to the determination of disability, as described in § 416.935, receives less than the correct amount of SSI benefits, adjustment is effected as described in §§ 416.542 and 416.543 and the additional rule described in § 416.544 applies.

(c) [Reserved]

(d) *Additional rules for eligible aliens and for their sponsors.* When an individual who is an alien is overpaid SSI benefits during the 3-year period in which deeming from a sponsor applies (see § 416.1160(a)(3)), the sponsor and the alien may be jointly and individually liable for repayment of the overpayment. The sponsor is liable for the overpayment if he or she failed to report correct information that affected

the alien's eligibility or payment amount. This means information about the income and resources of the sponsor and, if they live together, of the sponsor's spouse. However, the sponsor is not liable for repayment if the sponsor was without fault or had good cause for failing to report correctly. A special rule that applies to adjustment of other benefits due the alien and the sponsor to recover an overpayment is described in § 416.570(b).

(e) *Sponsor without fault or good cause exists for failure to report.* Without fault or good cause will be found to exist if the failure to report was not willful. To establish willful failure, the evidence must show that the sponsor knowingly failed to supply pertinent information regarding his or her income and resources.

[52 FR 8881, Mar. 20, 1987, as amended at 60 FR 8149, Feb. 10, 1995]

§ 416.536 Underpayments—defined.

An underpayment can occur only with respect to a period for which a recipient filed an application, if required, for benefits and met all conditions of eligibility for benefits. An underpayment, including any amounts of State supplementary payments which are due and administered by the Social Security Administration, is:

(a) Nonpayment, where payment was due but was not made; or

(b) Payment of less than the amount due. For purposes of this section, payment has been made when certified by the Social Security Administration to the Department of the Treasury, except that payment has not been made where payment has not been received by the designated payee, or where payment was returned.

[58 FR 52912, Oct. 13, 1993]

§ 416.537 Overpayments—defined.

(a) *Overpayments.* As used in this subpart, the term *overpayment* means payment of more than the amount due for any period, including any amounts of State supplementary payments which are due and administered by the Social Security Administration. For purposes of this section, payment has been made when certified by the Social Security Administration to the Department of the Treasury, except that payment has not been made where payment has not been received by the designated payee, or where payment was returned. When a payment of more than the amount due 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 is the surviving spouse of the deceased individual and was eligible for a payment under title XVI of the Act (including any State supplementation payment paid by the Secretary) as an eligible spouse (or as either member of an eligible couple) for 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 surviving spouse.

(b) *Actions which are not overpayments*—(1) *Presumptive disability and presumptive blindness.* Any payment made for any month, including an advance payment of benefits under § 416.520, is not an overpayment to the extent it meets the criteria for payment under § 416.931. Payments made on the basis of presumptive disability or presumptive blindness will not be considered overpayments where ineligibility is determined because the individual or eligible spouse is not disabled or blind. However, where it is determined that all or a portion of the presumptive payments made are incorrect for reasons other than disability or blindness, these incorrect payments are considered overpayments (as defined in paragraph (a) of this section). Overpayments may occur, for example, when the person who received payments on the basis of presumptive disability or presumptive blindness is determined to be ineligible for all or any part of the payments because of excess resources or is determined to have received excess payment for those months based on an incorrect estimate of income.

(2) *Penalty.* The imposition of a penalty pursuant to § 416.724 is not an adjustment of an overpayment and is imposed only against any amount due the penalized recipient, or, after death, any amount due the deceased which

otherwise would be paid to a survivor as defined in § 416.542.

[40 FR 47763, Oct. 10, 1975, as amended at 43 FR 17354, Apr. 24, 1978; 50 FR 48572, Nov. 26, 1985; 55 FR 7313, Mar. 1, 1990; 58 FR 52912, Oct. 13, 1993]

§ 416.538 Amount of underpayment or overpayment.

(a) *General.* The amount of an underpayment or overpayment is the difference between the amount paid to a recipient and the amount of payment actually due such recipient for a given period. An underpayment or overpayment period begins with the first month for which there is a difference between the amount paid and the amount actually due for that month. The period ends with the month the initial determination of overpayment or underpayment is made. With respect to the period established, there can be no underpayment to a recipient or his or her eligible spouse if more than the correct amount payable under title XVI of the Act has been paid, whether or not adjustment or recovery of any overpayment for that period to the recipient or his or her eligible spouse has been waived under the provisions of §§ 416.550 through 416.556. A subsequent initial determination of overpayment will require no change with respect to a prior determination of overpayment or to the period relating to such determination to the extent that the basis of the prior overpayment remains the same.

(b) *Limited delay in payment of underpaid amount to recipient or eligible surviving spouse.* Where an apparent overpayment has been detected but determination of the overpayment has not been made (see § 416.558(a)), a determination of an underpayment and payment of an underpaid amount which is otherwise due cannot be delayed to a recipient or eligible surviving spouse unless a determination with respect to the apparent overpayment can be made before the close of the month following the month in which the underpaid amount was discovered.

(c) *Delay in payment of underpaid amount to ineligible individual or survivor.* A determination of an underpayment and payment of an underpaid amount which is otherwise due an individual who is no longer eligible for SSI or is payable to a survivor pursuant to § 416.542(b) will be delayed for the resolution of all overpayments, incorrect payments, adjustments, and penalties.

(d) *Reduction of underpaid amount.* Any underpayment amount otherwise payable to a survivor on account of a deceased recipient is reduced by the amount of any outstanding penalty imposed against the benefits payable to such deceased recipient or survivor under section 1631(e) of the Act (see § 416.537(b)(2)).

[58 FR 52912, Oct. 13, 1993]

§ 416.542 Underpayments—to whom underpaid amount is payable.

(a) *Underpaid recipient alive—underpayment payable.* (1) If an underpaid recipient is alive, the amount of any underpayment due him or her will be paid to him or her in a separate payment or by increasing the amount of his or her monthly payment.

(2) If an underpaid recipient whose drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 416.935) is alive, the amount of any underpayment due the recipient will be paid through his or her representative payee in installment payments. No underpayment may be paid directly to the recipient. If the recipient dies before we have paid all benefits due through his or her representative payee, we will follow the rules which apply to underpayments for the payment of any remaining amounts due to any eligible survivor of a deceased recipient as described in paragraph (b) of this section.

(b) *Underpaid recipient deceased—underpaid amount payable to survivor.* (1) If a recipient dies before we have paid all benefits due or before the recipient endorses the check for the correct payment, we may pay the amount due to the deceased recipient's surviving eligible spouse or to his or her surviving spouse who was living with the underpaid recipient within the meaning of section 202(i) of the Act (see § 404.347) in the month he or she died or within 6 months immediately preceding the month of death.

(2) If the deceased underpaid recipient was a disabled or blind child when

the underpayment occurred, the underpaid amount may be paid to the natural or adoptive parent(s) of the underpaid recipient who lived with the underpaid recipient in the month he or she died or within the 6 months preceding death. We consider the underpaid recipient to have been living with the natural or adoptive parent(s) in the period if the underpaid recipient satisfies the ''living with'' criteria we use when applying § 416.1165 or would have satisfied the criteria had his or her death not precluded the application of such criteria throughout a month.

(3) If the deceased individual was living with his or her spouse within the meaning of section 202(i) of the Act in the month of death or within 6 months immediately preceding the month of death, and was also living with his or her natural or adoptive parent(s) in the month of death or within 6 months preceding the month of death, we will pay the parent(s) any SSI underpayment due the deceased individual for months he or she was a blind or disabled child and we will pay the spouse any SSI underpayment due the deceased individual for months he or she no longer met the definition of ''child'' as set forth at § 416.1856. If no parent(s) can be paid in such cases due to death or other reason, then we will pay the SSI underpayment due the deceased individual for months he or she was a blind or disabled child to the spouse.

(4) No benefits may be paid to the estate of any underpaid recipient, the estate of the surviving spouse, the estate of a parent, or to any survivor other than those listed in paragraph (b)(1) through (3) of this section. Payment of an underpaid amount to an ineligible spouse or surviving parent(s) may only be made for benefits payable for months after May 1986. Payment to surviving parent(s) may be made only for months of eligibility during which the deceased underpaid recipient was a child. We will not pay benefits to a survivor other than the eligible spouse who requests payment of an underpaid amount more than 24 months after the month of the individual's death.

(c) *Underpaid recipient's death caused by an intentional act.* No benefits due the deceased individual may be paid to a survivor found guilty by a court of competent jurisdiction of intentionally causing the underpaid recipient's death.

[40 FR 47763, Oct. 10, 1975, as amended at 58 FR 52913, Oct. 13, 1993; 60 FR 8149, Feb. 10, 1995]

§ 416.543 Underpayments—applied to reduce overpayments.

We apply any underpayment due an individual to reduce any overpayment to that individual that we determine to exist (see § 416.558) for a different period, unless we have waived recovery of the overpayment under the provisions of §§ 416.550 through 416.556. Similarly, when an underpaid recipient dies, we first apply any amounts due the deceased recipient that would be payable to a survivor under § 416.542(b) against any overpayment to the survivor unless we have waived recovery of such overpayment under the provisions of §§ 416.550 through 416.556.

Example: A disabled child, eligible for payments under title XVI, and his parent, also an eligible individual receiving payments under title XVI, were living together. The disabled child dies at a time when he was underpaid $100. The deceased child's underpaid benefit is payable to the surviving parent. However, since the parent must repay an SSI overpayment of $225 on his own record, the $100 underpayment will be applied to reduce the parent's own overpayment to $125.

[58 FR 52913, Oct. 13, 1993]

§ 416.544 Paying benefits in installments: Drug addiction or alcoholism.

(a) *General.* For disabled recipients who receive benefit payments through a representative payee because drug addiction or alcoholism is a contributing factor material to the determination of disability, certain amounts due the recipient 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 recipient 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 current benefit due cannot exceed twice the Federal Benefit Rate plus any federally-administered State supplementation payable to an eligible individual for the preceding month.

(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 recipient accrues benefit amounts subject to payment in installments if the recipient has unpaid housing expenses which result in a high risk of homelessness for the recipient. 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 recipient does not have a representative payee, payment of amounts subject to installments cannot be made until a representative payee is selected.

(e) *Underpaid recipient no longer eligible.* In the case of a recipient who is no longer currently eligible for monthly payments, but to whom amounts defined in paragraph (a) of this section are still owing, we will continue to make installment payments of such benefits through a representative payee.

(f) *Recipient currently not receiving SSI benefits because of suspension for noncompliance with treatment.* If a recipient is currently not receiving SSI benefits because his or her benefits have been suspended for noncompliance with treatment (as defined in § 416.936), the payment of amounts under paragraph (a) of this section will stop until the recipient has demonstrated compliance with treatment as described in § 416.1326 and will again commence with the first month the recipient begins to receive benefits.

(g) *Underpaid recipient deceased.* Upon the death of a recipient, any remaining unpaid amounts as defined in paragraph (a) of this section will be treated as underpayments in accordance with § 416.542(b).

[60 FR 8150, Feb. 10, 1995]

§ 416.550 Waiver of adjustment or recovery—when applicable.

Waiver of adjustment or recovery of an overpayment of SSI benefits may be granted when (EXCEPTION: This section does not apply to a sponsor of an alien):

(a) The overpaid individual was without fault in connection with an overpayment, and

(b) Adjustment or recovery of such overpayment would either:

(1) Defeat the purpose of title XVI, or

(2) Be against equity and good conscience, or

(3) Impede efficient or effective administration of title XVI due to the small amount involved.

[52 FR 8882, Mar. 20, 1987, as amended at 53 FR 16543, May 10, 1988]

§ 416.551 Waiver of adjustment or recovery—effect of.

Waiver of adjustment or recovery of an overpayment from the overpaid person himself (or, after his death, from his estate) frees him and his eligible spouse from the obligation to repay the amount of the overpayment covered by the waiver. Waiver of adjustment or recovery of an overpayment from anyone

other than the overpaid person himself or his estate (e.g., a surviving eligible spouse) does not preclude adjustment or recovery against the overpaid person or his estate.

Example: The recipient was overpaid $390. It was found that the overpaid recipient was eligible for waiver of adjustment or recovery of $260 of that amount, and such action was taken. Only $130 of the overpayment remained to be recovered by adjustment, refund, or the like.

[40 FR 47763, Oct. 10, 1975]

§ 416.552 Waiver of adjustment or recovery—without fault.

Without fault relates only to the situation of the individual seeking relief from adjustment or recovery of an overpayment. The overpaid individual (and any other individual from whom the Social Security Administration seeks to recover the overpayment) is not relieved of liability and is not *without fault* solely because the Social Security Administration may have been at fault in making the overpayment. In determining whether an individual is without fault, the *fault* of the overpaid person and the *fault* of the individual seeking relief under the waiver provision are considered. Whether an individual is *without fault* depends on all the pertinent circumstances surrounding the overpayment in the particular case. The Social Security Administration considers the individual's understanding of the reporting requirements, the agreement to report events affecting payments, knowledge of the occurrence of events that should have been reported, efforts to comply with the reporting requirements, opportunities to comply with the reporting requirements, understanding of the obligation to return checks which were not due, and ability to comply with the reporting requirements (e.g., age, comprehension, memory, physical and mental condition). In determining whether an individual is without fault based on a consideration of these factors, the Social Security Administration will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have. Although the finding depends on all of the circumstances in the particular case, an individual will be found to have been at fault in connection with an overpayment when an incorrect payment resulted from one of the following:

(a) Failure to furnish information which the individual knew or should have known was material;

(b) An incorrect statement made by the individual which he knew or should have known was incorrect (this includes the individual's furnishing his opinion or conclusion when he was asked for facts), or

(c) The individual did not return a payment which he knew or could have been expected to know was incorrect.

[40 FR 47763, Oct. 10, 1975, as amended at 59 FR 1636, Jan. 12, 1994]

§ 416.553 Waiver of adjustment or recovery—defeat the purpose of the supplemental security income program.

We will waive adjustment or recovery of an overpayment when an individual on whose behalf waiver is being considered is without fault (as defined in § 416.552) and adjustment or recovery of the overpayment would defeat the purpose of the supplemental security income program.

(a) *General rule.* We consider adjustment or recovery of an overpayment to defeat the purpose of the supplemental security income (SSI) program if the individual's income and resources are needed for ordinary and necessary living expenses under the criteria set out in § 404.508(a) of this chapter

(b) *Alternative criteria for individuals currently eligible for SSI benefits.* We consider an individual or couple currently eligible for SSI benefits to have met the test in paragraph (a) of this section if the individual's or couple's current monthly income (that is, the income upon which the individual's or couple's eligibility for the current month is determined) does not exceed—

(1) The applicable Federal monthly benefit rate for the month in which the determination of waiver is made (see subpart D of this part); plus

(2) The $20 monthly general income exclusion described in §§ 416.1112(c)(3) and 416.1124(c)(10); plus

(3) The monthly earned income exclusion described in § 416.1112(c)(4); plus

(4) The applicable State supplementary payment, if any (see subpart T of this part) for the month in which determination of waiver is made.

For those SSI recipients whose income exceeds these criteria, we follow the general rule in paragraph (a) of this section.

[45 FR 72649, Nov. 3, 1980, as amended at 50 FR 48573, Nov. 26, 1985]

§ 416.554 Waiver of adjustment or recovery—against equity and good conscience.

We will waive adjustment or recovery of an overpayment when an individual on whose behalf waiver is being considered is without fault (as defined in § 416.552) and adjustment or recovery would be *against equity and good conscience.* Adjustment or recovery is considered to be *against equity and good conscience* if an individual changed his or her position for the worse or relinquished a valuable right because of reliance upon a notice that payment would be made or because of the incorrect payment itself. In addition, adjustment or recovery is considered to be *against equity and good conscience* for an individual who is a member of an eligible couple that is legally separated and/or living apart for that part of an overpayment not received, but subject to recovery under § 416.570.

Example 1: Upon being notified that he was eligible for supplemental security income payments, an individual signed a lease on an apartment renting for $15 a month more than the room he had previously occupied. It was subsequently found that eligibility for the payment should not have been established. In such a case, recovery would be considered ''against equity and good conscience.''

Example 2: An individual fails to take advantage of a private or organization charity, relying instead on the award of supplemental security income payments to support himself. It was subsequently found that the money was improperly paid. Recovery would be considered ''against equity and good conscience.''

Example 3: Mr. and Mrs. Smith—members of an eligible couple—separate in July. Later in July, Mr. Smith receives earned income resulting in an overpayment to both. Mrs. Smith is found to be without fault in causing the overpayment. Recovery from Mrs. Smith of Mr. Smith's part of the couple's overpayment is waived as being *against equity and good conscience.* Whether recovery of Mr. Smith's portion of the couple's overpayment can be waived will be evaluated separately.

[60 FR 16375, Mar. 30, 1995]

§ 416.555 Waiver of adjustment or recovery—impede administration.

Waiver of adjustment or recovery is proper when the overpaid person on whose behalf waiver is being considered is without fault, as defined in § 416.552, and adjustment or recovery would impede efficient or effective administration of title XVI due to the small amount involved. The amount of overpayment determined to meet such criteria is measured by the current average administrative cost of handling such overpayment case through such adjustment or recovery processes. In determining whether the criterion is met, the overpaid person's financial circumstances are not considered.

[40 FR 47764, Oct. 10, 1975]

§ 416.556 Waiver of adjustment or recovery—countable resources in excess of the limits prescribed in § 416.1205 by $50 or less.

(a) If any overpayment with respect to an individual (or an individual and his or her spouse if any) is attributable solely to the ownership or possession by the individual (and spouse if any) of countable resources having a value which exceeds the applicable dollar figure specified in § 416.1205 by an amount of $50.00 or less, including those resources deemed to an individual in accordance with § 416.1202, such individual (and spouse if any) shall be deemed to have been without fault in connection with the overpayment, and waiver of adjustment or recovery will be made, unless the failure to report the value of the excess resources correctly and in a timely manner was willful and knowing.

(b) Failure to report the excess resources correctly and in a timely manner will be considered to be willful and knowing and the individual will be found to be at fault when the evidence clearly shows the individual (and spouse if any) was fully aware of the requirements of the law and of the excess resources and chose to conceal these resources. When an individual incurred a similar overpayment in the past and received an explanation and

instructions at the time of the previous overpayment, we will generally find the individual to be at fault. However, in determining whether the individual is at fault, we will consider all aspects of the current and prior overpayment situations, and where we determine the individual is not at fault, we will waive adjustment or recovery of the subsequent overpayment. In making any determination or decision under this section concerning whether an individual is at fault, including a determination or decision of whether the failure to report the excess resources correctly and in a timely manner was willful and knowing, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) of the individual (and spouse if any).

[53 FR 16544, May 10, 1988, as amended at 59 FR 1636, Jan. 12, 1994]

§ 416.558 Notice relating to overpayments and underpayments.

(a) *Notice of overpayment and underpayment determination.* Whenever a determination concerning the amount paid and payable for any period is made and it is found that, with respect to any month in the period, more or less than the correct amount was paid, written notice of the correct and incorrect amounts for each such month in the period will be sent to the individual against whom adjustment or recovery of the overpayment as defined in § 416.537(a) may be effected or to whom the underpayment as defined in §§ 416.536 and any amounts subject to installment payments as defined in § 416.544 would be payable, notwithstanding the fact that part or all of the underpayment must be withheld in accordance with § 416.543. When notifying an individual of a determination of overpayment, the Social Security Administration will, in the notice, also advise the individual that adjustment or recovery is required, as set forth in § 416.571, except under certain specified conditions, and of his or her right to request waiver of adjustment or recovery of the overpayment under the provisions of § 416.550.

(b) *Notice of waiver determination.* Written notice of an initial determination of waiver shall be given the individual in accordance with § 416.1404 unless the individual was not given notice of the overpayment in accordance with paragraph (a) of this section.

(c) *Notice relating to installment payments to individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.* Whenever a determination is made concerning the amount of any benefits due for a period that must be paid in installments, the written notice will also explain the amount of the installment payment and when an increased initial installment payment may be made (as described in § 416.544). This written notice will be sent to the individual and his or her representative payee.

[40 FR 47764, Oct. 10, 1975, as amended at 55 FR 33668, Aug. 17, 1990; 60 FR 8150, Feb. 10, 1995]

§ 416.560 Recovery—refund.

An overpayment may be refunded by the overpaid recipient or by anyone on his or her behalf. Refund should be made in every case where the overpaid individual is not currently eligible for SSI benefits. If the individual is currently eligible for SSI benefits and has not refunded the overpayment, adjustment as set forth in § 416.570 will be proposed.

[55 FR 33669, Aug. 17, 1990]

§ 416.570 Adjustment—general rule.

Where a recipient has been overpaid, the overpayment has not been refunded, and waiver of adjustment or recovery is not applicable, any payment due the overpaid recipient or his or her eligible spouse (or recovery from the estate of either or both when either or both die before adjustment is completed) is adjusted for recovery of the overpayment. Adjustment will generally be accomplished by withholding each month the amount set forth in § 416.571 from the benefit payable to the individual except that, when the overpayment results from the disposition of resources as provided by §§ 416.1240(b) and 416.1244, the overpayment will be recovered by withholding any payments due the overpaid recipient or his or her eligible spouse before any further payment is made. Absent a specific request from the person from

whom recovery is sought, no overpayment made under title II or XVIII of the Act shall be recovered by adjusting SSI benefits, and absent a specific request, no overpayment of SSI benefits shall be adjusted against benefits payable under title II of the Act. In no case shall an overpayment of SSI benefits be adjusted against title XVIII benefits.

[55 FR 33669, Aug. 17, 1990; 55 FR 42148, Oct. 17, 1990]

§ 416.571 10-percent limitation of recoupment rate—overpayment.

Any adjustment or recovery of an overpayment for an individual in current payment status is limited in amount in any month to the lesser of (1) the amount of the individual's benefit payment for that month or (2) an amount equal to 10 percent of the individual's total income (countable income plus SSI and State supplementary payments) for that month. The countable income used is the countable income used in determining the SSI and State supplementary payments for that month under § 416.420. When the overpaid individual is notified of the proposed SSI and/or federally administered State supplementary overpayment adjustment or recovery, the individual will be given the opportunity to request that such adjustment or recovery be made at a higher or lower rate than that proposed. If a lower rate is requested, a rate of withholding that is appropriate to the financial condition of the overpaid individual will be set after an evaluation of all the pertinent facts. An appropriate rate is one that will not deprive the individual of income required for ordinary and necessary living expenses. This will include an evaluation of the individual's income, resources, and other financial obligations. The 10-percent limitation does not apply where it is determined that the overpayment occurred because of fraud, willful misrepresentation, or concealment of material information committed by the individual or his or her spouse. Concealment of material information means an intentional, knowing, and purposeful delay in making or failure to make a report that will affect payment amount and/or eligibility. It does not include a mere omission on the part of the recipient; it is an affirmative act to conceal. The 10-percent limitation does not apply to the recovery of overpayments incurred under agreements to dispose of resources pursuant to § 416.1240. In addition, the 10-percent limitation does not apply to the reduction of any future SSI benefits as a consequence of the misuse of funds set aside in accordance with § 416.1231(b) to meet burial expenses. Adjustment or recovery will be suspended if the recipient is subject to a reduced benefit rate under § 416.414 because of residing in a medical facility in which Medicaid is paying a substantial portion of the recipient's cost of care.

[55 FR 33669, Aug. 17, 1990]

Subpart F—Representative Payment

AUTHORITY: Secs. 702(a)(5), 1631 (a)(2) and (d)(1) of the Social Security Act (42 U.S.C. 902(a)(5) and 1383 (a)(2) and (d)(1)).

SOURCE: 47 FR 30475, July 14, 1982, unless otherwise noted.

§ 416.601 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 own 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. However, we must select a representative payee for an individual who is eligible for benefits solely on the basis of disability if drug addiction or alcoholism is a contributing factor material to the determination of disability.

(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.

[47 FR 30475, July 14, 1982, as amended at 60 FR 8150, Feb. 10, 1995]

§ 416.610 When payment will be made to a 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; or

(3) Eligible for benefits solely on the basis of disability and drug addiction or alcoholism is a contributing factor material to the determination of disability.

(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 payment to a beneficiary under age 18 if the beneficiary is—

(1) 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

(2) Capable of using the benefits to provide for his or her current needs and no qualified payee is available; or

(3) Within 7 months of attaining age 18 and is initially filing an application for benefits.

[47 FR 30475, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989; 60 FR 8150, Feb. 10, 1995]

§ 416.615 Information considered in determining whether to make representative payment.

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.

§ 416.620 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.

§ 416.621 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 interests. 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 the 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.

§ 416.625 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.

§ 416.630 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.

§ 416.635 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 (See subpart G of this part concerning these reporting requirements);

(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.

§ 416.640 Use of benefit payments.

(a) *Current maintenance.* We will consider that payments we certify to a representive 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 costs incurred in obtaining food, shelter, clothing, medical care and personal comfort items.

Example: A Supplemental Security Income beneficiary is entitled to a monthly benefit of $264. The beneficiary's son, who is the representative payee, disburses the benefits in the following manner:

Rent and Utilities	$166
Medical	20
Food	60
Clothing	10
Miscellaneous	8

The above expenditures would represent proper disbursements on behalf of the beneficiary.

(b) *Institution not receiving Medicaid funds on beneficiary's behalf.* If a beneficiary is receiving care in a Federal, State, or private institution because of mental or physical incapacity, current maintenance will include the customary charges for the care and services provided by an institution, expenditures for those items which will aid in the beneficiary's recovery or release from the institution, and nominal expenses for personal needs (e.g., personal hygiene items, snacks, candy) which will improve the beneficiary's condition. Except as provided under § 416.212, there is no restriction in using SSI benefits for a beneficiary's current maintenance in an institution. Any payments remaining from SSI benefits may be used for a temporary period to maintain the beneficiary's residence outside of the institution unless a physician has certified that the beneficiary is not likely to return home.

EXAMPLE: A hospitalized disabled beneficiary is entitled to a monthly benefit of $264. The beneficiary, who resides in a boarding home, has resided there for over 6 years. It is doubtful that the beneficiary will leave the boarding home in the near future. The boarding home charges $215 per month for the beneficiary's room and board.

The beneficiary's representative payee pays the boarding home $215 (assuming an unsuccessful effort was made to negotiate a lower rate during the beneficiary's absence) and uses the balance to purchase miscellaneous personal items for the beneficiary. There are no benefits remaining which can be conserved on behalf of the beneficiary. The payee's use of the benefits is consistent with our guidelines.

(c) *Institution receiving Medicaid funds on beneficiary's behalf.* Except in the case of a beneficiary receiving benefits payable under § 416.212, if a beneficiary resides throughout a month in an institution that receives more than 50 percent of the cost of care on behalf of the

beneficiary from Medicaid, any payments due shall be used only for the personal needs of the beneficiary and not for other items of current maintenance.

EXAMPLE: A disabled beneficiary resides in a hospital. The superintendent of the hospital receives $30 per month as the beneficiary's payee. The benefit payment is disbursed in the following manner, which would be consistent with our guidelines:

Miscellaneous canteen items	$10
Clothing	15
Conserved for future needs of the beneficiary	5

(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 disabled beneficiary was determined to be eligible for a monthly benefit payment of $208 effective April 1981. The benefits were certified to the beneficiary's brother who was appointed as the representative payee. The payee conserved $27 of the benefits received. In June 1981 the payee received a bill from a doctor who had treated the beneficiary in February and March 1981. The bill was for $175.

After reviewing the beneficiary's current needs and resources, the payee decided not to use any of the benefits to pay the doctor's bill. (Approximately $180 a month is required for the beneficiary's current monthly living expenses—rent, utilities, food, and insurance—and the beneficiary will need new shoes and a coat within the next few months.)

Based upon the above, the payee's decision not to pay the doctor's bill is consistent with our guidelines.

[47 FR 30475, July 14, 1982, as amended at 61 FR 10278, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10278, Mar. 13, 1996, in § 416.640 paragraphs (b) and (c) were revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.640 Use of benefit payments.

* * * * *

(b) *Institution not receiving Medicaid funds on beneficiary's behalf.* 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 for care and services provided by the institution, and 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. Any payments remaining may be used for a temporary period to maintain the beneficiary's residence outside of the institution unless a physician has certified that the beneficiary is not likely to return home.

Example: A disabled beneficiary is entitled to a monthly benefit of $264. The beneficiary, who resides in a boarding home, has resided there for over six years. It is doubtful that the beneficiary will leave the boarding home in the near future. The boarding home charges $215 per month for the beneficiary's room and board.

The beneficiary's payee pays the boarding home $215 and uses the balance to purchase miscellaneous personal items for the beneficiary. There are no benefits remaining which can be conserved on behalf of the beneficiary. The payee's use of the benefits is consistent with our guidelines.

(c) *Institution receiving Medicaid funds on beneficiary's behalf.* If a beneficiary is in an institution throughout a month and the institution receives Medicaid funds on behalf of the beneficiary, any payments due shall be used only for the personal needs of the beneficiary, and not for current maintenance.

Example: A disabled beneficiary resides in a psychiatric hospital. The superintendent of the hospital receives $25 per month as the beneficiary's payee. The benefit payment is disbursed in the following manner which would be consistent with our guidelines:

Miscellaneous canteen items	$9
Clothing	11
Conserved for future needs of the beneficiary	5

* * * * *

§ 416.640a 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 § 416.641.

(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 § 416.645.

(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.

(7) An authorized organization may collect a fee for representative payee services from the entire monthly benefit amount received, including any payment of a federally-administered State supplementary payment under subpart T of this part.

(8) In the case of an institutionalized beneficiary a fee may not be withheld from benefits which must be set aside for the beneficiary's personal needs in accordance with § 416.640(c).

[57 FR 23057, June 1, 1992; 57 FR 27091, June 17, 1992]

§ 416.641 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 personally, and not SSA, may be liable if the payee misuses the beneficiary's benefits.

§ 416.645 Conservation and investment of benefit payments.

(a) *General.* If payments are not needed for the beneficiary's current maintenance or reasonably foreseeable needs, they 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 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 personal needs of the beneficiaries. However, not all those funds were disbursed for this purpose. As a result, 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 Supplemental Security Income 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.

§ 416.650 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.

§ 416.655 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.

§ 416.660 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.

§ 416.665 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 G—Reports Required

AUTHORITY: Secs. 702(a)(5), 1611, 1612, 1613, 1614, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1382, 1382a, 1382b, 1382c, and 1383); sec. 211, Pub. L. 93–66, 87 Stat. 154 (42 U.S.C. 1382 note).

SOURCE: 46 FR 5873, Jan. 21, 1981, unless otherwise noted.

INTRODUCTION

§ 416.701 Scope of subpart.

(a) *Report provisions.* The Social Security Administration, to achieve efficient administration of the Supplemental Security Income (SSI) program for the Aged, Blind, and Disabled, requires that you (or your representative) must report certain events to us. It is important for us to know about these events because they may affect your continued eligibility for SSI benefits or the amount of your benefits. This subpart tells you what events you must report; what your reports must include; and when reports are due. The rules regarding reports are in §§ 416.704 through 416.714.

(b) *Penalty deductions.* If you fail to make a required report when it is due, you may suffer a penalty. This subpart describes the penalties; discusses when we may impose them; and explains that we will not impose a penalty if you have good cause for failing to report timely. The rules regarding penalties are in §§ 416.722 through 416.732.

§ 416.702 Definitions.

For purposes of this subpart—

Essential person means someone whose presence was believed to be necessary for your welfare under the State program that preceded the SSI program. (See §§ 416.241 through 416.249.)

Parent means a natural parent, an adoptive parent, or the spouse of a natural or adoptive parent.

Representative payee means an individual, an agency, or an institution selected by us to receive and manage SSI benefits on your behalf. (See subpart F of this part for details describing when a representative payee is selected and a representative payee's responsibilities.)

Residence in the United States means that your permanent home is in the United States.

United States or *U.S.* means the 50 States, the District of Columbia, and the Northern Mariana Islands.

We, Us, or *Our* means the Social Security Administration.

You or *Your* means an applicant, an eligible individual, an eligible spouse, or an eligible child.

REPORT PROVISIONS

§ 416.704 Who must make reports.

(a) You are responsible for making required reports to us if you are—

(1) An eligible individual (see § 416.120(c)(13));

(2) An eligible spouse (see § 416.120(c)(14));

(3) An eligible child (see §§ 416.120(c)(13) and 416.1856); or

(4) An applicant awaiting a final determination upon an application.

(b) If you have a representative payee, and you have not been legally adjudged incompetent, either you or your representative payee must make the required reports.

(c) If you have a representative payee and you have been legally adjudged incompetent, you are not responsible for making reports to us; however, your representative payee is responsible for making required reports to us.

[46 FR 5873, Jan. 21, 1981, as amended at 51 FR 10616, Mar. 28, 1986]

§ 416.708 What you must report.

This section describes the events that you must report to us. They are—

(a) *A change of address.* You must report to us any change in your mailing address and any change in the address where you live.

(b) *A change in living arrangements.* You must report to us any change in the make-up of your household: That is, any person who comes to live in your household and any person who moves out of your household.

(c) *A change in income.* You must report to us any increase or decrease in your income, and any increase or decrease in the income of—

(1) Your ineligible spouse who lives with you;

(2) Your essential person;

(3) Your parent, if you are an eligible child and your parent lives with you; or

(4) An ineligible child who lives with you.

However, you need not report an increase in your Social Security benefits if the increase is only a cost-of-living adjustment. (For a complete discussion of what we consider income, see subpart K. See subpart M, § 416.1323 regarding suspension because of excess income.)

(d) *A change in resources.* You must report to us any resources you receive or part with, and any resources received or parted with by—

(1) Your ineligible spouse who lives with you;

(2) Your essential person; or

(3) Your parent, if you are an eligible child and your parent lives with you. (For a complete discussion of what we consider a resource, see subpart L. See subpart M, § 416.1324 regarding suspension because of excess resources.)

(e) *Eligibility for other benefits.* You must report to us your eligibility for benefits other than SSI benefits. See

§§ 416.210 and 416.1330 regarding your responsibility to apply for any other benefits for which you may be eligible.

(f) *Certain deaths.* (1) If you are an eligible individual, you must report the death of your eligible spouse, the death of your ineligible spouse who was living with you, and the death of any other person who was living with you.

(2) If you are an eligible spouse, you must report the death of your spouse, and the death of any other person who was living with you.

(3) If you are an eligible child, you must report the death of a parent who was living with you, and the death of any other person who was living with you.

(4) If you are a representative payee, you must report the death of an eligible individual, eligible spouse, or eligible child whom you represent; and the death of any other person who was living in the household of the individual you represent.

(5) If you have a representative payee, you must report the death of your representative payee.

(g) *A change in marital status.* You must report to us—

(1) Your marriage, your divorce, or the annulment of your marriage;

(2) The marriage, divorce, or annulment of marriage of your parent who lives with you, if you are an eligible child;

(3) The marriage of an ineligible child who lives with you, if you are an eligible child; and

(4) The marriage of an ineligible child who lives with you if you are an eligible individual living with an ineligible spouse.

(h) *Medical improvements.* If you are eligible for SSI benefits because of disability or blindness, you must report any improvement in your medical condition to us.

(i) *Refusal to accept vocational rehabilitation services.* If we have referred you for vocational rehabilitation services and you refuse to accept these services, you must report your refusal to us.

(j) *Refusal to accept treatment for drug addiction or alcoholism; discontinuance of treatment.* If you have been medically determined to be a drug addict or an alcoholic, and you refuse to accept treatment for drug addiction or alcoholism at an approved facility or institution, or if you discontinue treatment, you must report your refusal or discontinuance to us.

(k) *Admission to or discharge from a medical facility, public institution, or private institution.* You must report to us your admission to or discharge from—

(1) A hospital;

(2) A skilled nursing facility;

(3) An intermediate care facility; or

(4) A public institution (defined in § 416.201); or

(5) A private institution. *Private institution* means an institution as defined in § 416.201 which is not administered by or the responsibility of a governmental unit.

(l) *A change in school attendance.* You must report to us—

(1) A change in your school attendance if you are an eligible child;

(2) A change in school attendance of an ineligible child who is at least age 18 but less than 21 and who lives with you if you are an eligible child; and

(3) A change in school attendance of an ineligible child who is at least age 18 but less than 21 and who lives with you if you are an eligible individual living with an ineligible spouse.

(m) *A termination of residence in the U.S.* You must report to us if you leave the United States voluntarily with the intention of abandoning your residence in the United States or you leave the United States involuntarily (for example, you are deported).

(n) *Leaving the U.S. temporarily.* You must report to us if you leave the United States for 30 or more consecutive days or for a full calendar month (without the intention of abandoning your residence in the U.S.).

[46 FR 5873, Jan. 21, 1981, as amended at 51 FR 10616, Mar. 14, 1986]

§ 416.710 What reports must include.

When you make a report you must tell us—

(a) The name and social security number under which benefits are paid;

(b) The name of the person about whom you are reporting;

(c) The event you are reporting and the date it happened; and

(d) Your name.

§ 416.712 Form of the report.

You may make a report in any of the ways described in this section.

(a) *Written reports.* You may write a report on your own paper or on a printed form supplied by us. You may mail a written report or bring it to one of our offices.

(b) *Oral reports.* You may report to us by telephone, or you may come to one of our offices and tell one of our employees what you are reporting.

(c) *Other forms.* You may use any other suitable method of reporting—for example, a telegram or a cable.

§ 416.714 When reports are due.

(a) *A reportable event happens.* You should report to us as soon as an event listed in § 416.708 happens. If you do not report within 10 days after the close of the month in which the event happens, your report will be late. We may impose a penalty deduction from your benefits for a late report (see §§ 416.722 through 416.732).

(b) *We request a report.* We may request a report from you if we need information to determine continuing eligibility or the correct amount of your SSI benefit payments. If you do not report within 30 days of our written request, we may determine that you are ineligible to receive SSI benefits. We will suspend your benefits effective with the month following the month in which we determine that you are ineligible to receive SSI benefits because of your failure to give us necessary information.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

PENALTY DEDUCTIONS

§ 416.722 Circumstances under which we make a penalty deduction.

A penalty deduction is made from your benefits if—

(a) You fail to make a required report on time (see §§ 416.708 and 416.714);

(b) We must reduce, suspend, or terminate your benefits because of the event you have not reported;

(c) You received and accepted an SSI benefit for the penalty period (see §§ 416.724 through 416.728 for penalty period definitions); and

(d) You do not have good cause for not reporting on time (see § 416.732).

§ 416.724 Amounts of penalty deductions.

(a) *Amounts deducted.* If we find that we must impose a penalty deduction, you will lose from your SSI benefits a total amount of—

(1) $25 for a report overdue in the first penalty period;

(2) $50 for a report overdue in the second penalty period; and

(3) $100 for a report overdue in the third (or any following) penalty period.

(b) *Limit on number of penalties.* Even though more than one required report is overdue from you at the end of a penalty period, we will limit the number of penalty deductions imposed to one penalty deduction for any one penalty period.

§ 416.726 Penalty period: First failure to report.

(a) *First penalty period.* The first penalty period begins on the first day of the month you apply for SSI benefits and ends on the day we first learn that you should have made a required report, but did not do so within 10 days after the close of the month in which the event happened. There may be more than one required report overdue at the end of the first penalty period, but we will impose no more than one penalty deduction for the period.

(b) *Extension of first penalty period.* If you have good cause for not making a report on time (see § 416.732), we will extend the first penalty period to the day when we learn that you should have made another required report, but did not do so within 10 days after the close of the month in which the event happened. There may be more than one required report overdue at the end of the extended first penalty period, but we will impose no more than one penalty deduction for the extended period.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

§ 416.728 Penalty period: Second failure to report.

(a) *Second penalty period.* The second penalty period begins on the day after the first penalty period ends. The second penalty period ends on the day we

first learn that you should have made a required report, but did not do so within 10 days after the close of the month in which the event happened. (The event may have happened during the first penalty period, with the reporting due date in the second penalty period. The due date and the failure to report on time are the important factors in establishing a penalty period.) There may be more than one required report overdue at the end of the second penalty period, but we will impose no more than one penalty deduction for the period.

(b) *Extension of second penalty period.* If you have good cause for not making a report on time (see § 416.732), we will extend the second penalty period to the day when we learn that you should have made another required report, but did not do so within 10 days after the close of the month in which the event happened. There may be more than one required report overdue at the end of the extended second penalty period, but we will impose no more than one penalty deduction for the extended period.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

§ 416.730 Penalty period: Three or more failures to report.

(a) *Third (or a following) penalty period.* A third (or a following) penalty period begins the day after the last penalty period ends. This penalty period ends on the day we first learn that you should have made a required report during the penalty period, but did not do so within 10 days after the close of the month in which the event happened. (The event may have happened during an earlier penalty period, with the reporting due date in the third (or a following) penalty period. The due date and the failure to report on time are the important factors in establishing a penalty period.) There may be more than one required report overdue at the end of a penalty period, but we will impose no more than one penalty deduction for any one penalty period.

(b) *Extension of third (or a following) penalty period.* Just as with the first and second penalty periods, if you have good cause for not making a report on time during the third (or a following) penalty period (see § 416.732), we will extend the penalty period to the day when we learn that you should have made another required report, but did not do so within 10 days after the close of the month in which the event happened. There may be more than one required report overdue at the end of an extended penalty period, but we will impose no more than one penalty deduction for any one extended penalty period.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

§ 416.732 No penalty deduction if you have good cause for failure to report timely.

(a) We will find that you have good cause for failure to report timely and we will not impose a penalty deduction, if—

(1) You are ''without fault'' as defined in § 416.552; or

(2) Your failure or delay in reporting is not willful. ''Not willful'' means that—

(i) You did not have full knowledge of the existence of your obligation to make a required report; or

(ii) You did not intentionally, knowingly, and purposely fail to make a required report.

However, in either case we may require that you refund an overpayment caused by your failure to report. See subpart E of this part for waiver of recovery of overpayments.

(b) In determining whether you have good cause for failure to report timely, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) you may have.

[59 FR 1636, Jan. 12, 1994]

Subpart H—Determination of Age

AUTHORITY: Secs. 702(a)(5), 1601, 1614(a)(1) and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1381, 1382c(a)(1), and 1383).

SOURCE: 39 FR 12731, Apr. 8, 1974, unless otherwise noted.

§ 416.801 Evidence as to age—when required.

An applicant for benefits under title XVI of the Act shall file supporting evidence showing the date of his birth if his age is a condition of eligibility for benefits or is otherwise relevant to the payment of benefits pursuant to such title XVI. Such evidence may also be required by the Administration as to the age of any other individual when such other individual's age is relevant to the determination of the applicant's eligibility or benefit amount. In the absence of evidence to the contrary, if the applicant alleges that he is at least 68 years of age and submits any documentary evidence at least 3 years old which supports his allegation, no further evidence of his age is required. In the absence of evidence to the contrary, if a State required reasonably acceptable evidence of age and provides a statement as to an applicant's age, no further evidence of his age is required unless a statistically valid quality control sample has shown that a State's determination of age procedures do not yield an acceptable low rate of error.

§ 416.802 Type of evidence to be submitted.

Where an individual is required to submit evidence of date of birth as indicated in § 416.801, he shall submit a public record of birth or a religious record of birth or baptism established or recorded before his fifth birthday, if available. Where no such document recorded or established before age 5 is available the individual shall submit as evidence of age another document or documents which may serve as the basis for a determination of the individual's date of birth provided such evidence is corroborated by other evidence or by information in the records of the Administration.

§ 416.803 Evaluation of evidence.

Generally, the highest probative value will be accorded to a public record of birth or a religious record of birth or baptism established or recorded before age 5. Where such record is not available, and other documents are submitted as evidence of age, in determining their probative value, consideration will be given to when such other documents were established or recorded, and the circumstances attending their establishment or recordation. Among the documents which may be submitted for such purpose are: school record, census record, Bible or other family record, church record of baptism or confirmation in youth or early adult life, insurance policy, marriage record, employment record, labor union record, fraternal organization record, military record, voting record, vaccination record, delayed birth certificate, birth certificate of child of applicant, physician's or midwife's record of birth, immigration record, naturalization record, or passport.

§ 416.804 Certified copy in lieu of original.

In lieu of the original of any record, except a Bible or other family record, there may be submitted as evidence of age a copy of such record or a statement as to the date of birth shown by such record, which has been duly certified (see § 404.701(g) of this chapter).

§ 416.805 When additional evidence may be required.

If the evidence submitted is not convincing, additional evidence may be required.

§ 416.806 Expedited adjudication based on documentary evidence of age.

Where documentary evidence of age recorded at least 3 years before the application is filed, which reasonably supports an aged applicant's allegation as to his age, is submitted, payment of benefits may be initiated even though additional evidence of age may be required by §§ 416.801 through 416.805. The applicant will be advised that additional evidence is required and that, if it is subsequently established that the prior finding of age is incorrect, the applicant will be liable for refund of any overpayment he has received. If any of the evidence initially submitted tends to show that the age of the applicant or such other person does not correspond with the alleged age, no benefits will be paid until the evidence required by §§ 416.801 through 416.805 is submitted.

Subpart I—Determining Disability and Blindness

AUTHORITY: Secs. 702(a)(5), 1611, 1614, 1619, 1631(a), (c), and (d)(1), and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), and (d)(1), and 1383b); secs. 4(c) and 5, 6(c)–(e), 14(a) and 15, Pub. L. 98–460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, 1382h note).

SOURCE: 45 FR 55621, Aug. 20, 1980, unless otherwise noted.

GENERAL

§ 416.901 Scope of subpart.

In order for you to become entitled to any benefits based upon disability or blindness you must be disabled or blind as defined in title XVI of the Social Security Act. This subpart explains how we determine whether you are disabled or blind. We have organized the rules in the following way.

(a) We define general terms, then discuss who makes our disability or blindness determinations and state that disability and blindness 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 §§ 416.905 through 416.910.

(c) Sections 416.912 through 416.918 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 for adults filing new applications are stated in §§ 416.920 through 416.923. We describe the steps that we go through and the order in which they are considered.

(e) Our general rules on evaluating disability for children filing new applications are stated in §§ 416.924 through 416.924e.

(f) Our rules on medical considerations are found in §§ 416.925 through 416.930. We explain in these rules—

(1) The purpose and use of the Listing of Impairments found in appendix 1 of subpart P of part 404 of this chapter;

(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.

(g) In §§ 416.931 through 416.934 we explain that we may make payments on the basis of presumptive disability or presumptive blindness.

(h) In §§ 416.935 through 416.939 we explain the rules which apply in cases of drug addiction and alcoholism.

(i) In §§ 416.945 through 416.946 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.

(j) Our rules on vocational considerations are found in §§ 416.960 through 416.969a. 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 how the Guidelines in appendix 2 of subpart P of part 404 of this chapter apply to claims under part 416, 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.

(k) Our rules on substantial gainful activity are found in §§ 416.971 through 416.974. These explain what we mean by substantial gainful activity and how we evaluate your work activity.

(l) In §§ 416.981 through 416.985 we discuss blindness.

(m) Our rules on when disability or blindness continues and stops are contained in §§ 416.986 and 416.988 through

416.998. We explain what your responsibilities are in telling us of any events that may cause a change in your disability or blindness 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 determining whether you are still disabled.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 50136, Dec. 6, 1985; 56 FR 5553, Feb. 11, 1991; 56 FR 57944, Nov. 14, 1991]

§ 416.902 General definitions and terms for this subpart.

As used in this subpart—

Adult means a person who is age 18 or older.

Child means a person who has not attained age 18.

Medical sources refers to treating sources, sources of record, and consultative examiners for us. See § 416.913.

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 benefits. 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 or is receiving benefits based on disability or blindness.

[56 FR 36962, Aug. 1, 1991, as amended at 58 FR 47577, Sept. 9, 1993]

DETERMINATIONS

§ 416.903 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 J 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 § 416.1016 for the qualifications we consider necessary for a psychologist to be a psychological consultant and § 416.1017 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 other than a qualified psychologist unless the mental impairment alone would justify a finding of disability.

(f) *Determinations for childhood impairments.* In making a determination under title XVI with respect to the disability of a child to whom paragraph (e) of this section does not apply, we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment(s) evaluates the case of the child.

[46 FR 29211, May 29, 1981, as amended at 52 FR 33927, Sept. 9, 1987; 58 FR 47577, Sept. 9, 1993]

§ 416.903a 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 §§ 416.919 and 416.919g(b).

[56 FR 36963, Aug. 1, 1991]

§ 416.904 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

§ 416.905 Basic definition of disability for adults.

(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 (see § 416.920).

(b) There are different rules for determining disability for individuals who are statutorily blind. We discuss these in §§ 416.981 through 416.985.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5553, Feb. 11, 1991]

§ 416.906 Basic definition of disability for children.

If you are under age 18, we will consider you disabled if you are suffering from any medically determinable physical or mental impairment which compares in severity to an impairment that would make an adult (a person over age 18) disabled. We discuss our rules for determining disability in children in §§ 416.924, and 416.924a through 416.924e.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5553, Feb. 11, 1991]

§ 416.907 Disability under a State plan.

You will also be considered disabled for payment of supplemental security income benefits if—

(a) You were found to be permanently and totally disabled as defined under a State plan approved under title XIV or XVI of the Social Security Act, as in effect for October 1972;

(b) You received aid under the State plan because of your disability for the month of December 1973 and for at least one month before July 1973; and

(c) You continue to be disabled as defined under the State plan.

§ 416.908 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 § 416.927). (See § 416.928 for further information about what we mean by symptoms, signs, and laboratory findings.)

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 36963, Aug. 1, 1991]

§ 416.909 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.

§ 416.910 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 § 416.972 for further details about what we mean by substantial gainful activity.)

§ 416.911 Definition of disabling impairment.

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 subpart P of part 404 of this chapter or which, when considered with your age, education and work experience, would result in a finding that you are disabled under § 416.994. In determining

whether you have a disabling impairment, earnings are not considered.

[50 FR 50137, Dec. 6, 1985]

EVIDENCE

§ 416.912 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 § 416.928 (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 § 416.913(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 § 416.927(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 §§ 416.960 through 416.969, 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 that your disability began earlier.

(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 §§416.917 through 416.919t 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 36963, Aug. 1, 1991]

§ 416.913 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 (see paragraph (f) of this section for the evidence needed for statutory blindness); 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.

(6) A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is also considered acceptable medical evidence.

(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 § 416.927.

(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 §§ 416.927 and 416.945(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.

(3) If you are a child, the medical source's opinion about your physical or mental abilities to function independently, appropriately, and effectively in an age-appropriate manner, as described in § 416.924d.

(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(s) affects your ability to work or, if you are a child, your ability to function independently, appropriately, and effectively in an age-appropriate manner. Other sources may include, and are not limited to—

(1) Public and private social welfare agencies and social workers;

(2) Observations by people who know you (for example, spouses, parents and other caregivers, siblings, other relatives, friends or neighbors, clergy);

(3) Other practitioners (for example, nurse practitioners and physicians' assistants, naturopaths, and chiropractors);

(4) Therapists (for example, physical, occupational, or speech and language therapists); and

(5) Educational agencies and personnel (for example, school teachers, school psychologists who are not acceptable medical sources under paragraph (a), school counselors, preschools, early intervention teams, developmental centers, and daycare centers).

(f) *Evidence we need to establish statutory blindness.* If you are applying for benefits on the basis of statutory blindness, we will require an examination by a physician skilled in diseases of the eye or by an optometrist, whichever you may select.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5553, Feb. 11, 1991; 56 FR 36964, Aug. 1, 1991; 58 FR 47577, Sept. 9, 1993]

§ 416.914 When we will purchase existing evidence.

We need specific medical evidence to determine whether you are disabled or blind. We will pay for the medical evidence we request, if there is a charge. We will also be responsible for the cost of medical evidence we ask you to get.

§ 416.915 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 or blindness 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 C of this part.

§ 416.916 If you fail to submit medical and other evidence.

You (and if you are a child, your parent, guardian, relative, or other person

acting on your behalf) must co-operate in furnishing us with, or in helping us to obtain or identify, available medical or other evidence about your impairment(s). When you fail to co-operate with us in obtaining evidence, 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.

[58 FR 47577, Sept. 9, 1993]

§ 416.917 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 36964, Aug. 1, 1991]

§ 416.918 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 55621, Aug. 20, 1980, as amended at 59 FR 1636, Jan. 12, 1994]

STANDARDS TO BE USED IN DETERMINING WHEN A CONSULTATIVE EXAMINATION WILL BE OBTAINED IN CONNECTION WITH DISABILITY DETERMINATIONS

§ 416.919 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 § 416.919a through § 416.919f. Selection of the source for the examination will be consistent with the provisions of § 416.903a and §§ 416.919g

through 416.919j. The rules and procedures for requesting consultative examinations set forth in §§ 416.919a and 416.919b are applicable at the reconsideration and hearing levels of review, as well as the initial level of determination.

[56 FR 36964, Aug. 1, 1991]

§ 416.919a 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 § 416.912 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 36964, Aug. 1, 1991]

§ 416.919b 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) When any issues about your actual performance of substantial gainful activity have not been resolved;

(b) When you do not meet all of the nondisability requirements.

[56 FR 36965, Aug. 1, 1991]

STANDARDS FOR THE TYPE OF REFERRAL AND FOR REPORT CONTENT

§ 416.919f 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 36965, Aug. 1, 1991]

§ 416.919g 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 § 416.913(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 §416.903a. 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 §416.903a.

[56 FR 36965, Aug. 1, 1991]

§416.919h 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 36965, Aug. 1, 1991]

§416.919i 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 which 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 36965, Aug. 1, 1991]

§416.919j 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 §416.919s. 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 36965, Aug. 1, 1991]

§416.919k 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 public 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 §§ 416.1024 and 416.1026.

(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 36965, Aug. 1, 1991]

§ 416.919m 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 Supplemental Security Income 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 36966, Aug. 1, 1991]

§ 416.919n 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 that 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 Subpart P of Part 404 of this Chapter);

(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 36966, Aug. 1, 1991]

§ 416.919o 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 disability which has ended; or

(4) Allowance with an onset date later than the filing date.

[56 FR 36967, Aug. 1, 1991]

§ 416.919p 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 36967, Aug. 1, 1991]

§416.919q 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 36967, Aug. 1, 1991]

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

§416.919s 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 and Supplemental Security Income 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 § 416.919m.

(7) procedures for the ongoing review of consultative examination results to ensure compliance with written guidelines;

(8) Procedures to encourage active participation by physicians and psychologists 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 36967, Aug. 1, 1991]

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

§ 416.919t 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 36968, Aug. 1, 1991]

EVALUATION OF DISABILITY

§ 416.920 Evaluation of disability of adults, 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 Supplemental Security Income disability benefits and are age 18 or older, 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 eligible for Supplemental Security Income benefits based on disability, we follow a somewhat different order of evaluation to determine whether your eligibility continues, as explained in § 416.994(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.

(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 impairment(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 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 § 416.962).

[50 FR 8728, Mar. 5, 1985; 50 FR 19164, May 7, 1985, as amended at 56 FR 5554, Feb. 11, 1991; 56 FR 36968, Aug. 1, 1991]

§ 416.920a Evaluation of mental impairments.

(a) *General.* The steps outlined in § 416.920 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 administrative 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 § 416.908 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 represents 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 § 416.921).

(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, unless you are claiming benefits as a disabled child.

(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 35070, Aug. 28, 1985, as amended at 55 FR 51236, Dec. 12, 1990]

§ 416.921 What we mean by a not severe impairment(s) in an adult.

(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 8729, Mar. 5, 1985, as amended at 56 FR 5554, Feb. 11, 1991]

§ 416.922 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 8729, Mar. 5, 1985]

§ 416.923 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 §§ 416.920 and 416.924).

[50 FR 8729, Mar. 5, 1985, as amended at 56 FR 5554, Feb. 11, 1991]

§ 416.924 How we determine disability for children.

(a) *Definition of comparable severity.* If you are a child, we will find you disabled if you are not engaging in substantial gainful activity and you have

an impairment or combination of impairments that is of comparable severity to an impairment or combination of impairments that would disable an adult and which meets the duration requirement (see § 416.909). By the term *comparable severity,* we mean that your physical or mental impairment(s) so limits your ability to function independently, appropriately, and effectively in an age-appropriate manner that your impairment(s) and the limitations resulting from it are comparable to those which would disable an adult. Specifically, your impairment(s) must substantially reduce your ability to—

(1) Grow, develop, or mature physically, mentally, or emotionally and, thus, to attain developmental milestones (see § 416.924b(b)(2)) at an age-appropriate rate; or

(2) Grow, develop, or mature physically, mentally, or emotionally and, thus, to engage in age-appropriate activities of daily living (see § 416.924b(b)(3)) in self-care, play and recreation, school and academics, community activities, vocational settings, peer relationships, or family life; or

(3) Acquire the skills needed to assume roles reasonably expected of adults (see § 416.924b(b)(4)).

(b) *Steps in evaluating disability.* We consider all evidence in your case record when we make a determination or decision whether you are disabled. If you allege more than one impairment, we will evaluate all the impairments for which we have evidence. Thus, we will consider the combined effects of all your impairments upon your overall health and ability to function. We will also evaluate any limitations in your ability to function that result from your symptoms, including pain (see § 416.929). When you file a claim, we use the evaluation process set forth in (c) through (f) of this section. We follow a set order to determine whether you are disabled. If you are doing substantial gainful activity, we will determine that you are not disabled and not review your claim further. If you are not doing substantial gainful activity, we will consider your physical or mental impairment(s) first to see if you have an impairment or combination of impairments that is severe. If your impairment(s) is not severe, we will determine that you are not disabled and not review your claim further. If your impairment(s) is severe, we will review your claim further to see if you have an impairment(s) that meets or equals in severity any impairment that is listed in appendix 1 of subpart P of part 404 of this chapter, in which case we will find you disabled. If you do not have such an impairment(s), we will do an individualized functional assessment and determine whether you are disabled. Once you have been found eligible for disability benefits, we follow a somewhat different procedure to determine whether your eligibility continues, as explained in § 416.994a.

(c) *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 age, education, or work experience. (For our rules on how we decide whether you are engaging in substantial gainful activity, see §§ 416.971 through 416.976.)

(d) *You must have a severe impairment(s).* If your impairment is a slight abnormality or a combination of slight abnormalities that causes no more than minimal limitation in your ability to function independently, appropriately, and effectively in an age-appropriate manner, we will find that you do not have a severe impairment and are, therefore, not disabled.

(e) *When your impairment(s) meets or equals a listed impairment in appendix 1.* The Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter is set at a level of severity that precludes any gainful activity or that is comparable in severity to an impairment that would preclude an adult from engaging in any gainful activity. Therefore, if you have an impairment(s) which meets the duration requirement and is listed in appendix 1, or is equal to a listed impairment, we will find you disabled. We will not deny your claim on the basis of a finding that your impairment(s) does not meet the requirements for any listed impairment or is not equal in severity to any of the impairments listed in appendix 1. We explain our rules for deciding whether an impairment meets a listing in § 416.925. Our rules for how

we decide whether an impairment(s) equals a listing are set forth in §416.926a.

(f) *Your impairment(s) must be of comparable severity to an impairment(s) that would disable an adult.* When we determine that your impairment(s) is severe, but that it does not meet or equal in severity any listed impairment, we will assess the impact of your impairment(s) on your overall ability to function independently, appropriately, and effectively in an age-appropriate manner. We will use this individualized functional assessment to decide whether you have an impairment(s) of comparable severity to an impairment(s) that would prevent an adult from engaging in substantial gainful activity and, thus, to determine whether or not you are disabled. We will use the individualized functional assessment in the following manner:

(1) If:

(i) Our evaluation of all the evidence in your claim shows that your impairment(s) substantially reduces your physical or mental ability to function independently, appropriately, and effectively in an age-appropriate manner, and

(ii) Your impairment(s) meets the duration requirement, we will find you disabled.

(2) If we find that your impairment(s) does not substantially reduce your physical or mental ability to function independently, appropriately, and effectively in an age-appropriate manner, or if your impairment(s) does not meet the duration requirement, we will find that you are not disabled.

(g) *Basic considerations.* When we determine whether you are disabled, we will consider all relevant evidence in your case record. This may include medical evidence, school records, information from people who know you and can provide evidence about your functioning—such as your parents, caregivers, and teachers—and other evidence that can help us assess your functioning on a longitudinal basis.

(1) Medical evidence of your impairment(s) must describe symptoms, signs, or laboratory findings. The medical evidence may include formal testing that provides information about your development or functioning in terms of percentiles, percentages, standard deviations, or chronology (such as months of delay). Whenever possible, a medical source's findings should reflect consideration of information from your parents or other people who know you, as well as the medical source's findings and observations on examination; any discrepancies between formal test results and your customary behavior and daily activities should be duly noted and resolved.

(2) Your functional limitations may also be observed and reported by others. Parents (or other caregivers), and other family members may provide important evidence on how well you are functioning on a day-to-day basis. Educational and other intervention programs may be important sources of evidence about your functioning, and will often have documentary evidence in the form of evaluation instruments and other evidence from a variety of disciplines.

[58 FR 47577, Sept. 9, 1993]

§416.924a Age as a factor of evaluation in childhood disability.

(a) *General.* In this regulation, we explain how we consider age when we decide whether you are disabled. Your age may or may not be a factor in our determination whether your impairment(s) meets or equals a listing, depending on the listing we use for comparison. However, your age is always an important factor when we decide whether your impairment(s) is severe (see §416.924(d)) or whether you are disabled based on an individualized functional assessment (see §416.924(f)). Except in the case of certain premature infants, as described in paragraph (c) of this section, age means chronological age.

(1) When we determine whether you have an impairment or combination of impairments that is severe, we will always consider the significance of your impairment(s) in relation to your age.

(2) The Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter contains examples of impairments that we consider of such significance that they prevent a child from

functioning independently, appropriately, and effectively in an age-appropriate manner. Therefore, we will usually decide whether your impairment meets a listing without giving special consideration to your age. However, several listings are divided into age categories. If the listing appropriate for evaluating your impairment includes such age categories, we will evaluate your impairment under the criteria for your age when we decide whether your impairment meets that listing.

(3) When we compare an unlisted impairment or combination of impairments with a listed impairment to determine whether you have an impairment(s) which equals a listing, the way in which we consider your age will depend on the listing we use for comparison. We will use the same principles for considering your age as in paragraph (a)(2) of this section; that is, we will consider your age only if we are comparing your impairment(s) to a listing that includes specific age categories.

(4) When we determine whether you have an impairment(s) which, though not meeting or equaling the listings, is of comparable severity to an impairment that would disable an adult, we will always consider the significance of your impairment(s) in relation to your age. We will consider the functions, behaviors, and activities that are appropriate to your age, and will evaluate the effect of your impairment(s), either alone or in conjunction with other relevant factors, on your ability to perform these functions, behaviors, and activities. (We explain how we do this individualized functional assessment in §§ 416.924d and 416.924e.)

(5) In any disability determination, we will consider your age and whether it affects your ability to be tested. Even when your impairment(s) is not amenable to formal testing because of your age, we will consider all evidence that will help us decide whether you are disabled.

(b) *Age categories*. When we determine whether you are functioning independently, appropriately, and effectively in an age-appropriate manner, we will consider your age in the following categories:

(1) Newborn and young infants (birth to attainment of age 1).

(2) Older infants and toddlers (age 1 to attainment of age 3).

(3) Children (age 3 to attainment of age 18), considered according to the following subcategories:

(i) Preschool children (age 3 to attainment of age 6).

(ii) School-age children (age 6 to attainment of age 12).

(iii) Young adolescents (age 12 to attainment of age 16), and

(iv) Older adolescents (age 16 to attainment of age 18).

(c) *Correcting chronological age of premature infants.* We generally use chronological age (that is, a child's age based on birth date) when we decide whether, or the extent to which, a physical or mental impairment(s) affects a child's ability to function independently, appropriately, and effectively in an age-appropriate manner. However, if you were born prematurely, we may consider you to be younger than your chronological age. When we evaluate the development or linear growth of a child born prematurely, we may use a ''corrected'' chronological age; that is, the chronological age adjusted by a period of gestational prematurity. We consider an infant born at less than 37 weeks' gestation to be born prematurely.

(1) We apply a corrected chronological age in these situations—

(i) When we evaluate developmental delay in premature children until the child's prematurity is no longer a relevant factor; generally no later than about chronological age 2 (see paragraph (c)(2) of this section);

(ii) When we evaluate an impairment of linear growth, such as under the listings in § 100.00 in appendix 1 of subpart P of part 404 of this chapter, until the child is 12 months old. In this situation, we refer to neonatal growth charts which have been developed to evaluate growth in premature infants (see paragraph (c)(2) of this section).

(2) We compute a corrected chronological age as follows—(i) If you have not attained age 1, we will correct your chronological age. We compute the corrected chronological age by subtracting the number of weeks of

prematurity (i.e., the difference between 40 weeks of full-term gestation and the number of actual weeks of gestation) from your chronological age. The result is your corrected chronological age.

(ii) If you are over age 1, have a developmental delay, and prematurity is still a relevant factor in your case (generally, no later than about chronological age 2), we will decide whether to correct your chronological age. Our decision will be based on our judgment and all the facts of your case. If we decide to correct your chronological age, we may correct it by subtracting the full number of weeks of prematurity or a lesser number of weeks. We will also decide not to correct your chronological age if we can determine from the evidence that your developmental delay is the result of your medically determinable impairment(s) and is not attributable to your prematurity.

(3) Notwithstanding the provisions in paragraph (c)(1) of this section, we will not compute a corrected chronological age if the medical evidence shows that your treating source or other medical source has already taken your prematurity into consideration in his or her assessment of your development. Also, we will not compute a corrected chronological age when we find you disabled using the examples of functional equivalence based on low birth weight in § 416.926a(d) (8) or (9).

(d) *Age and the impact of severe impairments on younger children and older adolescents.* Although a child may become disabled at any age, impairments of similar severity may have different effects on children of different ages. The following guidelines apply to determinations of disability for children of different ages, especially very young children and children approaching adulthood.

(1) We recognize that how a particular child adapts to an impairment(s) depends on many factors (e.g., the nature and severity of the impairment(s), the child's temperament, the quality of adult intervention, and the child's age at onset of the impairment(s)). By *adapting to an impairment,* we mean the child's ability to learn those skills, habits, or behaviors which allow the child to compensate for the impairment(s) and, thus, to function in an age-appropriate manner as well as possible despite the impairment(s). Therefore, our disability determination will consider how you are adapting to your impairment(s) and the extent to which you are able to function independently, appropriately, and effectively in an age-appropriate manner as set forth in this section and §§ 416.924 and 416.924c through 416.924e.

(2) When we decide whether you are disabled, we will generally consider the factor of age in a manner opposite from that described in the rules for determining whether an adult has the ability to adjust to other work (see §§ 416.920(f) and 416.963). Thus, we consider that the older a child is, the more he or she is like a younger adult; we consider an older adolescent (i.e., a child aged 16 to 18) to be most like a ''younger person'' (i.e., a person in the age category 18 to 45 (see § 416.963(b)), and younger children to be most like older adults in terms of the significance of their impairments.

(3) Although various kinds of growth and development occur throughout childhood and adolescence, the earliest years, from birth to approximately attainment of age 6, are characterized by complex and rapid changes; for example, learning to walk, talk, and care for basic physical and emotional needs.

(i) The development of fundamental skills is a cumulative process founded upon skills acquired at each stage of a child's life. A child's ability to acquire or perform these skills ultimately determines his or her ability to master learning tasks in school and more complex physical activities and, eventually, affects the ability to work. Therefore, deficits of function resulting from impairments that occur before the attainment of age 6 may have a potentially greater, more limiting effect on a child's overall growth and development than impairments that occur later in life; and such deficits are increasingly significant with decreasing age.

(ii) Furthermore, the mastery of skills in early childhood is a highly interactive and interdependent process within a child. This interdependence is especially true of development in certain areas; e.g., cognitive skill deficits

may affect communication, and social and emotional deficits may affect cognitive and communicative development. This interdependent process also requires proper functioning in areas that may not be obviously relevant to the acquisition of the skill. For example, physical mobility is affected by how well a child sees; therefore, visual impairment, especially in a young child, can affect the way a child acquires certain motor skills even though the child does not have a specific motor impairment. Similarly, emotional bonding to parents can be affected by how well a child hears. Therefore, the impact of such seemingly isolated impairments can have implications for the overall development of the youngest children.

(4) As children approach adulthood—that is, by about age 16—the functional abilities, skills, and behaviors that are age-appropriate for them are those that are also age-appropriate for 18-year-olds, i.e., those that are needed to assume roles reasonably expected of adults. Older adolescents generally also share with the youngest adults the same abilities to adapt to work-related activities despite a severe impairment(s).

(i) By the age of adolescence, children have developed basic physical and mental skills and behaviors, so that impairments occurring in adolescence may not have the cumulative interactive effects on functioning that impairments occurring in infancy and early childhood do. (However, as set forth in paragraph (d)(1) of this section, we also recognize that young and older adolescents may experience a variety of impairments with different effects on their ability to function in an age-appropriate manner. For instance, a child born with a degenerative disorder may experience a worsening of its effects as he or she grows older so that functioning is more limited for the older child than it is for a younger child with the same illness or disorder.)

(ii) Inasmuch as age-appropriate functioning for an older adolescent is also that of an 18-year-old young adult, the disability determination for an older adolescent must be consistent with the disability determination we would make for an 18-year-old person having the same functional limitations.

[58 FR 47578, Sept. 9, 1993]

§ 416.924b Functioning in children.

(a) *General.* When we evaluate your functioning, we will consider all of your mental and physical limitations that result from your impairment(s). We will evaluate the extent to which you can engage in age-appropriate activities in an independent, appropriate, and effective manner and, when applicable, whether you can do these things on a sustained basis appropriate to your age.

(b) *Terms used to describe functioning*—(1) *Age-appropriate activities.* As used in these regulations, the term *age-appropriate activities* is a comprehensive term that refers to what a child is expected to be able to do given his or her age. A child's activities may be described in terms of the achievement of ''developmental milestones,'' ''activities of daily living,'' or other such terms. Information about a child's activities creates a profile of how the child is functioning, i.e., what a child does, and thus what he or she is able to do. This makes possible a comparison between the child's profile and the activities that are age-appropriate for that child.

(2) *Developmental milestones.* The term *developmental milestones* refers to a child's expected principal developmental achievements at particular points in time. Ordinarily, failures to achieve developmental milestones are the most important indicators of impaired functioning from birth until the attainment of age 3, although they may be used to evaluate older children, especially preschool children.

(3) *Activities of daily living.* The term *activities of daily living* refers to those activities of children that involve continuity of purpose and action, and goal or task orientation; that is, the practical implementation of skills mastered at earlier ages. Ordinarily, activities of daily living are the most important indicators of functional limitations in children aged 3 to attainment of age 16, although they may be used to evaluate children younger than age 3.

(4) *Work-related activities.* The term *work-related activities* refers to those physical and mental activities that are

associated with, or related to, activities in the workplace, as manifested in a person's activities in age-appropriate contexts, such as school, work, vocational programs, and organized activities. Ordinarily, inability to perform work-related activities is the most important indicator of impaired functioning in older adolescents, aged 16 to attainment of age 18.

(5) *Domains and behaviors.* The terms *developmental domains, functional domains,* and *behaviors,* which we use when we perform an individualized functional assessment, refer to broad areas of functioning that can be identified in infancy and traced throughout a child's growth and maturation into adulthood. The domains describe the child's major spheres of activity—i.e., physical, cognitive, communicative, social/ emotional, and personal/behavioral. In addition, there are certain areas of behavior that are applicable to specific age categories (i.e., responsiveness to stimuli; concentration, persistence, and pace). The domains and behaviors we use in these regulations are intended to encompass and reflect all the things that a child may do at any particular age, and are, therefore, intended to include all of a child's functioning. All the effects of a child's impairment(s) on daily functioning will be considered within these domains and behaviors. The presence of pain or other symptoms can adversely affect functioning in the domains or behaviors. In these regulations, the term *developmental domains* is generally used when we discuss the functioning of younger children, i.e., from birth to age 3; the term *functional domains* is generally used when we discuss older children and adolescents, i.e., from age 3 to age 18. (See §416.924d for descriptions of the various domains and behaviors as they pertain to the different age categories.)

[58 FR 47580, Sept. 9, 1993]

§416.924c Other factors we will consider.

(a) *General.* When we evaluate how you are able to function, we will consider all factors that are relevant to the evaluation of the effects of your impairment(s) on your functioning, such as the effects of your medications, the setting in which you live, your need for assistive devices, and your functioning in school. Therefore, when we assess the effect of your impairment(s) on your functioning, we will consider all evidence from medical and nonmedical sources—such as your parents, teachers, and other people who know you—that can help us to understand how your impairment(s) affects your ability to function, and help us to assess your functioning within the domains and behaviors (see §416.924b(b)(5)). Some of the factors we will consider include, but are not limited to, the factors in paragraphs (b) through (g) of this section.

(b) *Chronic illness.* If you have a chronic impairment(s) that is characterized by episodes of exacerbation (worsening) or remission (improvement), we will consider the frequency and severity of your episodes of exacerbation and your periods of remission as factors in our determination of your overall ability to function. For instance, if you require repeated hospitalizations or frequent outpatient care with supportive therapy for a chronic impairment(s), we will consider this need for treatment in our determination. When we determine whether you can function independently, appropriately, and effectively in an age-appropriate manner, we will consider how the level of treatment you need for your chronic illness affects your functioning. We will consider whether the length and frequency of your hospitalizations or episodes of exacerbation significantly interfere with your overall functioning on a longitudinal basis, or whether your outpatient care (because of its frequency, effects on your functioning, or both) significantly interferes with your activities of daily living.

(c) *Effects of medication.* We will consider the effects of medication on your symptoms, signs, and laboratory findings, including your ability to function. Although medications may control the most obvious manifestations of your condition(s), they may or may not affect the functional limitations imposed by your impairment(s). If your symptoms or signs are reduced by medications, we will consider whether you have any functional limitations

which may nevertheless persist, even if there is apparent improvement from the medications. We will also consider whether your medications create any side effects which cause or contribute to your functional limitations.

(d) *Effects of structured or highly supportive settings.* Children with severe impairments may spend much of their time in structured or highly supportive settings. A structured or highly supportive setting may be your own home, in which family members make extraordinary adjustments to accommodate your impairment(s); or your classroom at school, whether a regular class in which you are accommodated or a special classroom; or a residential facility or school where you live for a period of time. Children with chronic impairments also commonly have their lives structured in such a way as to minimize stress and reduce their symptoms or signs, and may be relatively free of obvious symptoms or signs of impairment; others may continue to have persistent pain, fatigue, decreased energy, or other symptoms or signs, though at a lesser level of severity. Such children may be more impaired in their overall ability to function in an age-appropriate manner than their symptoms and signs would indicate. Therefore, if your symptoms or signs are controlled or reduced by the environment in which you live, we will consider your ability to function independently, appropriately, and effectively in an age-appropriate manner outside of this highly structured setting.

(e) *Adaptations.* We will consider the nature and extent of any other adaptations that are made for you in order to enable you to function. Such adaptations may include assistive devices, appliances, or technology. Some adaptations may enable you to function normally, or almost normally (e.g., eyeglasses, hearing aids). Others may increase your ability to function, even though you may still have limitations in your ability to function in an age-appropriate manner (e.g., ankle-foot orthoses, hand or foot splints, and specially adapted or custom-made tools, utensils, or devices for self-care activities such as bathing, feeding, toileting, and dressing). When we evaluate your overall ability to function with an adaptation, we will consider the degree to which the adaptation enables you to function independently, appropriately, and effectively in an age-appropriate manner.

(f) *Time spent in therapy.* You may need frequent and ongoing therapy from one or more kinds of health care professionals in order to maintain or improve your functional status. Therapy may include occupational, physical, or speech and language therapy, special nursing services, psychotherapy, or psychosocial counseling. Frequent and continuous therapy, although intended to improve your functioning, may also interfere significantly with your opportunities to engage in, and sustain, age-appropriate activities. If you receive such therapy at school during a normal school day, it may or may not interfere significantly with your doing age-appropriate activities. If you must frequently interrupt your activities at school or at home for therapy, these interruptions may interfere with your development and age-appropriate functioning. When we determine whether you can function independently, appropriately, and effectively in an age-appropriate manner, we will consider the frequency of any multidisciplinary therapy that you must have, how long you have needed the therapy or will need the therapy, and the extent to which it interferes with your age-appropriate functioning.

(g) *School attendance.* (1) School records and information from people at school who know you or who have examined you, such as teachers and school psychologists, psychiatrists, or therapists, may be important sources of information about your impairment(s) and its effect on your ability to function. If you attend school, we will consider this evidence when it is relevant and available to us.

(2) The fact that you are able to attend school will not, in itself, be an indication that you are not disabled. We will consider the circumstances of your school attendance, such as your ability to function independently, appropriately, and effectively in a regular classroom setting in an age-appropriate manner. Likewise, the fact that you are in a special education classroom setting, or that you are not in

such a setting, will not in itself establish your actual limitations or abilities. We will consider the fact of such placement or lack of placement in the context of the remainder of the evidence in your case record.

(3) However, if you are unable to attend school on a regular basis because of your impairment(s), we will consider this when we determine whether you are able to function independently, appropriately, and effectively in an age-appropriate manner.

(h) *Treatment and intervention, in general.* With adequate treatment or intervention, some children not only have their symptoms and signs reduced, but also return to or achieve a level of functioning that is consistent with the norms for their age. We will, therefore, evaluate the effects of your treatment or intervention to determine the actual outcome of the treatment or intervention in your particular case.

[58 FR 47581, Sept. 9, 1993]

§416.924d Individualized functional assessment for children.

(a) *General.* If your impairment(s) is severe, but does not meet or equal in severity any of the listings in appendix 1 of subpart P of part 404 of this chapter, we will do an individualized functional assessment to determine whether you have an impairment or combination of impairments which would nevertheless be of comparable severity to an impairment(s) that would disable an adult. When we assess your functioning, we will consider all information in your case record that can help us determine the impact of your impairment(s) on your physical and mental functioning. We will consider the nature of your impairment(s), your age, your ability to be tested given your age, your ability to perform age-appropriate daily activities, and other relevant factors. (See §§416.924a through 416.924c.) We will assess the extent to which you are able to function independently, appropriately, and effectively in an age-appropriate manner despite your impairment(s), and use this assessment to determine whether you are disabled.

(b) *Responsibility for individualized functional assessment.* In cases where the State agency or other designee of the Secretary makes the initial or reconsideration disability determination, a State agency staff medical or psychological consultant or other designee of the Secretary (see §416.1016) has the overall responsibility for the individualized functional assessment. This assessment is based on all of the evidence we have, from all sources, 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. For cases in the disability hearing process, the responsibility for the individualized functional assessment rests with either the disability hearing officer or, if the disability hearing officer's reconsidered determination is changed under §416.1418, with the Associate Commissioner for Disability or his or her delegate. For cases at the Administrative Law Judge hearing or Appeals Council level, the responsibility for the individualized functional assessment rests with the Administrative Law Judge or Appeals Council.

(c) *Domains of development or functioning.* The following are the domains of development or functioning, or specific behaviors, that may be addressed in an individualized functional assessment:

(1) Cognition;

(2) Communication;

(3) Motor abilities;

(4) Social abilities;

(5) Responsiveness to stimuli (in children from birth to the attainment of age 1);

(6) Personal/behavioral patterns (in children from age 1 to the attainment of age 18); and

(7) Concentration, persistence, and pace in task completion (in children from age 3 to the attainment of age 18).

(d) *How we use the domains.* (1) When we do an individualized functional assessment, we will consider the extent of your impairment-related limitations in the domains or behaviors affected by your impairment(s), and how well you are able to do age-appropriate activities despite your limitations. We will also consider how your impairment(s) in one domain affects your development or functioning in other domains.

(2) We will consider whether any help or intervention that you need from others to enable you to do any particular activity is appropriate to your age.

(3) The guidelines in paragraphs (e) through (j) of this section describe, in terms of the age categories outlined in § 416.924a(b), the domains of development or functioning and the behaviors used in doing an individualized functional assessment, and the general kinds of age-related activities that may be affected by your impairment(s). (See § 416.924a(a)(5) for guidelines on age and a child's ability to be tested, and § 416.924e for guidelines for determining disability using an individualized functional assessment.)

(e) *Newborns and young infants (birth to attainment of age 1).* Children in this age group are evaluated in an individualized functional assessment in terms of four developmental domains and an area of behavior important to newborns and young infants.

(1) Cognitive development, e.g., your ability to begin to organize and regulate how you feel and the ways you react to your environment;

(2) Communicative development (includes speech and language), e.g., your ability to communicate spontaneously and with intention through visual, motor, and vocal exchanges;

(3) Motor development (includes gross and fine motor skills), e.g., your ability to explore your environment by moving your body, and your ability to manipulate your environment by using your hands;

(4) Social development, e.g., your ability to form patterns of self-regulation, to form and maintain intimate relationships with your primary caregivers, and to exchange a variety of age-appropriate emotional cues and begin to organize intentional behavior;

(5) Responsiveness to stimuli, i.e., your ability to respond appropriately to stimulation, e.g., visual, auditory, and tactile.

(f) *Older infants and toddlers (age 1 to attainment of age 3).* Children in this age group are evaluated in an individualized functional assessment in terms of five developmental domains.

(1) Cognitive development, e.g., your ability to understand by responding to increasingly complex requests, instructions or questions, by referring to yourself and things around you by pointing and eventually by naming, and by copying things or imitating actions shown to you by others, and by knowing what you want, as illustrated, for example, by searching for a toy or asking for a special food;

(2) Communicative development (includes speech and language), e.g., your ability to communicate your wishes or needs by using gestures or pretend play, and by understanding, imitating, and using an increasing number of intelligible words, and eventually forming two-to-four word sentences in spontaneous, interactive conversation;

(3) Motor development (includes gross and fine motor skills), e.g., your ability to move in your environment using your body with steadily increasing dexterity and independence from support by others, and your ability to use your hands to do something that you want or get something that you need;

(4) Social development, e.g., your ability to express normal dependence upon, and intimacy with, your primary caregivers, as well as increasing independence from them, to initiate and respond to a variety of age-appropriate emotional cues, and to regulate and organize emotions and behaviors;

(5) Personal/behavioral development, e.g., your ability to help yourself and to cooperate with others in taking care of your personal needs, in adapting to your environment, in responding to limits, and in learning new skills.

(g) *Preschool children (age 3 to attainment of age 6).* Children in this age group are evaluated in an individualized functional assessment in terms of five developmental domains and an area of behavior important to preschool children.

(1) Cognitive development, e.g., your ability to understand, to reason and to solve problems, and to use acquired knowledge and concepts;

(2) Communicative development (includes speech and language), e.g., your ability to communicate by telling, requesting, predicting, and relating information, by following and giving directions, by describing actions and functions, and by expressing your needs, feelings, and preferences in a

spontaneous, interactive, and increasingly intelligible manner, using simple sentences in grammatical form;

(3) Motor development (includes gross and fine motor skills), e.g., your ability to move and use your arms and legs in increasingly more intricate and coordinated activity, and your ability to use your hands with increasing coordination to manipulate small objects during play.

(4) Social development, e.g., your ability to initiate age-appropriate social exchanges and to respond to your social environment through appropriate and increasingly complex interpersonal behaviors, such as showing affection, sharing, cooperating, helping, and relating to other children as individuals or as a group;

(5) Personal/behavioral development, e.g., your ability to help yourself and to cooperate with others in taking care of your personal needs, in adapting to your environment, in responding to limits, and in learning new skills;

(6) Concentration, persistence, and pace, e.g., your ability to engage in an activity, such as dressing or playing, and to sustain the activity for a period of time and at a pace appropriate to your age.

(h) *School-age children (age 6 to attainment of age 12).* Children in this age group are evaluated in an individualized functional assessment in terms of five functional domains and an area of behavior important to school-age children.

(1) Cognitive function, e.g., your ability to progress in learning the skills involved in reading, writing, and mathematics;

(2) Communicative function (includes speech and language), e.g., your ability to communicate pragmatically (i.e., to meet your needs) and conversationally (i.e., to exchange information and ideas with peers and family or with groups such as your school classes) in a spontaneous, interactive, sustained, and intelligible manner;

(3) Motor function (includes gross and fine motor skills), e.g., your ability to engage in the physical activities involved in play and physical education, appropriate to your age;

(4) Social function, e.g., your ability to play alone, or with another child, or in a group; to initiate and develop friendships, to respond to your social environments through appropriate and increasingly complex interpersonal behaviors, such as empathizing with others and tolerating differences; and to relate appropriately to individuals and groups (e.g., siblings, parents or caregivers, peers, teachers, school classes, neighborhood groups);

(5) Personal/behavioral function, e.g., your ability to help yourself and to cooperate with others in taking care of your personal needs and safety; to respond appropriately to authority and school rules; to manifest a sense of responsibility for yourself and respect for others; to adapt to your environment; and to learn new skills;

(6) Concentration, persistence, and pace, e.g., your ability to engage in an activity, such as playing or reading, and to sustain the activity for a period of time and at a pace appropriate to your age.

(i) *Young adolescents (age 12 to attainment of age 16).* Children in this age group are evaluated in an individualized functional assessment in terms of five functional domains and an area of behavior important to young adolescents.

(1) Cognitive function, e.g., your ability to progress in applying the skills involved in reading, writing, and mathematics; your conceptual growth, reasoning and problem-solving abilities;

(2) Communicative function (includes speech and language), e.g., your ability to communicate pragmatically (i.e., to meet your needs) and to converse spontaneously and interactively, expressing complex thoughts with increasing vocabulary in all communication environments (e.g., home, classroom, playground, extra-curricular activities, job) and with all communication partners (e.g., parents or caregivers, siblings, peers, school classes, teachers, other authority figures);

(3) Motor function (includes gross and fine motor skills), e.g., your ability to engage in the physical activities involved in physical education, sports, and social events appropriate to your age;

(4) Social function, e.g., your ability to initiate and develop friendships, to relate appropriately to individual peers

and adults and to peer and adult groups, and to reconcile conflicts between yourself and peers or family members or other adults outside your family;

(5) Personal/behavioral function, e.g., your ability to help yourself in taking care of your personal needs and safety, to respond appropriately to authority and school rules, to manifest a sense of responsibility for yourself and respect for others; to adapt to your environment; and to learn new skills;

(6) Concentration, persistence, and pace, e.g., your ability to engage in an activity, such as studying or practicing a sport, and to sustain the activity for a period of time and at a pace appropriate to your age.

(j) *Older adolescents (age 16 to attainment of age 18).* (1) Descriptive information about your activities of daily living will tell us about the nature and age-appropriateness of your activities with respect to your cognitive functioning, communicative functioning, motor functioning, social functioning, personal/behavioral functioning, and your concentration, persistence, and pace in school or work-related activities. (See § 416.924d(i) (1) through (6) for a description of these domains and behaviors.)

(2) As you approach adulthood (i.e., beginning at about age 16), we will consider some of your school activities as evidence of your ability to function in a job setting. For example, we will consider your ability to understand, carry out, and remember simple instructions and work-like procedures in the classroom as evidence of your ability to do these things in a job. We will consider your ability to communicate spontaneously, interactively, and age-appropriately in the classroom as evidence of your ability to do this in a job. We will consider your ability to maintain attention for extended periods of time and to sustain an ordinary daily routine without special supervision as evidence of your ability to do these things in a job. We will consider your ability to deal with authority figures and to follow directions in school, responding appropriately to correction or criticism, as evidence of your ability to deal with supervision on a job. We will consider your ability to interact with peers in school, school-related activities, and other age-appropriate environments as evidence of your ability to relate to co-workers in a job. We will consider your ability to regulate your mood and behavior in various school settings as evidence of your ability to deal with change in a work setting. We will consider your ability to engage in physical activities both in and out of school as evidence of your ability to perform the physical demands of work. We will also consider whether you have acquired any skills from specific vocational education and whether you have pursued any part-time or stay-in-school employment.

(3) If you are working or have worked, we will evaluate such things as: The physical activities in which you are engaged on the job; the regularity and punctuality of your attendance; your ability to follow directions and deal with supervisors; and your ability to work independently and to deal with others in your job.

[58 FR 47582, Sept. 9, 1993]

§ 416.924e Guidelines for determining disability using the individualized functional assessment.

(a) *General.* The guidelines in this section are provided as a framework for deciding whether a child who has a severe impairment(s) that does not meet or equal the listings nevertheless has an impairment(s) that is of comparable severity to one that would disable an adult, and is, therefore, disabled. The guidelines illustrate a level of impairment severity that is generally, though not invariably, sufficient to establish comparable severity; i.e., to establish that there is an impairment or combination of impairments that substantially reduces your ability to function independently, appropriately, and effectively in an age-appropriate manner. The examples in this section are only guidelines to illustrate severity and are not all-inclusive rules. The determination of your claim is based on all relevant evidence in the case record, using the principles and guidance in §§ 416.924 through 416.924d on a case-by-case basis.

(b) *How we describe functional limitations.* The terms used in this section to describe functional severity of both

physical and mental impairments employ as a frame of reference the terminology and definitions in the childhood mental listings in 112.00 of the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter. Hence, the examples of ''moderate'' and other limitations are derived from a comparison with the ''marked'' levels of functional limitation in the listings. As in those listings, ''marked'' and ''moderate'' are not the number of activities or functions which are restricted, but the overall degree of restriction or combination of restrictions in a domain or behavior. A marked or moderate limitation may arise when several activities or functions in a domain or behavior are impaired, or even when only one is impaired.

(1) If you are a younger child, from birth to the attainment of age 3, your functional limitations will generally be described in the examples in terms of a developmental delay, or the fraction or percentage of your chronological age that represents the levels of your functioning; e.g., three-fourths of chronological age. If you are functioning in one of the domains or behaviors described for your age in § 416.924d at more than one-half, but not more than two-thirds, of your chronological age, you are said to have a marked impairment in that domain or behavior. If you are functioning in one of the domains or behaviors described for your age in § 416.924d at more than two-thirds, but not more than three-fourths of your chronological age, we describe your impairment in that domain or behavior as moderate.

(2) If you are an older child or young adolescent, from age 3 to the attainment of age 16, your impairment(s) will generally be described in the examples in terms of specific kinds of age-appropriate activities, functional abilities, or abnormal behaviors. Although it is sometimes appropriate to evaluate severity in this age group in the same terms as are used in paragraph (b)(1) of this section, which describes moderate limitation of functioning in terms of a level that is more than two-thirds but not more than three-fourths of a child's chronological age, the older a child becomes, the less precise are the means of determining this kind of profile. The spectrum of limitations that may constitute ''moderate'' impairment in this age group ranges from limitations that may be close to the ''marked'' level in severity to limitations that may be close to the ''mild'' level and, thus, considerably less limiting. Use of the examples as guides in the evaluation of older children and young adolescents, therefore, requires careful evaluation and judgment in each individual case, taking into account the child's age (as explained in § 416.924a) and all other relevant factors described in §§ 416.924 through 416.924d.

(3) If you are an older adolescent, aged 16 to the attainment of age 18, functional limitations are generally evaluated in terms of physical and mental activities that are the same as, or similar to, activities of young adults. Hence, the guidance and examples in paragraph (d) of this section focus on physical abilities (exertional and nonexertional) and mental abilities associated with work activities, as described in §§ 416.921, 416.945, 416.967, 416.968, and 416.969a. However, assessment of an older adolescent's abilities and limitations is to be made in an age-appropriate context, as demonstrated by performance in school, work, and other relevant settings.

(c) *How we evaluate children from birth to attainment of age 16*—(1) *Young children (birth to attainment of age 3).* If you are a newborn or young infant (birth to the attainment of age 1), we evaluate the severity of your impairment(s) with respect to four developmental domains (cognitive, communicative, motor, and social development) and your responsiveness to stimuli. If you are an older infant or toddler (age 1 to the attainment of age 3), we evaluate the severity of your impairment(s) with respect to five developmental domains (cognitive, communicative, motor, social, and personal/behavioral development). (See § 416.924d(e) and (f) for descriptions of the domains and behaviors appropriate to each age group.) Our evaluation of severity is based on comparison with the descriptors of functional severity in Listings 112.02–112.12 for childhood mental disorders: If you achieve development of only one-half or less of your chronological age in a single domain, or of only two-thirds

or less of your chronological age in two domains, your limitations are at listing-level severity. Examples of when we will generally find comparable severity (as defined in paragraph (a) of this section) and, thus, find you disabled include the following situations described in paragraphs (c)(1) (i) through (ii) of this section. However, the guidance provided by these examples for evaluating young children is not intended to be a standard by which all cases must be judged. Each case must be evaluated on its own merits using the principles and guidelines of all the regulations addressing childhood disability.

(i) You are functioning in one domain (e.g., motor development) at a level that is more than one-half, but not more than two-thirds of the normal age-appropriate level for a child your age and you are functioning in another domain (e.g., communicative) at a level that is more than two-thirds but not more than three-fourths of the normal age-appropriate level for a child your age; or

(ii) You are functioning in three domains (e.g., cognitive, motor, and social development) at a level that is more than two-thirds, but not more than three-fourths of the normal age-appropriate level for a child your age.

(2) *Older children and young adolescents, age 3 to attainment of age 16.* If you are in this age group, we evaluate the severity of your impairment(s) with respect to five functional domains (cognitive, communicative, motor, social, and personal/behavioral function), and your concentration, persistence, and pace in the completion of age-appropriate tasks. (See § 416.924d(g) through (i) for descriptions of the domains and behaviors appropriate to this age group.) The level of severity illustrating the term ''moderate,'' and the overall level of disability at less than the listing level, are based on comparison with the listing-level requirement for marked impairment in two domains, as described in 112.00C of the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter. In the case of preschoolers (age 3 to the attainment of age 6), it may be appropriate to evaluate the level of severity in terms of developmental age, as in younger children. Examples of when we will generally find comparable severity (as defined in paragraph (a) of this section) and, thus, find you disabled include the following situations described in paragraphs (c)(2) (i) through (ii) of this section. However, the guidance provided by these examples for evaluating older children and young adolescents is not intended to be a standard by which all cases must be judged. Each case must be evaluated on its own merits using the principles and guidelines of all the regulations addressing childhood disability.

(i) You are functioning at the marked level in one domain or behavior (e.g., in the domain of social functioning, you are generally unable to maintain age-appropriate relationships with peers and adults, with frequent serious conflicts with your family, classmates, and teachers; or in the domain of motor functioning, your range of motion in your elbows, wrists, and fingers is limited by less than 50 percent and you have difficulty writing, typing, picking up and handling small objects, carrying, reaching, and engaging in physical activities which rely heavily on the use of the upper extremities), *and* you are functioning at the moderate level in another domain or behavior (e.g., in the domain of personal/behavioral functioning, you are frequently unable to perform self-care activities independently); or

(ii) You are functioning at the moderate level in three areas (e.g., in the domain of cognitive functioning, you have a valid full scale IQ of 74; in the domain of social functioning you have limited age-appropriate relationships with peers and adults, with occasional serious conflicts with family, classmates, teachers, and others; and with respect to the behavior of concentration, persistence and pace, you are frequently unable to complete age-appropriate complex tasks, and occasionally unable to perform simple age-appropriate tasks adequately).

(d) *How we evaluate older adolescents, from age 16 to attainment of age 18*—(1) *General.* As we explain in § 416.924d(j), children aged 16 to 18 are closely approaching adulthood and can be evaluated in terms that are the same as, or

similar to, those used for the evaluation of the youngest adults. Children in this age range who do not have impairment-related limitations are ordinarily expected to be able to do the kinds of physical and mental activities expected of individuals who are at least 18 years old.

(i) The discussions in this section are predicated on the foregoing principles. They describe limitations of physical and mental functions that are associated with, or related to, functions in the workplace, as demonstrated by a child's performance of age-appropriate activities in age-appropriate context, such as school, part-time or full-time work, vocational programs, and organized activities. (See also § 416.924d(j).)

(ii) As in the examples for younger children, the guidance for evaluating older adolescents is not intended to be a standard by which all cases must be judged. Each case must be evaluated on its own merits using the principles and guidelines of all of the regulations addressing childhood disability.

(2) *Mental functions.* Based on the profile of your activities and functioning in the relevant domains and behavior of cognition, communication, social functioning, personal/behavioral functioning, and your concentration, persistence, and pace in age-appropriate activities, we will consider your mental capacities to perform on a sustained basis (i.e., 8 hours a day, 5 days a week) the general kinds of mental activities that we evaluate for adults. We will consider such things as your ability to understand, carry out, and remember simple instructions; to maintain attention for extended periods of time; to use judgment; to make simple decisions; to take necessary safety precautions; to respond appropriately to supervision and peers (e.g., by being able to accept instructions and criticism, by not requiring special supervision, and by not being unduly distracted by your peers or unduly distracting to them in a school or work setting); and dealing with changes in your routine school or work setting. (See also, § 416.924d(j).)

(3) *Physical functions.* Based on the profile of your activities in the relevant domain of motor functioning, and your concentration, persistence, and pace in age-appropriate activities, we will consider your physical capacity to perform on a sustained basis (i.e., 8 hours a day, 5 days a week) the types and ranges of exertional and nonexertional activities that we evaluate for adults; e.g., sitting, standing, walking, lifting, carrying, pushing, pulling, reaching, handling, manipulating, seeing, hearing, and speaking. (See also, § 416.924d(j).)

(4) *Evaluation.* If an individualized functional assessment shows that you experience a substantial loss or deficit of capacity to perform the age-appropriate mental or physical activities described, we will find that your impairment(s) seriously interferes with your ability to function independently, appropriately, and effectively in an age-appropriate manner, and that it has substantially reduced your ability to acquire the skills needed to assume roles reasonably expected of adults. Therefore, we will conclude that you have an impairment(s) that is comparable in severity to an impairment that would disable an adult, and that you are disabled.

(i) The term ''substantial loss or deficit'' is not a precise number, percentage, or quantitative measure.

(ii) *Substantial loss or deficit* means that you are unable to meet the basic physical demands of at least sedentary work (as defined in § 416.967(a)); or you are unable to meet the basic mental demands of at least unskilled work (as defined in § 416.968(a)); or that you have an impairment(s) that would severely limit the potential occupational base of a person age 18 through 45 and that would justify a finding of inability to perform other work even for a person with favorable age, education, and work experience (see §§ 416.969, 416.969a, and appendix 2 to subpart P of part 404 of this chapter).

[58 FR 47584, Sept. 9, 1993]

MEDICAL CONSIDERATIONS

§ 416.925 Listing of Impairments in Appendix 1 of Subpart P of Part 404 of this chapter.

(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) *Diagnoses of impairments.* We will not consider your impairment to be one listed in appendix 1 of subpart P of part 404 of this chapter solely because it has the diagnosis of a listed impairment. It must also have the findings shown in the Listing for 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 55621, Aug. 20, 1980, as amended at 56 FR 57944, Nov. 14, 1991]

§ 416.926 Medical equivalence for adults.

(a) *How medical equivalence is determined.* We will decide that your impairment(s) is medically equivalent to a listed impairment in appendix 1 of subpart P of part 404 of this chapter 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 §416.1016.)

(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 §416.1016 for the qualifications we consider necessary for a psychologist to be a consultant.)

[45 FR 55621, Aug. 20, 1980, as amended at 52 FR 33928, Sept. 9, 1987; 56 FR 5561, Feb. 11, 1991]

§416.926a Equivalence for children.

(a) *General.* If you are a child and you do not have an impairment that meets the requirements of a listing, we will determine whether you have an impairment or combination of impairments that is equivalent in severity to any listed impairment in appendix 1 of subpart P of part 404, as set forth in this section. While all possible impairments are not addressed within the Listing of Impairments, within the listed impairments are all the physical and mental functional limitations, i.e., what a child cannot do as a result of an impairment, that are considered severe enough to prevent a child from functioning independently, appropriately, and effectively in an age-appropriate manner. We will compare the symptoms, signs, and laboratory findings about your impairment(s), including, where appropriate, any functional limitations that result from your medically determinable impairment(s), with the corresponding criteria shown for any listed impairment. When we make an equivalence decision, we will consider all relevant evidence in your case record.

(b) *How we determine the equivalence of impairments for children.* Equivalence can be found in three ways:

(1) If you have an impairment that is described in the Listing of Impairments in appendix 1 of subpart P of part 404, but:

(i) You do not exhibit one or more of the medical findings specified in the particular listing, or

(ii) You exhibit all of the medical findings, but one or more of the findings is not as severe as specified in the listing,

we will nevertheless find that your impairment is equivalent to that listing if you have other medical findings related to your impairment that are at least of equal medical significance.

(2) If you have an impairment that is not described in the Listing of Impairments in appendix 1, or you have a combination of impairments, no one of which meets or is equivalent to a listing, we will compare your medical findings with those for closely analogous listed impairments. If the findings associated with your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your impairment(s) is equivalent to the analogous listing.

(3) If we cannot find equivalence under either of the foregoing provisions, we will assess the overall functional limitations that result from your impairment(s), i.e., what you cannot do because of your impairment(s). If you have more than one impairment, we will consider the combined effects of all your impairments on your overall functioning. We will compare the functional limitations(s) resulting from your impairment(s) with the functional consequences of any listed impairment which includes the same functional limitations; the listing we choose for comparison need not be medically related to your impairment(s). If the functional limitation(s) resulting from your impairment(s) is the same as the disabling functional consequences of a listed impairment, we will find that your impairment(s) is equivalent to that listed impairment. When we make a determination or decision using this rule, the primary focus will be on the disabling consequences of your impairment(s), as long as there is a direct, medically determinable cause for these consequences.

(c) *Responsibility for determining equivalence.* In cases where the State agency or other designee of the Secretary makes the initial or reconsideration disability determination, a State agency staff medical or psychological consultant or other designee of the Secretary (see § 416.1016) has the overall responsibility for determining equivalence. For cases in the disability hearing process, the responsibility for determining equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsidered determination is changed under § 416.1418, with the Associate Commissioner for Disability or his or her delegate. For cases at the Administrative Law Judge or Appeals Council level, the responsibility for deciding equivalence rests with the Administrative Law Judge or Appeals Council.

(d) *Examples of impairments of children that are functionally equivalent to the listings.* The following are some examples of consequences of impairments that are functionally equivalent to listed impairments. The consequences of each child's impairment(s) must be assessed to determine whether they are functionally equivalent to those of a listed impairment. Findings of equivalence based on the disabling functional consequences of a child's impairment(s) should not be limited to the examples below, because these examples do not describe all the possible effects of impairments that might be found to be equivalent to a listed impairment. As with any disabling impairment, the duration requirement must also be met (see §§ 416.909 and 416.924(a)).

(1) Documented need for major organ transplant (e.g., heart, liver).

(2) Any condition that is disabling at the time of onset, requiring a series of staged surgical procedures within 12 months after onset as a life-saving measure or for salvage or restoration of function, and such major function is not restored or is not expected to be restored within 12 months after onset of the condition.

(3) Frequent need for a life-sustaining device (e.g., central venous alimentation catheter), at home or elsewhere.

(4) Marked inability to stand and walk; e.g., ambulation possible only with obligatory bilateral upper limb assistance.

(5) Any physical impairment(s) or combination of physical and mental impairments causing marked restriction of age-appropriate activities of daily living and marked difficulties in maintaining age-appropriate social functioning.

(6) Any physical impairment(s) or combination of physical and mental impairments causing complete inability to function independently outside the area of one's home within age-appropriate norms.

(7) Requirement for 24-hour-a-day supervision for medical or behavioral reasons.

(8) Infants weighing less than 1200 grams at birth, until attainment of 1 year of age.

(9) Infants weighing at least 1200 but less than 2000 grams at birth, *and* who are small for gestational age, until attainment of 1 year of age. (*Small for gestational age* means a birth weight that is at or more than 2 standard

deviations below the mean or that is below the 3rd growth percentile.)

(10) In an infant who has not attained age 1 year, any physical impairment(s) or combination of physical and mental impairments that satisfies the requirements of Listing 112.12.

(11) Major congenital organ dysfunction (e.g., congenital heart disease) which could be expected to result in death within the first year of life without surgical correction, and the impairment is expected to be disabling (because of residual impairment following surgery, or the recovery time required, or both) until attainment of 1 year of age.

(12) Gastrostomy in a child who has not attained age 3.

[56 FR 5561, Feb. 11, 1991, as amended at 58 FR 47586, Sept. 9, 1993; 58 FR 52367, Oct. 7, 1993]

§ 416.927 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 l2 months. See § 4l6.905. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. See § 416.908.

(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), includinq 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 §§ 416.912 and 416.919 through 416.919h. 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 to subpart P of part 404 of this chapter, your residual functional capacity (see §§ 416.945 and 416.946), 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 subpart P of part 404 of this chapter, 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 § 416.912(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 subpart P of part 404 of this chapter.

(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 36968, Aug. 1, 1991]

§ 416.928 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. If you are a child under age 18 and are unable to adequately describe your symptom(s), we will accept as a statement of this symptom(s) the description given by the person who is most familiar with you, such as a parent, other relative, or guardian. Your statements (or those of another person) alone, however, 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. Psychiatric 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 a 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.

[45 FR 55621, Aug. 20, 1980, as amended at 58 FR 47586, Sept. 9, 1993]

§ 416.929 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 § 416.928 (b) and (c). By other evidence, we mean the kinds of evidence described in §§ 416.912(b) (2) through (6) and 416.913 (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 (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner). 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 (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner). 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 416.927 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 (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner).

(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 or for functioning in an age-appropriate manner*—(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 § 416.927. 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 (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner), 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 (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner) 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. If you are a child, we will also consider all of the evidence presented, including evidence submitted by your treating, examining or consulting physician or psychologist, information from educational agencies and personnel, statements from parents and other relatives, and evidence submitted by social welfare agencies, therapists, and other practitioners. Section 416.927 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 (or to function in an age-appropriate manner).* In determining the extent to which your symptoms, such as pain, affect your capacity to perform basic work activities (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner), 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 (or if you are a child, age-appropriate 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 416.920 and 416.920a (for adults) and 416.924 (for children) 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. The procedure we follow in reviewing whether your disability continues is explained in § 416.994 (for adults) and § 416.994a (for children).

(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 § 416.920(c) for adults and § 416.924(d) for children.)

(2) *Decision whether the Listing of Impairments is met.* Some listed impairment(s) include symptoms, such as pain, as criteria. Section 416.925(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. Sections 416.926 and 416.926a explain how we make this determination. Under §§416.926(b) and 416.926a(b) (1) and (2), 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 you are a child and we cannot find equivalence based on medical evidence only, we will consider pain and other symptoms under §416.926a(b)(3) in determining whether you have an impairment(s) that results in overall functional limitations that are the same as the disabling functional consequences of a listed impairment.) Regardless of whether you are an adult or a child, 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 you are a child and your impairment(s) is equivalent in severity to a listed impairment under the rules in §416.926a(b)(3), we also will find you disabled.) If they are not, we will consider the impact of your symptoms on your residual functional capacity if you are an adult or, if you are a child, on your ability to function in an age-appropriate manner. (See paragraph (d)(4) of this section.)

(4) *Impact of symptoms (including pain) on residual functional capacity or individualized functional assessment.* 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 subpart P of part 404 of this chapter, we will consider the impact of your impairment(s) and any related symptoms, including pain, on your residual functional capacity, or if you are a child, on your ability to function independently, appropriately, and effectively in an age-appropriate manner. (See §§416.945 and 416.924a through 416.924d.)

[56 FR 57944, Nov. 14, 1991]

§ 416.930 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 blind 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 enormity (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 55621, Aug. 20, 1980, as amended at 59 FR 1636, Jan. 12, 1994]

PRESUMPTIVE DISABILITY AND BLINDNESS

§ 416.931 The meaning of presumptive disability or presumptive blindness.

If you are applying for supplemental security income benefits on the basis of disability or blindness, we may pay you benefits before we make a formal finding of whether or not you are disabled or blind. In order to receive these payments, we must find that you are presumptively disabled or presumptively blind. You must also meet all other eligibility requirements for supplemental security income benefits. We may make these payments to you for a period not longer than 6 months. These payments will not be considered overpayments if we later find that you are not disabled or blind.

[45 FR 55621, Aug. 20, 1980, as amended at 57 FR 53853, Nov. 13, 1992]

§ 416.932 When presumptive payments begin and end.

We may make payments to you on the basis of presumptive disability or presumptive blindness before we make a formal determination about your disability or blindness. The payments can not be made for more than 6 months. They start for a period of not more than 6 months beginning in the month we make the presumptive disability or presumptive blindness finding. The payments end the earliest of—

(a) The month in which we make a formal finding on whether or not you are disabled or blind;

(b) The month for which we make the sixth monthly payment based on presumptive disability or presumptive blindness to you; or

(c) The month in which you no longer meet one of the other eligibility requirements (e.g., your income exceeds the limits).

[45 FR 55621, Aug. 20, 1980, as amended at 57 FR 53853, Nov. 13, 1992]

§ 416.933 How we make a finding of presumptive disability or presumptive blindness.

We may make a finding of presumptive disability or presumptive blindness if the evidence available at the time we make the presumptive disability or presumptive blindness finding reflects a high degree of probability that you are disabled or blind. In the case of readily observable impairments (e.g., amputation of extremities, total blindness), we will find that you are disabled or blind for purposes of this section without medical or other evidence. For other impairments, a finding of disability or blindness must be based on medical evidence or other information that, though not sufficient for a formal determination of disability or blindness, is sufficient for us to find that there is a high degree of probability that you are disabled or blind. For example, for claims involving the human immunodeficiency virus (HIV), the Social Security Field Office may make a finding of presumptive disability if your medical source provides us with information that confirms that your disease manifestations meet the severity of listing-level criteria for HIV. Of course, regardless of the specific HIV manifestations, the State agency may make a finding of presumptive disability if the medical evidence or other information reflects a high degree of probability that you are disabled.

[58 FR 36063, July 2, 1993]

§ 416.934 Impairments which may warrant a finding of presumptive disability or presumptive blindness.

We may make findings of presumptive disability and presumptive blindness in specific impairment categories without obtaining any medical evidence. These specific impairment categories are—

(a) Amputation of two limbs;

(b) Amputation of a leg at the hip;

(c) Allegation of total deafness;

(d) Allegation of total blindness;

(e) Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, due to a long-standing condition, excluding recent accident and recent surgery;

(f) Allegation of a stroke (cerebral vascular accident) more than 3 months

in the past and continued marked difficulty in walking or using a hand or arm;

(g) Allegation of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms.

(h) Allegation of diabetes with amputation of a foot;

(i) Allegation of Down's syndrome (Mongolism); and

(j) Allegation of severe mental deficiency made by another individual filing on behalf of a claimant who is at least 7 years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 5574, Feb. 11, 1985; 53 FR 3741, Feb. 9, 1988; 56 FR 65684, Dec. 18, 1991]

DRUG ADDICTION AND ALCOHOLISM

§ 416.935 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, unless we find that you are eligible for benefits because of your age or blindness.

(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 8151, Feb. 10, 1995]

§ 416.936 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, 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 § 416.1326.

[60 FR 8151, Feb. 10, 1995]

§ 416.937 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 8151, Feb. 10, 1995]

§ 416.938 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 8151, Feb. 10, 1995]

§ 416.939 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 8151, Feb. 10, 1995]

§ 416.940 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 8151, Feb. 10, 1995]

§ 416.941 Establishment and use of referral and monitoring agencies.

We will contract with one or more agencies in each of the States 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 § 416.935) 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 8152, Feb. 10, 1995]

RESIDUAL FUNCTIONAL CAPACITY

§ 416.945 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 §§ 416.960 through 416.969a, 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 § 416.994.

(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, coworkers, 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 subpart P of part 404 of this chapter, 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 § 416.929(c).

[56 FR 57947, Nov. 14, 1991]

§ 416.946 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 § 416.945. 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 § 416.918, 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 36970, Aug. 1, 1991]

VOCATIONAL CONSIDERATIONS

§ 416.960 When your vocational background will be considered.

(a) *General.* If you are age 18 or older and applying for benefits based on disability 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]

§ 416.961 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 416.963 through 416.965 explain how we evaluate your age, education, and work experience when we are deciding whether or not you are able to do other work.

§ 416.962 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.

§ 416.963 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 age as a vocational factor in appendix 2 of subpart P of part 404 of this chapter. 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 of subpart P of part 404 of this chapter).

(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 § 416.967(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, we will ask you for evidence of your age.

§ 416.964 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.

§ 416.965 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 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.

§ 416.966 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.

§ 416.967 Physical exertion requirements.

To determine the physical exertion requirments 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.

§ 416.968 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.

§ 416.969 Listing of Medical-Vocational Guidelines in Appendix 2 of Subpart P of Part 404 of this chapter.

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.

§ 416.969a 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 416.967 and 416.969 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 416.920(f) and 416.994(b)(5)(viii) 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 (§ 416.920(f)) or continue to be disabled (§ 416.994(b)(5)(viii)). Paragraphs (b), (c), and (d) of this section explain how we apply the medical-vocational guidelines in appendix 2 of subpart P of part 404 of this chapter 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, 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 57947, Nov. 14, 1991]

SUBSTANTIAL GAINFUL ACTIVITY

§ 416.971 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 § 416.984.) 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.

§ 416.972 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.

§ 416.973 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.

(f) *Possible effect on income and resource levels.* Your earnings, including earnings from work done during a trial work period, will be considered under the income and resource provisions in subparts K and L of this part to determine whether or not your earnings cause you to exceed the limitations on income or resources under the Supplemental Security Income Program.

§ 416.974 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 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 § 416.976, 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 critera 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 4871, Jan. 19, 1981, as amended at 48 FR 21939, May 16, 1983; 49 FR 22274, May 29, 1984; 54 FR 53605, Dec. 29, 1989]

§ 416.975 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 § 416.974(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 participate 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 § 416.976 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 § 416.974(b)(2); or

(2) It averages less than the amounts described in § 416.974(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 4872, Jan. 19, 1981, as amended at 48 FR 21940, May 16, 1983; 49 FR 22274, May 29, 1984]

§ 416.976 Impairment-related work expenses.

(a) *General.* When we figure your earnings in deciding if you have done substantial gainful activity, and in determining your countable earned income (see § 416.1112(c)(5)), 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 §§ 416.905 through 416.907;

(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 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, 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 wheel-chair 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 work space or modification of the work space 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 paragraph (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, 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.* For the purpose of determining SGA, 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. For the purpose of determining your SSI monthly payment amount, a payment you make for services may be deducted if the payment is made in the month your earned income is received and the earned income is for work done in the month you received the services. If you begin working and make a payment before the month earned income is received, the payment is also deductible. If you make a payment after you stop working, and the payment is made in the

month you received earned income for work done in the month you received the services, the payment is also deductible.

(3) *Payment for items.* For the purpose of determining SGA, 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. For the purpose of determining your SSI monthly payment amount, a payment you make toward the cost of a deductible item (regardless of when it is acquired) may be deducted if the payment is made in the month your earned income is received and the earned income is for work done in the month you used the item. If you begin working and make a payment before the month earned income is received, the payment is also deductible. If you make a payment after you stop working, and the payment is made in the month you received earned income for work done in the month you used the item, the payment is also deductible. 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 as described in paragraph (d) of this section.

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 (for SGA purposes) and for each month earned income is received (for SSI payment purposes) 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. For the purpose of determining SGA, 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. For the purpose of determining your SSI monthly payment amount, if you are working in the month you make the payment and the payment is made in a month earned income is received, we will either deduct the entire amount in that month, or we will allocate the amount over a 12 consecutive month period, beginning with that month, whichever you select. If you begin working and do not receive earned income in the month you make the payment, we will either deduct or begin allocating the payment amount in the first month you do receive earned income. If you make a payment for services or items after you stopped working, we will deduct the payment if it was made in the month you received earned income for work done in the month you received the services or used the item.

Example. A begins working in October 1981 and earns and receives $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 both SGA and SSI payment purposes 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 (for SGA purposes) and for each month earned income is received (for SSI payment purposes) 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 and receives $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 (for SGA purposes) and for each month earned income is received (for SSI payment purposes) 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 (for SGA purposes) and for each month earned income is received (for SSI payment purposes) 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. (D earns and receives $500 a month.) 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 (for SGA purposes) and for each month earned income is received (for SSI payment purposes) 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 (for SGA purposes) and for each month earned income is received (for SSI payment purposes).

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 for the purpose of determining SGA and in the first month earned income is received for the purpose of determining the SSI monthly payment amount. For the purpose of determining SGA, we will deduct either the 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. For the purpose of determining the SSI payment amount, we will either deduct the entire amount in the first month earned income is received or allocate it over a 12-consecutive month period beginning

with the first month earned income is received, whichever you select. In the above examples, the individual would have the choice of having the entire $450 deducted in the first month earned income is received or of having $37.50 a month ($450 divided by 12) deducted for each month he receives earned income (for work) over a 12-consecutive month period, beginning with the first month earned income is received. 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 toward 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 § 416.992(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 §§ 416.974(b)(6) (i) and (ii), and 416.975(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. The amount of deductions must, therefore, be the same for determinations as to substantial gainful activity under both programs. The deductions that apply in determining the SSI payment amounts, though determined in the same manner as for SGA determinations, are applied so that they correspond to the timing of the receipt of the earned income to be excluded.

(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 21940, May 16, 1983]

BLINDNESS

§ 416.981 Meaning of blindness as defined in the law.

We will consider you blind under the law for payment of supplemental security income benefits if we determine that you are statutorily blind. Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of a 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.

§ 416.982 Blindness under a State plan.

We shall also consider you blind for the purposes of payment of supplemental security income benefits if—

(a) You were found to be blind as defined under a State plan approved under title X or title XVI of the Social Security Act, as in effect for October 1972;

(b) You received aid under the State plan because of your blindness for the month of December 1973; and

(c) You continue to be blind as defined under the State plan.

§ 416.983 How we evaluate statutory blindness.

We will find that you are blind if you are *statutorily blind* within the meaning of § 416.981. For us to find that you are statutorily blind, it is not necessary—

(a) That your blindness meet the duration requirement; or

(b) That you be unable to do any substantial gainful activity.

§ 416.984 If you are statutorily blind and still working.

There is no requirement that you be unable to work in order for us to find that you are blind. However, if you are working, your earnings will be considered under the income and resources rules in subparts K and L of this part. This means that if your income or resources exceed the limitations, you will not be eligible for benefits, even though you are blind.

§ 416.985 How we evaluate other visual impairments.

If you are not blind as defined in the law, we will evaluate a visual impairment the same as we evaluate other impairments in determining disability. Although you will not qualify for benefits on the basis of blindness, you may still be eligible for benefits if we find that you are disabled as defined in §§ 416.905 through 416.907.

§ 416.986 Why and when we will find that you are no longer entitled to benefits based on statutory blindness.

(a) *If your vision does not meet the definition of blindness.* If you become entitled to payments as a statutorily blind person and your statutory blindness ends, your eligibility for payments generally will end 2 months after your blindness ends. We will find that your statutory blindness has ended beginning with the earliest of the following months—

(1) The month your vision, based on current medical evidence, does not meet the definition of blindness 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, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not now blind; or

(3) The first month in which you fail to follow prescribed treatment that can restore your ability to work (see § 416.930).

(b) *If you were found blind as defined in a State plan.* If you become eligible for payments because you were blind as defined in a State plan, we will find that your blindness has ended beginning with the first month in which your vision, as shown by medical or other evidence, does not meet the criteria of the appropriate State plan or the first month in which your vision does not meet the definition of statutory blindness (§ 416.981), whichever is later, and in neither event earlier than the month in which we mail you a

notice saying that we have determined that you are not now blind under a State plan or not now statutorily blind, as appropriate.

(c) *If you do not cooperate with us.* If you are asked 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 blindness ended if you fail, without good cause, to do what we ask. Section 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your blindness ends will be the month in which you fail to do what we asked.

(d) *Before we stop your payments.* Before we stop payment of your benefits we will give you a chance to give us your reasons why we should not stop payment. Subpart M of this part describes your rights and the procedures we will follow.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 50137, Dec. 6, 1985; 51 FR 7603, Feb. 28, 1986; 59 FR 1636, Jan. 12, 1994]

CONTINUING OR STOPPING DISABILITY OR BLINDNESS

§ 416.988 Your responsibility to tell us of events that may change your disability or blindness status.

If you are entitled to payments because you are disabled or blind, you should promptly tell us if—

(a) Your condition improves;

(b) Your return to work;

(c) You increase the amount of your work; or

(d) Your earnings increase.

§ 416.989 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 payments based on disability. 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 payments, 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 payments, 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 your payments, we will notify you in writing and give you an opportunity to appeal. In § 416.990 we describe those events that may prompt us to review whether you continue to be disabled.

[51 FR 16826, May 7, 1986]

§ 416.989a We may conduct a review to find out whether you continue to be blind.

After we find that you are blind, we must evaluate your impairment(s) from time to time to determine if you are still eligible for payments based on blindness. 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 payments, why we are reviewing your eligibility, that our review could result in the termination of your payments, 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 blind. If this review shows that we should stop your payments, we will notify you in writing and give you an opportunity to appeal. In § 416.990 we describe those events

that may prompt us to review whether you continue to be blind.

[51 FR 16826, May 7, 1986]

§ 416.990 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 or blindness requirements of the law. Payment ends if the medical or other evidence shows that you are not disabled or blind as determined under the standards set out in section 1614(a) of the Social Security Act if you receive benefits based on disability or § 416.986 of this subpart if you receive benefits based on blindness.

(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 or blind, 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 or blindness 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 a 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 the 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 § 416.994(b)(2)(iv)(D) or § 416.994(c)(2)(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 of subpart P or part 404 of this chapter.

(2) Amyotrophic Lateral Sclerosis which has reached the level of severity necessary to meet the Listing in

appendix 1 of subpart P of part 404 of this chapter.

(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 of subpart P of part 404 of this chapter.

(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 or blindness 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 payments based on disability or blindness 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 payments at least once every 3 years. If your disability is considered permanent, we will review your continuing eligibility for payments 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, payments 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 (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 16826, May 7, 1986]

§ 416.991 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 § 416.992).

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 reviewed your claim 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 50137, Dec. 6, 1985]

§ 416.992 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, during this trial work period we will evaluate your earnings under the income and resources rules in subparts K and L of this part. This means that if your income or resources exceed the limitations, you will not be eligible for payments even though you have not worked a full 9 months. (See paragraph (e) of this section.) 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 1978 you earn more than $75 a month ($50 a month is the figure for earnings in any calendar year before 1979). If you are self-employed, we will consider your activities *services* if in any calendar year after 1978 your net earnings are more than $75 a month ($50 a month is the figure for earning in any calendar year before 1979), or you work more than 15 hours a month in the business. 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 payments.

(d) *When the trial work period begins and ends.* The trial work period begins with the month in which you become entitled to benefits. It cannot begin before the month in which you file your application for benefits. 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 § 416.994).

(e) *If you fail to meet other eligibility factors.* We will count the services you do while disabled towards your period of trial work even though you may be ineligible for payments for other reasons. The months in which you are eligible for payments will be evaluated for trial work purposes upon reestablishment of your eligibility for payments under this part as though your eligibility had not been interrupted.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 50137, Dec. 6, 1985; 51 FR 16015, Apr. 30, 1986]

§ 416.992a 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 you ability to work if you have a disabling impairment.

Generally, you will not be paid benefits for any month, after the third month, in this period in which you do substantial gainful activity unless you qualify for the special benefits explained in § 416.261. You will be paid benefits for months in which you do not do substantial gainful activity and you meet all the other eligibility requirements. (See § 416.1331.) 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 SGA in a month during the reentitlement period we only consider 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 is determined to no longer exist or not to be disabling; or

(2) The last day of the 15th month following the end of your trial work period. (See § 416.1331 for when your benefits end.)

[49 FR 22274, May 29, 1984]

§ 416.993 Medical evidence in continuing disability review cases.

(a) *General.* If you are entitled to benefits 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 §§ 416.979 and 416.994.

(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 § 416.912. You must have a good reason for not giving us this information or we may find that your disability has ended. See § 416.994(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 § 416.912(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 § 416.912(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 § 416.917. We will decide whether or not to purchase a consultative examination in accordance with the standards in §§ 416.919a through 416.919b.

[56 FR 36970, Aug. 1, 1991]

§ 416.994 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. Our rules for deciding whether your disability continues are set forth in paragraph (b) of this section. Additional rules apply if you were found disabled under a State plan, as set forth in paragraph (c) of this section.

(b) *Disabled persons age 18 or over (adults).* If you are entitled to disability benefits as a disabled person age 18 or over (adult) 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 so 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 (b)(4) 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.

(1) *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.

(i) *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 § 416.928).

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 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.

(ii) *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)(i) 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)(1)(iv) 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 work 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.

(iii) *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)(i) 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)(1)(iv) 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)(1)(v) 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 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 subpart P of part 404 of this chapter (see paragraph (b)(2)(iii)(A) of this section). In fact, you no longer have an impairment which is severe (see § 416.921) and your disability will be found to have ended.

(iv) *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 § 416.945. Unless an impairment is so severe that it is deemed to prevent you from doing substantial gainful activity (see §§ 416.925 and 416.926) 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.

(A) 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 symptoms, signs 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)(1)(vi) of this section).

(B) 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.

(C) 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.

(v) *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 consideration alone (as discussed in §§ 416.925 and 416.926), 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 §§ 416.945 through 416.969.

(vi) *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 §§ 416.912 through 416.918. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(vii) *Point of comparison.* For purpose 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 the previously existing impairments 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.

(2) *Determining medical improvement and its relationship to your abilities to do work.* Paragraphs (b)(1)(i) through (b)(1)(iii) 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.

(i) *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).

(ii) *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)(1)(iv) 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)(1)(iv) of this section) based on the current severity of the impairment(s) which was present at your last favorable medical decision.

(iii) 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 actual 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.

(iv) Following are some additional factors and considerations which we

will apply in making these determinations.

(A) *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 subpart P of part 404 of this chapter, 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 subpart P of part 404 of this chapter describes impairments which, if severe enough, affect a person's ability to work. If the appendix level severity is met or equaled the individual is deemed, in the absence of evidence to 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. We must, of course, also establish that you can currently engage in substantial gainful activity before finding that your disability has ended.

(B) *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.

(C) *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 subpart P of part 404 of this chapter) 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 a decision of 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.

(D) *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 impairment, 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.

(E) *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 (b)(4) 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 § 416.988.

(3) *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.

(i) *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 § 416.945.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits as explained in § 416.261. 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.

(ii) *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 § 416.945.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits as explained in § 416.261. 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.

(iii) *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.

(A) *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.

(B) *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.

(*1*) Some of the future changes in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter will be based on new or improved diagnostic or evaluation techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved techniques will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(*2*) A cumulative list since 1970 of new or approved 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.

(iv) *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:

(A) 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 subpart P of part 404 of this chapter or a medical/vocational rule in appendix 2 of subpart P of part 404 of this chapter 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 electroencephalogram 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 subpart P of part 404 of this chapter. 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.

(B) 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.

(C) 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.

(D) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see §§416.1488 through 416.1489) are met.

(v) *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 §416.992. 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 if you are eligible to receive special Supplemental Security Income cash benefits as explained in §416.261. This exception also does not apply in determining whether you continue to have a disabling impairment(s) (§416.911) for purposes of deciding your eligibility for a reentitlement period (§416.992a).

(4) *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.

(i) *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 §416.1488. 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.

(ii) *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 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, §416.918 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.

(iii) *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 suspend your payments. The month your payments are suspended will be the first month in which the question arose and we could not find you.

(iv) *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 §416.930(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(5) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that a decision of continuing disability can be made in the most expeditious and administratively efficent 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:

(i) 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 (b)(3)(v) of this section).

(ii) 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 subpart P of part 404 of this chapter? If you do, your disability will be found to continue.

(iii) If you do not, has there been medical improvement as defined in paragraph (b)(1)(i) of this section? If there has been medical improvement as shown by a decrease in medical severity, see step (iv). If there has been no decrease in medical severity, there has been no medical improvement. (See step (v).)

(iv) 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)(i) through (b)(1)(iv) 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 work, see step (v). If medical improvement *is* related to your ability to do work, see step (vi).

(v) If we found at step (iii) that there has been no medical improvement or if we found at step (iv) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (b)(3) and (b)(4) 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 (vi). 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.

(vi) 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 § 416.921). This determination will consider all your current impairments and the impact of the combination of these impairments on your ability to function. If the residual functional capacity assessment in step (iv) above shows significant limitaton of your ability to do basic work activities, see step (vii). 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.

(vii) If your impairment(s) is severe, we will assess your current ability to engage in substantial gainful activity in accordance with § 416.961. 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.

(viii) 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.

(6) *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 following month—

(i) For purposes of § 416.1331 (under which benefits can be paid for the month in which disability ends and the two following months) the earliest of the following months—

(A) The month the evidence shows that 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;

(B) The month the evidence shows that 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;

(C) 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 §416.991);

(D) The first month following completion of your trial work period for which it is determined that you have demonstrated the ability to do substantial gainful activity;

(E) The first month in which you fail without good cause to follow prescribed treatment, when the rule set out in paragraph (b)(4)(iv) of this section applies;

(F) The first month in which you were told by your physician that you could return to work provided there is no substantial conflict between your physkcian's and your statements regarding your awareness of your capacity for work and the earlier date is supported by substantial evidence; or

(G) The first month in which you failed without good cause to do what we asked, when the rule set out in paragraph (b)(4)(ii) of this section applies.

(ii) For all other purposes, the month preceding the termination month. The termination month, as that term is used in this paragraph, is the first month after the 15-month reentitlement period (described in §416.992a, in which you engage in or are determined able to engage in substantial gainful activity or, if earlier, the first month after a trial work period in which your impairment is determined, based on medical or other evidence, to no longer exist or not be a disabling impairment as described in §416.911.

(7) *Before we stop your benefits.* If we find you are no longer disabled, before we stop your benefits, we will give you a chance to explain why we should not do so. Subparts M and N of this part describe your rights and the procedures we will follow.

(c) *Persons who were found disabled under a State plan.* If you became entitled to benefits because you were found to be disabled under a State plan, we will first evaluate your impairment(s) under the rules explained in paragraph (b) of this section. We will apply the same steps as described in paragraph (b) of this section to the last decision granting or affirming entitlement to benefits under the State plan. If we are not able to find that your disability continues on the basis of these rules, we will then evaluate your impairment(s) under the appropriate State plan. If we are not able to find that your disability continues under these State plan criteria, we will find that your disability ends. Disability will be found to end the month the evidence shows that you are no longer disabled under the criteria in paragraph (b) of this section (or appropriate State plan criteria), subject to the rules set out in paragraph (b)(6) of this section.

[50 FR 50137, Dec. 6, 1985; 51 FR 7063, Feb. 28, 1986; 51 FR 16015, Apr. 30, 1986, as amended at 52 FR 44971, Nov. 24, 1987; 56 FR 5562, Feb. 11, 1991; 59 FR 1636, Jan. 12, 1994]

§416.994a How we will determine whether your disability continues or ends, disabled children.

(a) *Evaluation of continuing disability, in general.* There is a statutory requirement that, if you are eligible for disability benefits as a disabled child, your continued eligibility for such benefits must be reviewed periodically. There are a number of factors we consider when we decide whether your disability continues.

(1) If your current impairment(s) does not meet or equal any current listing, we determine whether there has been any medical improvement in your impairment(s) that is ''related to the ability to work,'' i.e., your ability to function independently, appropriately, and effectively in an age-appropriate manner. (We define the term ''medical improvement'' in paragraph (c). We define the term ''related to the ability to work'' as it applies to children in paragraph (d).) If there has not been any medical improvement in your impairment(s), or if the medical improvement is not related to the ability to work, we will generally find that your disability continues; there are exceptions to this general rule, which we describe in paragraphs (f) and (g). If there has been medical improvement related to the ability to work, or when certain exceptions apply, we will

determine whether you are currently disabled under the rules in §§ 416.924 through 416.924e. Even where medical improvement related to your ability to work or an exception applies, in most cases, we will find that your disability has ended only if we also find that you are not currently disabled.

(2) Our determinations and 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 been previously found disabled. We will consider all evidence you submit, as well as all evidence we obtain from your treating physician(s) and other medical and nonmedical sources. What constitutes ''evidence'' and our procedures for obtaining it are set out in §§ 416.912 through 416.918. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(b) *Sequence of evaluation.* 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 follow specific steps in determining whether your disability continues. If we can make a favorable determination or decision at any point in the sequence, we do not review further. The steps are:

(1) *Do you have an impairment(s) that meets or equals the severity of any impairment listed in appendix 1 of subpart P of part 404 of this chapter?* If you have an impairment that meets a current listing, or an impairment or combination of impairments that is of equivalent severity to a current listing, we will find that your disability continues. For our rules on how we determine whether impairments meet or are equivalent to listings, see §§ 416.925 and 416.926a.

(2) *Has there been medical improvement in your condition(s)?* If you do not have an impairment(s) that meets or is equivalent to any current listing we will determine whether there has been medical improvement in your impairment(s) since our most recent favorable determination or decision. (The term *medical improvement* is defined in paragraph (c).) If there has been medical improvement, as shown by a decrease in the medical severity of your impairment(s), we will proceed to the next step. If there has been no decrease in the medical severity of your impairment(s), we will find that your disability continues, unless one of the exceptions to medical improvement described in (f) or (g) applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to step 4.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(3) *If there has been medical improvement, is it related to the ability to work?* If there has been medical improvement in your impairment(s), we will determine whether your medical improvement is related to the ability to work, as defined for children in (d). If it is, we will proceed to the next step. If the medical improvement of your impairment(s) is not related to the ability to work, we will find that your disability continues, unless one of the exceptions to medical improvement described in (f) or (g) applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to the next step.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(4) *Do you have a severe impairment or combination of impairments?* If there has been medical improvement in your impairment(s) related to the ability to work, or if one of the first group of exceptions applies, we will determine whether your current impairment(s) is severe, as defined in § 416.924(d). If your impairment(s) is not severe, we will find that your disability has ended. If your impairment(s) is severe, we will proceed to the last step.

(5) *Are you currently disabled?* In connection with our determination that there has been medical improvement in your impairment(s) related to the ability to work, or if one of the first group of exceptions applies, and you have a severe impairment or combination of impairments, we will do an individualized functional assessment of the

impact of your impairment(s) on your overall ability to function independently, appropriately, and effectively in an age-appropriate manner. (See §§ 416.924d and 416.924e.) We will use this individualized functional assessment to decide whether you are currently disabled; that is, whether you have an impairment(s) of comparable severity to an impairment that would prevent an adult from engaging in substantial gainful activity. We will apply the rules and guidelines governing the last step of the childhood sequential evaluation process for initial claims in §§ 416.924 through 416.924e. If you are currently disabled, your eligibility will continue. If you are not currently disabled, your eligibility for disability benefits will end.

(c) *What we mean by 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 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, or laboratory findings associated with your impairment(s).

(1) The most recent favorable decision is the latest final determination or decision involving a consideration of the medical evidence and whether you were disabled or continued to be disabled.

(2) The terms *symptoms, signs,* and *laboratory findings* are defined in § 416.928. For children, our definitions of the terms *symptoms, signs,* and *laboratory findings* may include any abnormalities of physical and mental functioning that we used in making our most recent favorable decision.

(3) Some impairments are subject to temporary remissions, which can give the appearance of medical improvement when in fact there has been none. If you have the kind of impairment that is subject to temporary remissions, we will be careful to consider the longitudinal history of the impairment, including the occurrence of prior remissions and prospects for future worsenings, when we decide whether there has been medical improvement. Improvements that are only temporary will not warrant a finding of medical improvement.

(4) If we find that there has been improvement in your symptoms, signs, or laboratory findings, we will find that medical improvement has occurred and proceed to determine whether the medical improvement is related to your ability to work.

(d) *What we mean by medical improvement related to the ability to work.* For a child, we say that medical improvement is related to the ability to work when there has been an increase in the ability to function independently, appropriately, and effectively in an age-appropriate manner. Hence, if your impairment(s) has medically improved as defined in (c), but your ability to function in an age-appropriate manner has not increased, we will find that your medical improvement is not related to your ability to work. A determination that there has been medical improvement related to your ability to work does not necessarily mean that we will find that your disability has ended. We must also show that you are not currently disabled using rules governing severity and the last step of the childhood sequential evaluation process for initial claims in §§ 416.924 through 416.924e. We determine whether medical improvement is related to the ability to work as follows:

(1) *Previous decision based on a finding that your impairment(s) met or equaled a listing.* (i) We do not consider whether your impairment(s) has medically improved until we have decided that you do not have an impairment(s) that meets or equals a current listing. If our most recent favorable decision was based on a finding that your impairment(s) met or equaled in severity a listing that is in our current Listing of Impairments and your impairment(s) no longer meets or equals that listing, we will find at this step that your medical improvement was related to your ability to work. We will do an individualized functional assessment and proceed to determine whether you are currently disabled or whether one of the exceptions applies, as set forth in paragraph (b)(5) of this section.

(ii) If our most recent favorable decision was based on a finding that your

impairment(s) met or equaled a listing that is no longer in the Listing of Impairments or that has since been revised, we will consider whether your impairment(s) continues to meet or equal that prior listing at this step. If your impairment(s) continues to meet or equal the prior listing, we will find that your disability continues, even though your impairment(s) does not meet or equal any current listing. If your impairment does not meet or equal the prior listing, we will find that your medical improvement was related to your ability to work. We will do an individualized functional assessment and proceed to determine whether you are currently disabled or whether one of the exceptions applies, as set forth in paragraph (b)(5) of this section.

(2) *Previous decision based on an individualized functional assessment.* If our most recent favorable decision was based on an individualized functional assessment, we will do a new individualized functional assessment based on the previously existing impairments. However, the new individualized functional assessment will take into consideration any current medical findings or functional limitations related to the previously existing impairments, and will be based on those functions that are appropriate to your current age.

(i) We will use this assessment to determine whether there has been an increase in your ability to function in an age-appropriate manner since our most recent favorable decision by comparing our current assessment with the assessment we made at the time of the most recent favorable decision.

(ii) We will not generally do a new individualized functional assessment for the time of the most recent favorable decision; we will use the assessment we made at the time of the last decision. However, if the most recent favorable decision was based on an individualized functional assessment and we do not have that assessment (for example, because it is missing from your file), we will have to reconstruct the assessment. We will do this by assuming that you had the maximum functional abilities consistent with a decision of allowance or continuance at the time of the most recent favorable decision.

(iii) If there has been improvement in your age-appropriate functioning, we will find that your medical improvement is related to the ability to work, and proceed to determine whether you are currently disabled or whether one of the exceptions applies, as set forth in paragraph (b)(5) of this section.

(e) *Prior file cannot be located.* If we cannot locate your prior file, we will first determine whether you are currently disabled under the sequence set forth in § 416.924. (In this way, we will determine that your benefits continue at the earliest time without reconstructing prior evidence.) If so, your benefits will continue unless one of the second group of exceptions applies (see paragraph (g) of this section). If not, 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 decision (e.g., school records, 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 decision. If relevant parts of the prior record are not reconstructed, either because we decide not to attempt reconstruction or because our efforts failed, we will not find that you have medically improved. The documentation of your current impairment(s) will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any determination or decision under this section, in accordance with § 416.1488.

(f) *First group of exceptions to medical improvement.* The law provides 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 of comparable severity to any impairment(s) that would make an adult disabled. 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 your impairment(s) is now no longer of comparable severity to any impairment(s) that would disable an adult before we can find you are no longer disabled, taking all your current impairments into account, not just those that existed at the time of our most recent favorable decision. 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 reduced 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 or your ability to function in an age-appropriate manner. This decision will be based on substantial evidence which includes new medical evidence and a new individualized functional assessment. (See §§ 416.924d and 416.924e.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits, as explained in § 416.261. 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 should, therefore, have 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, education, training, or work experience that improves your ability to meet the vocational requirements of jobs. This decision will be based on substantial evidence which includes new medical evidence and a new individualized functional assessment. (See §§ 416.924d and 416.924e.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits, as explained in § 416.261. 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.

(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 rise to, and will continue to give rise to, improved methods for determining the causes of (i.e., diagnosing) and measuring and documenting the effects of various impairments on children and their functioning. 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 decision, such evidence may serve as a basis for a finding that you are no longer disabled, provided that you do not currently have an impairment(s) that is of comparable severity to an impairment(s) that would disable an adult. 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 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 subpart P of part 404 of this chapter 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) From time to time, we will publish in the FEDERAL REGISTER cumulative lists of new or approved diagnostic techniques or evaluations that have been in use since 1970, how they changed the evaluation of the applicable impairment and the month and year they became generally available. We will include any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 that are reflective of new or improved techniques. We will not process any cases under this exception using a new or improved diagnostic technique that we have not included in a published notice until we have published an updated cumulative list. The period between publications will be determined by the volume of changes needed.

(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 or decision of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination or decision) demonstrates that a prior determination or decision (of allowance or continuance) was in error. A prior determination or decision will be found in error only if:

(i) Substantial evidence shows on its face that the determination or 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 subpart P of part 404 of this chapter, was misapplied).

(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 or decision, disability would not have been found.

(iii) New substantial evidence that relates to the prior determination or decision refutes the conclusions that were based upon the prior evidence at the time of that determination or decision (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 or decision) been considered at the time of the prior determination or decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable determination or decision will not be the basis for applying this exception.

(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 §§ 416.1488 and 416.1489) are met.

(g) *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 or decision that you are no longer disabled. In these situations, the determination or decision will be made without a finding that you have demonstrated medical improvement related to the ability to work or that you are currently not disabled under the rules in §§ 416.924 through 416.924e. There is no set point in the continuing disability review sequence described in paragraph (b) of this section at which we must consider

these exceptions; exceptions in the second group may be considered at any point in the process.

(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 § 416.1488. 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 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 416.918 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 suspend your payments. The month your payments are suspended 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 function independently, appropriately, and effectively in an age-appropriate manner.* If treatment has been prescribed for you which would be expected to restore your ability to function independently, appropriately, and effectively in an age-appropriate manner, 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 § 416.930(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(h) *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 following month—

(1) The month the evidence shows that 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 that 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 return to, or begin, full-time work with no significant medical restrictions, and acknowledge that medical improvement has occurred, and we expected your impairment(s) to improve (see § 416.991);

(4) The first month in which you fail without good cause to follow prescribed treatment, when the rule set out in paragraph (g)(4) of this section applies;

(5) The first month in which you were told by your physician that you could return to age-appropriate activities, provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity, and the earlier date is supported by substantial evidence; or

(6) The first month in which you failed without good cause to do what we asked, when the rule set out in paragraph (g)(2) of this section applies.

(i) *Before we stop your benefits.* If we find you are no longer disabled, before we stop your benefits, we will give you a chance to explain why we should not do so. Subparts M and N of this part describe your rights and the procedures we will follow.

[56 FR 5562, Feb. 11, 1991; 56 FR 13266, 13365, Apr. 1, 1991, as amended at 58 FR 47586, Sept. 9, 1993; 59 FR 1637, Jan. 12, 1994]

§ 416.995 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 disability or blindness benefits were payable has ceased, did not exist or is no longer disabling (a medical cessation determination), your benefits will stop. 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 disability or blindness benefits be continued under § 416.996. The continued benefit provisions of this section do not apply to an initial determination on an application for disability or blindness benefits or to a determination that you were disabled or blind only for a specified period of time.

[53 FR 29023, Aug. 2, 1988]

§ 416.996 Continued disability or blindness benefits pending appeal of a medical cessation determination.

(a) *General.* If we determine that you are not eligible for disability or blindness 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 disability or blindness benefits, including special cash benefits or special SSI eligibility status under §§ 416.261 and 416.264, continued pending reconsideration and/or a hearing before an administrative law judge on the disability/blindness cessation determination. 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.

(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 after October 1984.

(2) Continued 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 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 in which no timely request for reconsideration or administrative law judge hearing is pending after notification of our initial or reconsideration cessation determination. These benefits may be stopped or adjusted because of certain events (such as, change in income or resources or your living arrangements) which may occur while you are receiving these continued benefits, in accordance with § 416.1336(b).

(b) *Statement of choice.* If you or another party (see § 416.1432(a)) request reconsideration under § 416.1409 or a hearing before an administrative law judge in accordance with § 416.1433 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 indicating that you wish to have benefits continued pending the outcome of the reconsideration or administrative law judge hearing. If you request reconsideration and/or hearing 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 continued during the appeal. A separate election must be made at each level of appeal.

(c) *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 § 416.1409, and you must request continued benefits using a statement in accordance with paragraph (b) of this section.

(2) If you fail to request reconsideration and continued benefits within the 10-day period required by paragraph (c)(1) of this section, but later ask that we continue your benefits pending a reconsidered determination, we will use the rules in § 416.1411 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.

(d) *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 § 416.1433, and you must request continued benefits using a statement in accordance with paragraph (b) of this section.

(2) If you fail to request a hearing and continued benefits within the 10-day period required under paragraph (d)(1) of this section, but you later ask that we continue your benefits pending an administrative law judge's decision, we will use the rules as provided in § 416.1411 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 delayed request to be timely and will pay continued benefits only if good cause for delay is established.

(e) *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 § 416.1477, and the administrative law judge's decision or dismissal order issued on your medical cessation appeal is vacated and is no longer in effect, you may be eligible for continued benefits pending a new decision by the administrative law judge or final action by the Appeals Council on the administrative law judge's recommended decision.

(1) When your case is remanded to an administrative law judge, and you have elected to receive continued benefits, we will contact you to update our file to verify that you continue to meet the nonmedical requirements to receive benefits based on disability or blindness. To determine your correct payment amount, we will ask you to provide information about events such as changes in living arrangements, income, or resources since our last contact with you. If you have returned to work, we will request additional information about this work activity. Unless your earnings cause your income to be too much to receive benefits, your continued benefits will be paid while your appeal of the medical cessation of your disability/blindness is still pending, unless you have completed a trial work period and are engaging in substantial gainful activity. If you have completed a trial work period and previously received continued benefits you may still be eligible for special cash benefits under § 416.261 or special SSI eligibility status under § 416.264. (Effective July 1, 1987, a title XVI individual is no longer subject to a trial work period or cessation based on engaging in substantial gainful activity in order to be eligible for special benefits under § 416.261 or special status under § 416.264.) If we determine that you no longer meet a requirement to receive benefits, we will send you a written notice. The written notice will explain why your continued benefits will not be reinstated or will be for an amount less than you received before the prior administrative law judge's

decision. The notice will also explain your right to reconsideration under § 416.1407, if you disagree. If you request a reconsideration, you will have the chance to explain why you believe your benefits should be reinstated or should be at a higher amount. 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 any right to reentitlement to benefits including special benefits under § 416.261 or special status under § 416.264. If you disagree with our determination on your appeal, you will have the right to appeal this decision.

(2) After we verify that you meet all the nonmedical requirements to receive benefits as stated in paragraph (e)(1) of this section, and if you previously elected to receive continued benefits pending the administrative law judge's decision, we will start continued benefits again. We will send you a notice telling you this. You do not have to complete a request to have these same benefits continued through the month before the month the new decision or order of dismissal is issued by the administrative law judge or through the month before the month the Appeals Council takes final action on the administrative law judge's recommended decision. These continued 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 continued benefits will also tell you to report to us any changes or events that affect your receipt of benefits.

(3) When your case is remanded to an administrative law judge, and if you did *not* previously elect to have benefits continued pending an administrative law judge decision, we will send you a notice telling you that if you want to change that election, you must request to do so no later than 10 days after you receive our notice. If you do make this new election, and after we verify that you meet all the nonmedical requirements as explained in paragraph (e)(1) of this section, benefits will begin with the month of the Appeals Council remand order and will continue as stated in paragraph (e)(2) of this section.

(4) 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 § 416.1483, the administrative law judge's decision or dismissal order on your medical cessation appeal is vacated and is no longer in effect. You may be eligible for continued benefits pending a new decision by the administrative law judge or final action 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 paragraph (e) (1), (2), and (3) of this section.

(f) *What if your benefits are suspended, reduced or terminated for other reasons.* If we determine that your payments should be reduced, suspended or terminated for reasons not connected with your medical condition (see subpart M of Regulations No. 16) benefits may be continued under the procedure described in § 416.1336.

(g) *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, you will have the right to ask that you not be required to pay back the benefits as described in the overpayment recovery and waiver provisions of subpart E of this part.

(2) Waiver of recovery of an overpayment resulting from continued benefits to you may be considered as long as the cessation determination was appealed in good faith. We will assume that your appeal was made in good faith and, therefore, you have the right to waiver consideration *unless* you fail to cooperate in connection with the appeal, e.g., if you fail (without good reason) to give us medical or other evidence we request, or to go for a physical or mental examination when requested, in connection with the appeal. In determining whether you have 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) you may have which may have caused your failure to cooperate.

[53 FR 29023, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988, as amended at 59 FR 1637, Jan. 12, 1994]

§416.998 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 §416.994.

[50 FR 50147, Dec. 6, 1985; 51 FR 16015, Apr. 30, 1986]

Subpart J—Determinations of Disability

AUTHORITY: Secs. 702(a)(5), 1614, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382c, 1383, and 1383b).

SOURCE: 46 FR 29211, May 29, 1981, unless otherwise noted.

GENERAL PROVISIONS

§416.1001 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 XVI of the Act. It also establishes the Secretary's responsibilities in carrying out the disability determination function.

(a) Sections 416.1001 through 416.1003 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 416.1010 through 416.1018 describe the Secretary's and the State's responsibilities in performing the disability determination function.

(c) Sections 416.1020 through 416.1033 describe the administrative responsibilities and requirements of the States. The corresponding role of the Secretary is also set out.

(d) Sections 416.1040 through 416.1050 describe the performance accuracy and processing time standards for measuring State agency performance.

(e) Sections 416.1060 through 416.1061 describe when and what kind of assistance the Secretary will provide State agencies to help them improve performance.

(f) Sections 416.1070 through 416.1075 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 416.1080 through 416.1083 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 416.1090 through 416.1094 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.

§416.1002 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 1614(a)(2) and (3) of the Act.

Disability determination function means making determinations as to disability or blindness and carrying out related administrative and other responsibilities.

Disability program means the Federal program for providing supplemental security income benefits for the blind

and disabled under title XVI of the Act, as amended.

Initial means the first level of disability or blindness 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 1102, 1631(c) and 1633(a) 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 and the District of Columbia. 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 29211, May 29, 1981, as amended at 56 FR 11021, Mar. 14, 1991]

§ 416.1003 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 § 416.1022);

(3) Provide funds to the State agency for the necessary cost of performing the disability determination function (see § 416.1026);

(4) Monitor and evaluate the performance of the State agency under the established standards (see §§ 416.1044 and 416.1045); 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 (§§ 416.1020 through 416.1024);

(3) Furnish reports and records relating to the administration of the disability program (§ 416.1025);

(4) Submit budgets (§ 416.1026);

(5) Cooperate with audits (§ 416.1027);

(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 (§ 416.1028);

(8) Take part in the research and demonstration projects (§ 416.1029);

(9) Coordinate with other agencies (§ 416.1030);

(10) Safeguard the records created by the State in performing the disability determination function (§ 416.1031);

(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 (§416.1033);

(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

§416.1010 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.

§416.1011 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.

§416.1013 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 §416.903(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.

§416.1014 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 responsibility for making disability determinations in those classes of cases described in the written guidelines for which the State agency does not make the determination.

§ 416.1015 Making disability determinations.

(a) When making a disability determination, the State agency will apply subpart I, part 416, 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 § 416.918); or

(3) A State agency disability hearing officer.

See § 416.1016 for the definition of medical or psychological consultant and § 416.1415 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 § 416.972 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 § 416.1016 for the qualifications we consider necessary for a psychologist to be a psychological consultant and § 416.1017 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) In making a determination under title XVI with respect to the disability of a child to whom paragraph (d) of this section does not apply, we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment(s) evaluates the case of the child.

(f) The State agency will certify each determination of disability to us on forms we provide.

(g) The State agency will furnish us with all the evidence it considered in making its determination.

(h) 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 23928, Sept. 9, 1987, as amended at 56 FR 11021, Mar. 14, 1991; 58 FR 47587, Sept. 9, 1993; 61 FR 11136, Mar. 19, 1996]

EFFECTIVE DATE NOTE: At 61 FR 11136, Mar. 19, 1996, § 416.1015 was amended by removing the ''or'' at the end of paragraph (c)(1), by redesignating paragraph (c)(2) as paragraph (c)(3), and by adding a new paragraph (c)(2), effective April 18, 1996.

§ 416.1016 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 23928, Sept. 9, 1987]

§416.1017 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 §416.1015(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 23928, Sept. 9, 1987]

§416.1018 Notifying claimant of the disability determination.

The State agency will prepare denial notices in accordance with subpart N of this part whenever it makes a disability determination which is wholly or partly unfavorable to the claimant.

ADMINISTRATIVE RESPONSIBILITIES AND REQUIREMENTS

§416.1020 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 29211, May 29, 1981, as amended at 56 FR 11021, Mar. 14, 1991; 56 FR 13365, Apr. 1, 1991]

§ 416.1021 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.

§ 416.1022 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.

§ 416.1023 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 29211, May 29, 1981, as amended at 56 FR 11022, Mar. 14, 1991]

§ 416.1024 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.

§ 416.1025 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).

§ 416.1026 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 § 416.1027), 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–74–4 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 29211, May 29, 1981, as amended at 56 FR 11022, Mar. 14, 1991]

§ 416.1027 Audits.

(a) *Audits performed by the State*—(1) *Generally.* Audits of account 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 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 administration of the disability programs under the Act will be audited by the Department of Health and Human Services' Inspector General or audited

[1] The circular is available from the Office of Administration, Publications Unit, Rm. G–236, New Executive Office Bldg., Washington, DC 20503.

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, MD 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 § 416.1083.

[56 FR 11022, Mar. 14, 1991]

§ 416.1028 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.

§ 416.1029 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.

§ 416.1030 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.

§416.1031 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 §416.1033).

§416.1032 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).

§416.1033 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 §416.1002 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 effect 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 29211, May 29, 1981, as amended at 56 FR 11023, Mar. 14, 1991]

PERFORMANCE STANDARDS

§416.1040 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 program 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 11023, Mar. 14, 1991]

§416.1041 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 29211, May 29, 1981, as amended at 56 FR 11023, Mar. 14, 1991]

§ 416.1042 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 29211, May 29, 1981, as amended at 56 FR 11023, Mar. 14, 1991]

§ 416.1043 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.

§ 416.1044 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 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 29211, May 29, 1981, as amended at 56 FR 11023, Mar. 14, 1991]

§416.1045 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.

§416.1050 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 §§416.1060, 416.1061 and 416.1062 for a period of up to 12 months.

[56 FR 11023, Mar. 14, 1991]

PERFORMANCE MONITORING AND SUPPORT

§416.1060 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 11023, Mar. 14, 1991]

§416.1061 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 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 11023, Mar. 14, 1991]

§416.1062 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 11024, Mar. 14, 1991]

SUBSTANTIAL FAILURE

§ 416.1070 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 §§ 416.1090 and 416.1092.

[56 FR 11024, Mar. 14, 1991]

§ 416.1071 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 11024, Mar. 14, 1991]

§ 416.1075 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

§ 416.1080 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 11024, Mar. 14, 1991]

§416.1081 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 §416.1027.)

[56 FR 11024, Mar. 14, 1991]

§416.1082 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).

§416.1083 Hearings and appeals process.

The rules for hearings and appeals before the Board are provided in 45 CFR part 16. A notice under §416.1080 of this subpart will be considered a ''final written decision'' for purposes of Board review.

ASSUMPTION OF DISABILITY DETERMINATION FUNCTION

§416.1090 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 §416.1092.

§416.1091 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 §416.1092. 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.

§416.1092 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 §416.1090 or §416.1091, 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.

§ 416.1093 Limitation on State expenditures after notice.

The State agency may not, after it receives the notice referred to in § 416.1090, or gives the notice referred to in § 416.1091, 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.

§ 416.1094 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 § 416.1026 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 416.

Subpart K—Income

AUTHORITY: Secs. 702(a)(5), 1602, 1611, 1612, 1613, 1614(f), 1621, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, and 1383); sec. 211, Pub. L. 93–66, 87 Stat. 154 (42 U.S.C. 1382 note).

SOURCE: 45 FR 65547, Oct. 3, 1980, unless otherwise noted.

GENERAL

§ 416.1100 Income and SSI eligibility.

You are eligible for supplemental security income (SSI) benefits if you are an aged, blind, or disabled person who meets the requirements described in subpart B and who has limited income and resources. Thus, the amount of income you have is a major factor in deciding whether you are eligible for SSI benefits and the amount of your benefit. We count income on a monthly basis. Generally, the more income you have the less your benefit will be. If you have too much income, you are not eligible for a benefit. However, we do not count all of your income to determine your eligibility and benefit amount. We explain in the following sections how we treat your income for the SSI program. These rules apply to the Federal benefit and to any optional State supplement paid by us on behalf of a State (§ 416.2025) except as noted in subpart T and in the Federal-State agreements with individual States. While this subpart explains how we count income, subpart D of these regulations explains how we determine your benefits, including the provision that we generally use countable income in a prior month to determine how much your benefit amount will be for a month in which you are eligible (§ 416.420).

[50 FR 48573, Nov. 26, 1985]

§ 416.1101 Definition of terms.

As used in this subpart—

Calendar quarter means a period of three full calendar months beginning with January, April, July, or October.

Child means someone who is not married, is not the head of a household, and is either under age 18 or is under age 22 and a student. (See § 416.1856)

Couple means an eligible individual and his or her eligible spouse.

Current market value means the price of an item on the open market in your locality.

Federal benefit rate means the monthly payment rate for an eligible individual or couple. It is the figure from which we substract countable income

to find out how much your Federal SSI benefit should be. The Federal benefit rate does not include the rate for any State supplement paid by us on behalf of a State.

Institution means an establishment which makes available some treatment or services beyond food and shelter to four or more persons who are not related to the proprietor. (See §416.201)

Spouse means someone who lives with another person as that person's husband or wife. (See §416.1806)

We, Us, or *Our* means the Social Security Administration.

You or *Your* means a person who is applying for, or already receiving, SSI benefits.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48573, Nov. 26, 1985; 51 FR 10616, Mar. 28, 1986; 60 FR 16375, Mar. 30, 1995]

§416.1102 What is income.

Income is anything you receive in cash or in kind that you can use to meet your needs for food, clothing, and shelter. Sometimes income also includes more or less than you actually receive (see §416.1110 and §416.1123(b)). In-kind income is not cash, but is actually food, clothing, or shelter, or something you can use to get one of these.

[56 FR 3212, Jan. 29, 1991]

§416.1103 What is not income.

Some things you receive are not income because you cannot use them as food, clothing, or shelter, or use them to obtain food, clothing, or shelter. In addition, what you receive from the sale or exchange of your own property is not income; it remains a resource. The following are some items that are not income:

(a) *Medical care and services.* Medical care and services are not income if they are any of the following:

(1) Given to you free of charge or paid for directly to the provider by someone else;

(2) Room and board you receive during a medical confinement;

(3) Assistance provided in cash or in kind (including food, clothing, or shelter) under a Federal, State, or local government program, whose purpose is to provide medical care or services (including vocational rehabilitation);

(4) In-kind assistance (except food, clothing, or shelter) provided under a nongovernmental program whose purpose is to provide medical care or medical services;

(5) Cash provided by any nongovernmental medical care or medical services program or under a health insurance policy (except cash to cover food, clothing, or shelter) if the cash is either:

(i) Repayment for program-approved services you have already paid for; or

(ii) A payment restricted to the future purchase of a program-approved service.

Example: If you have paid for prescription drugs and get the money back from your health insurance, the money is not income.

(6) Direct payment of your medical insurance premiums by anyone on your behalf.

(7) Payments from the Department of Veterans Affairs resulting from unusual medical expenses.

(b) *Social services.* Social services are not income if they are any of the following:

(1) Assistance provided in cash or in kind (but not received in return for a service you perform) under any Federal, State, or local government program whose purpose is to provide social services including vocational rehabilitation (Example: Cash given you by the Department of Veterans Affairs to purchase aid and attendance);

(2) In-kind assistance (except food, clothing, or shelter) provided under a nongovernmental program whose purpose is to provide social services; or

(3) Cash provided by a nongovernmental social services program (except cash to cover food, clothing, or shelter) if the cash is either:

(i) Repayment for program-approved services you already have paid for; or

(ii) A payment restricted to the future purchase of a program-approved service.

Example: If you are unable to do your own household chores and a private social services agency provides you with cash to pay a homemaker the cash is not income.

(c) *Receipts from the sale, exchange, or replacement of a resource.* Receipts from the sale, exchange, or replacement of a resource are not income but are

resources that have changed their form. This includes any cash or in-kind item that is provided to replace or repair a resource (see subpart L) that has been lost, damaged, or stolen. Sections 416.1150 and 416.1151 discuss treatment of receipts to replace or repair a resource following a major disaster or following some other event causing damage or loss of a resource.

Example: If you sell your automobile, the money you receive is not income; it is another form of a resource.

(d) *Income tax refunds.* Any amount refunded on income taxes you have already paid is not income.

(e) *Payments by credit life or credit disability insurance.* Payments made under a credit life or credit disability insurance policy on your behalf are not income.

Example: If a credit disability policy pays off the mortgage on your home after you become disabled in an accident, we do not consider either the payment or your increased equity in the home to be income.

(f) *Proceeds of a loan.* Money you borrow or money you receive as repayment of a loan is not income. However, interest you receive on money you have lent is income. Buying on credit is treated as though you were borrowing money and what you purchase this way is not income.

(g) *Bills paid for you.* Payment of your bills by someone else directly to the supplier is not income. However, we count the value of anything you receive because of the payment if it is in-kind income as defined in § 416.1102.

Examples: If your daughter uses her own money to pay the grocer to provide you with food, the payment itself is not your income because you do not receive it. However, because of your daughter's payment, the grocer provides you with food; the food is in-kind income to you. Similarly, if you buy clothing on credit and your son later pays the bill, the payment to the store is not income to you but the clothing is in-kind income to you. In this example, if your son pays for the clothing in a quarter after the quarter of purchase, we will count the in-kind income to you in the quarter in which he pays the bill. On the other hand, if your brother pays a lawn service to mow your grass, the payment is not income to you because the mowing cannot be used to meet your needs for food, clothing, or shelter. Therefore, it is not in-kind income as defined in § 416.1102.

(h) *Replacement of income you have already received.* If income is lost, destroyed, or stolen and you receive a replacement, the replacement is not income.

Example: If your paycheck is stolen and you get a replacement check, we count the first check as income. The replacement check is not income.

(i) *Weatherization assistance.* Weatherization assistance (Examples: Insulation, storm doors and windows) is not income.

(j) *Receipt of certain noncash items.* Any item you receive (except shelter as defined in § 416.1130, food, or clothing) which would be an excluded nonliquid resource (as described in subpart L of this part) if you kept it, is not income.

Example 1: A community takes up a collection to buy you a specially equipped van which is your only vehicle. The value of this gift *is not* income because the van does not provide you with food, clothing, or shelter and will become an excluded nonliquid resource under § 416.1218 in the month following the month of receipt.

Example 2: You inherit a house which is your principal place of residence. The value of this inheritance *is* income because the house provides you with shelter and shelter is income. However, we value the house under the rule in § 416.1140.

[45 FR 65547, Oct. 3, 1980, as amended at 49 FR 48038, Dec. 10, 1984; 57 FR 53850, Nov. 13, 1992; 59 FR 33907, July 1, 1994]

§ 416.1104 Income we count.

We have described generally what income is and is not for SSI purposes (§ 416.1103). There are different types of income, earned and unearned, and we have rules for counting each. The earned income rules are described in §§ 416.1110 through 416.1112 and the unearned income rules are described in §§ 416.1120 through 416.1124. One type of unearned income is in-kind support and maintenance (food, clothing, or shelter). The way we value it depends on your living arrangement. These rules are described in §§ 416.1130 through 416.1146. In some situations we must consider the income of certain people with whom you live as available to you and part of your income. These rules are described in §§ 416.1160 through 416.1169. We use all of these rules to determine the amount of your countable income—the amount that is left after

we subtract what is not income or is not counted.

EARNED INCOME

§416.1110 What is earned income.

Earned income may be in cash or in kind. We may include more of your earned income than you actually receive. We include more than you actually receive if amounts are withheld from earned income because of a garnishment or to pay a debt or other legal obligation, or to make any other payments. Earned income consists of the following types of payments:

(a) *Wages.* Wages are what you receive (before any deductions) for working as someone else's employee. Wages are the same for SSI purposes as for the earnings test in the social security retirement program. (See §404.429(c) of this chapter.) Wages include salaries, commissions, bonuses, severance pay, and any other special payments received because of your employment. They may also include the value of food, clothing, or shelter, or other items provided instead of cash. We refer to this as in-kind earned income. However, if you are a domestic or agricultural worker, the law requires us to treat your in-kind pay as unearned income.

(b) *Net earnings from self-employment.* Net earnings from self-employment are your gross income from any trade or business that you operate, less allowable deductions for that trade or business. Net earnings also include your share of profit or loss in any partnership to which you belong. These are the same net earnings that we would count under the social security retirement insurance program and that you would report on your Federal income tax return. (See §404.1080 of this chapter.)

(c) *Refunds of Federal income taxes and advance payments by employers made in accordance with the earned income credit provisions of the Internal Revenue Code.* Refunds on account of earned income credits are payments made to you under the provisions of section 43 of the Internal Revenue Code of 1954, as amended. These *refunds* may be greater than taxes you have paid. You may receive earned income tax credit payments along with any other Federal income tax refund you receive because of overpayment of your income tax, (Federal income tax refunds made on the basis of taxes you have already paid are not income to you as stated in §416.1103(d).) Advance payments of earned income tax credits are made by your employer under the provisions of section 3507 of the same code. You can receive earned income tax credit payments only if you meet certain requirements of family composition and income limits.

(d) *Payments for services performed in a sheltered workshop or work activities center.* Payments for services performed in a sheltered workshop or work activities center are what you receive for participating in a program designed to help you become self-supporting.

(e) *Certain royalties and honoraria.* Royalties that are earned income are payments to an individual in connection with any publication of the work of the individual. (See §416.1110(b) if you receive a royalty as part of your trade or business. See §416.1121(c) if you receive another type of royalty.) Honoraria that are earned income are those portions of payments, such as an honorary payment, reward, or donation, received in consideration of services rendered for which no payment can be enforced by law. (See §416.1120 if you receive another type of honorarium.)

[45 FR 65547, Oct. 3, 1980, as amended at 48 FR 23179, May 24, 1983; 50 FR 48574, Nov. 26, 1985; 56 FR 3212, Jan. 29, 1991; 59 FR 43471, Aug. 24, 1994]

§416.1111 How we count earned income.

(a) *Wages.* We count wages at the earliest of the following points: when you receive them or when they are credited to your account or set aside for your use. We determine wages for each month.

(b) *Net earnings from self-employment.* We count net earnings from self-employment on a taxable year basis. However, we divide the total of these earnings equally among the months in the taxable year to get your earnings for each month. For example, if your net earnings for a taxable year are $2,400, we consider that you received $200 in each month. If you have net losses from self-employment, we divide them

over the taxable year in the same way, and we deduct them only from your other earned income.

(c) *Payments for services in a sheltered workshop or activities center.* We count payments you receive for services performed in a sheltered workshop or work activities center when you receive them or when they are set aside for your use. We determine the amount of the payments for each calendar quarter.

(d) *In-kind earned income.* We use the current market value of in-kind earned income for SSI purposes. (See § 416.1101 for a definition of current market value.) If you receive an item that is not fully paid for and are responsible for the unpaid balance, only the paid-up value is income to you. (See the example in § 416.1123(c)).

(e) *Royalties and honoraria.* We count payments of royalties to you in connection with any publication of your work, and honoraria, to the extent received for services rendered, at the earliest of the following points: when you receive them, when they are credited to your account, or when they are set aside for your use. (See § 416.1111(b) if you receive royalties as part of your trade or business.)

[45 FR 65547, Oct. 3, 1980, as amended at 48 FR 23179, May 24, 1983; 48 FR 30357, July 1, 1983; 50 FR 48574, Nov. 26, 1985; 58 FR 63889, Dec. 3, 1993; 59 FR 43471, Aug. 24, 1994]

§ 416.1112 Earned income we do not count.

(a) *General.* While we must know the source and amount of all of your earned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your income in the month. We never reduce your earned income below zero or apply any unused earned income exclusion to unearned income.

(b) *Other Federal laws.* Some Federal laws other than the Social Security Act provide that we cannot count some of your earned income for SSI purposes. We list the laws and exclusions in the appendix to this subpart which we update periodically.

(c) *Other earned income we do not count.* We do not count as earned income—

(1) Any refund of Federal income taxes you receive under section 32 of the Internal Revenue Code (relating to earned income tax credit) and any payment you receive from an employer under section 3507 of the Internal Revenue Code (relating to advance payment of earned income tax credit);

(2) Up to $10 of earned income in a month if it is infrequent or irregular; that is, if you receive it only once in a calendar quarter from a single source or if you cannot reasonably expect it. If the total amount of your infrequent or irregular earned income for a month exceeds $10, we cannot use this exclusion;

(3) Up to $400 per month but not more than $1,620 in a calendar year, if you are a blind or disabled child who is a student regularly attending school as described in § 416.1861;

(4) Any portion of the $20 monthly exclusion in § 416.1124(c)(10) which has not been excluded from your unearned income in that same month;

(5) $65 of earned income in a month;

(6) Earned income you use to pay impairment-related work expenses described in § 416.976, if you are disabled (but not blind) and under age 65 or you are disabled (but not blind) and received SSI as a disabled individual (or received disability payments under a former State plan) for the month before you reached age 65.

(i) For periods prior to December 1, 1990, you must be able, however, to establish your initial eligibility for Federal benefits without the use of the impairment-related work expense exclusion. Once you establish your initial eligibility without the use of the impairment-related work expense exclusion, the exclusion applies for determining your eligibility for all subsequent consecutive months for which you are eligible for regular SSI benefits, federally administered optional State supplementary payments, special SSI cash benefits or special SSI eligibility status. If, in a subsequent month, you are not eligible for any of these benefits, you cannot reestablish

your eligibility for Federal SSI benefits or federally administered optional State supplementary payments before December 1, 1990, using the impairment-related work expense exclusion.

(ii) For periods after November 30, 1990, you may also use the impairment-related work expense exclusion to establish initial eligibility and reeligibility following a month in which you were not eligible for regular SSI benefits, a federally administered optional State supplementary payment, special SSI cash benefits or special SSI eligibility status.

(7) One-half of remaining earned income in a month;

(8) Earned income used to meet any expenses reasonably attributable to the earning of the income if you are blind and under age 65 or if you receive SSI as a blind person for the month before you reach age 65. (We consider that you ''reach'' a certain age on the day before that particular birthday.); and

(9) Any earned income you receive and use to fulfill an approved plan to achieve self-support if you are blind or disabled and under age 65 or blind or disabled and received SSI as a blind or disabled person for the month before you reached age 65. See §§416.1180 through 416.1182 for an explanation of plans to achieve self-support and for the rules on when this exclusion applies.

[45 FR 65547, Oct. 3, 1980, as amended at 48 FR 21943, May 16, 1983; 50 FR 48574, Nov. 26, 1985; 58 FR 63889, Dec. 3, 1993; 59 FR 41405, Aug. 12, 1994]

UNEARNED INCOME

§ 416.1120 What is unearned income.

Unearned income is all income that is not earned income. We describe some of the types of unearned income in §416.1121. We consider all of these items as unearned income, whether you receive them in cash or in kind.

§ 416.1121 Types of unearned income.

Some types of unearned income are—

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

(b) *Alimony and support payments.* For SSI purposes, alimony and support payments are cash or in-kind contributions to meet some or all of a person's needs for food, clothing, or shelter. Support payments may be made voluntarily or because of a court order. Alimony (sometimes called *maintenance*) is an allowance made by a court from the funds of one spouse to the other spouse in connection with a suit for separation or divorce.

(c) *Dividends, interest, and certain royalties.* Dividends and interest are returns on capital investments, such as stocks, bonds, or savings accounts. Royalties are compensation paid to the owner for the use of property, usually copyrighted material or natural resources such as mines, oil wells, or timber tracts. Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced. (See §416.1110(b) if you receive royalties as part of your trade or business and §416.1110(e) if you receive royalties in connection with the publication of your work.)

(d) *Rents.* Rents are payments you receive for the use of real or personal property such as land, housing, or machinery. We deduct from rental payments your ordinary and necessary expenses in the same taxable year. These include only those expenses necessary for the production or collection of the rental income and they must be deducted when paid, not when they are incurred. Some examples of deductible expenses are interest on debts, State and local taxes on real and personal property and on motor fuels, general sales taxes, and expenses of managing or maintaining the property. (Sections 163, 164, and 212 of the Internal Revenue Code of 1954 and related regulations explain this in more detail.) We do not consider depreciation or depletion of property a deductible expense. (See §416.1110(b) for rules on rental income that is earned from self-employment. For example, you may be in the business of renting properties.)

(e) *Death benefits.* We count payments you get which were occasioned by the

death of another person except for the amount of such payments that you spend on the deceased person's last illness and burial expenses. Last illness and burial expenses include related hospital and medical expenses, funeral, burial plot and interment expenses, and other related costs.

Example: If you receive $2,000 from your uncle's life insurance policy and you spend $900 on his last illness and burial expenses, the balance, $1,100, is unearned income. If you spend the entire $2,000 for the last illness and burial, there is no unearned income.

(f) *Prizes and awards.* A prize is generally something you win in a contest, lottery or game of chance. An award is usually something you receive as the result of a decision by a court, board of arbitration, or the like.

(g) *Gifts and inheritances.* A gift is something you receive which is not repayment to you for goods or services you provided and which is not given to you because of a legal obligation on the giver's part. An inheritance is something that comes to you as a result of someone's death. It can be in cash or in kind, including any right in real or personal property. Gifts and inheritances occasioned by the death of another person, to the extent that they are used to pay the expenses of the deceased's last illness and burial, as defined in paragraph (e) of this section, are not considered income.

(h) *Support and maintenance in kind.* This is food, clothing, or shelter furnished to you. Our rules for valuing this income depend on your living arrangement. We use one rule if you are living in the household of a person who provides you with both food and shelter. We use different rules for other situations where you receive food, clothing, or shelter. We discuss all of the rules in §§ 416.1130 through 416.1147.

[45 FR 65547, Oct. 3, 1980, as amended at 56 FR 36000, July 30, 1991; 59 FR 43471, Aug. 24, 1994]

§ 416.1123 How we count unearned income.

(a) *When we count unearned income.* We count unearned income at the earliest of the following points: When you receive it or when it is credited to your account or set aside for your use. We determine your unearned income for each month. We describe an exception to the rule on how we count unearned income in paragraph (d) of this section.

(b) *Amount considered as income.* We may include more or less of your unearned income than you actually receive.

(1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see § 416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. *Exception:* We do not include more than you actually receive if you received both SSI benefits and the other benefit at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.

Example: Joe, an SSI beneficiary, is also entitled to social security insurance benefits in the amount of $200 per month. However, because of a prior overpayment of his social security insurance benefits, $20 per month is being withheld to recover the overpayment. In figuring the amount of his SSI benefits, the full monthly social security insurance benefit of $200 is included in Joe's unearned income. However, if Joe was receiving both benefits when the overpayment of the social security insurance benefit occurred and we then included the overpaid amount as income, we will compute his SSI benefit on the basis of receiving $180 as a social security insurance benefit. This is because we recognize that we computed his SSI benefit on the basis of the higher amount when he was overpaid.

(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligaton, or to make any other payment such as payment of your Medicare premiums.

(3) We include less than you actually receive if part of the payment is for an expense you had in getting the payment. For example, if you are paid for damages you receive in an accident, we subtract from the amount of the payment your medical, legal, or other expenses connected with the accident. If you receive a retroactive check from a benefit program other than SSI, legal fees connected with the claim are

subtracted. We do not subtract from any taxable unearned income the part you have to use to pay personal income taxes. The payment of taxes is not an expense you have in getting income.

(4) In certain situations, we may consider someone else's income to be available to you, whether or not it actually is. (For the rules on this process, called deeming, see §§ 416.1160 through 416.1169.)

(c) *In-kind income.* We use the current market value (defined in § 416.1101) of in-kind unearned income to determine its value for SSI purposes. We describe some exceptions to this rule in §§ 416.1131 through 416.1147. If you receive an item that is not fully paid for and are responsible for the balance, only the paid-up value is income to you.

Example: You are given a $1500 automobile but must pay the $1000 due on it. You are receiving income of $500.

(d) *Retroactive monthly social security benefits.* We count retroactive monthly social security benefits according to the rule in paragraph (d)(1) of this section, unless the exception in paragraph (d)(2) of this section applies:

(1) *Periods for which SSI payments have been made.* When you file an application for social security benefits and retroactive monthly social security benefits are payable on that application for a period for which you also received SSI payments (including federally-administered State supplementary payments), we count your retroactive monthly social security benefits as unearned income received in that period. Rather than reducing your SSI payments in months prior to your receipt of a retroactive monthly social security benefit, we will reduce the retroactive social security benefits by an amount equal to the amount of SSI payments (including federally-administered State supplementary payments) that we would not have paid to you if your social security benefits had been paid when regularly due rather than retroactively (see § 404.408b(b)). If a balance is due you from your retroactive social security benefits after this reduction, for SSI purposes we will not count the balance as unearned income in a subsequent month in which you receive it. This is because your social security benefits were used to determine the amount of the reduction. This exception to the unearned income counting rule does not apply to any monthly social security benefits for a period for which you did not receive SSI.

(2) *Social security disability benefits where drug addiction or alcoholism is a contributing factor material to the determination of disability.* If your retroactive social security benefits must be paid in installments because of the limitations on paying lump sum retroactive benefits to disabled recipients whose drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 404.480, we will count the total of such retroactive social security benefits as unearned income in the first month such installments are paid, except to the extent the rule in paragraph (d)(1) of this section would provide that such benefits not be counted.

(e) *Certain veterans benefits.* (1) If you receive a veterans benefit that includes an amount paid to you because of a dependent, we do not count as your unearned income the amount paid to you because of the dependent.

(2) If you are a dependent of an individual who receives a veterans benefit and a portion of the benefit is attributable to you as a dependent, we count the amount attributable to you as your unearned cash income if—

(i) You reside with the individual who receives the veterans benefit, or

(ii) You receive your own separate payment from the Department of Veterans Affairs.

(Reporting and recordkeeping requirements in paragraph (b) have been approved by the Office of Management and Budget under control number 0960–0128)

[45 FR 65547, Oct. 3, 1980, as amended at 47 FR 4988, Feb. 3, 1982; 47 FR 13794, Apr. 1, 1982; 50 FR 48574, Nov. 26, 1985; 55 FR 20599, May 18, 1990; 56 FR 3212, Jan. 29, 1991; 59 FR 59364, Nov. 17, 1994; 60 FR 8152, Feb. 10, 1995]

§ 416.1124 Unearned income we do not count.

(a) *General.* While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal

laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the $20 general exclusion described in paragraph (c)(12) of this section.

(b) *Other Federal laws.* Some Federal laws other than the Social Security Act provide that we cannot count some of your unearned income for SSI purposes. We list the laws and the exclusions in the appendix to this subpart which we update periodically.

(c) *Other unearned income we do not count.* We do not count as unearned income—

(1) Any public agency's refund of taxes on real property or food;

(2) Assistance based on need which is wholly funded by a State or one of its political subdivisions. (For purposes of this rule, an Indian tribe is considered a political subdivision of a State.) Assistance is based on need when it is provided under a program which uses the amount of your income as one factor to determine your eligibility. Assistance based on need includes State supplementation of Federal SSI benefits as defined in subpart T of this part but does not include payments under a Federal/State grant program such as Aid to Families with Dependent Children under title IV–A of the Social Security Act;

(3) Any portion of a grant, scholarship, or fellowship used for paying tuition, fees, or other necessary educational expenses. However, we do count any portion set aside or actually used for food, clothing, or shelter;

(4) Food which you or your spouse raise if it is consumed by you or your household;

(5) Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster. See § 416.1150 for a more detailed discussion of this assistance, particularly the treatment of in-kind support and maintenance received as the result of a major disaster;

(6) Up to $20 of unearned income in a month if it is infrequent or irregular; that is, if you receive a type of income listed in § 416.1121 only once during a calendar quarter from a single source or if you cannot reasonably expect it. If the total amount of infrequent or irregular unearned income in a month exceeds $20, we cannot use this exclusion;

(7) Periodic payments made by a State under a program established before July 1, 1973, and based solely on your length of residence and attainment of age 65;

(8) Payments for providing foster care to an ineligible child who was placed in your home by a public or private nonprofit child placement or child care agency;

(9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become a part of the separately identifiable burial fund. (See § 416.1231 for an explanation of the exclusion of burial assets.) This exclusion from income applies to interest earned on burial funds or appreciation in value of excluded burial arrangements which occur beginning November 1, 1982, or the date you first become eligible for SSI benefits, if later;

(10) Certain support and maintenance assistance as described in § 416.1157;

(11) One-third of support payments made to or for you by an absent parent if you are a child;

(12) The first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see § 416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility. The $20 exclusion does not apply to a benefit based on need that is totally or partially funded by the Federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions is excluded totally from income as described in § 416.1124(c)(2). If you have less than $20 of unearned income in a month and you have earned income in

that month, we will use the rest of the $20 exclusion to reduce the amount of your countable earned income;

(13) Any unearned income you receive and use to fulfill an approved plan to achieve self-support if you are blind or disabled and under age 65 or blind or disabled and received SSI as a blind or disabled person for the month before you reached age 65. See §§ 416.1180 through 416.1182 for an explanation of plans to achieve self-support and for the rules on when this exclusion applies;

(14) The value of any assistance paid with respect to a dwelling unit under—

(i) The United States Housing Act of 1937;

(ii) The National Housing Act;

(iii) Section 101 of the Housing and Urban Development Act of 1965;

(iv) Title V of the Housing Act of 1949; or

(v) Section 202(h) of the Housing Act of 1959;

(15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement. This exclusion from income applies to interest accrued on or after April 1, 1990;

(16) The value of any commercial transportation ticket, for travel by you or your spouse among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by you or your spouse and is not converted to cash. If such a ticket is converted to cash, the cash you receive is income in the month you receive the cash;

(17) Payments received by you from a fund established by a State to aid victims of crime; and

(18) Relocation assistance provided you by a State or local government that is comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by section 216 of that Act.

[45 FR 65547, Oct. 3, 1980, as amended at 47 FR 55213, Dec. 8, 1982; 48 FR 21943, May 16, 1983; 48 FR 33258, July 21, 1983; 48 FR 57127, Dec. 28, 1983; 50 FR 48574, Nov. 26, 1985; 51 FR 39523, Oct. 29, 1986; 54 FR 19164, May 4, 1989; 55 FR 28378, July 11, 1990; 57 FR 1384, Jan. 14, 1992; 57 FR 53850, Nov. 13, 1992; 58 FR 63888, Dec. 3, 1993; 61 FR 1712, Jan. 23, 1996]

IN-KIND SUPPORT AND MAINTENANCE

§ 416.1130 Introduction.

(a) *General.* Both earned income and unearned income include items received in kind (§ 416.1102). Generally we value in-kind items at their current market value and we apply the various exclusions for both earned and unearned income. However, we have special rules for valuing food, clothing, or shelter that is received as unearned income (in-kind support and maintenance). This section and the ones that follow discuss these rules. In these sections (§§ 416.1130 through 416.1148) the Federal benefit rate that applies for the purpose of valuing in-kind support and maintenance is the rate for the month in which you receive the in-kind support and maintenance.

Example: Joe receives an SSI benefit which is computed by subtracting one-third from the Federal benefit rate. This one-third represents the value of the income he receives by reason of the fact that he lives in the household of a son who provides both food and shelter (in-kind support and maintenance). When the SSI benefit rate is increased in January, his SSI benefit for that month is based on the value of the in-kind support and maintenance he received in November (measured as one-third of the Federal benefit rate for November).

(b) *How we define in-kind support and maintenance.* In-kind support and maintenance means any food, clothing, or shelter that is given to you or that you receive because someone else pays for it. Shelter includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services. You are not receiving in-kind support and maintenance in the form of

room or rent if you are paying the amount charged under a business arrangement. A business arrangement exists when the amount of monthly rent required to be paid equals the current market rental value (see § 416.1101). *Exception:* In the States in the Seventh Circuit (Illinois, Indiana, and Wisconsin), a business arrangement exists when the amount of monthly rent required to be paid equals or exceeds the presumed maximum value described in § 416.1140(a)(1). In those States, if the required amount of rent is less than the presumed maximum value, we will impute as in-kind support and maintenance, the difference between the required amount of rent and either the presumed maximum value or the current market value, whichever is less.

(c) *How we value in-kind support and maintenance.* Essentially, we have two rules for valuing the in-kind support and maintenance which we must count. The one-third reduction rule applies if you are living in the household of a person who provides you with both food and shelter (§§ 416.1131 through 416.1133). The presumed value rule applies in all other situations where you are receiving countable in-kind support and maintenance (§§ 416.1140 through 416.1145). If certain conditions exist, we do not count in-kind support and maintenance. These are discussed in §§ 416.1141 through 416.1145.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48574, Nov. 26, 1985; 51 FR 13488, Apr. 21, 1986; 60 FR 16375, Mar. 30, 1995]

§ 416.1131 The one-third reduction rule.

(a) *What the rule is.* Instead of determining the actual dollar value of in-kind support and maintenance, we count one–third of the Federal benefit rate as additional income if you (or you and your eligible spouse)—

(1) Live in another person's household (see § 416.1132) for a full calendar month except for temporary absences (see § 416.1149), and

(2) Receive both food and shelter from the person in whose household you are living. (If you do not receive both food and shelter from this person, see § 416.1140.)

(b) *How we apply the one-third reduction rule.* The one-third reduction applies in full or not at all. When you are living in another person's household, and the one-third reduction rule applies, we do not apply any income exclusions to the reduction amount. However, we do apply appropriate exclusions to any other earned or unearned income you receive. If you have an eligible spouse we apply the rules described in § 416.1147.

(c) *If you receive other support and maintenance.* If the one-third reduction rule applies to you, we do not count any other in-kind support and maintenance you receive.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48574, Nov. 26, 1985]

§ 416.1132 What we mean by "living in another person's household".

(a) *Household.* For purposes of this subpart, we consider a household to be a personal place of residence. A commercial establishment such as a hotel or boarding house is not a household but a household can exist within a commercial establishment. If you live in a commercial establishment, we do not automatically consider you to be a member of the household of the proprietor. You may, however, live in the household of a roomer or boarder within the hotel or boarding house. An institution is not a household and a household cannot exist within an institution. (Institution is defined in § 416.1101.)

(b) *Another person's household.* You live in another person's household if paragraph (c) of this section does not apply and if the person who supplies the support and maintenance lives in the same household and is not—

(1) Your spouse (as defined in § 416.1806);

(2) A minor child; or

(3) An ineligible person (your spouse, parent, or essential person) whose income may be deemed to you as described in §§ 416.1160 through 416.1169.

(c) *Your own household—not another person's household.* You are not living in another person's household (you live in your own household) if—

(1) You (or your spouse who lives with you or any person whose income is deemed to you) have an ownership interest or a life estate interest in the home;

(2) You (or your spouse who lives with you or any person whose income is deemed to you) are liable to the landlord for payment of any part of the rental charges;

(3) You live in a noninstitutional care situation as described in §416.1143;

(4) You pay at least a pro rata share of household and operating expenses (see §416.1133); or

(5) All members of the household receive public income—maintenance payments (§416.1142).

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48574, Nov. 26, 1985]

§416.1133 What is a pro rata share of household operating expenses.

(a) *General.* If you pay your pro rata share toward monthly household operating expenses, you are living in your own household and are not receiving in-kind support and maintenance from anyone else in the household. The one-third reduction, therefore, does not apply to you. (If you are receiving food, clothing, or shelter from someone outside the household, we value it under the rule in §416.1140.)

(b) *How we determine a pro rata share.* Your pro rata share of household operating expenses is the average monthly household operating expenses (based on a reasonable estimate if exact figures are not available) divided by the number of people in the household, regardless of age.

(c) *Average household operating expenses.* Household operating expenses are the household's total monthly expenditures for food, rent, mortgage, property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection service. (The term does not include the cost of these items if someone outside the household pays for them.) Generally, we average household operating expenses over the past 12 months to determine a pro rata share.

§416.1140 The presumed value rule.

(a) *How we apply the presumed value rule.* (1) When you receive in-kind support and maintenance and the one-third reduction rule does not apply, we use the presumed value rule. Instead of determining the actual dollar value of any food, clothing, or shelter you receive, we presume that it is worth a maximum value. This maximum value is one-third of your Federal benefit rate plus the amount of the general income exclusion described in §416.1124(c)(12).

(2) The presumed value rule allows you to show that your in-kind support and maintenance is not equal to the presumed value. We will not use the presumed value if you show us that—

(i) The current market value of any food, clothing, or shelter you receive, minus any payment you make for them, is lower than the presumed value; or

(ii) The actual amount someone else pays for your food, clothing, or shelter is lower than the presumed value.

(b) *How we determine the amount of your unearned income under the presumed value rule.* (1) If you choose not to question the use of the presumed value, or if the presumed value is less than the actual value of the food, clothing, or shelter you receive, we use the presumed value to figure your unearned income.

(2) If you show us, as provided in paragraph (a)(2) of this section, that the presumed value is higher than the actual value of the food, clothing, or shelter you receive, we use the actual amount to figure your unearned income.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48575, Nov. 26, 1985; 58 FR 63888, Dec. 3, 1993]

§416.1141 When the presumed value rule applies.

The presumed value rule applies whenever we must count in-kind support and maintenance as unearned income and the one-third reduction rule does not apply. This means that the presumed value rule applies if you are living—

(a) In another person's household (as described in §416.1132(b)) but not receiving both food and shelter from that person;

(b) In your own household (as described in §416.1132(c)). For exceptions, see §416.1142 if you are in a public assistance household and §416.1143 if you are in a noninstitutional care situation;

(c) In a nonmedical institution including any—

(1) Public nonmedical institution if you are there for less than a full calendar month;

(2) Public or private nonprofit educational or vocational training insitution;

(3) Private nonprofit retirement home or similar institution where there is an express obligation to provide your full support and maintenance or where someone else pays for your support and maintenance. For exceptions, see § 416.1144; and

(4) For-profit institution where someone else pays for your support and maintenance. If you or the institution pay for it, see § 416.1145.

§ 416.1142 If you live in a public assistance household.

(a) *Definition.* A public assistance household is one in which every member receives some kind of public income-maintenance payments. These are payments made under—

(1) Title IV–A of the Social Security Act (Aid to Families with Dependent Children);

(2) Title XVI of the Social Security Act (SSI, including federally administered State supplements and State administered mandatory supplements);

(3) The Refugee Act of 1980 (Those payments based on need);

(4) The Disaster Relief and Emergency Assistance Act;

(5) General assistance programs of the Bureau of Indian Affairs;

(6) State or local government assistance programs based on need (tax credits or refunds are not assistance based on need); and

(7) U.S. Department of Veterans Affairs programs (those payments based on need).

(b) *How the presumed value rule applies.* If you live in a public assistance household, we consider that you are not receiving in-kind support and maintenance from members of the household. In this situation, we use the presumed value rule only if you receive food, clothing, or shelter from someone outside the household.

[45 FR 65547, Oct. 3, 1980, as amended at 57 FR 53850, Nov. 13, 1992]

§ 416.1143 If you live in a noninstitutional care situation.

(a) *Definitions.* For purposes of this subpart you live in a noninstitutional care situation if all the following conditions exist:

(1) You are placed by a public or private agency under a specific program such as foster or family care;

(2) The placing agency is responsible for your care;

(3) You are in a private household (not an institution) which is licensed or approved by the placing agency to provide care; and

(4) You, a public agency, or someone else pays for your care.

(b) *How the presumed value rule applies.* You are not receiving in-kind support and maintenance and the presumed value rule does not apply if you pay the rate the placing agency establishes. We consider this established rate to be the current market value for the in-kind support and maintenance you are receiving. The presumed value rule applies if you pay less than the established rate and the difference is paid by someone else other than a public or private agency providing social services described in § 416.1103(b) or assistance based on need described in § 416.1124(c)(2).

§ 416.1144 If you live in a nonprofit retirement home or similar institution.

(a) *Definitions.* For purposes of this section the following definitions apply:

(1) *Nonprofit retirement home or similar institution* means a nongovernmental institution as defined under § 416.1101, which is, or is controlled by, a private nonprofit organization and which does not provide you with—

(i) Services which are (or could be) covered under Medicaid, or

(ii) Education or vocational training.

(2) *Nonprofit organization* means a private organization which is tax exempt under section 501(a) of the Internal Revenue Code of 1954 and is of the kind described in section 501(c) or (d) of that code.

(3) An *express obligation to provide your full support and maintenance* means there is either a legally enforceable written contract or set of membership

rules providing that the home, institution, or organization—

(i) Will provide at least all of your food and shelter needs; and

(ii) Does not require any current or future payment for that food and shelter. (For purposes of this paragraph, a lump sum prepayment for lifetime care is not a current payment.)

(b) *How the presumed value rule applies.* The presumed value rule applies if you are living in a nonprofit retirement home or similar institution where there is an express obligation to provide your full support and maintenance or where someone else pays for your support and maintenance. The rule does not apply to the extent that—

(1) The home, institution, or nonprofit organization does not have an express obligation to provide your full support and maintenance; and

(2) The home, institution, or nonprofit organization receives no payment for your food, clothing, or shelter, or receives payment from another nonprofit organization.

[45 FR 65547, Oct. 3, 1980, as amended at 51 FR 34464, Sept. 29, 1986]

§416.1145 How the presumed value rule applies in a nonmedical for-profit institution.

If you live in a nonmedical for-profit institution, we consider the amount accepted by that institution as payment in full to be the current market value of whatever food, clothing, or shelter the institution provides. If you are paying or are legally indebted for that amount, you are not receiving in-kind support and maintenance. We do not use the presumed value rule unless someone else pays for you.

IN-KIND SUPPORT AND MAINTENANCE IN SPECIAL CIRCUMSTANCES

§416.1147 How we value in-kind support and maintenance for a couple.

(a) *Both members of a couple live in another person's household and receive food and shelter from that person.* When both of you live in another person's household throughout a month and receive food and shelter from that person, we apply the one-third reduction to the Federal benefit rate for a couple (§416.1131).

(b) *One member of a couple lives in another person's household and receives food and shelter from that person and the other member of the couple is in a medical institution.* (1) If one of you is living in the household of another person who provides you with both food and shelter, and the other is temporarily absent from the household as provided in §416.1149(c)(1) (in a medical institution that receives substantial Medicaid payments for his or her care (§416.211(b))), and is ineligible in the month for either benefit payable under §416.212, we compute your benefits as if you were separately eligible individuals (see §416.414(b)(3)). This begins with the first full calendar month that one of you is in the medical institution. The one living in another person's household is eligible at an eligible individual's Federal benefit rate and one-third of that rate is counted as income not subject to any income exclusions. The one in the medical institution cannot receive more than the reduced benefit described in §416.414(b)(3)(i).

(2) If the one member of the couple in the institution is eligible for one of the benefits payable under the §416.212 provisions, we compute benefits as a couple at the rate specified under §416.412. However, if that one member remains in the institution for a full month after expiration of the period benefits based on §416.212 can be paid, benefits will be computed as if each person were separately eligible as described under paragraph (c)(1) of this section. This begins with the first calendar month after expiration of the period benefits based on §416.212 can be paid.

(c) *Both members of a couple are subject to the presumed value rule.* If the presumed value rule applies to both of you, we value any food, clothing, or shelter you and your spouse receive at one-third of the Federal benefit rate for a couple plus the amount of the general income exclusion (§416.1124(c)(12)), unless you can show that their value is less as described in §416.1140(a)(2).

(d) *One member of a couple is subject to the presumed value rule and the other member is in a medical institution.* (1) If one of you is subject to the presumed value rule and the other is temporarily absent from the household as provided

in § 416.1149(c)(1) (in a medical institution that receives substantial Medicaid payments for his or her care (§ 416.211(b))), and is ineligible in that month for either benefit payable under § 416.212, we compute your benefits as if both members of the couple are separately eligible individuals (see § 416.414(b)(3)). This begins with the first full calendar month that one of you is in the medical institution (see § 416.211(b)). We value any food, clothing, or shelter received by the one outside of the medical institution at one-third of an eligible individual's Federal benefit rate, plus the amount of the general income exclusion (§ 416.1124(c)(12)), unless you can show that their value is less as described in § 416.1140(a)(2). The member of the couple in the medical institution cannot receive more than the reduced benefit described in § 416.414(b)(3)(i).

(2) If one of you is subject to the presumed value rule and the other in the institution is eligible for one of the benefits payable under § 416.212, we compute the benefits as a couple at the rate specified under § 416.412. However, if the one in the institution remains in the institution after the period benefits based on § 416.212 can be paid, we will compute benefits as if each member of the couple were separately eligible as described in paragraph (d)(1) of this section.

[60 FR 16375, Mar. 30, 1995, as amended at 61 FR 10279, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10279, Mar. 13, 1996, in § 416.1147, paragraphs (b) and (d) were revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.1147 How we value in-kind support and maintenance for a couple.

* * * * *

(b) *One member of a couple lives in another person's household and receives food and shelter from that person and the other is in a medical institution.* If one of you is living in the household of another person who provides you with both food and shelter and the other is temporarily absent from the household as provided in § 416.1149(c)(1) (in a medical institution that receives Medicaid payments for his or her care (§ 416.211(b)), we compute your benefits as if you were separately eligible individuals (see § 416.414(b)(3)). This begins with the first full calendar month one of you is in the medical institution. The one living in another person's household is eligible at an eligible individual's Federal benefit rate and one-third of that rate is counted as income not subject to any income exclusions. The one in the medical institution cannot receive more than the rate described in § 416.414(b)(3)(i).

* * * * *

(d) *One member of a couple is subject to the presumed value rule and the other is in a medical institution.* If one of you is subject to the presumed value rule and the other is temporarily absent from the household as provided in § 416.1149(c)(1) (in a medical institution that receives Medicaid payments for his or her care (§ 416.211(b)), we compute your benefits as if you were separately eligible individuals (see § 416.414(b)(3)). This begins with the first full calendar month that one of you is in the medical institution (§ 416.211(b)). We value any food, clothing, or shelter received by the one outside of the medical institution at one-third of an eligible individual's Federal benefit rate, plus the amount of the general income exclusion (§ 416.1124(c)(12)), unless you can show that their value is less as described in § 416.1140(a)(2). The one in the medical institution cannot receive more than the rate described in § 416.414(b)(3)(i).

§ 416.1147a Income rules in change-of-status situations involving in-kind support and maintenance.

(a) *General.* This section explains the rules for determining countable income, including in-kind support and maintenance, when eligible individuals become an eligible couple or when an eligible couple becomes eligible individuals. Generally, under retrospective monthly accounting, income in a prior month, including in-kind support and maintenance, affects benefit amounts for a current month. The prior month may be the first or second month prior to the current month (as explained in § 416.420(a)) and the rules in this section apply when a change-of-status becomes effective between the prior month and the current month.

(b) *Eligible individuals become an eligible couple.* If you and your spouse have been eligible individuals and become an eligible couple, we combine the earned and unearned income each of you had as an eligible individual in the prior month. If either or both of you received in-kind support and maintenance, we include its value as income. This may

be one-third of the Federal benefit rate that applied in the prior month for one or both of you who lived in the household of another. It may be the presumed maximum value (one-third of the Federal benefit rate plus $20 as explained in §416.1140) for one or both of you as appropriate. It may also be a combination of the two if each of you received income in one of these forms. We also include income deemed to either or both of you in the prior month.

(c) *Eligible couple becomes one or two eligible individuals.* If you are an eligible individual in the current month but were a member of an eligible couple in the prior month, we determine your countable income in the prior month separately from that of your spouse. We determine the value of any in-kind support and maintenance you and your spouse received in the prior month using the rules contained in §416.1147. For example, if both of you lived in the household of another and the one-third reduction applied, each of you would have income equal to one-sixth of the Federal benefit rate fov a couple. Also, for example, if you received in-kind support and maintenance and the presumed maximum value applied, you would have income equal to one-sixth of the Federal benefit rate for a couple, plus $10. We divide any other income you had as an eligible couple according to who owned the income. If ownership of jointly owned income cannot be determined, we allocate one-half of it to you.

[50 FR 48575, Nov. 26, 1985]

§416.1148 If you have both in-kind support and maintenance and income that is deemed to you.

(a) *The one-third reduction and deeming of income.* If you live in the household of your spouse, parent, essential person, or sponsor whose income can be deemed to you, or the household of a parent whose income is not deemed to you because of the provisions of §416.1165(i), the one-third reduction does not apply to you. The rules on deeming income are in §§416.1160 through 416.1169. However, if you live in another person's household as described in §416.1131, and someone whose income can be deemed to you lives in the same household, we must apply both the one-third reduction and the deeming rules to you.

(b) *The presumed value rule and deeming of income.* (1) If you live in the same household with someone whose income can be deemed to you (§§416.1160 through 416.1169), or with a parent whose income is not deemed to you because of the provisions of §416.1165(i), any food, clothing, or shelter that person provides is not income to you. However, if you receive any food, clothing, or shelter from another source, it is income and we value it under the presumed value rule (§416.1140). We also apply the deeming rules.

(2) If you are a child under age 18 who lives in the same household with an ineligible parent whose income may be deemed to you, and you are temporarily absent from the household to attend school (§416.1167(b)), any food, clothing, or shelter you receive at school is income to you unless your parent purchases it. Unless otherwise excluded, we value this income under the presumed value rule (§416.1140). We also apply the deeming rules to you (§416.1165).

[60 FR 361, Jan. 4, 1995]

TEMPORARY ABSENCE

§416.1149 What is a temporary absence from your living arrangement.

(a) *General.* A temporary absence may be due to employment, hospitalization, vacations, or visits. The length of time an absence can be temporary varies depending on the reason for your absence. For purposes of valuing in-kind support and maintenance under §§416.1130 through 416.1148, we apply the rules in this section. In general, we will find a temporary absence from your permanent living arrangement if you (or you and your eligible spouse)–

(1) Become a resident of a public institution, or a public or private medical care facility where over 50 percent of the cost of care is paid by Medicaid, and are eligible for the benefits payable under §416.212; or

(2) Were in your permanent living arrangement for at least 1 full calendar month prior to the absence and intend to, and do, return to your permanent

living arrangement in the same calendar month in which you (or you and your spouse) leave, or in the next month.

(b) *Rules we apply during a temporary absence.* During a temporary absence, we continue to value your support and maintenance the same way that we did in your permanent living arrangement. For example, if the one-third reduction applies in your permanent living arrangement, we continue to apply the same rule during a temporary absence. However, if you receive in-kind support and maintenance only during a temporary absence we do not count it since you are still responsible for maintaining your permanent quarters during the absence.

(c) *Rules for temporary absence in certain circumstances.* (1)(i) If you enter a medical care facility that receives substantial Medicaid payments for your care (as described in § 416.211(b)) and you are not eligible for either benefit payable under § 416.212 (and you have not received such benefits during your current period of confinement) and you intend to return to your prior living arrangement (and you are eligible for the reduced benefits payable under § 416.414 for full months in the facility), we consider this a temporary absence regardless of the length of your stay in the facility. We use the rules that apply to your permanent living arrangement to value any food, clothing, or shelter you receive during the month (for which reduced benefits under § 416.414 are not payable) you enter or leave the facility. During any full calendar month you are in the medical care facility, you cannot receive more than the Federal benefit rate described in § 416.414(b)(1). We do not consider food or shelter provided during a medical confinement to be income.

(ii) If you enter a medical care facility and you are eligible for either benefit payable under § 416.212, we also consider this a temporary absence from your permanent living arrangement. We use the rules that apply to your permanent living arrangement to value any food, clothing, or shelter you receive during the month you enter the facility and throughout the period you are eligible for these benefits. We consider your absence to be temporary through the last month benefits under § 416.212 are paid unless you are discharged from the facility in the following month. In that case, we consider your absence to be temporary through the date of discharge.

(2)(i) Generally, if you are a child under age 22, you are temporarily absent while you are away at school, regardless of how long you are away, if you come home on some weekends, lengthy holidays, and vacations (or for extended visits as provided in school regulations).

(ii) However, if you are a child under age 18, and your permanent living arrangement is with an ineligible parent or essential person (§ 416.222), we follow the rules in § 416.1148(b)(2). When you reach age 18, or if you are under age 18 and deeming does not apply, we consider the circumstances of your permanent living arrangement to value any in-kind support and maintenance you receive.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48575, Nov. 26, 1985; 52 FR 8882, Mar. 20, 1987; 61 FR 10279, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10279, Mar. 13, 1996, in § 416.1149, paragraphs (a) and (c)(1) were revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.1149 What is a temporary absence from your living arrangement.

(a) *General.* A temporary absence may be due to employment, hospitalization, vacations, or visits. The length of time an absence can be temporary varies depending on the reason for your absence. For purposes of valuing in-kind support and maintenance under §§ 416.1130 through 416.1148, we apply the rules in this section. In general, we consider that you are temporarily absent from your permanent living arrangement if you (or you and your eligible spouse)—

(1) Were in your permanent living arrangement for at least one full calendar month prior to your absence; and

(2) Intend to, and do, return to your permanent living arrangement in the same calendar month in which you leave, or in the next month.

* * * * *

(c) * * * (1) If you enter a medical care facility that receives Medicaid payments for your care (as described in § 416.211(b)) with the intention of returning to your prior

living arrangement, we consider this a temporary absence regardless of the length of your stay in the facility. We use the rules that apply to your permanent living arrangement to value any food, clothing, or shelter you receive during the month you enter or leave the facility. During any full calendar month you are in the medical care facility, you cannot receive more than the Federal benefit rate described in § 416.414(b)(1). We do not consider food or shelter provided during a medical confinement to be income.

* * * * *

DISASTERS

§ 416.1150 How we treat income received because of a major disaster.

(a) *General.* The Disaster Relief and Emergency Assistance Act and other Federal statutes provide assistance to victims of major disasters. In this section we describe when we do not count certain kinds of assistance you receive under these statutes.

(b) *Support and maintenance.* (1) We do not count the value of support and maintenance (in cash or in kind) received from a Federal, State, or local government source, or from a disaster assistance organization, and the one-third reduction rule does not apply if—

(i) You live in a household which you or you and another person maintain as your home when a catastrophe occurs in the area;

(ii) The President of the United States declares the catastrophe to be a major disaster for purposes of the Disaster Relief and Emergency Assistance Act;

(iii) You stop living in the home because of the catastrophe and within 30 days after the catastrophe you begin to receive support and maintenance; and

(iv) You receive the support and maintenance while living in a residential facility maintained by another person.

(2) We do not count the value of support and maintenance (in cash or in kind) received from any other source, such as from a private household, and the one-third reduction rule does not apply for up to 18 months after you begin to receive it if—

(i) You live in a household which you or you and another person maintain as your home when a catastrophe occurs in the area;

(ii) The President of the United States declares the catastrophe to be a major disaster for purposes of the Disaster Relief and Emergency Assistance Act;

(iii) You stop living in the home because of the catastrophe and within 30 days after the catastrophe you begin to receive support and maintenance; and

(iv) You receive the support and maintenance while living in a residential facility (including a private household) maintained by another person.

(c) *Other assistance you receive.* We do not consider other assistance to be income if you receive it under the Disaster Relief and Emergency Assistance Act or under another Federal statute because of a catastrophe which the President declares to be a major disaster or if you receive it from a State or local government or from a disaster assistance organization. For example, you may receive payments to repair or replace your home or other property.

(d) *Interest payments.* We do not count any interest earned on the assistance payments described in paragraph (c) of this section.

[57 FR 53850, Nov. 13, 1992]

§ 416.1151 How we treat the repair or replacement of lost, damaged, or stolen resources.

(a) *General rule.* If a resource is lost, damaged, or stolen, you may receive cash to repair or replace it or the resource may be repaired or replaced for you. We do not count the cash or the repair or replacement of the resource as your income.

(b) *Interest on cash for repair or replacement of a noncash resource.* We do not count any interest earned on the cash you receive for repair or replacement of a noncash resource if the interest is earned within 9 months of the date you receive the cash. We can extend the 9-month period for up to an additional 9 months if we find you have good cause for not repairing or replacing the resource within the initial period. Good cause exists, for example, if you show that circumstances beyond your control prevent the repair or replacement, or contracting for the repair or replacement, of the resource within the first 9-month period.

(c) *Temporary replacement of a damaged or destroyed home.* In determining the amount of in-kind support and maintenance you receive (§§ 416.1130 through 416.1140), we do not count temporary housing if—

(1) Your excluded home is damaged or destroyed, and

(2) You receive the temporary housing only until your home is repaired or replaced.

HOME ENERGY ASSISTANCE

§ 416.1157 Support and maintenance assistance.

(a) *General.* Section 2639 of Pub. L. 98–369, effective October 1, 1984, amended section 1612(b)(13) to provide that certain support and maintenance assistance, which includes home energy assistance, be excluded from countable income for SSI purposes. This section discusses how we apply section 1612(b)(13).

(b) *Definitions.* For support and maintenance assistance purposes—

Appropriate State agency means the agency designated by the chief executive officer of the State to handle the State's responsibilities as set out in paragraph (c) of this section.

Based on need means that the provider of the assistance: (1) Does not have an express obligation to provide the assistance; (2) States that the aid is given for the purpose of support or maintenance assistance or for home energy assistance (e.g., vouchers for heating or cooling bills, storm doors); and (3) Provides the aid for an SSI claimant, a member of the household in which an SSI claimant lives or an SSI claimant's ineligible spouse, parent, sponsor (or the sponsor's spouse) of an alien, or essential person.

Private nonprofit agency means a religious, charitable, educational, or other organization such as described in section 501(c) of the Internal Revenue Code of 1954. (Actual tax exempt certification by IRS is not necessary.)

Rate-of-return entity means an entity whose revenues are primarily received from the entity's charges to the public for goods or services and such charges are based on rates regulated by a State or Federal governmental body.

Support and maintenance assistance means cash provided for the purpose of meeting food, clothing, or shelter needs or in-kind support and maintenance as defined in § 416.1121(h). Support and maintenance assistance includes home energy assistance. Home energy assistance means any assistance related to meeting the costs of heating or cooling a home. Home energy assistance includes such items as payments for utility service or bulk fuels; assistance in kind such as portable heaters, fans, blankets, storm doors, or other items which help reduce the costs of heating and cooling such as conservation or weatherization materials and services; etc.

(c) *What assistance we do not count as income.* We do not count as income certain support and maintenance assistance received on or after October 1, 1984, by you or your ineligible spouse, parent, sponsor (or your sponsor's spouse) if you are an alien, or an essential person. We also do not consider certain support and maintenance assistance in determining a pro rata share of household operating expenses under § 416.1133. We do not count that assistance which is certified in writing by the appropriate State agency to be both based on need and—

(1) Provided in kind by a private nonprofit agency; or

(2) Provided in cash or in kind by—

(i) A supplier of home heating oil or gas;

(ii) A rate-of-return entity providing home energy; or

(iii) A municipal utility providing home energy.

[51 FR 39523, Oct. 29, 1986; 51 FR 43709, Dec. 3, 1986, as amended at 53 FR 35808, Sept. 15, 1988]

DEEMING OF INCOME

§ 416.1160 What is deeming of income.

(a) *General.* We use the term deeming to identify the process of considering another person's income to be your own. When the deeming rules apply, it does not matter whether the income of the other person is actually available to you. We must apply these rules anyway. There are four categories of individuals whose income may be deemed to you.

(1) *Ineligible spouse.* If you live in the same household with your ineligible spouse, we look at your spouse's income to decide whether we must deem some of it to you. We do this because we expect your spouse to use some of his or her income to take care of some of your needs.

(2) *Ineligible parent.* If you are a child to whom deeming rules apply (See § 416.1165), we look at your parent's income (and that of your parent's spouse) to decide whether we must deem some of it to be yours. We do this because we expect your parent to use some of his or her income to take care of your needs.

(3) *Sponsor of an alien.* If you are an alien who has a sponsor and you first apply for SSI benefits after September 30, 1980, we look at your sponsor's income to decide whether we must deem some of it to be yours. This rule applies for 3 years after you are admitted to the United States for permanent residence and regardless of whether you live in the same household as your sponsor. We deem your sponsor's income to you because your sponsor agreed to support you (signed an affidavit of support) as a condition of your admission to the United States. If two deeming rules could apply to you because your sponsor is also your ineligible spouse or parent who lives with you, we use the appropriate spouse-to-spouse or parent-to-child deeming rules instead of the sponsor-to-alien rules. If you have a sponsor and also have an ineligible spouse or parent who is not your sponsor and whose income can be deemed to you, both rules apply. If your sponsor is not your parent or spouse but is the ineligible spouse or parent of another SSI beneficiary, we use the sponsor-to-alien deeming rules for you and the appropriate spouse-to-spouse or parent-to-child deeming rules for the other SSI beneficiary.

(4) *Essential person.* If you live in the same household with your essential person (as defined in § 416.222), we must look at that person's income to decide whether we must deem some of it to you. We do this because we have increased your benefit to help meet the needs of your essential person.

(b) *When we deem.* We deem income to determine whether you are eligible for a benefit and to determine the amount of your benefit. However, we may consider this income in different months for each purpose.

(1) *Eligibility.* We consider the income of your ineligible spouse, ineligible parent, sponsor or essential person in the current month to determine whether you are eligible for SSI benefits for that month.

(2) *Amount of benefit.* We consider the income of your ineligible spouse, ineligible parent, sponsor, or essential person in the second month prior to the current month to determine your benefit amount for the current month. *Exceptions:* (i) To determine your benefit amount for the first month you are eligible or for a month after you have been ineligible for at least a month, we use the same countable income that we use to determine your eligibility. In the following month (the second month) we use the same countable income that we used in the preceding month to determine your benefit amount.

(ii) To determine the amount of your benefit in the current month, if there are certain changes in your situation which we list below, we use only your own countable income in a prior month, excluding any income deemed to you in that month from an ineligible spouse or parent. These changes are the death of your spouse or parent, your attainment of age 18, or your becoming subject to the $30 Federal benefit rate (§ 416.211(b)).

(iii) To determine the amount of your benefit for the current month, we do not use income deemed from your essential person beginning with the month you can no longer qualify for the essential person increment (§ 416.413). We use only your own countable income in a prior month to determine the amount of your benefit for the current month.

(c) *Steps in deeming.* Although the way we deem income varies depending upon whether you are an eligible individual, an eligible child, an alien with a sponsor, or an individual with an essential person, we follow several general steps to determine how much income to deem.

(1) We determine how much earned and unearned income your ineligible

spouse, ineligible parent, sponsor, or essential person has, and we apply the appropriate exclusions. (See § 416.1161(a) for exclusions that apply to an ineligible parent or spouse, and § 416.1161(b) for those that apply to an essential person or to a sponsor.)

(2) Before we deem income to you from either your ineligible spouse or ineligible parent, we allocate an amount for each ineligible child in the household. (Allocations for ineligible children are explained in § 416.1163(b) and § 416.1165(b).) We also allocate an amount for each eligible alien who is subject to deeming from your ineligible spouse or parent as a sponsor. (Allocations for eligible aliens are explained in § 416.1163(c).)

(3) We then follow the deeming rules which apply to you.

(i) For deeming income from your ineligible spouse, see § 416.1163.

(ii) For deeming income from your ineligible parent, see § 416.1165.

(iii) For deeming income from your ineligible spouse when you also have an eligible child, see § 416.1166.

(iv) For deeming income from your sponsor if you are an alien, see § 416.1166a.

(v) For deeming income from your essential person, see § 416.1168. The rules on when we stop deeming income from your essential person are in § 416.1169.

(vi) For provisions on change in status involving couples see § 416.1163(f) and for those involving parents see § 416.1165(g).

(d) *Definitions for deeming purposes.* For deeming purposes—

Date of admission to or *date of entry into the United States* means the date established by the Immigration and Naturalization Service as the date the alien is admitted for permanent residence.

Dependent means the same thing as it does for Federal income tax purposes—we mean someone for whom you are entitled to take a deduction on your personal income tax return. *Exception:* An alien and an alien's spouse are not considered to be dependents of the alien's sponsor for the purposes of these rules.

Essential person means someone who was identified as essential to your welfare under a State program that preceded the SSI program. (See §§ 416.220 through 416.223 for the rules on essential persons.)

Ineligible child means your natural child or adopted child, or the natural or adopted child of your spouse, or the natural or adopted child of your parent or of your parent's spouse (as the terms *child* and *spouse* are defined in § 416.1101), who is under age 21, lives in the same household with you, and is not eligible for SSI benefits.

Ineligible parent means a natural or adoptive parent, or the spouse (as defined in § 416.1101) of a natural or adoptive parent, who lives with you and is not eligible for SSI benefits. The income of ineligible parents affects your benefit only if you are a child under age 18.

Ineligible spouse means someone who lives with you as your husband or wife and is not eligible for SSI benefits.

Sponsor means an individual (but not an organization such as the congregation of a church or a service club, or an employer who only guarantees employment for an alien upon entry but does not sign an affadavit of support) who signs an affidavit of support agreeing to support you as a condition of your admission as an alien for permanent residence in the United States.

[52 FR 8882, Mar. 20, 1987, as amended at 54 FR 19164, May 4, 1989]

§ 416.1161 Income of an ineligible spouse, ineligible parent, and essential person for deeming purposes.

The first step in deeming is determining how much income your ineligible spouse, ineligible parent (if you are a child), your sponsor (if you are an alien), or your essential person, has. We do not always include all of their income when we determine how much income to deem. In this section we explain the rules for determining how much of their income is subject to deeming. As part of the process of deeming income from your ineligible spouse or parent, we must determine the amount of income of any ineligible children in the household.

(a) *For an ineligible spouse or parent.* We do not include any of the following types of income (see § 416.1102) of an ineligible spouse or parent:

(1) Income excluded by Federal laws other than the Social Security Act (See the Appendix to this subpart.)

(2) Any public income-maintenance payments (§ 416.1142(a)) your ineligible spouse or parent receives, and any income which was counted or excluded in figuring the amount of that payment;

(3) Any of the income of your ineligible spouse or parent that is used by a public income-maintenance program (§ 416.1142(a)) to determine the amount of that program's benefit to someone else;

(4) Any portion of a grant, scholarship, or fellowship used to pay tuition or fees;

(5) Money received for providing foster care to an ineligible child;

(6) The value of food stamps and the value of Department of Agriculture donated foods;

(7) Food raised by your parent or spouse and consumed by members of the household in which you live;

(8) Tax refunds on income, real property, or food purchased by the family;

(9) Income used to fulfill an approved plan for achieving self-support (see §§ 416.1180 through 416.1182);

(10) Income used to comply with the terms of court-ordered support, or support payments enforced under title IV–D of the Act;

(11) The value of in-kind support and maintenance;

(12) Periodic payments made by a State under a program established before July 1, 1973, and based solely on duration of residence and attainment of age 65;

(13) Disaster assistance as described in §§ 416.1150 and 416.1151;

(14) Income received infrequently or irregularly (see §§ 416.1112(c)(1) and 416.1124(c)(6));

(15) Work expenses if the ineligible spouse or parent is blind;

(16) Income of your ineligible spouse or ineligible parent which was paid under a Federal, State, or local government program (For example, payments under title XX of the Social Security Act) to provide you with chore, attendant or homemaker services;

(17) Certain support and maintenance assistance as described in § 416.1157(c);

(18) Housing assistance as provided in § 416.1124(c)(14);

(19) The value of a commercial transportation ticket as described in § 416.1124(c)(16). However, if such a ticket is converted to cash, the cash is income in the month your spouse or parent receives the cash;

(20) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in § 416.1112(c);

(21) Payments from a fund established by a State to aid victims of crime (see § 416.1124(c)(17)); and

(22) Relocation assistance, as described in § 416.1124(c)(18).

(b) *For an essential person or for a sponsor of an alien.* We include all the income (as defined in § 416.1102) of an essential person or of a sponsor of an alien and of the spouse of the sponsor (if the sponsor and spouse live in the same household) except for support and maintenance assistance described in § 416.1157(c), and income excluded under Federal laws other than the Social Security Act. For information on these laws see the appendix to this subpart.

(c) *For an ineligible child.* Although we do not deem any income to you from an ineligible child, we reduce his or her allocation if the ineligible child has income (see § 416.1163(b)(2)). For this purpose, we do not include any of the child's income listed in paragraph (a) of this section. In addition, if the ineligible child is a student (see § 416.1861), we exclude any of the child's earned income up to $400 a month but not more than $1,620 per year.

(d) *For an eligible alien.* Although we do not deem any income to you from an eligible alien, if your ineligible spouse or ineligible parent is also a sponsor of an eligible alien, we reduce the alien's allocation if he or she has income (see § 416.1163(c)(2)). For this purpose exclude any of the alien's income listed in paragraph (a) of this section.

[45 FR 65547, Oct. 3, 1980, as amended at 46 FR 57276, Nov. 23, 1981; 48 FR 33259, July 21, 1983; 50 FR 48576, Nov. 26, 1985; 51 FR 39523, Oct. 29, 1986; 52 FR 8883, Mar. 20, 1987; 52 FR 44971, Nov. 24, 1987; 55 FR 28378, July 11, 1990; 58 FR 63888, 63890, Dec. 3, 1993; 61 FR 1712, Jan. 23, 1996]

§ 416.1161a Income for deeming purposes where Medicaid eligibility is affected.

(a) *General.* In many States, an individual who is eligible for SSI or a Federally administered State optional supplementary payment is in turn eligible for Medicaid. Also, several other States use SSI deeming rules in determining eligibility for Medicaid. In all of these States, in extraordinary cases, the Department will not apply the usual rules on deeming of income where those rules would result in an individual's being ineligible for SSI (or a Federally administered State optional supplementary payment) and Medicaid. Any determination made under this section may at any time be revised based on new information or changed circumstances.

(b) *When special deeming rules apply:* (1) The Department will consider not applying the usual deeming rules only upon application by a State Medicaid agency (requirement approved under OMB No. 0960–0304) and on condition that the agency must show:

(i) Deeming would result in lack of Medicaid eligibility for the individual.

(ii) Medicaid eligibility would, prospectively, result in savings to the Medicaid program; and

(iii) The quality of medical care necessary for the individual would be maintained under the arrangements contemplated.

(2) The Department may also in particular cases require that additional facts be demonstrated, or that other criteria or standards be met, before it determines not to apply the usual deeming rules.

(c) *Amount of income to be deemed.* If the usual rules of deeming do not apply, the Department will determine an amount, if any, to be deemed.

(d) *Temporary effect of special deeming rules.* This provision is temporary and will be continued only through December 31, 1984. Determinations made under this section will nevertheless remain in effect unless they are revised based on changed circumstances (including establishment in the State of a Medicaid program of home and community-based services or eligibility under a State plan provision) or new information.

[49 FR 5747, Feb. 15, 1984]

§ 416.1163 How we deem income to you from your ineligible spouse.

If you have an ineligible spouse who lives in the same household, we apply the deeming rules to your ineligible spouse's income in the following order.

(a) *Determining your ineligible spouse's income.* We first determine how much earned and unearned income your ineligible spouse has, using the appropriate exclusions in § 416.1161(a).

(b) *Allocations for ineligible children.* We then deduct an allocation for ineligible children in the household to help meet their needs. *Exception:* We do not allocate for ineligible children who are receiving public income-maintenance payments (see § 416.1142(a)).

(1) The allocation for each ineligible child is the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual. The amount of the allocation automatically increases whenever the Federal benefit rate increases. The amount of the allocation that we use to determine the amount of a benefit for a current month is based on the Federal benefit rate that applied in the second prior month unless one of the exceptions in § 416.1160(b)(2) applies.

(2) Each ineligible child's allocation is reduced by the amount of his or her own income as described in § 416.1161(c).

(3) We first deduct the allocations from your ineligible spouse's unearned income. If your ineligible spouse does not have enough unearned income to cover the allocations we deduct the balance from your ineligible spouse's earned income.

(c) *Allocations for aliens sponsored by your ineligible spouse.* We also deduct an allocation for eligible aliens who have been sponsored by and who have income deemed from your ineligible spouse.

(1) The allocation for each alien who is sponsored by and who has income deemed from your ineligible spouse is the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual. The amount of the allocation automatically increases whenever the

Federal benefit rate increases. The amount of the allocation that we use to compute your benefit for a current month is based on the Federal benefit rate that applied in the second prior month (unless the current month is the first or second month of eligibility or re-eligibility as explained in § 416.420(a) and (b) (2) and (3)).

(2) Each alien's allocation is reduced by the amount of his or her own income as described in § 416.1161(d).

(3) We first deduct the allocations from your ineligible spouse's unearned income. If your ineligible spouse does not have enough unearned income to cover the allocations, we deduct the balance from your ineligible spouse's earned income.

(d) *Determining your eligibility for SSI.* (1) If the amount of your ineligible spouse's income that remains after appropriate allocations is not more than the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual, there is no income to deem to you from your spouse. In this situation, we subtract only your own countable income from the Federal benefit rate for an individual to determine whether you are eligible for SSI benefits.

(2) If the amount of your ineligible spouse's income that remains after appropriate allocations is more than the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual, we treat you and your ineligible spouse as an eligible couple. We do this by:

(i) Combining the remainder of your spouse's unearned income with your own unearned income and the remainder of your spouse's earned income with your earned income;

(ii) Applying all appropriate income exclusions in §§ 416.1112 and 416.1124; and

(iii) Subtracting the couple's countable income from the Federal benefit rate for an eligible couple. (See § 416.2025(b) for determination of the State supplementary payment amount.)

(e) *Determining your SSI benefit.* (1) In determining your SSI benefit amount we follow the procedure in paragraphs (a) through (d) of this section. However, we use your ineligible spouse's income in the second month prior to the current month. We vary this rule if any of the exceptions in § 416.1160(b)(2) applies (for example, if this is the first month you are eligible for an SSI benefit or if you are again eligible after at least a month of being ineligible). In the first month of your eligibility (or re-eligibility), we deem your ineligible spouse's income in the current month to determine both whether you are eligible for a benefit and the amount of your benefit. In the second month, we deem your ineligible spouse's income in that month to determine whether you are eligible for a benefit but we deem your ineligible spouse's income in the first month to determine the amount of your benefit.

(2) Your SSI benefit under the deeming rules cannot be higher than it would be if deeming did not apply. Therefore, your benefit is the lesser of the amount computed under the rules in paragraph (d)(2) of this section or the amount remaining after we subtract only your own countable income from an individual's Federal benefit rate.

(f) *Special rules for couples when a change in status occurs.* We have special rules to determine how to deem your spouse's income to you when there is a change in your situation.

(1) *Ineligible spouse becomes eligible.* If your ineligible spouse becomes eligible for SSI benefits, we treat both of you as newly eligible. Therefore, your eligibility and benefit amount for the first month you are an eligible couple will be based on your income in that month. In the second month, your benefit amount will also be based on your income in the first month.

(2) *Spouses separate or divorce.* If you separate from your ineligible spouse or your marriage to an ineligible spouse ends by divorce, we do not deem your ineligible spouse's income to you to determine your eligibility for benefits beginning with the first month following the event. If you remain eligible, we determine your benefit amount by following the rule in paragraph (e) of this section provided deeming from your spouse applied in the prior month.

(3) *Eligible individual begins living with an ineligible spouse.* If you begin to live with your ineligible spouse, we deem your ineligible spouse's income to you in the first month thereafter to determine whether you continue to be eligible for SSI benefits. If you continue to be eligible, we follow the rule in § 416.420(a) to determine your benefit amount.

(4) *Ineligible spouse dies.* If your ineligible spouse dies, we do not deem your spouse's income to you to determine your eligibility for SSI benefits beginning with the month following the month of death. In determining your benefit amount beginning with the month following the month of death, we use only your own countable income in a prior month, excluding any income deemed to you in that month from your ineligible spouse.

(5) *You become subject to the $30 Federal benefit rate.* If you become a resident of a medical care facility and the $30 Federal benefit rate applies, we do not deem your ineligible spouse's income to you to determine your eligibility for SSI benefits beginning with the first month for which the $30 Federal benefit rate applies. In determining your benefit amount beginning with the first month for which the $30 Federal benefit rate applies, we use only your own countable income in a prior month, excluding any income deemed to you in that month from your ineligible spouse.

(g) *Examples.* These examples show how we deem income from an ineligible spouse to an eligible individual in cases which do not involve any of the exceptions in § 416.1160(b)(2). The income, the income exclusions, and the allocations are monthly amounts. The Federal benefit rates used are those effective January 1, 1986.

Example 1. In September 1986, Mr. Todd, an aged individual, lives with his ineligible spouse, Mrs. Todd, and their ineligible child, Mike. Mr. Todd has a Federal benefit rate of $336 per month. Mrs. Todd receives $252 unearned income per month. She has no earned income and Mike has no income at all. Before we deem any income, we allocate to Mike $168 (the difference between the September Federal benefit rate for an eligible couple and the September Federal benefit rate for an eligible individual). We subtract the $168 allocation from Mrs. Todd's $252 unearned income, leaving $84. Since Mrs. Todd's $84 remaining income is not more than $168, which is the difference between the September Federal benefit rate for an eligible couple and the September Federal benefit rate for an eligible individual, we do not deem any income to Mr. Todd. Instead, we compare only Mr. Todd's own countable income with the Federal benefit rate for an eligible individual to determine whether he is eligible. If Mr. Todd's own countable income is less than his Federal benefit rate, he is eligible. To determine the amount of his benefit, we determine his countable income, including any income deemed from Mrs. Todd, in July and subtract this income from the appropriate Federal benefit rate for September.

Example 2. In September 1986, Mr. Jones, a disabled individual, lives with his ineligible spouse, Mrs. Jones, and ineligible child, Christine. Mr. Jones and Christine have no income. Mrs. Jones has earned income of $401 a month and unearned income of $252 a month. Before we deem any income, we allocate $168 to Christine. We take the $168 allocation from Mrs. Jones' $252 unearned income, leaving $84 in unearned income. Since Mrs. Jones' total remaining income ($84 unearned plus $401 earned) is more than $168, which is the difference between the September Federal benefit rate for an eligible couple and the September Federal benefit rate for an eligible individual, we compute the combined countable income as we do for a couple. We apply the $20 general income exclusion to the unearned income, reducing it further to $64. We then apply the earned income exclusion ($65 plus one-half the remainder) to Mrs. Jones' earned income of $401, leaving $168. We combine the $64 countable unearned income and $168 countable earned income, and compare it ($232) with the $504 September Federal benefit rate for a couple, and determine that Mr. Jones is eligible. Since Mr. Jones is eligible, we determine the amount of his benefit by subtracting his countable income in July (including any deemed from Mrs. Jones) from September's Federal benefit rate for a couple.

Example 3. In September 1986, Mr. Smith, a disabled individual, lives with his ineligible spouse, Mrs. Smith, who earns $201 per month. Mr. Smith receives a pension (unearned income) of $100 a month. Since Mrs. Smith's income is greater than $168, which is the difference between the September Federal benefit rate for an eligible couple and the September Federal benefit rate for an eligible individual, we deem all of her income to be available to both Mr. and Mrs. Smith and compute the combined countable income for the couple. We apply the $20 general income exclusion to Mr. Smith's $100 unearned income, leaving $80. Then we apply the earned income exclusion ($65 plus one-half of the remainder) to Mrs. Smith's $201, leaving

$68. This gives the couple total countable income of $148. This is less than the $504 September Federal benefit rate for a couple, so Mr. Smith is eligible based on deeming. Since he is eligible, we determine the amount of his benefit based on his income (including any deemed from Mrs. Smith) in July.

Example 4. In September 1986, Mr. Simon has a disabled spouse, Mrs. Simon, and has sponsored an eligible alien, Mr. Ollie. Mrs. Simon has monthly unearned income of $100 and Mr. Simon has earned income of $405. From Mr. Simon's earned income we allocate to Mr. Ollie $168, which is the difference between the Federal benefit rate for an eligible couple and the rate for an eligible individual. Mr. Ollie has no other income. This reduces Mr. Simon's earned income from $405 to $237. Since $237 is more than $168 (the difference between the Federal benefit rate for an eligible couple and the rate for an eligible individual), we deem all of Mr. Simon's remaining income to be available to Mr. and Mrs. Simon and compute the combined countable income for the couple. We apply the $20 general income exclusion to Mrs. Simon's unearned income, leaving $80. Then we apply the general earned income exclusion ($65 plus one-half the remainder) to Mr. Simon's $237 earned income, leaving $86. This gives the couple total income of $166 ($80+$86.). The $166 is less than the $504 Federal benefit rate for a couple so Mrs. Simon would be eligible based on deeming. Since she is eligible, we determine the amount of her benefit based on her income (including any deemed from Mr. Simon) in July . For the way we deem Mr. Simon's income to Mr. Ollie, see the rules in §416.1166a.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48576, Nov. 26, 1985; 52 FR 8883, Mar. 20, 1987; 53 FR 25151, July 5, 1988; 54 FR 19164, May 4, 1989]

§416.1165 How we deem income to you from your ineligible parent(s).

If you are a child living with your parents, we apply the deeming rules to you through the month in which you reach age 18. We follow the rules in paragraphs (a) through (e) of this section to determine your eligibility. To determine your benefit amount, we follow the rules in paragraph (f) of this section. The rules in paragraph (g) of this section apply to changes in your family situation. Paragraph (i) of this section discusses the conditions under which we will not deem your ineligible parents' income to you if you are a disabled child living with your parents.

(a) *Determining your ineligible parent's income.* We first determine how much current monthly earned and unearned income your ineligible parents have, using the appropriate exclusions in §416.1161(a).

(b) *Allocations for ineligible children.* We next deduct an allocation for each ineligible child in the household as described in §416.1163(b).

(c) *Allocations for aliens who are sponsored by and have income deemed from your ineligible parent.* We also deduct an allocation for eligible aliens who have been sponsored by and have income deemed from your ineligible parent as described in §416.1163(c).

(d) *Allocations for your ineligible parent(s).* We next deduct allocations for your parent(s). We do not deduct an allocation for a parent who is receiving public income-maintenance payments (see §416.1142(a)). The allocations are calculated as follows:

(1) We first deduct $20 from the parents' combined unearned income, if any. If they have less than $20 in unearned income, we subtract the balance of the $20 from their combined earned income.

(2) Next, we subtract $65 plus one-half the remainder of their earned income.

(3) We total the remaining earned and unearned income and subtract—

(i) The Federal benefit rate for the month for a couple if both parents live with you; or

(ii) The Federal benefit rate for the month for an individual if only one parent lives with you.

(e)(1) *When you are the only eligible child.* If you are the only eligible child in the household, we deem any of your parents' current monthly income that remains to be your unearned income. We combine it with your own unearned income and apply the exclusions in §416.1124 to determine your countable unearned income in the month. We add this to any countable earned income you may have and subtract the total from the Federal benefit rate for an individual to determine whether you are eligible for benefits.

(2) *When you are not the only eligible child.* If your parents have more than one eligible child under age 18 in the

household, we divide the parental income to be deemed equally among those eligible children.

(3) *When one child's income makes that child ineligible.* We do not deem more income to an eligible child than the amount which, when combined with the child's own income, reduces his or her SSI benefit to zero. (For purposes of this paragraph, an SSI benefit includes any federally administered State supplement). If the share of parental income that would be deemed to a child makes that child ineligible (reduces the amount to zero) because that child has other countable income, we deem any remaining parental income to other eligible children under age 18 in the household in the manner described in paragraph (e)(2) of this section.

(f) *Determining your SSI benefit.* In determining your SSI benefit amount we follow the procedure in paragraphs (a) through (d) of this section. However, we use your ineligible parents' income in the second month prior to the current month. We vary this rule if any of the exceptions in § 416.1160(b)(2) applies (for example, if this is the first month you are eligible for an SSI benefit or if you are again eligible after at least a month of being ineligible). In the first month of your eligibility (or re-eligibility) we deem your ineligible parents' income in the current month to determine both whether you are eligible for a benefit and the amount of your benefit. In the second month, we deem your ineligible parents' income in that month to determine whether you are eligible for a benefit but we again use your countable income (including any that was deemed to you) in the first month to determine the amount of your benefit.

(g) *Special rules for a change in status.* We have special rules to begin or stop deeming your ineligible parents' income to you when a change in your family situation occurs.

(1) *Ineligible parent becomes eligible.* If your ineligible parent becomes eligible for SSI benefits, there will be no income to deem from that parent to you to determine your eligibility for SSI benefits beginning with the month your parent becomes eligible. However, to determine your benefit amount, we follow the rule in § 416.420.

(2) *Eligible parent becomes ineligible.* If your eligible parent becomes ineligible, we deem your parents' income to you in the first month of the parents' ineligibility to determine whether you continue to be eligible for SSI benefits. However, if you continue to be eligible, in order to determine your benefit amount, we follow the regular rule of counting your income in the second month prior to the current month.

(3) *Ineligible parent dies.* If your ineligible parent dies, we do not deem that parent's income to you to determine your eligibility for SSI benefits beginning with the month following the month of death. In determining your benefit amount beginning with the month following the month of death, we use only your own countable income in a prior month, excluding any income deemed to you in that month from your ineligible parent (see § 416.1160(b)(2)(B)). However, if you live with two ineligible parents, and one dies, we continue to deem income from the surviving parent.

(4) *Ineligible parent and you no longer live in the same household.* If your ineligible parent and you no longer live in the same household, we do not deem that parent's income to you to determine your eligibility for SSI benefits beginning with the first month following the month in which one of you leaves. However (if you continue to be eligible), to determine your benefit amount we follow the rule in § 416.420 of counting your income including income deemed from your parent in the second month prior to the current month.

(5) *Ineligible parent and you begin living in the same household.* If your ineligible parent and you begin living in the same household, we consider that parent's income to determine whether you continue to be eligible for SSI benefits beginning with the month following the month of change. However (if you continue to be eligible), to determine your benefit amount, we follow the rule in § 416.420 of counting your income in the second month prior to the current month.

(6) *You become subject to the $30 Federal benefit rate.* If you become a resident of a medical care facility and the $30 Federal benefit rate applies, we do not deem your ineligible parent's income to you to determine your eligibility for SSI benefits beginning with the first month for which the $30 Federal benefit rate applies. In determining your benefit amount beginning with the first month for which the $30 Federal benefit rate applies, we only use your own countable income in a prior month, excluding any income deemed to you in that month from your ineligible parent.

(7) *You attain age 18.* In the month following the month in which you attain age 18 and thereafter, we do not deem your ineligible parent's income to you to determine your eligibility for SSI benefits. In determining your benefit amount beginning with the month following your attainment of age 18, we only use your own countable income in a prior month, excluding any income deemed to you in that month from your ineligible parent (see § 416.1160(b)(2)(B)). Your income for the current and subsequent months must include any income in the form of cash or in-kind support and maintenance provided by your parents. If you attain age 18 and stop living in the same household with your ineligible parent, these rules take precedence over paragraph (g)(4) of this section which requires continued use of deemed income in the benefit computation for 2 months following the month you no longer live in the same household.

(h) *Examples.* These examples show how we deem an ineligible parent's income to an eligible child when none of the exceptions in § 416.1160(b)(2) applies. The Federal benefit rates are those effective January 1, 1992.

Example 1. Henry, a disabled child, lives with his mother and father and a 12-year-old ineligible brother. His mother receives a pension (unearned income) of $365 per month and his father earns $1,165 per month. Henry and his brother have no income. First we deduct an allocation of $211 for Henry's brother from the unearned income. This leaves $154 in unearned income. We reduce the remaining unearned income further by the $20 general income exclusion, leaving $134. We then reduce the earned income of $1,165 by $65 leaving $1,100. Then we subtract one-half of the remainder, leaving $550. To this we add the remaining unearned income of $134 resulting in $684. From this, we subtract the parent allocation of $633 (the Federal benefit rate for a couple) leaving $51 to be deemed as Henry's unearned income. Henry has no other income. We apply Henry's $20 general income exclusion which reduces his countable income to $31. Since that amount is less than the $422 Federal benefit rate for an individual, Henry is eligible. We determine his benefit amount by subtracting his countable income (including deemed income) in a prior month from the Federal benefit rate for an individual for the current month. See § 416.420.

Example 2. James and Tony are disabled children who live with their mother. The children have no income but their mother receives $542 a month in unearned income. We reduce the unearned income by the $20 general income exclusion, leaving $522. We then subtract the amount we allocate for the mother's needs, $422 (the Federal benefit rate for an individual). The amount remaining to be deemed to James and Tony is $100, which we divide equally between them resulting in $50 deemed unearned income to each child. We then apply the $20 general income exclusion, leaving each child with $30 countable income. The $30 of unearned income is less than the $422 Federal benefit rate for an individual, so the children are eligible. We then determine each child's benefit by subtracting his countable income (including deemed income) in a prior month from the Federal benefit rate for an individual for the current month. See § 416.420.

Example 3. Mrs. Jones is the ineligible mother of two disabled children, Beth and Linda, and has sponsored an eligible alien, Mr. Sean. Beth, Linda, and Mr. Sean have no income; Mrs. Jones has unearned income of $924 per month. We reduce the mother's unearned income by the $211 allocation for Mr. Sean, leaving $713. We further reduce her income by the $20 general income exclusion, which leaves a balance of $693. Next, we subtract the amount we allocate for the mother's needs, $422 (the amount of the Federal benefit rate for an individual). The balance of $271 to be deemed is divided equally between Beth and Linda. Each now has unearned income of $135.50 from which we deduct the $20 general income exclusion, leaving each child with $115.50 countable income. Since this is less than the $422 Federal benefit rate for an individual, the girls are eligible. We then determine each child's benefit by subtracting her countable income (including deemed income) in a prior month from the Federal benefit rate for an individual for the current month. See § 416.420. (For the way we deem the mother's income to Mr. Sean, see examples No. 3 and No. 4 in § 416.1166a.)

Example 4. Jack, a disabled child, lives with his mother, father, and two brothers, none of

whom are eligible for SSI. Jack's mother receives a private pension of $350 per month and his father works and earns $1,525 per month. We allocate a total of $422 for Jack's ineligible brothers and subtract this from the parents' total unearned income of $350; the parents' unearned income is completely offset by the allocations for the ineligible children with an excess allocation of $72 remaining. We subtract the excess of $72 from the parents' total earned income leaving $1,453. We next subtract the combined general income and earned income exclusions of $85 leaving a remainder of $1,368. We subtract one-half the remainder, leaving $684 from which we subtract the parents' allocation of $633. This results in $51 deemed to Jack. Jack has no other income, so we subtract the general income exclusion of $20 from the deemed income leaving $31 as Jack's countable income. Since this is below the $422 Federal benefit rate for an individual, Jack is eligible. We determine his payment amount by subtracting his countable income (including deemed income) in a prior month from the Federal benefit rate for an individual for the current month. See § 416.420.

(i) *Disabled child under age 18.* If you are a disabled child under the age of 18 living with your parents, we will not deem your parents' income to you if—

(1) You previously received a reduced SSI benefit while a resident of a medical facility for which Medicaid paid more than 50 percent of the cost of your care;

(2) You are eligible for medical assistance under a Medicaid State home care plan approved by the Secretary under the provisions of section 1915(c) or authorized under section 1902(e)(3) of the Act; and

(3) You would otherwise be ineligible for a Federal SSI benefit because of the deeming of your parents' income or resources.

[52 FR 8885, Mar. 20, 1987, as amended at 54 FR 19164, May 4, 1989; 57 FR 48562, Oct. 27, 1992; 60 FR 361, Jan. 4, 1995]

§ 416.1166 How we deem income to you and your eligible child from your ineligible spouse.

If you and your eligible child live in the same household with your ineligible spouse, we deem your ineligible spouse's income first to you, and then we deem any remainder to your eligible child. For the purpose of this section, SSI benefits include any federally administered State supplement. We then follow the rules in § 416.1165(e) to determine the child's eligibility for SSI benefits and in § 416.1165(f) to determine the benefit amount.

(a) *Determining your ineligible spouse's income.* We first determine how much earned and unearned income your ineligible spouse has, using the appropriate exclusions in § 416.1161(a).

(b) *Allocations for ineligible children.* We next deduct an allocation for each ineligible child in the household as described in § 416.1163(b).

(c) *Allocations for aliens who are sponsored by and have income deemed from your ineligible spouse.* We also deduct an allocation for eligible aliens who have been sponsored by and have income deemed from your ineligible spouse as described in § 416.1163(c).

(d) *Determining your eligibility for SSI benefits and benefit amount.* We then follow the rules in § 416.1163(c) to find out if any of your ineligible spouse's current monthly income is deemed to you and, if so, to determine countable income for a couple. Next, we follow (d) below to determine your child's eligibility. However, if none of your spouse's income is deemed to you, none is deemed to your child. Whether or not your spouse's income is deemed to you in determining your eligibility, we determine your benefit amount as explained in § 416.1163(d).

(e) *Determining your child's eligibility and amount of benefits.* (1) If you are eligible for SSI benefits after your spouse's income has been deemed to you, we do not deem any income to your child. To determine the child's eligibility, we subtract the child's own countable income without deeming from the benefit rate for an individual.

(2) If you are not eligible for SSI benefits after your ineligible spouse's income has been deemed to you, we deem to your eligible child any of your spouse's income which was not used to reduce your SSI benefits to zero.

(f) *Examples.* These examples show how we deem income to an eligible individual and an eligible child in the same household. The Federal benefit rates used are those effective January 1, 1984.

Example 1. Mary, a blind individual, lives with her husband, John, and their disabled child, Peter. Mary and Peter have no income, but John is employed and earns $605 per month. We determine Mary's eligibility first.

Since John's income is more than $157, which is one-half of the Federal benefit rate for an eligible individual, we treat the entire $605 as earned income available to John and Mary as a couple. Because they have no unearned income, we reduce the $605 by the $20 general income exclusion, and then by the earned income exclusion of $65 plus one-half the remainder. This leaves John and Mary with $260 in countable income. The $260 countable income is less than the $472 Federal benefit rate for a couple, so Mary is eligible; therefore, there is no income to be deemed to Peter.

Example 2. Al, a disabled individual, resides with his ineligible spouse, Dora, and their disabled son, Jeff. Al and Jeff have no income, but Dora is employed and earns $1,065 a month. Since Dora's income is more than $157, which is one-half of the Federal benefit rate for an eligible individual, we treat the entire $1,065 as earned income available to Al and Dora as a couple. We reduce this income by the $20 general income exclusion and then by $65 plus one-half the remainder (earned income exclusion), leaving $490 in countable income. Al is ineligible because the couple's $490 countable income exceeds the $472 Federal benefit rate for a couple. Since Al is ineligible, we deem to Jeff $18, the amount of income over and above the amount which causes Al to be ineligible (the difference between the countable income and the Federal benefit rate for a couple). We treat the $18 deemed to Jeff as unearned income, and we apply the $20 general income exclusion, reducing Jeff's countable income to zero. Jeff is eligible.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48578, Nov. 26, 1985; 52 FR 8887, Mar. 20, 1987]

§ 416.1166a How we deem income to you from your sponsor if you are an alien.

Before we deem your sponsor's income to you if you are an alien, we determine how much earned and unearned income your sponsor has under § 416.1161(b). We then deduct allocations for the sponsor and the sponsor's dependents. This is an amount equal to the Federal benefit rate for an individual for the sponsor (or for each sponsor even if two sponsors are married to each other and living together) plus an amount equal to one-half the Federal benefit rate for an eligible individual for each dependent of the sponsor. An ineligible dependent's income is not subtracted from the sponsor's dependent's allocation. We deem the balance of the income to be your unearned income.

(a) *If you are the only alien applying for or already eligible for SSI benefits who has income deemed to you from your sponsor.* If you are the only alien who is applying for or already eligible for SSI benefits and who is sponsored by your sponsor, all the deemed income is your unearned income.

(b) *If you are not the only alien who is applying for or already eligible for SSI benefits and who has income deemed from your sponsor.* If you and other aliens applying for or already eligible for SSI benefits are sponsored by the same sponsor, we deem the income to each of you as though you were the only alien sponsored by that person. The income deemed to you becomes your unearned income.

(c) *When you are an alien and income is no longer deemed from your sponsor.* If you are an alien and have had your sponsor's income deemed to you, we stop deeming the income with the month in which the third anniversary of your admission into the United States occurs.

(d) *When sponsor deeming rules do not apply to you if you are an alien.* If you are an alien, we do not apply the sponsor deeming rules to you if—

(1) *You are a refugee.* You are a refugee admitted to the United States as the result of application of one of three sections of the Immigration and Nationality Act: (1) Section 203(a)(7), effective before April 1, 1980; (2) Section 207(c)(1), effective after March 31, 1980; or (3) Section 212(d)(5);

(2) *You have been granted asylum.* You have been granted political asylum by the Attorney General of the United States; or

(3) *You become blind or disabled.* If you become blind or disabled as defined in § 416.901 (at any age) after your admission to the United States, we do not deem your sponsor's income to you to determine your eligibility for SSI benefits beginning with the month in which your disability or blindness begins. However, to determine your benefit payment, we follow the rule in § 416.420 of counting your income in the second month prior to the current month.

(e) *Examples.* These examples show how we deem a sponsor's income to an eligible individual who is an alien when

none of the exceptions in § 416.1160(b)(2) applies. The income, income exclusions, and the benefit rates are in monthly amounts. The Federal benefit rates are those effective January 1, 1986.

Example 1. Mr. John, an alien who has no income, has been sponsored by Mr. Herbert who has monthly earned income of $1,300 and unearned income of $70. Mr. Herbert's wife and three children have no income. We add Mr. Herbert's earned and unearned income for a total of $1,370 and apply the allocations for the sponsor and his dependents. Allocations total $1,008. These are made up of $336 (the Federal benefit rate for an eligible individual) for the sponsor, plus $672 (one-half the Federal benefit rate for an eligible individual, $168 each) for Mr. Herbert's wife and three children. The $1,008 is subtracted from Mr. Herbert's total income of $1,370 which leaves $362 to be deemed to Mr. John as his unearned income. Mr. John's only exclusion is the $20 general income exclusion. Since the $342 balance exceeds the $336 Federal benefit rate, Mr. John is ineligible.

Example 2. Mr. and Mrs. Smith are an alien couple who have no income and who have been sponsored by Mr. Hart. Mr. Hart has earned income of $1,350 and his wife, Mrs. Hart, who lives with him, has earned income of $150. Their two children have no income. We combine Mr. and Mrs. Hart's income ($1,350+$150=$1,500). We deduct the allocations of $336 for Mr. Hart (the Federal benefit rate for an individual) and $504 for Mrs. Hart and the two children ($168 or one-half the Federal benefit rate for an eligible individual for each), a total of $840. The allocations ($840) are deducted from the total $1,500 income which leaves $660. This amount must be deemed independently to Mr. and Mrs. Smith. Mr. and Mrs. Smith would qualify for SSI benefits as a couple in the amount of $504 if no income had been deemed to them. The $1,320 ($660 each to Mr. and Mrs. Smith) deemed income is unearned income to Mr. and Mrs. Smith and is subject to the $20 general income exclusion, leaving $1,300. This exceeds the couple's rate of $504 so Mr. and Mrs. Smith are ineligible for SSI benefits.

Example 3. Mr. Bert and Mr. Davis are aliens sponsored by their sister Mrs. Jean, who has earned income of $800. She also receives $250 as survivors' benefits for her two minor children. We do not consider the $250 survivors' benefits to be Mrs. Jean's income because it is the children's income. We exclude $336 for Mrs. Jean (the Federal benefit rate for an individual) plus $336 ($168, one-half the Federal benefit rate for an eligible individual for each child), a total of $672. We subtract the $672 from Mrs. Jean's income of $800, which leaves $128 to be deemed to Mr. Bert and Mr. Davis. Each of the brothers is liable for rent in the boarding house (a commercial establishment) where they live. Each lives in his own household, receives no in-kind support and maintenance, and is eligible for the Federal benefit rate of $336. The $128 deemed income is deemed both to Mr. Bert and to Mr. Davis. As a result, each has countable income of $108 ($128 minus the $20 general income exclusion). This is less than $336, the Federal benefit rate for an individual, so that both are eligible for SSI. We use their income in a prior month to determine their benefit payments.

Example 4. The same situation applies as in example 3 except that one of Mrs. Jean's children is disabled and eligible for SSI benefits. The eligibility of the disabled child does not affect the amount of income deemed to Mr. Bert and Mr. Davis since the sponsor-to-alien and parent-to-child rules are applied independently. The child's countable income is computed under the rules in § 416.1165.

[52 FR 8887, Mar. 20, 1987]

§ 416.1167 Temporary absences and deeming rules.

(a) *General.* During a temporary absence, we continue to consider the absent person a member of the household. A temporary absence occurs when—

(1) You, your ineligible spouse, parent, or an ineligible child leaves the household but intends to and does return in the same month or the month immediately following; or

(2) You enter a medical care facility and are eligible for either benefit payable under § 416.212. We consider your absence to be temporary through the last month benefits under § 416.212 were paid unless you were discharged from the facility in the following month. In that case, we consider your absence to be temporary through the date of discharge.

(b) *Child away at school.* If you are an eligible child who is away at school but comes home on some weekends or lengthy holidays and if you are subject to the control of your parents, we consider you temporarily absent from your parents' household. However, if you are not subject to parental control, we do not consider your absence temporary and we do not deem parental income (or resources) to you. Being subject to parental control affects deeming to you only if you are away at school.

[50 FR 48579, Nov. 26, 1985, as amended at 61 FR 10280, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10280, Mar. 13, 1996, in §416.1167, paragraph (a) was revised, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§416.1167 Temporary absences and deeming rules.

(a) *General.* A temporary absence, for the purpose of deeming, occurs when you or your ineligible spouse or parent or an ineligible child leaves the household but intends to, and does, return in the same month or the month immediately following. If the absence is temporary, we continue to consider the person a member of the household.

* * * * *

§416.1168 How we deem income to you from your essential person.

(a) *Essential person's income.* If you have an essential person, we deem all of that person's income (except any not counted because of other Federal statutes as described in §416.1161(b)) to be your own unearned income. If your essential person is also your ineligible spouse, or if you are a child whose essential person is your ineligible parent, we apply the essential person deeming rules in this section. See §416.1169 for the rules that apply when an ineligible spouse or parent ceases to be your essential person.

(b) *Determining your eligibility for an SSI benefit.* We apply the exclusions to which you are entitled under §§416.1112 and 416.1124 to your earned income and to your unearned income which includes any income deemed from your essential person. After combining the remaining amounts of countable income, we compare the total with the Federal benefit rate for a qualified individual (see §416.413) to determine whether you are eligible for an SSI benefit.

(c) *Determining your SSI benefit amount.* We determine your SSI benefit amount in the same way that we determine your eligibility. However, in following the procedure in paragraphs (a) and (b) of this section we use your essential person's income that we deemed to you in the second month prior to the current month. *Exception:* Beginning with the month in which you no longer have your essential person, we do not use any of the income deemed to you from that essential person in a prior month to determine the amount of your benefit (see §416.1160(a)(3)(ii)(C)). We use only your own countable income in a prior month.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48579, Nov. 26, 1985]

§416.1169 When we stop deeming income from an essential person.

If including the income deemed to you from your essential person causes you to be ineligible for an SSI benefit, you are no longer considered to have that essential person whose income makes you ineligible. To determine your eligibility for that month we deduct only your own countable income from your Federal benefit rate. However, other deeming rules may then apply as follows:

(a) *Essential person is your spouse.* If the person who was your essential person is your ineligible spouse, we apply the deeming rules in §416.1163 beginning with the month that the income of your essential person is no longer deemed to you.

(b) *Essential person is your parent.* If you are a child under age 18, and the person who was your essential person is your ineligible parent, we apply the deeming rules in §416.1165 beginning with the month that the income of your essential person is no longer deemed to you.

[50 FR 48579, Nov. 26, 1985]

ALTERNATIVE INCOME COUNTING RULES FOR CERTAIN BLIND INDIVIDUALS

§416.1170 General.

(a) *What the alternative is.* If you are blind and meet the requirements in §416.1171, we use one of two rules to see how much countable income you have. We use whichever of the following rules results in the lower amount of countable income:

(1) The SSI income exclusions in §§416.1112 and 416.1124; or

(2) The disregards that would have applied under the State plan for October 1972.

(b) *State plan.* As used in this subpart, *State plan for October 1972* means a State plan for providing assistance to the blind under title X or XVI (AABD) of the Social Security Act. That plan must have been approved under the

provisions of 45 CFR Chapter II as in effect for October 1972.

§ 416.1171 When the alternative rules apply.

(a) *Eligibility for the alternative.* We use the alternative income counting rules for you if you meet all the following conditions:

(1) You were eligible for, and received, assistance for December 1973 under a State plan for October 1972;

(2) You have continued to live in that same State since December 1973;

(3) You were transferred to the SSI rolls and received a benefit for January 1974; and

(4) You have not been ineligible for an SSI benefit for any period of more than 6 consecutive months. (For purposes of this section, an SSI benefit means a Federal benefit; it does not include any State supplementation.)

(b) *Living in the same State.* For purposes of this section, you have continued to live in the same State since December 1973 unless you have left it at any time with the intention of moving to another State. If there is no evidence to the contrary, we assume that—

(1) If you leave the State for 90 calendar days or less, the absence is temporary and you still live in that State; and

(2) If you leave the State for more than 90 calendar days, you are no longer living there.

RULES FOR HELPING BLIND AND DISABLED INDIVIDUALS ACHIEVE SELF-SUPPORT

§ 416.1180 General.

One of the objectives of the SSI program is to help blind or disabled persons become self-supporting. If you are blind or disabled, we will pay you SSI benefits and will not count the part of your income that you use of set aside to use under a plan to become self-supporting. (See §§416.1112(c)(8) and 1124(c)(13).) You may develop a plan for achieving self-support on your own or with our help. As appropriate, we will refer you to a State rehabilitation agency or agency for the blind for additional assistance in developing a plan.

[45 FR 65547, Oct. 3, 1980, as amended at 51 FR 10616, Mar. 28, 1986]

§ 416.1181 What a plan to achieve self-support is.

A plan to achieve self-support must—

(a) Be designed especially for you;

(b) Be in writing;

(c) Be approved by us (a change of plan must also be approved);

(d) Be designed for an initial period of not more than 18 months. We may extend the period for up to another 18 months if you cannot complete the plan in the first period. We may allow a total of up to 48 months to fulfill a plan for a lengthy education or training program;

(e) Show your specific occupational goal;

(f) Show what money you have and will receive, how you will spend it, and how you will use it to attain your occupational goal; and

(g) Show how the money you set aside under the plan will be separated from your other funds.

§ 416.1182 When we begin to count the income excluded under the plan.

We will begin to count the earned and unearned income that would have been excluded under your plan in the month in which any of the following circumstances first exist:

(a) You fail to follow the conditions of your plan;

(b) You abandon your plan;

(c) You complete the time schedule outlined in the plan; or

(d) You reach your goal as outlined in the plan.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48579, Nov. 26, 1985]

APPENDIX TO SUBPART K OF PART 416—LIST OF TYPES OF INCOME EXCLUDED UNDER THE SSI PROGRAM AS PROVIDED BY FEDERAL LAWS OTHER THAN THE SOCIAL SECURITY ACT

Many Federal statutes in addition to the Social Security Act provide assistance or benefits for individuals and specify that the assistance or benefit will not be considered in deciding eligibility for SSI. We have listed these statutes in this appendix and have placed them in categories according to the

kind of income or assistance they provide. The list gives the name of the Federal statute (where possible), the public law number, and the citation. Each item briefly describes what the statute provides that will not reduce or eliminate an SSI payment. More detailed information is available from a social security office or by reference to the statutes.

We update this list periodically. However, when new Federal statutes of this kind are enacted, or existing statutes are changed, we apply the law currently in effect, even before this appendix is updated.

I. Food

(a) Value of food coupons under the Food Stamp Act of 1977, section 1301 of Pub. L. 95–113 (91 Stat. 968, 7 U.S.C. 2017(b)).

(b) Value of federally donated foods distributed under section 32 of Pub. L. 74–320 (49 Stat. 774) or section 416 of the Agriculture Act of 1949 (63 Stat. 1058, 7 CFR 250.6(e)(9)).

(c) Value of free or reduced price food for women and children under the—

(1) Child Nutrition Act of 1966, section 11(b) of Pub. L. 89–642 (80 Stat. 889, 42 U.S.C. 1780(b)) and section 17 of that Act as added by Pub. L. 92–433 (86 Stat. 729, 42 U.S.C. 1786); and

(2) National School Lunch Act, section 13(h)(3), as amended by section 3 of Pub. L. 90–302 (82 Stat. 119, 42 U.S.C. 1761(h)(3)).

(d) Services, except for wages paid to residents who assist in providing congregate services such as meals and personal care, provided a resident of an eligible housing project under a congregate services program under section 802 of the Cranston-Gonzales National Affordable Housing Act, Public Law 101–625 (104 Stat. 4313, 42 U.S.C. 8011).

II. Housing and Utilities

(a) Assistance to prevent fuel cut-offs and to promote energy efficiency under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program as authorized by section 222(a)(5) of the Economic Opportunity Act of 1964, as amended by section 5(d)(1) of Pub. L. No. 93–644 and section 5(a)(2) of Pub. L. 95–568 (88 Stat. 2294 as amended, 42 U.S.C. 2809(a)(5)).

(b) Home energy assistance payments or allowances under title XXVI of the Omnibus Budget Reconciliation Act of 1981, Public Law 97–35, as amended (42 U.S.C. 8624(f)).

NOTE.—This exclusion applies to a sponsor's income only if the alien is living in the housing unit for which the sponsor receives the home energy assistance payments or allowances.

(c) Value of any assistance paid with respect to a dwelling unit under—

(1) The United States Housing Act of 1937;

(2) The National Housing Act;

(3) Section 101 of the Housing and Urban Development Act of 1965; or

(4) Title V of the Housing Act of 1949.

NOTE— This exclusion applies to a sponsor's income only if the alien is living in the housing unit for which the sponsor receives the housing assistance.

(d) Payments for relocating, made to persons displaced by Federal or federally assisted programs which acquire real property, under section 216 of Pub. L. 91–646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636).

III. Education and Employment

(a) Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under section 507 of the Higher Education Amendments of 1968, Pub. L. 90–575 (82 Stat. 1063).

(b) Any wages, allowances, or reimbursement for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by an eligible handicapped individual employed in a project under title VI of the Rehabilitation Act of 1973 as added by title II of Pub. L. 95–602 (92 Stat. 2992, 29 U.S.C. 795(b)(c)).

(c) Student financial assistance for attendance costs received from a program funded in whole or in part under title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under section 14(27) of Public Law 100–50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. 1087uu).

IV. Native Americans

(a) Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act, as follows: Cash, including cash dividends on stock received from a Native Corporation, to the extent that it does not, in the aggregate, exceed $2,000 per individual each year; stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; a partnership interest; land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on

stock; and an interest in a settlement trust. This exclusion is pursuant to section 15 of the Alaska Native Claims Settlement Act Amendments of 1987, Public Law 100–241 (43 U.S.C. 1626(c)), effective February 3, 1988.

NOTE— This exclusion does not apply in deeming income from sponsors to aliens.

(b) Indian tribes—Distribution of per capita judgment funds to members of—

(1) The Blackfeet and Gros Ventre Tribes under section 4 of Pub. L. No. 92–254 (86 Stat. 265, 25 U.S.C. 1264) and under section 6 of Pub. L. No. 97–408 (96 Stat. 2036);

(2) The Papago Tribe of Arizona Indians under section 8(d) of Pub. L. No. 97–408 (96 Stat. 2038);

(3) The Grand River Band of Ottawa Indians in Indian Claims Commission docket numbered 40–K under section 6 of Pub. L. No. 94–540 (90 Stat. 2504);

NOTE— This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(4) The Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation as authorized by section 2 of Pub. L. No. 95–433 (92 Stat. 1047, 25 U.S.C. 609c–1);

(5) The Wyandot Tribe of Indians under section 6 of Pub. L. No. 97–371 (96 Stat. 1814, 42 U.S.C. 1305);

(6) The Shawnee Tribe of Indians under section 7 of Pub. L. No. 97–372 (96 Stat. 1816, 42 U.S.C. 1305);

(7) The Indians of the Miami Tribe of Oklahoma and Indiana under section 7 of Pub. L. No. 97–376 (96 Stat. 1829, 42 U.S.C. 1305);

(8) The Clallam Tribe of Indians under section 6 of Pub. L. No. 97–402 (96 Stat. 2021);

(9) The Pembina Chippewa Indians under section 9 of Pub. L. No. 97–403 (96 Stat. 2025);

(10) The Confederated Tribes of the Warm Springs Reservation under section 4 of Pub. L. No. 97–436 (96 Stat. 2284);

NOTE— This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(11) The Red Lake Band of Chippewa Indians under section 3 of Pub. L. No. 98–123 (97 Stat. 816); and

(12) The Assiniboine Tribe of Fort Peck Montana under section 5 of Pub. L. No. 98–124 (97 Stat. 818, 42 U.S.C. 1305) and the Assiniboine Tribe of Fort Belknap under section 5 of Pub. L. No. 98–124 (97 Stat. 818, 42 U.S.C. 1305) and section 6 of Pub. L. No. 97–408 (96 Stat. 2036).

(c) Receipts from land held in trust by the Federal government and distributed to members of certain Indian tribes under section 6 of Pub. L. No. 94–114 (89 Stat. 579).

NOTE— This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(1) The Pueblo of Santa Ana Indians of New Mexico under section 6 of Pub. L. No. 95–498 (92 Stat. 1677, 42 U.S.C. 1305); and

(2) The Pueblo of Zia Indians of New Mexico under section 6 of Pub. L. No. 95–499 (92 Stat. 1680, 42 U.S.C. 1305).

(d) Revenues from the Maine Indian Claims Settlement Fund and the Maine Indian Land Acquisition Fund paid under section 5 of the Maine Indian Claims Settlement Act of 1980, Pub. L. No. 96–420 (94 Stat. 1796, 25 U.S.C. 1728(c)).

NOTE— This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(e) Funds, assets, or income under section 6(b) of the Puyallup Tribe of Indians Settlement Act of 1989, Public Law 101–41 (25 U.S.C. 1773h(c)).

NOTE.—This exclusion does not apply in deeming income from sponsors to aliens.

(f) Payments, funds, distributions, or income derived from them under section 8(b) of the Seneca Nation Settlement Act of 1990, Public Law 101–503 (104 Stat. 1297, 25 U.S.C. 1774f).

NOTE—This exclusion does not apply in deeming income from sponsors to aliens.

(g) Indian judgment funds that are held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93–134 as amended by Public Law 97–458 (25 U.S.C. 1407). Indian judgment funds include interest and investment income accrued while such funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds. This exclusion does not apply to sales or conversions of initial purchases or to subsequent purchases.

NOTE—This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(h) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe are excluded from income under Public Law 98–64 (25 U.S.C. 117b). Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from countable income under this exclusion. For ANRVC dividend distributions, see paragraph IV(a) of this appendix.

V. Other

(a) Compensation provided volunteers in the foster grandparents program and other similar programs, unless determined by the Director of the Action Agency to constitute the minimum wage, under sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973 (87 Stat. 409, 413), as amended by Pub. L. No. 96–143; (93 Stat. 1077); 42 U.S.C. 5044(g) and 5058).

NOTE— This exclusion does not apply to the income of sponsors of aliens.

(b) Any assistance to an individual (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102(h)(1) of Pub. L. 95–478 (92 Stat. 1515, 42 U.S.C. 3020a).

(c) Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts for losses suffered as a result of evacuation, relocation, and internment during World War II, under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, sections 105(f) and 206(d) of Public Law 100–383 (50 U.S.C. App. 1989 b and c).

(d) Payments made on or after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under Public Law 101–201 (103 Stat. 1795) and section 10405 of Public Law 101–239 (103 Stat. 2489).

(e) Payments made under section 6 of the Radiation Exposure Compensation Act, Public Law 101–426 (104 Stat. 925, 42 U.S.C. 2210).

[45 FR 65547, Oct. 3, 1980, as amended at 52 FR 8888, Mar. 20, 1987; 57 FR 53851, Nov. 13, 1992; 57 FR 55088, Nov. 24, 1992; 59 FR 8538, Feb. 23, 1994]

Subpart L—Resources and Exclusions

AUTHORITY: Secs. 702(a)(5), 1602, 1611, 1612, 1613, 1614(f), 1621, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, and 1383); sec. 211, Pub. L. 93–66, 87 Stat. 154 (42 U.S.C. 1382 note).

SOURCE: 40 FR 48915, Oct. 20, 1975, unless otherwise noted.

§416.1201 Resources; general.

(a) *Resources; defined.* For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

(2) Support and maintenance assistance not counted as income under §416.1157(c) will not be considered a resource.

(3) Except for cash reimbursement of medical or social services expenses already paid for by the individual, cash received for medical or social services that is not income under §416.1103(a) or (b), or a retroactive cash payment which is income that is excluded from deeming under §416.1161(a)(16), is not a resource for the calendar month following the month of its receipt. However, cash retained until the first moment of the second calendar month following its receipt is a resource at that time.

(i) For purposes of this provision, a retroactive cash payment is one that is paid after the month in which it was due.

(ii) This provision applies only to the unspent portion of those cash payments identified in this paragraph (a)(3). Once the cash from such payments is spent, this provision does not apply to items purchased with the money, even if the period described above has not expired.

(iii) Unspent money from those cash payments identified in this paragraph (a)(3) must be identifiable from other resources for this provision to apply. The money may be commingled with other funds, but if this is done in such a fashion that an amount from such payments can no longer be separately identified, that amount will count toward the resource limit described in §416.1205.

(4) Death benefits, including gifts and inheritances, received by an individual, to the extent that they are not income in accordance with paragraphs (e) and (g) of §416.1121 because they are to be spent on costs resulting from the last illness and burial of the deceased, are not resources for the calendar month following the month of receipt. However, such death benefits retained until the first moment of the second calendar month following their receipt are resources at that time.

(b) *Liquid resources.* Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking,

and time deposits, also known as certificates of deposit) and similar items. Liquid resources, other than cash, are evaluated according to the individual's equity in the resources. (See § 416.1208 for the treatment of funds held in individual and joint financial institution accounts.)

(c) *Nonliquid resources.* (1) Nonliquid resources are property which is not cash and which cannot be converted to cash within 20 days excluding certain nonwork days as explained in § 416.120(d). Examples of resources that are ordinarily nonliquid are loan agreements, household goods, automobiles, trucks, tractors, boats, machinery, livestock, buildings and land. Nonliquid resources are evaluated according to their equity value except as otherwise provided. (See § 416.1218 for treatment of automobiles.)

(2) For purposes of this subpart L, the *equity value* of an item is defined as:

(i) The price that item can reasonably be expected to sell for on the open market in the particular geographic area involved; minus

(ii) Any encumbrances.

[40 FR 48915, Oct. 20, 1975, as amended at 44 FR 43266, July 24, 1979; 48 FR 33259, July 21, 1983; 52 FR 4283, Feb. 11, 1987; 52 FR 16845, May 6, 1987; 53 FR 23231, June 21, 1988; 56 FR 36001, July 30, 1991; 57 FR 35461, Aug. 10, 1992; 57 FR 55089, Nov. 24, 1992; 59 FR 27988, May 31, 1994]

§ 416.1202 Deeming of resources.

(a) *Married individual.* In the case of an individual who is living with a person not eligible under this part and who is considered to be the husband or wife of such individual under the criteria in §§ 416.1806 and 416.1811, such individual's resources shall be deemed to include any resources, not otherwise excluded under this subpart, of such spouse whether or not such resources are available to such individual. In addition to the exclusions listed in § 416.1210, pension funds which the ineligible spouse may have are also excluded. *Pension funds* are defined as funds held in individual retirement accounts (IRA), as described by the Internal Revenue Code, or in work-related pension plans (including such plans for self-employed individuals, sometimes referred to as Keogh plans).

(b) *Child*—(1) *General.* In the case of a child (as defined in § 416.1856) who is under age 18, such child's resources shall be deemed to include any resources, not otherwise excluded under this subpart, of an ineligible parent of such child (or the ineligible spouse of a parent) who is living in the same household (as defined in § 416.1851) as such child, whether or not available to such child, to the extent that the resources of such parent (or such spouse of a parent) exceed the resource limits described in § 416.1205 except as provided in paragraph (b)(2) of this section. (If the child is living with only one parent, the resource limit for an individual applies. If the child is living with both parents (or one parent and his or her spouse), the resource limit for an individual and spouse applies.) In addition to the exclusions listed in § 416.1210, pension funds which the ineligible parent or spouse of a parent may have are also excluded. ''Pension funds'' are defined in paragraph (a) of this section. As used in this section, the term ''parent'' means the natural or adoptive parent of a child and ''spouse of a parent'' means the spouse (as defined in § 416.1806) of such natural or adoptive parent.

(2) *Disabled child under age 18.* In the case of a disabled child under age 18 who is living in the same household with his or her parents, the deeming provisions of paragraph (b)(1) of this section shall not apply if such child—

(i) Previously received a reduced SSI benefit while a resident of a medical facility for which Medicaid paid more than 50 percent of the cost of the individual's care;

(ii) Is eligible for medical assistance under a Medicaid State home care plan approved by the Secretary under the provisions of section 1915(c) or authorized under section 1902(e)(3) of the Act; and

(iii) Would otherwise be ineligible because of the deeming of his or her parents' resources or income.

(c) *Applicability.* When used in this subpart L, the term *individual* refers to an eligible aged, blind, or disabled person, and also includes a person whose resources are deemed to be the resources of such individual (as provided

in paragraphs (a) and (b) of this section).

[40 FR 48915, Oct. 20, 1975, as amended at 50 FR 38982, Sept. 26, 1985; 52 FR 8888, Mar. 20, 1987; 52 FR 29841, Aug. 12, 1987; 52 FR 32240, Aug. 26, 1987; 60 FR 361, Jan. 4, 1995]

§416.1203 Deeming of resources of an essential person.

In the case of a qualified individual (as defined in §416.221) whose payment standard has been increased because of the presence of an essential person (as defined in §416.222), the resources of such qualified individual shall be deemed to include all the resources of such essential person. If such qualified individual would not meet the resource criteria for eligibility (as defined in §§416.1205 and 416.1260) because of the deemed resources, then the payment standard increase because of the essential person will be nullified and the provision of this section will not apply; essential person status is lost permanently. However, if such essential person is an ineligible spouse of a qualified individual or a parent (or spouse of a parent) of a qualified individual who is a child under age 21, then the resources of such person will be deemed to such qualified individual in accordance with the provision in §416.1202.

[39 FR 33797, Sept. 20, 1974, as amended at 51 FR 10616, Mar. 28, 1986]

§416.1204 Deeming of resources of the sponsor of an alien.

The resources of an alien who first applies for SSI benefits after September 30, 1980, are deemed to include the resources of the alien's sponsor for 3 years after the alien's date of admission into the United States. The *date of admission* is the date established by the Immigration and Naturalization Service as the date of admission for permanent residence. The resources of the sponsor's spouse are included if the sponsor and spouse live in the same household. Deeming of these resources applies regardless of whether the alien and sponsor live in the same household and regardless of whether the resources are actually available to the alien. For rules that apply in specific situations, see §416.1166a(d).

(a) *Exclusions from the sponsor's resources.* Before we deem a sponsor's resources to an alien, we exclude the same kinds of resources that are excluded from the resources of an individual eligible for SSI benefits. The applicable exclusions from resources are explained in §416.1210 (paragraphs (a) through (i), (k), and (m) through (q)) through §416.1239. For resources excluded by Federal statutes other than the Social Security Act, as applicable to the resources of sponsors deemed to aliens, see the appendix to subpart K of part 416. We next allocate for the sponsor or for the sponsor and spouse (if living together). (The amount of the allocation is the applicable resource limit described in §416.1205 for an eligible individual and an individual and spouse.)

(b) *An alien sponsored by more than one sponsor.* The resources of an alien who has been sponsored by more than one person are deemed to include the resources of each sponsor.

(c) *More than one alien sponsored by one individual.* If more than one alien is sponsored by one individual the deemed resources are deemed to each alien as if he or she were the only one sponsored by the individual.

(d) *Alien has a sponsor and a parent or a spouse with deemable resources.* Resources may be deemed to an alien from both a sponsor and a spouse or parent (if the alien is a child) provided that the sponsor and the spouse or parent are not the same person and the conditions for each rule are met.

(e) *Alien's sponsor is also the alien's ineligible spouse or parent.* If the sponsor is also the alien's ineligible spouse or parent who lives in the same household, the spouse-to-spouse or parent-to-child deeming rules apply instead of the sponsor-to-alien deeming rules. If the spouse or parent deeming rules cease to apply, the sponsor deeming rules will begin to apply. The spouse or parent rules may cease to apply if an alien child reaches age 18 or if either the sponsor who is the ineligible spouse or parent, or the alien moves to a separate household.

(f) *Alien's sponsor also is the ineligible spouse or parent of another SSI beneficiary.* If the sponsor is also the ineligible spouse or ineligible parent of an SSI beneficiary other than the alien, the sponsor's resources are deemed to the alien under the rules in paragraph

(a), and to the eligible spouse or child under the rules in §§ 416.1202, 1205, 1234, 1236, and 1237.

[52 FR 8888, Mar. 20, 1987, as amended at 61 FR 1712, Jan. 23, 1996]

§ 416.1204a Deeming of resources where Medicaid eligibility is affected.

Section 416.1161a of this part describes certain circumstances affecting Medicaid eligibility in which the Department will not deem family income to an individual. The Department will follow the same standards, procedures, and limitations set forth in that section with respect to deeming of resources.

[49 FR 5747, Feb. 15, 1984]

§ 416.1205 Limitation on resources.

(a) *Individual with no eligible spouse.* An aged, blind, or disabled individual with no spouse is eligible for benefits under title XVI of the Act if his or her nonexcludable resources do not exceed $1,500 prior to January 1, 1985, and all other eligibility requirements are met. An individual who is living with an ineligible spouse is eligible for benefits under title XVI of the Act if his or her nonexcludable resources, including the resources of the spouse, do not exceed $2,250 prior to January 1, 1985, and all other eligibility requirements are met.

(b) *Individual with an eligible spouse.* An aged, blind, or disabled individual who has an eligible spouse is eligible for benefits under title XVI of the Act if their nonexcludable resources do not exceed $2,250 prior to January 1, 1985, and all other eligibility requirements are met.

(c) *Effective January 1, 1985 and later.* The resources limits and effective dates for January 1, 1985 and later are as follows:

Effective date	Individual	Individual and spouse
Jan. 1, 1985	$1,600	$2,400
Jan. 1, 1986	1,700	$2,550
Jan. 1, 1987	1,800	$2,700
Jan. 1, 1988	1,900	$2,850
Jan. 1, 1989	2,000	$3,000

[50 FR 38982, Sept. 26, 1985]

§ 416.1207 Resources determinations.

(a) *General.* Resources determinations are made as of the first moment of the month. A resource determination is based on what assets an individual has, what their values are, and whether or not they are excluded as of the first moment of the month.

(b) *Increase in value of resources.* If, during a month, a resource increases in value or an individual acquires an additional resource or replaces an excluded resource with one that is not excluded, the increase in the value of the resources is counted as of the first moment of the next month

(c) *Decrease in value of resources.* If, during a month, a resource decreases in value or an individual spends a resource or replaces a resource that is not excluded with one that is excluded, the decrease in the value of the resources is counted as of the first moment of the next month.

(d) *Treatment of items under income and resource counting rules.* Items received in cash or in kind during a month are evaluated first under the income counting rules and, if retained until the first moment of the following month, are subject to the rules for counting resources at that time.

(e) *Receipts from the sale, exchange, or replacement of a resource.* If an individual sells, exchanges or replaces a resource, the receipts are not income. They are still considered to be a resource. This rule includes resources that have never been counted as such because they were sold, exchanged or replaced in the month in which they were received. See § 416.1246 for the rule on resources disposed of for less than fair market value (including those disposed of during the month of receipt).

Example: Miss L., a disabled individual, receives a $350 unemployment insurance benefit on January 10, 1986. The benefit is unearned income to Miss L. when she receives it. On January 14, Miss L. uses the $350 payment to purchase shares of stock. Miss L. has exchanged one item (cash) for another item (stock). The $350 payment is never counted as a resource to Miss L. because she exchanged it in the same month she received it. The stock is not income; it is a different form of a resource exchanged for the cash. Since a resource is not countable until the

first moment of the month following its receipt, the stock is not a countable resource to Miss L. until February 1.

[52 FR 4283, Feb. 11, 1987]

§416.1208 How funds held in financial institution accounts are counted.

(a) *General.* Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled.

(b) *Individually-held account.* If an individual is designated as sole owner by the account title and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, we presume that the individual owns 100 percent of the funds in the account. This presumption is non-rebuttable.

(c) *Jointly-held account*—(1) *Account holders include one or more SSI claimants or recipients.* If there is only one SSI claimant or recipient account holder on a jointly held account, we presume that all of the funds in the account belong to that individual. If there is more than one claimant or recipient account holder, we presume that all the funds in the account belong to those individuals in equal shares.

(2) *Account holders include one or more deemors.* If none of the account holders is a claimant or recipient, we presume that all of the funds in a jointly-held account belong to the deemor(s), in equal shares if there is more than one deemor. A deemor is a person whose income and resources are required to be considered when determining eligibility and computing the SSI benefit for an eligible individual (see §§416.1160 and 416.1202).

(3) *Right to rebut presumption of ownership.* If the claimant, recipient, or deemor objects or disagrees with an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, we give the individual the opportunity to rebut the presumption. Rebuttal is a procedure as described in paragraph (c)(4) of this section, which permits an individual to furnish evidence and establish that some or all of the funds in a jointly-held account do not belong to him or her. Successful rebuttal establishes that the individual does not own some or all of the funds. The effect of successful rebuttal may be retroactive as well as prospective.

Example: The recipient's first month of eligibility is January 1993. In May 1993 the recipient successfully establishes that none of the funds in a 5-year-old jointly-held account belong to her. We do not count any of the funds as resources for the months of January 1993 and continuing.

(4) *Procedure for rebuttal.* To rebut an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, the individual must:

(i) Submit his/her statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

(ii) Submit account records showing deposits, withdrawals, and interest (if any) in the months for which ownership of funds is at issue; and

(iii) Correct the account title to show that the individual is no longer a co-owner if the individual owns none of the funds; or, if the individual owns only a portion of the funds, separate the funds owned by the other account holder(s) from his/her own funds and correct the account title on the individual's own funds to show they are solely-owned by the individual.

[59 FR 27989, May 31, 1994]

§416.1210 Exclusions from resources; general.

In determining the resources of an individual (and spouse, if any) the following items shall be excluded:

(a) The home (including the land appertaining thereto) to the extent its value does not exceed the amount set forth in §416.1212;

(b) Household goods and personal effects to the extent that their total

value does not exceed the amount provided in § 416.1216;

(c) An automobile to the extent that its value does not exceed the amount provided in § 416.1218;

(d) Property of a trade or business which is essential to the means of self-support as provided in § 416.1222;

(e) Nonbusiness property which is essential to the means of self-support as provided in § 416.1224;

(f) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support as provided in § 416.1226;

(g) Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act (see § 416.1228);

(h) Life insurance owned by an individual (and spouse, if any) to the extent provided in § 416.1230;

(i) Restricted allotted Indian lands as provided in § 416.1234;

(j) Payments or benefits provided under a Federal statute other than title XVI of the Social Security Act where exclusion is required by such statute;

(k) Disaster relief assistance as provided in § 416.1237;

(l) Burial spaces and certain funds up to $1,500 for burial expenses as provided in § 416.1231;

(m) Title XVI or title II retroactive payments as provided in § 416.1233;

(n) Housing assistance as provided in § 416.1238;

(o) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in § 416.1235;

(p) Payments received as compensation for expenses incurred or losses suffered as a result of a crime as provided in § 416.1229; and

(q) Relocation assistance from a State or local government as provided in § 416.1239.

[40 FR 48915, Oct. 20, 1975, as amended at 41 FR 13338, Mar. 30, 1976; 44 FR 15664, Mar. 15, 1979; 48 FR 57127, Dec. 28, 1983; 51 FR 34464, Sept. 29, 1986; 55 FR 28378, July 11, 1990; 58 FR 63890, Dec. 3, 1993; 59 FR 8538, Feb. 23, 1994; 61 FR 1712, Jan. 23, 1996]

§ 416.1212 Exclusion of the home.

(a) *Defined.* A home is any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.

(b) *Home not counted.* We do not count a home regardless of its value. However, see §§ 416.1220 through 416.1224 when there is an income-producing property located on the home property that does not qualify under the home exclusion.

(c) *If an individual changes principal place of residence.* If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, we still consider the home to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

(d) *Proceeds from the sale of an excluded home.* (1) The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within 3 months of the date of receipt of the proceeds.

(2) The value of a promissory note or similar installment sales contract constitutes a ''proceed'' which can be excluded from resources if—

(i) The note results from the sale of an individual's home as described in § 416.1212(a);

(ii) Within 3 months of receipt (execution) of the note, the individual purchases a replacement home as described in § 416.1212(a) (see paragraph

(e) of this section for an exception); and

(iii) All note-generated proceeds are reinvested in the replacement home within 3 months of receipt (see paragraph (f) of this section for an exception).

(3) In addition to excluding the value of the note itself, other proceeds from the sale of the former home are excluded resources if they are used within 3 months of receipt to make payment on the replacement home. Such proceeds, which consist of the downpayment and that portion of any installment amount constituting payment against the principal, represent a conversion of a resource.

(e) *Failure to purchase another excluded home timely.* If the individual does not purchase a replacement home within the 3-month period specified in paragraph (d)(2)(ii) of this section, the value of a promissory note or similar installment sales contract received from the sale of an excluded home is a countable resource effective with the first moment of the month following the month the note is executed. If the individual purchases a replacement home after the expiration of the 3-month period, the note becomes an excluded resource the month following the month of purchase of the replacement home provided that all other proceeds are fully and timely reinvested as explained in paragraph (f) of this section.

(f) *Failure to reinvest proceeds timely.* (1) If the proceeds (e.g., installment amounts constituting payment against the principal) from the sale of an excluded home under a promissory note or similar installment sales contract are not reinvested fully and timely (within 3 months of receipt) in a replacement home, as of the first moment of the month following receipt of the payment, the individual's countable resources will include:

(i) The value of the note; and

(ii) That portion of the proceeds, retained by the individual, which was not timely reinvested.

(2) The note remains a countable resource until the first moment of the month following the receipt of proceeds that are fully and timely reinvested in the replacement home. Failure to reinvest proceeds for a period of time does not permanently preclude exclusion of the promissory note or installment sales contract. However, previously received proceeds that were not timely reinvested remain countable resources to the extent they are retained.

Example 1. On July 10, an SSI recipient received his quarterly payment of $200 from the buyer of his former home under an installment sales contract. As of October 31, the recipient has used only $150 of the July payment in connection with the purchase of a new home. The exclusion of the unused $50 (and of the installment contract itself) is revoked back to July 10. As a result, the $50 and the value of the contract as of August 1, are included in a revised determination of resources for August and subsequent months.

Example 2. On April 10, an SSI recipient received a payment of $250 from the buyer of his former home under an installment sales contract. On May 3, he reinvested $200 of the payment in the purchase of a new home. On May 10, the recipient received another $250 payment, and reinvested the full amount on June 3. As of July 31, since the recipient has used only $200 of the April payment in connection with the purchase of the new home, the exclusion of the unused $50 (and of the installment contract itself) is revoked back to April 10. As a result, the $50 and the value of the contract as of May 1 are includable resources. Since the recipient fully and timely reinvested the May payment, the installment contract and the payment are again excludable resources as of June 1. However, the $50 left over from the previous payment remains a countable resource.

(g) *Interest payments.* If interest is received as part of an installment payment resulting from the sale of an excluded home under a promissory note or similar installment sales contract, the interest payments do not represent conversion of a resource. The interest is income under the provisions of §§ 416.1102, 416.1120, and 416.1121(c).

[50 FR 42686, Oct. 22, 1985, as amended at 51 FR 7437, Mar. 4, 1986; 59 FR 43285, Aug. 23, 1994]

§ 416.1216 Exclusion of household goods and personal effects.

(a) *Household goods and personal effects; defined.* Household goods are defined as including household furniture, furnishings and equipment which are commonly found in or about a house and are used in connection with the operation, maintenance and occupancy of the home. Household goods would also

include the furniture, furnishings and equipment which are used in the functions and activities of home and family life as well as those items which are for comfort and accommodation. Personal effects are defined as including clothing, jewelry, items of personal care, individual education and recreational items such as books, musical instruments, and hobbies.

(b) *Limitation on household goods and personal effects.* In determining the resources of an individual (and spouse, if any), household goods and personal effects are excluded if their total equity value is $2,000 or less. If the total equity value of household goods and personal effects is in excess of $2,000, the excess is counted against the resource limitation.

(c) *Additional exclusions of household goods and personal effects.* In determining the resources of an individual (and spouse, if any) and in determining the value of the household goods and personal effects of such individual (and spouse), there shall be excluded a wedding ring and an engagement ring and household goods and personal effects such as prosthetic devices, dialysis machines, hospital beds, wheel chairs and similar equipment required because of a person's physical condition. The exclusion of items required because of a person's physical condition is not applicable to items which are used extensively and primarily by members of the household in addition to the person whose physical condition requires the item.

[40 FR 48915, Oct. 20,1975, as amended at 44 FR 43266, July 24, 1979]

§ 416.1218 Exclusion of the automobile.

(a) *Automobile; defined.* As used in this section, the term *automobile* includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

(b) *Limitation on automobiles.* In determining the resources of an individual (and spouse, if any), automobiles are excluded or counted as follows:

(1) *Total exclusion.* One automobile is totally excluded regardless of its value if, for the individual or a member of the individual's household—

(i) It is necessary for employment;

(ii) It is necessary for the medical treatment of a specific or regular medical problem;

(iii) It is modified for operation by or transportation of a handicapped person; or

(iv) It (or other type of vehicle) is necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

(2) *Exclusion to $4,500 of the market value.* If no automobile is excluded under paragraph (b)(1) of this section, one automobile is excluded from counting as a resource to the extent its current market value does not exceed $4,500. If the market value of the automobile exceeds $4,500, the excess is counted against the resource limit.

(3) *Other automobiles.* Any other automobiles are treated as nonliquid resources and counted against the resource limit to the extent of the individual's equity (see § 416.1201(c)).

(c) *Current market value.* The *current market value* of an automobile is the average price an automobile of that particular year, make, model, and condition will sell for on the open market (to a private individual) in the particular geographic area involved.

[40 FR 48915, Oct. 20, 1975, as amended at 44 FR 43266, July 24, 1979; 50 FR 42687, Oct. 22, 1985]

§ 416.1220 Property essential to self-support; general.

When counting the value of resources an individual (and spouse, if any) has, the value of property essential to self-support is not counted, within certain limits. There are different rules for considering this property depending on whether it is income-producing or not. Property essential to self-support can include real and personal property (for example, land, buildings, equipment and supplies, motor vehicles, and tools, etc.) used in a trade or business (as defined in § 404.1066 of part 404), nonbusiness income-producing property (houses or apartments for rent, land other than home property, etc.) and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as part of a trade or business are not property essential to self-

support. If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self-support.

[50 FR 42687, Oct. 22, 1985]

§416.1222 How income-producing property essential to self-support is counted.

(a) *General.* When deciding the value of property used in a trade or business or nonbusiness income-producing activity, only the individual's equity in the property is counted. We will exclude as essential to self-support up to $6,000 of an individual's equity in income-producing property if it produces a net annual income to the individual of at least 6 percent of the excluded equity. If the individual's equity is greater than $6,000, we count only the amount that exceeds $6,000 toward the allowable resource limit specified in §416.1205 if the net annual income requirement of 6 percent is met on the excluded equity. If the activity produces less than a 6-percent return due to circumstances beyond the individual's control (for example, crop failure, illness, etc.), and there is a reasonable expectation that the individual's activity will again produce a 6-percent return, the property is also excluded. If the individual owns more than one piece of property and each produces income, each is looked at to see if the 6-percent rule is met and then the amounts of the individual's equity in all of those properties producing 6 percent are totaled to see if the total equity is $6,000 or less. The equity in those properties that do not meet the 6-percent rule is counted toward the allowable resource limit specified in §416.1205. If the individual's total equity in the properties producing 6-percent income is over the $6,000 equity limit, the amount of equity exceeding $6,000 is counted as a resource toward the allowable resource limit.

Example 1. Sharon has a small business in her home making hand-woven rugs. The looms and other equipment used in the business have a current market value of $7,000. The value of her equity is $5,500 since she owes $1,500 on the looms. Sharon's net earnings from self-employment is $400. Since Sharon's equity in the looms and other equipment ($5,500) is under the $6,000 limit for property essential to self-support and her net income after expenses ($400) is greater than 6 percent of her equity, her income-producing property is excluded from countable resources. The home is not considered in any way in valuing property essential to self-support.

Example 2. Charlotte operates a farm. She owns 3 acres of land on which her home is located. She also owns 10 acres of farm land not connected to her home. There are 2 tool sheds and 2 animal shelters located on the 10 acres. She has various pieces of farm equipment that are necessary for her farming activities. We exclude the house and the 3 acres under the home exclusion (see §416.1212). However, we look at the other 10 acres of land, the buildings and equipment separately to see if her total equity in them is no more than $6,000 and if the annual rate of return is 6 percent of her equity. In this case, the 10 acres and buildings are valued at $4,000 and the few items of farm equipment and other inventory are valued at $1,500. Charlotte sells produce which nets her more than 6 percent for this year. The 10 acres and other items are excluded as essential to her self-support and they continue to be excluded as long as she meets the 6-percent annual return requirement and the equity value of the 10 acres and other items remains less than $6,000.

Example 3. Henry has an automobile repair business valued at $5,000. There are no debts on the property and bills are paid monthly. For the past 4 years the business has just broken even. Since Henry's income from the business is less then 6 percent of his equity, the entire $5,000 is counted as his resources. Since this exceeds the resources limit as described in §416.1205, he is not eligible for SSI benefits.

(b) *Exception.* Property that represents the authority granted by a governmental agency to engage in an income-producing activity is excluded as property essential to self-support if it is:

(1) Used in a trade or business or nonbusiness income-producing activity; or

(2) Not used due to circumstances beyond the individual's control, e.g., illness, and there is a reasonable expectation that the use will resume.

Example John owns a commercial fishing permit granted by the State Commerce Commission, a boat, and fishing tackle. The boat and tackle have an equity value of $6,500. Last year, John earned $2,000 from his fishing business. The value of the fishing permit is not detemined because the permit is excluded under the exception. The boat and tackle are producing in excess of a 6 percent return on the excluded equity value, so they are excluded under the general rule (see

paragraph (a) of this section) up to $6,000. The $500 excess value is counted toward the resource limit as described in § 416.1205.

[50 FR 42687, Oct. 22, 1985]

§ 416.1224 How nonbusiness property used to produce goods or services essential to self-support is counted.

Nonbusiness property is considered to be essential for an individual's (and spouse, if any) self-support if it is used to produce goods or services necessary for his or her daily activities. This type of property includes real property such as land which is used to produce vegetables or livestock only for personal consumption in the individual's household (for example, corn, tomatoes, chicken, cattle). This type of property also includes personal property necessary to perform daily functions exclusive of passenger cars, trucks, boats, or other special vehicles. (See § 416.1218 for a discussion on how automobiles are counted.) Property used to produce goods or services or property necessary to perform daily functions is excluded if the individual's equity in the property does not exceed $6,000. Personal property which is required by the individual's employer for work is not counted, regardless of value, while the individual is employed. Examples of this type of personal property include tools, safety equipment, uniforms and similar items.

Example Bill owns a small unimproved lot several blocks from his home. He uses the lot, which is valued at $4,800, to grow vegetables and fruit only for his own consumption. Since his equity in the property is less than $6,000, the property is excluded as necessary to self-support.

[50 FR 42687, Oct. 22, 1985]

§ 416.1225 An approved plan for self-support; general.

If the individual is blind or disabled, resources will not be counted that are identified as necessary to fulfill a plan for achieving self-support which is in writing, has been approved by the Social Security Administration and is being pursued by the individual.

[50 FR 42688, Oct. 22, 1985]

§ 416.1226 What a plan to achieve self-support is.

A plan to achieve self-support must—

(a) Be designed especially for the individual;

(b) Be in writing;

(c) Be approved by the Social Security Administration (a change of plan must also be approved);

(d) Be designed for an initial period of not more than 18 months. The period may be extended for up to another 18 months if the individual cannot complete the plan in the first 18-month period. A total of up to 48 months may be allowed to fulfill a plan for a lengthy education or training program designed to make the individual self-supporting;

(e) Show the individual's specific occupational goal;

(f) Show what resources the individual has or will receive for purposes of the plan and how he or she will use them to attain his or her occupational goal; and

(g) Show how the resources the individual set aside under the plan will be kept identifiable from his or her other funds.

[50 FR 42688, Oct. 22, 1985]

§ 416.1227 When the resources excluded under a plan to achieve self-support begin to count.

The resources that were excluded under the individual's plan will begin to be counted as of the first day of the month following the month in which any of these circumstances occur:

(a) Failing to follow the conditions of the plan:

(b) Abandoning the plan;

(c) Completing the time schedule outlined in the plan; or

(d) Reaching the goal as outlined in the plan.

[50 FR 42688, Oct. 22, 1985]

§ 416.1228 Exclusion of Alaskan natives' stock in regional or village corporations.

(a) In determining the resources of a native of Alaska (and spouse, if any) there will be excluded from resources, shares of stock held in a regional or village corporation during the period of 20 years in which such stock is inalienable, as provided by sections 7(h) and 8(c) of the Alaska Native Claims Settlement Act (43 U.S.C. 1606, 1607). The 20-year period of inalienability terminates on January 1, 1992.

(b) As used in this section, *native of Alaska* has the same meaning as that contained in section 3(b) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(b)).

§ 416.1229 Exclusion of payments received as compensation for expenses incurred or losses suffered as a result of a crime.

(a) In determining the resources of an individual (and spouse, if any), any amount received from a fund established by a State to aid victims of crime is excluded from resources for a period of 9 months beginning with the month following the month of receipt.

(b) To be excluded from resources under this section, the individual (or spouse) must demonstrate that any amount received was compensation for expenses incurred or losses suffered as the result of a crime.

[61 FR 1712, Jan. 23, 1996]

§ 416.1230 Exclusion of life insurance.

(a) *General.* In determining the resources of an individual (and spouse, if any), life insurance owned by the individual (and spouse, if any) will be considered to the extent of its cash surrender value. If, however, the total face value of all life insurance policies on any person does not exceed $1,500, no part of the cash surrender value of such life insurance will be taken into account in determining the resources of the individual (and spouse, if any). In determining the face value of life insurance on the individual (and spouse, if any), term insurance and burial insurance will not be taken into account.

(b) *Definitions*—(1) *Life insurance.* Life insurance is a contract under which the insurer agrees to pay a specified amount upon the death of the insured.

(2) *Insurer.* The insurer is the company or association which contracts with the owner of the insurance.

(3) *Insured.* The insured is the person upon whose life insurance is effected.

(4) *Owner.* The owner is the person who has the right to change the policy. This is normally the person who pays the premiums.

(5) *Term insurance.* Term insurance is a form of life insurance having no cash surrender value and generally furnishing insurance protection for only a specified or limited period of time.

(6) *Face value.* Face value is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or under other special provisions.

(7) *Cash surrender value.* Cash surrender value is the amount which the insurer will pay (usually to the owner) upon cancellation of the policy before death of the insured or before maturity of the policy.

(8) *Burial insurance.* Burial insurance is insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured.

§ 416.1231 Burial spaces and certain funds set aside for burial expenses.

(a) *Burial spaces*—(1) *General.* In determining the resources of an individual, the value of burial spaces for the individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources.

(2) *Burial spaces defined.* For purposes of this section ''burial spaces'' include burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

(3) *An agreement representing the purchase of a burial space.* The value of an agreement representing the purchase of a burial space, including any accumulated interest, will be excluded from resources. We do not consider a burial space ''held for'' an individual under an agreement unless the individual currently owns and is currently entitled to the use of the space under that agreement. For example, we will not consider a burial space ''held for'' an individual under an installment sales agreement or other similar device under which the individual does not

currently own nor currently have the right to use the space, nor is the seller currently obligated to provide the space, until the purchase amount is paid in full.

(4) *Immediate family defined.* For purposes of this section *immediate family* means an individual's minor and adult children, including adopted children and step-children; an individual's brothers, sisters, parents, adoptive parents, and the spouses of those individuals. Neither dependency nor living-in-the-same-household will be a factor in determining whether a person is an immediate family member.

(b) *Funds set aside for burial expenses.* (1) *Exclusion.* In determining the resources of an individual (and spouse, if any) there shall be excluded an amount not in excess of $1,500 each of funds specifically set aside for the burial expenses of the individual or the individual's spouse. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual (or spouse) and are clearly designated as set aside for the individual's (or spouse's) burial expenses. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds. This exclusion is in addition to the burial space exclusion.

(2) *Exception for parental deeming situations.* If an individual is an eligible child, the burial funds (up to $1,500) that are set aside for the burial arrangements of the eligible child's ineligible parent or parent's spouse will not be counted in determining the resources of such eligible child.

(3) *Burial funds defined.* For purposes of this section ''burial funds'' are revocable burial contracts, burial trusts, other burial arrangements (including amounts paid on installment sales contracts for burial spaces), cash, accounts, or other financial instruments with a definite cash value clearly designated for the individual's (or spouse's, if any) burial expenses and kept separate from nonburial-related assets. Property other than listed in this definition will not be considered ''burial funds.''

(4) *Recipients currently receiving SSI benefits.* Recipients currently eligible as of July 11, 1990, who have had burial funds excluded which do not meet all of the requirements of paragraphs (b) (1) and (3) of this section must convert or separate such funds to meet these requirements unless there is an impediment to such conversion or separation; i.e., a circumstance beyond an individual's control which makes conversion/separation impossible or impracticable. For so long as such an impediment or circumstance exists, the burial funds will be excluded if the individual remains otherwise continuously eligible for the exclusion.

(5) *Reductions.* Each person's (as described in §§416.1231(b)(1) and 416.1231(b)(2)) $1,500 exclusion must be reduced by:

(i) The face value of insurance policies on the life of an individual owned by the individual or spouse (if any) if the cash surrender value of those policies has been excluded from resources as provided in §416.1230; and

(ii) Amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial expenses.

(6) *Irrevocable trust or other irrevocable arrangement.* Funds in an irrevocable trust or other irrevocable arrangement which are available for burial are funds which are held in an irrevocable burial contract, an irrevocable burial trust, or an amount in an irrevocable trust which is specifically identified as available for burial expenses.

(7) *Increase in value of burial funds.* Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which occur beginning November 1, 1982, or the date of first SSI eligibility, whichever is later, are excluded from resources if left to accumulate and become part of the separate burial fund.

(8) *Burial funds used for some other purpose.* (i) Excluded burial funds must be used solely for that purpose.

(ii) If any excluded funds are used for a purpose other than the burial arrangements of the individual or the individual's spouse for whom the funds were set aside, future SSI benefits of the individual (or the individual and eligible spouse) will be reduced by an amount equal to the amount of excluded burial funds used for another

purpose. This penalty for use of excluded burial funds for a purpose other than the burial arrangements of the individual (or spouse) will apply only if, as of the first moment of the month of use, the individual would have had resources in excess of the limit specified in §416.1205 without application of the exclusion.

(9) *Extension of burial fund exclusion during suspension.* The exclusion of burial funds and accumulated interest and appreciation will continue to apply throughout a period of suspension as described in §416.1321, so long as the individual's eligibility has not been terminated as described in §§416.1331 through 416.1335.

[48 FR 57127, Dec. 28, 1983, as amended at 55 FR 28377, July 11, 1990; 57 FR 1384, Jan. 14, 1992]

§416.1232 Replacement of lost, damaged, or stolen excluded resources.

(a) Cash (including any interest earned on the cash) or in-kind replacement received from any source for purposes of repairing or replacing an excluded resource (as defined in §416.1210) that is lost, damaged, or stolen is excluded as a resource. This exclusion applies if the cash (and the interest) is used to repair or replace the excluded resource within 9 months of the date the individual received the cash. Any of the cash (and interest) that is not used to repair or replace the excluded resource will be counted as a resource beginning with the month after the 9-month period expires.

(b) The initial 9-month time period will be extended for a reasonable period up to an additional 9 months where we find the individual had good cause for not replacing or repairing the resource. An individual will be found to have good cause when circumstances beyond his or her control prevented the repair or replacement or the contracting for the repair or replacement of the resource. The 9-month extension can only be granted if the individual intends to use the cash or in-kind replacement items to repair or replace the lost, stolen, or damaged excluded resource in addition to having good cause for not having done so. If good cause is found for an individual, any unused cash (and interest) is counted as a resource beginning with the month after the good cause extension period expires. *Exception: For victims of Hurricane Andrew only,* the extension period for good cause may be extended for up to an additional 12 months beyond the 9-month extension when we find that the individual had good cause for not replacing or repairing an excluded resource within the 9-month extension.

(c) The time period described in paragraph (b) of this section (except the time period for individuals granted an additional extension under the Hurricane Andrew provision) may be extended for a reasonable period up to an additional 12 months in the case of a catastrophe which is declared to be a major disaster by the President of the United States if the excluded resource is geographically located within the disaster area as defined by the Presidential order; the individual intends to repair or replace the excluded resource; and, the individual demonstrates good cause why he or she has not been able to repair or replace the excluded resource within the 18-month period.

(d) Where an extension of the time period is made for good cause and the individual changes his or her intent to repair or replace the excluded resource, funds previously held for replacement or repair will be counted as a resource effective with the month that the individual reports this change of intent.

[44 FR 15662, Mar. 15, 1979, as amended at 50 FR 48579, Nov. 26, 1985; 61 FR 5944, Feb. 15, 1996]

§416.1233 Exclusion of certain underpayments from resources.

(a) *General.* In determining the resources of an eligible individual (and spouse, if any), we will exclude, for 6 months following the month of receipt, the unspent portion of any title II or title XVI retroactive payment received on or after October 1, 1984. *Exception:* We will exclude for 9 months following the month of receipt the unspent portion of any title II of title XVI retroactive payment received during the period beginning October 1, 1987, and ending September 30, 1989. This exclusion also applies to such payments received by any other person whose resources are subject to deeming under this subpart.

(b) *Retroactive payments.* For purposes of this exclusion, a retroactive payment is one that is paid after the month in which it was due. A title XVI retroactive payment includes any retroactive amount of federally administered State supplementation.

(c) *Limitation on exclusion.* This exclusion applies only to any unspent portion of retroactive payments made under title II or XVI. Once the money from the retroactive payment is spent, this exclusion does not apply to items purchased with the money, even if the 6-month or 9-month period, whichever is applicable (see paragraph (a) of this section), has not expired. However, other exclusions may be applicable. As long as the funds from the retroactive payment are not spent, they are excluded for the full 6-month or 9-month period, whichever is applicable.

(d) *Funds must be identifiable.* Unspent money from a retroactive payment must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds but, if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount will count toward the resource limit described in § 416.1205.

(e) *Written notice.* We will give each recipient a written notice of the exclusion limitation when we make the retroactive payment.

[51 FR 34464, Sept. 29, 1986, as amended at 54 FR 19164, May 4, 1989]

§ 416.1234 Exclusion of Indian lands.

In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, we will exclude any interest of the individual (or spouse, if any) in land which is held in trust by the United States for an individual Indian or tribe, or which is held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the Federal Government.

[59 FR 8538, Feb. 23, 1994]

§ 416.1235 Exclusion of earned income tax credit.

In determining the resources of an individual (and spouse, if any), we exclude in the month following the month of receipt the unspent portion of any refund of Federal income taxes under section 32 of the Internal Revenue Code (relating to earned income tax credit) and the unspent portion of any payment from an employer under section 3507 of the Internal Revenue Code (relating to advance payment of earned income tax credit). Any unspent funds retained until the first moment of the second month following their receipt are subject to resource counting rules at that time.

[58 FR 63890, Dec. 3, 1993]

§ 416.1236 Exclusions from resources; provided by other statutes.

(a) For the purpose of § 416.1210(j), payments or benefits provided under a Federal statute other than title XVI of the Social Security Act where exclusion from resources is required by such statute include:

(1) Payments made under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636).

(2) Judgment payments to members of the Blackfeet and Gros Ventre Tribes of Indians under the provisions of Pub. L. 92–254 (86 Stat. 65, 25 U.S.C. 1264); and judgment payments distributed to, or held in trust for, members of the Grand River Band of Ottawa Indians in Indian Claims Commission docket numbered 40–K under the provisions of Pub. L. 94–540 (90 Stat. 2503).

(3) Indian judgment funds held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93–134, as amended by Public Law 97–458 (25 U.S.C. 1407). Indian judgment funds include interest and investment income accrued while the funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds. This exclusion will not

apply to proceeds from sales or conversions of initial purchases or to subsequent purchases.

(4) The value of the coupon allotment in excess of the amount paid for the coupons under the Food Stamp Act of 1964 (78 Stat. 705, as amended, 7 U.S.C. 2016(c)).

(5) The value of assistance to children under the National School Lunch Act (60 Stat. 230, 42 U.S.C. 1751 *et seq.*) as amended by Pub. L. 90–302 (82 Stat. 117, 42 U.S.C. 1761(h)(3)).

(6) The value of assistance to children under the Child Nutrition Act of 1966 (80 Stat. 889, 42 U.S.C. 1780(b)).

(7) Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education as provided by section 507 of the Higher Education Amendments of 1968, Pub. L. 90–575 (82 Stat. 1063).

(8) Incentive allowances received under title I of the Comprehensive Employment and Training Act of 1973 (87 Stat. 849, 29 U.S.C. 821(a)).

(9) Payments to volunteers under the Domestic Volunteer Service Act of 1973 as provided by section 404(g) of that act (87 Stat. 409, 42 U.S.C. 5044).

(10) Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act, as follows: cash, including cash dividends on stock received from a Native Corporation, is disregarded to the extent that it does not, in the aggregate, exceed $2,000 per individual each year (the $2,000 limit is applied separately each year, and cash distributions up to $2,000 which an individual received in a prior year and retained into subsequent years will not be counted as resources in those years); stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; a partnership interest; land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; and an interest in a settlement trust. This exclusion is pursuant to the exclusion under section 15 of the Alaska Native Claims Settlement Act Amendments of 1987, Public Law 100–241 (43 U.S.C. 1626(c)), effective February 3, 1988.

(11) Value of Federally donated foods distributed pursuant to section 32 of Pub. L. 74–320 or section 416 of the Agriculture Act of 1949 (7 CFR 250.6(e)(9) as authorized by 5 U.S.C. 301).

(12) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under Public Law 98–64. Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from resources under this exclusion. For treatment of ANRVC dividend distributions, see paragraph IV(a)(10) of this appendix.

(13) Effective October 17, 1975, pursuant to section 6 of Public Law 94–114 (89 Stat. 577, 25 U.S.C. 459e), receipts distributed to members of certain Indian tribes which are referred to in section 5 of Public Law 94–114 (89 Stat. 577, 25 U.S.C. 459d).

(14) Home energy assistance payments or allowances under the Low-Income Home Energy Assistance Act of 1981, as added by title XXVI of the Omnibus Budget Reconciliation Act of 1981, Public Law 97–35 (42 U.S.C. 8624(f)).

(15) Student financial assistance for attendance costs received from a program funded in whole or in part under title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under section 14(27) of Public Law 100–50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. 1087uu), or under Bureau of Indian Affairs student assistance programs.

(16) Funds, assets, or income under section 6(b) of the Puyallup Tribe of Indians Settlement Act of 1989, Public Law 101–41 (25 U.S.C. 1773h(c)).

(17) Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, sections 105(f) and 206(d) of Public Law 100–383 (50 U.S.C. app. 1989 b and c).

(18) Payments made on or after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under Public Law 101–201 (103 Stat. 1795) and section 10405 of Public Law 101–239 (103 Stat. 2489).

(19) Payments, funds, distributions, or income derived from them under section 8(b) of the Seneca Nation Settlement Act of 1990, Public Law 101–503 (104 Stat. 1297, 25 U.S.C. 1774f).

(20) Payments made under section 6 of the Radiation Exposure Compensation Act, Public Law 101–426 (104 Stat. 925, 42 U.S.C. 2210).

(b) In order for payments and benefits listed in paragraph (a) to be excluded from resources, such funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

[41 FR 13338, Mar. 30, 1976, as amended at 42 FR 44221, Sept. 2, 1977; 42 FR 54945, Oct. 12, 1977; 43 FR 45555, Oct. 3, 1978; 57 FR 53851, Nov. 13, 1992; 57 FR 55089, Nov. 24, 1992; 59 FR 8538, Feb. 23, 1994]

§ 416.1237 Assistance received on account of major disaster.

(a) Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States or comparable assistance received from a State or local government, or from a disaster assistance organization, is excluded in determining countable resources under § 416.1210.

(b) Interest earned on the assistance is excluded from resources.

[57 FR 53852, Nov. 13, 1992]

§ 416.1238 Exclusion of certain housing assistance.

The value of any assistance paid with respect to a dwelling under the statutes listed in § 416.1124(c)(14) is excluded from resources.

[55 FR 28378, July 11, 1990]

§ 416.1239 Exclusion of State or local relocation assistance payments.

In determining the resources of an individual (or spouse, if any), relocation assistance provided by a State or local government (as described in § 416.1124(c)(18)) is excluded from resources for a period of 9 months beginning with the month following the month of receipt.

[61 FR 1712, Jan. 23, 1996]

§ 416.1240 Disposition of resources.

(a) Where the resources of an individual (and spouse, if any) are determined to exceed the limitations prescribed in § 416.1205, such individual (and spouse, if any) shall not be eligible for payment except under the conditions provided in this section. Payment will be made to an individual (and spouse, if any) if:

(1) Total includable liquid resources (as defined in § 416.1201(b)) do not exceed one-fourth of the applicable dollar amount referenced in section 1611(b)(1) of the Act in the case of an individual and in section 1611(b)(2) in the case of an individual and spouse (as increased pursuant to section 1617 of the Act and published in the FEDERAL REGISTER pursuant to section 215(i)(2)(D)); and

(2) The individual agrees in writing to:

(i) Dispose, at current market value, of the nonliquid resources (as defined in § 416.1201(c)) in excess of the limitations prescribed in § 416.1205 within the time period specified in § 416.1242; and

(ii) Repay any overpayments (as defined in § 416.1244) with the proceeds of such disposition.

(b) Payment made for the period during which the resources are being disposed of will be conditioned upon the disposition of those resources as prescribed in paragraph (a)(2) of this section. Any payments so made are (at the time of disposition) considered overpayments to the extent they would not

have been paid had the disposition occurred at the beginning of the period for which such payments were made.

(c) If an individual fails to dispose of the resources prescribed in paragraph (a)(2) of this section, regardless of the efforts he or she makes to dispose of them, the resources will be counted at their current market value and the individual will be ineligible due to excess resources. The original estimate of current market value will be used unless the individual submits evidence establishing a lower value (e.g., an estimate from a disinterested knowledgeable source.)

[52 FR 31762, Aug. 24, 1987]

§416.1242 Time limits for disposing of resources.

(a) In order for payment conditioned on the disposition of nonliquid resources to be made, the individual must agree in writing to dispose of real property within 9 months and personal property within 3 months. The time period for disposal of property begins on the date we accept the individual's signed written agreement to dispose of the property. If we receive a signed agreement on or after the date we have determined that the individual meets the eligibility requirements described in §416.202 of this part, with the exception of the resource requirements described in this subpart, our acceptance of the written agreement will occur on the date the individual receives our written notice that the agreement is in effect. If we receive a signed agreement prior to the date we determine that all nonresource requirements are met, our acceptance of the written agreement will not occur until the date the individual receives our written notice that all nonresource requirements are met and that the agreement is in effect. When the written notice is mailed to the individual, we assume that the notice was received 5 days after the date shown on the notice unless the individual shows us that he or she did not receive it within the 5-day period.

(b) The 3-month time period for disposition of personal property will be extended an additional 3 months where it is found that the individual had ''good cause'' for failing to dispose of the resources within the original time period. The rules on the valuation of real property not disposed of within 9 months are described in §416.1245(b).

(c) An individual will be found to have ''good cause'' for failing to dispose of a resource if, despite reasonable and diligent effort on his part, he was prevented by circumstances beyond his control from disposing of the resource.

(d) In determining whether the appropriate time limits discussed in paragraphs (a) and (b) of this section have elapsed, no month will be counted for which an individual's benefits have been suspended as described in §416.1321, provided that the reason for the suspension is unrelated to the requirements in §416.1245(b) and that the individual's eligibility has not been terminated as defined in §§416.1331 through 416.1335.

[40 FR 48915, Oct. 20, 1975, as amended at 53 FR 13257, Apr. 22, 1988; 55 FR 10419, Mar. 21, 1990; 58 FR 60105, Nov. 15, 1993]

§416.1244 Treatment of proceeds from disposition of resources.

(a) Upon disposition of the resources, the net proceeds to the individual from the sale are considered available to repay that portion of the payments that would not have been made had the disposition occurred at the beginning of the period for which payment was made.

(b) The net proceeds from disposition will normally be the sales price less any encumbrance on the resource and the expenses of sale such as transfer taxes, fees, advertising costs, etc. where, however, a resource has been sold (or otherwise transferred) by an individual to a friend or relative for less than its current market value, the net proceeds will be the current market value less costs of sale and encumbrance.

(c) After deducting any amount necessary to raise the individual's (and spouse's, if any) resources to the applicable limits described in §416.1205, as of the beginning of the disposition period, the balance of the net proceeds will be used to recover the payments made to the individual (and spouse, if any). Any remaining proceeds are considered liquid resources.

(d) The overpayment to be recovered is equal to the balance of the net proceeds (as described in paragraph (c) of this section) or the total payments made to the individual (and spouse, if any) for the period of disposition, whichever is less.

[40 FR 48915, Oct. 20, 1975, as amended at 50 FR 38982, Sept. 28, 1985]

§ 416.1245 Exceptions to required disposition of real property.

(a) *Loss of housing for joint owner.* Excess real property which would be a resource under § 416.1201 is not a countable resource for conditional benefit purposes when: it is jointly owned; and sale of the property by an individual would cause the other owner undue hardship due to loss of housing. Undue hardship would result when the property serves as the principal place of residence for one (or more) of the other owners, sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner (e.g., the other owner does not own another house that is legally available for occupancy). However, if undue hardship ceases to exist, its value will be included in countable resources as described in § 416.1207.

(b) *Reasonable efforts to sell.* (1) Excess real property is not included in countable resources for so long as the individual's reasonable efforts to sell it have been unsuccessful. The basis for determining whether efforts to sell are reasonable, as well as unsuccessful, will be a 9-month conditional benefits period described in § 416.1242. If it is determined that reasonable efforts to sell have been unsuccessful, further SSI payments will not be conditioned on the disposition of the property and only the 9 months of conditional benefits will be subject to recovery. In order to be eligible for payments after the conditional benefits period, the individual must continue to make reasonable efforts to sell.

(2) A conditional benefits period involving excess real property begins as described at § 416.1242(a). The conditional benefits period ends at the earliest of the following times:

(i) Sale of the property;

(ii) Lack of continued reasonable efforts to sell;

(iii) The individual's written request for cancellation of the agreement;

(iv) Countable resources, even without the conditional exclusion, fall below the applicable limit (e.g., liquid resources have been depleted); or

(v) The 9 months of conditional benefits have been paid.

(3) Reasonable efforts to sell property consist of taking all necessary steps to sell it in the geographic area covered by the media serving the area in which the property is located, unless the individual has good cause for not taking these steps. More specifically, making a reasonable effort to sell means that:

(i) Except for gaps of no more than 1 week, an individual must attempt to sell the property by listing it with a real estate agent or by undertaking to sell it himself;

(ii) Within 30 days of signing a conditional benefits agreement, and absent good cause for not doing so, the individual must:

(A) List the property with an agent; or

(B) Begin to advertise it in at least one of the appropriate local media, place a ''For Sale'' sign on the property (if permitted), begin to conduct ''open houses'' or otherwise show the property to interested parties on a continuous basis, and attempt any other appropriate methods of sale; and

(iii) The individual accepts any reasonable offer to buy and has the burden of demonstrating that an offer was rejected because it was not reasonable. If the individual receives an offer that is at least two-thirds of the latest estimate of current market value, the individual must present evidence to establish that the offer was unreasonable and was rejected.

(4) An individual will be found to have ''good cause'' for failing to make reasonable efforts to sell under paragraph (b)(3) of this section if he or she was prevented by circumstances beyond his or her control from taking the steps specified in paragraph (b)(3) (i) through (ii) of this section.

(5) An individual who has received 9 months of conditional benefits and whose benefits have been suspended as

described at §416.1321 for reasons unrelated to the property excluded under the conditional benefits agreement, but whose eligibility has not been terminated as defined at §§416.1331 through 416.1335, can continue to have the excess real property not included in countable resources upon reinstatement of SSI payments if reasonable efforts to sell the property resume within 1 week of reinstatement. Such an individual will not have to go through a subsequent conditional benefits period. However, the individual whose eligibility has been terminated as defined as §§416.1331 through 416.1335 and who subsequently reapplies would be subject to a new conditional benefits period if there is still excess real property.

[55 FR 10419, Mar. 21, 1990]

§416.1246 Disposal of resources at less than fair market value.

(a) *General.* (1) An individual (or eligible spouse) who gives away or sells a nonexcluded resource for less than fair market value for the purpose of establishing SSI or Medicaid eligibility will be charged with the difference between the fair market value of the resource and the amount of compensation received. The difference is referred to as uncompensated value and is counted toward the resource limit (see §416.1205) for a period of 24 months from the date of transfer.

(2) If the transferred resource (asset) is returned to the individual, the uncompensated value is no longer counted as of the date of return. If the transferred asset is cash, the uncompensated value is reduced as of the date of return by the amount of cash that is returned. No income will be charged as a result of such returns. The returned asset will be evaluated as a resource according to the rules described in §§416.1201 through 416.1230 as of the first day of the following month.

(3) If the individual receives additional compensation in the form of cash for the transferred asset the uncompensated value is reduced, as of the date the additional cash compensation is received, by the amount of that additional compensation.

(b) *Fair market value.* Fair market value is equal to the current market value of a resource at the time of transfer or contract of sale, if earlier. See §416.1101 for definition of current market value.

(c) *Compensation.* The compensation for a resource includes all money, real or personal property, food, shelter, or services received by the individual (or eligible spouse) at or after the time of transfer in exchange for the resource if the compensation was provided pursuant to a binding (legally enforceable) agreement in effect at the time of transfer. Compensation also includes all money, real or personal property, food, shelter, or services received prior to the actual transfer if they were provided pursuant to a binding (legally enforceable) agreement whereby the eligible individual would transfer the resource or otherwise pay for such items. In addition, payment or assumption of a legal debt owed by the eligible individual in exchange for the asset is considered compensation.

(d)(1) *Uncompensated value—General.* The uncompensated value is the fair market value of a resource at the time of transfer minus the amount of compensation received by the individual (or eligible spouse) in exchange for the resource. However, if the transferred resource was partially excluded, we will not count uncompensated value in an amount greater than the countable value of the resources at the time of transfer.

(2) *Suspension of counting as a resource the uncompensated value where necessary to avoid undue hardship.* We will suspend counting as a resource the uncompensated value of the transferred asset for any month in the 24-month period if such counting will result in undue hardship. We will resume counting the uncompensated value as a resource for any month of the 24-month period in which counting will not result in undue hardship. We will treat as part of the 24-month period any months during which we suspend the counting of uncompensated value.

(3) *When undue hardship exists.* Undue hardship exists when:

(i) An individual alleges that failure to receive SSI benefits would deprive the individual of food or shelter; and

(ii) The applicable Federal benefit rate (plus the federally-administered

State supplementary payment level) exceeds the sum of: The individual's monthly countable and excludable income and monthly countable and excludable liquid resources.

(e) *Presumption that resource was transferred to establish SSI or Medicaid eligibility.* Transfer of a resource for less than fair market value is presumed to have been made for the purpose of establishing SSI or Medicaid eligibility unless the individual (or eligible spouse) furnishes convincing evidence that the resource was transferred exclusively for some other reason. Convincing evidence may be pertinent documentary or non-documentary evidence which shows, for example, that the transfer was ordered by a court, or that at the time of transfer the individual could not have anticipated becoming eligible due to the existence of other circumstances which would have precluded eligibility. The burden of rebutting the presumption that a resource was transferrred to establish SSI or Medicaid eligibility rests with the individual (or eligible spouse).

(f) *Applicability.* This section applies only to transfers of resources that occurred before July 1, 1988. Paragraphs (d)(2) and (d)(3) of this section, regarding undue hardship, are effective for such transfers on or after April 1, 1988.

[48 FR 40885, Sept. 12, 1983, as amended at 50 FR 38982, Sept. 26, 1985; 53 FR 13257, Apr. 22, 1988; 55 FR 10419, Mar. 21, 1990]

§ 416.1260 Special resource provision for recipients under a State plan.

(a) *General.* In the case of any individual (or individual and spouse, as the case may be) who for the month of December 1973 was a recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI, of the Act (see § 416.121), the resources of such individual (or individual and spouse, as the case may be) shall be deemed not to exceed the amount specified in § 416.1205 during any period that the resources of such individual (or individual and spouse, as the case may be) do not exceed the maximum amount of resources specified in such State plan as in effect in October 1972, provided that such individual:

(1) Has, since December 1973, resided continuously in the State under whose plan he was eligible for the month of December 1973; and

(2) Has not, since December 1973, been ineligible for an SSI benefit for a period exceeding 6 consecutive months. An SSI benefit means a Federal benefit only; it does not include any State supplementation.

(b) For purposes of this section, an individual will cease to reside continuously in a State if he leaves the State with the present intention to abandon his home there. In the absence of evidence to the contrary,

(1) If an individual leaves the State for a period of 90 calendar days or less, his absence from the State will be considered temporary and he will be considered to continue to reside in such State; and

(2) If an individual leaves the State for a period in excess of 90 calendar days, he will no longer be considered to reside continuously in such State.

(c) *State plan; defined.* As used in this subpart, *an approved State plan as in effect in October 1972* and *State plan for October 1972* means a State plan as approved under the provisions of 45 CFR Ch. II as in effect in October 1972.

[41 FR 47424, Oct. 29, 1976, as amended at 52 FR 29841, Aug. 12, 1987]

§ 416.1261 Application of special resource provision.

In determining the resources of an individual (and spouse, if any) who meets the conditions specified in § 416.1260(a), either the State plan resource limit and exclusions (as specified in § 416.1260) or the resource limit (as specified in § 416.1205) and exclusions (as specified in § 416.1210), whichever is most advantageous to the individual (and spouse, if any) will be used.

§ 416.1262 Special resource provision applicable in cases involving essential persons.

(a) *Essential persons continuously meet criteria of eligibility.* In determining the resources of an individual (and spouse, if any) who meet the conditions specified in § 416.1260 and whose payment standard is increased because such individual has in his home an essential person (as defined in § 416.222), either

the State plan resource limit and exclusions (as specified in §416.1260) applicable to cases in which the needs of an essential person are taken into account in determining the individual's needs, or the resource limit as specified in §416.1205 and exclusions as specified in §416.1210, whichever is most advantageous to the individual (and spouse), will be used.

(b) *Essential person fails to meet criteria of eligibility*. If for any month after December 1973 a person fails to meet the criteria for an essential person as specified in §416.222, in determining the resources of an individual (and spouse, if any) either the State plan resource limit and criteria as specified in §416.1260 applicable to the individual or individual and spouse, as the case may be, or the resource limit as specified in §416.1205 and exclusions as specified in §416.1210, whichever is most advantageous to the individual (and spouse), will be used.

[39 FR 33797, Sept. 20, 1974, as amended at 51 FR 10616, Mar. 28, 1986]

§416.1264 Spouse ineligible under a State plan in December 1973.

In the case of an individual who meets the conditions specified in §416.1260 but whose spouse does not meet such conditions, whichever of the following is most advantageous for the individual (and spouse, if any) will be applied:

(a) The resource limitation and exclusions for an individual as in effect under the approved State plan for October 1972, or

(b) The resource limitation (as specified in §416.1205) and exclusions (as specified in §416.1210) for an individual and eligible spouse or an individual living with an ineligible spouse.

§416.1266 Individual under special resource provision dies after December 1973.

Where only one person, either the eligible individual or the eligible spouse, meets the conditions specified in §416.1260 and that person dies after December 1973, the State plan resource limitation and exclusions will not be applied to determine the amount of resources of the surviving individual. The resource limitation (as specified in §416.1205) and exclusions (as specified in §416.1210) will be applied for the now eligible individual beginning with the month such person is considered the eligible individual as defined in subpart A of this part.

Subpart M—Suspensions and Terminations

AUTHORITY: Secs. 702(a)(5), 1611–1615, 1619, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1382–1382d, 1382h, and 1383).

SOURCE: 40 FR 1510, Jan. 8, 1975, unless otherwise noted.

§416.1321 Suspensions; general.

(a) *When suspension is proper*. Suspension of benefit payments is required when a recipient is alive but no longer meets the requirements of eligibility under title XVI of the Act (see subpart B of this part) and termination in accordance with §§416.1331 through 416.1335 does not apply. (This subpart does not cover suspension of payments for administrative reasons, as, for example, when mail is returned as undeliverable by the Postal Service and the Administration does not have a valid mailing address for a recipient or when the representative payee dies and a search is underway for a substitute representative payee.)

(b) *Effect of suspension*. (1) When payments are correctly suspended due to the ineligibility of a recipient, payments shall not be resumed until the individual again meets all requirements for eligibility except the filing of a new application. Such recipient, upon requesting reinstatement, shall be required to submit such evidence as may be necessary (except evidence of age, disability, or blindness) to establish that he or she again meets all requirements for eligibility under this part. Payments to such recipient shall be reinstated effective with the first day such recipient meets all requirements for eligibility except the filing of a new application.

(2) A month of ineligibility for purposes of determining when to prorate the SSI benefit payment for a subsequent month, is a month for which the individual is ineligible for any Federal SSI benefit and any federally administered State supplementation.

(c) *Actions which are not suspensions.* Payments are not ''suspended,'' but the claim is disallowed, when it is found that:

(1) The claimant was notified in accordance with § 416.210(c) at or about the time he filed application and before he received payment of a benefit that he should file a claim for a payment of the type discussed in § 416.1330 and such claimant has failed, without good cause (see § 416.210(e)(2)), to take all appropriate steps within 30 days after receipt of such notice to file and prosecute an application for such payment;

(2) Upon initial application, payment of benefits was conditioned upon disposal of specified resources which exceeded the permitted amount and the claimant did not comply with the agreed-upon conditions;

(3) Payment was made to an individual faced with a financial emergency who was later found to have been not eligible for payment; or

(4) Payment was made to an individual presumed to be disabled and such disability is not established.

(d) *Exception.* Even though conditions described in paragraph (a) of this section apply because your impairment is no longer disabling, we will not suspend your benefits if after November 1980:

(1) 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;

(2) Your disability did not end before December 1, 1980; and

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

[40 FR 1510, Jan. 8, 1975, and 47 FR 31544, July 21, 1982; 47 FR 52693, Nov. 23, 1982, as amended at 51 FR 13494, Apr. 21, 1986; 51 FR 17618, May 14, 1986; 56 FR 55453, Oct. 28, 1991]

§ 416.1322 Suspension due to failure to comply with request for information.

(a) Suspension of benefit payments is required effective with the month following the month in which it is determined in accordance with § 416.714(b) that the individual is ineligible for payment due to his or her failure to comply with our request for necessary information. When we have information to establish that benefit payments are again payable, the benefit payments will be reinstated for any previous month for which the individual continued to meet the eligibility requirements of § 416.202. If the reason that an individual's benefits were suspended was failure to comply with our request for information, the payments for the months that benefits are reinstated will not be prorated under § 416.421.

(b) A suspension of payment for failure to comply with our request for information will not apply with respect to any month for which a determination as to eligibility for or amount of payment can be made based on information on record, whether or not furnished by an individual specified in § 416.704(a). Where it is determined that the information of record does not permit a determination with respect to eligibility for or amount of payment, notice of a suspension of payment due to a recipient's failure to comply with a request for information will be sent in accordance with §§ 416.1336 and 416.1404.

[51 FR 13494, Apr. 21, 1986]

§ 416.1323 Suspension due to excess income.

(a) *Effective date.* Suspension of payments due to ineligibility for benefits because of excess income is effective with the first month in which ''countable income'' (see § 416.1115) equals or exceeds the amount of benefits otherwise payable for such month (see subpart D of this part). This rule applies regardless of the month in which the income is received.

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the first month in which a recipient's monthly countable

income becomes less than the applicable Federal benefit rate (or the sum of that rate and the level for any federally administered State supplementary payment) for that month. If the reason that a recipient's benefits were suspended was excess income, the payment for the first month that benefits are reinstated will not be prorated under §416.421.

[40 FR 1510, Jan. 8, 1975, as amended at 51 FR 13494, Apr. 21, 1986]

§416.1324 Suspension due to excess resources.

(a) *Effective date.* Except as specified in §§416.1240 through 416.1242, suspension of benefit payments because of excess resources is required effective with the month in which:

(1) Ineligibility exists because countable resources are in excess of:

(i) The resource limits prescribed in §416.1205 for an individual and an individual and spouse, or

(ii) In the case of an eligible individual (and eligible spouse, if any) who for the month of December 1973 was a recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI of the Act, the maximum amount of resources specified in such State plan as in effect for October 1972, if greater than the amounts specified in §416.1205, as applicable; or

(2) After eligibility has been established, payment of benefits was conditioned upon disposal of specified resources, which exceeded the permitted amount and the claimant did not comply with the agreed upon conditions.

(3) The amount of an individual's or couple's countable resources is determined as of the first moment of each calendar quarter.

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the start of the month after the month in which a recipient's countable resources no longer exceed the limit that applies. If the reason that a recipient's benefits were suspended was excess resources, the payment for the first month that benefits are reinstated will not be prorated under §416.421.

[40 FR 1510, Jan. 8, 1975, as amended at 50 FR 38982, Sept. 26, 1985; 51 FR 13494, Apr. 21, 1986]

§416.1325 Suspension due to status as a resident of a public institution.

(a) Except as provided in §416.211(b) and (c), a recipient is ineligible for benefits for the first full calendar month in which he or she is a resident of a public institution (as defined in §416.201) throughout the calendar month (as defined in §416.211(a)), and payments are suspended effective with such first full month. Such ineligibility continues for so long as such individual remains a resident of a public institution.

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the earliest day of the month in which a recipient is no longer a resident of a public institution. See §416.421. A transfer from one public institution to another or a temporary absence from the institution lasting 14 days or less, however, will not change his or her status as a resident, and the suspension will continue.

[51 FR 13494, Apr. 21, 1986]

416.1326 Suspension for failure to comply with treatment for drug addiction or alcoholism.

(a) *Basis for suspension.* If you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability as described in §416.935, we will refer you to appropriate treatment as defined in §416.937. You will not be an eligible individual and we will suspend your benefits if you do not comply with the terms, conditions and requirements of treatment prescribed by the institution or facility. (See §416.940 which explains how we evaluate compliance with treatment.)

(b) *Date of suspension.* We will suspend your benefits for a period starting with the first month after we notify you in writing that you failed to comply with prescribed treatment.

(c) *Resumption of benefits.* If you are complying with prescribed treatment and are otherwise eligible for benefits, we will resume benefits effective with the first day of the month after you demonstrate and maintain compliance with appropriate treatment for these periods—

(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.

[60 FR 8152, Feb. 10, 1995]

§ 416.1327 Suspension due to absence from the United States.

(a) *Suspension effective date.* A recipient is not eligible for SSI benefits if he is outside the United States for a full calendar month. For purposes of this paragraph—

(1) *United States* means the 50 States, the District of Columbia, and the Northern Mariana Islands:

(2) *Day* means a full 24–hour day; and

(3) In determining whether a recipient has been outside the United States for a full calendar month, it must be established whether the recipient is outside the United States for 30 consecutive days or more. If yes, he or she will be treated as remaining outside the United States until he or she has returned to and remained in the United States for a period of 30 consecutive days. When a recipient has been outside the United States, the first period of 30 consecutive days of absence is counted beginning with the day after the day the recipient departs from the United States and ending with the day before the day on which he or she returns to the United States. When a recipient has returned to the United States, the second period of 30 consecutive days starts on the day the individual returned and ends on the 30th day of continuous presence in the United States. Benefits will be suspended effective with the first full calendar month in which a recipient is outside the United States.

(b) *Resumption of payments after absence from the United States.* If benefits are otherwise payable they will be resumed—

(1) Effective with the day following the 30th day of continuous presence in the United States after the recipient's return if the absence was for 30 consecutive days or more.

(2) Effective with the day the recipient returned to the United States, if the absence from the United States was for a full calendar month, but for less than 30 consecutive days (this can occur only for the calendar month of February).

Example 1: Mike left the United States on March 1 and returned on April 1. Counting March 2 through March 31, he was outside the United States for 30 consecutive days; thus he is also deemed to be outside the United States for 30 additional consecutive days. Therefore, for April 1 through April 30, he is deemed to be outside the United States and not eligible for the calendar month of April. Payments start effective May 1.

Example 2: Mary left the United States on April 15 and returned on July 1. Counting April 16 through June 30, she was actually outside the United States and not eligible for the calendar months of May and June. Since she was absent for more than 30 consecutive days, she is deemed to be outside the United States for 30 additional consecutive days. Therefore, for July 1 through July 30, she is deemed to be outside the United States and not eligible for payment until July 31.

[51 FR 13494, Apr. 21, 1986; 51 FR 17332, May 12, 1986]

§ 416.1328 Suspension due to refusal to accept vocational rehabilitation services.

(a) *Suspension effective date.* A recipient who is paid on account of blindness or disability is ineligible for benefits for the first month, and his payments are subject to suspension effective with such first month, in which he refuses, without good cause, to accept appropriate vocational rehabilitation services (see subpart Q of this part).

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the earliest day of the month on which the recipient no longer refuses without good cause to accept vocational rehabilitation services. See § 416.421.

[40 FR 1510, Jan. 8, 1975, as amended at 51 FR 13495, Apr. 21, 1986]

§ 416.1329 Suspension due to loss of United States residency, United States citizenship, or status as an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(a) A recipient ceases to be an eligible individual or eligible spouse, under section 1614(a)(1)(B) of the Act, when he or she ceases to meet the requirement of § 416.202(b) with respect to United

States residency, United States citizenship, or status as an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payments are suspended effective with the first month after the last month in which a recipient meets the requirements of § 416.202(b).

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the earliest day of the month on which the recipient again meets both the residence and citizenship or lawfully admitted alien or color of law requirements. See § 416.421.

[51 FR 13495, Apr. 21, 1986]

§ 416.1330 Suspension due to failure to apply for and obtain other benefits.

(a) *Suspension effective date.* A recipient ceases to be an eligible individual or eligible spouse when, in the absence of a showing of incapacity to do so, or other good cause, he or she fails within 30 days after notice from the Social Security Administration of probable eligibility, to take all appropriate steps to apply for and, if eligible, to obtain payments such as an annuity, pension, retirement, or disability benefit, including veterans' compensation, old-age, survivors, and disability insurance benefit, railroad retirement annuity or pension, or unemployment insurance benefit. Benefit payments are suspended due to such ineligibility effective with the month in which the recipient was notified in writing of the requirement that he or she file and take all appropriate steps to receive the other benefits. See § 416.210(e).

(b) *Resumption of payment.* If benefits are otherwise payable, they will be resumed effective with the earliest day of the month on which the recipient takes the necessary steps to obtain the other benefits. See § 416.421.

[51 FR 13495, Apr. 21, 1986]

§ 416.1331 Termination of your disability or blindness payments.

(a) *General.* The last month for which we can pay you benefits based on disability is the earlier of the second month after the first month in which you are able to do substantial gainful activity following a trial work period (described in § 416.992), or the second month after the first month in which you are determined to no longer have a disabling impairment (described in § 416.911). (See § 416.1338 for an exception to this rule if you are participating in an appropriate vocational rehabilitation program, and § 416.261 for an explanation of special benefits to which you may be entitled.) However, benefits may be resumed during the reentitlement period (described in § 416.992a) under certain circumstances. If you have a disabling impairment, you will receive benefits based on disability for any month in which you do not do substantial gainful activity in the reentitlement period and if we determine that you are not able to do substantial gainful activity in the first month following the reentitlement period, we will pay you benefits after the reentitlement period until you are able to do substantial gainful activity. These payments will stop with the earlier of the month before the first month in which you do substantial gainful activity or the month before the month in which you are determined to no longer have a disabling impairment. The last month for which we can pay you benefits based on blindness is the second month after the month in which your blindness ends (see § 416.986 for when blindness ends). You must meet the income, resources, and other eligibility requirements to receive any of the benefits described in this paragraph. We will also stop payment of your benefits if you have not cooperated with us in getting information about your disability or blindness.

(b) *After we make a determination that you are not now disabled.* If we determine that you do not meet the disability requirements of the law, we will send you an advance written notice telling you why we believe you are not disabled and when your benefits should stop. The notice will explain your right to appeal if you disagree with our determination. You may still appeal our determination that you are not now disabled even though your payments are continuing because of your participation in an appropriate vocational rehabilitation program. You may also appeal a determination that your completion of or 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.

(c) *When benefits terminate due to 12 consecutive suspension months for failure to comply with treatment for drug addiction or alcoholism.* If you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 416.935, your benefits will terminate after 12 consecutive months of suspension for noncompliance with treatment requirements as described in § 416.1326.

(d) *When benefits terminate due to payment of 36 months of benefits based on disability when drug addiction or alcoholism is a contributing factor material to the determination of disability.* If you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 416.935, your benefits will terminate after you receive a total of 36 months of SSI benefits. The 36-month limit is no longer effective for benefits for months beginning after September 2004.

(e) *Months we count in determining the 36 months of benefits when drug addiction or alcoholism is a contributing factor material to the determination of disability.* Beginning March 1995, we will count all months for which you were paid an SSI benefit, a federally-administered State supplement, a special SSI cash benefit, or you were in special SSI eligibility status, toward the 36 months described in paragraph (d) of this section. Months for which you were not eligible for benefits will not count toward the 36 months.

[49 FR 22274, May 29, 1984, as amended at 60 FR 8152, Feb. 10, 1995]

§ 416.1332 Termination of benefit for disabled individual: Exception.

Special SSI cash benefits (see § 416.261) will be payable for the period beginning January 1, 1981, and ending June 30, 1987 if you meet eligibility requirements in § 416.262. These requirements apply if you, as a disabled recipient, are no longer eligible for regular SSI benefits because you demonstrate that you are able to engage in SGA.

[47 FR 15325, Apr. 9, 1982, as amended at 50 FR 46763, Nov. 13, 1985]

§ 416.1333 Termination at the request of the recipient.

A recipient, his legal guardian, or his representative payee, may terminate his eligibility for benefits under this part by filing a written request for termination which shows an understanding that such termination may extend to other benefits resulting from eligibility under this part. In the case of a representative payee there must also be a showing which establishes that no hardship would result if an eligible recipient were not covered by the supplemental security income program. When such a request is filed, the recipient ceases to be an eligible individual, or eligible spouse, effective with the month following the month the request is filed with the Social Security Administration unless the recipient specifies some other month. However, the Social Security Administration will not effectuate the request for any month for which payment has been or will be made unless there is repayment, or assurance of repayment, of any amounts paid for those months (e.g., from special payments which would be payable for such months under section 228 of the Act). When the Social Security Administration effectuates a termination of eligibility at the request of the recipient, his legal guardian, or his representative payee, notice of the determination will be sent in accordance with § 416.1404, and eligibility, once terminated, can be reestablished, except as provided by § 416.1408, only upon the filing of a new application.

[42 FR 39100, Aug. 2, 1977]

§ 416.1334 Termination due to death of recipient.

Eligibility for benefits ends with the month in which the recipient dies. Payments are terminated effective with the month after the month of death.

§ 416.1335 Termination due to continuous suspension.

We will terminate your eligibility for benefits following 12 consecutive

months of benefit suspension for any reason beginning with the first month you were no longer eligible for regular SSI cash benefits, federally-administered State supplementation, special SSI cash benefits described in §416.262, or special SSI eligibility status described in §416.265. We will count the 12-month suspension period either from the start of the first month you are no longer receiving your cash benefits (see §416.1321(a)) or the start of the month after the month your special SSI eligibility status described in §416.265 ended. This termination is effective with the start of the 13th month after the suspension began.

[60 FR 8153, Feb. 10, 1995]

§416.1336 Notice of intended action affecting recipient's payment status.

(a) *Advance written notice requirement.* Advance written notice of intent to discontinue payment because of an event requiring suspension, reduction (see subpart D of this part), or termination of payments shall be given in all cases, prior to effectuation of the action, except where the Social Security Administration has factual information confirming the death of the recipient, e.g., as enumerated in §404.704(b) of this chapter, or a report by a surviving spouse, a legal guardian, a parent or other close relative, or a landlord.

(b) *Continuation of payment pending an appeal.* The written notice of intent to suspend, reduce, or terminate payments shall allow 60 days after the date of receipt of the notice for the recipient to request the appropriate appellate review (see subpart N of this part). If appeal is filed within 10 days after the individual's receipt of the notice, the payment shall be continued or reinstated at the previously established payment level (subject to the effects of intervening events on the payment which are not appealed within 10 days of receipt of a required advance notice or which do not require advance notice, e.g., an increase in the benefit amount) until a decision on such initial appeal is issued, unless the individual specifically waives in writing his right to continuation of payment at the previously established level in accordance with paragraph (c) of this section. (See §416.1337 for exceptions to the continuation of payment level.) Where the request for the appropriate appellate review is filed more than 10 days after the notice is received but within the 60-day period specified in §416.1410 or §416.1426, there shall be no right to continuation or reinstatement of payment at the previously established level unless good cause is established under the criteria specified in §416.1474 for failure to appeal within 10 days after receipt of the notice. For purposes of this paragraph, the date of receipt of the notice of intent to suspend, reduce, or terminate payments shall be presumed to be 5 days after the date on the face of such notice, unless there is a reasonable showing to the contrary.

(c) *Waiver of right to continued payment.* Notwithstanding any other provisions of this section, the recipient, in order to avoid the possibility of an overpayment of benefits, may waive continuation of payment at the previously established level (subject to intervening events which would have increased the benefit for the month in which the incorrect payment was made, in which case the higher amount shall be paid), after having received a full explanation of his rights. The request for waiver of continuation of payment shall be in writing, state that waiver action is being initiated solely at the recipient's request, and state that the recipient understands his right to receive continued payment at the previously established level.

[43 FR 18170, Apr. 28, 1978]

§416.1337 Exceptions to the continuation of previously established payment level.

(a) *Multiple payments exception.* (1) Where it is determined that a recipient is receiving two or more regular monthly payments in one month, the Social Security Administration shall determine the correct payment amount and, as soon as practicable thereafter, send the recipient an advance written notice of intent to make subsequent payment in that amount. Payment for the following month shall be made in the correct amount, except as provided in paragraph (a)(3) of this section.

(2) The advance notice shall explain:

(i) That multiple payments were made in the one or more months identified in the notice;

(ii) The correct amount of monthly benefits that the recipient is eligible to receive; and

(iii) The recipient's appeal rights.

(3) If an appeal is filed within 10 days after receipt of the written notice of intent, the highest of the two or more check amounts, or the correct amount if higher (subject to the dollar limitation provisions), shall be continued until a decision on such initial level of appeal is issued. See § 416.1474 for criteria as to good cause for failure to file a timely appeal. For purposes of this paragraph, the date of receipt of the notice of intent shall be presumed to be 5 days after the date on the face of such notice, unless there is a reasonable showing to the contrary.

(4) The fact that a recipient is receiving multiple payments is established if the records of the Social Security Administration show that:

(i) Two or more checks are being sent to an individual under the same name or a common logical spelling variation of the name;

(ii) The social security number is the same or a pseudo number appears;

(iii) The checks are being sent to the same address;

(iv) The sex code for such individual is the same; and

(v) The date of birth for such individual is the same.

(b) *Dollar limitation exception.* (1) Where it is determined that a recipient is receiving an erroneous monthly payment which exceeds the dollar limitation applicable to the recipient's payment category, as set forth in paragraph (b)(4) of this section, the Social Security Administration shall determine the correct payment amount and, as soon as practicable thereafter, send the recipient an advance written notice of intent to make subsequent payment in that amount. Payment for the following month shall be made in the correct amount, except as provided in paragraph (b)(3) of this section.

(2) The advance notice shall explain:

(i) That an erroneous monthly payment which exceeds the dollar limitation applicable to the recipient's payment category was made in the one or more months identified in the notice;

(ii) The correct amount of monthly benefits that the recipient is eligible to receive; and

(iii) The recipient's appeal rights.

(3) If an appeal is filed within 10 days after receipt of the written notice of the intent (see § 416.1474 for criteria as to good cause for failure to file a timely appeal), the amount of payment to be continued, pending decision on appeal, shall be determined as follows:

(i) *Recipient in payment status.* Where the recipient is in payment status, the payment shall be in the amount the recipient received in the month immediately preceding the month the dollar limitation was first exceeded (subject to intervening events which would have increased the benefit for the month in which the incorrect payment was made, in which case the higher amount shall be paid).

(ii) *Recipient in nonpayment status.* If the recipient's benefits were suspended in the month immediately preceding the month the dollar limitation was first exceeded, the payment shall be based on that amount which should have been paid in the month in which the incorrect payment was made. However, if the individual's benefits had been correctly suspended as provided in §§ 416.1321 through 416.1330 and they should have remained suspended but a benefit that exceeded the dollar limitation was paid, no futher payment shall be made to him at this time and notice of the planned action shall not contain any provision regarding continuation of payment pending appeal.

For purposes of this paragraph, the date of receipt of the notice of planned action shall be presumed to be 5 days after the date on the face of such notice, unless there is a reasonable showing to the contrary.

(4) The payment categories and dollar limitations are as follows:

PAYMENT CATEGORY AND DOLLAR LIMITATION

(i) *Federal supplemental security income benefit only.*—$200.

Recipients whose records indicate eligibility for Federal supplemental security income benefits for the month before the month the dollar limitation was first exceeded.

(ii) *Federal supplemental security income benefit and optional supplementation, or optional supplementation only.*—$700

Recipients whose records indicate they were eligible for Federal supplemental security income benefits plus federally-administered optional supplementation, or eligible for federally-administered optional supplementation only, for the month before the month the dollar limitation was first exceeded.

(iii) *Federal supplemental security income benefit and mandatory or other supplementation, or mandatory supplementation only.*—$2,000

Recipients whose records show eligibility for Federal supplemental security income benefits and federally-administered mandatory supplementation or essential person increment for the month before the month the dollar limitation was first exceeded. This category also includes those eligible for federally-administered mandatory supplementation only and those eligible for Federal supplemental security income benefits plus an essential person increment and federally-administered optional supplementation.

[43 FR 18170, Apr. 28, 1978]

§ 416.1338 If you are participating in a vocational rehabilitation program.

(a) *When your benefits based on disability may be continued.* Your benefits may be continued after your impairment is no longer disabling if—

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

(2) You are participating in a program of vocational rehabilitation that has been approved under a State plan approved under Title I of the Rehabilitation Act of 1973 and which meets the requirements of 34 CFR part 361 for a rehabilitation program;

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

(4) 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.

(b) *When your benefits will be stopped.* Your benefits generally will be stopped with the month—

(1) You complete the program;

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

(3) We determine that your continuing participation in the program will not significantly increase the likelihood that you may 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, provided that you are otherwise eligible for benefits through such month.

[47 FR 31544, July 21, 1982, as amended at 47 FR 52693, Nov. 23, 1982; 51 FR 17618, May 14, 1986]

Subpart N—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

AUTHORITY: Sec. 702(a)(5), 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1383, and 1383b).

SOURCE: 45 FR 52096, Aug. 5, 1980, unless otherwise noted.

INTRODUCTION, DEFINITIONS, AND INITIAL DETERMINATIONS

§ 416.1400 Introduction.

(a) *Explanation of the administrative review process.* This subpart explains the procedures we follow in determining your rights under title XVI 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. 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 eligibility or your continuing eligibility for benefits or about any other matter, as discussed in § 416.1402, 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 §§ 416.1470(b) and 416.1476(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 52096, Aug. 5, 1980, as amended at 51 FR 305, Jan. 3, 1986; 52 FR 4004, Feb. 9, 1987]

§ 416.1401 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.

Mass change means a State-initiated change in the level(s) of federally administered State supplementary payments applicable to all recipients of such payments, or to categories of such recipients, due, for example, to State legislative or executive action.

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 or the eligible spouse of any person claiming or receiving supplemental security income benefits.

[45 FR 52096, Aug. 5, 1980, as amended at 59 FR 43038, Aug. 22, 1994]

§ 416.1402 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. Initial determinations regarding supplemental security income benefits include, but are not limited to, determinations about—

(a) Your eligibility for, or the amount of, your supplemental security income benefits or your special SSI cash benefits under §416.262, except actions solely involving transitions to eligibility between these types of benefits (see §§416.1403 (a)(13) and (a)(14)).

(b) Suspension, reduction, or termination of your SSI benefits or special SSI cash benefits (see §§416.261 and 416.262) or suspension or termination of your special SSI eligibility status (see §§416.264 through 416.269);

(c) Whether an overpayment of benefits must be repaid to us;

(d) Whether payments 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;

(e) Who will act as your payee if we determine that representative payment will be made;

(f) Imposing penalties for failing to report important information;

(g) Your drug addiction or alcoholism;

(h) Whether you are eligible for special SSI eligibility status under §416.265;

(i) Your disability;

(j) 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;

(k) Whether or not you have a disabling impairment as defined in §416.911;

(l) How much and to whom benefits due a deceased individual will be paid;

(m) A claim for benefits under §416.351 based on alleged misinformation; and

(n) Our calculation of the amount of change in your federally administered State supplementary payment amount (i.e., a reduction, suspension, or termination) which results from a mass change, as defined in §416.1401.

[45 FR 52096, Aug. 5, 1980, as amended at 47 FR 15325, Apr. 9, 1982; 49 FR 22275, May 29, 1984; 58 FR 52913, Oct. 13, 1993; 59 FR 41405, Aug. 12, 1994; 59 FR 43039, Aug. 22, 1994; 59 FR 44928, Aug. 31, 1994; 60 FR 8153, Feb. 10, 1995; 60 FR 14215, Mar. 15, 1995]

§416.1403 Administrative actions that are not initial determinations.

(a) 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 about—

(1) Presumptive disability or presumptive blindness;

(2) An emergency advance payment (as defined in §416.520(b));

(3) Denial of a request to be made a representative payee;

(4) Denial of a request to use the expedited appeals process;

(5) Denial of a request to reopen a determination or a decision;

(6) The fee that may be charged or received by a person who has represented you in connection with a proceeding before us;

(7) Disqualifying or suspending a person from acting as your representative in a proceeding before us (see §416.1545);

(8) Denying your request to extend the time period for requesting review of a determination or a decision;

(9) Determining whether (and the amount of) travel expenses incurred are reimbursable in connection with proceedings before us;

(10) Denying your request to readjudicate your claim and apply an Acquiescence Ruling;

(11) Determining whether an organization may collect a fee from you for expenses it incurs in serving as your representative payee (see §416.640a);

(12) Declining under §416.351(f) to make a determination on a claim for benefits based on alleged misinformation because one or more of the conditions specified in §416.351(f) are not met;

(13) Transition to eligibility for special SSI cash benefits (§416.262) in a month immediately following a month

for which you were eligible for regular SSI benefits;

(14) Transition to eligibility for regular SSI benefits in a month immediately following a month for which you were eligible for special SSI cash benefits (§ 416.262);

(15) The determination to reduce, suspend, or terminate your federally administered State supplementary payments due to a State-initiated mass change, as defined in § 416.1401, in the levels of such payments, except as provided in § 416.1402(n); and

(16) Termination of Federal administration of State supplementary payments.

(b) We send some notices of actions that are not initial determinations:

(1) If you receive an emergency advance payment or presumptive disability or presumptive blindness payments, we will provide a notice explaining the nature and conditions of the payments.

(2) If you receive presumptive disability or presumptive blindness payments, we shall send you a notice when these payments are exhausted.

(3) If there is a termination of Federal administration of State supplementary payments.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 8809, Mar. 14, 1986; 55 FR 1020, Jan. 11, 1990; 55 FR 4423, Feb. 8, 1990; 57 FR 23058, June 1, 1992; 59 FR 41405, Aug. 12, 1994; 59 FR 43039, Aug. 22, 1994; 59 FR 44928, Aug. 31, 1994]

§ 416.1404 Notice of the initial determination.

(a) We shall mail a written notice of the initial determination to you at your last known address. Generally, we will not send a notice if your benefits are stopped because of your death, or if the initial determination is a redetermination that your eligibility for benefits and the amount of your benefits have not changed.

(b) The written notice that we send will tell you—

(1) What our initial determination is;

(2) The reasons for our determination; and

(3) What rights you have to a reconsideration of the determination.

(c) If our initial determination is that we must suspend, reduce or terminate your benefits, the notice will also tell you that you have a right to a reconsideration before the determination takes effect (see § 416.1336).

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 305, Jan. 3, 1986]

§ 416.1405 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 305, Jan. 3, 1986]

§ 416.1406 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 SSI payments based on disability; 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. Paragraph (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 SSI payments 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 SSI disability program to you, including the definition of disability and how we determine whether you meet all the requirements for SSI payments 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 of eligibility for SSI payments 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 § 416.1015). 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 § 416.1017). Similarly, in making an initial determination with respect to the disability of a child under age 18 claiming SSI payments based on disability, the decisionmaker will make reasonable efforts to ensure that a qualified pediatrician, or other individual who specializes in a field of medicine appropriate to the child's impairment(s), evaluates the claim of such child (see § 416.903(f)). 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 of eligibility for SSI payments 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 also 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 the date 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 § 416.1411 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 § 416.902), 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 § 416.919a). 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 SSI payments 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 N of this part.

[60 FR 20028, Apr. 24, 1995]

RECONSIDERATION

§ 416.1407 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 reconsideration determination, you may request a hearing before an administrative law judge.

[51 FR 305, Jan. 3, 1986]

§ 416.1408 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.

§ 416.1409 How to request reconsideration.

(a) We shall reconsider an initial determination if you or any other party to the reconsideration files a written request at one of our offices 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).

(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 it 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 § 416.1411.

§416.1411 Good cause for missing the deadline to request review.

(a) In determining whether you have shown that you have 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 Appeals 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 initial 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 52096, Aug. 5, 1980, as amended at 59 FR 1637, Jan. 12, 1994]

§416.1413 Reconsideration procedures.

If you request reconsideration, we will give you a chance to present your case. How you can present your case depends upon the issue involved and whether you are asking us to reconsider an initial determination on an application or an initial determination on a suspension, reduction or termination of benefits. The methods of reconsideration include the following:

(a) *Case review.* We will give you and the other parties to the reconsideration an opportunity to review the evidence in our files and then to present oral and written evidence to us. We will then make a decision based on all of this evidence. The official who reviews the case will make the reconsidered determination.

(b) *Informal conference.* In addition to following the procedures of a case review, an informal conference allows you and the other parties to the reconsideration an opportunity to present witnesses. A summary record of this proceeding will become part of the case record. The official who conducts the informal conference will make the reconsidered determination.

(c) *Formal conference.* In addition to following the procedures of an informal conference, a formal conference allows you and the other parties to a reconsideration an opportunity to request us to subpoena adverse witnesses and relevant documents and to cross-examine adverse witnesses. A summary record of this proceeding will become a part of the case record. The official who conducts the formal conference will make the reconsidered determination.

(d) *Disability hearing.* If you have been receiving supplemental security income benefits because you are blind or disabled and you request reconsideration of an initial or revised determination that, based on medical factors, you are not now blind or disabled, we will give you and the other parties

to the reconsideration an opportunity for a disability hearing. (See §§ 416.1414 through 416.1418.)

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 305, Jan. 3, 1986]

§ 416.1413a Reconsiderations of initial determinations on applications.

The method of reconsideration we will use when you appeal an initial determination on your application for benefits depends on the issue involved in your case.

(a) *Nonmedical issues.* If you challenge our finding on a nonmedical issue, we shall offer you a case review or an informal conference, and will reach our reconsidered determination on the basis of the review you select.

(b) *Medical issues.* If you challenge our finding on a medical issue (even if you received payments because we presumed you were blind or disabled), we shall reach our reconsidered determination on the basis of a case review.

[45 FR 52096, Aug. 5, 1980. Redesignated at 51 FR 305, Jan. 3, 1986]

§ 416.1413b Reconsideration procedures for post-eligiblity claims.

If you are eligible for supplemental security income benefits and we notify you that we are going to suspend, reduce or terminate your benefits, you can appeal our determination within 60 days of the date you receive our notice. The 60-day period may be extended if you have good cause for an extension of time under the conditions stated in § 416.1411(b). If you appeal a suspension, reduction, or termination of benefits, the method of reconsideration we will use depends on the issue in your case. If the issue in your case is that you are no longer blind or disabled for medical reasons, you will receive an opportunity for a disability hearing. If any other issue is involved, you have the choice of a case review, informal conference or formal conference.

[51 FR 305, Jan. 3, 1986]

§ 416.1413c Arrangement for conferences.

(a) As soon as we receive a request for a formal or informal conference, we shall set the time, date and place for the conference.

(b) We shall send you and any other parties to the reconsideration a written notice about the conference (either by mailing it to your last known address or by personally serving you with it) at least 10 days before the conference. However, we may hold the conference sooner if we all agree. We will not send written notice of the time, date, and place of the conference if you waive your right to receive it.

(c) We shall schedule the conference within 15 days after you request it, but, at our discretion or at your request, we will delay the conference if we think the delay will ensure that the conference is conducted efficiently and properly.

(d) We shall hold the conference at one of our offices, by telephone or in person, whichever you prefer. We will hold the conference elsewhere in person if you show circumstances that make this arrangement reasonably necessary.

[45 FR 52096, Aug. 5, 1980. Redesignated at 51 FR 305, Jan. 3, 1986]

§ 416.1414 Disability hearing—general.

(a) *Availability.* We will provide you with an opportunity for a disability hearing if:

(1) You have been receiving supplemental security income benefits based on a medical impairment that renders you blind or disabled;

(2) We have made an initial or revised determination based on medical factors that you are not blind or 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 blind or disabled. Any other issues you raise in connection with your request for reconsideration will be reviewed in accordance with the reconsideration procedures described in § 416.1413 (a) through (c).

(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 §§416.1495–416.1499 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 §416.1436 (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 (§§416.1414 through 416.1418) *we, us,* or *our* means the Social Security Administration or the State agency.

[51 FR 305, Jan. 3, 1986, as amended at 51 FR 8809, Mar. 14, 1986]

§416.1415 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) of this section.

(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 305, Jan. 3, 1986]

§416.1416 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 determination, based on medical factors, that you are not now blind or disabled, as described in §416.1414(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 §416.1450(d) for the administrative law judge hearing process;

(2) You may have a representative at the hearing appointed under subpart O 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; and

(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 evidence, including arrangements 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 reconsidered determination without a hearing.* If the evidence in your case file supports a finding that you are now blind or disabled, either the component that prepares your case for hearing under paragraph (c) or the disability hearing officer will issue a written favorable reconsidered 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 § 416.1411(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 306, Jan. 3, 1986]

§ 416.1417 Disability hearing—disability hearing officer's reconsidered determination.

(a) *General.* The disability hearing officer who conducts your disability hearing will prepare and will 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 § 416.1416(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 § 416.1418.

(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 your case file.

(c) *Notice.* We will mail you and the other parties a notice of reconsidered determination in accordance with §416.1422.

(d) *Effect.* The disability hearing officer's reconsidered determination, or, if it is changed under §416.1418, 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 §416.1421, subject to the exceptions specified in that section.

[51 FR 306, Jan. 3, 1986]

§416.1418 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 —ction 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 §416.1416(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, her 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 § 416.1411(b). The Director or his or her delegate will consider your comments before taking any further action on your case.

[51 FR 307, Jan. 3, 1986]

§ 416.1419 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 52096, Aug. 5, 1980. Redesignated at 51 FR 306, Jan. 3, 1986]

§ 416.1420 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. The person who makes the reconsidered determination shall have had no prior involvement with the initial determination.

[45 FR 52096, Aug. 5, 1980. Redesignated at 51 FR 307, Jan. 3, 1986]

§ 416.1421 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 307, Jan. 3, 1986]

§ 416.1422 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 52096, Aug. 5, 1980. Redesignated at 51 FR 306, Jan. 3, 1986]

EXPEDITED APPEALS PROCESS

§ 416.1423 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.

§ 416.1424 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.

§ 416.1425 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.

(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 it 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 §416.1411.

§416.1426 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.

§416.1427 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 52096, Aug. 5, 1980, as amended at 49 FR 46370, Nov. 26, 1984]

§416.1428 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

§416.1429 Hearing before an administrative law judge—general.

If you are dissatisfied with one of the determinations or decisions listed in §416.1430 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 a 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 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1430 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 reconsideration of a revised determination of an initial or reconsidered determination that involves a suspension, reduction or termination of benefits;

(3) A revised initial determination or revised reconsidered determination that does not involve a suspension, reduction or termination of benfits; or

(4) 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 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1432 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 § 416.1430. 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 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1433 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) Your name and social security number;

(2) The name and social security number of your spouse, if any;

(3) The reasons you disagree with the previous determination or decision;

(4) A statement of additional evidence to be submitted and the date you will submit it; and

(5) The name and address of any designated representative.

(b) *When and where to file.* The request must be filed at one of our offices 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).

(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 § 416.1411.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1435 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 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§416.1436 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 and the Northern Mariana 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 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. Section 416.1438 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 a physical, mental, educational, or linguistic limitation (including any lack of facility with the English language) which you may have.

[45 FR 52096, Aug. 5, 1980, as amended at 50 FR 21438, May 24, 1985; 51 FR 307, Jan. 3, 1986; 59 FR 1637, Jan. 12, 1994]

§416.1438 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 § 416.1436 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 21439, May 24, 1985, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1439 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.

§ 416.1440 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.

§ 416.1441 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 will 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 of 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.

§ 416.1442 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 SSI 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 § 416.1459 unless it is vacated by an administrative law judge or the Appeals Council pursuant to § 416.1460. 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 § 416.1469 as explained in paragraph (f)(3) of this section; or

(3) The decision of the attorney advisor is revised under the procedures explained in § 416.1487.

(f) *Ancillary provisions.* For the purposes of the procedures authorized by this section, the regulations of part 416 shall apply to—

(1) Authorize an attorney advisor to exercise the functions performed by an administrative law judge under §§ 416.920a, 416.924d(b), and 416.946;

(2) Define the term ''decision'' to include a decision made by an attorney advisor, as well as the decisions identified in § 416.1401; and

(3) Make the decision of an attorney advisor subject to review by the Appeals Council under § 416.1469 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 34132, June 30, 1995]

§ 416.1443 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 §§ 416.905 and 416.906 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 § 416.1406. 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 § 416.1406. 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 §§ 416.905 and 416.906 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 § 416.1433(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 § 416.1411.

(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, (§ 416.1436), considering any additional evidence or arguments submitted (§§ 416.1435, 416.1444, 416.1449, 416.1450), and issuing a decision or dismissal of your request for a hearing, as may be appropriate (§§ 416.1448, 416.1453, 416.1457). 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 § 416.1401. 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 § 416.946. 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 § 416.920a. 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 § 416.1469;

(iii) The decision is revised under the procedures explained in §§ 416.1487 through 416.1489; or

(iv) In a case remanded by a Federal court, the Appeals Council assumes jurisdiction under the procedures in § 416.1484.

(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 O 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 47476, Sept. 13, 1995]

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURES

§ 416.1444 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 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1446 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 § 416.1438, unless you have indicated in writing that you do not wish to receive the notice.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1448 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 which 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 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1449 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 into the record. A copy of your written statements should be filed for each party.

§ 416.1450 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 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1451 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 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1452 Consolidated hearings before an administrative law judge.

(a) *General.* (1) A consolidated hearing may be held if—

(i) You have requested a hearing to decide your eligibility for supplemental security income benefits 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 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1453 The decision of an administrative law judge.

(a) *General.* The administrative law judge shall issue a written decision which 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) *Time for the administrative law judge's decision.* (1) The administrative law judge must issue the hearing decision no later than 90 days after the request for hearing is filed, unless—

(i) The matter to be decided is whether you are disabled; or

(ii) There is good cause for extending the time period because of unavoidable circumstances.

(2) Good cause for extending the time period may be found under the following circumstances:

(i) *Delay caused by you or by your representative's action.* The time period for decision in this instance may be extended by the total number of days of the delays. The delays include delays in submitting evidence, briefs, or other statements, postponements or adjournments made at your request, and any other delays caused by you or your representative.

(ii) *Other delays.* The time period for decision may be extended where delays occur through no fault of the Secretary. In this instance, the decision will be issued as soon as practicable.

(c) *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 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986; 54 FR 37793, Sept. 13, 1989]

§ 416.1455 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 § 416.1487;

(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 § 416.1484.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986; 54 FR 37793, Sept. 13, 1989]

§ 416.1456 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 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1457 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 a 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 § 416.1430;

(3) You did not request a hearing within the stated time period and we have not extended the time for requesting a hearing under § 416.1433(c); or

(4) You die, there are no other parties, and we have no information to show that you may have a survivor who may be paid benefits due to you under § 416.542(b) and who wishes to pursue the request for hearing, or that you authorized interim assistance reimbursement to a State pursuant to section 1631(g) of the Act. The administrative law judge, however, will vacate a dismissal of the hearing request if, within 60 days after the date of the dismissal:

(i) A person claiming to be your survivor, who may be paid benefits due to you under § 416.542(b), submits a written request for a hearing, and shows that a decision on the issues that were to be considered at the hearing may adversely affect him or her; or

(ii) We receive information showing that you authorized interim assistance reimbursement to a State pursuant to section 1631(g) of the Act.

[45 FR 52096, Aug. 5, 1980, as amended at 50 FR 21439, May 24, 1985; 51 FR 308, Jan. 3, 1986; 58 FR 52913, Oct. 13, 1993; 59 FR 1637, Jan. 12, 1994]

§ 416.1458 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 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1459 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 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1460 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 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1461 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.

§ 416.1465 [Reserved]

APPEALS COUNCIL REVIEW

§ 416.1467 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.

§416.1468 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 at one of our offices 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).

(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 §416.1411.

§416.1469 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.

§416.1470 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) In reviewing decisions based on an application for benefits, 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. In reviewing decisions other than those based on an application for benefits, the Appeals Council shall evaluate the entire record including any new and material evidence submitted. 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 52096, Aug. 5, 1980, as amended at 52 FR 4004, Feb. 9, 1987]

§416.1471 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 die, there are no other parties, and we have no information to show that you may have a survivor who may be paid benefits due to you under §416.542(b) and who wishes to pursue the request for review, or that you authorized interim assistance reimbursement to a State pursuant to section 1631(g) of the Act. The Appeals Council, however, will vacate a dismissal of the request for review if, within 60 days after the date of the dismissal:

(1) A person claiming to be your survivor, who may be paid benefits due to you under §416.542(b), submits a written request for review, and shows that a decision on the issues that were to be considered on review may adversely affect him or her; or

(2) We receive information showing that you authorized interim assistance

reimbursement to a State pursuant to section 1631(g) of the Act.

[45 FR 52096, Aug. 5, 1980, as amended at 58 FR 52914, Oct. 13, 1993]

§ 416.1472 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.

§ 416.1473 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.

§ 416.1474 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.

§ 416.1475 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.

§ 416.1476 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) In reviewing decisions based on an application for benefits, the Appeals Council will consider the evidence in the administrative law judge hearing record and any new and material evidence only if it 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 an application within 60 days 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 § 416.340. If a new application is filed within 60 days of this notice, the date of the request for review will be used as the filing date for your application.

(2) In reviewing decisions other than those based on an application for benefits, the Appeals Council will consider the evidence in the administrative law judge hearing record and any additional evidence it believes is material to an issue being considered.

(3) 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 52096, Aug. 5, 1980, as amended at 52 FR 4004, Feb. 9, 1987]

§ 416.1477 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 explained 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.

§416.1479 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 §§416.1470(b) and 416.1476(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 4005, Feb. 9, 1987]

§416.1481 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.

§416.1482 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 §416.1411.

COURT REMAND CASES

§416.1483 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 § 416.1477 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 37793, Sept. 13, 1989]

§ 416.1484 Appeals Council review of administrative law judge decision in a case remanded by a Federal court.

(a) *General.* In accordance with § 416.1483, 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 37793, Sept. 13, 1989]

§416.1485 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, redeterminations or 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 section 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. 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 on an issue 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 1020, Jan. 11, 1990]

REOPENING AND REVISING DETERMINATIONS AND DECISIONS

§ 416.1487 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 § 416.1488.

[59 FR 8535, Feb. 23, 1994]

§416.1488 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 two years of the date of the notice of the initial determination if we find good cause, as defined in §416.1489, to reopen the case; or

(c) At any time if it was obtained by fraud or similar fault. In determining whether a determination or decision was obtained by fraud or similar fault, 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.

[45 FR 52096, Aug. 5, 1980, as amended at 59 FR 1637, Jan. 12, 1994]

§416.1489 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 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 administrative ruling upon which the determination or decision was made.

§416.1491 Late completion of timely investigation.

We may revise a determination or decision after the applicable time period in §416.1488(a) or §416.1488(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 46370, Nov. 26, 1984; 49 FR 48036, Dec. 10, 1984]

§416.1492 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 determination is revised and the revised determination requires that your benefits be suspended, reduced, or terminated, the notice will inform you of your right to continued payment (see §416.1336 and the exceptions set out in §416.1337) and of your right of reconsideration.

(c) If a determination is revised and the revised determination does not require that your benefits be suspended, reduced, or terminated, the notice will inform you of your right to a hearing before an administrative law judge.

(d) If a reconsidered determination that you are blind or 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.

(e) 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.

(f) 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.

(g) An administrative law judge may, in connection with a valid request for a hearing, propose to reopen an issue other than the issue on which the request for a hearing was based. The administrative law judge will follow the time limits for reopenings set out in § 416.1488. The administrative law judge shall mail to the parties at their last known address a notice of the reopening.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1493 Effect of revised determination or decision.

A revised determination or decision is binding unless—

(a) You or a party to the revised determination file a written request for a reconsideration or a hearing;

(b) You or another party to the revised decision file, as appropriate, a request for review by the Appeals Council or a hearing;

(c) The Appeals Council reviews the revised decision; or

(d) The revised determination or decision is further revised.

§ 416.1494 Time and place to request further review or a hearing on revised determination or decision.

You or another party to the revised determination or decision may request, as appropriate, 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.

PAYMENT OF CERTAIN TRAVEL EXPENSES

§ 416.1495 Payment of certain travel expenses—general.

When you file a claim for supplemental security income (SSI) benefits, you may incur certain travel expenses in pursuing your claim. Sections 416.1496 through 416.1499 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 § 416.1496(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 8810, Mar. 14, 1986]

§ 416.1496 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 § 416.917);

(2) You, your representative (see § 416.1505 (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 SSI benefits before an administrative law judge.

(b) Sections 416.1495 through 416.1499 do not apply to subpoenaed witnesses. They are reimbursed under §§ 416.1450(d) and 416.1416(b)(1).

[51 FR 8810, Mar. 14, 1986]

§ 416.1498 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 §§ 416.1496 through 416.1499 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 §§ 416.1496 through 416.1499 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 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 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 condition 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 § 416.120(c)(10).

(2) When the travel is performed after September 30, 1981, 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 (as defined in § 416.120(c)(9)) 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 8810, Mar. 14, 1986, as amended at 59 FR 8532, Feb. 23, 1994]

§ 416.1499 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 8810, Mar. 14, 1986, as amended by 51 FR 44983, Dec. 16, 1986]

Subpart O—Representation of Parties

AUTHORITY: Secs. 702(a)(5) and 1631(d) of the Social Security Act (42 U.S.C. 902(a)(5) and 1383(d)).

SOURCE: 45 FR 52106, Aug. 5, 1980, unless otherwise noted.

§416.1500 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.

§416.1503 Definitions.

As used in this subpart:

Representative means an attorney who meets all of the requirements of §416.1505(a), or a person other than an attorney who meets all of the requirements of §416.1505(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 or the eligible spouse of any person claiming or receiving supplemental security income benefits.

§416.1505 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 dealing with us; and

(4) Is not prohibited by any law from acting as a representative.

§416.1506 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 N of this part and it does not grant all of the benefits or other relief you requested or it adversely affects any eligibility 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]

§416.1507 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 requested reconsideration; with an administrative law judge if you have requested a hearing; or with the Appeals Council if you have requested a review of the administrative law judge's decision.

§ 416.1510 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 XVI of the Act unless authorized to do so under § 416.315.

§ 416.1515 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.

§ 416.1520 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.

(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; 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 representative's services before the Social Security Administration under title XVI.

§ 416.1525 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 to you 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 supplemental security income program, which is to assure a minimum level of income 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.

§ 416.1528 Proceedings before a State or Federal court.

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 has also 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 § 416.1525.

§ 416.1535 Services in a proceeding under title XVI of the Act.

Services provided a claimant in any dealing with us under title XVI 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 XVI 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.

§ 416.1540 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 XVI 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.

§ 416.1545 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 § 416.1540;

(b) Has been convicted of a violation under section 1631(d)(2) of the Act; or

(c) Has otherwise refused to comply with our rules and regulations on representing claimants in dealings with us.

[45 FR 52106, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991]

§ 416.1550 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 § 416.1565(g).

[45 FR 52106, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991]

§ 416.1555 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.

§ 416.1565 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) *Hearing officer.* (1) 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 decision 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 52106, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991]

§ 416.1570 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 § 416.1599.

(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.

(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 §416.1599.

(3) If the final decision is that a person is suspended for a specified period of time from being a representative in dealings with us, he or she will not be permitted to represent anyone in dealings with us during the period of suspension unless authorized to do so under the provisions of §416.1599.

[45 FR 52106, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991]

§416.1575 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.

§416.1576 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]

§416.1580 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.

§416.1585 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.

§416.1590 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;

(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 52106, Aug. 5, 1980, as amended at 56 FR 24133, May 29, 1991]

§ 416.1595 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.

§ 416.1597 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.

§ 416.1599 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 1631(d)(2) of the Act, and to our 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 52106, Aug. 5, 1980, as amended at 56 FR 24133, May 29, 1991]

Subpart P—Residence and Citizenship

AUTHORITY: Secs. 702(a)(5), 1614(a)(1)(B) and (e), and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1382c(a)(1)(B) and (e), and 1383); 8 U.S.C. 1254a; sec. 502, Pub. L. 94–241, 90 Stat. 268 (48 U.S.C. 1681 note).

SOURCE: 47 FR 3106, Jan. 22, 1982, unless otherwise noted.

§416.1600 Introduction.

You are eligible for supplemental security income (SSI) benefits if you meet the requirements in subpart B. Among these are requirements that you must be a resident of the United States and either a citizen, a national, or an alien with a lawful right to reside permanently in the United States. In this subpart, we tell you what kinds of evidence show that you are a resident of the United States (see §416.1603) and—

(a) A citizen or a national of the United States (see §416.1610);

(b) An alien lawfully admitted for permanent residence in the United States (see §416.1615); or

(c) An alien permanently residing in the United States under color of law (see §416.1618).

§416.1601 Definitions and terms used in this subpart.

We or *Us* means the Social Security Administration.

You or *Your* means the person who applies for or receives SSI benefits or the person for whom an application is filed.

§416.1603 How to prove you are a resident of the United States.

(a) *What you should give us.* Your home address in the United States may be sufficient to establish that you are a resident. However, if we have any reason to question that you are a resident of the United States we will ask for evidence. You can prove you are a resident of the United States by giving us papers or documents showing that you live in the United States such as—

(1) Property, income, or other tax forms or receipts;

(2) Utility bills, leases or rent payment records;

(3) Documents that show you participate in a social services program in the United States; or

(4) Other records or documents that show you live in the United States.

(b) *What ''resident of the United States'' means.* We use the term ''resident of the United States'' to mean a person who is living within the geographical limits of the United States.

(c) *What ''United States'' means.* We use the term ''United States'' in this section to mean the 50 States, the District of Columbia, and the Northern Mariana Islands.

§416.1610 How to prove you are a citizen or a national of the United States.

(a) *What you should give us.* You can prove that you are a citizen or a national of the United States by giving us—

(1) A certified copy of your birth certificate which shows that you were born in the United States;

(2) A certified copy of a religious record of your birth or baptism which shows you were born in the United States;

(3) Your naturalization certificate;

(4) Your United States passport;

(5) Your certificate of citizenship;

(6) An identification card for use of resident citizens in the United States (Immigration and Naturalization Service Form I–197); or

(7) An identification card for use of resident citizens of the United States by both or naturalization of parents (INS Form I–179).

(b) *How to prove you are an interim citizen of the United States if you live in the Northern Mariana Islands.* As a resident of the Northern Mariana Islands you must meet certain conditions to prove you are an interim citizen of the United States. You must prove that you were domiciled in the Northern Mariana Islands as required by section 8 of the Schedule of Transitional Matters of the Constitution of the Northern Mariana Islands, or that you were born there after March 6, 1977. By ''domiciled'' we mean that you maintained a residence with the intention of continuing that residence for an unlimited or indefinite period, and that you intended to return to that residence whenever absent, even for an extended period. You must also give us proof of your citizenship if you are a citizen of the Trust Territory of the Pacific Islands of which the Marianas are a part.

(1) You can prove you were domiciled in the Northern Mariana Islands by giving us—

(i) Statements of civil authorities; or

(ii) Receipts or other evidence that show you were domiciled there.

(2) You can prove that you are a citizen of the Trust Territory of the Pacific Islands by giving us—

(i) Your identification card issued by the Trust Territory of the Pacific Islands and a public or religious record of age which shows you were born in this territory;

(ii) Your voter's registration card;

(iii) A Chammoro Family Record showing your birth in the Trust Territory of the Pacific Islands; or

(iv) Your naturalization certificate.

(c) *What to do if you cannot give us the information listed in paragraph (a) or (b).* If you cannot give us any of the documents listed in paragraph (a) or (b), we may find you to be a citizen or a national of the United States if you—

(1) Explain why you cannot give us any of the documents; and

(2) Give us any information you have which shows or results in proof that you are a citizen or a national of the United States. The kind of information we are most concerned about shows—

(i) The date and place of your birth in the United States;

(ii) That you have voted or are otherwise known to be a citizen or national of the United States; or

(iii) The relationship to you and the citizenship of any person through whom you obtain citizenship.

(d) *What ''United States'' means.* We use the term ''United States'' in this section to mean the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands of the United States, American Samoa, Swain's Island, and the Northern Mariana Islands.

§ 416.1615 How to prove you are lawfully admitted for permanent residence in the United States.

(a) *What you should give us.* You can prove that you are lawfully admitted for permanent residence in the United States by giving us—

(1) An Alien Registration Receipt Card (Immigration and Naturalization (INS) Form I–151 or I–551, including temporary I–551s which are stamped in a passport or on INS Form I–94 (Arrival-Departure Record) for aliens admitted under sections 204, 206, or 245 of the Immigration and Nationality Act, and the earlier version INS Form AR–3 or AR–3a);

(2) A reentry permit;

(3) An alien identification card issued by the government of the Northern Mariana Islands showing that you are admitted to the Northern Mariana Islands for permanent residence; or

(4) INS Form I–688 which shows that you have been granted lawful temporary resident status under section 210 or section 210A of the Immigration and Nationality Act.

(b) *What to do if you cannot give us the information listed in paragraph (a).* If you cannot give us any of the documents listed in paragraph (a), we may find you to be lawfully admitted for permanent residence in the United States if you—

(1) Explain why you cannot give us any of the documents; and

(2) Give us any information you have which shows or results in proof that you are lawfully admitted for permanent residence in the United States.

(c) *What ''United States'' means.* We use the term ''United States'' in this section to mean the 50 States, the District of Columbia, and the Northern Mariana Islands.

(Approved by the Office of Management and Budget under control number 0960–0451)

[47 FR 3106, Jan. 22, 1982, as amended at 52 FR 21943, June 10, 1987; 56 FR 55075, Oct. 24, 1991]

§ 416.1618 When you are considered permanently residing in the United States under color of law.

(a) *General.* We will consider you to be permanently residing in the United States under color of law and you may be eligible for SSI benefits if you are an alien residing in the United States with the knowledge and permission of the Immigration and Naturalization Service and that agency does not contemplate enforcing your departure. The Immigration and Naturalization Service does not contemplate enforcing your departure if it is the policy or practice of that agency not to enforce the departure of aliens in the same category or if from all the facts and circumstances in your case it appears

that the Immigration and Naturalization Service is otherwise permitting you to reside in the United States indefinitely. We make these decisions by verifying your status with the Immigration and Naturalization Service following the rules contained in paragraphs (b) through (e) of this section.

(b) *Categories of aliens who are permanently residing in the United States under color of law.* Aliens who are permanently residing in the United States under color of law are listed below. None of the categories includes applicants for an Immigration and Naturalization status other than those applicants listed in paragraph (b)(6) of this section or those covered under paragraph (b)(17) of this section. None of the categories allows SSI eligibility for nonimmigrants; for example, students or visitors. Also listed are the most common documents that the Immigration and Naturalization Service provides to aliens in these categories:

(1) Aliens admitted to the United States pursuant to 8 U.S.C. 1153(a)(7), (section 203(a)(7) of the Immigration and Nationality Act). We ask for INS Form I–94 endorsed ''Refugee-Conditional Entry'';

(2) Aliens paroled into the United States pursuant to 8 U.S.C. 1182(d)(5) (section 212(d)(5) of the Immigration and Nationality Act) including Cuban/Haitian Entrants. We ask for INS Form I–94 with the notation that the alien was paroled pursuant to section 212(d)(5) of the Immigration and Nationality Act. For Cuban/Haitian Entrants, we ask for INS Form I–94 stamped ''Cuban/Haitian Entrant (Status Pending) reviewable January 15, 1981. Employment authorized until January 15, 1981.'' (Although the forms bear this notation, Cuban/Haitian Entrants are admitted under section 212(d)(5) of the Immigration and Nationality Act.);

(3) Aliens residing in the United States pursuant to an indefinite stay of deportation. We ask for an Immigration and Naturalization Service letter with this information or INS Form I–94 with such a notation;

(4) Aliens residing in the United States pursuant to an indefinite voluntary departure. We ask for an Immigration and Naturalization Service letter or INS Form I–94 showing that a voluntary departure has been granted for an indefinite time period;

(5) Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for a copy of INS Form I–94 or I–210 letter showing that status;

(6) Aliens who have filed applications for adjustment of status pursuant to section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) that the Immigration and Naturalization Service has accepted as ''properly filed'' (within the meaning of 8 CFR 245.2(a)(1) or (2)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for INS Form I–181 or a passport properly endorsed;

(7) Aliens granted stays of deportation by court order, statute or regulation, or by individual determination of the Immigration and Naturalization Service pursuant to section 106 of the Immigration and Nationality Act (8 U.S.C. 1105a) or relevant Immigration and Naturalization Service instructions, whose departure that agency does not contemplate enforcing. We ask for INS Form I–94 or a letter from the Immigration and Naturalization Service, or copy of a court order establishing the alien's status;

(8) Aliens granted asylum pursuant to section 208 of the Immigration and Nationality Act (8 U.S.C. 1158). We ask for INS Form I–94 and a letter establishing this status;

(9) Aliens admitted as refugees pursuant to section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7)). We ask for INS Form I–94 properly endorsed;

(10) Aliens granted voluntary departure pursuant to section 242(b) of the Immigration and Nationality Act (8 U.S.C. 1252(b)) or 8 CFR 242.5 whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for INS

Form I–94 or I–210 bearing a departure date;

(11) Aliens granted deferred action status pursuant to Immigration and Naturalization Service Operations Instruction 103.1(a)(ii) prior to June 15, 1984 or 242.1(a)(22) issued June 15, 1984 and later. We ask for INS Form I–210 or a letter showing that departure has been deferred;

(12) Aliens residing in the United States under orders of supervision pursuant to section 242 of the Immigration and Nationality Act (8 U.S.C. 1252(d)). We ask for INS Form I–220B;

(13) Aliens who have entered and continuously resided in the United States since before January 1, 1972 (or any date established by section 249 of the Immigration and Nationality Act, 8 U.S.C. 1259). We ask for any proof establishing this entry and continuous residence;

(14) Aliens granted suspension of deportation pursuant to section 244 of the Immigration and Nationality Act (8 U.S.C. 1254) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for an order from the immigration judge;

(15) Aliens whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)). We ask for an order from an immigration judge showing that deportation has been withheld;

(16) Aliens granted lawful temporary resident status pursuant to section 245A of the Immigration and Nationality Act (8 U.S.C. 1255a). We ask for INS form I–688 showing that status; or

(17) Any other aliens living in the United States with the knowledge and permission of the Immigration and Naturalization Service and whose departure that agency does not contemplate enforcing.

(c) *How to prove you are in a category listed in paragraph (b) of this section.* You must give us proof that you are in one of the categories in paragraph (b) of this section. You may give us—

(1) Any of the documents listed in paragraph (b) of this section; or

(2) Other information which shows that you are in one of the categories listed in paragraph (b) of this section.

(d) *We must contact the Immigration and Naturalization Service.* (1) We must contact the Immigration and Naturalization Service to verify the information you give us to prove you are permanently residing in the United States under color of law.

(2) If you give us any of the documents listed in paragraphs (b)(1), (2), (3), (4), (8), (9), (11), (12), (13), (15), or (16) of this section, we will pay you benefits if you meet all other eligibility requirements. We will contact the Immigration and Naturalization Service to verify that the document you give us is currently valid.

(3) If you give us any of the documents listed in paragraphs (b)(5), (6), (7), (10), or (14) of this section, or documents that indicate that you meet paragraph (b)(17) of this section, or any other information to prove you are permanently residing in the United States under color of law, we will contact the Immigration and Naturalization Service to verify that the document or other information is currently valid. We must also get information from the Immigration and Naturalization Service as to whether that agency contemplates enforcing your departure. We will apply the following rules:

(i) If you have a document that shows that you have an Immigration and Naturalization Service status that is valid for an indefinite period we will assume that the Immigration and Naturalization Service does not contemplate enforcing your departure. Therefore, we will pay you benefits if you meet all other eligibility requirements. If, based on the information we get from the Immigration and Naturalization Service, we find that your document is currently valid, we will consider this sufficient proof that the Immigration and Naturalization Service does not contemplate enforcing your departure. We will continue your benefits. However, if we find that your document is not currently valid, we will suspend your benefits under § 416.1321.

(ii) If you have a document that appears currently valid and shows you have an Immigration and Naturalization Service status for at least 1 year, or that shows the Immigration and Naturalization Service is allowing you to remain in the United States for a

specified period due to conditions in your home country, we will assume that the Immigration and Naturalization Service does not contemplate enforcing your departure. Therefore, we will pay you benefits if you meet all other eligibility requirements. If, based on the information we get from the Immigration and Naturalization Service, we learn that your document is currently valid and that agency does not contemplate enforcing your departure, we will continue your benefits. However, if we learn that your document is not currently valid or that the Immigration and Naturalization Service does contemplate enforcing your departure, we will suspend your benefits under §416.1321.

(iii) If you have a document that shows you have an Immigration and Naturalization Service status valid for less than 1 year, or if your document has no expiration date, or if you have no document, we will not pay you benefits until the Immigration and Naturalization Service confirms that your document is currently valid and we get information from that agency that indicates whether it contemplates enforcing your departure. If that agency does not contemplate enforcing your departure, we will pay you benefits if you meet all other eligibility requirements.

(iv) If at any time after you begin receiving benefits we receive information from the Immigration and Naturalization Service which indicates that the Immigration and Naturalization Service contemplates enforcing your departure, we will suspend your benefits under §416.1321 and any benefits you have received after the date that the Immigration and Naturalization Service began contemplating enforcing departure will be overpayments under subpart E of this part.

(e) *What ''United States'' means.* We use the term ''United States'' in this section to mean the 50 States, the District of Columbia, and the Northern Mariana Islands.

(Approved by the Office of Management and Budget under control number 0960–0451)

[52 FR 21943, June 10, 1987, as amended at 56 FR 55075, Oct. 24, 1991; 56 FR 61287, Dec. 2, 1991]

§416.1619 When you cannot be considered permanently residing in the United States under color of law.

We will not consider you to be permanently residing in the United States under color of law and you are not eligible for SSI benefits during a period in which you have been granted temporary protected status by the Immigration and Naturalization Service under section 244A of the Immigration and Nationality Act.

[58 FR 41182, Aug. 3, 1993]

Subpart Q—Referral of Persons Eligible for Supplemental Security Income to Other Agencies

AUTHORITY: Secs. 702(a)(5), 1611(e)(3), 1615, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1382(e)(3), 1382d, and 1383).

SOURCE: 45 FR 70859, Oct. 27, 1980, unless otherwise noted.

GENERAL

§416.1701 Scope of subpart.

This subpart describes whom we refer to agencies for (a) vocational rehabilitation services or (b) treatment for alcoholism or drug addiction. The purpose of these services or treatments is to restore your ability to work. This subpart also describes the conditions under which you can refuse these services or treatments after we have referred you. If these conditions are not met, this subpart describes how your benefits are effected when you refuse these services or treatments.

§416.1705 Definitions.

As used in this subpart—

Vocational rehabilitation services refers to services provided blind or disabled persons under the State plan approved under the Rehabilitation Act of 1973 (see 45 CFR 401.120ff for requirements of these State plans).

We or *us* refers to either the Social Security Administration or the State agency making the disability or blindness determination.

You or *your* refers to the person who applies for or receives benefits or the person for whom an application is filed.

REFERRAL FOR VOCATIONAL REHABILITATION SERVICES

§ 416.1710 Whom we refer and when.

(a) *Whom we refer.* If you are 16 years of age or older and under 65 years old, and receiving supplemental security income (SSI) benefits, we will refer you to the State agency providing vocational rehabilitation services. If you are under age 16, we will refer you to an agency administering services under the Maternal and Child Health Services (Title V) Block Grant Act.

(b) *When we refer.* We will make this referral when we find you eligible for benefits or at any other time that we find you might be helped by vocational rehabilitation services.

[45 FR 70859, Oct. 27, 1980, as amended at 48 FR 6297, Feb. 23, 1983]

§ 416.1715 Effect of your rejecting vocational rehabilitation services.

(a) *Ineligible for benefits if you do not have good cause.* If we refer you to the State agency providing vocational rehabilitation services, you are not eligible for SSI benefits for any month that you refuse, without good cause, to accept services available to you (see § 416.1328(a) on suspension because of a refusal). In determining whether you have good cause for refusing vocational rehabilitation services, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which may have caused you to refuse such services. If you believe good cause exists to refuse these services, you will be asked to submit proof showing this.

(b) *Examples of good cause.* If you can show good cause for not accepting vocational rehabilitation services offered to you, you will continue to be eligible for benefits. Examples of good cause include the following: (1) The services that are offered are not designed to restore your ability to work.

(2) You are already in a program (either governmental or private) that is expected to restore your ability to work.

(3) You are regularly attending a school, college, or university or are attending a course of vocational or technical training, and the program you are attending is designed to restore your ability to work.

(4) You are physically or mentally unable to participate in the services that are offered.

(5) The services offered would interfere with a medical program provided for you.

(6) The services would require you to be away from home and your absence would be harmful to the health and welfare of your family.

(7) You are working at the present time or you will be working within 3 months.

(8) You are a member or a follower of a recognized church or religious sect which teaches its members or followers to rely solely on prayer or other spiritual means for the treatment and care of any physical or mental illness, and you refuse to accept these services solely because of your belief in these teachings.

[45 FR 70859, Oct. 27, 1980, as amended at 59 FR 1637, Jan. 12, 1994]

REFERRAL FOR TREATMENT OF ALCOHOLISM OR DRUG ADDICTION

§ 416.1720 Whom we refer.

We will refer you to an approved facility for treatment of your alcoholism or drug addiction if—

(a) You are disabled;

(b) You are not blind;

(c) You are not 65 years old or older; and

(d) Alcoholism or drug addiction is a contributing factor to your disability.

§ 416.1725 Effect of your failure to comply with treatment requirements for your drug addiction or alcoholism.

(a) *Suspension of benefits.* Your eligibility for benefits will be suspended beginning with the first month after we notify you in writing that we have determined that you have failed to comply with the treatment requirements for your drug addiction or alcoholism as defined in § 416.940. Your benefits will be suspended and reinstated in accordance with the provisions in § 416.1326.

(b) *Termination of benefits.* If your benefits are suspended for 12 consecutive months for failure to comply with

treatment in accordance with §416.1326, your eligibility for disability benefits will be terminated in accordance with §416.1331.

[60 FR 8153, Feb. 10, 1995]

Subpart R—Relationship

AUTHORITY: Secs. 702(a)(5), 1614(b), (c), and (d), and 1631(d)(1) and (e) of the Social Security Act (42 U.S.C. 902(a)(5), 1382c (b), (c), and (d), and 1383 (d)(1) and (e)).

SOURCE: 45 FR 71795, Oct. 30, 1980, unless otherwise noted. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981.

§416.1801 Introduction.

(a) *What is in this subpart.* This subpart contains the basic rules for deciding for SSI purposes whether a person is considered married and, if so, to whom; whether a person is considered a child; and whether a person is considered another person's parent. It tells what information and evidence we need to decide these facts.

(b) *Related subparts.* Subpart D discusses how to determine the amount of a person's benefits; subpart G discusses what changes in a person's situation he or she must report to us; subpart K discusses how we count income; and subpart L discusses how we count resources (money and property). The questions of whether a person is married, to whom a person is married, whether a person is a child, and who is a person's parent must be answered in order to know which rules in subparts D, G, K, and L apply.

(c) *Definitions.* In this subpart—

Eligible spouse means a person—

(1) Who is eligible for SSI,

(2) Whom we consider the spouse of another person who is eligible for SSI, and

(3) Who was living in the same household with that person on—

(i) The date of filing an application for benefits (for the month of an application);

(ii) The date a request for reinstatement of eligibility is filed (for the month of such request); or

(iii) The first day of the month, for all other months. An individual is considered to be living with an eligible spouse during temporary absences as defined in §416.1149 and while receiving continued benefits under section 1611(e)(1) (E) or (G) of the Act.

Spouse means a person's husband or wife under the rules of §§416.1806 and 416.1811.

We and *us* mean the Social Security Administration.

You means a person who has applied for or has been receiving SSI benefits, or a person for whom someone else has applied for or has been receiving SSI benefits.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, as amended at 60 FR 16376, Mar. 30, 1995]

WHO IS CONSIDERED YOUR SPOUSE

§416.1802 Effects of marriage on eligibility and amount of benefits.

(a) *If you have an ineligible spouse*—(1) *Counting income.* If you apply for or receive SSI benefits, and you are married to someone who is not eligible for SSI benefits and are living in the same household as that person, we may count part of that person's income as yours. Counting part of that person's income as yours may reduce the amount of your benefits or even make you ineligible. Section 416.410 discusses the amount of benefits and §416.1163 explains how we count income for an individual with an ineligible spouse.

(2) *Counting resources.* If you are married to someone who is not eligible for SSI benefits and are living in the same household as that person, we will count the value of that person's resources (money and property), minus certain exclusions, as yours when we determine your eligibility. Section 416.1202(a) gives a more detailed statement of how we count resources and §416.1205(a) gives the limit of resources allowed for eligibility of a person with an ineligible spouse.

(b) *If you have an eligible spouse*—

(1) *Counting income.* If you apply for or receive SSI benefits and have an eligible spouse as defined in §416.1801(c), we will count your combined income and calculated the benefit amount for you as a couple. Section 416.412 gives a detailed statement of the amount of benefits and subpart K of this part explains how we count income for an eligible couple.

(2) *Counting resources.* If you have an eligible spouse as defined in § 416.1801(c), we will count the value of your combined resources (money and property), minus certain exclusions, and use the couple's resource limit when we determine your eligibility. Section 416.1205(b) gives a detailed statement of the resource limit for an eligible couple.

(c) *If you are married, we do not consider you a child.* The rules for counting income and resources are different for children than for adults. (Section 416.1851 discusses the effects of being considered a child on eligibility and amount of benefits.) Regardless of your age, if you are married we do not consider you to be a child.

(d)(1) *General rule:* Benefits depend on whether you are married or not married at the beginning of each month. If you get married, even on the first day of a month we will treat you as single until the next month. If your marriage ends, even on the first day of a month, we will treat you as married until the next month.

(2) *Exception: If you both meet eligibility requirements after your date of marriage or after your marriage ends.* If, in the month that you marry, each of you first meets all eligibility requirements after the date of your marriage, we will treat you as an eligible couple for that month. If, in the month that your marriage ends, each of you first meets all eligibility requirements after the date your marriage ends, we will treat you as eligible individuals. (See subparts D and E regarding how your benefits will be prorated.)

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, and amended at 51 FR 13495, Apr. 21, 1986; 60 FR 16376, Mar. 30, 1995]

§ 416.1806 Whether you are married and who is your spouse.

(a) We will consider someone to be your spouse (and therefore consider you to be married) for SSI purposes if—

(1) You are legally married under the laws of the State where your and his or her permanent home is (or was when you lived together);

(2) We have decided that either of you is entitled to husband's or wife's Social Security insurance benefits as the spouse of the other (this decision will not affect your SSI benefits for any month before it is made); or

(3) You and an unrelated person of the opposite sex are living together in the same household at or after the time you apply for SSI benefits, and you both lead people to believe that you are husband and wife.

(b) if more than one person would qualify as your husband or wife under paragraph (a) of this section, we will consider the person you are presently living with to be your spouse for SSI purposes.

[60 FR 16376, Mar. 30, 1995]

§ 416.1816 Information we need concerning marriage when you apply for SSI.

When you apply for SSI benefits, we will ask whether you are married. If you are married, we will ask whether you are living with your spouse. If you are unmarried or you are married but not living with your spouse, we will ask whether you are living in the same household with anyone of the opposite sex who is not related to you. If you are, we will ask whether you and that person lead other people to believe that you are husband and wife.

§ 416.1821 Showing that you are married when you apply for SSI.

(a) *General rule: Proof is unnecessary.* If you tell us you are married we will consider you married unless we have information to the contrary. We will also consider you married, on the basis of your statement, if you say you are living with an unrelated person of the opposite sex and you both lead people to believe you are married. However, if we have information contrary to what you tell us, we will ask for evidence as described in paragraph (c).

(b) *Exception: If you are a child to whom parental deeming rules apply.* If you are a child to whom the parental deeming rules apply and we receive information from you or others that you are married, we will ask for evidence of your marriage. The rules on deeming parental income are in §§ 416.1165 and 416.1166. The rules on deeming of parental resources are in § 416.1202.

(c) *Evidence of marriage.* If paragraph (a) or (b) of this section indicates that

you must show us evidence that you are married, you must show us your marriage certificate (which can be the original certificate, a certified copy of the public record of marriage, or a certified copy of the church record) if you can. If you cannot, you must tell us why not and give us whatever evidence you can.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, and amended at 52 FR 8889, Mar. 20, 1987]

§416.1826 Showing that you are not married when you apply for SSI.

(a) *General rule: Proof is unnecessary.* If you do not live with an unrelated person of the opposite sex and you say that you are not married, we will generally accept your statement unless we have information to the contrary.

(b) *Exception: If you are under age 22 and have been married.* If you are under age 22 and have been married, to prove that your marriage has ended you must show us the decree of divorce or annulment or the death certificate if you can. If you cannot, you must tell us why not and give us whatever evidence you can.

(c) *Exception: If you are living with an unrelated person of the opposite sex.* (1) If you are living with an unrelated person of the opposite sex, you and the person you are living with must explain to us what your relationship is and answer questions such as the following:

(i) What names are the two of you known by?

(ii) Do you introduce yourselves as husband and wife? If not, how are you introduced?

(iii) What names are used on mail for each of you?

(iv) Who owns or rents the place where you live?

(v) Do any deeds, leases, time payment papers, tax papers, or any other papers show you as husband and wife?

(2) We will consider you married to the person you live with unless the information we have, including the answers to the questions in paragraph (c)(1) of this section, all considered together, show that the two of you do not lead people to believe that you are each other's husband and wife.

§416.1830 When we stop considering you and your spouse an eligible couple.

We will stop considering you and your spouse an eligible couple, even if you both remain eligible, at the beginning of whichever of these months comes first—

(a) The calendar month after the month you stopped living with your eligible spouse, or

(b) The calendar month after the month in which your marriage ends.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, as amended at 60 FR 16376, Mar. 30, 1995]

§416.1832 When we consider your marriage ended.

We consider your marriage ended when—

(a) Your spouse dies;

(b) Your divorce or annulment becomes final;

(c) We decide that either of you is not a spouse of the other for purposes of husband's or wife's social security insurance benefits, if we considered you married only because of §416.1806(a)(2); or

(d) You and your spouse stop living together, if we considered you married only because of §416.1806(a)(3).

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, as amended at 60 FR 16376, Mar. 30, 1995]

§416.1835 Information we need about separation or end of marriage after you become eligible for SSI.

(a) *If you and your spouse stop living together.* If you and your spouse stop living together, you must promptly report that fact to us, so that we can decide whether there has been a change that affects either person's benefits. You must also answer questions such as the following. If you cannot answer our questions you must tell us why not and give us whatever information you can.

(1) When did you stop living together?

(2) Do you expect to live together again?

(3) If so, when?

(4) Where is your husband or wife living?

(5) Is either of you living with someone else as husband and wife?

(b) *Evidence of end of marriage*—(1) *Death.* We will accept your statement that your husband or wife died unless we have information to the contrary. If we have contrary information, you must show us the death certificate if you can. If you cannot, you must tell us why not and give us whatever evidence you can.

(2) *Divorce or annulment.* If your marriage ends by divorce or annulment, you must show us the decree of divorce or annulment if you can. If you cannot, you must tell us why not and give us whatever evidence you can.

(3) *Other reason.* If your marriage ends for reasons other than death, divorce, or annulment, you must give us any information we ask you to give us about the end of the marriage. If you cannot, you must explain why you cannot. We will consider all of the relevant information to decide if and when your marriage ends.

WHO IS CONSIDERED A CHILD

§ 416.1851 Effects of being considered a child.

If we consider you to be a child for SSI purposes, the rules in this section apply when we determine your eligibility for SSI and the amount of your SSI benefits.

(a) If we consider you to be a student, we will not count all of your earned income when we determine your SSI eligibility and benefit amount. Section 416.1110 tells what we mean by earned income. Section 416.1112(c)(2) tells how much of your earned income we will not count.

(b) If you have a parent who does not live with you but who pays money to help support you, we will not count one-third of that money when we count your income. Section 416.1124(c)(9) discusses this rule.

(c) If you are under age 18 and live with your parent or stepparent who is not eligible for SSI benefits, we consider (deem) part of his or her income and resources to be your own. Sections 416.1165 and 416.1166 explain the rules and the exception to the rules on deeming your parent's income to be yours, and § 416.1202 explains the rules and the exception to the rules on deeming your parent's resources to be yours.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, and amended at 52 FR 8889, Mar. 20, 1987]

§ 416.1856 Who is considered a child.

We consider you to be a child if—

(a)(1) You are under 18 years old; or

(2) You are under 22 years old and you are a student regularly attending school or college or training that is designed to prepare you for a paying job;

(b) You are not married; and

(c) You are not the head of a household.

§ 416.1861 Deciding whether you are a child: Are you a student?

(a) *Are you a student?* You are a student regularly attending school or college or training that is designed to prepare you for a paying job if you are enrolled for one or more courses of study and you attend class—

(1) In a college or university for at least 8 hours a week under a semester or quarter system;

(2) In grades 7–12 for at least 12 hours a week;

(3) In a course of training to prepare you for a paying job, and you are attending that training for at least 15 hours a week if the training involves shop practice or 12 hours a week if it does not involve shop practice (this kind of training includes anti-poverty programs, such as the Job Corps, and government-supported courses in self-improvement); or

(4) Less than the amount of time given in paragraph (a) (1), (2), or (3) of this section for reasons you cannot control, such as illness, if the circumstances justify your reduced credit load or attendance.

(b) *If you have to stay home.* You may be a student regularly attending school, college, or training to prepare you for a paying job if—

(1) You have to stay home because of your disability;

(2) You are studying at home a course or courses given by a school (grades 7–12), college, university, or government agency; and

(3) A home visitor or tutor directs your study or training.

(c) *When you are not in school*—(1) *When school is out.* We will consider you to be a student regularly attending school, college, or training to prepare you for a paying job even when classes are out if you actually attend regularly just before the time classes are out and you—

(i) Tell us that you intend to resume attending regularly when school opens again; or

(ii) Actually do resume attending regularly when school opens again.

(2) *Other times.* Your counselor or teacher may believe you need to stay out of class for a short time during the course or between courses to enable you to continue your study or training. That will not stop us from considering you to be a student regularly attending school, college, or training to prepare you for a paying job if you are in—

(i) A course designed to prepare disabled people for work; or

(ii) A course to prepare you for a job that is specially set up for people who cannot work at ordinary jobs.

(d) *Last month of school.* We will consider you to be a student regularly attending school, college, or training to prepare you for a paying job for the month in which you complete or stop your course of study or training.

(e) *When we need evidence that you are a student.* We need evidence that you are a student if—

(1) You are 18 years old or older but under age 22, because we will not consider you to be a child unless we consider you to be a student; or

(2) We consider you to be a child and you expect to earn over $195 in any 3-month period, because we will not count all of your earned income if we consider you to be a student.

(f) *What evidence we need.* If we need evidence that you are a student, you must—

(1) Show us any paper you have that shows you are a student in a school, college, or training program, such as a student identification card or tuition receipt; and

(2) Tell us—

(i) What courses you are taking;

(ii) How many hours a week you spend in classes;

(iii) The name and address of the school or college you attend or the agency training you; and

(iv) The name and telephone number of someone at the school, college, or agency who can tell us more about your courses, in case we need information you cannot give us.

§ 416.1866 Deciding whether you are a child: Are you the head of a household?

(a) *Meaning of head of household.* You are the head of a household if you have left your parental home on a permanent basis and you are responsible for the day-to-day decisions on the operation of your own household. If you live with your parent(s) or stepparents, we will ordinarily assume you are not the head of a household. However, we will consider you to be the head of a household if for some reason (such as your parent's illness) you are the one who makes the day-to-day decisions. You need not have someone living with you to be the head of a household.

(b) *If you share decision-making equally.* If you live with one or more people and everyone has an equal voice in the decision-making (for example, a group of students who share off-campus housing), that group is not a household. Each person who has left the parental home on a permanent basis is the head of his or her own household.

WHO IS CONSIDERED YOUR PARENT

§ 416.1876 Effects a parent (or parents) can have on the child's benefits.

Section 416.1851 (b) and (c) tells what effects a parent's income and resources can have on his or her child's benefits.

§ 416.1881 Deciding whether someone is your parent or stepparent.

(a) We consider your parent to be—

(1) Your natural mother or father; or

(2) A person who legally adopted you.

(b) We consider your stepparent to be the present husband or wife of your natural or adoptive parent. A person is not your stepparent if your natural or adoptive parent, to whom your stepparent was married, has died, or if your parent and stepparent have been divorced or their marriage has been annulled.

(c) *Necessary evidence.* We will accept your statement on whether or not someone is your parent or stepparent unless we have information to the contrary. If we have contrary information, you must show us, if you can, one or more of the following kinds of evidence that would help to prove whether or not the person is your parent or stepparent: Certificate of birth, baptism, marriage, or death, or decree of adoption, divorce, or annulment. If you cannot, you must tell us why not and show us any other evidence that would help to show whether or not the person is your parent or stepparent.

Subpart S—Interim Assistance Provisions

AUTHORITY: Secs. 702(a)(5) and 1631 of the Social Security Act (42 U.S.C. 902(a)(5) and 1383).

SOURCE: 46 FR 47449, Sept. 27, 1981, unless otherwise noted.

INTRODUCTION

§ 416.1901 Scope of subpart S.

(a) *General.* This subpart explains that we may withhold your SSI benefit and/or State supplementary payments and send them to the State (or a political subdivision of the State) as repayment for interim assistance it gave you while your application for SSI was pending, or while your SSI benefits were suspended or terminated if you are subsequently found to have been eligible for such benefits. Before we will do this, the State must have entered into an interim assistance agreement with us authorizing such reimbursement, and you must have given written authorization for us to repay the State (or a political subdivision of the State).

(b) *Organization of this subpart.* We have organized this subpart as follows:

(1) *Definitions.* Section 416.1902 contains definitions of terms used in this subpart.

(2) *Authorizations.* Sections 416.1904 through 416.1908 give the rules that apply to your written authorization.

(3) *Interim assistance agreements.* Section 416.1910 gives the requirements for interim assistance agreements between us and the State.

(4) *Appeals.* Sections 416.1920 through 416.1922 describe your appeal rights in the State and in SSA.

[46 FR 47449, Sept. 27, 1981, as amended at 56 FR 19262, Apr. 26, 1991]

§ 416.1902 Definitions.

For purposes of this subpart—

Authorization means your written permission, in a form legally acceptable to us and to the State from which you received interim assistance, for us to withhold the appropriate SSI benefit payment and send it to the State.

Interim assistance means assistance the State gives you, including payments made on your behalf to providers of goods or services, to meet your basic needs, beginning with the day of the month you apply for SSI benefits and are eligible for them, and ending with, and including, the month your SSI benefit payments begin, or assistance the State gives you beginning with the day for which your eligibility for SSI benefits is reinstated after a period of suspension or termination and ending with, and including, the month the Secretary makes the first payment of benefits following the suspension or termination if it is determined subsequently that you were eligible for benefits during that period. It does not include assistance the State gives to or for any other person. If the State has prepared and cannot stop delivery of its last assistance payment to you when it receives your SSI benefit payment from us, that assistance payment is included as interim assistance to be reimbursed. Interim assistance does not include assistance payments financed wholly or partly with Federal funds.

SSI benefit payment means your Federal benefit and any State supplementary payment made by us to you on behalf of a State (see subpart T of this part) which is due you at the time we make the first payment of benefits or when your benefits are reinstated after suspension or termination. Advance payment, as defined in § 416.520, payment based upon presumptive disability or presumptive blindness, as defined in § 416.931, or certain payments made under the administrative immediate payment procedure, are not

considered SSI benefit payments for interim assistance purposes.

State for purposes of an interim assistance agreement, means a State of the United States, the District of Columbia, or the Northern Mariana Islands. For all other purposes (for example, payment, appeals, notices) *State* also means a political subdivision of any of these.

We, Us, or *Our* means the Social Security Administration.

You or *Your* means someone who has applied for or is already receiving SSI benefits.

[46 FR 47449, Sept. 28, 1981; 46 FR 50947, Oct. 16, 1981, as amended at 56 FR 19262, Apr. 26, 1991; 56 FR 25446, June 4, 1991]

AUTHORIZATIONS

§416.1904 Authorization to withhold SSI benefits.

We may withhold your SSI benefit payment and send it to the State to repay the State for the interim assistance it gave to you, if—

(a) We have an interim assistance agreement with the State at the time your authorization goes into effect; and

(b) Your authorization is in effect at the time we make the SSI benefit payment.

§416.1906 When your authorization is in effect.

Your authorization for us to withhold your SSI benefit payment, to repay the State for interim assistance the State gives you, is effective when we receive it, or (if our agreement with the State allows) when we receive notice from the State that it has received your authorization. It remains in effect until—

(a) We make the first SSI benefit payment on your initial application for benefits or, in the case of an authorization effective for a period of suspense or termination, until the initial payment following the termination or suspension of your benefits.

(b) We make a final determination on your claim (if your SSI claim is denied, the denial is the final determination, unless you file a timely appeal as described in subpart N of this part);

(c) You and the State agree to terminate your authorization; or

(d) If earlier than the event in paragraph (a), (b), or (c) of this section, the date (if any) specified in your authorization.

[46 FR 47449, Sept. 27, 1981, as amended at 56 FR 19262, Apr. 26, 1991]

§416.1908 When we need another authorization.

Once an event described in §416.1906 occurs, your authorization is no longer effective. If you reapply for SSI benefits, or the authorization has expired, the State must obtain a new authorization from you in order for us to repay the State for interim assistance it gives you.

INTERIM ASSISTANCE AGREEMENTS

§416.1910 Requirements for Interim assistance agreement.

An interim assistance agreement must be in effect between us and the State if we are to repay the State for interim assistance. The following requirements must be part of the agreement:

(a) *SSA to repay the State.* We must agree to repay the State for interim assistance it gives you. Repayment to the State takes priority over any underpayments due you (see §§416.525 and 416.542).

(b) *State to pay any excess repayment to you.* The State must agree that, if we repay it an amount greater than the amount of interim assistance it gave to you, the State will—

(1) Pay the excess amount to you no later than 10 working days from the date the State receives repayment from us; or

(2) Refund the excess amount to us for disposition under the rules in subpart E of the this part on payment of benefits if the State cannot pay it to you (for example, you die or you move and the State cannot locate you).

(c) *State to notify you.* The State must agree to give you written notice explaining—

(1) How much we have repaid the State for interim assistance it gave you;

(2) The excess amount, if any, due you; and

(3) That it will give you an opportunity for a hearing if you disagree

with State's actions regarding repayment of interim assistance.

(d) *Duration of the agreement.* We and the State must agree to the length of time that the agreement will remain in effect.

(e) *State to comply with other regulations.* The State must agree to comply with any other regulations that we find necessary to administer the interim assistance provisions.

APPEALS

§ 416.1920 Your appeal rights in the State.

Under its interim assistance agreement with us, the State must agree to give you an opportunity for a hearing if you disagree with the State's actions regarding repayment of interim assistance. For example, you are entitled to a hearing by the State if you disagree with the State regarding the amount of the repayment the State keeps or the amount of any excess the State pays to you. You are not entitled to a Federal hearing on the State's actions regarding repayment of interim assistance.

§ 416.1922 Your appeal rights in SSA.

If you disagree with the total amount of money we have withheld and sent to the State for the interim assistance it gave to you, you have a right to appeal to us, as described in subpart N of this part.

Subpart T—State Supplementation Provisions; Agreement; Payments

AUTHORITY: Secs. 702(a)(5), 1616, 1618, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1382e, 1382g, and 1383); sec. 212, Pub. L. 93–66, 87 Stat. 155 (42 U.S.C. 1382 note); sec. 8(a), (b)(1)–(b)(3), Pub. L. 93–233, 87 Stat. 956 (7 U.S.C. 612c note, 1431 note and 42 U.S.C. 1382e note); secs. 1(a)–(c) and 2(a), 2(b)(1), 2(b)(2), Pub. L. 93–335, 88 Stat. 291 (42 U.S.C. 1382 note, 1382e note).

SOURCE: 40 FR 7640, Feb. 21, 1975, unless otherwise noted.

§ 416.2001 State supplementary payments; general.

(a) *State supplementary payments; defined.* State supplementary payments are any payments made by a State or one of its political subdivisions (including any such payments for which reimbursement is available from the Social Security Administration pursuant to Pub. L. 94–23, as amended) to a recipient of supplemental security income benefits (or to an individual who would be eligible for such benefits except for income), if the payments are made:

(1) In supplementation of the Federal supplemental security income benefits; i.e., as a complement to the Federal benefit amount, thereby increasing the amount of income available to the recipient to meet his needs; and

(2) Regularly, on a periodic recurring, or routine basis of at least once a quarter; and

(3) In cash, which may be actual currency or any negotiable instrument, convertible into cash upon demand; and

(4) In an amount based on the need or income of an individual or couple.

(b) *State; defined.* For purposes of this subpart, *State* means a State of the United States or the District of Columbia.

(c) *Mandatory minimum supplementary payments.* In order for a State to be eligible for payments pursuant to title XIX of the Act with respect to expenditures for any quarter beginning after December 1973, such State must have in effect an agreement with the Secretary under which such State will provide to aged, blind, and disabled individuals (as defined in § 416.202) residing in the State who were recipients of aid or assistance for December 1973 as defined in § 416.121, under such State's plan approved under title I, X, XIV, or XVI of the Act, mandatory minimum supplementary payments beginning in January 1974 in an amount determined in accordance with § 416.2050 in order to maintain their income levels of December 1973. (See §§ 416.2065 and 416.2070.)

(d) *Supplementary payments for recipients of special SSI cash bentfits.* A State which makes supplementary payments (regardless of whether they are mandatory or optional and whether the payments are federally administered), has the option of making those payments to individuals who receive cash benefits under section 1619(a) of the Act (see § 416.261), or who would be eligible to

receive cash benefits except for their income.

[40 FR 7640, Feb. 21, 1975, as amended at 43 FR 48995, Oct. 20, 1978; 45 FR 54748, July 18, 1980; 47 FR 15326, Apr. 9, 1982]

§416.2005 Administration agreements with the Secretary.

(a) *Agreement—mandatory only.* Subject to the provisions of paragraph (d) of this section, any State having an agreement with the Secretary under §416.2001(c) may enter into an administration agreement with the Secretary under which the Secretary will make the mandatory minimum supplementary payments on behalf of such State. An agreement under §416.2001(c) and an administration agreement under this paragraph may be consolidated into one agreement.

(b) *Agreement—mandatory and optional payments.* Subject to the provisions of paragraph (d) of this section, any State may enter into an agreement with the Secretary under which the State will provide both mandatory and optional State supplementary payments and elect Federal administration of such State supplementary payment programs. If the Secretary agrees to administer such State's optional supplementary payments, the State must also have the Secretary administer its mandatory minimum supplementary payments unless the State is able to provide sufficient justification for exemption from this requirement.

(c) *Administration—combination.* Any State may enter into an agreement with the Secretary under which the State will provide mandatory minimum supplementary payments and elect Federal administration of such payments while providing optional State supplementary payments which it shall administer itself. If the State chooses to administer such payment itself, it may establish its own criteria for determining eligibility requirements as well as the amounts.

(d) *Conditions of administration agreement.* The State and the Secretary may, subject to the provisions of this subpart, enter into a written agreement, in such form and containing such provisions not inconsistent with this part as are found necessary by the Secretary, under which the Secretary will administer the State supplementary payments on behalf of a State (or political subdivision). Under such an agreement between the Secretary and a State, specific Federal and State responsibilities for administration and fiscal responsibilities will be stipulated. The regulations in effect for the supplemental security income program shall be applicable in the Federal administration of State supplementary payments except as may otherwise be provided in this subpart as found by the Secretary to be necessary for the effective and efficient administration of both the basic Federal benefit and the State supplementary payment.

§416.2010 Essentials of the administration agreements.

(a) *Payments.* Any agreement between the Secretary and a State made pursuant to §416.2005 must provide that, if for optional supplementation, such State supplementary payments are made to all individuals and/or couples who are:

(1) Receiving (or at the option of the State would, but for the amount of their income, be eligible to receive) supplemental security income benefits under title XVI of the Social Security Act, and

(2) Within the variations and categories (as defined in §416.2030) for which the State (or political subdivision) wishes to provide a supplementary payment, and

(3) Residing, subject to the provisions of §416.2035(a), in such State (or political subdivision thereof).

(b) *Fiscal bases specified.* If, for any fiscal year, a State wishes to claim fiscal protection under the provisions of §416.2080, the agreement between a State and the Secretary will specify the dollar amount(s) of the adjusted payment level(s), as defined in §416.2085. The non-Federal share of expenditures for calendar year 1972 as defined in §416.2082 will also be stated in the agreement. These amounts, if not known at the time the agreement is entered into, may be provisionally agreed upon and subsequently verified by Department of Health, Education, and Welfare audits. If the State elects options available under this subpart (specified in §§416.2015 through

416.2035), such options must be specified in the administration agreement.

(c) *Administrative costs.* The agreement between the State and the Secretary shall specify that all administrative costs incurred by the Secretary will be borne by the Federal Government.

(d) *Agreement period.* The agreement period for a State which, prior to January 1, 1974, elects Federal administration of its supplement will extend from January 1, 1974, through June 30, 1974. The agreement will be automatically renewed for a period of 1 year unless either the State or the Secretary gives written notice not to renew, at least 90 days before the beginning of the new period. For a State to elect Federal administration after January 1, 1974, it must notify the Secretary of its intent to enter into an agreement, furnishing the necessary payment specifications, at least 120 days before the first day of the month for which it wishes Federal administration to begin, and have executed such agreement at least 30 days before such day. Such a State's initial agreement period will run until the following June 30 at which time its agreement will be automatically renewed for 1 year unless the State or the Secretary has given written notice not to renew at least 90 days before the end of that period.

(e) *Modification or termination.* The agreement may be modified at any time by mutual consent. The State or the Secretary may terminate the agreement upon 90 days written notice to the other party, provided the effective date of the termination is the last day of a quarter. However, the State may terminate the agreement upon 45 days written notice to the Secretary where: (1) The State does not wish to comply with a regulation promulgated by the Secretary subsequent to the execution of the agreement; and (2) the State provides such written notice within 30 days of the effective date of the regulation. The Secretary is not precluded from terminating the agreement in less than 90 days where he finds that a State has failed to materially comply with the provisions of paragraph (f) of this section or § 416.2090.

(f) *Mandatory minimum State supplementation.* Any administration agreement between the Secretary and a State under which the Secretary will make such State's mandatory minimum State supplementary payments shall provide that the State will:

(1) *Certify income and payment amount.* Certify to the Secretary the names of each individual who, for December 1973 was eligible for and a recipient of aid or assistance in the form of money payments under a plan of such State approved under title I, X, XIV, or XVI of the Act (§ 416.121), together with the amount of such aid or assistance payable to each such individual and the amount of such individual's other income (as defined in § 416.2050(b)(2)), and

(2) *Additional data.* Provide the Secretary with such additional data at such times as the Secretary may reasonably require in order to properly, economically, and efficiently carry out such administration agreement. This shall include required information on changes in countable income as well as changes in special needs and circumstances that would result in a decrease in the mandatory income level being maintained by the State, unless the State has specified in the agreement that the minimum income level shall not be lowered by such changes.

§ 416.2015 Establishing eligibility.

(a) *Applications.* Any person who meets the application requirements of subpart C of this part is deemed to have filed an application for any federally administered State supplementation for which he may be eligible unless supplementation has been waived pursuant to § 416.2047. However, a supplemental statement will be required where additional information is necessary to establish eligibility or to determine the correct payment amount.

(b) *Evidentiary requirements.* The evidentiary requirements and developmental procedures of this part are applicable with respect to federally administered State supplementary payments.

(c) *Determination.* Where not inconsistent with the provisions of this subpart, eligibility for and the amount of the State supplementary payment will

be determined pursuant to the provisions of subparts A through Q of this part.

(d) *Categories; aged, blind, disabled.* An applicant will be deemed to have filed for the State supplementary payment amount provided for the category under which his application for a Federal supplemental security income benefit is filed. As in the Federal supplemental security income program, an individual who establishes eligibility as a blind or disabled individual, and continually remains on the rolls, will continue to be considered blind or disabled after he attains age 65.

(e) *Concurrent categories.* (1) In States where the supplementary payment provided for the aged category is higher than for the blind or disabled category aged individuals will be paid the State supplement on the basis of age.

(2) If the administration agreement pursuant to § 416.2005(b) provides for higher supplementary payments to the blind or disabled than to the aged category, then, at the option of the State, the agreement may provide that individuals who are age 65 or over at time of application and who are blind or disabled may elect to receive such higher supplementary payments.

§ 416.2020 Federally administered supplementary payments.

(a) *Payment procedures.* A federally administered State supplementary payment will be made on a monthly basis and will be included in the same check as a Federal benefit that is payable. A State supplementary payment shall be for the same month as the Federal benefit.

(b) *Maximum amount.* There is no restriction on the amount of a State supplementary payment that the Federal Government will administer on behalf of a State.

(c) *Minimum amount.* The Federal Government will not administer optional State supplementary payments in amounts less than $1 per month. Hence, optional supplementary payment amounts of less than $1 will be raised to a dollar.

(d) *Optional supplementation: nine categories possible.* A State may elect Federal administration of its supplementary payments for up to nine categories, depending on the assistance titles in effect in that State in January 1972 (i.e., title I, X, XIV, or XVI). It can have no more than two categories (one for individuals and one for couples) for each title in effect for January 1972:

(1) Since a State with a title XVI program had just the one title in effect, it can supplement only to two categories, the individual (aged, blind, or disabled), the couple (both of whom are aged, blind, or disabled).

(2) Other States could supplement up to nine categories, depending on the plans they had in effect. Six of these categories would be for:

(i) Aged Individual,
(ii) Aged Couple,
(iii) Blind Individual,
(iv) Blind Couple,
(v) Disabled Individual,
(vi) Disabled Couple.

(3) In addition to those enumerated in paragraph (d)(2) of this section, there are three additional couple categories for which a State may elect to provide a federally administered supplement. These categories are created when one individual in the couple is:

(i) Aged and the other blind, or
(ii) Aged and the other disabled, or
(iii) Blind and the other disabled.

[40 FR 7640, Feb. 21, 1975, as amended at 50 FR 48579, Nov. 26, 1985]

§ 416.2025 Optional supplementation: Countable income.

(a) *Earned and unearned income.* No less than the amounts of earned or unearned income which were excluded in determining eligibility for or amount of a title XVI supplemental security income benefit must be excludable by a State in the Federal-State agreement for purposes of determining eligibility for or amount of the State supplementary payment.

(b) *Effect of countable income on payment amounts. Countable income* of an eligible individual or eligible couple is determined in the same manner as such income is determined under the title XVI supplemental security income program. Countable income will affect the amount of the State supplementary payments as follows:

(1) As provided in § 416.420, countable income will first be deducted from the Federal benefit rate applicable to an

eligible individual or eligible couple. In the case of an eligible individual living with an ineligible spouse with income (the deeming provisions of § 416.1163 apply), the Federal benefit rate from which countable income will be deducted is the Federal benefit rate applicable to an eligible couple, except that an eligible individual's payment amount may not exceed the amount he or she would have received if he or she were not subject to the deeming provisions (§ 416.1163(e)(2)).

(2) If countable income is equal to or less than the amount of the Federal benefit rate, the full amount of the State supplementary payment as specified in the Federal agreement will be made.

(3) If countable income exceeds the amount of the Federal benefit rate, the State supplementary benefit will be reduced by the amount of such excess. In the case of an eligible individual living with an ineligible spouse with income (the deeming methodology of § 416.1163 applies), the State supplementary payment rate from which the excess income will be deducted is the higher of the State supplementary rates for an eligible couple or an eligible individual, except that an eligible individual's payment amount may not exceed the amount he or she would have received if he or she were not subject to the deeming provisions (see § 416.1163(e)(2)). For purposes of determining the State supplementary couple rate, the ineligible spouse is considered to be in the same category as the eligible individual.

(4) No State supplementary payment will be made where countable income is equal to or exceeds the sum of the Federal benefit rate and the State supplementary payment rate.

(c) *Effect of additional income exclusions on payment amounts.* A State has the option of excluding amounts of earned and unearned income in addition to the amounts it is required to exclude under paragraph (a) of this section in determining a person's eligibility for State supplementary payments. Such additional income exclusions affect the amount of the State supplementary payments as follows:

(1) Countable income (as determined under the Federal eligibility rules) will first be deducted from the Federal benefit rate applicable to an eligible individual or eligible couple.

(2) Such countable income is then reduced by the amount of the additional income exclusion specified by the State.

(3) If the remaining countable income is equal to or less than the amount of the Federal benefit rate, the full amount of the State supplementary payment will be made.

(4) If the remaining countable income exceeds the amount of the Federal benefit rate, the State supplementary payment will be reduced by the amount of such excess.

(Secs. 1102, 1614(f), 1616(a), 1631, Social Security Act, as amended, 49 Stat. 647, as amended, 86 Stat. 1473, 1474(a), and 1475 (42 U.S.C. 1302, 1382c(f), 1382e(a), 1383))

[40 FR 7640, Feb. 21, 1975, as amended at 43 FR 39570, Sept. 6, 1978; 53 FR 25151, July 5, 1988]

§ 416.2030 Optional supplementation: Variations in payments.

(a) *Payment level.* The level of State supplementary payments may vary for each category the State elects to include in its federally administered supplement. These categorical variations of payment levels must be specified in the agreement between the Secretary and the State. If any State has in effect for July 1974 an agreement which provides for variations in addition to those specified in this section, the State may, at its option, continue such variations but only for periods ending before July 1, 1976.

(1) *Geographical variations.* A State may elect to include two different geographical variations. A third may be elected if adequate justification, e.g., substantial differences in living costs, can be demonstrated. All such variations must be readily identifiable by county or ZIP code or other readily identifiable factor.

(2) *Living arrangements.* In addition, a State may elect up to six variations in recognition of the different needs which result from various living arrangements. If a State elects six payment level variations based on differences in living arrangements, one of these six variations must apply only to individuals in Medicaid facilities, that

is, facilities receiving title XIX payments with respect to such persons for the cost of their care (see §416.211(b)(1)). In any event, States are limited to one payment level variation for residents of Medicaid facilities. Types of other living arrangements for which payment variations may be allowed include arrangements such as:

(i) Living alone;

(ii) Living with an ineligible spouse;

(iii) Personal care facility; or,

(iv) Domiciliary or congregate care facility.

(b) *Relationship to actual cost differences.* Under the agreement, variations in State supplementary payment levels will be permitted for each living arrangement the State elects. These differences must be based on rational distinctions between both the types of living arrangements and the costs of those arrangements.

(c) *Effective month of State supplementary payment category.* The State supplementary payment category which applies in the current month will be used to determine the State payment level in that month. This rule applies even if the countable income in a prior month is used to determine the amount of State supplementary payment.

[40 FR 7640, Feb. 21, 1975, as amended at 50 FR 48579, Nov. 26, 1985; 56 FR 41455, Aug. 21, 1991]

§416.2035 Optional supplementation: Additional State options.

(a) *Residency requirement.* A State or political subdivision may impose, as a condition of eligibility, a residency requirement which excludes from eligibility for State supplementary payment any individual who has resided in such State (or political subdivision thereof) for less than a minimum period prescribed by the State. Any such residency requirement will be specified in the agreement.

(b) *Lien and relative responsibility.* A State which elects Federal administration of its supplementary payments may place a lien upon property of an individual as a consequence of the receipt of such payments or may require that a relative of the individual contribute to a reasonable extent to the support of the individual, providing it is stated in the agreement that:

(1) The Secretary has determined that the specific State laws and their enforcement are consistent with the supplemental security income program purpose of providing unencumbered cash payments to recipients; and

(2) The Federal Government is not involved in the administration of such laws and will not vary the State supplementary payment amount it makes to comply with such laws; and

(3) Neither the basic Federal benefit nor any part of the State supplementary payment financed by Federal funds will be subject to the liens or encumbrances of such laws.

§416.2040 Limitations on eligibility.

Notwithstanding any other provision of this subpart, the eligibility of an individual (or couple) for optional State supplementary payments administered by the Federal Government in accordance with this subpart shall be limited as follows:

(a) *Inmate of public institution.* A person who is a resident in a public institution for a month, is ineligible for a Federal benefit for that month under the provision of §416.211(a), and does not meet the requirements for any of the exceptions in §416.211 (b), (c), or (d), or §416.212, also shall be ineligible for a federally administered State supplementary payment for that month.

(b) *Ineligible persons.* No person who is ineligible for a Federal benefit for any month under sections 1611(e)(1)(A), (2), (3), or (f) of the Act (failure to file; refuses treatment for drug addiction or alcoholism; outside the United States) or section 1615 of the Act (refuses vocational rehabilitation) or other reasons (other than the amount of income) shall be eligible for such State supplementation for such month.

(c) *Recipient eligible for benefits under §416.212.* A recipient who is institutionalized and is eligible for either benefit payable under §416.212 for a month or months may also receive federally administered State supplementation for that month. Additionally, a recipient who would be eligible for benefits under §416.212 but for countable income which reduces his or her Federal SSI benefit to zero, may still be eligible to

receive federally administered State supplementation.

[40 FR 7640, Feb. 21, 1975, as amended at 56 FR 41455, Aug. 21, 1991; 61 FR 10280, Mar. 13, 1996]

EFFECTIVE DATE NOTE: At 61 FR 10280, Mar. 13, 1996, in § 416.2040, paragraph (a) was revised, and (c) was added, effective May 13, 1996. For the convenience of the reader, the superseded text is set forth below.

§ 416.2040 Limitations on eligibility.

* * * * *

(a) *Inmate of public institution.* No person who is ineligible for a Federal benefit pursuant to § 416.231(a)(1) shall be eligible for such State supplementation for that month.

* * * * *

§ 416.2045 Overpayments and underpayments; federally administered supplementation.

(a) *Overpayments.* Upon determination that an overpayment has been made, adjustments will be made against future federally administered State supplementary payments for which the person is entitled. Rules and requirements (see §§ 416.550 through 416.572) in effect for recovery (or waiver) of supplemental security income benefit overpayments shall also apply to the recovery (or waiver) of federally administered State supplementary overpaid amounts. If the overpaid person's entitlement to the State supplementary payments is terminated prior to recoupment of the overpaid State supplementary payment amount, and the overpayment cannot be recovered from a Federal benefit payable under this part, the person's record will be annotated (specifying the amount of the overpayment) to permit recoupment if the person becomes reentitled to supplementary payments of such State or to a Federal benefit under this part.

(b) *Underpayments.* Upon determination that an underpayment of State supplementary payments is due and payable, the underpaid amount shall be paid to the underpaid claimant directly, or his representative. If the underpaid person dies before receiving the underpaid amount of State supplementary payment the underpaid amount shall be paid to the claimant's eligible spouse. If the deceased claimant has no eligible spouse, no payment of the underpaid amount shall be made. (See §§ 416.538 through 416.543.)

§ 416.2047 Waiver of State supplementary payments.

(a) *Waiver request in writing.* Any person who is eligible to receive State supplementary payments or who would be eligible to receive such State supplementary payments may waive his right to receive such payments if such person makes a written request for waiver of State supplementary payments. Any such request made at time of application for the Federal benefit shall be effective immediately. Any such request filed after the application is filed shall be effective the month the request is received in a social security office, or earlier if the recipient refunds to the Social Security Administration the amount of any supplementary payment(s) made to him for the subject period.

(b) *Revocation of waiver.* Any individual who has waived State supplementary payments may revoke such waiver at any time by making a written request to any social security office. The revocation will be effective the month in which it is filed. The date such request is received in a social security office or the postmarked date, if the written request was mailed, will be the filing date, whichever is earlier.

§ 416.2050 Mandatory minimum State supplementation.

(a) *Determining the amount.* The amount of a mandatory State supplementary payment in the case of any eligible individual or couple for any month is equal to:

(1) The amount by which such individual or couple's December 1973 income (as defined in paragraph (b) of this section) exceeds the amount of such individual or couple's title XVI benefit plus other income which would have been used by such State in computing the assistance payable under the State's approved plan for such month; or

(2) Such greater amount as the State may specify.

(b) *December 1973 income.* ''December 1973 income'' means an amount equal to the aggregate of:

(1) *Money payments.* The amount of the aid or assistance in the form of money payments (as defined in 45 CFR 234.11(a)) which an individual would have received (including any part of such amount which is attributable to meeting special needs or special circumstances) under a State plan approved under title I, X, XIV, or XVI of the Act in accordance with the terms and conditions of such plan relating to eligibility for and amount of such aid or assistance payable thereunder which were in effect for the month of June 1973 together with the bonus value of food stamps for January 1972 (as defined in §416.2085(e)) if for such month such individual resides in a State which the Secretary has determined provides supplementary payments the level of which has been found by the Secretary pursuant to section 8 of Pub. L. 93–233 (87 Stat. 956) to have been specifically increased so as to include the bonus value of food stamps, and

(2) *Income.* The amount of the income of such individual other than aid or assistance, received by such individual in December 1973, remaining after application of all appropriate income exclusions and used in computation of the amount of aid or assistance, minus any such income which did not result, but which if properly reported, would have resulted in a reduction in the amount of such aid or assistance. Income, which because a State paid less than 100% of its standard of need, did not cause a reduction in the amount of aid or assistance is included.

(c) *Special needs or circumstances.* Special needs or circumstances include needs of essential persons (as defined in §416.222), special allowances for housing, and such other situations for which money payments to or for an eligible individual were made under a State plan approved under title I, X, XIV, or XVI of the Act as in effect for June 1973.

(d) *Optional supplement payable.* A recipient meeting the requirements of paragraph (a) of this section who would otherwise qualify for a payment under a State's program of optional State supplementation (provided for by §416.2010) which is greater than the amount required by paragraph (a) of this section, shall be paid such greater amount.

[40 FR 7640, Feb. 21, 1975, as amended at 51 FR 10616, Mar. 14, 1986]

§416.2055 Mandatory minimum supplementation reduced.

If for any month after December 1973 there is a change with respect to any special need or special circumstance which, if such change had existed in December 1973, would have caused a reduction in the amount of such individual's aid or assistance payment, then, for such month and for each month thereafter, the amount of the mandatory minimum supplement payable to such individual may, at the option of the State, be reduced in accordance with the terms and conditions of the State's plan approved under title I, X, XIV, or XVI of the Act in effect for the month of June 1973.

§416.2060 Mandatory minimum supplementary payments not applicable.

An individual eligible for mandatory minimum supplementary payments from a State beginning in January 1974 shall not be eligible for such payments:

(a) *Month after the month of death.* Beginning with the month after the month in which the individual dies; or

(b) *Not aged, blind, or disabled.* Beginning with the first month after the month in which such individual ceases to be an aged, blind, or disabled individual (as defined in §416.202); or

(c) *Not entitled to a Federal payment.* During any month in which such individual was ineligible to receive supplemental income benefits under title XVI of the Social Security Act by reason of the provisions of section 1611(e)(1)(A), (2) or (3), 1611(f), or 1615(c) of such Act; or

(d) *Month of change in residence.* During any full month such individual is not a resident of such State.

§416.2065 Mandatory minimum State supplementation: Agreement deemed.

A State shall be deemed to have entered into an agreement with the Secretary under which such State shall

provide mandatory minimum supplementary payments if such State has entered into an agreement with the Secretary under section 1616 of the Act under which:

(a) *Other eligible individuals.* Supplementary payments are made to individuals other than those aged, blind, and disabled individuals who were eligible to receive aid or assistance in the form of money payments for the month of December 1973 under a State plan approved under title I, X, XIV, or XVI of the Act, under terms and conditions of such plan in effect for June 1973, and

(b) *Minimum requirements.* Supplementary payments which meet the mandatory minimum requirements of this subpart are payable to all aged, blind, or disabled individuals who were eligible to receive aid or assistance in the form of money payments for the month of December 1973 under a State plan approved under title I, X, XIV, or XVI of the Act, under terms and conditions of such plan in effect for June 1973.

§ 416.2070 Mandatory supplementation: State compliance not applicable.

The requirement that a State must have in effect an agreement with the Secretary whereby such State shall provide individual aged, blind, and disabled recipients residing in the State mandatory minimum supplementary payments beginning in January 1974 shall not be applicable in the case of any State where:

(a) *State constitution.* The State constitution limits expenditures that may be paid as public assistance to, or on behalf of, any needy person to an amount that does not exceed the amount of State public assistance payments that are matched by Federal funds under title I, IV, X, XIV, XVI or XIX of the Social Security Act making it impossible for such State to enter into and commence carrying out (on January 1, 1974) such agreement with the Secretary, and

(b) *Attorney General decision.* The Attorney General (or other appropriate State official) has, prior to July 1, 1973, made a finding that the State constitution of such State contains limitations which prevent such State from making supplementary payments of the type described in section 1616 of the Act.

§ 416.2075 Monitoring of mandatory minimum supplementary payments.

(a) *Access to records.* Any State entering into an agreement with the Secretary whereby such State will provide mandatory minimum supplementary payments in accordance with § 416.2001(c) shall agree that the Secretary shall have access to and the right to examine any directly pertinent books, documents, papers, and records of the State involving transactions related to this agreement.

(b) *Additional data.* Any State entering into an agreement in accordance with § 416.2005 shall provide the Secretary with such additional data at such times as the Secretary may reasonably require in order to properly, economically, and efficiently be assessed of such State's compliance with such State agreements.

§ 416.2080 Limitation of fiscal liability of States.

(a) *Fiscal limits.* (1) *Fiscal years before fiscal year 1982.* For each fiscal year before fiscal 1982, the amount payable to the Secretary by a State for the amount of the supplementary payments described in paragraph (c) of this section which are made on its behalf pursuant to the administration agreement with the Secretary as described in § 416.2005 shall not exceed the total amount of the State's calendar year 1972 non-Federal share of expenditures as aid or assistance under the State plan(s) approved under title I, X, XIV, or XVI of the Act, as set forth in § 416.2082.

(2) *Fiscal years after fiscal year 1981.* For each fiscal year after fiscal year 1981, the amount payable to the Secretary by a State for the amount of the supplementary payments described in paragraph (c) of this section which are made on its behalf pursuant to the administration agreement with the Secretary as described in § 416.2005 shall not exceed the total amount of the State's calendar year 1972 non-Federal share of expenditures as aid or assistance under the State plan(s) approved under title I, X, XIV, or XVI of the Act, as set forth in § 416.2082. *Except that:* If

the total amount of the supplementary payments described in paragraph (c) (protected payments) exceeds the total amount of the State's calendar year 1972 non-Federal share of expenditures as set forth in § 416.2082, for any fiscal year after fiscal year 1981, additional amounts shall be payable to the Secretary by the State as follows:

(i) For fiscal year 1982, 40 percent of the amount of the total protected payments that exceeds the State's calendar year 1972 non-federal share of expenditures;

(ii) For fiscal year 1983, 60 percent of the amount of the total protected payments that exceeds the State's calendar year 1972 non-federal share of expenditures;

(iii) For fiscal year 1984, 80 percent of the amount of the total protected payments that exceeds the State's calendar year 1972 non-federal share of expenditures; and

(iv) For fiscal years after fiscal year 1984, 100 percent of the amount of total protected payments that exceeds the State's calendar year 1972 non-federal share of expenditures.

(b) *Less than full fiscal year period.* Should the agreement cover less than a full fiscal year, the limitation on the amount of the State's fiscal liability protection is the same as described in paragraph (a) of this section. The only exceptions are the fiscal liability protection for States for January through June of 1974 which will be determined by dividing the calendar year 1972 non-Federal share of expenditures as described in § 416.2082 by two and the fiscal liability protection for States for July through September of 1976 which will be determined by dividing the calendar year 1972 non-Federal share of expenditures as described in § 416.2082 by four.

(c) *State fiscal protection.* Except as provided in paragraph (e) of this section, the provisions of paragraphs (a) and (b) of this section apply only to that portion of the State supplementary payments made by the Secretary on behalf of a State under an agreement for any month that does not exceed, in the case of any individual (or couple), the difference between—

(1) The adjusted payment level as defined in § 416.2085 under the appropriate approved State plan(s) as in effect for January 1972; and

(2) An amount equal to—

(i) The benefits paid for the current month under title XVI; plus

(ii) Any income not excluded under subpart K of this part; less

(iii) The amount of any cost-of-living increase in Federal benefits under section 1617 of the Social Security Act (or any general increase enacted by law in the dollar amounts referred to in section 1617) becoming effective after June 30, 1977.

(d) *Unprotected payments.* Except as provided in paragraph (e) of this section, the State shall make entirely at State expense that portion of the State supplementary payment that is, in the case of any individual, more than the difference between (1) the State's January 1972 adjusted payment level and (2) the Federal benefit plus income counted under Federal eligibility rules and less the amount of any cost-of-living or general increase in the Federal benefits becoming effective after June 30, 1977.

(e) *Credits and debits.* For purposes of determining the extent of protected payments where State supplementary payments are paid at varying levels, to the extent that payments above the adjusted payment level do not exceed the difference by which variations in payment levels (variant payment levels) are established below the adjusted payment level, payments count toward the amount of a State's fiscal liability protection. This provision is explained as follows:

(1) The variant payment levels must be both above and below the adjusted payment level. The variant payment level is the sum of the Federal benefit plus income counted under Federal eligibility rules; less the amount of the cost-of-living and general increases in the Federal benefits becoming effective after June 30, 1977; plus the State supplementary payment.

(2) In each case where the variant payment level is below the adjusted payment level and a State supplementary payment is made, a credit will be given to the extent of the difference between the adjusted payment level and the variant payment level. While countable income affects the amount of the State's supplementary payment,

it has no effect on the amount of credit given. Cumulative credit will be given for the number of cases in each variation below the adjusted payment level. The credit given to each case within such a variation is always the same because it is not adjusted to reflect payments that are reduced due to income.

(3) In each case where the variant payment level is above the adjusted payment level and a State supplementary payment is made which equals either the full or partial difference between the variant payment level and the adjusted payment level, a debit will be given to the extent of such difference. A cumulative debit amount will be given for such cases in each variation that exceeds the adjusted payment level.

(4) Neither a credit nor a debit is applicable to those cases where a State's variant payment level is equal to the adjusted payment level.

(5) For those States which apply additional income exclusions as explained in § 416.2025(c), the computation of credits and debits will be made as if supplementary payments had been made without regard to such additional income exclusions.

(6) For purposes of paragraph (e)(4) of this section, credits may be applied to debits at any time within a fiscal year. The amount that would count toward a State's fiscal liability protection once the non-Federal share of 1972 expenditures has been met will be determined by the extent to which total credits within each category of supplementation equal total debits within each category of supplementation in a fiscal year. The amount by which total debits exceed total credits will be borne entirely at State expense.

(f) *Fiscal limit not applicable.* The limitation on the fiscal liability provision does not apply to any State supplementary payments, that are made to individuals or couples within any category for which the adjusted payment level is less than, or equal to the Federal monthly benefit rate (excluding the cost-of-living and general increases in the Federal benefits becoming effective after June 30, 1977) for an eligible individual or eligible couple as specified in §§ 416.410 and 416.412. Further, the provisions of paragraph (a) of this section do not apply to the amount of any State supplementary payment that results from the application of additional income exclusions specified by the State in its agreement with the Secretary (see § 416.2025(c)). In addition, the provisions of paragraph (a) of this section do not apply with respect to supplementary payments to any individual (or couple) who—

(1) Is not required to be included in the agreement administered by the Secretary (see § 416.2010(a)); and

(2) Would have been ineligible (for reasons other than income) for payments under the appropriate approved State plan as in effect for January 1972.

(g) *Refugee assistance.* The State shall not be liable under this subpart to the Secretary for the amount of any State supplementary payment for which reimbursement is available from the Social and Rehabilitation Service pursuant to the Indochina Migration and Refugee Assistance Act of 1975 (Pub. L. 94–23), as amended. Further, such amount shall not be considered or included as a State supplementary payment for any purpose under this section, e.g., it shall not be included for determining when a State has exceeded the total amount described in paragraph (a) of this section, it does not give rise to debits or credits under paragraph (e) of this section, etc.

[40 FR 7640, Feb. 21, 1975, as amended at 41 FR 36017, Aug. 26, 1976; 42 FR 52392, Sept. 30, 1977; 45 FR 54748, July 18, 1980; 48 FR 27539, June 16, 1983]

§ 416.2082 Non-Federal share of expenditures; defined.

The term ''non-Federal'' share of expenditures as aid or assistance for quarters in the calendar year 1972 under the plans of a State approved under title I, X, XIV, or XVI of the Act means the difference between:

(a) The total matchable expenditures as aid or assistance for such plans (excluding expenditures authorized under section 1119 of the Act as in effect prior to October 30, 1972, for repairing the home of an individual who was receiving aid or assistance under one of the appropriate approved State plans); and

(b) The total of the amounts determined under sections 3, 1003, 1118, 1403, and 1603 of the Act and under section 9 of the Act of April 19, 1950, for such State with respect to such expenditures in such quarters.

§416.2085 Adjusted payment level.

(a) *Adjusted payment level; defined.* ''Adjusted payment level'' means the amount of the money payment under the appropriate State plan(s) approved under title I, X, XIV, or XVI of the Social Security Act to individuals (or couples) within a category who had no other income (excluding eligible recipients who received no payments) for the month of January 1972; plus (at State option) an amount no greater than the sum of a payment level modification (as described in paragraph (d) of this section) and (at State option) beginning July 1, 1975, the bonus value of food stamps in the State for January 1972 (as described in paragraph (e) of this section). Also, prior to July 1, 1975, those States which the Secretary has determined provide supplementary payments the level of which has been found by the Secretary pursuant to section 8 of Pub. L. 93–233 (87 Stat. 956) to have been specifically increased so as to include the bonus value of food stamps may include such bonus value in the computation of the adjusted payment level. (See 7 CFR 271.10 published at 39 FR 3812, January 30, 1974.)

(1) *Amount of money payment.* The amount of the money payment will be determined by computing the average of the cash payments made for basic needs and special needs, (but excluding cases involving only personal needs payments to recipients residing in medical facilities, and payments that included an amount for the needs of an ''essential person'') to individuals who were not living in the household of another, whose support and maintenance was not contributed to by another, and who had no other income. In addition, States may include domiciliary care payments to individuals with no other income (within each category).

(2) *No other income.* Cases in which income which was totally disregarded by a State in determining the amount of the money payment will be considered cases in which there was ''no other income.'' For these purposes, in-kind or imputed income will be treated the same as cash income.

(b) *Adjusted payment levels for couples: Computation method.* If the State's records do not contain sufficient information to compute the actual amount of the money payment for couples for January 1972, then the adjusted payment level for couples may be computed by multiplying the sum of the average money payment to individuals in the appropriate category (as defined in §416.2020(d)) and the payment level modification for that category by the ratio of the payment standard for a couple to the payment standard for an individual in that category, and then in accordance with paragraph (a) of this section, adding the bonus value of food stamps to the result. With respect to adjusted payment levels used for the period January 1, 1974, through June 30, 1974, the ratio of the payment standards, if less than 1.5 shall be raised to 1.5; ratios in excess of 2.0 shall be lowered to 2.0.

(c) *Payment standard.* ''Payment standard'' (PS) means the amount specified as the ''payment standard'' in the approved State plan as in effect for January 1972 under title I, X, XIV, or XVI of the Act.

(d) *Payment level modification.* ''Payment level modification'' (PLM) with respect to any State plan means the amount by which a State which paid less than 100 percent of its standard of need could have increased its January 1972 money payments for basic needs to persons with no other income by reducing the need standard and raising the maximum amount payable so that the increased payments equal 100 percent of the new standard without increasing the non-Federal share of expenditures under titles I, X, XIV, and XVI of the Act for calendar year 1972.

(1) *Maximum amount payable.* The ''maximum amount payable'' (M) means the amount specified as the largest amount payable for basic needs in the approved State plan as in effect for January 1972 under title I, X, XIV, or XVI of the Act.

(2) *Computing the payment level modification.* The payment level modification shall be determined by computing a Reduced Payment Standard (RS) and

subtracting the maximum amount payable (PLM=RS−M).

(i) The Reduced Payment Standard shall be computed (within a category) by use of the following formula:

$$RS=(TP+TCI)\div TR$$

(TP=Total Payments for January 1972 for basic needs,
TCI=Total Countable Incomes of recipients for January 1972, and
TR=Total Number of Recipients for January 1972.)

(ii) For a State entitled to a payment level modification and for which State total countable incomes of recipients for January 1972 cannot be determined, TCI may be estimated using the following formula:

$$TCI=(TN-TP)(PS\div M).$$

(TN=PS×TR=Total Needs for January 1972.)

(e) *Bonus value of food stamps.* (1) The term ''bonus value of food stamps in a State for January 1972'' means (with respect to any individual) the difference between:

(i) The face value of the coupon allotment which would have been provided to such individual under the Food Stamp Act of 1964 (7 U.S.C. 2011 ff.) for January 1972, and

(ii) The charge which such individual would have paid for such coupon allotment.

(2) *Income schedules.* The total face value of such coupon allotment and the cost thereof for January 1972 shall be determined in accordance with the schedules prescribed by the Secretary of Agriculture. Such schedules for 48 States and the District of Columbia are those published in the FEDERAL REGISTER on January 26, 1972 (37 FR 1180). Such schedules for Alaska and Hawaii are those published in the FEDERAL REGISTER on March 3, 1972 (37 FR 4456–58). The schedule as applicable to a household of one shall be used with respect to an individual, and the schedule as applicable to a household of two shall be used with respect to a couple.

(3) *Determining bonus value.* In determining the charge such individual (or couple) would have paid for such coupon allotment, the individual's (or couple's) monthly net income will be considered to equal the State's January 1972 adjusted payment level as set forth in paragraph (a) of this section including the results of any payment level modification as described in paragraph (d) of this section but excluding the bonus value of food stamps. If such amount exceeds the maximum allowable monthly income for food stamp eligibility (as published for non-public assistance households), the bonus value is the difference between the monthly coupon allotment and the monthly purchase requirement listed in the schedule for households with the maximum allowable monthly income. (This situation may occur since public assistance households are eligible for food stamps regardless of income.)

§ 416.2090 State funds advanced for supplementary payments.

(a) *Advance payment and adjustment.* Any State which has entered into an agreement with the Secretary which provides for Federal administration of such State's supplementary payments shall pay to the Secretary either: (1) An amount equal to the Secretary's estimate of State supplementary payments for any month which shall be made by the Secretary on behalf of such State; or (2) where the provisions of § 416.2080 are applicable, an amount equal to one-twelfth of the State's non-Federal share of expenditures (as described in § 416.2082) plus the unprotected payments which are payable for the month for which funds are provided. In order for the Secretary to make State supplementary payments as provided by the agreement, the necessary amount of State funds must be on deposit with the Secretary on or before the date payments are to be received by the recipients, unless otherwise agreed to by the Secretary. The amount of State funds paid to the Secretary for State supplementary payments will be adjusted as necessary to maintain the balance with State supplementary payments paid out by the Secretary on behalf of the State.

(b) *Accounting of State funds.* (1) As soon as feasible, after the end of each calendar month, the Secretary will provide the State with a statement showing, cumulatively, the total amounts paid by the Secretary on behalf of the State during the current fiscal year; the State's total liability therefore; and the end-of-month

balance of the State's cash on deposit with the Secretary.

(2) The Secretary shall provide an accounting of State funds received and paid as State supplementary payments within 3 calendar months following the termination of an agreement under §416.2005.

(3) Adjustment will be made because of State funds due and payable or amounts of State funds recovered for calendar months for which the agreement was in effect. No interest shall be charged or payable by the Secretary or the State with respect to the adjustment and accounting of State supplementary funds.

(c) *State audit.* Any State entering into an agreement with the Secretary which provides for Federal administration of the State's supplementary payments has the right to an audit (at State expense) of the payments made by the Secretary on behalf of such State. The Secretary and the State shall mutually agree upon a satisfactory audit arrangement to verify that supplementary payments paid by the Secretary on behalf of the State were made in accordance with the terms of the administration agreement under §416.2005. Resolution of audit findings shall be made in accordance with the provisions of the State's agreement with the Secretary.

(d) *Advance payment and adjustment not applicable.* The provisions of paragraphs (a) and (b) of this section shall not apply with respect to any State supplementary payment for which reimbursement is available from the Social and Rehabilitation Service pursuant to the Indochina Migration and Refugee Assistance Act of 1975 (Pub. L. 94–23; 89 Stat. 87), as amended, since such amounts are not considered to be State supplementary payments for purposes of §416.2080.

[40 FR 7640, Feb. 21, 1975, as amended at 41 FR 36018, Aug. 26, 1976]

§416.2095 Pass-along of Federal benefit increases.

(a) *General.* This section and the four sections that follow describe the rules for passing along increases in the Federal SSI benefit to recipients of State supplementary payments.

(1) Section 416.2095(b) indicates when the pass-along rules apply to State supplementary payments.

(2) Section 416.2096 describes the basic pass-along rules. The States must have an agreement to ''pass-along'' increases in Federal SSI benefits. A State passes along an increase when it maintains (rather than decreases) the levels of all its supplementary payments after a Federal benefit increase has occurred. Generally, a pass-along of the increase permits recipients to receive an additional amount in combined benefits equal to the Federal benefit increase. Except for the supplementary payment level made to residents of Medicaid facilities (see §416.2096(d)), a State can decrease one or more of its payment levels if it meets an annual total expenditures test.

(3) Section 416.2097 explains the required combined supplementary/SSI payment level.

(4) Section 416.2098 explains how to compute the March 1983, December 1981, and December 1976 supplementary payment levels.

(5) Section 416.2099 discusses what information a State must provide to the Secretary concerning its supplementation programs so that the Secretary can determine whether the State is in compliance. That section also discusses the basis for findings of noncompliance and what will occur if a State is found out of compliance.

(b) *When the pass-along provisions apply.* (1) The pass-along requirements apply to all States (and the District of Columbia) that make supplementary payments on or after June 30, 1977, and wish to participate in the Medicaid program.

(2) The pass-along requirements apply to both optional State supplementary payments of the type described in §416.2001(a) and mandatory minimum State supplementary payments as described in §416.2001(c), whether or not these State supplementary payments are Federally administered.

(3) The requirements apply to State supplementary payments both for recipients who receive Federal SSI benefits and those who, because of

countable income, receive only a State supplementary payment.

(4) The requirements apply to State supplementary payments for recipients eligible for a State supplementary payment on or after June 30, 1977.

(5) Supplementary payments made by a State include payments made by a political subdivision (including Indian tribes) where—

(i) The payment levels are set by the State; and

(ii) The payments are funded in whole or in part by the State.

[52 FR 36241, Sept. 28, 1988, as amended at 54 FR 19165, May 4, 1989]

§ 416.2096 Basic pass-along rules.

(a) *State agreements to maintain supplementary payment levels.* (1) In order to be eligible to receive Medicaid reimbursement, any State that makes supplementary payments, other than payments to residents of Medicaid facilities where Medicaid pays more than 50 percent of the cost of their care (see paragraph (d) of this section for definition of Medicaid facility and § 416.414 for discussion of the reduced SSI benefit amount payable to residents of Medicaid facilities), on or after June 30, 1977, must have in effect an agreement with the Secretary. In this agreement—

(i) The State must agree to continue to make the supplementary payments;

(ii) For months from July 1977 through March 1983, the State must agree to maintain the supplementary payments at levels at least equal to the December 1976 levels (or, if a State first makes supplementary payments after December 1976, the levels for the first month the State makes supplementary payments). For months in the period July 1, 1982 through March 31, 1983, a State may elect to maintain the levels described in paragraph (b)(2) of this section; and

(iii) For months after March 1983, the State must agree to maintain supplementary payments at least sufficient to maintain the combined supplementary/SSI payment levels in effect in March 1983, increased by any subsequent SSI benefit increases, except as provided in § 416.2097(b) and § 416.2097(c).

(2) We will find that the State has met the requirements of paragraph (a)(1) of this section if the State has the appropriate agreement in effect and complies with the conditions in either paragraph (b) or (c) of this section. We will consider a State to have made supplementary payments on or after June 30, 1977, unless the State furnishes us satisfactory evidence to the contrary.

(b) *Meeting the pass-along requirements—supplementary payment levels.* The provisions of this paragraph do not apply to the supplementary payment level for residents of Medicaid facilities (see paragraph (d) of this section).

(1) We will consider a State to have met the requirements for maintaining its supplementary payment levels (described in § 416.2098) for a particular month or months after March 1983 if the combined supplementary/SSI payment levels have not been reduced below the levels in effect in March 1983 (or if a State first made supplementary payments after March 1983, the combined supplementary/SSI payment levels in effect the first month the State made supplementary payments), increased by any subsequent Federal SSI benefit increases, except as provided in § 416.2097(b) and § 416.2097(c). We will consider a State to have met the requirements for maintaining its supplementary payment levels for a particular month or months between June 1977 and April 1983 if the supplementary payment levels have not been reduced below the levels in effect in December 1976 (or if a State first made supplementary payments after December 1976, the levels in effect the first month the State made supplementary payments, or in certain cases described in paragraph (b)(2) of this section, the levels in effect in December 1981.)

(2) We will also consider a State to have met the requirements for maintaining its supplementary payment levels for a particular month or months in the period July 1, 1982, through March 31, 1983, if the State had met the requirements of paragraph (c) of this section for a particular month or months in the 12-month period July 1, 1981 through June 30, 1982, and, with respect to any month in the period July 1, 1982 through March 31, 1983, the State maintained the payment levels in effect in December 1981.

(3) If a State reduced any of its supplementary payment levels for a month or months within any 12-month period beginning with the effective date of a Federal benefit increase, we will consider the State to have met the requirement to maintain its supplementary payment levels if—

(i) Within 12 months after the relevant 12-month period, the State restores the levels retroactively; and

(ii) The State makes a single retroactive benefit payment to each of the beneficiaries eligible for the retroactive payment.

(c) *Meeting the passalong requirement—total expenditures. Exception*— The provisions of this paragraph do not apply to the supplementary payment level for residents of Medicaid facilities (see paragraph (d) of this section).

(1) If a State does not meet the conditions in paragraph (b) of this section, we will consider a State to have met the requirement for maintaining supplementary payment levels for a particular month or months if total State expenditures for supplementary payments in the 12-month period within which the month or months fall, beginning on the effective date of a Federal SSI benefit increase, are at least equal to the total State expenditures for supplementary payments in the 12-month period immediately before the Federal SSI benefit increase provided that the State was in compliance for such preceding 12-month period. The combined Federal/State payment level for those persons receiving a mandatory minimum State supplementary payment can be no lower than the recipient's total income for December 1973 as defined in section 212(a)(3)(B) of Pub. L. 93–66.

(2) If total State expenditures in the relevant 12-month period are less than the total expenditures in the preceding 12-month period (a ''shortfall''), we also will consider a State to have met the requirement for maintaining supplementary payment levels for the relevant 12-month period if in the following 12-month period the State increases the total expenditures required for that period by an amount at least equal to the amount of the shortfall in the relevant 12-month period. The increased amount up to the amount needed to correct the shortfall shall be deemed to be an expenditure in the relevant 12-month period, for pass-along purposes only. (See paragraph (c)(5) of this section.)

(3)(i) Exception for the 6-month period from July 1, 1983 through December 31, 1983: We will consider the State to have met the total-expenditures requirement for the 6-month period July 1, 1983 through December 31, 1983, if—

(A) Total expenditures for State supplementary payments for the period July 1, 1983 through December 31, 1983, equal or exceed the total of such expenditures for the period July l, 1982 through December 31, 1982;

(B) Total expenditures for State supplementary payments for the period January 1, 1983 through December 31, 1983, equal or exceed the total of such expenditures for the period January 1, 1982 through December 31, 1982; or

(C) Total expenditures for State supplementary payments for the period July 1, 1983 through December 31, 1983 equal or exceed one-half of the total of such expenditures for the period July 1, 1982 through June 30, 1983. The provisions of paragraphs (c)(4) and (c)(5) of this section and of § 416.2099 (b), (c), and (d) shall apply to this 6-month period in the same manner as they apply to the 12-month periods referred to therein.

(ii) Exception for the 12-month period ending June 30, 1981: If a State did not meet the conditions in paragraph (b) of this section, we will consider a State to have met the maintenance-of-supplementary-payment-levels requirement for this 12-month period if the State's expenditures for supplementary payments in that period were at least equal to its expenditures for such payments for the 12-month period ending June 30, 1977 (or, if the State made no supplementary payments in that period, the expenditures for the first 12-month period ending June 30 in which the State made such payments); if a State made additional State supplementary payments during the period July 1, 1981 through June 30, 1982, in order to make up a shortfall in the 12-month period ending June 30, 1981 (determined by a comparison with the preceding 12-month period) which later resulted in an excess payment

(determined by comparison with the 12-month period July 1, 1976 through June 30, 1977) we will credit the State with the amount of the excess payments if the State so requests. This credit will be applied to any shortfall(s) in total expenditures (should one exist) in any period(s) ending on or before December 31, 1986.

(4) Total State expenditures for supplementary payments are the State's total payments for both mandatory minimum and optional State supplementary payments in the appropriate 12-month period less any amounts deemed to be expenditures for another 12-month period under paragraph (c)(2) of this section, less the amount of any payments recovered and other adjustments made in that period. Total State expenditures do not include State administrative expenses, interim assistance payments, vendor payments, or payments made under other Federal programs, such as titles IV, XIX, or XX of the Social Security Act.

(5) Adjustments in total State supplementary payments made after the expiration of the relevant 12-month period for purposes of meeting total State expenditures under paragraph (c) of this section shall be considered a State expenditure in the relevant 12-month period only for purposes of the pass-along requirement. For purposes of § 416.2080, which discusses the rules for limitation on fiscal liability of States (hold harmless), these retroactive adjustments are State expenditures when made and shall be counted as a State expenditure in the fiscal year in which the adjustments are made.

(d) *Payments to residents to Medicaid facilities.* A Medicaid facility is a medical care facility where Medicaid pays more than 50 percent of the cost of a person's care. In order to be eligible to receive Medicaid reimbursement, any State that has a supplementary payment level for residents of Medicaid facilities on or after October 1, 1987, must have in effect an agreement with the Secretary to maintain such supplementary payment level at least equal to the October 1987 level (or if a State first makes such supplementary payments after October 1, 1987, but before July 1, 1988, the level for the first month the State makes such supplementary payments).

[52 FR 36241, Sept. 28, 1988, as amended at 54 FR 19165, May 4, 1989; 56 FR 55453, Oct. 28, 1991]

§ 416.2097 Combined supplementary/SSI payment levels.

(a) Other than the level for residents of Medicaid facilities (see paragraph (d) of this section), the combined supplementary/SSI payment level for each payment category that must be provided in any month after March 1983 (or if a State first made supplementary payments after March 1983, the combined supplementary SSI payment levels in effect the first month the State made supplementary payments) in order for a State to meet the requirement of the first sentence of § 416.2096(b) is the sum of—

(1) The SSI Federal benefit rate (FBR) for March 1983 for a recipient with no countable income;

(2) That portion of the July 1983 benefit increase computed in accordance with paragraph (b) of this section;

(3) The full amount of all SSI benefit increases after July 1983; and

(4) The State supplementary payment level for March 1983 as determined under § 416.2098.

(b) The monthly FBR's were increased in July 1983 by $20 for an eligible individual and $30 for an eligible couple, and the monthly increment for essential persons was increased by $10 in lieu of the expected cost-of-living adjustment which was delayed until January 1984. However, in computing the required combined supplementary/SSI payment levels for the purpose of determining pass-along compliance, we use only the amounts by which the FBR's and the essential person increment would have increased had there been a cost-of-living adjustment in July 1983 (a 3.5 percent increase would have occurred). These amounts are $9.70 for an eligible individual, $14.60 for an eligible couple and $4.50 for an essential person.

(c) For the 24-month period January 1, 1984, through December 31, 1985, a State will not be found out of compliance with respect to its payment levels if in the period January 1, 1986, through December 31, 1986, its supplementary

payment levels are not less than its supplementary payment levels in effect in December 1976 increased by the percentage by which the FBR has increased after December 1976 and before February 1986. The FBR for an individual in December 1976 was $167.80. The FBR for an individual in effect on January 31, 1986, was $336.00, an increase of 100.24 percent over the December 1976 FBR. In order for a State to take advantage of this provision for the 24-month period January 1, 1984, through December 31, 1985, the State supplementary payment levels in effect for calendar year 1986 must be at least 100.24 percent higher than the State supplementary payment levels in effect in December 1976. This provision does not apply to State supplementary payments to recipients in Federal living arrangement ''D'' (residents of a medical facility where title XIX pays more than 50 percent of the costs).

(d) The combined supplementary/SSI payment level which must be maintained for residents of Medicaid facilities is the State supplement payable on October 1, 1987, or if no such payments were made on October 1, 1987, the supplementary payment amount made in the first month that a supplementary payment was made after October 1987 but before July 1, 1988, plus the Federal benefit rate in effect in October 1987 increased by $5 for an individual/$10 for a couple effective July 1, 1988.

[52 FR 36242, Sept. 28, 1988, as amended at 54 FR 19165, May 4, 1989; 54 FR 23018, May 30, 1989]

§416.2098 Supplementary payment levels.

(a) *General.* For the purpose of determining the combined supplementary/SSI payment levels described in §416.2097(a) (i.e., the levels that must be provided in any month after March 1983), the supplementary payment level, except for the level for residents of Medicaid facilities (see §416.2097(d)), for each payment category must be no less than the total State payment for March 1983 for that payment category that a State provided an eligible individual (or couple) with no countable income in excess of the FBR for March 1983. For States that did not make supplementary payments in March 1983, the supplementary payment level for each payment category must be no less than the total State payment for the first month after March 1983 in which a State makes supplementary payments.

(b) *Calculation of the required mandatory minimum State supplementary payment level.* (1) Except for States described in paragraph (b)(2) of this section, the mandatory minimum State supplementary payment level for March 1983 is a recipient's December 1973 income, as defined in section 212(a)(3)(B) of Pub. L. 93–66, plus any State increases prior to April 1983, less any reductions made at any time after December 1973 due to changes in special needs or circumstances, less the March 1983 FBR. The amount determined under the previous sentence shall continue for April, May, and June 1983. For July 1983 and later the amount calculated in the first sentence shall continue except that it may be reduced by the amount of the July 1983 Federal increase that was not related to the cost of living (i.e., $10.30), so long as that reduction does not cause the mandatory minimum State supplementary level to fall below that required by section 212(a)(3)(A) of Pub. L. 93–66.

(2) Section 1618(c) of the Act permitted any State that had satisfied the requirements of section 1618 of the Act by the total-expenditures method for the 12-month period July 1, 1981, through June 30, 1982, and that elected to change and meet the section 1618 requirements by the maintenance-of-payment-levels method for the period July 1, 1982, through June 30, 1983, to do so by paying benefits at levels no lower than the levels of such payments in effect for December 1981. However, a recipient's December 1981 total income (December 1981 mandatory minimum State supplement plus the FBR) could not be less than the recipient's total income for December 1973 as defined in section 212(a)(3)(B) of Pub. L. 93–66. For a State that elected the option in the preceding two sentences, the mandatory minimum State supplementary payment level for March 1983 is a recipient's December 1981 total income (but not less than the total income for December 1973 as defined by section 212(a)(3)(B) of Pub. L. 93–66) plus any

State increases after December 1981 and prior to April 1983, less any reductions made at any time after December 1981 due to changes in special needs or circumstances, less the March 1983 FBR. The amount determined under the previous sentence shall continue for April, May, and June 1983. For July 1983 and later, the amount calculated under the preceding sentence defining the required March 1983 mandatory minimum State supplementary payment level would continue except that it may be reduced by the amount of the July 1983 Federal increase that was not related to the cost of living (i.e., $10.30), so long as that reduction does not cause the mandatory minimum State supplementary level to fall below that required by section 212(a)(3)(A) of Pub. L. 93–66.

(c) *Calculation of the required optional State supplementary payment level for flat grant amounts.* The optional State supplementary payment level for March 1983 for flat grant amounts is the total amount that an eligible individual (or couple) with no countable income received for March 1983 in excess of the FBR for March 1983. The amount determined under the previous sentence shall continue for April, May, and June 1983. For July 1983 and later the amount calculated in the first sentence shall continue except that it may be reduced by the amount of the July 1983 Federal increase that was not related to the cost of living (i.e., $10.30). If the State varied its payment levels for different groups of recipients (e.g., paid recipients different amounts based on eligibility categories, geographic areas, living arrangements, or marital status), each variation represents a separate supplementary payment level.

(d) *Calculation of the required optional State supplementary payment level for individually budgeted grant amounts.* The optional State supplementary payment level for individually budgeted grant amounts for March 1983 is the amount that the State budgeted for March 1983 in excess of the March 1983 FBR for an eligible individual (or couple) having the same needs and no countable income. The amount determined under the previous sentence shall continue for April, May, and June 1983. For July 1983 and later the amount calculated in the first sentence shall continue except that it may be reduced by the amount of the July 1983 Federal increase that was not related to the cost of living (i.e., $10.30).

(e) *Optional State supplementary payment level for per diem based grant amounts.* (1) The optional State supplementary payment level for March 1983 for per diem grant amounts is the total dollar amount that the State paid to an eligible individual (or couple) with no countable income at rates in effect for March 1983 (number of days in the calendar month multiplied by the March 1983 per diem rate plus any March 1983 personal needs allowance) in excess of the March 1983 FBR.

Example:

March 1983:

$15.40	Per diem rate.
×31	Days in month.
477.40	
477.40	
+42.00	Personal needs allowance.
519.40	
519.40	Combined State supplementary/SSI payment.
−284.30	March 1983 FBR.
235.10	State supplementary payment level.

(2) The optional State supplementary payment level for months subsequent to March 1983 for per diem grant amounts is the total dollar amount that the State paid to an individual (or couple) with no countable income at rates in effect in March 1983 (number of days in the calendar month multiplied by the March 1983 per diem rate plus any March 1983 personal needs allowance) in excess of the March 1983 FBR for an individual (or couple) with no countable income increased by all FBR increases subsequent to March 1983 with the exception of the July 1, 1983 increase. For the July 1, 1983 increase to the FBR, a State need pass-along only that portion of the increase which represented the increase in the cost of living adjustment (3.5 percent).

Example:

NOTE.—Example assumes the State passed along only $9.70 of the $20.00 increase in the FBR effective July 1, 1983.

The March 1983 combined supplementary/SSI payment level for a 31-day month was $519.40.

July 1983 level:	
$519.40	March 1983 combined payment.
+9.70	July 1983 COLA-equivalent.
529.10	Required July 1983 combined payment level.
529.10	Required July 1983 combined payment level.
−304.30	July 1983 FBR.
224.80	Required State Supplementary payment level.
529.10	Required July 1983 combined payment level.
−42.00	Personal needs allowance.
487.10	
487.10	
+31	Days in month.
15.71	Per diem rate.

The required July 1983 combined supplementary/SSI payment level for a 31-day month was $529.10. This amount is equal to the March 1983 combined payment amount for a 31-day month plus the July 1983 COLA-equivalent ($519.40+$9.70).

(f) *Required Optional State supplementary payment level for months prior to April 1983.* In determining pass-along compliance under the maintenance-of-payment-levels test for months from July 1977 through March 1983, we used December 1976 (or December 1981 under the circumstances described in paragraph (g) of this section) as the standard month for determining the required State supplementary payment level. To determine the December 1976 State supplementary payment levels for categories described in paragraphs (a) through (e) of this section substitute ''December 1976'' for ''March 1983'' and ''January 1977'' for ''April 1983'' whenever they appear in these paragraphs only.

(g) *Alternative required Optional State supplementary payment level for July 1982 through March 1983.* States which were in compliance solely under the total-expenditures test for the 12-month period ending June 30, 1982, had the option of substituting December 1981 for December 1976 and switching to the maintenance-of-payment-levels test for July 1982 through March 1983 (see § 416.2096(b)(2)). If this situation applies, determine the December 1981 State supplementary payment levels for categories described in paragraphs (a) through (e) of this section by substituting ''December 1981'' for ''March 1983'' and ''January 1982'' for ''April 1983'' whenever they appear in these paragraphs only.

[52 FR 36243, Sept. 28, 1988; 53 FR 4135, Feb. 12, 1988, as amended at 54 FR 19165, May 4, 1989; 54 FR 23018, May 30, 1989]

§ 416.2099 Compliance with pass-along.

(a) *Information regarding compliance.* Any State required to enter into a pass-along agreement with the Secretary shall provide appropriate and timely information to demonstrate to the Secretary's satisfaction that the State is meeting the pass-along requirements. The information shall include, where relevant—

(1) The State's December 1976 supplementary payment levels, any subsequent supplementary payment levels, and any change in State eligibility requirements. If the State made no supplementary payments in December 1976, it shall provide such information about the first month in which it makes supplementary payments;

(2) The State's March 1983 supplementary payment levels, any subsequent supplementary payment levels, and any changes in State eligibility requirements;

(3) The total State expenditures for supplementary payments in the 12-month period beginning July 1976 through June 1977, in each subsequent 12-month period, and in any other 12-month period beginning on the effective date of a Federal SSI benefit increase. The State shall also submit advance estimates of its total supplementary payments in each 12-month period covered by the agreement;

(4) The total State expenditures for supplementary payments in the 6-month periods July 1, 1982 through December 31, 1982 and July 1, 1983 through December 31, 1983; and

(5) The State supplementary payment level payable to residents of Medicaid facilities (see § 416.2096(d)) on October 1, 1987 (or, if a State first makes such supplementary payments after October 1, 1987, but before July 1, 1988, the level for the month the State first makes such supplementary payments). The State shall also report all changes in such payment levels.

(b) *Records.* Except where the Secretary administers the State supplementary payments, the State shall maintain records about its supplementary payment levels and total 12-month (or 6-month where applicable) expenditures for supplementary payments and permit inspection and audit by the Secretary or someone designated by the Secretary.

(c) *Noncompliance by the States.* Any State that makes supplementary payments on or after June 30, 1977, and does not have a pass-along agreement with the Secretary in effect, shall be determined by the Secretary to be ineligible for payments under title XIX of the Act. A State does not have an agreement in effect if it has not entered into an agreement or has not complied with the terms of the agreement. Ineligibility shall apply to total expenditures for any calendar quarter beginning after June 30, 1977, for which a State has not entered into an agreement. A State that enters into an agreement but does not maintain its payment levels or meet the total-expenditures test in a particular 12-month or transitional 6-month period, shall be determined by the Secretary not to have an agreement in effect for any month that the State did not meet the pass-along requirements during that particular period. The State shall then be ineligible for title XIX payments for any calendar quarter containing a month for which an agreement was not in effect. If a State first makes supplementary payments beginning with a month after June 1977, ineligibility shall apply to any calendar quarter beginning after the calendar quarter in which the State first makes payments.

(d) *Notices to States about potential noncompliance.* Within 90 days after the end of the relevant 12-month period, the Secretary shall send a notice to any State that has not maintained its supplementary payment levels and that appears not to have maintained its total expenditures during the period. The notice will advise the State of the available methods of compliance and the time within which corrective action must be taken (see §§ 416.2096(b)(3) and 416.2096(c)(2)) in order to avoid a determination of noncompliance. If the State fails to take the corrective action, the Secretary shall make a timely determination of noncompliance.

(Approved by the Office of Management and Budget under control number 0960–0240)

[52 FR 36244, Sept. 28, 1988, as amended at 54 FR 19165, May 4, 1989]

Subpart U—Medicaid Eligibility Determinations

AUTHORITY: Secs. 702(a)(5), 1106, 1631(d)(1), and 1634 of the Social Security Act (42 U.S.C. 902(a)(5), 1306, 1383(d)(1), and 1383c).

SOURCE: 53 FR 12941, Apr. 20, 1988, unless otherwise noted.

§ 416.2101 Introduction.

(a) *What is in this subpart.* This subpart describes the agreements we make with States under which we determine the Medicaid eligibility of individuals who receive Supplemental Security Income (SSI) benefits. It includes a general description of the services we will provide under these agreements and the costs to the States for the services.

(b) *Related regulations.* The comprehensive regulations on eligibility for the Medicaid program, administered by the Health Care Financing Administration, are in part 435 of title 42 of the Code of Federal Regulations.

(c) *Definitions.* In this subpart——

SSI benefits means Federal SSI benefits, including special SSI cash benefits under section 1619(a) of the Social Security Act. In addition, we consider a person who has special SSI eligibility status under section 1619(b) of the Social Security Act to be receiving SSI benefits.

State Medicaid Plan means a State's medical assistance plan which the Secretary has approved under title XIX of the Act for Federal payment of a share of the State's medical assistance expenses.

State supplementary payments means supplementary payments we administer for a State under subpart T of this part.

We, us, or *our* refers to the Social Security Administration.

§416.2111 Conditions for our agreeing to make Medicaid eligibility determinations.

We will agree to make Medicaid eligibility determinations for a State only if the State's Medicaid eligibility requirements for recipients of SSI benefits and for recipients of State supplementary payments are the same as the requirements for receiving SSI benefits and the requirements for receiving State supplementary payments, respectively. Exceptions: We may agree to make Medicaid eligibility determinations—

(a) For one, two, or all of the three categories of people (i.e., aged, blind, and disabled) who receive SSI benefits or State supplementary payments; or

(b) Even though the State's Medicaid eligibility requirements for recipients of SSI benefits or of State supplementary payments, or both, differ from the requirements for SSI or State supplementary payments, or both, in ways mandated by Federal law.

§416.2116 Medicaid eligibility determinations.

If a State requests, we may agree, under the conditions in this subpart, to make Medicaid eligibility determinations on behalf of the State. Under these agreements, we make the Medicaid determinations when determinations or redeterminations are necessary for SSI purposes. Our determinations may include non-SSI requirements that are mandated by Federal law. When we determine that a person is eligible for Medicaid in accordance with §416.2111 or that we are not making the determination, we notify the State of that fact.

§416.2130 Effect of the agreement and responsibilities of States.

(a) An agreement under this subpart does not change—

(1) The provisions of a State's Medicaid plan;

(2) The conditions under which the Secretary will approve a State's Medicaid plan; or

(3) A State's responsibilities under the State Medicaid plan.

(b) Following are examples of functions we will not agree to carry out for the State:

(1) Stationing of our employees at hospitals or nursing homes to take Medicaid applications;

(2) Determining whether a person is eligible for Medicaid for any period before he or she applied for SSI benefits;

(3) Giving approval for emergency medical care under Medicaid before a determination has been made on whether a person is eligible for SSI benefits;

(4) Setting up or running a State's system for requiring a person to pay part of the cost of services he or she receives under Medicaid; or

(5) Giving identification cards to people to show that they are eligible for Medicaid.

§416.2140 Liability for erroneous Medicaid eligibility determinations.

If the State suffers any financial loss, directly or indirectly, through using any information we provide under an agreement described in this subpart, we will not be responsible for that loss. However, if we erroneously tell a State that a person is eligible for Medicaid and the State therefore makes erroneous Medicaid payments, the State will be paid the Federal share of those payments under the Medicaid program as if they were correct.

§416.2145 Services other than Medicaid determinations.

We will agree under authority of section 1106 of the Act and 31 U.S.C. 6505 to provide services other than Medicaid determinations to help the State administer its Medicaid program. We will do this only if we determine it is the most efficient and economical way to accomplish the State's purpose and does not interfere with administration of the SSI program. The services can be part of a Medicaid eligibility determination agreement or a separate agreement. Under either agreement we will—

(a) Give the State basic information relevant to Medicaid eligibility from individuals' applications for SSI benefits;

(b) Give the State answers to certain purely Medicaid-related questions (in addition to any that may be necessary under §416.2111(b)), such as whether the SSI applicant has any unpaid medical

expenses for the current month or the previous 3 calendar months;

(c) Conduct statistical or other studies for the State; and

(d) Provide other services the State and we agree on.

§ 416.2161 Charges to States.

(a) *States with Medicaid eligibility determination agreement.* A State with which we have an agreement to make Medicaid eligibility determinations is charged in the following manner:

(1) If making Medicaid determinations and providing basic SSI application information for a State causes us additional cost, the State must pay half of that additional cost. ''Additional cost'' in this section means cost in addition to costs we would have had anyway in administering the SSI program.

(2) The State must pay half our additional cost caused by providing any information that we collect for Medicaid purposes and by any other services directly related to making Medicaid eligibility determinations.

(3) The State must pay our full additional cost for statistical or other studies and any other services that are not directly related to making Medicaid eligibility determinations.

(b) *States without Medicaid eligibility determination agreement.* A State with which we do not have an agreement to make Medicaid eligibility determinations is charged in the following manner:

(1) If providing basic SSI application information causes us additional cost, the State must pay our full additional cost.

(2) The State must pay our full additional cost caused by providing any information that we collect for Medicaid purposes and for statistical or other studies and any other services.

§ 416.2166 Changing the agreement.

The State and we can agree in writing to change the agreement at any time.

§ 416.2171 Duration of agreement.

An agreement under this subpart is automatically renewed for 1 year at the end of the term stated in the agreement and again at the end of each 1-year renewal term, unless—

(a) The State and we agree in writing to end it at any time;

(b) Either the State or we end it at any time without the other's consent by giving written notice at least 90 days before the end of a term, or 120 days before any other ending date selected by whoever wants to end the agreement; or

(c)(1) The State fails to pay our costs as agreed;

(2) We notify the State in writing, at least 30 days before the ending date we select, why we intend to end the agreement; and

(3) The State does not give a good reason for keeping the agreement in force beyond the ending date we selected. If the State does provide a good reason, the termination will be postponed or the agreement will be kept in force until the end of the term.

§ 416.2176 Disagreements between a State and us.

(a) If a State with which we have an agreement under this subpart and we are unable to agree about any question of performance under the agreement, the State may appeal the question to the Commissioner of Social Security. The Commissioner or his or her designee will, within 90 days after receiving the State's appeal, give the State either a written decision or a written explanation of why a decision cannot be made within 90 days, what is needed before a decision can be made, and when a decision is expected to be made.

(b) The Commissioner's decision will be the final decision of the Department of Health and Human Services, unless the State appeals the decision within 30 days after receiving it to the Department's Grant Appeals Board under procedures in 45 CFR part 16.

Subpart V—Payments for Vocational Rehabilitation Services

AUTHORITY: Secs. 702(a)(5), 1615, and 1631(d)(1) and (e) of the Social Security Act (42 U.S.C. 902(a)(5), 1382d, and 1383(d)(1) and (e)); sec. 2344, Pub. L. 97–35, 95 Stat. 867 (42 U.S.C. 1382d note).

SOURCE: 48 FR 6297, Feb. 10, 1983, unless otherwise noted.

GENERAL PROVISIONS

§416.2201 General.

Section 1615(d) of the Social Security Act authorizes payment from the general fund for the reasonable and necessary costs of vocational rehabilitation (VR) services provided certain disabled or blind individuals eligible under section 1614(a)(2), 1614(a)(3), 1619(a), or who continue to receive payment under 1631(a)(6) of the Social Security Act. The purpose of this provision is to make VR services more readily available to disabled or blind individuals, help State VR agencies and alternate participants to recover some of their costs in VR refusal situations, as described in §416.2213, and ensure that savings accrue to the general 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 §§416.2210 through 416.2211;

(b) The individual continues to receive disability or blindness payments from us, even though his or her disability or blindness 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 or blindness rolls (see §416.2212); 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 succesful rehabilitation (see §416.2213).

[55 FR 8456, Mar. 8, 1990]

§416.2202 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 or blind individuals under one or more of the three provisions discussed in §416.2201.

(a) Sections 416.2201 through 416.2203 describe the purpose of these regulations and the meaning of terms we frequently use in them.

(b) Section 416.2204 explains how State VR agencies or alternate participants may participate in the payment program under this subpart.

(c) Section 416.2206 describes the basic qualifications for alternate participants.

(d) Sections 416.2208 through 416.2209 describe the requirements and conditions under which we will pay a State VR agency or alternate participant under this subpart.

(e) Sections 416.2210 through 416.2211 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 416.2212 and 416.2213 describe when payment will be made to a VR agency or alternate participant because an individual's disability or blindness 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 416.2214 through 416.2215 describe services for which payment will be made.

(h) Section 416.2216 describes the filing deadlines for claims for payment for VR services.

(i) Section 416.2217 describes the payment conditions.

(j) Section 416.2218 describes the applicability of these regulations to alternate participants.

(k) Section 416.2219 describes how we will make payment to State VR agencies or alternate participants for rehabilitation services.

(l) Sections 416.2220 and 416.2221 describe the audits and the prepayment and postpayment validation reviews we will conduct.

(m) Section 416.2222 discusses confidentiality of information and records.

(n) Section 416.2223 provides for the applicability of other Federal laws and regulations.

(o) Section 416.2227 provides for the resolution of disputes.

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990; 59 FR 11916, Mar. 15, 1994]

§ 416.2203 Definitions.

For purposes of this subpart:

Accept the recipient 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 § 416.2204)), organizations, institutions, or individuals with whom the Commissioner has entered into an agreement or contract to provide VR services.

Blindness means ''blindness'' as defined in section 1614(a)(2) of the Act.

Commissioner means the Commissioner of Social Security or the Commissioner's designee.

Disability means ''disability'' as defined in section 1614(a)(3) of the Act.

Eligible means meets all the requirements for supplemental security income benefits under sections 1614(a)(2), 1614(a)(3), or 1619(a) and is receiving SSI payments or continues to receive benefits under section 1631(a)(6) of the Act.

Good cause for VR refusal (as described in § 416.2213) is defined in § 416.1715 of this part.

Medical recovery for purposes of this subpart is established when a disabled or blind recipient's eligibility ceases for any medical reason (other than death). The determination of medical recovery is made by the Commissioner in deciding a recipient's continuing eligibility for benefits.

Place the recipient 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 Health and Human Services or the Secretary's designee.

SGA means substantial gainful activity performed by an individual as defined in §§ 416.971 through 416.975 of this subpart or § 404.1584 of this chapter.

State means any of the 50 States of the United States, the District of Columbia, or the Northern Mariana Islands. It includes the State VR agency.

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.

We, us, and *our* refer to the Social Security Administration (SSA) or the Secretary, as appropriate.

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990; 55 FR 19423, May 9, 1990; 59 FR 1637, Jan. 12, 1994; 59 FR 11916, Mar. 15, 1994]

§ 416.2204 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 § 416.2206.

(b) *Participation by States.* (1) The opportunity to participate through its VR agency(ies) with respect to disabled or blind recipients 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 disabled or blind recipients. 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 recipients in the State in accordance with paragraph (d) of this section. We would arrange for VR services for disabled recipients 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 disabled or blind recipients in the State by referring such recipients first to the State VR agency(ies) for necessary VR services. A State, through its VR agency(ies), may participate with respect to any recipient so referred by accepting the recipient as a client for VR services or placing the recipient 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 disabled or blind recipient 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 recipient as a client for VR services or to place the recipient 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 recipient to the State VR agency. If we do not receive such notice with respect to a recipient whom we referred to the State VR agency, we may arrange for VR services for that recipient 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 recipient 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 recipient as a client for VR services. If we receive a notice of a decision by the State VR agency to accept the recipient as a client for VR services following the completion of the extended evaluation, the State may continue to participate with respect to such recipient. If we receive a notice of a decision by the State VR agency not to accept the recipient as a client for VR services following the completion of the extended evaluation, we may arrange for VR services for that recipient 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 disabled or blind recipients in the State, we will give the State the opportunity to participate with respect to such class(es) of disabled or blind recipients by referring such recipients first to the State VR agency(ies) for necessary VR services. The State, through its VR agency(ies), may participate with respect to any recipient so referred by accepting the recipient as a client for VR services or placing the recipient 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 disabled or blind recipients in the State, or it may choose to limit participation of its VR agency(ies) to a certain class(es) of disabled or blind recipients 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 disabled or blind recipients in the State.

(ii) If a State has decided to limit participation of its VR agency(ies) to a certain class(es) of disabled or blind recipients, we may arrange for VR services through an alternate participant(s) for the class(es) of disabled or blind recipients 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 disabled or blind recipient 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 recipient 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 disabled or blind recipients in that State:

(1) A disabled or blind recipient 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 recipient as a client for VR services or to place the recipient into an extended evaluation process;

(2) A disabled or blind recipient 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 recipient as a client for VR services following the completion of the extended evaluation;

(3) The class(es) of disabled or blind recipients 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 disabled or blind recipients in the State if the State has decided not to participate through its VR agency(ies).

[59 FR 11917, Mar. 15, 1994]

§ 416.2206 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 § 416.2204(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 §416.2204(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 11918, Mar. 15, 1994]

PAYMENT PROVISIONS

§416.2208 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 §416.2216;

(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 §416.2215;

(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 §416.2214;

(e) The individual must meet one of the VR payment provisions specified in §416.2201;

(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 disabled or blind recipients 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 §416.2217.

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990; 59 FR 11918, Mar. 15, 1994]

§416.2209 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 or blindness recipient whose disability or blindness has ceased should continue to receive payments under section 1631(a)(6) of the Social Security Act for a month after October 1984 or, in the case of a blindness recipient, for a month after March 1988, 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 an individual's disability or blindness payment should be suspended;

(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 § 416.2214; and

(h) What VR costs were reasonable and necessary and will be paid.

[55 FR 8456, Mar. 8, 1990, as amended at 59 FR 11918, Mar. 15, 1994]

§ 416.2210 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 §§ 416.972 through 416.975. 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) of this chapter.

(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 § 416.974(b)(2), or § 404.1584(d) of this chapter 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 1, 1981, during a trial work period, and after eligibility for disability or blindness payments ended. We will ordinarily consider only the first 9 months of SGA that occurs. The exception will be if an individual who completed 9 months of SGA later stops performing SGA, received VR services and then performs SGA for a 9-month period. See § 416.2215 for the use of the continuous period in determining payment for VR services.

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8457, Mar. 8, 1990]

§ 416.2211 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 § 416.2214 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 6297, Feb. 10, 1983, as amended at 59 FR 11918, Mar. 15, 1994]

§416.2212 Payment for VR services in a case where an individual continues to receive disability or blindness payment based on participation in an approved VR program.

Section 1631(a)(6) of the Social Security Act contains the criteria we will use in determining if an individual whose disability or blindness has ceased should continue to receive disability or blindness payments 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 payments in a month or months after October 1984, or, in the case of blindness payments, in a month or months after March 1988, based on this provision. 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 §416.2215, subject to the other payment and administrative provisions of this subpart.

[55 FR 8457, Mar. 8, 1990]

§416.2213 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 §416.2209(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 the individual's monthly disability or blindness payment has been suspended or terminated for a

month or months after October 1984 because of VR refusal.

[59 FR 11919, Mar. 15, 1994]

§ 416.2214 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 or blind 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 11919, Mar. 15, 1994]

§416.2215 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) During months the individual is eligible for SSI disability or blindness payments; and

(3) Before completion of a continuous 9-month period of SGA.

(b) Where disability or blindness payments are made simultaneously to an individual based on the provisions of both this part and part 404, the determination as to when services must have been provided may be made under this section or §404.2115, whichever is advantageous to the State VR agency or alternate participant that is participating in both VR programs.

[55 FR 8457, Mar. 8, 1990]

§416.2216 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 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 or blindness benefits were continued after disability or blindness 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 or blindness benefit payments are suspended because of VR refusal, or if later, within 12 months after the month of publication of this section.

[55 FR 8457, Mar. 8, 1990]

§416.2217 What costs will be paid.

In accordance with section 1615(d) of the Social Security Act, the Secretary will pay the State VR agency or alternate participant for the VR services described in §416.2214 which were provided during the period described in §416.2215 and which meet the criteria in §416.2211, §416.2212, or §416.2213, 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 §416.2214. 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 general funds (a ''net saving'' is the difference between the estimated savings to the general fund, if payments for disability or blindness remain reduced or 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 Janauary 28, 1981 (see § 416.2218(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 §§ 416.2211 through 416.2213 of this subpart and similar provisions in §§ 404.2111 through 404.2113 of subpart v of part 404. 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 6297, Feb. 10, 1983. Redesignated and amended at 55 FR 8457, 8458, Mar. 8, 1990; 55 FR 14916, Apr. 19, 1990; 59 FR 11919, Mar. 15, 1994]

ADMINISTRATIVE PROVISIONS

§ 416.2218 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 part 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 6297, Feb. 10, 1983. Redesignated at 55 FR 8457, Mar. 8, 1990]

§416.2219 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 8458, Mar. 8, 1990]

§416.2220 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. They 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 §416.2218(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 the 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 6297, Feb. 10, 1983, as amended at 55 FR 8458, Mar. 8, 1990]

§416.2221 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 §416.2201(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 §416.2201(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 § 416.2227. For purposes of this section, an appeal must be filed within 60 days after receiving the notice of our determination.

[59 FR 11920, Mar. 15, 1994]

§ 416.2222 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 § 416.2223).

§ 416.2223 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.

§ 416.2227 Resolution of disputes.

(a) *Disputes on the amount to be paid.* The appropriate SSA official will notify the State VR agency or alternate participant in writing of his or her determination concerning the amount to be paid. If the State VR agency (see § 416.2218(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 disabled or blind beneficiary's rights to benefits.* Determinations made by the Secretary which affect an individual's right to benefits (e.g., determinations that disability or blindness 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 intergral part of the disability or blindness 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 6297, Feb. 10, 1983, as amended at 55 FR 8458, Mar. 8, 1990]

PART 422—ORGANIZATION AND PROCEDURES

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SOURCE: 32 FR 13653, Sept. 29, 1967, unless otherwise noted.